Submission No 14

INQUIRY INTO PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

Organisation: Aged Care Crisis Inc.

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Submission to Inquiry into the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020

Aged Care Crisis Inc.

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1 Introduction

Aged Care Crisis (ACC) welcomes the opportunity to make another submission in regard to the issues to be addressed in this inquiry. ACC has already made submissions to two 2016 NSW inquiries that are relevant to the issues raised, both of which failed to have any impact in addressing the issues. We strongly supported similar legislation in 2016.

1.1 Previous relevant submissions

1. ACC submission to the Inquiry into Registered Nurses in New South Wales Nursing Homes, 23 July 2015[1]

In this submission to the General Purpose Standing Committee, we addressed the absence of reliable data, the problems that had developed in the sector and the way policy and pressures in the system put ever greater pressure on staffing costs and so drove down skilled staffing levels - particularly Registered nurses who played a key role. We explained the power imbalance that prevented staff and families from speaking out and then compared staffing and care issues in the USA, the UK and Australia.

We strongly supported NSW legislation that required a Registered Nurse to be on duty at all times. We also supported proper staffing ratios based on accurate data and the publication of that data.

2. ACC submission to the Inquiry into Elder Abuse in New South Wales, 12 February 2016[2]

In this submission to the General Purpose Standing Committee, we focused on abuse in aged care and described the terrible things that were happening and the often toxic cultures that resulted. This arises from the role conflicts that develop when the service requires trained carers who are motivated by altruism and humanitarian societal values, but those who provide and manage the service are primarily driven by self-interest and commercial values. The latter's priorities resulted in the steady replacement of highly trained more costly nurses and particularly registered Nurses with less well trained, part time, casualised personal care workers with less training.

At the root of the problems were a lack of data, poor staffing, poor culture and the power imbalance that disempowered and thwarted staff and resident whistle blowers. They feared for their jobs or the care of their family members if they spoke out.

In a supplementary submission on 18 March 2016[3], we illustrated this by indicating that 65% of submissions to the 2016 Senate Workforce Inquiry were confidential, names were withheld or submissions made anonymously. Many would have been staff and families too frightened to speak out publicly.

We pressed for empowered regional community based structures to assume greater oversight of care in our aged care institutions and our communities. They would support and protect whistleblowers and be close enough and on-site often enough to monitor what was happening.

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1 Submission no. 147: https://www.parliament.nsw.gov.au/lcdocs/submissions/39092/0147%20Aged%20Care%20Crisis.pdf

2 Submission no. 110: https://www.parliament.nsw.gov.au/lcdocs/submissions/53922/0110%20Aged%20Care%20Crisis.pdf

3 Submission no. 110a: https://bit.ly/3aV2w6N

2 Executive Summary

2.1 Big changes in aged care: 2016 - 2020

The situation in aged care has deteriorated and there is now much more data showing what has happened. While the rejected 2016 legislation is still badly needed, it is now clear that much more is required and we urge all those who recognise the problems, as this Committee did in 2016, to become more involved and to now press for root and branch reform.

2.2 In response to the Terms of Reference

(a) We are critical of the separation of aged care from health care and point out that Registered Nurses are the central lynchpin around which aged care revolves. They are the essential bridge between medical care and nursing care as well as social and community care. Without them the system fails and that has happened. Bringing back Registered Nurses is only the first step.

(b) We stress the importance of caring relationships in preserving dignity and protecting the rights of the vulnerable. Registered Nurses are the role models for caring and caring relationships. It is difficult to form these relationships in a marketised and managed sector. The conflict between the motivations in markets and care create cultural and role conflicts and these result in toxic cultures. This leads to abusive relationships instead of safety and dignity.

(c) Registered Nurses are needed to identify the medical crises that are not only more common but more difficult to recognise at this age.

(d) Minimum standards and staffing are a necessary condition for good care, but not a sufficient one. Staff must work in a sector where they can express the humanity that motivates them if they are to be effective.

(e) Medication is more complex and there are more potential interactions than in hospitals. Well trained nurses supervised by registered Nurses are required.

(f) The current funding is inappropriate and inhibits the provision of effective care in several ways.

(g) Registered Nurses have the knowledge and skills needed to make decisions about complex medical conditions.

(h) The inability of an inflexibly managed and process driven system to adapt to changes like increasing acuity has steadily weakened the system. COVID-19 glaringly exposed this problem as well as the lack of resilience to unexpected stresses.

(i) Much has happened since 2016. It is now clear that simply regulating and legislating more requirements is not going to be a lasting solution. Major restructuring of the system is required. Those who have become aware of the growing problems will need a good grasp of what is happening and what actually needs to be done. We urge your committee to become part of a movement for real structural change. We address this in appendices.

2.3 Appendix 1: Root Cause Analysis of failures in aged care

Aged care is a community service to vulnerable citizens and a responsibility of our citizens and society. It has been provided within a 'market driven' free market context. Attempts to address its failures have been undertaken by market and management experts seeking to make a market that has failed citizens work. When examined from any other perspective the strong perverse pressures that have been introduced become apparent. The reasons why these expert's efforts to centrally manage and use free market strategies continue to fail, are readily apparent.

In this analysis we summarise multiple alternative perspectives that throw more light on to this problem. They reveal why the market in aged care has failed to provide the community service that is required. This analysis reveals what the problems responsible for failures are as well as why they, as well as suggestions for addressing them, have been ignored.

2.4 Appendix 2: Analysis of aged care as a failed complex social system

The growing socio-ecological and social system failures across the world have prompted social scientists to study these systems in regard to their adaptability and resilience. They have developed models which examine the forces acting within and on these social systems. They illustrate what is happening and why they not only fail but continue to fail repeatedly when governments attempt to address this.

They describe how resistant they are to change and find that there is often only a brief window of opportunity after failures are exposed when needed changes can be made. They examine how these systems can be restructured at this time to break the cycle of recurrent failure and why it often fails.

We have been unable to find any studies that have analysed the failure of aged care systems within this complex social system framework. We have analysed the Australian system within these models and it seems to fit well. There are useful insights. Because this seems to be new and provides additional insights we have included our analysis in Appendix 2.

This is the second time aged care has failed and we compare the two failures to assess the likelihood that we will break out of the cycles of recurrent failure this time. We look at the Royal Commission and the difficulties it has. We are not sure that it will do so although it remains a possibility. We argue that the Royal Commission will, at best, only be a beginning. More action is required and we should be ready to take it.

2.5 Attached: Workforce submission – Supplementary submission to Royal Commission into Aged Care Quality and Safety, 6 Dec, 2019

The attached submission is our response to the Royal Commission's workforce policy issues paper. We summarise our analysis of the system and of the workforce problem then respond to the policy issues raised by the Commission. We argue that "*in addition to addressing numbers and skills, structural changes must address the beliefs and resultant policies that are causing alienation, toxic cultures and the provision of task focused care rather than relationship based care*". We argue that to be effective this restructuring must address the power imbalance in the system. We express our concern at the different path that the Commission seems to be taking.

2.6 Conclusion

We conclude that the centralised market driven system has failed for multiple reasons. It does not meet the necessary conditions for a market to work, particularly in vulnerable sectors like aged care. What is required to enable this market to work in aged care is a centrally integrated and supported but regionally managed system that works closely with a network of local community and professional organisations that include local providers of care.

This will require considerable restructuring and a change of thinking within government, industry and local communities who will need to be more directly involved in organizing and managing care. These analyses show that this would be the best way of rebalancing the forces within the system in ways that will enable citizens and local providers to work together to make it work.

The Grattan Institute has recently issued a report making recommendations that if adopted, would be the first real change since 1997. If adopted it would be a step that opened the system to developing along these lines.

3 Recommendations

We must have enough nurses and enough skilled staff. When we make choices we must be able to compare staffing in each facility with well-researched data describing the minimum safe levels for that facility. But nursing requirements are only the firsts step in real reform.

Recommendation 1: That legislation requiring the presence of a registered nurse in all nursing homes at all times be passed.

Recommendation 2: That the committee press for and support the establishment of minimum safe nursing levels and skills based on an assessment of the acuity levels of residents and monitored by tracking outcomes.

Recommendation 3: That the committee press for and support the regular publishing of verified staffing levels and skills in each nursing home alongside the minimum levels required based on an assessment of the acuity of residents in that facility.

Recommendation 4: That there be greater integration with health services locally. Local hospitals and regional health bodies should become part of a reach down and support system for aged care, assuming responsibility for the care provided in the aged care sector in their regions. Registered nurses are the essential lynchpin on which such a system would depend.

Recommendation 5 (See Appendices 1 and 2): That the Committee support and press for a restructuring of aged care around a centrally integrated and mentored system of regional management and oversight working closely with local networks of knowledgeable citizens who have involved themselves in supporting and watching over residents and who network with local providers of aged care.

4 Big changes in aged care: 2016-2020

Much has happened in the last four years as the system has come apart. First there was the Oakden scandal in South Australia which exposed the multiple failures of the federal regulatory framework. This was followed by an avalanche of press reports of more failures and then the ABC Four Corners two-part expose in October 2018. Multiple attempts to reform the system by moving the pieces around has not convinced anyone. It needs real change.

The federal government succumbed to pressure and called a Royal Commission. Its damning report in October 2019 titled "Neglect" exposed a disgraceful poorly staffed system that was neglecting and abusing those it was charged to care for. Critics were finally vindicated and Australia was rightly ashamed.

The COVID-19 pandemic exposed just how bad the situation was and how little resilience there was in our aged care system. Seventy-five percent of our deaths occurred in our nursing homes, one of the highest incidence in the world. The majority of those were within the private sector in Victoria (for-profit and non-profit).

State owned facilities in Victoria were largely spared in the pandemic. This is a state where government has imposed and funded staffing levels on the facilities it manages. It cannot control federally regulated privately run facilities. The perverse incentives in the federally managed free market aged care system had driven staffing and other resources to unacceptable levels and there was no reserve capacity.

The Committee's recommendations in 2016 requiring Registered Nurses at all times have been vindicated. It is now also clear that while this legislation is still urgently required, it is only a beginning. The root causes of failure lie much deeper and they need attention. On-site Registered Nurses are a necessary condition for a good system but not a sufficient one.

A far more fundamental restructuring of the system is now required. That will require all of our legislators and our society as a whole to properly confront what has happened, analyse the root causes and step up to address the problems. We are not sure that this is happening. Political and market vested interests are challenged.

In Appendix 1 we have summarised the root cause analysis that has been missing from the debate. We have included our recent analysis of system adaptability and resilience in aged care in Appendix 2. These root causes have been raised with the Royal Commission but they have not been addressed – at least publicly. We appeal to the Committee to take up the baton and drive the process further. What is needed is now clear but there are powerful vested interests that may do everything they can to resist this.

5 Responding to the Terms of Reference

(a) The need to have a Registered Nurse on duty at all times in nursing homes and other aged care facilities with residents who require a high level of residential care.

Illusions: Since the late 1990s there has been a self-serving illusionary myth based on the idea that ageing is not a disease, therefore nursing homes are not hospitals. Aged care is therefore not part of the health system, and you do not need high level medical care or skilled nurses to care for the old. When nursing homes became regimented and impersonal in the pursuit of efficiency, this was blamed on the 'medical model' rather than the commercial 'wrinkle ranching' model.

Every dysfunctional ideology, and we are certainly in the grip of another one that is failing us, is based on misconceptions. In order to maintain its legitimacy many more illusionary justifications are invented and this was one of them.

In 2014, it was used at the highest level to justify the unfortunate decision to transfer aged care from the Department of Health to the Department of Social Services. Scott Morrison was Social Services Minister at the time. This change was associated with rapid deterioration in care. Since the 1990s this sort of rationalisation has been used across the market to justify the replacement of trained nurses, particularly Registered Nurses with relatively untrained personal care workers.

Comparisons: On average, Australian aged care facilities now provide half the amount of trained nursing care, including registered nursing care, provided in the USA. The USA is a country that has similar policies and problems, but Australia has deteriorated faster and further.

Debunking the illusion: In the real world the degenerative physical and mental processes responsible for ageing are core clinical matters. They, like all other medical diseases, require medical care in order to attain the optimal physical and mental function needed to lead effective and meaningful lives for as long as possible. The primary role of medical care has always been to enable health and so increase our patient's capacity to lead a full life. That should not stop when we get old. Clearly that goal has not always been attained.

Nursing home residents are among the sickest and frailest of all citizens. Their need for skilled medical, paramedical and nursing care is as great as most hospital patients. But being in optimal condition is of little value if its benefits cannot be realised in meaningful lives.

Meaningful lives: Because these are permanent residents, this is also their home and it needs to be structured as such. This is where they must create meaningful lives. Being a part of community is essential in order to do so. Creating and building community is the responsibility of both the staff and of the wider community in which the roots of aged lives still lie.

Staff need the time to engage and form empathic supportive relationships. The wider community should be playing a critical and inclusive role. Current ideology and ageism have intruded. Local communities have often been excluded from what should be a fundamental social responsibility.

Registered Nurses are the lynch pin around which both hospitals and nursing homes operate. They have the clinical skills needed to form the bridge between medical and paramedical services and the nursing staff that they manage. They also handle relationships with family and the public and so the integration of the community into the life of the nursing home.

Registered Nurses have the skills needed to provide palliative care and almost all residents would rather spend their last days at home if possible. Almost all nursing home residents die within a year or two and the medical and nursing skills needed should be available.

Without Registered Nurses the system cannot function. They are essential. But if we are going to address all of the problems we need to understand the unopposed forces at play because they have many other consequences in addition to poor staffing. Simply addressing staffing numbers is the first step but it is not enough. It is not going to be a permanent solution.

(b) the impact Registered Nurses have on the safety and dignity of people in care

As indicated, they set the ethos within the facilities and they bring with them the caring traditions -- the tradition of empathic relationships built on trust and trustworthiness. These are the traditions of the health professions. They go back over 2000 years. They were brought to nursing in Australia in the 1870s by the Nightingale nurses. They had been trained by Florence Nightingale in the Crimean war.

People in caring relationships protect one another, respect one another's dignity and do not abuse the rights of one another. When there are paradigm conflicts (conflicting ways of understanding the work you are doing) and staff are required to work within a paradigm that does not value these traditions and so is unsuitable then you get cultural conflict and role conflict within the organisation.

Professor Michael Fine has analysed the nature of these relationships in aged care and has shown how difficult it is to form and maintain them in the current market system[4]. Top down tightly managed systems where there are paradigm conflicts readily generate the sort of toxic cultures that result in neglect and abuse.

Toxic cultures have developed at the highest level in the health department itself[5]. They have been exposed on many occasions within nursing homes by whistleblowers including at the Royal Commission hearings. In the worst cases staff have joined in abusing those they are responsible for.

Otherwise well-adjusted and responsible people can become desensitized and then become part of a pack abusing those they are responsible for. This was well documented at the Winterbourne facility[6] in the UK in 2012. There have been several similar instances in Australia[7].

In the sort of centrally managed and controlled system that has become common in Australia, Registered Nurses struggle to inculcate professional values. They are unable to prevent this from happening. They are unhappy and good nurses unable to accommodate to this sort of care go elsewhere.

An adequate number of staff is essential but by itself is not enough to address the problem of poor staff morale and toxic cultures. Much more is needed. We need a balanced system where nursing values, nursing roles and caring relationships are strongly supported locally in our communities and on site in nursing homes. We have addressed the issue of balanced forces later in Appendix 2.

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4 Brief outlines and links to several of Professor Fine's papers are available here. "The Nature of Care" https://www.insideagedcare.com/aged-care-analysis/theory-and-research/nature-of-care

5 The federal Health Department: 80-hour weeks, bullying, command and control The Canberra Times 8 Dec 2014 http://bit.ly/2L8PPt6

6 Winterbourne View care home staff jailed for abusing residents The Guardian 26 October 2012 https://www.theguardian.com/society/2012/oct/26/winterbourne-view-care-staff-jailed

7 Sacked nurse back at aged care home, The Advertiser, 16 Sep 2007
Body parts used in sickening 'game' at nursing home, Herald Sun, 31 Dec 2007
Corey Lucas stressed about work when he abused Clarence Hausler at nursing home, court documents show, Adelaide Now, 27 Jul 2016

(c) the impact on residential care of a lack of registered nursing staff on duty in a nursing home or other aged care facility at all times

As we have indicated, they are the lynchpins around which aged care is built. They are a vital cog in the system and hold it together. Without good well-trained Registered Nurses to support staff and uphold our values and altruistic humanitarian traditions, self-interest becomes the driving force and the consequences described above are likely.

In this aged group medical crises are frequent and can occur at any time. It is essential that well qualified staff with clinical skills are available to handle these situations.

(d) the need for further regulation and minimum standards of care and appropriate staffing levels in nursing homes and other aged care facilities

Clearly minimum standards and minimum required staffing levels and skills are essential wherever care is required. Too often minimum standards and minimum levels in vulnerable market systems, which are driven by competition, profitability and growth, can lead to a race to the bottom. Providers see these as restrictions on their profitability rather than a warning that what they are doing is becoming unacceptable. More is required to ensure this does not happen.

Minimum staffing requirements should be based on assessed need and there should be sufficient redundancy to enable relationship building. But regulation and sufficient numbers by themselves are not enough. If these staff are to work well, we also require a system where the humanitarian values of our society are supported and fostered and that is currently often not the case

Without an environment in which they can express their humanity, staff will continue to come under pressure. They will have their values challenged and undermined. Cultural and role conflict will occur and toxic cultures will develop. Major structural change is required to create a context where staff morale is fostered.

(e) the administration, procurement, storage and recording of medication by non-registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, as compared with hospital clinical settings

These residents are sicker and take more medications than most hospital patients. Many have dementia. They require even greater skills in medication management than those in hospital as there are fewer doctors in regular attendance. It should only be managed by well-trained nurses able to recognise drug reactions and side effects. They are more common in this frail and vulnerable group. Registered Nurses must be in control of this.

(f) the potential for cost-shifting onto other parts of the public health system as a result of any legislative change to the current provisions for care in nursing homes or other aged care facilities

We are unable to comment specifically on this but we note that government owned and operated aged care nursing homes are unfairly discriminated against in funding[8] and that the Victorian Government contributes *"around $75 million over five years, diverting revenue from other priorities"* in order to maintain safe staffing and good care.

The separation of the administration and funding of federal nursing homes from state run hospitals has been unfortunate. Until 1953 the frail elderly were cared for in hospitals. The *National Health Act* in 1953 defined nursing homes as separate from hospitals for the first time.

[8] Victorian Government submission to Royal Commission into Aged Care Quality and Safety, October 2019 https://bit.ly/3ij2mro

Aged care is a part of health care but as happens in some other areas of health care, it needs to be operated in partnership with the community if it is to work well.

This is a system where health care needs to be integrated using a 'reach down and support' model. Local hospitals should assume responsibility and oversight of care in nursing homes in their region. There should be funding for this. Appropriate specialists need to visit periodically and be responsible for overseeing services in their areas of expertise. There should be facilities for them. Registered Nurses would be central in organising and integrating this.

The Aged Care Funding Instrument (ACFI) distorts care because care is forced to follow the money rather than the needs of residents. This needs to be addressed.

(g) the role of Registered Nurses in responding to critical incidents and preventing unnecessary hospital admissions and unnecessary ambulance call outs and the consequent effect of this upon the provision of ambulance services to the wider community.

As indicated, Registered Nurses have clinical skills and are critical in managing the interface between health and social care. They oversee and manage care, and take these decisions. They should be working closely with medical, nursing and paramedical staff from their local hospitals and communities. They should be discussing issues with them when needed.

(h) the lessons that can be learnt in New South Wales from the impact of the COVID-19 crisis on private aged care facilities where staffing ratios are not mandated, and

It is no secret that this was very badly managed and that early lessons were not learned. As we show in the two appendices, the system was tightly managed, process driven and structured to ensure maximum economic efficiency and resist criticism. It was unable to adapt to changing circumstances including greater acuity so was already failing. There was no redundancy so that it lacked the resilience to respond to the challenge created by a pandemic. This is a structural problem and major structural change is needed.

The stark differences between state operated nursing homes and those in the private sector revealed by both the incidence and mortality, are revealing of what has been happening but denied repeatedly across Australia. The reasons for this are set out in the October 2019 Victorian Government submission to the Royal Commission well before the COVID outbreak commenced[8]. They highlighted some of the key factors that motivate nurses to work in nursing homes:

- Recognition that residential aged care requires specialist nursing knowledge;
- The nurses value their autonomous role;
- The focus on resident's health and wellbeing rather than focusing on disease processes; and
- Nurses value building meaningful long-term relationships with residents and their families.

The report also identifies factors that contribute to recruitment and retention in the sector including:

- Aged care was seen as a more flexible workplace, which fits in with family and caring responsibilities;
- A more stable workforce resulting in more predictable and family friendly rostering;
- The introduction of student placements into residential care and vocational training opportunities.

Registered nurses are critically important in enabling this.

The Victorian Government was the first to introduce staff ratios in the health services it operated in 2000 through the Enterprise Agreement (State Government of Victoria - Department of Health 2012). In 2015 it became the first Australian jurisdiction to legislate mandatory skilled staff ratios in the facilities it operates (Victorian Government *Safe Patient Care Act 2015*[9]). This was on the basis that the pre-existing ratios had *'assisted in maintaining the safety of Victorian patients since they were introduced in 2000, and contribute to better outcomes for Victorians'*. They have consistently supported legislated staffing requirements.

Queensland has recently introduced staffing ratios in the facilities it operates. Queensland's 16 government-run residential aged care facilities will be required to provide a minimum 3.65 hours of nursing care to each resident per day and have staff ratios of 30 per cent Registered Nurses, 20 per cent Enrolled Nurses, and 50 per cent Assistants in Nursing.

It attempted to force private operators to disclose theirs. The state government did not have the power to do so and federal government joined industry bodies in opposing it. It nevertheless passed the *Health Transparency Bill 2019,* which requires that all Queensland's aged care facilities —including the State's estimated 400 private facilities—to be asked to report their daily resident care hours and staffing skill mix, among other information. While they do not have the power to make it compulsory for providers to report this information, facilities failing to do so will be named on a public website[10].

(i) any other related matter

Industry led aged care: We have an aged care system that was largely designed by industry, for industry. Industry and government have been locked in a tight embrace since 1997. Industry has advised and been consulted at every step. Nothing has been done without their approval. Every beneficial change has been reluctantly acceded to under pressure from the community and the press. Many proposals have been watered down by industry's influence.

Witnesses giving evidence to the Royal Commission included family members described the abusive treatment and neglect their loved ones received. Many explained how powerless they were in the face of providers and how frustrating, impersonal and unhelpful they found the distant complaints system.

Aged care is a striking example of the close embrace between industry and government, and the exclusion of community in Australia.

[9] Why don't private nursing homes have ratios? 3 Oct 2018, ANMF: http://bit.ly/2AiOkAB

[10] Queensland passes aged care ratio and care hours laws, ANMF, 6 Dec 2019: http://bit.ly/3oPDtq1

These are just a few examples.

Example 1: Single Aged Care Quality Framework

In 2016 the Quality Agency mounted a public relations exercise about quality before coming up with a proposal to reduce accreditation from 44 standards to only 8 under the guise of the ***Single Aged Care Quality Framework***. While benefits and effectiveness were proclaimed, it was clearly based on the neoliberal free-market discourse advocating less regulation.

A consultation process was setup and submissions invited. The department consulted with the industry dominated group National Aged Care Alliance (NACA) through their various sub-groups including the Quality Action Group (QAG) and Standards Technical Advisory Group (STAG/TAG) ahead of the public consultation process.

We felt this reduction in the number of standards was a response to pressure from the industry and free-market politicians. They were pressing for less regulation and a reduced regulatory burden. It was difficult enough to separate the good from the bad with only 44 standards where 98% got perfect scores *(the USA has over 150 and only 7% get perfect scores so a wide spread)*. Eight standards makes it almost impossible, so insulating the systems failures from further exposure.

LASA's response in their April 2017 submission to the draft standards indicators, which came into effect in July 2019 illustrates the influence industry has. LASA queried a line that referred to ensuring a ***"comfortable internal temperature"*** for residents because this could be interpreted as requiring air conditioning. It was struck from the final code. There was critical press coverage about this to which LASA responded.

LASA in their submission also objected to Clause 3.7 in the Health Department's Consultation paper. This was a requirement that nursing homes identify and manage high-risk conditions such as *"pressure injuries, medication misadventure, choking, malnutrition, dehydration, pain and delirium"*. The reason given for this was because *"Having a list may give the impression only those incidences listed need to be monitored to meet this standard or it could be taken more literally"**.*** It said in its 2017 submission on the draft standards *"LASA has reservations about 'lists' per se, given they can change over time."* These were also struck from the final code.

Appearing at the Royal Commission in February 2019, LASA's CEO Sean Rooney was asked why his group suggested the federal government remove a reference to *"continuously"* monitoring the quality of care in the new standards with the word *"regularly"**,*** an amendment that was adopted.

Example 2: Serious Incident Response Scheme (SIRS)

We note that the recently launched **Serious Incident Response Scheme** depends on the goodwill of providers who have ample opportunity to cover their tracks and whose business models depend on positive public relations, particularly branding and marketing. Self-reported data is not reliable. This is no longer acceptable.

Example 3: Minimising use of Restraints

The SIRS's consultation process is reminiscent of the changes made to the *'Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019'***.** This was developed by the department and its stakeholders too.

A suggestion that the community and those who would implement it be consulted was rejected. The latter were faced by a fete accompli. Those who had to implement it were horrified and wrote to politicians strongly opposing it.

The *'Parliamentary Joint Committee on Human Rights'* was persuaded to review the matter. Those expected to implement the changes asked the parliament to intervene and discard the changes to the principles that had been made.

In the case of both the Single Aged Care Quality Framework and SIRS, starting a belated public consultation when all the important decisions have already been made, is not much of an improvement.

Example 4: Aged Care Workforce Taskforce

Government made industry, whose self-interest was the driving force in the steady erosion of staffing and care, responsible for addressing this problem. It was their influence and control of government that made it possible for them to do this in the face of opposition from staff and community.

Aged Care Crisis attended the first of the Aged Care Workforce Taskforce consultations. Much of it was a branding exercise. No data about staffing was provided. No effort was made to explore the possible reasons why staffing had deteriorated over the years. That the behaviour of this industry itself might be largely responsible could not be a consideration, although we tried to raise that issue! This resistance to introspection is worrying and needs to be understood.

The Aged Care Workforce Taskforce 2018 report *'A Matter of Care: Australia's Aged Care Workforce Strategy'*[11] did not publish staffing data which was readily available. While it acknowledged the need for better staffing, it did not recommend ~~any~~ staffing ratios or disclosure of them.

It relied on a *'voluntary code of conduct'* to induce the industry to take action which would impair their profitability This was an industry that had supported and accepted the myth that aged care was not an illness and nursing homes were not hospitals and so didi not need skilled nurses.

While supporting engagement with the community, this report fell a long way short of what is required in this sector. The way the market operated and the conflicts of interest were not confronted.

Industry has turned aged care into a market-driven service that informed seniors and their families are now avoiding at all costs. They know who was responsible. That is not going to change while it is still led by industry and regulated entirely by government.

[11] A Matter of Care: Australia's Aged Care Workforce Strategy: https://www.health.gov.au/resources/publications/a-matter-of-care-australias-aged-care-workforce-strategy

The Royal Commission: We are not persuaded that the proposed recommendations by Counsel to the Royal Commission are sufficient to address these problems or to eradicate the power imbalance described by those family members who had the courage to tell their stories by making submissions or giving evidence to the Royal Commission. We are not convinced that future residents and their families will be adequately protected from similar treatment.

We worry that the Royal Commission has consulted primarily with the architects of the existing broken system. We doubt that those they consulted have the insight and analytic courage to confront the flaws in their past thinking and acknowledge the need for the sort of real change that deprives the market of the power it has over citizens and government.

If their advice is followed then, in the long term, any new system is likely to suffer from the same malady. We will be back here some-time in the future, but only after more needless suffering of vulnerable residents in aged care.

We remain ever hopeful but not confidant that the Commissioners themselves will have greater insight and go further in their report by recommending changes that can become the basis for the major long term structural and societal changes that are needed to turn aged care into a community led system – one which ensures that only those who can be trusted provide care and holds those who do not to account.

Required change: A root cause analysis shows that major structural changes are required and it is unlikely that the Royal Commission can or will advise everything that needs to be done. We can only hope that it will set a new direction on which society can build.

To succeed these structural changes must neutralize the perverse incentives within the current system and address the imbalance of power responsible. This would be best accomplished by moving the centre of gravity of the system into the regions and communities where the care is provided. A system and a market that depends on community and professional values should be community led.

If this happens it will be a significant change for all concerned. Responsibility will fall on our elected leaders and our communities. Both will need to become involved. Both will need to understand what has been happening and why the system has failed so badly.

What has happened and what needs to be done can be understood by looking at aged care from different points of view to those currently adopted. There is also work that has been done on complex social and socio-ecological systems that fail to deliver desired outcomes and are resistant to change.

Aged care is a complex social system that has failed. In Appendix 2 we have taken the liberty of showing how well aged care matches this model and what it shows needs to be done. As far as we are aware this model has not been applied to aged care before.

While this is not directly related to Registered Nurses, your Committee was one of the first to recognise that there was a serious problem in 2016. Its members are more likely to understand and lead the way in reform.