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Submission to the 2022 Review of the Aged Care Quality Standards

November 2022

About the Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 20,000 medical specialist physicians and 9,000 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients and the community.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the review of the Aged Care Quality Standards and the opportunity to provide feedback.

The Standards are foundational in describing the level of care and services the community can expect from organisations providing aged care. Physicians who provide healthcare services to older persons in the community and in residential aged care facilities (RACFs) play a vital role in the assessment, diagnosis, management of older people, as well as key medical leadership. As healthcare providers the goal is to ensure older people receive safe, high quality, timely and comprehensive health care.

The RACP feedback on the revised Standards reflect the expert views of physician contributors. We respond as a medical member-based peak body. The feedback covers two aspects: where a relevant element has been omitted, and where further definition or specificity is needed to ensure providers are able to respond to the Standards as intended.

Key points recommended for inclusion:

- That providers have a moral duty to ensure older people under their care can access the healthcare services they need. This should be explicit and underpin Standard 5 as the users of aged care services have complex healthcare needs.
- That providers have an obligation to facilitate timely access to good quality primary and specialist medical care, as well as multidisciplinary allied health care, as a prefacing statement with respect to residential aged care.
- Reference to specialist medical care (meaning consultant physicians). This is not referred to in the Standards. For example, geriatricians are not mentioned in the Standards. As experts in the health care of older persons they are a crucial inclusion.
- Greater emphasis on access to clinical care that supports rehabilitation and reablement. Reablement is currently only mentioned in the context of Outcome 3.2, and Action 6.4.3. There is an integral relationship between medical illness, functional decline and quality of life for older people and rehabilitation and reablement plays a critical role.

Key points on which further expansion is recommended:

- *Supported decision-making and capacity.* This is a principal area of the Standards that warrants additional explanation and guidance for providers. Our feedback below highlights aspects for your consideration.
- *Complexity of decision making*. This relates to the above point when capacity is referred to. The complexity of decision making with older people with impaired cognition, including dementia, is not sufficiently recognised in the Standards.
- *Culturally safe care*. Culturally safe care needs to be embedded as a core principle across all standards in the health and aged care sectors. Whilst culturally safe care has been included in the Standards, the extent of and approach to this needs to be strengthened.
- *Areas that use general and non-specific language and rely on the broad term "processes*". There are areas in the Standards where the language is general and refers to "processes", which we suggest is not sufficient to assist providers, nor ensure the needed changes are introduced effectively. There is a risk of the requirements not being fully understood.

We acknowledge and welcome that the Standards place specific emphasis on the needs of people with dementia.

Feedback

The following feedback relates to two of the survey questions:

6. Are there opportunities to make the revised Quality Standards more meaningful and empowering for older people?

7. Are there any outcome statements or actions that could not readily be demonstrated by providers?

The feedback below primarily focuses on Standard 5 but offers additional constructive comments on the other Standards.

Standard 5: Clinical care of older people

This Standard is important because if the healthcare needs of older persons are not adequately addressed often functional decline follows, leading to increased dependency, as well as a decline in quality of life and wellbeing.

It is recommended this Standard would be improved by:

- Including a prefacing statement with respect to residential aged care, that the provider has an obligation to facilitate timely access to good quality primary and specialist medical care, as well as multidisciplinary allied health care. Although this may appear to be covered somewhat under Outcome 3.4: Coordination of care and services, this is not sufficient and should be a specific part of Standard 5.
- Mentioning the role of specialist medical care, in particular the importance of access to specialist geriatric services. Specialist medical care (meaning consultant physicians) is not referred to in the Standards. For example, geriatricians are not mentioned in the Standards. As experts in the health care of older persons they have a crucial role. Geriatricians have extensive expertise in the assessment and management of the complex multidimensional health problems faced by older people, are skilled in recognising the impact of potentially reversible health conditions on function, and have expertise in rehabilitation of older people. They are also experts in the assessment and management of dementia, the prevalence of which in aged care settings is acknowledged in the Standards and associated materials.
- Including the need to facilitate timely access to specialist palliative care services. At any given time, a substantial proportion of people in residential aged care are approaching the end of life, and many will have complex care needs as death approaches. Timely access means potentially futile and burdensome interventions can be avoided, care priorities re-evaluated, and older people and their loved ones provided a better experience at the end of life.

Outcome 5.1: Clinical governance

- Provider actions should cover the following provisions:
  - Availability of an appropriately equipped, maintained and private space for consultation and treatment. This should include equipment to support use of telehealth services.
  - Availability of (preferably) nursing and/or other care staff to enable adequate clinical handover and support consultation and treatment.
  - Ready access to information systems. While the Standards appear to distinguish between clinical information systems (eg. Action 5.1.3) and information systems designed to support routine assessment and delivery of everyday care and services (eg. Outcome 3.3), the boundary between these information systems is not distinct, and it is critical that healthcare providers can gain access to all information that may be relevant in the circumstance.
- It is noted that the Action 5.1.5 requires providers to "… *implement a system for identifying capacity and obtaining informed consent from the older person prior to clinical care being provided."* This may require more guidance, ie. how a system for identifying capacity could be introduced. A high proportion of residents may be living with dementia or cognitive impairment, so how is informed consent obtained for those without capacity, as well as how the relevant substitute decision maker is identified.

- We suggest an action should support the active involvement of the older person, their care partners, substitute decision makers, and other healthcare providers, in their healthcare assessment and planning, in accordance with the person's wishes and capabilities. This is not the same as Action 5.1.6 "*The provider implements a system for older people to be partners in their own clinical care"*. The recommendation we make here involves ensuring that a care partner or substitute decision maker is present (either in-person or virtually) at the time of a healthcare consultation, and also ensuring the provision of appropriate interpreter services.
- We suggest there be a requirement that appropriate health care follow-up and onward referral is acted upon and occurs.
- Greater emphasis is vital in these Standards regarding access to clinical care that supports rehabilitation and reablement. There is an integral relationship between medical illness, functional decline, and quality of life for older persons. Access to **co-ordinated multidisciplinary** allied health services is an essential component of clinical care in this regard. It is noted that reablement is mentioned in Outcome 3.2, and Action 6.4.3 but should also be part of Standard 5.

Outcome 5.2: Preventing and controlling infections in clinical care

- The appropriate use of antibiotics should be expanded upon in terms of how this might be achieved by a provider.

Outcome 5.3: Medication Safety

- We suggest it is relevant to include an action for timely access to geriatricians as medical specialists with competencies in the comprehensive review of medications, management of polypharmacy, and deprescribing (see Action 5.3.2):
  - Geriatricians have an important role supporting general medical practitioners (and providers) in achieving medication safety outcomes for their older patients.
  - Geriatricians are trained to recognise potentially inappropriate medications and evaluate the relative risks and benefits of medicines and incorporate this evaluation into a comprehensive holistic assessment of the older person.
  - Geriatricians have expertise in the management of changed behaviours in the context of dementia, including the appropriate use of psychotropic medicines.
- For Action 5.3.5 reference to the definitions of high-risk medications will need to be included, along with guidance on how inappropriate use of antipsychotics will be reduced.

Outcome 5.4: Comprehensive Care

- Where the outcome statement for this refers to clinical safety risks to older people being identified, managed and minimised, we recommend more clarity for providers on the nature of the clinical safety risks to which this is referring.
- We suggest the following amendments to Action 5.4.2:
  - Rewording to be less broad and more achievable.
  - Adding more detail on how this might be done.
  - Adding how it would be measured or confirmed to have been achieved.
- We suggest that Action 5.4.8 requires further guidance or explanation for providers. Whilst it is a worthy action to for providers to implement processes for the early recognition of dementia and delirium, information suggests this is not done as the 'norm' and would constitute a change in practice and implementation of new processes.
- Similarly with falls, Action 5.4.10, we suggest a detailed clinical guideline to accompany this requirement to make it actionable. Additional detail that would support achievement of this outcome would include a definition of falls, description of what is "timely assessment", what is meant by minimising falls, post fall management, and maximising mobility (for example, if this is to include the use of a mobility aid, the number of steps taken etc).
- More information in this outcome is needed on the role of allied health, such as expectations of access (refer to Action 5.4.8 for example). We suggest access to co-ordinated multidisciplinary

allied health services is an essential component of reablement and clinical care as referred to earlier.

Outcome 5.5: Care at the end of life

- On Action 5.5.1 "*the provider has processes to recognise when the older person is approaching the end of life, supports them to prepare for the end of life and responds to their changing needs and preferences",* we suggest the addition of further details would assist providers to undertake this action. For example, stating how providers are to recognise end of life, where responsibility sits for doing this, if referrals should go to general practitioners or specialists, how "end of life" is defined and the tools used, and management of terminal care.
- Action 5.5.3 should specify the need to facilitate access to palliative medicine physicians as required for symptom management. There is a distinction between specialist palliative care services and specialist palliative medicine physicians.
- On Action 5.5.4 "*the provider implements processes to minimise harm to older people in the last days of life",* similar detail is required as for Action 5.5.1. For example, guidance on how the provider is to recognise the last days of life, and how they would recognise delirium, if a tool is to be used etc.
- Regarding "*(d) minimising unnecessary transfers to hospital*", how this would be measured should be addressed. Regarding *"(e) ensure that medicines to manage pain and symptoms are prescribed, administered and available 24-hours a day",* it needs to be acknowledged that access to medications are not currently available 24 hours a day, therefore some additional provisions need to be made. We also raise the query as to whether providers will be supported to have an IMPREST system.[1]
- Further consideration on how providers are expected to provide *"early recognition, referral and medications for delirium and dementia"* is warranted.

Capacity, capacity assessment and supported decision making

We suggest the issue of capacity needs further consideration within the Standards, particularly related to decision making. Decision making has inherent complexity when it concerns older people with impaired cognition, including dementia.

Overarching guidance is needed that recognises the complexity of capacity assessment and its navigation. Practical guidance about how to implement Standard 1 (including considerations of supported decision making and use of valid surrogate decision makers, for example in Actions 1.3.3 and 1.3.4) with older people with cognitive impairment is recommended as providers are likely to need support navigating capacity assessment.

On Standard 5, Action 5.1.5 requires "*the provider implements a system for identifying capacity and obtaining informed consent from the older person prior to clinical care being provided".* Further guidance is needed on this important issue. Conflict situations can arise when people deemed to have impaired capacity assert their autonomy in ways that are perceived to be contrary to their best interest.

Restrictive practices

We suggest the following for Action 3.2.5:

- Defining restrictive practices.
- Defining the use of secure areas.
- Adding reference to compliance with legislative requirements, for example, that approved providers have specific responsibilities under the *Aged Care Act 1997* and the *Quality of*

[1] 'Imprest drugs' describes Schedule 4 and Schedule 8 poisons that are not supplied on prescription for a specific person, but which are obtained by an establishment under the authority of a Health Services Permit (HSP)

Care Principles 2014 (updated in 2021) relating to the use of any restrictive practice in residential aged care or short-term restorative care in a residential care setting.

- Add details regarding the reporting and reviewing of this action.
- Consideration that the older person needs to consent to restrictive practices as this is not usually possible if the person does not have capacity.

Cultural safety

Culturally safe care is a core principle for the health and aged care sectors. Whilst culturally safe care has been included in the Standards, the extent of and approach to this needs to be strengthened. We have highlighted areas where this can be improved, drawing on our existing body of work that has been led by Aboriginal and Torres Strait Islander members and partner organisations.

Cultural safety is a core principle, which requires reflection from providers on their own attitudes and biases, and this extends to all aspects of care. More emphasis on culturally safe care requiring providers to focus on their own cultural identities and attitudes is required. The RACP Indigenous Strategic Framework provides useful background on this and notes that "*an important principle of cultural safety is that it doesn't ask people to focus on the cultural dimensions of any culture other than their own*."

We support the use of the definition of 'cultural safety' from the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 in the Standards, however, the elements listed in the 'How to' section of the definition have not been included. We include it here for reference:

How to:
To ensure culturally safe and respectful practice, health practitioners must:

a) *Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health.*
b) *Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism.*
c) *Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community.*
d) *Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.*

Inclusion of this 'How to' information would both provide more tangible guidance to providers, while more meaningfully capturing the principle of cultural safety highlighted above.

The Standards often group the need for culturally safe care with trauma- and healing-informed care. While there are similarities in these concepts, cultural safety is much broader than this and the National Plan recognises that effective trauma- and healing-informed care for Aboriginal and Torres Strait Island people requires a level of cultural safety to already exist. To emphasise that cultural safety is a core principle and a pre-requisite to all other aspects of care for Aboriginal and Torres Strait Islander people, it could be listed separately and before other points. For example, in 1.1.2, delivering care that is culturally safe should be listed before strategies for identifying the older person's individual background, culture, diversity and beliefs.

Cultural safety needs to be included in all the Standards. While it is included in numerous sections of the document, it is not included in sections 4 – 'The Environment', 6 – 'Food and Nutrition', and 7 – 'The Residential Community.

Healthy eating approaches

Noting that Standard 6 is intended to apply only to residential aged care services we refer here to a statement in the intent section *"support older people to eat all the food they want".* This statement could be modified to better reflect good health and dietary advice and refer to appropriate guidelines as these are applicable for all persons, regardless of age.

Healthy eating is designed to reduce the risk of tooth decay and unhealthy weight and other ailments. For some residents this can be serious and have implications for the provision of care. The reference to contemporary evidence-based practice is acknowledged (Action 6.1.2), however the statement of intent should align.

It is noted there is no reference to access to alcohol and/or recreational drugs in the Standards and this is an oversight for providers.

Closing remarks

The RACP's feedback on the Standards describes numerous areas on which the addition of further clarity, definition and explanation will better enable providers to consistently and confidently operationalise and adhere to the Standards. It is also important that direct reference be made to consultant physicians with respect to the health care of older persons, for whom timely comprehensive care and early diagnosis can be critical.

Further, the RACP emphasises the need for there to be guidelines that sit alongside these Standards to ensure the effective and correct implementation of the Standards and to mitigate the risks of poor or inadequate implementation. It would be appropriate and sensible as healthcare experts for the RACP to have representation and a strong role in the development of guidance documents regarding the care and wellbeing of older persons.

For engagement on this important matter, please contact Policy and Advocacy via email policy@racp.edu.au for any additional information.