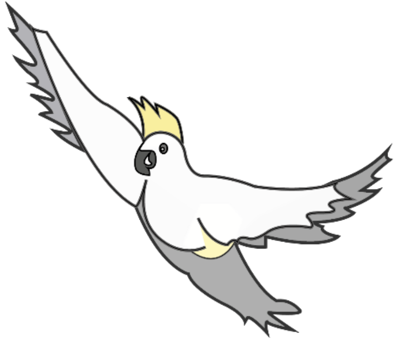

SARRAH

Services for Australian Rural and Remote Allied Health

25 November 2022

Attention: Joshua Maldon

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Services for Australian Rural and Remote Allied Health (SARRAH) submission: Aged Care Quality Standards

Thank you for the opportunity to contribute to consultation process for the revised Aged Care Quality Standards. We note that the consultation encourages feedback through the on-line survey, rather than in writing. For the sake of completeness, we will respond to the on-line survey, but felt there are important issues that warrant consideration regarding the Quality Standards that are not readily conveyed through the on-line survey structure.

As background, **SARRAH is the peak body representing rural and remote allied health professionals** (AHPs) working in the public and private sector, across aged care, health, disability, and other services and settings. SARRAH advocates on behalf of rural and remote Australian communities to improve access to allied health services that support equitable and sustainable health and well-being, including to support aged Australians to maintain and recover the ability to make choices about their own lives, to act on those choices and pursue what they value in life, supporting independence, dignity and autonomy. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians.

SARRAHs priorities and approach to aged care services is consistent with those we consider most beneficial, effective and sustainable in health care, disability or other services: to prioritise person-centred, enabling and collaborative models of care that optimise individuals' outcomes.

Overarching comments

The revised Standards provide a sound and necessarily broad base around which to strengthen the development, delivery and effective monitoring oversight of monitor an appropriate aged care system. There is scope for the Standards to be further improved, and our specific comments, following, aim to assist in this regard. In the main, the expectations are clear and well supported.

However, a fundamental concern remains that improving Standards and stated expectations does not mean they will be met. They must be backed up with:

- policy and programs that enable them to be met (e.g., having available workforce and skills, especially in rural and remote Australia) and
- robust and effective quality improvement and compliance regimes that match the expectations and provide assurance to aged care recipients and others that the standards are being applied in good faith.

SARRAH recognises the Standards are one element of an extensive, multi-faceted reform of Australia's Aged Care system. We understand other major reform elements are being progressed in response to the specific Recommendations of the Aged Care Royal Commission (ACRC) or otherwise. However, it is also important to recognise that Australia's aged care system has included quality standards and expectations over a long period, yet as the Royal commission found, sector performance and the assurance of quality care has been seriously wanting.

SARRAH is concerned that several of the Recommendations of the Royal Commission are not being acted on with any priority and this is exposing aged care residents to serious continuing sub-standard care and risk: which are acknowledged in many respects by the content of the Quality Standards but have yet to be acted on in any tangible way so as to significantly promote or ensure the adherence by providers to the Quality Standards.

Allied health is referred to more than 30 times in the ACRC Recommendations, including:

> ***Recommendation 36: Care at home to include allied health care***
>
> > *1. From 1 July 2023, the System Governor should ensure care at home includes a level of allied health care appropriate to each person's needs.*
>
> ***Recommendation 38: Residential aged care to include allied health care***
>
> > *To ensure residential aged care includes a level of allied health care appropriate to each person's needs, the System Governor should, by no later than 1 July 2024:*

The Recommendations provide a timeframe for actions to be ensured, allowing for implementation timeframes. However, we believe it is unlikely that identifying those timeframes the Commissioners considered the level and quality of allied health care provided to Aged Care recipients should diminish until that time.

The actual risks for Aged Care residents now – despite existing Standards and the prospect of revised Standards being applied - is the fact the Aged Care Royal Commission:

- was advised that an average of 22 minutes in allied health care per resident per day would be appropriate benchmark,
- found an average of 8 minutes per day was being delivered; and

- we understand that figure is now being reported as being around 2 minutes per day - or about 10 per cent of the benchmark level suggested to the Royal Commission.

There are many issues that impact the capacity and quality of aged care service provision nationally, not the least of which is workforce availability and distribution. The underlying maldistribution of allied health workforce, with severe, chronic shortages across rural and remote Australia, presents an enormous challenge to ensuring providers are able or will prioritise delivery of allied health services to support the application of the revised (or any other reasonable) Standard of quality care. These are serious contextual factors that directly impact the application and delivery against the Standards and, to date, they have received little attention in Governments' response to the ACRC or community need.

SARRAH would welcome the opportunity to work with the Government and other stakeholders to address these challenges.

Detailed comments

Standard 1

1.1.3 - noting "respect for autonomy" – we suggest this be reinforced with a note that indicates this should include supporting the maintenance and recovery of autonomy where it is reduced or lost.

Re: Choice – we note the Standards include comment on informed choice, however, this also could be reinforced to promote an understanding of "choice" generally as being informed and active. (1.3.1)

1.3.5 – "Dignity of risk" is an important concept and strongly support it. Autonomy involves risk, inherently, however that risk can be minimised with effective interventions. To balance the issues, SARRAH suggests including a dot-point or note that explicitly identifies the risks associated with inaction/ avoidance of risk, such as physical and cognitive decline and loss of independence.

1.4 – Re: transparency of agreements, including costs, fees etc. These are important considerations which should also include discussion/ communication about the level and quality of enabling services (e.g., therapies) that are, may, are not covered in costs: to inform choice.

Standard 2

It is crucial that services delivered to aged care recipients are delivered by qualified and competent staff.

We welcome the clear information in the revised Standards explaining that provision of appropriate clinical care is a responsibility for governance bodies (including provider Boards) and that that accountability extends to ensuring competent qualified people provide expert services to aged care recipients and that other staff, not qualified to do so, are not put in a position where they put themselves or aged care recipients at risk.

2.4.2 – suggest another dot point be added to highlight the risks associated with inaction and promotes proactivity/facilitation of enabling capacity maintenance etc.

2.5 –Incident Management – suggest further explanation be added to the notes, along the lines of the following – an *omission or circumstance could include absence of prevision of therapies to maintain strength and mobility resulting in a fall and/or avoidable hospitalisation.*

2.8 Workforce Planning – As noted in the overarching comments, workforce shortages pose a major systemic challenge and risk to the aged care system. SARRAH notes the particular challenges faced through the lack of allied health workforce and service capacity in rural and remote Australia and the need for this to be addressed nationally and at a multi-system level as a matter of urgency.

Without suggesting the Quality Standards should be compromised to reflect the implications of these shortages, it is important that providers and other stakeholders are supported to mitigate and manage the risks involved and to attempt to satisfy the Quality Standards as best they can in the circumstances.

Standard 3

We recommend strengthening the expectation that clinical care needs at entry and review involve multi-disciplinary teams with the expertise to ensure a thorough assessment, that opportunities for effective and beneficial care are not missed and avoidable problems and deterioration is averted, saving the aged care recipients and the system poorer outcomes and cost.

We commend the expectation inherent in Standard 3 – for example, *3.1.4 c) include information about the risks associated with care and service delivery and how workers can support older people to manage these risks*.

Re: *Care and service plans are reviewed regularly, including when:*
3.1.5 b) the older person's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes

- We suggest the Quality Standard also include consideration of where such a deterioration or change occurs that the include prospects for regaining/stabilising the situation be assessed.

Standard 5

Standard 5 (and others) mention allied health services but there remains a disconnect between the Standards and the AN-ACC tool, which does not establish any minimum care standards (which would be appropriate in a system that professes to value prevention and the retention of independent capacity). Further allied health care is implicit across the range of clinical care standards (and others) but there is no commensurate clarity or certainty of these being funded or delivered.

To reiterate an overarching point, it is unclear how this Standard will be met or enabled given severe allied health workforce shortages in rural and remote Australia. With regard to services and workforce commitments, we note the different views of Commissioners Briggs and Pagone

regarding whether allied health services should be ensured through direct employment. Direct employment of a minimum profile of allied health professionals (favoured by Commissioner Briggs) would pose specific difficulties for smaller and rural and remote providers especially. Less prescriptive engagement arrangements (favoured by Commissioner Pagone) would still confront chronic workforce supply difficulties. These issues cannot be ignored in applying Quality Standards that serve a purpose.

With regards to Falls and Mobility, which are grouped together. There is an innate tension between and need to balance the objective of optimising mobility and the increased risk of falls that comes with increasing/increased mobility. This tension is reflected in other aspects of the revised Standards which recognise risk as a factor that should be managed rather than avoided in efforts to enable, maintain and enhance independence and informed individual choice. Achieving a genuine, person-centred balance of these factors can be particularly difficult in risk-averse environments (as are many aged care settings), especially where cost-factors and other provider imperatives influence behaviour.

Independent assessment and review capacity needs to exist monitor and act, as needed, in ensuring the Standards are being applied in a balanced way and in line with the informed and enabled choice of the individual.

5.3 Medication Safety – SARRAH suggests that comment be added as a dot point action or in the notes that consider whether medication is the most appropriate and best treatment, whether an alternative therapy might be appropriate as a complement or possible option for reducing medication reliance (e.g., in pain management). Similarly, this option should be considered when medications are being reviewed. This would be consistent with a multi-disciplinary, person-centred approach to care.

5.4.2 – Significant functional decline would be associated with several of the conditions/events listed, however it might be listed as a “clinical safety risk” in its own right and prompt important assessments to be done.
5.4.10 – Falls and Mobility – it may better align with the onus on wellness and prevention if point c) *maximises mobility to prevent functional decline* were moved to point a).

If you would like to discuss issues raised in SARRAHs response or require further information, please contact me at catherine@sarrah.org.au or Allan Groth at allan@sarrah.org.au. More information about SARRAH is available on our website.

Yours Sincerely

Cath Maloney
Chief Executive Officer