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ACEM Submission to the Royal Commission into Aged Care Quality and Safety

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Executive Summary

The Australasian College for Emergency Medicine (The College, ACEM) welcomes the opportunity to provide a submission to the Royal Commission into Aged Care Quality and Safety.

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand.

It is ACEM's position that all older people should be able to access timely, responsive, affordable and appropriate health care, particularly acute healthcare. Such care should be person-centric, delivered in the environment of their choice (whether it be their own home, emergency department or residential aged care facility) and of a high standard.

As Australia's population ages, there is an increasing number of older people with complex health needs presenting to Emergency Departments (EDs). Australians living in residential aged care facilities (RACFs) are some of the most vulnerable people in society and have increasingly complex health and personal care needs, often exceeding what can be provided by informal care from family and friends. In many circumstances, the ED is the best equipped and most appropriate place for this care to be delivered, and ACEM is committed to ensuring excellent emergency care for people from RACFs. However, ACEM also recognises that between 13-40% of all transfers of residents from RACFs to the ED are potentially avoidable through the provision of quality clinical care in the RACF.[1] Falls, antimicrobial misuse, poor wound management, medication error, escalation plans for expected deterioration of chronic diseases, end of life care and palliative care reflect some of the key contributors to avoidable presentations.

While Australian EDs and hospitals are often perceived as a safe and secure environment, older people do not always receive the quality of care they require. Older people experience longer waits, have higher rates of admission and may not have their comfort or pain adequately addressed. The hospital environment poses a number of substantial risks to older people, especially patients from RACFs including; hospital acquired infections, deconditioning, delirium, pressure injuries and further falls.

It is therefore vital that both the harms and the benefits of a transfer to the ED are weighed up in an effort to reduce avoidable and potentially harmful ED transfers. ACEM recommends all transfer decisions are subject to a risk-benefit analysis, the results of which are communicated to the older person or their substitute decision maker. Simultaneously, ACEM recognises more work must be done to improve the quality of care that is delivered to older people within the ED, such that the risks which ED care poses are minimised

[1] Morphet, J., Innes, K., Griffiths, D., Crawford, K. and Williams, A. (2015) 'Resident transfers from aged care facilities to emergency departments: Can they be avoided?', *Emergency Medicine Australasia,* vol. 27, pp. 412-418.

as much as possible. Finally, ACEM supports actions to increase access to clinical care outside of the ED environment, thus ensuring that avoidable and unnecessary transfers are eliminated.

Key to any efforts to improve clinical care is to ensure care aligns with the wishes of the older person. Research has consistently shown that Advance Care Planning is the single most useful strategy to avoid unwanted transfers from RACF. ACEM calls on the Royal Commission to recommend an ambitious national target for the rate of Advance Care Planning documentation by and for residents of RACFs. On top of this, ACEM recognises a number of interventions can be implemented to address many of the gaps in providing episodic clinical care. One example is advanced practice nurses who are based within an ED and conduct an acute assessment of the resident and assist the decision-making capacity of RACF staff. Similarly, there are other models, such as 'Communities of Practice' which promote communication and the skill base and knowledge between EDs, RACF staff and paramedics.

Finally our submission highlights other factors external to RACFs which compromise access to the health services attributed to federal and state funding divides. As a result, residents of RACFs are often unable to access the same services compared to older people living in the community, with the assumption that such services are being delivered in RACFs including specialist community nursing programs, palliative care programs, hospital in the home programs, allied health and mental health programs.

Our recommendations are summarised below:

Meeting the healthcare needs of older people

- All older people should be able to access timely, responsive, appropriate, high quality and affordable healthcare.

- All healthcare delivered to older people should be person-centric and received in the environment in accordance with the older person's wishes whether it be the ED, primary care, their own home or a RACF, particularly when they are acutely unwell or at the end of their life.

Funding reform

- Amendments are made to Medicare item numbers to ensure that they adequately account for the delivery of primary care including both General Practitioners and Nurse Practitioners undertaking advance care planning as well as the provision of Mental Health Care Plans for residents of RACFs.

- Funding is committed for integrated care models that support acute healthcare needs being met in the right place, at the right time and in a setting that is concordant with resident choice. This can include telehealth support, equipment, competencies as well as funding mechanisms for GPs to review residents of RACFs.
- Funding is committed towards advanced practice nurses to deliver programs to enhance the education of RACF staff, improve clinical decision-making and ensure seamless transitions between RACFs, EDs and hospital wards. Ongoing evaluation of these programs is also required.

Legislative reform

- ACEM recommends that the *Aged Care Act 1997* is amended to reflect the need for all RACFs to have registered nurse to resident ratios to ensure that residents receive the high standard of clinical care they require. This could be aligned to rehabilitation ratios in acute hospitals and should consider the frailty and complexity of care required by residents. Aged Care Registered Nursing awards should be at parity with acute hospital nursing.

Data linkage

- The Federal Government facilitates data linkage between My Aged Care and State/Territory jurisdictional hospital clinical data systems to allow reliable and early identification of RACF residents and older persons with home care packages to facilitate safe transitions of care.

Improving patient transfer and discharge

- Older people, their family and carers should be informed of the risks associated with hospital admission. Where appropriate, shared decision-making should be employed to facilitate such discussions with the older person about their healthcare goals.

- Discharge summaries are sent to RACFs when patients are discharged from EDs and hospitals. This should also include specific information required for both transfer to and from hospital to assist clinicians in both settings to provide the best care.

- Standardised risks assessments are implemented in RACFs to assist in decision-making regarding transfers of residents to the ED.

Quality of care reform

- All people entering care in an RACF, require a detailed discussion about their health needs which should include a discussion with them, their family and carers or nominee regarding Advance Care Planning and Advance Care Directives. These discussions need to be ongoing, annually reviewed, and documented including after each acute hospital admission and any time their care needs change.

- Standardised treatment, clinical documentation and decision-making protocols that support individual residents' goals of care are established and use is monitored across RACFs to ensure that residents receive the highest standard of clinical care. This would also require ongoing evaluation to ensure evidence based care is delivered.

- Mandatory clinical quality measures are implemented, reported, benchmarked and linked to accreditation in order to measure and drive improvements to the quality and standard of clinical care delivered in RACFs. Domains for measures should include, at a minimum, risk adjusted measures of:
    - pressure injury rates;
    - acute hospital transfer rates;
    - antipsychotic, sedative and opioid prescribing rates;
    - antimicrobial prescribing rates; and
    - advance care planning rates.

- Development of quality use of medicines standards for RACFs, including rates and quality of Residential Medication Management Review (RMMRs), be considered as a quality measure.

Workforce education

- Development of training and education pathways for RACF based nurse practitioners working in collaboration with GPs along with hospitals, community services and the older person and their families.

- Funding is committed towards programs or 'Communities of Practice' that build knowledge and capacity of RACF clinicians and GPs in partnership with ED, hospital and ambulance staff to optimally provide for the healthcare needs of their frail residents.

Introduction

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide a submission to the Royal Commission into Aged Care Quality and Safety.

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand.

In preparing this submission, ACEM has drawn upon relevant data and academic literature, as well as the expertise and knowledge of its Geriatric Emergency Medicine (GEM) Section, and a cohort of Fellows of ACEM (FACEMs) who are passionate about advancing the GEM field.

1. Older people and the right to access equitable acute healthcare

All Australians regardless of age have the right to timely, responsive and high quality acute care whether this is within the emergency department, in the home, primary health care or residential aged care facilities (RACFs). It is vitally important that older people, as with all Australians receive continuity of care throughout the healthcare system.[2]

It is ACEM's position that underpinning this care, all older people are entitled to:

- equitable access to acute health care;
- participation in decision-making related to their care (shared decision-making);
- respect for their dignity and autonomy; and
- involvement of family and carers in their care, where desired by the patient.

However, many older people do not receive the timely and appropriate health care that they require. Furthermore, ACEM recognises that healthcare is not always delivered in a culturally safe manner to Aboriginal and Torres Strait Islander and culturally and linguistically diverse older people, their families and communities.

It is also concerning that many of these issues have been identified in repeated government inquiries, reflecting systemic issues in Australia's aged care and health system. While ACEM has developed specific recommendations to address key areas in the care of older people, ACEM believes that immediate action should be taken across the healthcare system and aged care system to ensure that this vulnerable cohort of Australians receive the healthcare they require.

Recommendation 1: All older people should be able to access timely, responsive, appropriate, high quality and affordable healthcare.

Recommendation 2: All healthcare delivered to older people should be person-centric and received in the environment in accordance with the older person's wishes whether it be the ED, primary care, their own home or a RACF, particularly when they are acutely unwell or at the end of their life.

2. Healthcare needs of older people

Australia's population is ageing. In 2017, 15% of the population was aged 65 and over and this is projected to increase to 22% by 2057.[3] As people age, the rate of disability increases, particularly once people reach the age of 85. While many older people continue to live in their own homes, in 2017-2018

[2] Burkett, E. and Scott, I. (2015) 'CARE-PACT: a new paradigm of care for acutely unwell residents in aged care facilities', *Australian Family Physician*, vol. 44, no. 5, pp. 204-209.
[3] AIHW (2018) *Older Australia at a glance,* https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-aged-care-service-use/health-care-gps-specialists

there were 270,490 older people living in RACFs, of which 181,000 were permanent residents.[4] This does not include people living independently in retirement villages.

Residents of RACFs represent some of the most vulnerable people in society and have complex health needs. Approximately 86% of people living in RACFs have at least one mental health or behavioural condition.[5] In 2018, 49% were diagnosed with depression and 52% had dementia.[6]

The percentage of residents who require support for activities of daily living (ADL) has increased from 33% in 2009 to 59% in 2018. The number of residents with complex health care needs has increased from 12.7% in 2009 to 53% in 2018 (peaking in 2016 at 61%).[7] At least 31% of permanent residents in RACFs require support for three domains including; ADLs, complex health care needs, and cognition and behaviour.[8] On average, people that enter RACFs live there for 2.5 years.[9]

3. Geriatric emergency care

Emergency physicians are specialists at delivering care when presented with an undifferentiated acute illness. Delivering emergency care to the geriatric population presents increased complexities in the emergency environment. Older people regularly present with multiple comorbidities, polypharmacy and an altered cognitive state. Similarly, it may be more difficult to obtain a history of the patient, particularly if there is inadequate handover or where handover information does not reach ED staff.[10] Older people are also more vulnerable in the hospital environment due to risks associated with adverse outcomes and reduced capacity to express their goals and values of care.[11]

Furthermore, older people often require comprehensive and multidisciplinary screening and risk assessments to determine the most appropriate treatment and follow up plan. This can be especially difficult given that many EDs are not designed to adequately meet the needs of older people. Consequently, some perceive such a standard of care as "an oxymoron for the ED environment".[12]

FACEMs have also raised cultural biases towards older people presenting for care at EDs. As studies have shown, such biases may compromise the care older people receive in the ED, particularly amongst people with dementia whose challenging behaviours and pain may be difficult to manage in this setting.[13] In addition, people with dementia are more likely to be sedated and prescribed antipsychotics or anticholinergics.[14] Similarly, such biases may also prevent open dialogues between staff of RACFs and EDs. RACF staff have also expressed a reluctance to transfer residents to the ED, as they know the residents and their needs when compared to staff in the ED.[15]

3.1 ED presentations of older people

In 2016-17 people aged 65 and over accounted for 21.1% of all ED presentations.[16] Geriatric patients were significantly more likely than other patient groups to arrive by ambulance (50.9% compared to 29.3% for other age groups). As a result, older people are at greater risk of delayed offloading from

[4] AIHW (2019a) *People using aged care 2017-18* https://www.gen-agedcaredata.gov.au/Resources/Dashboards/People-using-aged-care-2017%E2%80%9318
[5] AIHW (2019b) *People's care needs in aged care* https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care
[6] Ibid.
[7] Ibid.
[8] AIHW (2019c) *Explore people's care needs in aged care* https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care/Explore-care-needs-in-aged-care
[9] AIHW (2019a)
[10] Belfrage, M., Chiminello, C., Cooper, D. and Douglas, S. (2009), 'Pushing the envelope: clinical handover from the aged-care home to the emergency department', *Medical Journal of Australia*, vol. 190, no. 1, pp. S117-S120.
[11] Southerland, L., Pearson, S., Hullick, C., Carpenter, C. and Arendts, G. (2019), 'Safe to send home? Discharge risk assessment in the emergency department', *Emergency Medicine Australasia*, vol. 31, pp. 266-270.
[12] Southerland et al. (2019)
[13] Stokoe, A., Hullick, C., Higgins, I., Hewitt, J., Armitage, D., O'Dea, I. (2016), 'Caring for acutely unwell older residents in residential aged care facilities: Perspectives of staff and general practitioners', *Australasian Journal on Ageing*, vol. 35, no. 2, pp. 127-132.
[14] Kable, A., Fullerton, A., Fraser, S., Palazzi, K., Hullick, C., Oldmeadow, C., Pond, D., Searles, A., Edmunds, K. and Attia, J. (2019) 'Comparison of Potentially Inappropriate Medications for People with Dementia at Admission and Discharge during an Unplanned Admission to Hospital: Results from the SMS Dementia Study', *Healthcare*, vol. 7, no. 8.
[15] Stokoe et al. (2016)
[16] Unpublished National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD) (2016-17)

an ambulance which is associated with poorer patient outcomes.[17] Furthermore, when compared with adult or paediatric presentations, geriatric presentations were more likely to be classified in more urgent triage categories (ATS 1-3). Older people, due to the complexity of the acute care they require, utilise a greater amount of resources in the ED compared to younger people.[18]

The number of ED presentations that are the result of transfers from RACFs are not available from the National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD). However, estimates suggest that there are at least 30 transfers from RACF to EDs per 100 beds per year, with 75% of these transfers being unplanned.[19] While the majority of ED presentations are considered to be appropriate,[20] approximately 13-40% of such presentations could have been avoided through the provision of appropriate care within the RACF.[21] Furthermore, residents transferred from RACFs to EDs have higher levels of re-presentation to the ED.[22]

Older people are also more likely to experience longer waits and access block (a stay in the ED of 8 hours or more) in the ED.[23] Analysis from ED data shows that in 2016 geriatric patients (54.3%) were less likely to be seen within four hours compared to paediatric (84%) or adult patients (73.7%). Geriatric patients were also more likely to experience access block (15% compared to 2.2% for paediatric patients and 6.6% for adult patients). The rate of access block increased to 23% for geriatric patients who were admitted to the hospital, with over 9,548 people (1%) spending more than 24 hours in the ED. Such long waits expose older people to poorer outcomes, including increased morbidity and mortality.

3.2 Adverse outcomes associated with hospital admission

In 2016-17 more than half of geriatric ED presentations resulted in admission to hospital (55%) or were referred to another hospital for admission (3%).[24] The rate of hospital admission among geriatric patients was 2-3 times higher than that of adult and paediatric patients.[25] While in many circumstances the care needs of the older person warrant an admission, such admissions may also be reflective of shifting the risk associated with discharging a patient from the ED to the inpatient ward.[26]

Furthermore, admission to the hospital also presents a series of risks to older people. In particular, residents from RACFs are at risk of further deterioration, with hospital admission associated with high rates of delirium, falls, pressure sores, nosocomial infections, and medication errors.[27] In addition, frail patients and those with dementia may experience deconditioning. However, in many circumstances these risks associated with hospital admission are downplayed by physicians or not communicated appropriately to older patients.[28]

Recommendation 3: ACEM recommends that older people, their family and carers should be informed of the risks associated with hospital admission. Where appropriate, shared decision-making should be employed to facilitate such discussions with the older person about their healthcare goals.

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[17] Crilly, J., Keijzers, G., Tippett, V., O'Dwyer, J., Lind, J., Bost, N., O'Dwyer, M., Shiels, S. and Wallis, M. (2015) 'Improved outcomes for emergency department patients whose ambulance off-stretcher time is not delayed', *Emergency Medicine Australasia,* vol. 27, pp. 216-224.

[18] Burkett, E., Martin-Khan, M. and Gray, L. (2019), 'Comparative emergency department resource utilisation across age groups', *Australian Health Review*, vol. 43, pp. 194-199.

[19] R., Stoelwinder, J., Gabbe, B. and Lowthian, J. (2015), 'Unplanned Transfer to Emergency Departments for Frail Elderly Residents of Aged Care Facilities: A Review of Patient and Organizational Factors', *JAMDA*, online, p.1-12.; Morphet et al. (2015)

[20] Finn, J., Flickers, L., Mackenzie, E., Jacobs, I.G., Fatovich, D.M., Drummond, S., Harris, M., Holman, D.C., Sprivulis, P. (2006), 'Interface between residential aged care facilities and a teaching hospital emergency department in Western Australia.', *Medical Journal of Australia*, vol. 184, no. 9, pp. 432-435.

[21] Morphet et al. (2015)

[22] Lukin, B., Fan, L., Zhao, J., Sun, J., Dingle, K., Purtill, R., Tapp, S. and Hou, X. (2016), 'Emergency department use among patients from residential aged care facilities under a Hospital in the Nursing Home scheme in public hospitals in Queensland Australia', *World Journal of Emergency Medicine,* vol. 7, no. 3, pp. 183-190.

[23] Burkett et al. (2019)

[24] Unpublished National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD) (2016-17)

[25] Ibid.

[26] Southerland et al. (2019)

[27] Dwyer et al. (2015)

[28] Southerland et al. (2019)

3.3 Discharge/transitions of care

ACEM notes that in many circumstances discharge from the ED back to the RACF could be significantly improved, particularly in terms of clinical handover. For example, if an older person is discharged from the ED, ED staff may not always provide new medications or document if medications have been changed or added.[29] RACFs may not be able to administer or obtain such medications, thus impacting on the care of the older person.

However, there are examples where clinical handover is done well. For example, one study showed that using envelopes containing a checklist for ED staff, ambulance officers and RACF staff to complete was both easy to use and makes clinical handover safer for residents.[30] Currently, the Australian Commission on Safety and Quality in Health Care (ACSQHC) requires that following discharge from hospital both patients and GPs receive a copy. However, there is no standard that mandates that RACFs are to receive a copy, even though they provide much of the nursing care to the older person, and there may be delays before the resident's GP visits.

Hospital data collection systems are often limited in their ability to identify residents from RACFs. In addition, *My Aged Care* data is not linked into hospital data systems, making it difficult to know that assessments have occurred, and if so, whether care is being provided in the community through a home care package or via a RACF. Data linkage would assist in identifying residents of RACFs in hospital datasets to support discharge and transitions of care.

Recommendation 4: ACEM recommends that the Federal Government facilitates data linkage between *My Aged Care* and hospital clinical data systems to allow for reliable and early identification of RACF residents and older persons with home care packages to facilitate safe transitions of care.

Recommendation 5: ACEM recommends that discharge summaries are sent to RACFs when patients are discharged from EDs and hospital. This should also include specific information required for both transfer to and from hospital to assist clinicians in both settings to provide the best care.

4. Potentially preventable contributors to ED presentations

ACEM will always support the right to access ED care when that care aligns with the wishes of the patient and yields health value. However, ACEM acknowledges that in some circumstances ED transfers are harmful because either the transfer results in iatrogenic harm and distress, and/or equivalent care could be provided at a lower cost in the RACF. ACEM wishes to highlight three such causes of potentially preventable ED presentations. In many circumstances these presentations could be prevented with adequate resourcing, skill mix and capacity of RACFs along with a support network which will be explored in the subsequent section of the submission.

4.1 Falls

Residents from RACFs are regularly transferred to EDs after falls. While falls are often associated with serious injury and can be potentially fatal, not all falls require a transfer to the ED.[31] Instead, monitoring of the resident as well as evaluating fall risk factors can be conducted within the RACF. Residents with injuries related to falls, particularly fractures and lacerations, may need to be transferred to the ED. However, a number of FACEMs have noted a significant increase in the number of older people from RACFs being transferred to the ED for a head CT scan following a fall without a prior risk assessment or system in place to determine whether the scan will alter clinical care. This has been linked to the findings of the South Australian Coroner, who recommended "the possible adoption of a protocol under which nursing facilities would refer patients following falls resulting in minor head injuries to hospital for assessment, and that hospitals receiving such patients should give consideration to the carrying out of a CT scan for at least those patients who are on anticoagulation therapy". Following this case, a number of alerts were issued, including by the Australian Government Department of Health, to prompt transfers of all residents who are on

[29] Stokoe et al. (2016)
[30] Belfrage et al. (2009)
[31] Lemoyne, S., Herbots, H., De Blick, D., Remmen, R., Monsieurs, K. and Van Bogaert, P. (2019), 'Appropriateness of transferring nursing home residents to emergency departments: a systematic review', *BMC Geriatrics, vol. 19 no. 17.*

anticoagulants and had a fall involving a head injury. While ACEM supports the transfer of residents, this must be preceded by first aid, an assessment of risk, and aligned with the resident's goals of care.

4.2 Medication errors

Internationally, 91% of residents of RACFs take five or more medications, while 65% take 10 or more medications regularly.[32] As a result of such polypharmacy, residents are subject to higher medication error rates, impacting at least 16-27% of RACF residents.[33] Medication errors result in preventable harm to residents of aged care facilities and pose a significant financial burden to the health system. In addition, there are high rates of medication errors across transitions of care; medication administration errors occur in 20% of residents discharged from hospital to RACFs, with contributors cited as failure to identify RACF residents in hospitals; poor quality of transfer information; delays in supply of medication in the required format; and absence of accurate medication charts available to nurses at the RACF on resident discharge.[34]

ACEM notes that the Medicare item for the Residential Medication Management Review (RMMR) is a useful tool to prevent inappropriate polypharmacy. However, there needs to be increased commitment to reduce adverse outcomes associated with polypharmacy. Some RACFs also have trialled co-locating pharmacists to increase oversight of medications and reduce polypharmacy where appropriate.

Recommendation 6: ACEM recommends the development of quality use of medicines standards for RACFs, including rates and quality of Residential Medication Management Review (RMMRs), to be considered as a quality measure.

4.3 Admissions for end-of-life care and palliative care

The number of ED presentations for end of life care are increasing. One study found that 20% of RACF residents who were transferred to the ED were for end of life (EoL) care.[35] Transferring older people from these facilities in order to provide EoL care within another setting, such as an ED, can be distressing and can deny the right to a good death surrounded by family, staff and an environment they know.[36]

ACEM notes that many RACFs provide excellent, patient-centred EoL care. However, challenges are created by a lack of access to primary care as well as clinicians fearing litigation.[37] In addition, not all residents have Advance Care Directives (ACDs) or Advance Care Plans (ACPs) in place, which have been shown to reduce avoidable transfers to the ED. The ACSQHC also suggests that Australia has a 'death denying' culture making it difficult for patients, clinicians, and relatives to have conversations about EoL and death.[38]

ACEM notes that whilst managing death and dying is a routine part of work in the ED, the practice of EoL care in the ED is best undertaken for patients with an unexpected or acute catastrophic event.[39] The provision of EoL care for patients on a predictable and anticipated course of a life-limiting chronic illness should ideally not occur in an ED. This requires good planning processes for EoL care including anticipatory management of the signs and symptoms of the dying process. Primary care

[32] Kosari, S., McDerby, N., Thomas, J. and Naunton, M. (2018), 'Quality use of medicines in aged care facilities: A need for new models of care', *Journal of Clinical Pharmacy and Therapeutics*, vol. 43, pp. 591-593.
[33] Ferrah, N., Lovell, J. and Ibrahim, J. (2017) Systematic Review of the Prevalence of Medication Errors Resulting in Hospitalization and Death of Nursing Home Residents, Journal of the American Geriatrics Society, vol. 65, no. 2, pp. 433-442.
[34] Elliott, R. and Booth, J. (2014) Problems with medicine use in older Australians: a review of recent literature, Journal of Pharmacy Practice, vol. 44, pp. 258-271.
[35] Dwyer et al. (2015)
[36] Ibid.
[37] Peng Leong, L. and Crawford, G. (2018) 'Residential aged care residents and components of end of life care in an Australian hospital', BMC Palliative Care, vol. 17, no. 84; Australian Commission on Safety and Quality in Health Care (2013) *Safety and Quality of End-of-life care in acute hospitals: a background paper*, https://www.safetyandquality.gov.au/wp-content/uploads/2013/09/SAQ083_End_of_life_care_V15_FILM_REVISED_TAGGED.pdf
[38] Australian Commission on Safety and Quality in Health Care (2013)
[39] Bradley, V., Burney, C. and Hughes, G. (2013) "Do patients die well in your emergency department?" *Emergency Medicine Australasia*, 25: 334.

prescribers need to be supported and empowered to both prescribe anticipatory drugs as well as de-prescribe unnecessary drugs.

Palliative care is a component of EoL care and its primary aim is to improve the quality of life of patients, as well as the families and carers of those approaching the end of their life.[40] Palliative care focuses on the provision of pain management and relief of suffering through early identification and assessment, as well as services that can assist with the psychosocial or spiritual needs of patients and their families.[41]

The use of ACDs is the intervention that is the most strongly supported by trial evidence to reduce unnecessary hospital admissions from RACFs.[42] ACEM strongly supports advanced planning of EoL care that can improve the quality of life of patients who are facing life-threatening illness or who are in the final stage of their life.[43] Research has shown that EoL care interventions can prove to be more beneficial if commenced early, and ACEM encourages broad community discussion regarding EoL care, limitations of medical interventions, and treatment of those who are nearing the end of their life due to terminal illness, including dementia, as well as the goals of EoL care.[44]

ACEM recommends that discussions regarding EoL and appointment of substitute decision-makers should be had with all patients who are entering a Residential Aged Care Facility (RACF). Dependent on the wishes of the patient, these discussions should involve their family, carer or, if appointed, a substitute decision-maker. Wherever possible, ACEM considers that these discussions should lead to an ACD or ACP, and that these ACDs and ACPs should be shared with all those involved in the care of the patient, including uploading into My Health Record. If the discussion does not lead to sufficiently robust outcomes this should be clearly documented. This documentation should accompany the patient if being transported to hospital. FACEMs have reported that it is very stressful for residents and ED staff when patients are dying and distressed in the middle of the night alone without family and no one knowing what the resident would want if they had the capacity to speak for themselves.

Recommendation 7: ACEM recommends that all people entering care in an RACF require a detailed discussion about their health needs, which should include a discussion with them, their family and carers or nominee regarding Advance Care Planning and Advance Care Directives. These discussions need to be ongoing and annually reviewed as well as after each acute hospital admission or any time their care needs change.

5. Decisions to transfer a resident from an RACF

The decision to transfer a resident from an RACF is contingent on a number of factors and such decisions can be driven by staff at RACFs, residents or relatives.[45] Various studies have identified that staff at RACFs are often risk-averse and fear litigation if they do not transfer a resident, given their duty of care to that resident.[46] However, as one study found, many staff transferred residents to EDs knowing that it would have a limited clinical benefit to the residents.[47] A concerning aspect of this study was that despite ACDs with 'do not hospitalise' orders, residents were nonetheless transferred to the ED because their ACDs could not be located in the facility.[48] In other circumstances, staff went against the wishes of residents, transferring them to the ED (with suggestions that this could also

[40] Russ, A., Mountain, D., Rogers, I. et al (2015) 'Staff perceptions of palliative care in a public Australia, metropolitan emergency department', *Emergency Medicine Australasia* 1.
[41] Ibid.
[42] Dwyer et al. 2015
[43] Choosing Wisely Australia (2016) *Australasian College for Emergency Medicine: tests, treatments and procedures clinicians and consumers should question, available online at:* http://www.choosingwisely.org.au/recommendations/acem
[44] Russ et al. (2015)
[45] Arendts, G., Quine, S. and Howard, K. (2013a), 'Decision to transfer to an emergency department from residential aged care: A systematic review of qualitative research', *Geriatrics and Gerontology International*, vol. 13, no. 4, pp. 825-33; Arendts, G., Popescu, A., Howting, D., Quine, S. and Howard, K. (2013b), "They never talked to me about. . .': Perspectives on aged care resident transfer to emergency departments', *Australasian Journal on Ageing*, vol. 34, no. 2, pp. 95-102.
[46] Arendts (2013b); Stokoe, A., Hullick, C., Higgins, I., Hewitt, J., Armitage, D., O'Dea, I. (2016), 'Caring for acutely unwell older residents in residential aged care facilities: Perspectives of staff and general practitioners', *Australasian Journal on Ageing*, vol. 35, no. 2, pp. 127-132.
[47] Arendts (2013b)
[48] Ibid.

reflect cost-shifting strategies by the RACF).[49] Relatives and residents may also encourage their own resident transfer to the ED, viewing the hospital as a safe or secure environment compared to the RACF.[50] Staffing levels, staffing skill mix, experience in clinical management of acutely unwell residents, access to emergency medications such as morphine for pain relief, and a duty of care to transfer an acutely unwell resident all influenced the decision to transfer residents.[51] Underpinning many of these decisions is a lack of confidence in the ability and resourcing of the RACF to provide adequate acute clinical care, particularly where they feel unsupported by a GP or Palliative Care clinicians.[52]

5.1 Risk assessments

In many circumstances the risk to residents and their health as a result of a transfer is not assessed. Given the number of risks posed from a transfer to the ED and the hospital, as well as ongoing risks from a lack of access to appropriate clinical care, conducting a risk assessment within the RACF offers a useful tool to weigh up the harms and benefits of transferring a patient to the ED.

The Aged Care Emergency Service (ACE) model in NSW has involved the development of more than 20 evidence-based algorithms to assist RACF staff in managing common clinical issues amongst residents such as falls, urinary catheter issues and shortness of breath.[53] Such algorithms assist staff in determining when a transfer to an ED should be conducted.

Recommendation 8: ACEM recommends that standardised risks assessments are implemented in RACFs to assist in decision-making regarding transfers of residents to the ED.

6. Delivery of best practice clinical care

Older people deserve the highest quality clinical care; whether it is provided within the home, the RACF, primary care or the hospital system. As one study showed, RACFs would prefer to deliver care to their residents within the RACF to prevent distressing and potentially risky transfers to the ED and hospital.[54] However, it is clear that RACFs are not adequately funded and resourced to deliver the level of clinical care that the health needs of residents warrant. While it is expected that the Aged Care Quality and Safety Commission – through the new Aged Care Quality Standards – will increase the standard of clinical care in RACFs,[55] ACEM is cautious about the ability of providers and the Commission to implement and measure many of these clinical outcomes. ACEM is supportive of aligning accreditation to meeting these standards. However, RACFs require appropriate access and funding for clinically trained staff, and adequate resourcing to attend to the needs of residents and prevent avoidable and potentially harmful transfers to the ED.

6.1 Staffing and access to medical care

6.1.1 Registered nurse to patient ratios

According to the latest Aged Care Workforce Census, the RACF workforce who provide direct care is comprised of 15% registered nurses (RN), 10% enrolled nurses (EN), 0.3% nurse practitioners, and 70% personal care attendants.[56] RNs and ENs are registered with the Nursing and Midwifery Board and are trained to administer medication, control infection and ensure adequate nutrition.[57]

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[49] Arendts (2013b)
[50] Ibid.
[51] Stokoe et al. (2016)
[52] Arendts (2013a); Arendts (2013b); Stokoe et al. (2016)
[53] Hullick, C., Conway, J., Higgins, I., Hewitt, J., Dilworth, S., Holliday, E. and Attia, J. (2016), 'Emergency department transfers and hospital admissions from residential aged care facilities: a controlled pre-post design study', *BMC Geriatrics*, vol. 16, no. 102.
[54] Stokoe et al. (2016)
[55] Aged Care Quality and Safety Commission (2019) *Guidance and Resources for Providers to support Aged Care Quality Standards*, https://www.agedcarequality.gov.au/sites/default/files/media/Gudiance%20and%20Resources%20for%20Providers%20to%20support%20the%20Aged%20Care%20Quality%20Standards.pdf
[56] Mavromaras, K., Knight, G., Isherwood, L., Crettenden, A., Flavel, J., Karmel, T., Moskos, M., Smith, L., Walton, H. and Wei, Z. (2017) *The Aged Care Workforce, 2016* https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf
[57] Russell, S. (2016) 'Here's why we need nurse-resident ratios in aged care homes', *The Conversation*, https://theconversation.com/heres-why-we-need-nurse-resident-ratios-in-aged-care-homes-59682

Lower registered nurse to patient ratios are associated with increased transfers to EDs.[58] In a study where workers in RACFs were interviewed, such workers identified that patients were transferred to the ED because staff were concerned about their duty of care, and were ill-equipped in regards to acute illness management alongside a lack of access to other medical personnel.[59]

International research shows that increased registered nurse to patient ratios are associated with improved patient care and reduced transfers to the ED.[60] In particular, higher levels of direct registered nurse care time per resident is associated with lower incidence of pressure injuries, hospital transfers, lower levels of weight loss and deterioration in ability to perform activities of daily living, and greater use of oral nutritional supplements.[61] Nursing shortages are also associated with high incidences of missed care, particularly in regards to medication management, wound care and the measurement of vital signs.[62]

There have been numerous calls for amendments to the *Aged Care Act 1997*. Under this legislation providers must "maintain an adequate number of appropriately skilled staff to ensure that the care needs of the care recipients are met". Amendments to this legislation as part of the Living Longer Living Better reforms has resulted in a removal of the distinction between high and low care, rendering other state-based legislation – which ensures minimum nurse to patient ratios – such as the *Public Health Act 2014* (NSW) inadequate.

While Victoria has passed amendments within the *Safe Patient Care Act 2015* which establishes registered nurse to resident ratios, this is only in public high care residential aged care homes.[63] Given that the majority of aged care is delivered by non-government (for-profit and non-profit) it is vital that legislation covers all providers of RACFs nationwide. To improve transparency there should also be public reporting of registered nurse to patient ratios to assist older people and their families make informed decisions regarding RACFs.

In addition to ensuring adequate staffing levels of registered nurses, there is also inadequate pay parity between aged care and hospitals (due to different award rates). It is vital that these awards are aligned to ensure that pay does not become a disincentive for registered nurses to work in RACFs.

Recommendation 9: ACEM recommends that the *Aged Care Act 1997* is amended to reflect the need for all RACFs to have registered nurse to resident ratios to ensure that residents receive the high standard of clinical care they require. This could be aligned to rehabilitation ratios in acute hospitals and should consider the frailty and complexity of care required by RACF residents. Aged Care Registered Nursing awards should be at parity with acute hospital nursing.

6.1.2 Access to primary care

Access to primary care is an essential part of ensuring that residents in RACFs receive the clinical care they require, and a lack of access is compromising resident care. Only 21% of GPs are regularly engaged in RACF resident care, while just 50% of RACFs have facilities for GP visiting rooms.[64] Approximately 41-71% of decisions regarding the transfer of an RACF resident to an ED involves consulting with GPs or a primary care physician.[65] Similarly, GPs had reviewed a resident in 11-44% of cases before they were transferred.[66] Given that the number of residents in RACFs is only expected to

[58] Dwyer et al. (2015)
[59] Hullick et al. (2016); Dwyer et al. (2015)
[60] Dwyer et al. (2015)
[61] Ibid.
[62] Henderson, J., Wills, E., Xiao, L. and Blackman, I. (2017), 'Missed care in residential aged care in Australia: An exploratory study', *Collegian*, vol. 24, pp. 411-416.
[63] Department of Health and Human Services (2019) *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015,* https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/safe-patient-care-act
[64] Reed, R. (2015), 'Models of general practitioner services in residential aged care facilities', *Australian Family Physician*, vol. 44, no. 4, pp. 176-179; Hambleton, S. (2014) Aged care: three areas in need of support, *Financial Review*, 12. https://www.racgp.org.au/afp/2015/april/models-of-general-practitioner-services-in-residential-aged-care-facilities/
[65] Dwyer et al. (2015)
[66] Ibid.

increase, the present situation is unsustainable and is compromising the care of residents, resulting in transfers to the ED that could have been prevented through the provision of timely, appropriate and coordinated care.

Similarly, there are a number of community-based programs which have been shown to have positive health and social outcomes for older people. However, only older people living in their home are eligible to access many of these programs, preventing residents from RACFs receiving the benefits of these programs. Many of these eligibility requirements are due to funding limitations created between Federal and State funding divides. For example, some programs are funded under the Commonwealth Home Support Program (CHSP) or State-based health funding and as a result cannot accept residents from RACFs, who receive funding under a different instrument, thus considered to be 'double-dipping'. Examples of such state-funded programs include Mental Health Care Plans, access to rehabilitation discharge teams or home nursing programs for wounds, dressings and pathology, imaging, and hospital in the home. Furthermore, this distinction is often made because there is an assumption that RACFs are able to deliver these programs or provide allied health care to improve the functional capacity of residents. However, in reality this is not always the case. This presents an inequitable situation preventing RACF residents from receiving the health and social care they require.

Recommendation 10: ACEM recommends that funding is committed for integrated care models that support acute healthcare needs being met in the right place, at the right time and in a setting that is concordant with resident choice. This could be supported by ensuring that all RACFs have facilities for, and competencies in, delivery of telehealth.

Recommendation 11: ACEM recommends that amendments are made to Medicare item numbers to ensure that they adequately account for the delivery of primary care, including both GPs and Nurse Practitioners undertaking advance care planning as well as the provision of Mental Health Care Plans for residents of RACFs.

6.1.3 Professional isolation and Communities of Practice

Staff in RACFs commonly experience professional isolation, particularly if there is limited focus within their RACF on enhancing the clinical experience and professional development of staff. Committing to professional development and knowledge sharing may lead to enhanced clinical care for residents in RACFs. The Communities of Practice model is currently being implemented to assist in knowledge-sharing from experienced clinicians regarding common health needs of residents such as influenza and mental health. Such a model operates similar to a bimonthly interagency meeting involving personnel from ambulance services, hospitals and RACFs. The outcome of these meetings is reduced professional isolation, and assists in opening the dialogue between these professions, developing professional collaboration and relationships. It is also a forum to reinforce standardised pathways for common ED presentations for acutely unwell residents.

Recommendation 12: ACEM supports the development of training and education pathways for RACF based nurse practitioners working in collaboration with GPs along with hospitals, community services and the older person and their families.

Recommendation 13: ACEM recommends that funding is committed towards programs or 'Communities of Practice' that build knowledge and capacity of RACF clinicians and GPs in partnership with ED, hospital and ambulance staff to optimally provide for the healthcare needs of their frail residents.

6.2 Standardised treatment and decision-making protocols

Research has shown that between 40% and 66% of antimicrobials administered in RACFS do not meet the required criteria for clinical infection, and 31% of antibiotics are prescribed for more than six months.[67] As a result, RACF residents have a 24% higher risk of antibiotic related harm including

[67] ACSQHC (2016) *Antimicrobial prescribing and infections in Australian residential aged care facilities: results of the 2015 Aged Care National Antimicrobial Prescribing Survey Pilot*, Commonwealth of Australia: Sydney; Lim, C.J., et al. (2012), 'Surveillance of infection

the presence of multi-resistant organisms such as extended-spectrum beta-lactamase (ESBL)-producing E. coli.[68] RACF residents are at an increased risk of infection, with an associated mortality of 8% amongst this population.[69] In addition, wounds are a significant issue for residents of RACFs, with a prevalence of pressure injuries reported at 25-43% and evidence of avoidable morbidity and, in some cases, mortality.[70] A lack of timely referral and access to wound care specialists also frequently leads to delays in accessing wound specialist care and thus potentially avoidable transfers to EDs.

Many of the clinical issues attributed to poor wound management, antimicrobial misuse and medication errors could be appropriately managed through standardised procedures and protocols. There is also a lack of standardised medication incident reporting in RACFs, which can assist in improving the quality of clinical care that is provided. There is significant variance in RACF policy frameworks, and the system lacks a systematised application of screening and wound prevention programs including pressure-injury screening and prevention, access to pressure-relieving support surfaces, protein and energy supplementation, and continence management. Decision-making tools can also assist in determining whether a patient requires immediate transfer for an acute clinical need.

While the Victorian Department of Health and Human Services has developed 19 Standardised Care Processes for commonly occurring medical issues of residents, such standards are directed at publicly-owned residential aged care services. There is a lack of accountability and enforcement in the implementation of such measures, especially for non-government providers.

One example is the "Champions for Skin Integrity Program", a multi-modal education program utilising interactive DVDs, clinical pathways and RACF skin-integrity champions, that demonstrated increased implementation of evidence-based wound management and prevention strategies, decreased prevalence and severity of wounds in RACF residents, and improved staff skill and knowledge of wound management. Standardised wound pathways or computerised decision support are demonstrated to be cost-effective and associated with improved patient outcomes. Systematised pressure injury prevention programs, including pressure injury monitoring and management, use of pressure-relieving support surfaces, and dietary supplementation with protein and energy supplements are associated with reductions in pressure injury prevalence.

In NSW, Hunter New England operate the Aged Care Emergency (ACE) service and while the Hornsby, Ku-ring-gai Local Health District runs the Geriatric Rapid Acute Care Evaluation (GRACE). These pathways allow clinicians to all be on the same page for complex health issues in a complex health system, understanding local resources.

To assist in decision-making, residents of RACFs would also benefit from the development of an individualised action plan. These plans should be similar to an asthma action plan that guides RACF staff in management of expected deterioration of residents, including medication errors. This includes plans such as Chronic Obstructive Airways Disease, Congestive Cardiac Failure, Behavioural and Psychological symptoms of Dementia, and Diabetes.

Recommendation 14: ACEM recommends that mandatory clinical quality measures are implemented, reported, benchmarked and linked to accreditation in order to measure and drive improvements to the quality and standard of clinical care delivered in RACFs. Domains for measures should include, at a minimum, risk adjusted measures of:

- pressure injury rates;

burden in residential aged care facilities'. *Medical Journal of Australia*, vol. 196, no.5 p. 327-31; Stuart, R.L., et al. (2012) 'Antibiotic use and misuse in residential aged care facilities', *International Medical Journal*, vol.42, no. 10, pp. 1145-9.

[68] Stuart, R., Kotsanas, D., Webb, B., Vandergaaf, S., Gillespie, E., Hogg, G. and Korman, T. (2011) 'Prevalence of antimicrobial-resistant organisms in residential aged care facilities', *Medical Journal of Australia*, vol. 195, no. 9, pp. 530-533.

[69] Hunter, J.C., Mu, Y., Dumyati, G. et al. (2016) Burden of Nursing Home-Onset Clostridium difficile Infection in the United States: Estimates of Incidence and Patient Outcomes, *Open Forum Infectious Diseases*, vol. 3, no. 1, pp. ofv196

[70] Santamaria, N., Carville, K., Prentice, J., Ellis, I., Ellis, T., Lewin, G. and Newall, N. (2005), 'Pressure ulcer prevalence and its relationship to comorbidity in nursing home residents: results from phase 1 of the PRIME trial Primary intention', *The Australian Journal of Wound Management*, vol. 13, no. 3, pp. 107-116.

- acute hospital transfer rates;
- antipsychotic and sedative prescribing rates;
- antimicrobial prescribing rates; and
- advance care planning rates.

Recommendation 15: ACEM recommends that standardised treatment, clinical documentation and decision-making protocols that support individual RACF residents' goals of care are established and their use is monitored across RACFs to ensure that residents receive the highest standard of clinical care.

7. ED avoidance strategies

Hospital in the Nursing Home (HINH) has evolved from previous models of Hospital in the Home seeking to reduce avoidable transfers to the ED. The HINH model is funded by the Queensland Department of Health and is delivered by nurses within the ED who conduct screening, assessment and then coordinate with staff at RACFs, GPs, and other allied health professionals. In addition to clinical care, these critical care nurses deliver education to RACF staff and ensure open communication between stakeholders (resident, family, RACF staff, GP, ED staff and ward staff). An evaluation of this model demonstrated a 17% reduction in ED presentation and a 47% reduction in hospital admissions of residents.[71]

The ACE model has also been trialled in NSW and involves an ED practice nurse who coordinates care between the RACF and the ED.[72] In addition, this intervention involved more than 20 evidence-based algorithms to assist RACF staff in managing common clinical issues amongst residents such as falls, urinary catheter issues and shortness of breath.[73] This intervention similarly involves an educational component for RACF staff and case management. An evaluation of this intervention showed a reduction in the ED stays by 45 minutes and if admitted to the hospital, length of stay was reduced.[74] Other examples of similar models include Geriatric Emergency Department Intervention (Queensland)[75] and Silver Chain (Western Australia).[76]

Recommendation 16: ACEM recommends that funding is committed towards advanced practice nurses to deliver such programs to enhance the education of RACF staff, improve clinical decision-making and ensure seamless transitions between RACFs, EDs and hospital wards.

Thank you for the opportunity to provide a submission to this Royal Commission. If you have any questions please do not hesitate to contact Freya Saich, Policy Officer on 03 9230 0444 or Freya.Saich@acem.org.au.

Yours sincerely,

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[71] Lukin et al. (2016)
[72] Hullick et al. (2016)
[73] Ibid.
[74] Ibid.
[75] Queensland Government (2019) Geriatric Emergency Department Intervention (GEDI), available online at: https://clinicalexcellence.qld.gov.au/improvement-exchange/gedi

[76] Silver Chain (2019) Country services, available online at: https://www.silverchain.org.au/wa/health-care/country-services/