Learnings from the Royal Commission into Aged Care: Opportunities and Threats

A/Prof Steve Macfarlane
2010s
Australian Skills Quality Authority, Training for Aged and Community Care in Australia, 2013.
Senate Community Affairs References Committee, Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD), 2014.
Senate Community Affairs References Committee, Adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia, 2015.
House of Representatives Standing Committee on Health, Aged Care and Sport, Advisory report on the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018., 2018.
Senate Economics References Committee, Financial and tax practices of for-profit aged care providers, 2018
Senate Community Affairs Committee, Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. Final Report, 2019
Recurrent Themes....

• Reviews have repeatedly been asked to address similar concerns and have made remarkably similar recommendations.

• Responses often come years after the review and recount what has been done in an almost tangential way to the actual recommendations.

• When responses are provided, they can be opaque, rendering it near impossible to determine whether the Government intends to implement recommendations.

• Changes committed to are often slow to eventuate or fall away prior to implementation.
Commissioners identified three areas where immediate action can be taken:

• provide more Home Care Packages to reduce the waiting list

• respond to the significant over-reliance on chemical restraint in aged care

• stop the flow of younger people with a disability going into aged care, and speed up the process of getting out those young people already in aged care
“Chemical Restraint”: Opportunity, Threat, or Neither?

Quality of Care Principles 2014 (Amendment July 1st, 2019)

- **chemical restraint** means a restraint that is, or that involves, the use of medication or a chemical substance for the purpose of influencing a person’s behaviour, other than medication prescribed for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
PBS and MBS utilisation data - 2011, ABS
Proportion of population accessing PBS subsidised Antidepressant medications in 2011

Proportion of population accessing PBS subsidised Antipsychotic medications in 2011

Proportion of population accessing PBS subsidised Anxiolytics, Hypnotics & sedative medications in 2011
Dementia: What has the Commission Focussed On?

Sydney hearings: May 6-17

• the perspective and experience of PLWD, their family and carers
• quality and safety for PLWD
• restrictive practices in residential aged care
• good practice care for PLWD, particularly in the residential aged care context
Best Practice in BPSD Management?

• All published College, National and International Guidelines recommend behavioural interventions as first line, and the use of psychotropic drugs as a last resort
Barriers to the Implementation of Best Practice

• Assessing for the causes of behaviours and developing a management plan is a highly-specialised task, yet...

• PSA’s (average wage $34,291) are the front-line carers in RACFs

• PSA training: Cert. III in Individual Support (Ageing and Disability)
  • No academic pre-requisites (at all...)
  • None of the 7 core unit components relate to dementia
  • Dementia is one of 8 elective components only
  • Course duration 313 hours (~8/52 FTE)
  • Course can be completed entirely on-line plus a work placement component

Is it reasonable to even **expect** PCA’s to be able to deliver best-practice BPSD care?

• Sources: https://www.macquarie.nsw.edu.au/course/cert_iii_aged_care_disability
  https://www.opencolleges.edu.au/lp/certificate-iii-individual-support-disability?_bt=3155901861318&_bk=certificate%20iii%20in%20individual%20support%20and%20disability&_bm=e&_bn=g&_bg=583195460908&keyword_k=certificate%20iii%20in%20individual%20support%20and%20disability&utm_plasource=1643271077&gclid=EAIaIQobChMIqZzQ0M_P5QIVjrgCh2hiAuwEAAYAAEgZVID_BwE
Are Mandated “Ratios” the Solution?

• What do EN’s and RN’s learn about BPSD during undergraduate training?

• What do doctors learn about BPSD during undergraduate training?

• What do GP’s learn about BPSD during RACGP Fellowship training?

• What is the one place where BPSD is managed worse than in residential care?

• This is not to say that increasing staffing is not part of the solution....
Conclusions re staffing and best practice in BPSD?

• Absolute staffing numbers will have to increase

• Basic training requirements for frontline staff will have to increase?
  • PCA’s
  • EN/RN
  • Medical Undergraduates
  • General Practitioners

• In order to attract a better calibre of staff, basic pay rates will have to increase

• The government will **clearly** be unable to fund this
  → Increased emphasis on ‘user-pays’ system for those who can afford it
  → Will almost certainly require bipartisan support (e.g. the Sacred Cow of the Family Home)
“Chemical Restraint”

Quality of Care Principles 2014 (Amendment July 1st, 2019)

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• Unless this definition changes, nothing will change....
Possible Responses to “Chemical Restraint?”

- Interim report: RACF’s to collect and publish data on physical/chemical restraint?
  - Immediate benefit via “Hawthorne effect”
Possible Responses to “Chemical Restraint?”

- Require scripts to be initiated only by a psychiatrist (neurologist or geriatrician?)

  - Interim report flagged limiting the “initiation” of antipsychotic drugs in aged care to psychiatrists who were "likely to have greater knowledge about the diagnosis and treatment of psychiatric and psychological disorders“

  - Unfeasible, though this very fact may institute ‘supply-side’ constraints

  - Likely in the short-term to result merely in more ED presentations and APMH referrals

  - Perverse disincentive for GPs to reduce psychotropics post hospital discharge
Possible Responses to “Chemical Restraint?”

- Tightening of authority script requirements?
  
  - Compliance with current authority guidelines not audited
  - May just shift prescribing back to haloperidol....
Aged Care Quality Standard 3: Personal and Clinical Care (Effective July 1\textsuperscript{st} 2019)

The organisation demonstrates the following:

(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

(i) Is best practice; and
(ii) Is tailored to their needs; and
(iii) Optimises their health and well-being.
### DBMAS OUTCOMES

#### Figure 1. Impact of DBMAS on behaviour (1 March 2018 to 28 February 2019)

<table>
<thead>
<tr>
<th>DBMAS</th>
<th>NPI measure</th>
<th>Sample size (number of clients)</th>
<th>At point of service intake</th>
<th>At point of discharge from service</th>
<th>Significance level</th>
<th>Effect size</th>
<th>Per cent reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of types of behaviour exhibited</td>
<td>2085</td>
<td>4.73</td>
<td>2.76</td>
<td>p &lt; .0001</td>
<td>0.92</td>
<td>42 per cent</td>
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<tr>
<td>Total severity of behaviours</td>
<td>2054</td>
<td>9.72</td>
<td>3.76</td>
<td>p &lt; .0001</td>
<td>1.17</td>
<td>61 per cent</td>
<td></td>
</tr>
<tr>
<td>Total carer distress caused by behaviours</td>
<td>2064</td>
<td>13.25</td>
<td>4.3</td>
<td>p &lt; .0001</td>
<td>1.21</td>
<td>68 per cent</td>
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</table>
## SBRT OUTCOMES

**Figure 4. Impact of SBRT on behaviour (1 March 2018 to 28 February 2019)**

<table>
<thead>
<tr>
<th>SBRT</th>
<th>NPI measure</th>
<th>Sample size (number of clients)</th>
<th>At point of service intake</th>
<th>At point of discharge from service</th>
<th>Significance level</th>
<th>Effect size</th>
<th>Per cent reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of behaviours identified</td>
<td>273</td>
<td>5.76</td>
<td>3.02</td>
<td>$p &lt; .0001$</td>
<td>1.24</td>
<td>48 per cent</td>
<td></td>
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<tr>
<td>Total severity of behaviours</td>
<td>268</td>
<td>13.3</td>
<td>4.74</td>
<td>$p &lt; .0001$</td>
<td>1.58</td>
<td>64 per cent</td>
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<tr>
<td>Total carer distress caused by behaviours</td>
<td>264</td>
<td>18.69</td>
<td>5.76</td>
<td>$p &lt; .0001$</td>
<td>1.53</td>
<td>69 per cent</td>
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</table>
Effect size of Risperidone in BPSD
What's Next? RANZCP Submission

<table>
<thead>
<tr>
<th>Canberra Hearing</th>
<th>Date: 9 – 13 December 2019</th>
<th>Interfaces between the aged care and the health care system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location:</strong> The Vibe Hotel, Canberra, 1 Rogan St, Canberra ACT 2609</td>
<td></td>
<td>The Canberra hearing will inquire into interfaces between the aged care system and the health care system, including both Commonwealth and state/territory programs. It will examine whether older people, particularly those living in residential aged care facilities, are able to access the health services they need as they age.</td>
</tr>
<tr>
<td><strong>Time:</strong> 9:30am local time</td>
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