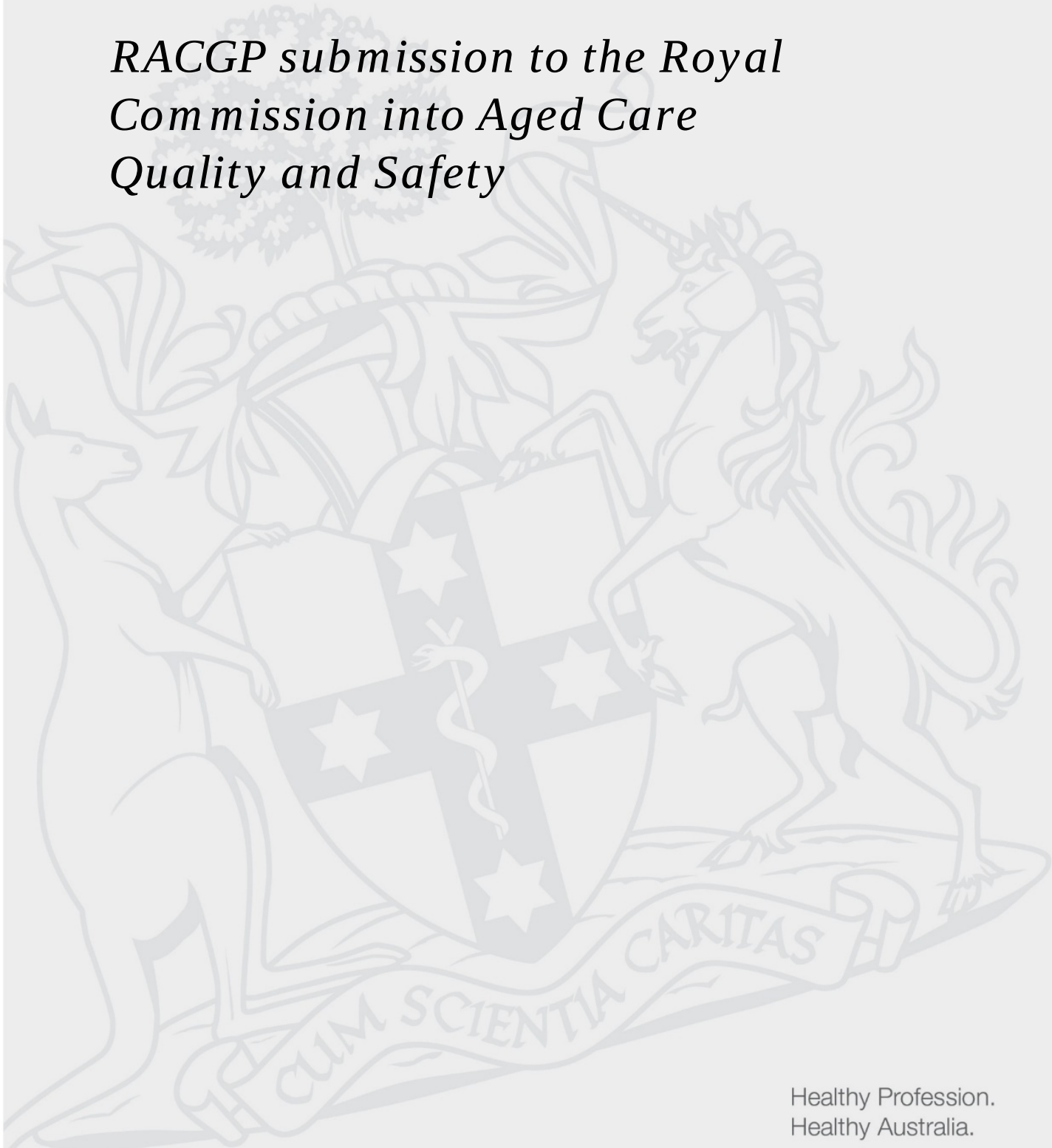
RACGP

Royal Australian College *of* General Practitioners

RACGP submission to the Royal Commission into Aged Care Quality and Safety



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RACGP submission to the Royal Commission into Aged Care Quality and Safety

Contents

Key recommendations

Patient-centred care

1. The most appropriate care for elderly people should integrate the wishes of the patient and, where appropriate, those of their family and carers
2. Government, health and social initiatives must be tailored to meet the needs of young people (aged <65 years) with disabilities and their carers. Residential aged care facilities (RACFs) may not be the most appropriate facilities for these patients

Access to medical care

3. Residents in RACFs must be able to access their own preferred GPs. If this is not possible, there should be a choice of general practitioners (GPs) provided to the resident and their family
4. RACFs should provide greater patient access to care from GPs and other members of the multidisciplinary care team (eg other specialist medical practitioners, allied health professionals)
5. Proper remuneration for GPs for their time spent performing unremunerated work, including new MBS rebate items, should be introduced to alleviate the barriers GPs currently face when working in RACFs

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6. A fully equipped office or consultation room needs to be available for GPs performing consultations in RACFs

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7. Improve supports (individualised to the region) to keep urban, rural and remote GPs engaged in the aged care sector as part of the aged care workforce strategy
8. Medical students and interns need to have opportunities to provide aged care services through rotations and training placements, to promote early exposure to, and interest in, the aged care sector
9. Strengthen the aged care workforce's knowledge, skills and capability to support patients with dementia
10. Establish a nationally consistent regulatory framework around minimum staffing and appropriate skills mix in RACFs
11. Staff employed by RACFs need better education and training in many core areas of aged care, including medication management, falls prevention, pressure sore and wound care, before they commence working in RACFs

Clinical governance

12. Resources should be developed to support GPs, nurses and RACF staff, care for patients with dementia in RACF
13. Establish a set of common quality assurance principles for RACFs based on shared purpose, and meeting the needs of residents and carers
14. Establish a minimum data set of key indicators, which include resident-reported, family-reported and staff-reported measures, that is publicly available
15. The management of difficult, aggressive and/or vexatious residents in RACFs and family members is an issue that needs attention

Executive summary

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to make this submission, and provides answers to the questions posed by the Royal Commission that are most relevant to the general practice profession.

The care of residents in residential aged care facilities (RACFs) is complex, and the important role of general practice and general practitioners (GPs) is almost always overlooked.

GPs often look after a patient for many decades before the patient becomes a resident in an RACF, and will usually be the only non-family familiar face that the resident regularly encounters. The patient's usual GP will typically know the medical and clinical history of the patient, often including the patient's whole life experience beyond medical encounters. The importance of allowing a patient and their family to choose their own GP cannot be over emphasised. A person, whether living in the community or in an RACF, should be able to choose their own nominated GP.

The RACGP therefore advocates for a model of medical care for RACF residents that integrates with general practice, and enables GPs to continue to oversee their patients' medical care. GPs should be able to work in collaboration with the patient's broader multidisciplinary healthcare team, including RACF staff, other specialist medical practitioners, and allied health professionals, in a way that focuses on residents' and carers' needs.

GPs face significant barriers in providing care to residents in RACFs, including a lack of recognition of their role as a patient's nominated GP; inadequate clinical, administrative and financial support; clinical complexity; time pressures; workforce issues; and lack of infrastructure and support structures. Suitably qualified and appropriately trained staff in RACFs is also essential to the quality of care provided to residents.

The Royal Australian College of General Practitioners

The RACGP is Australia's largest medical organisation, representing more than 40,000 members who provide more than 154 million general practice services each year to more than 24 million Australians.

The RACGP's mission is to improve the health and wellbeing of all people in Australia by supporting GPs, general practice registrars and medical students through its principal activities of education, training and research and by assessing doctors' skills and knowledge, supplying ongoing professional development activities, developing resources and guidelines, helping GPs with issues that affect their practice, and developing standards that general practices use to ensure high-quality healthcare.

The RACGP has a strong interest in the care of residents in RACFs, and publishes *Medical care of older persons in residential aged care facilities* (Silver Book), one of the RACGP's flagship clinical publications.

1. How well does the aged care system (or any part of that system) meet the needs of the people accessing the system?

As the professional body for GPs, the RACGP is principally concerned with the quality of healthcare provided to residents in RACFs. The healthcare needs of residents in RACFs are high and often complex, involving the management of multiple chronic health conditions. Providing high-quality medical care for elderly people living in RACFs requires a special set of knowledge, clinical skills, attitudes and practice arrangements.

GPs play a significant role in supporting patients to make the transition into residential care living. They can ease the move for the patient and their family by arranging community supports while waiting for a placement, by transferring medical records to the chosen GP at a new locality, or by accepting the care of a new patient moving into a local facility.

GPs perform these roles and have these skills, and are the main providers of care to elderly people; however, the important role that they play are almost always overlooked. Government initiatives, such as the recent My Aged Care website, fail to recognise the important role GPs play and consult appropriately with the profession when designing and implementing reforms. RACFs often fail to support and facilitate access for GPs.

4. If it is your view that the aged care system (or any part of the system) does not meet those needs, in what way and why is this the case?

Management of complex health needs

Residents in RACFs often have complex medical and health needs. Older people in RACFs are the most vulnerable subsection of an age group that manifests the highest rates of disability in the Australian population. Annually, 30% of residents have one or more falls and 7% fracture a hip. The prevalence of chronic conditions among residents in high care is estimated to be 80% sensory loss, 60% dementia, 40–80% chronic pain, 50% urinary incontinence, 45% sleep disorder, and 30–40% depression. Other common chronic conditions include:[1]

- arthritis
- asthma
- cancer (eg lung and colorectal cancer)

- cardiovascular disease (eg coronary heart disease and stroke)
- chronic obstructive pulmonary disease (COPD)
- diabetes.

The patient's usual GP will typically know the medical and clinical history of the patient, often including the patient's whole life experience beyond medical encounters. This knowledge and experience is crucial in ensuring continued high-quality medical care. The provision of continuity of care for patients as they age, and making clinical judgements on the most appropriate care for the individual, is a fundamental part of quality general practice. The most appropriate care would integrate the wishes of the patient and, where appropriate, those of their family and carers.

Despite GPs caring for their patients over many years, often many decades, their important role is often overlooked and not well supported.

GPs face significant barriers in providing care to residents in RACFs, including a lack of recognition of their role as a patient's nominated GP; inadequate clinical, administrative and financial support; clinical complexity; time pressures; workforce issues; and lack of infrastructure and support structures. Suitably qualified and appropriately trained staff in RACFs is also essential to the quality of care provided to residents.

These barriers are significantly amplified for GPs working in rural and remote communities. Distance is a constraint for rural and remote GPs who seek training to help meet the needs of their elderly patients. Access to broader supports from supplementary services (eg rehabilitation, disability services) can also be variable, requiring GPs to have a broad range of skills to meet their patients' needs.

Improving the supports required to keep urban, rural and remote GPs engaged in the aged care sector should be a key consideration in any aged care workforce strategy.

Preventive care

Preventive care remains an important priority for elderly people, and there is a need to continue with age-specific, sex-specific and ethnicity-specific guidelines to screen for the prevention of chronic disease, cardiovascular and metabolic risk factors, and cancer. Additionally, there needs to be a focus on immunisation; screening for falls risk, memory loss, vision loss and hearing impairments; and assessment of continence.

More information on preventive care in elderly people can be found in Chapter 5 of the RACGP's *Guidelines for preventive activities in general practice*.

Dementia

Elderly people with dementia account for more than half of all residents in RACFs. Therefore, it is vital the aged care workforce's knowledge, skills and capability to support these patients are strengthened.[2]

This is a significant challenge with dementia care within RACFs because of the high rates of staff turnover, leading to a dependence on agency staff who often have little background knowledge of the residents to whom they are providing care.

These high levels of turnover are often the result of the challenges posed by high demand for services and complex patient needs in an under-resourced environment. Additional resources should be made available to RACF staff and GPs who support patients with dementia in RACF and the community setting. These resources must ensure patients with dementia can continue to be treated within their RACF or usual residential setting (where

possible). Appropriately trained professionals must be readily available to patients in these settings, to support RACF staff and the patient's usual GP, to assist the patient, and manage the symptoms of dementia.

More information on the diagnosis and management of dementia can be found in Section 5.5 of the RACGP's *Guidelines for preventive activities in general practice*.

Multidisciplinary approach

Patient access to care from GPs and other members of their multidisciplinary care team (eg other specialist medical practitioners, allied health professionals) is important for this vulnerable population group. Assessment information and expertise from each discipline can be shared and used to define issues, set management goals and implement care plans. Teamwork is most effective within a climate that encourages the sharing of information and a spirit of cooperation. Some of the significant barriers around integration between services include:

- fragmentation between allied health services, where information flows are restricted because of separate medical records and low use of and, interoperability between, secure point-to-point messaging systems
- low uptake of the National Residential Medication Chart
- no integration between general practice medical records and RACF medical records.

Supporting and promoting better integration between the services provided to elderly people must be a priority as it will ensure the health and medical sector is better equipped to deliver care to these patients.

Mistreatment of elderly people

Residents in RACFs are particularly vulnerable to elder abuse, which can take many forms, including verbal, physical, emotional, sexual and economic. Elder abuse can occur whenever there is an imbalance of power, and is associated with increased mortality and disability. While there is no factual account of the prevalence of elder abuse, statistics estimate the figure to be around 2.3–5.4%.[3,4,5] It has been noted that there may be up to five unreported instances of elder abuse to every one reported.[6]

GPs are often the first and only independent professional to see residents from RACFs who are experiencing elder abuse. Tools such as the Elder Abuse Suspicion Index (EASI)[7] can be used if there is suspicion that elder abuse is taking place. If the suspicion is confirmed, patient consent must be obtained in order to report the information to appropriate parties. While there is no legal onus on GPs to report elder abuse, GPs have a responsibility to ensure the continued health and wellbeing of all patients.

More information on elder abuse can be found in Section 10.1 of the RACGP's *Abuse and violence: Working with our patients in general practice*.

Infrastructure

The significant lack of appropriate infrastructure in RACFs is another barrier for GPs attending and appropriately consulting elderly people. Key barriers around infrastructure include:

- lack of dedicated consultation rooms
- variable access to appropriate equipment (eg adequate lighting to undertake examinations)
- medical records that are held or shared in different locations (eg practice-based and RACF-based records).

For GPs providing services within an RACF, a fully equipped office or consultation room is essential. Access to computers with up-to-date software, which supports the management and sharing of sensitive patient information, is also important.

Young people with disabilities

There are currently 6000–7000 young Australians (aged <65 years) who reside in RACFs. These people usually have high complex medical needs. Often, existing government, health and social initiatives are not meeting the needs of these young people and their carers. The following objectives are crucial to the care of young people with disabilities in aged care:

- moving young people with disabilities in RACFs to appropriately supported disability accommodation
- diverting young people with disabilities from entering RACFs and into more appropriately supported disability accommodation
- supporting the access of specialist disability services to young people with disabilities in RACFs who choose to remain in RACFs or if RACFs are the only available suitable accommodation.

The current roll out of the National Disability Insurance Scheme (NDIS) for young people with disabilities has been slow, and is a significant barrier to these patients accessing appropriate supported disability accommodation.

Consumer protection

Consumer protection measures in Australian RACFs can have unintended negative consequences for residents. One example is the priority given to tracking complaint processes, which can be at the detriment of the provision of clinical care and companionship to residents. A move to an electronic system can help to ensure the process is more time efficient and effective in dealing with resident complaints.

The availability of the Charter of Care Recipients' Rights and Responsibilities (Charter) in RACFs is not in question; however, the ability of residents to comprehend and understand what is written is of concern. The Charter should be made available in Easy English and translated to languages other than English for residents from non–English speaking backgrounds. This will help to facilitate residents understanding their rights in RACFs.

Management of difficult, aggressive and/or vexatious residents

The management of difficult, aggressive and/or vexatious residents and family members is an issue that needs attention. In these situations, staff members and providers often do not have the ability to report these individuals, which has the potential to detract suitably qualified staff members from commencing or continuing employment, to the detriment of all residents in RACFs.

6. What do you consider will be the most important issues for the aged care system over the next 20 years and why?

Australia has an ageing population, where the number of elderly people aged 65 years or older is projected to more than double in coming years.[8] An estimated 215,000 people entered residential aged care, home care or transition care in 2016–17 alone.[9]

More than one in three general practice patient encounters are with elderly people aged 65 years and older, and GPs are increasingly seeing more elderly people in their consultation room.[10] Additionally, GPs are the main providers of medical care for those living in RACFs.

The types of care provided to patients in RACFs differ significantly from that provided in community general practice.

The RACGP's *Curriculum for Australian general practice 2016* notes that quality general practice care in elderly people integrates:[11]

- recognition and safe management of health conditions (including rational prescribing and mindfulness of the risks of polypharmacy)
- assessment of the functional impacts on the individual and recognition of consequences for their accommodation and care needs
- identification of effects on family and/or carers, in particular recognition of the need for respite care, identification of indicators of carer stress and potential for risk of elder abuse.

The important challenges and barriers noted in *4. If it is your view that the aged care system (or any part of the system) does not meet those needs, in what way and why is this the case?* cannot be over emphasised, and will continue to be challenges for the aged care sector well into the future. Significant initial and continued support must be made available to GPs and the general practice profession to counter these barriers for the health of older people in RACFs.

7. What changes might be made to improve the aged care system (or any part of the system) by the Australian Government, the aged care industry, families and the wider community?

The RACGP advocates for a model of medical care for RACF residents that integrates with general practice and enables GPs to continue to oversee their patients' medical care.

GPs should be able to work in collaboration with the broader multidisciplinary healthcare team, including appropriate numbers of adequately trained nursing and RACF staff, other specialist medical practitioners, and allied health professionals, in a way that focuses on residents' and carers' needs.

Funding and remuneration

A significant barrier to attracting and retaining GPs, general practice registrars and medical students in RACFs is the lack of remuneration for the significant amount of non-clinical work necessary to support effective patient care. Currently, GPs spend a large amount of time (some reporting up to half their time when working for RACF patients) performing unremunerated work, including:

- traveling to and from the RACF
- liaising with the patient's family and carers
- liaising with RACF nursing and support staff, hospital staff, allied health staff, dentists and other specialists
- gathering information on the patient's medical history, especially for the admission of new residents to an RACF
- follow-up phone calls post-consultation
- writing progress notes at the RACF and at their general practice
- discussing with pharmacists and providing repeat prescriptions (especially providing Schedule 8 drugs for palliative care patients)

- completing paperwork requested by the RACF (eg adjustments to medication charts, reports on health status)
- providing for patients who require out-of-RACF care (eg significant time in organising transport and dealing with hospitals and other facilities)
- providing for patients and their families after the patient has deceased (eg counselling family members, dealing with funeral services).

Properly remunerating GPs for their time spent performing the above important tasks, including through new Medicare Benefits Schedule (MBS) rebate items, can help to alleviate the barriers GPs currently face when working in RACFs.

The RACGP is encouraged to see additional funding for MBS rebates for services provided by GPs attending RACFs in the 2018–19 Federal Budget. However, we also note the continued low value of MBS rebates for general practice services provided to patients in RACFs. Given the difficulty of privately billing RACF patients for services, many GPs accept the MBS rebate as full payment for the care provided. However, the MBS patient rebates for RACF care have never reflected the true cost of providing the care.

GPs are deterred from charging a consultation fee because the current MBS rebate reduces for each RACF patient seen during a single visit. Patients therefore receive different rebates based on the number of patients seen before them that day, a unique situation that does not arise in a GP's consulting rooms, and does not affect other medical specialists seeing patients in hospitals.

The anticipated removal of the General Practitioner Aged Care Access Incentive (GPACAI) from May 2019 provides a further barrier to GPs supporting their patients in RACFs. The GPACAI is paid directly to eligible GPs, and supports them to provide services to RACF residents. Removal of the GPACAI will disadvantage RACF residents at a time when access to such services is already under strain. With the removal of this incentive, the aged care rebate should be reviewed and increased separately from the quality improvement incentive to offset the loss the GPACAI.

In addition, appropriately remunerating GPs for after-hours visits to RACFs is necessary.

Staffing

The RACGP believes a national, consistent regulatory framework around minimum staffing and appropriate skills mix in RACFs is vital. A commitment to ongoing training in aged care issues for all staff should be an essential component for RACFs. Training specific to palliative care, pain management, use of psychoactive medication, and use of antibiotics would be encouraged by the RACGP.

Suitably qualified nursing staff in RACFs are essential to the quality of care provided to residents. Concerns about RACF staffing levels and workforce skills are common, and are predominant reasons GPs find it difficult to provide care for their patients in RACFs. The RACGP is specifically concerned about the:

- insufficient number, and consistent lack of, nursing and other RACF staff available
- variable training and use of standard clinical communication tools
- heavy reliance on agency nursing staff
- high staff turnover
- heavy reliance on staff where English is their second language, which can lead to substandard communication skills.

Appropriate clinical governance, especially appropriately clinically staffed RACFs, has the potential to reduce negative health outcomes by focusing on prevention and management rather than escalation to acute settings, especially referrals to ambulance and hospital emergency departments at night. Appropriate nursing skills required in RACFs include:

- collaboration with GPs and other RACF staff
- communication with patients, GPs and other RACF staff
- assessment
- medication management
- clinical decision making and handover
- implementation of treatment plans.

Appropriately trained staff are also vital for the care of young people with disabilities. Staff in RACFs are often geared towards a more palliative care approach with residents; however, disability support staff for young people with disability should be geared towards supporting and developing skills and connectedness.

Education and training

Appropriately trained nursing staff to address clinical and governance issues within RACFs is strongly supported. RACF staff need to be well educated and trained in many core areas of aged care, including medication management, falls prevention, pressure sore and wound care, before they commence working in RACFs. Lack of adequate training for RACF staff can lead to poor patient outcomes and high staff turnover due to the challenges posed trying to meet complex patient needs when underskilled.

The employment of qualified and trained staff members in RACFs can also help to mitigate and prevent situations such as elder abuse. Inadequate staff numbers can inevitably lead to the neglect (ie unintended elderly abuse) of elderly people in RACFs. Government funding could be made available to train RACF staff members in caring for high-risk patient groups (eg patients with dementia, behavioural problems).

Medical students and interns need to have opportunities to provide aged care services through rotations and training placements be available, to promote early exposure to, and interest in, the aged care field.

9. Are you aware of any examples of good practice or innovative models for delivery of aged care services?

Alternate models of funding

An increasing number of RACFs are hiring their own GPs to provide ‘in-house’ services because of the poor remuneration and support for GPs visiting patients in RACFs. This is in place of having a GP visit from a local general practice, or having the patient’s usual GP provide care when the patient transitions into an RACF. This may offer some efficiencies, particularly in metropolitan areas, reducing travel time for GPs and providing the opportunity to have patients treated by the RACF’s preferred provider.

However, this alternate model of funding could also bring about the loss of longstanding therapeutic relationships between patient and GP at a crucial time in the patient’s life. While the RACGP recognises that care of patients in RACFs will continue to be provided by GPs from a range of backgrounds, it is vital that patients are able to access their own preferred GP.

An employer–employee relationship between a GP and RACF operator can bring undue and unnecessary pressures on GPs who work full-time in one particular RACF. There is an increasing number of GPs who only provide care to RACFs, and these GPs can bring the necessary skills and efficiencies to providing services in RACFs while still remaining independent of the ownership of the facilities.

10. What do the words ‘quality’ and ‘safety’ mean to you in the context of aged care?

The fundamental concepts of a quality system in RACFs should comprise:

- quality assurance
- quality improvement
- innovation.

A significant challenge to the quality system in RACFs is the disproportionate emphasis on quality assurance over quality improvement and innovation. While quality assurance is a vital component of a quality system, if done poorly, it can lead to a culture of compliance rather than commitment. This has the potential to create ‘tick-box’ approaches, where the purpose of quality assurance is merely to satisfy requirements.

It is important to establish a set of common principles for RACFs based on shared purpose, and meeting the needs of residents and carers, with an understanding of the particular needs of some population cohorts, and include principles that consider cultural needs and practices.

Furthermore, it would be important to establish a minimum data set of key indicators, which include resident-reported, family-reported and staff-reported measures, that is publicly available. These indicators should reflect a holistic understanding of health and wellbeing, and should be in addition to process or structure indicators that organisations use internally for improvement purposes.

Conclusion

The RACGP looks forward to hearing about the Royal Commission’s progress and outcomes, and further participation in future hearings and written submissions.

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