

Royal Commission into Aged Care Quality and Safety: the key clinical issues

The uncoupling of health care from aged care is a worrying trend

When the Prime Minister and the Health Minister jointly announced the Royal Commission into Aged Care Quality and Safety in Australia in September 2018, they did not mention health care. It was also absent from the terms of reference describing which matters will be the subject of this inquiry.¹ The uncoupling of health care from aged care is a worrying trend as the two are inextricably intertwined. Good health is an important contributor to quality of life, which is why the Convention on the Rights of People with Disabilities (article 25) includes equitable access to health care within a human rights framework. This article addresses the first of the Commission's seven broad terms of reference;¹ that is, the quality of residential aged care services (Box) from a clinical perspective.

Residential aged care facility (RACF) business models are moving away from a perceived medically dominated model of care provision.² This trend does not serve the rights of older people in residential care to equitable access to health care, many of whom have complex medical comorbidities. In contrast, the approach of acute care hospitals and state health departments is to consider RACFs as a quasi-acute health care facility, evident by the implementation of In-Reach services³ and other efforts to divert presentation of residents to emergency departments.⁴ The *Aged Care Act 1997* (Clth) does not provide clarity and describes that a person is eligible for entry to a RACF if they have "physical, medical, social or psychological needs that require the provision of care".⁵ Greater clarity is required from the Royal Commission to match the entry criteria with the actual health care service needs of residents and to articulate the setting in which this care is delivered.

Defining and setting standards

Evaluating quality and safety of health care requires defining standards and identifying who is responsible for meeting those standards. This clinical accountability is not clear in aged care.

Another, and complementary, approach to measuring processes of care is defining substandard care according to resident outcomes. Adverse events affecting residents may result from a spectrum of processes, including egregious criminal behaviour (sexual assault perpetrated by staff or other residents), organisational mismanagement (sanctions from the Aged Care Quality and Safety Commission), errors of commission or omission by health professionals (poor clinical care), and natural disease progression. Importantly, there are situations



in which clinical care is beyond reproach, and yet it is judged as being poor because of the occurrence of an undesirable outcome.

Determining if care is substandard requires establishing a direct, proximate and causal link between the delivery or omission of care and the outcome. This is not straightforward because of the presence of confounding variables including patient and disease factors.

Measuring against the standards

Annual, national data for evaluating the clinical management of frail older adults with chronic disease in RACFs is limited. The only publicly available source is ad hoc peer review articles of empirical research, which offer many examples of poor clinical care.⁶⁻¹¹ The Royal Commission will have access to other private and commercial-in-confidence information, which should shed even more light on the deficits in care.

The extent of known poor clinical care includes overprescribing of antipsychotics⁶ as a first-line treatment for behavioural and psychological symptoms of dementia, which continues to be a major, systemic industry-wide problem. A multipronged interdisciplinary intervention demonstrated that 39% of RACF residents prescribed antipsychotics and benzodiazepines could successfully have these agents ceased or doses reduced.⁷ The prevalence and severity of chronic respiratory conditions are underappreciated and undertreated.⁸ Moreover, a review of diabetes management⁹ identified a 10% frequency of hypoglycaemic events and 69% of residents with persistent hyperglycaemia (glycated haemoglobin > 10%). The list continues with suboptimal pain management¹⁰ and poor oral care with untreated dental caries.¹¹ The commissioners should be transparent in describing the prioritisation of actions to address gaps in care. The major danger is failing to address gaps because of the absence of

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doi: 10.5694/mja2.50168

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Terms of reference

Royal Commission into Aged Care Quality and Safety Terms of Reference, No. 1 (abridged)

“The quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, the causes of any systemic failures, and any actions that should be taken in response.”¹

empirical data. These are all concrete measurable outcomes.

Other measurable adverse resident outcomes are sexual assault,¹² serious injuries and preventable deaths from falls, choking, suicide, and resident assault.¹³ The plethora of inquiries provide more distressing data, perhaps the best known being the scandal at Oakden,¹⁴ and beyond this are the data held by the Department of Health. In 2017–18, the Department of Health received reports of serious incidents, including 3226 assaults, 513 unlawful sexual incidents and 1450 unexplained absences (absconding).¹⁵ The adverse outcomes experienced by individual residents that are most disturbing and visible to the public are regularly seen in the deaths investigated by coroners.¹⁶

Determining if variation from standards is due to random or assignable factors

It is unclear how much of the variance from accepted practice is random (due to chance) or assignable (due to poor quality care) and perhaps modifiable. There is a dearth of evidence-based guidelines for the care of patients in RACFs, meaning judgements about the quality of care are fraught.

Another complicating factor is the growth of outreach interventions and diversionary care provided by clinical services outside of RACFs, typically acute care hospitals.^{3,4} The provision of these services can be viewed in two ways. First, these services arise because there are not enough general practitioners or because the GPs lack the skills required to meet the needs of the residents. The alternative view is that acute care hospitals are behaving in an unreasonable manner by imposing upon RACFs and GPs the need to provide specialised acute care to avoid residents being hospitalised. Whichever argument is preferred, what is beyond debate is that this is evidence of a failure to recognise and align practice to the contemporary needs of the RACF population.

Addressing the assignable factors to remove the underlying causes

To begin addressing the underlying causes requires a cadre of recognised experienced health professionals knowledgeable and practising in RACFs. Panels comprising experts and consumers are required to adjudicate quality of care and not simply rely on accreditation assessors. Three of the many conditions required to eliminate variation in clinical care include promoting the use of clinically relevant data, clarity in the lines of accountability and clinical governance, and

achieving a sustainable medical workforce and new models of care.

Promoting the use of clinically relevant data

There is a paucity of annual, national level performance data, and existing data sources are underutilised. Apart from public sector RACFs in Victoria,¹⁷ the use of quality indicators nationally is poor, with about 10% of RACFs collating three clinical measures (pressure injuries, use of physical restraint, and unplanned weight loss).¹⁸ Public reporting of these results has not yet occurred, despite the known benefits to improving care shown in the United States.¹⁹

Improving the collection of data about the day-to-day performance of the health care professionals and aged care providers is beyond the remit of academic researchers. Instead, the government and regulatory bodies should mandate a core set of clinical data from all RACFs that are made available for performance monitoring and research.

Clarity in the lines of accountability and clinical governance

There is a need to unambiguously define and state the lines of accountability; that is, the clinical governance arrangements for RACFs. The general notion that the GP of the older patient is and remains solely responsible for their health care within the RACF is no longer sustainable or practical. The modern era requires management of chronic and complex conditions that are not frequently seen in everyday general practice and that need specialised, interdisciplinary, team-based care, which includes nurses, pharmacists and allied health professionals.

This may require revising the Charter of Care Recipients’ Rights and Responsibilities in Residential Care, which aims to protect the older persons’ personal, civil, legal and consumer rights. The charter contains a range of platitudes with no guidance on implementation. The lack of useful contemporary, Australian evidence-based clinical practice guidelines complicates the situation further.

Achieving a sustainable medical workforce and new models of care

A sustainable workforce requires addressing the barriers perceived by GPs to providing services in RACFs.²⁰ These include the small direct remuneration, opportunity cost, additional administrative burden, and unremunerated work. It may be more productive to explore different models of GP care, which include

GPs with a special interest in RACFs and models in which GPs partner with RACFs. Beyond the scope of this perspective, the Royal Commission should also investigate the absence of routine roles for geriatricians and psychogeriatricians and how this should be addressed to better support GPs.

Conclusion

The Royal Commission into Aged Care Quality and Safety needs to take a transformative approach that includes tightly coupling RACFs to health care. Addressing the egregious human rights breaches and developing strategies to reduce and eliminate harm from abuse, mistreatment and neglect are crucial.

Optimal health care is an essential requirement for maintaining and improving the lives of older people and this should be one of the core roles of RACFs. This requires the medical profession to establish new standards, identifying and bridging gaps in empirical knowledge, using performance data and advocating for the structural solutions that support promoting the use of evidence-based practice at the point of care.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed. ■

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