<table>
<tr><th>THEME</th><th>ISSUES IDENTIFED/ PRESENTED AT THE ROYAL COMMISSION</th><th>POTENTIAL OUTCOMES/ DIRECTIONS</th></tr>
<tr><td>Accessibility and transparency of the aged care system

(Volume 1, Part 3, Section 5)</td><td><u>Accessibility</u>
• The current aged care system assumes users are computer literate and have computer access.
• My Aged Care ('MAC') is not an appropriate interface for many elderly people, including culturally and linguistically diverse ('CALD') people, Aboriginal and Torres Strait Islander ('ATSI') people, and people with cognitive impairments.
• Insufficient number of interpreters available generally through MAC, and no provision of AUSLAN interpreters.
<u>Transparency</u>
• There is a lack of information available to the general public about the performance of aged care service providers, with the number of complaints, assaults and staff at a facility not being published.
• Taxpayers have a right to expect that a sector heavily funded by them should be open and accountable.
<u>Entry into aged care</u>
• The Commissioners heard evidence about how entry into residential care was commonly associated with a loss of autonomy, individuality, control and freedom.</td><td><u>Accessibility</u>
• Detailed information about the kinds of care and services available in a consumer's local area, who provides them, the costs of care, what level of government subsidy is available, the quality of the services available, and any assessment arrangements.
• The provision of face-to-face local supports to link older people with local services, and the expansion of the Victorian Government's Aged Care Navigator trials across Australia.
• Additional resources dedicated to interpreters.
<u>Transparency</u>
• Aged care facilities to be subject to a rating system to enable accurate information about staffing levels, number of hospitalisations, number of falls, frequency of psychotropic drug administration and average care hours spent on residents by registered nurses ('RNs'), enrolled nurses ('ENs') and allied health professionals to be available.
• The incorporation of 'checks and balances' on the kinds of services providers offer.
<u>Entry into aged care</u>
• Investment in innovative models of care, staffing and workforce.
• Nature of aged care funding to adapt to the desire of elderly people to age in their homes.
• Additional resources dedicated to providing respite care for carers.</td></tr>
<tr><td>The accreditation process

(Volume 1, Part 1, Section 1)</td><td>• The accreditation process is based on a 'pass/fail' assessment that sets a minimum standard, does not reward improvement or innovation, and does not deter poor practices.
• Industry attempts to reduce the obligations owed by providers were noted.
• The accreditation of commencing services was described as a "desktop exercise" that only required a self-assessment form to be completed.
• The Commissioners supported the introduction of the National Quality Indicator Program, but stated that data needed to be collected on other areas of care.
• The relatively low findings of non-compliance with the Quality Standards over the past 5 years was noted, as well as the similarly low rates of serious risk and sanctions.</td><td>• Pecuniary penalties for breach of the Quality Standards (as seen under the NDIS).
• Greater use of sanctions by enabling the ACQSC to impose sanctions without reference to or approval from the Department of Health.
• Shift from base line minimum standards to encouraging and incentivising providers to exceed the Quality Standards and rewarding such outcomes.
• Face-to-face assessments with commencing services.</td></tr>
<tr><td>Dementia care

(Volume 1, Part 2, Section 4)</td><td>• There is an increasing number of elderly people living with dementia.
• Information about alternative models of care which endorse best practice dementia care was heard.
• The Commissioners emphasised the lack of understanding around dementia care, and lack of dementia-trained staff.
• Unacceptable use of restrictive practices to address challenging dementia-related behaviours.
• The importance of the built environment to good dementia care ie providing a 'home like' environment.</td><td>• Mandated training in dementia care for aged care staff, and the provision of additional resources to facilitate education and training.
• Dementia care training placing a strong focus on enablement and dignity of risk.</td></tr>
<tr><td>Restrictive practices

(Volume 1, Part 3, Section 8)</td><td>• Restrictive practices are not narrowly defined and can include anything that limits a person's movement or freedom.
• Restrictive practices only to be used as a last resort and are not an appropriate response to addressing dementia-related or challenging behaviours.
• Proper documentation (such as time charts and monitoring of side effects), informed consent and consultation with external services (such as DBMAS) needs to occur prior to their use.
<u>Physical restraint</u>
• There are risks associated with unlawful physical restraint as well as respecting a resident's dignity of risk.
• Effects of being restrained and immobile include the deconditioning of the body and heightened risks from residents trying to escape from restraints.
• Many physical restraint charts do not place time limits or conditions on the use of restraints.
• Publication of data on the use of restraints will increase transparency and accountability for their use within facilities.
<u>Chemical restraint</u>
• Lack of evidence in regards to the over-prescription of psychotropic medication within facilities.
• No policies aimed at reducing the use and prescription of psychotropic drugs at facilities.</td><td>• Providers to follow their reporting obligations under the Minimising the Use of Restraint Principles 2019.
• Increased scrutiny on other forms of restraint ie environmental and psychological restraint.
• Mandated education and training on alternatives to the use of restrictive practices, and on appropriate management of the behavioural and psychological symptoms of dementia.
• Sanctions imposed for the use of restraints without documentation and informed consent.
• Medication reviews at frequent intervals and additional requirements for psychotropic drugs under the Pharmaceutical Benefits Scheme.
• Greater consideration for the design features of services to cater for people with dementia ie emphasis on the visual layout of facilities and having appropriate mixes of residents to decrease dementia-related behaviours.</td></tr>
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	• Ethical issues associated with general practitioners ('GPs') taking suggestions from RNs to prescribe medication without attending to resident. • Evidence confirmed that RNs are responsible for determining whether PRN medication can be administered. Environmental restraint • Includes any mechanism or thing which prevents a resident from being able to move freely inside or outside of a facility ie secured doors, alarm systems, fenced off areas.	
The aged care workforce (Volume 1, Part 3, Section 9)	The aged care workforce needs to promote itself as an 'employer of choice' to meet its future demand projections and compete with other human service industries. Wages of aged care staff • Disparity in pay levels between personal care attendants ('PCAs') and RNs in hospital and aged care sectors. • The wages of PCAs in residential aged care facilities does not amount to a living wage. Training of aged care staff • Training and education courses frequently miss core components of aged care such as dementia specific training, palliative care training and bereavement training. • Evidence presented about the 'evolution of a less-skilled workforce', with the decrease of RNs working in aged care being caused by demanding workloads, a lack of professional opportunities and RNs being paid more in hospital environments. • Lack of training of aged care staff may result in increased hospital admissions and a compromised handover process. • The majority of Certificate III qualifications are competency based and not time/curriculum based which may result in workers becoming qualified without sufficient experience. Staff ratios • The evidence highlighted the high ratio of casually employed staff and that there was no continuity of staff across services. • Calls were made from numerous witnesses for an evidence-based staffing methodology to enable facilities to appropriately staff and ensure all resident care needs are met. • However, there was also debate within the Interim Report as to whether staffing ratios were a blunt instrument. • Many staff within the sector stated that they were not in a position to provide the standard of care they would like.	• Greater career pathways and opportunities within the aged care sector. • Employee screening registers for PCAs (similar to AHPRA) to filter out inappropriate personnel and to increase the perceived value of the workforce. • Staffing ratios to recognise that staff must have time to provide for a resident's physical, psychological and social needs. • Training for aged care staff to incorporate Certificate III as an entry level qualification. • The use of subsidies, recognition of prior learning and work experience, and the provision of free training to incentivise people to enter the workforce. • Staff mix requirements to include allied health professionals.
Documentation (More information to be contained in Final Report)	• Issues surrounding the transfer of accurate clinical care information. • There is a link between insufficient numbers of RNs and compromised hand over processes. • Inadequate clinical documentation leads to adverse impacts on resident health and outcomes. • The importance of clinical documentation in maintaining the interface between hospitals and residential aged care facilities was emphasised, as well as how GPs make clinical assessments based on a resident's health record.	• Heavier penalties and increased sanctions for providers who fail to accurately document resident progress and care.
Governance (Hearings to be held in 2020 and more information to be contained in Final Report)	• Insufficient for providers to have board members with legal, business and financial backgrounds and no clinical knowledge. • Issues raised about the lack of formal reporting channels to boards about care governance issues. • The importance of genuine, timely apologies and an open disclosure framework was emphasised. • Facilities to implement a proactive approach to risk management instead of investigating incidents that have occurred.	• Mandated criteria for the membership composition of aged care boards. • Increased sanctions on facilities for failing to ensure they are up-to-date with any issues relating to the provision of clinical care. • Providers to demonstrate how quality and safety drive their operations.
Diversity in aged care	• As the makeup of the Australian population changes the demand for culturally appropriate services will increase, with diversity having to be incorporated as a 'deliberate design feature' of our aged care system. • Emphasis on understanding intersectionality and how people may not fit into one particular category of people.	• Clustering as a potential way forward for the aged care sector where providers group certain consumers together so they can become very good at catering to the needs of a particular group.

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(Volume 1, Part 3, Section 7 & more information to be contained in Final Report)	• The importance of language and communication in the provision of quality care and maintaining informed care plans. • The sector's peak bodies were criticised for their reluctance to make the Action Plans under the ACQSC's Diversity Framework mandatory. • The importance of trauma informed care was emphasised. • Extensive evidence was presented regarding the 'data gaps' across My Aged Care, and how this deficiency in information prevented a proper understanding of diversity issues across the aged care sector. • Concern was expressed that providers can hold themselves out to be LGBTI friendly when there are no checks and balances on those assertions. • Aged care providers are not required to proactively report on their obligations in relation to special needs places. • Difficulties associated with providing home care to people who do not have safe and affordable housing.	• Rewarding providers for recruiting a 'values based workforce' where staff are committed to principles of respect and dignity. • Providers having to demonstrate they are actively monitoring and meeting the needs of any special needs places they have obtained during the ACAR. • Making the ACQSC Diversity framework's Action Plans compulsory as a part of each provider's accreditation process. • Increased training of ACQSC assessors in cultural safety and education, with an increased focus on culture and diversity during contact assessments. • Additional funding dedicated to the provision of interpreters across the aged care sector.
Young people in residential aged care (Volume 1, Part 3, Section 10)	• Young people have different needs and preferences to older people, meaning the placement of young people in residential aged care is inappropriate. • The lack of alternative services for young people is the driving factor behind them entering residential aged care. • There is a need for increased access to rehabilitation through the hospital and health care sectors, more accessible and affordable housing options, and more palliative care options to decrease the admission of young people into residential aged care.	• Increased funding of Specialist Disability Accommodation and other care options for younger people. • Improved data collection about the circumstances of younger people living in residential aged care to enable more specific targets to be established. • Collaborative hospital discharge planning to reduce the likelihood of younger people being referred to an ACAT and being admitted to aged care. • Strict obligations for aged care providers to review any alternative care options available to younger people, and the auditing of ACAT assessments.
Aboriginals & Torres Strait Islander people in residential aged care (Volume 1, Part 3, Section 7)	• The importance of culturally safe and appropriate services, location, identity and connection to people and country. • ATSI people experience disproportionate levels of illness and disability as compared to the wider Australian population, and are more likely to require aged care services at a younger age. • Evidence led about intergenerational trauma and the distrust felt by ATSI people of mainstream government services. • ATSI people under-represented across the aged care system, with a lack of availability of appropriately tailored services.	• Greater provision of ATSI-specific services in cities and regional areas. • Placed-based partnership models for the delivery of aged care services, which will require consultation with ATSI communities to foster respect and the provision of culturally safe services. • The use of blended models of care that empower the local ATSI community to deliver culturally safe care to their Elders. • The incorporation of culturally appropriate assessment processes to access Australia's aged care system.
Home Care Packages (Volume 1, Part 3, Section 6)	• The preference of older people to 'age in place' was described, as well as the extensive wait time for consumers to access a Home Care Package ('HCP'). • Consumers are not notified by the Department about their progress or the wait times for a HCP to become available. • Issues surrounding consumers receiving lower level HCPs than what they were assessed for, which may result in early entry into residential aged care and increased hospital admissions. • Issues arising from the transition of HCPs to a Consumer Directed Care ('CDC') model, which prevents providers from being able to 'pool' resources. • Access to home care is predicated on consumers having secure accommodation, which means many vulnerable people cannot access care.	• Increase number of HCPs to address the current deficit. • Increased funding to be available for new home care providers. • Alternative models of home care to be catered towards homeless people. • Notifications on My Aged Care to inform consumers about their wait times, and the introduction of benchmarks for maximum waiting periods. • The introduction of a Level 5 package to allow people with higher care needs to stay at home longer.
Deficient data collection & interface between Commonwealth departments (Volume 1, Part 1, Section 3 & more evidence to be heard at Canberra 2019 hearings)	<u>Lack of interface</u> • Difficulties posed by the aged care sector being governed by Commonwealth legislation and the hospital sector being governed by stated based legislation. • The lack of interface between Commonwealth Departments, which may mean consumers 'fall through the cracks'. <u>Lack of data</u> • Data collection is crucial in ensuring the sector has an accurate understanding of the needs of the people it is servicing. • The disparity in information available for ATSI and CALD people, as compared to the rest of the aged care population. • The Department has failed to collect data on special needs groups, and has failed to introduce a mechanism to oversee the interrogation of data and set benchmarks to track the equitable distribution of resources.	• Increased efficiency in the data collected through My Aged Care to enable the Department to determine whether the guarantees made by providers in relation to special needs places during ACAR are met.

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	• There is a lack of information available to determine whether the transition of HCPs to CDC had improved the Department's ability to meet the needs of HCP recipients.	
Care issues (Volume 1, Part 2, Section 4)	Substandard care • Evidence was led about the inadequate prevention and management of wounds, poor continence management, poor food and nutrition, insufficient attention to oral health, the use of physical restraints, staff assaults on residents, the overprescribing and sedation of residents and fragmented palliative care processes. • There have been more than 35 major public reviews of the aged care system over the past 40 years which have not prevented instances of substandard care from occurring at frequent intervals. Person centred care • The centrality of the workforce in delivering person centred care. • The importance of communication, reciprocal relationships and dignity of choice of consumers. Care in rural/remote areas • The range of challenges for the delivery of aged care services across rural and remote areas of Australia was described. • The evidence outlined the lack of profit underlying care delivery in remote parts of Australia due to resourcing costs. Multidisciplinary care services • Multiple professions to be involved in consumers' clinical assessments to ensure they are comprehensive and dynamic. • The importance of timely and appropriate use of equipment, and the necessity of timely and inexpensive interventions.	• Minimum training requirements for staff. • Mandatory rostering of RNs on all shifts. • Registration or licensing of PCA staff. • Surveillance. • Financial penalties on providers for failing to meet the basic care needs of consumers. • Mandated allied health staff as part of staffing matrix.