

Australian Nursing And Midwifery Federation

**AUSTRALIAN AGED CARE
QUALITY AGENCY
AGED CARE STANDARDS
GUIDANCE MATERIAL
(JUNE 2018)**



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INTRODUCTION

The ANMF is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 268,500 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

Many of our members are involved in the provision of health care for older persons who move across sectors, depending on their health needs. As such, these members are also affected by changes in the aged care sector.

We therefore welcome the opportunity to provide feedback to the Aged Care Standards Guidance Material.



GENERAL COMMENTS

This consultation is one of a number of inquiries and consultations into aged care.¹²³ All have examined the factors that define quality in residential aged care facilities and those which contribute to failures. Many concluded that the contributing factors included systemic failures at provider level and failures attributed to poor regulation of the sector.

In addition there has been ongoing media interest in exposing an emerging epidemic of neglect in aged care. This is further substantiated by concerns raised by our members that unsafe staffing levels mean they are unable to provide effective, evidence based care and a safe place for people to live.⁴ It is a fundamental right of older Australians to live in a safe environment. Sadly, this has not been the case and is a shameful reflection of the value we place on both our older citizens and those who care for them.

The correlation between safe staffing and good quality care has been a common thread identified in previous consultations. The provision of safe staffing ratios and skills mix in aged care are intrinsically linked to safety and protection against neglect. Attempts to enhance quality standards will be futile unless legislative reforms also mandate measurable ratios and skills mix in residential aged care facilities.

For these reasons it is essential that any guidance intended to assess quality in residential aged care is fit for purpose and able to protect people from abusive practices, whether as a direct result of institutional practices, or as a consequence of the way an organisation is operated and managed.

We are concerned that whilst extensive in their current form, these draft guidelines that are not mandatory, have weakened what is already an inadequate assessment legislative framework. There is little prescriptive direction as to what quality outcomes look like and what assessors should observe. Terminology is vague and unhelpful and there is heavy reliance on provider reported self-assessment.

There are significant omissions in the assessment of staffing adequacy, medications management and maintaining a safe environment. Our concerns are heightened by the fact that these are already amongst the highest areas of non-compliance. This appears to be 'business as usual' for our members who remain as vulnerable within the system as those they care for.

It is essential the experience of recipients of care (the consumer), and their families/informal carers, is combined with evidence that underpins how, and what, minimum care should be delivered in aged care. Equipped with this, informed recipients of care, and their families/informal carers, can make choices on their experience and care within the service they choose.

All standards for nursing care, whether provided in the residential or community aged care settings, must always meet the accepted professional standards set by the regulatory authority (Nursing and Midwifery Board of Australia) for nursing practice. As these regulated standards for nurses are not negotiable, the Aged Care Standards must support nurses in complying with their professional and legal requirements.



Considering these complexities, the ANMF maintains the Aged Care guidance material must provide clear and concise information about specific requirements for compliance, be evidence based, and ensure the standards are not open to interpretation by the aged care provider.

SPECIFIC COMMENTS

The commentary to follow provides specific reference to the standards outlined in the consultation document. These comments are not exhaustive due to the timeline for this consultation, however the ANMF would be pleased to work with the Australian Aged Care Quality Agency at any point to provide further feedback on the guidance material and its implementation.

There are several grammatical errors within the consultation document, the ANMF will not provide any commentary on these as we anticipate this will be rectified with the next draft.

DEFINITIONS

The term 'culturally competent' is used on p.36 and should be defined.

STANDARD 1: CONSUMER DIGNITY AND CHOICE

The ANMF supports the importance of this standard and identifies an essential sentence within the content of this standard, namely: *The workforce needs support to enable them to involve, listen to and respect the views of the person, and seek to support the person to live the way they choose and enhance quality of life (p.9)*. If the workforce does not have the resources to empower the person to make choices on their care regarding when and where it suits them, then their quality of life can be compromised. The statement needs to be repeated throughout Standard 1.

The workforce can provide specific and meaningful examples of how the organisation has supported consumers to exercise choice and control even where that choice posed risks to them (p.20). Whilst we acknowledge the intent behind this statement, we argue that this could place unreasonable demands on the workforce, since our members tell us they are often unable to uphold the choices of residents for reasons beyond their control. Good care takes time and resources. Care is often compromised due to unsafe staffing ratios and skills mix - a factor which is outside the individual control of workers in most circumstances. We believe this example needs to be supported by an additional test of evidence, that the staffing model in operation enables the workforce to support residents to effectively maintain choice and control. Further, the emphasis on the example being that the person's choice posed risk to them is incorrect and should be changed. Rather, the emphasis should be on the importance of the organisation empowering residents to make choices in their care. If there is risk to the resident through that choice then this is part of the decision making process.



STANDARD 2: ONGOING ASSESSMENT AND PLANNING WITH CONSUMERS

The ANMF maintains this standard must clearly articulate who should be conducting the assessment, planning and evaluation. The Australian Commission on Safety and Quality in Health Care national standards use the term ‘clinician’ and define this term in their glossary.⁵ The ANMF recommends a similar approach be taken in this guidance material. The definition must include a ‘Nurse Practitioner, Registered Nurse or Medical Practitioner.’ It is critical these regulated health practitioners are identified throughout the guidance material as the only practitioners in the aged care sector to provide comprehensive assessment, planning and evaluation. This position is supported by the evidence that details how registered nurses positively affect health outcomes.⁶⁷⁸

Requirement 2.2: an assessment and plan of care is ineffective if these are not used to determine the required ratios of staff to residents, and if they are not used to determine the skills required from within the workforce to meet care needs. Good examples of this are in the assessment and planning of a behaviour management program. This will often require additional numbers of staff to provide supervision and diversional therapy. These are fundamental elements of assessment and care planning that appear to be overlooked in the evidence required to assess compliance against these draft standards. An additional example of evidence should include confirmation of how the assessment and subsequent plan of care is used to inform the model of care. For example, in the mapping of acuity and needs to the scheduling of appropriate qualification and numbers of staff to meet those needs.

Requirement 2.3: under point four: the term ‘competencies’ should be replaced with ‘qualifications’, to read as:

Monitor that staff undertaking assessment and planning:

- *have the capacity and qualifications to assess clinical, allied health and personal care needs, including palliative care needs.*

Requirement 2.7: under ‘Consumer experience,’ it states: *Evidence of a range of methodologies being used to seek and understand the consumer experience against this standard.* This sentence does not provide any context for auditors to assess compliance and is open to individual interpretation. If striving for a meaningful and purposeful audit of compliance it is recommended that use of vague terminology as a test of compliance is removed throughout the draft standards.

Requirement 2.7: Although it is important to ascertain that the workforce understand their role in the review of care, examples of evidence should also include a check that the staffing model is adaptable to the fluctuating needs of residents, following care reviews. A test of this would be to observe scheduling of staff on staffing rosters, clinical care outcomes and consumer feedback.



STANDARD 3: PERSONAL CARE AND CLINICAL CARE

The artificial separation of personal care and clinical care is not supported by the ANMF. It is not possible to separate care into two areas. Personal/clinical care for each person must be well planned, holistic in its approach and evaluated for its effectiveness in order to provide quality and person-centred care. Using the content provided, personal/clinical care requires the informed recipient to direct their care to ensure it is delivered by the right clinician. The statement regarding clinical care has the addition of best practice. It is incorrect to presume evidence is not used in delivering personal care. Best practice needs to be used for all areas of care.

Page 45: the list of key resources and relevant legislation is not comprehensive and focuses on dementia care and palliative care only. Although two of the major reasons for admission to residential care, there are many other medical conditions experienced by recipients of aged care.

Page 46: *in the case of [the category of] 'clinical care, is best practice' it is recognised that there is not always strong evidence for all aspects of care.* The Carnell and Paterson report: *Review of the National Aged Care Quality Regulation Process* clearly articulates the need for evidence; this guideline is insufficient. While levels and sources of evidence may vary from a systematic review, to randomised control trials to expert opinion, evidence is available to direct all care being provided.

Page 47: the list provided of high impact or high prevalence risks omits a number of important risks that members explain are becoming of increasing concern. These relate to the significant increase in residents with mental health issues and residents who require bariatric care. The poor management of these issues has a serious impact on the health and safety of residents and care workers. *It is recommended that mental health and bariatric care are added to the list of prevalent risks under requirement 3A.*

Also, under the dot point 'restrictive practices', the principles referred to in this sentence need to be identified.

B. Overall supporting strategies, reflective questions and evidence

Page 49: '*Supporting strategies*'. The list states: *Enable access to relevant allied health and medical services so the consumer is supported to maintain optimum health and wellbeing.* It is fundamental to health and wellbeing, particularly given the list of key risks on p.47, that nursing staff are also accessible to residents. It is vital that nursing and other direct care staff are provided in sufficient numbers to ensure they are able to deliver the services required. It is recommended that the wording is changed to read: *Enable access to relevant numbers of nursing, allied health and medical services so the person is supported to maintain optimum health and wellbeing.*

Page 49: '*Examples of evidence*'. This does not include assessment of how the care needs of consumers is matched to the provision of staffing. A further example of evidence should be added to standard 3B, as follows: *Evidence that there is a system in place to ensure the personal and clinical care needs of consumers informs the required number and skills mix of staff to ensure safe, effective care.*



D. Minimising the risk of falls and harm from falls.

Falls amongst the elderly occur for many reasons. However, good practice guidelines suggest that identification of risk factors and provision of education to staff alone are ineffective in falls prevention and must be accompanied by a strategy to ensure adequate supervision of residents.⁹ Given the volume of research to support that increased staff supervision is instrumental in reducing falls, particularly in those with dementia, it is fundamental that a test of sufficiency is applied to staffing in this standard.

F. Minimising choking risks

Under 'reflective questions' it is important not only to ensure organisations provide training but also that they keep records as to who attended.

G. Medication safety and minimising medication misadventure

An additional point needs to be added in the first paragraph before commencing on 'supporting strategies'. This point should state that *organisations are expected to have in place an organisation wide system to support and promote:*

- Appropriately qualified and experienced staff providing medicines administration

Under 'supporting strategies' it states: *Develop and implement a system for: defining and verifying the scope of clinical practice for administering medicines.* Medication mismanagement is the reason for the most number of complaints received by the Aged Care Complaints Commission, it is also the highest area of non-compliance reported by the Australian Aged Care Quality Agency, and a significant concern for our members working in aged care. One of the major contributory factors would appear to be a lack of clarification about roles and responsibilities in regard to the safe management of medicines in residential facilities which is, in part, due to the ability of aged care providers to self-determine the level of skill and qualification required.

The ANMF contends that the scope of clinical practice for administering medicines can only be determined through developing commonwealth and state legislation that is clear and provides sufficient direction to ensure the safe management of medicines. In addition, we believe it is the role of the Nursing and Midwifery Board of Australia to determine the scope of clinical practice for registered nurses and enrolled nurses. We argue that aged care providers, many of whom do not have a medical/nursing or clinical background, are not the sole determinate to define scope of clinical practice. This statement therefore needs to be revised.

In addition, registered nurses working in residential facilities are often caring for upwards of 100 residents and supervising unlicensed care workers. In some residential facilities this is without the clinical support of a Director of Nursing. This not only leaves those workers vulnerable, but also the people to whom they administer medicines. An additional test of how planning of staffing and skills mix allows for safe medication practices, should be included.



H. Supporting consumers to live without pain

The ANMF welcomes this guidance material to the standard as the issue of pain management in residential facilities is a major concern for our members working in both residential and community aged care settings. One of the main mitigating factors for failure to ensure adequate pain relief is the lack of available appropriately qualified staff to administer pain relief. Often the presence of a registered nurse is required to legally administer pain relieving medicines. This fact was further evidenced in the Review of the National Aged Care Quality Regulation Process report.¹⁰

Pain is not a condition restricted to office hours. It can occur at any time during the day or night on any given day. Therefore, the current trend toward reducing the availability of registered nurses outside office hours in residential facilities is counter-productive to achieving this draft standard. For this reason, a fundamental test of this would be to assess how staffing models ensure the right staff are present to assess, administer and monitor the effectiveness of pain relief and it is recommended this is added to the reflective strategies against 3H.

I. Skin care – Preventing and managing pressure injuries and wounds.

Having sufficient number and skills mix of workers to prevent pressure injuries and manage wounds is fundamental to achieving this draft standard.¹¹ The supporting strategies listed under 3I should therefore include examination of how workforce planning allows for safe implementation of preventative strategies to reduce the risk of pressure injuries and wounds occurring.

J. Minimising restrictive practice

The ANMF supports the intent of this standard and the importance of minimising restrictive practices, however, there is a balance to be achieved to ensure staff are also working within a safe environment. The ANMF have some concerns about the way this section is drafted. Specifically, Work Health and Safety (WHS) laws in state and territories need to be met. The employer has a duty to ensure, so far as is practicable, the health and safety of workers. This involves identifying risk, assessing risk and putting in place measures to eliminate risk as far as reasonably practicable (or to minimise risk). Under security of tenure provisions it is extremely difficult to remove a violent resident from a residential facility, leaving staff and other residents at ongoing risk of serious injury arising from assault.

Sometimes, even with the best behaviour management plans and medicines reviews, restrictive practices are the only available option. There needs to be specific guidance to assist clinicians and approved providers to implement short term strategies to manage such periods of crisis which aligns with the National Safety and Quality Health Service standards for use of restraint. While this section does not prevent the use of such practices, the current wording curtails its use, and is likely to result in an increase in incidents arising from aggressive behaviours. It is recommended that standard 3J includes the presence of a risk assessment which is regularly reviewed, and which clearly identifies the number and skills mix of workers required to minimise the risk of restrictive practices.

K. Preventing, identifying and managing delirium

The term 'patient' is used in this section and should be replaced with consumer for consistency throughout the document.



Requirement 3.4: 'examples of evidence' should also include how workforce planning ensures a palliative approach to care can be implemented. It is essential the right number and skills mix of workers are available at times as required for meeting residents' needs. The ANMF has examples from our members where registered nurses are being removed from night shift rosters leaving no qualified staff on duty to deliver effective pain relief for people at the end of their life. In some instances this has led to the paramedics service being called to deliver break through pain relief. This can and often does result in lengthy delays for pain relief, resulting in unnecessary suffering and compromised care. The ANMF believes a palliative approach cannot be effectively implemented without consideration of workforce planning, enabling the right numbers of nursing and carer staff with the qualifications required for pain assessment and relief management.

Page 67: under 'workforce and others experience' the importance of symptom management needs to be included in this section.

Requirement 3.5: we would agree that a supporting strategy should be in place to determine the level of training the workforce receives to be able to respond to unexpected changes in the person receiving care. However, the ANMF considers this would largely be ineffective in the absence of a staffing and skill mix methodology consistent with the assessed care needs of each individual care recipient (nurses and carers) to be rostered on duty to respond to such circumstances. We recommend an additional point be added under supporting strategies for 3.5 that the staffing model allows for timely recognition and response to unexpected changes in the persons condition.

Requirement 3.6: a reference is required in the section of 'monitoring, reporting and performance improvement' to outline the importance of digital health and the need for aged care providers to have effective electronic health records that are accessible. Reference to how the organisation manages its privacy and security of data is also important and needs to be included.

Requirement 3.7: the ability of the aged care provider to avoid unnecessary hospitalisation for residents is an obvious omission from this guidance material. It is an essential measure of quality of resident care. There is evidence that transfer of the person out of a residential facility can have a detrimental effect on their general wellbeing, and may also impact on their end of life choices. There is strong evidence that the presence of registered nurses within the skills mix of a residential facility can be an effective hospital avoidance strategy.¹² We recommend that an additional example of evidence is added under 3.7 to examine the hospital avoidance measures that are implemented, to include having registered nurses in the staffing and skills mix profile of each nursing home.

STANDARD 4: SERVICES AND SUPPORTS FOR DAILY LIVING

Requirement 4.1: access to technology to assist residents connecting with their community and family (should they be capable of doing so) needs to be included under 'supporting strategies'.

Requirement 4.3: digital health is not covered within the standards and it is a vital part of the future in the aged care sector. This needs to be expanded to incorporate the importance of providers moving towards the use of digital health and, at a minimum, having electronic health records.



Nurse Practitioners need to be included in the last dot point, under the workforce and others experience.

Requirement 4.5: an additional test of compliance should include a check of whether the staffing model provides enough staff to assist people to eat their meals in a way that ensures adequate hydration and nutrition, and upholds their dignity.

STANDARD 5: SERVICES AND SUPPORTS FOR DAILY LIVING

Requirement 5.2: An additional point needs to be added under the 'supporting strategies' which refers to the importance of the service environment also being safe for staff. We suggest the following: Create and maintain the service environment that will enable staff to complete their work without risks to their physical and psychological health and safety.

STANDARD 6: FEEDBACK AND COMPLAINTS

Requirement 6.2: There should be more explicit consideration of whistleblowing in this section. The ability of workers to raise clinical concerns and general issues in good faith is one of a range of protections that should be in place. It is recommended that this standard explicitly explores the measures taken to ensure workers are supported to raise issues in good faith, without fear of reprisal both internally and externally.

STANDARD 7: HUMAN RESOURCES

The workforce within the aged care services sector has severe structural problems including, at times, a lack of staffing numbers and/or an inadequate skills mix of available staff. For many years, the ANMF has been voicing our members' concerns about the increasingly dire situation they experience in their workplace. It is the ANMF members' primary priority to address the myriad of complex workforce issues within the sector as a matter of urgency in order to increase staffing numbers and improve skills mix levels, to provide safe care.

Nursing is legislated to assess, plan and co-ordinate care in accordance with the Aged Care Act 1997. This Act requires registered nurses to plan nursing care. Approved aged care providers are required under the *Aged Care Act 1997* and its principles to provide adequate numbers of care staff to carry out the assessed care needs, including a tailored plan for individualised person-centred care. Despite the very best efforts of those who work in the sector, there simply are neither enough workers nor workers with the necessary level of skill to provide quality care to all elderly Australians.

The ANMF supports the importance of the standard identifying the manner in which the workforce is planned and the number and mix of staff deployed as we have long argued the provision of appropriate number and skills mix of workers is fundamental to achieving these standards. It is clear that leaving decisions about staffing open to provider discretion does not always achieve the best outcomes for residents. The ANMF suggests the guidance material should include the following statement in the 'supporting strategies':



A residential facility must demonstrate minimum staff numbers using a mandated evidence-based methodology that accounts for the time taken to assess, perform and evaluate direct and indirect nursing and personal care for residents with the following minimum staffing skills mix: registered nurses (RN) 30%, enrolled nurses (EN) 20% and personal care worker (AIN/PCW) 50%.

This evidence based statement was established through the ANMF commissioned study: National Aged Care Staffing and Skills Mix Project, the report of which was released in 2016. The project is the first of its kind in Australia and demonstrates the urgent need for a staffing and skills mix methodology that considers both staffing levels (the right number) and skills mix (the right qualification) to meet the assessed needs of residents in residential aged care.

The reports key findings are:

- Evidence based staffing and skills mix methodology must be adopted nation-wide for residential aged care facilities.
- Residential aged Care facilities must incorporate the time taken for both direct and indirect nursing, and personal care tasks and assessment of residents; it also needs to reflect the level of care required by residents.
- Residents require an average 4 hours and 18 minutes (or 4.3 hours) of care per day - compared to 2.84 hours which is currently being provided.
- A skills mix of Registered Nurses (RN) 30%, Enrolled Nurses (EN) 20% and Personal Care Worker (PCA) 50% is the minimum skills mix to ensure safe residential care.¹⁴

This sentinel project is the evidence based solution for the workforce issues within residential care and needs to be clearly identified within this standard. The flow-on effect of this change will immediately begin to address all other workforce issues within the sector, including: the provision of quality care from a sufficient number of appropriately qualified and educated staff; retention and recruitment issues; and, appropriate education and training of staff.

A recent independent report by Professor Joseph Ibrahim highlighted a catalogue of preventable deaths arising in residential aged care facilities.¹⁵ His findings should serve as a timely warning of the need to invest more heavily in the aged care workforce; to increase access to skilled registered nurses; and, to provide greater levels of training for all cadres of workers. In reality, what data tells us is that staff have less access to continuing education, and that the numbers of registered nurses are decreasing in favour of unregulated care workers.¹⁶

Unless there are clear links between outcomes to be measured and well-defined legislation, auditors from the Australian Aged care Quality Agency will have little power to take swift remedial action where concerns are identified

Requirement 7.1: Volunteers should be removed from this standard. This standard should only be applied to the paid workforce. Volunteers within aged care are highly valued and make a beneficial contribution but they should not be considered in the formal planning of staff numbers and skill mix that enables safe and quality care.



An additional point should be added under 'supporting strategies' in this requirement relating to the importance of models of care that enable continuity of care.

The following statement needs to be changed: *is the organisation making every effort to employ staff that reflect the diverse characteristics of the consumer?* How is the organisations commitment to doing this evidenced? This could be perceived as encouraging an organisation to implement unfair employment practices. Employment opportunities and processes need to be fair and equitable and employers need to consider discrimination legislation within each state and territory.

Under the section '*policies and practices*' a point needs to be included relating to there being records of meetings where workforce feedback has been provided on the staffing and skills mix for the organisation.

An organisation should also provide evidence that their policies and practices are consistent with the requirements of national regulators for registered health practitioners, such as the Nursing and Midwifery Board of Australia, which regulates registered nurses and enrolled nurses.

Requirement 7.3: It is essential that organisations keep track of employees' registration details, identifying annual renewals and any notations, for example. The following statement should be added: to the 'supporting strategies': Monitor and document the details of health practitioner employees regulated through the Australian Health Practitioner Regulation Agency on an annual basis.

Whilst having a diverse group of workers enhances resident experience, our members regularly report that the written and verbal English skills of some workers, particularly those recruited from overseas, is problematic for residents. It would be helpful to include assessment of English language skills of workers as a quality measure. Communication difficulties can lead to compromised care to residents.

STANDARD 8: ORGANISATIONAL GOVERNANCE

Requirement 8.3 b: Risk management including managing impact or high prevalence risks associated with care of consumers. Managing pressure area care should be added to this section.

In addition to feedback provided to the draft guidance material, we have concerns that there are a number of items that were addressed in the current standards but have not been included in the guidance material.

The current standard 1.7 Inventory and equipment stocks of appropriate goods and equipment for quality service delivery are available has been removed. It is essential this is added to the guidance material. Our members regularly inform us of limitations being placed on use of equipment and stock, for example, personal protective equipment, incontinence pads, or items such as sick bags.

The current standard 2.13 Behaviour management, which required care recipients with challenging behaviours to be managed effectively, needs to be expanded in the guidance material. There are new sections on supporting people living with dementia and on minimising restrictive practice in the draft guidance material but these focus on the rights of the resident and not on ensuring that aggressive behaviour is managed for the safety of others, including staff and other residents. Not all aggression in aged care is attributed to dementia. Delirium, drug and alcohol misuse, mental health, intellectual disability, resistance to care and lifetime predisposition to violence towards family members and others, are all possible causal factors. This is not acknowledged in the draft standards and it is important that it be addressed.



CONCLUSION

The ANMF appreciates the opportunity to provide feedback to the draft Aged Care Standards Guidance Material. Our submission provided to this consultation reinforces the essential element to providing quality in all aspects of care, that being the importance of implementing an evidenced-based staffing and skills mix methodology in both the residential and community setting. Staffing numbers in residential facilities need to be based on a mandated evidence-based methodology that accounts for the time taken to assess, perform and evaluate direct and indirect nursing and personal care for residents. The safety and quality of aged care depends on the implementation of a minimum staffing skills mix of: registered nurses (RN) 30%, enrolled nurses (EN) 20% and personal care worker (AIN/PCW) 50%.



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