Australian Nursing and Midwifery Federation
submission to the

Department of Health and Aged Care Consultation - Review of the Aged Care Quality Standards

25 November 2022

Australian Nursing & Midwifery Federation

Annie Butler
Federal Secretary

Lori-Anne Sharp
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au

INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 322,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

With regard to care of older people, ANMF members work across all settings in which aged care is delivered, including over 40,000 members who are currently employed directly in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors (acute, residential, community and in-home care), depending on their health needs. Being at the forefront of aged care, and caring for older people over the twenty-four hour period in acute care, residential facilities and the community, our members are in a prime position to make clear recommendations to improve the care provided and enhance processes for access to that care.

The ANMF welcomes the opportunity to provide feedback on the revised Aged Care Quality Standards and any reform measures that improve care delivery in the aged care sector. Regulation of the aged care sector has been the subject of extensive and multiple reviews and inquiries over many years including, most recently, a *Royal Commission into Aged Care Quality and Safety*. All have unequivocally indicated that the aged care sector needs fundamental reform with the Royal Commission providing evidence-based recommendations for short and long term measures to address the significant and widespread shortcomings identified across the sector.

The *Royal Commission into Aged Care Quality and Safety, Final Report: Care Dignity and Respect* uncovered an unacceptably high level of neglect and abuse in residential care[1] concluding that the systemic failures identified across the aged care sector raise concerns about the capability, leadership and culture of the regulator.[2] During the Royal Commission's investigation into aged care, the Aged Care Quality and Safety Commission was utilising the regulatory tool of the Standards to assess Provider performance and care outcomes. As is clear from the findings of the Royal Commission, the existing Aged Care Quality Standards did not recognise the extent to which substandard care was occurring and, most critically, had little effect in preventing it, a situation recognised by the Royal Commission as completely unacceptable and highlighting the need for a review of the Aged Care Quality Standards. Recommendation 10 called for the abolishment of the Aged Care Quality and Safety Commission and this is supported by the ANMF.

The ANMF acknowledges and appreciates the urgency with which aged care reform is needed. However, the process of reform appears to lack clear coordination, transparency and staging. The development and introduction of the new Aged Care Act and Regulatory Model are fundamental to the reforms to aged care and should inform any revision and monitoring of the Aged Care Quality Standards. The ANMF, however does appreciate that the findings from the Royal Commission call for urgent revision of the existing Aged Care Quality Standards which proved to be ineffective in maintaining the safety of older people seeking aged care services. Given this dilemma, the ANMF recommends that the revised Aged Care Quality Standards are viewed as an interim measure only, with the expectation that once the new Aged Care Act and the Regulatory Model are decided, significant further review of the Standards be undertaken. The following feedback is provided based on that expectation.

The revised Standards have gaps in areas addressing the workforce and there are a number of ambiguous statements throughout that cloud the intent of the Standards and the articulation of provider expectations. In some instances the language also presents a problem and creates a hegemony about the purpose of aged care and the level of skill (or lack thereof) required to deliver high quality services. A significant issue is the lack of an implementation guide to accompany the revised Aged Care Quality Standards. Without an implementation guide it is difficult to envisage how the Standards will be applied and monitored. It is the view of the ANMF that the Aged Care Standards should align with the National Safety and Quality Health Service (NSQHS) Standards which, through the ACSQHC, are well established with a proven record of applying and assessing evidence-based health care delivery. These issues will be elaborated on in this submission.

1. **How satisfied are you that the revised Quality Standards will set the expectations for safe and quality care and services for older people in the future?**

The revised Aged Care Quality Standards must translate into tangible improvements to aged care service delivery, provider accountability and regulatory strength. The direction to providers regarding how to best meet the Standards is somewhat clearer however, without knowledge of the legislation, Regulatory Model and implementation guide, it is impossible to determine if this will result in improvements to the provision of aged care services.

2. **Do you think the expectation statements for older people are right?**

The improved person-centred focus of the revised Aged Care Quality Standards is welcomed but has resulted in broad statements that are difficult to interpret and subsequently to apply practically. For these statements to translate into practice, the direction for and expectations of the providers need to be clearly articulated and tied to measurement of the revised Aged Care Quality Standards. Using approaches such as those in the NSQHS Standards, particularly the use of the 'Standards, Criteria, Items, Action' format would improve clarity by constructively aligning expectations to outcomes and methods of measurement. The implementation guide may provide a level of detail that increases understanding around the intent of the revised Aged Care Quality Standards and would have been helpful during this consultation.

It is essential that work health and safety obligations of employers are not disregarded or underplayed as a result of supposed older person preferences. A nursing home must be safe for all, the older person using the service, carers and workers.

3. **Do you think the outcome statements and actions are clear and readily understood?**

As identified by the Royal Commission, a lack of clarity and firm direction in the existing Aged Care Quality Standards resulted in many providers working toward achieving the lowest level of compliance rather than investing in improvement. Ensuring providers do invest in improvement of aged care services must be a primary goal of the revised and future Aged Care Quality Standards. Whilst there has been an improvement in articulating expectations of providers, there is still ambiguous language in statements throughout the document. As previously noted, clear links between the standard and the outcomes is essential.

Whilst not an exhaustive list, examples of ambiguous statements include:

At 1.2.2, the Action states: *The relationship between older people and their carers is recognised and respected.* How would this statement be interpreted, implemented, and regulated?

Action 1.2.3 states: *The provider implements a system to prevent and respond to violence, abuse, racism, neglect, exploitation, and discrimination.* This raises the question that if violence is being prevented why the need for a system to respond to it? Processes are required to stop elder abuse along with systems that allow monitoring and reporting of abusive behaviour. A better approach might be,

- *The provider implements a risk management strategy to identify and minimise harm from violence, abuse, racism, neglect, exploitation, and discrimination*
- *The provider ensures risk minimisation strategies are implemented and regularly evaluated.*

The Outcome statement at 1.4 suggests: *Older people have autonomy and can take time and seek advice.* How will these outcomes be measured and how would the regulator determine from where advice should be sought? This is a great aspiration but a weak regulatory measure because it is near impossible to legislate, or quantify a breach.

Action 1.4.7 suggests: *The provider promptly addresses any overcharging* raising the questions, how will a quality assessor or older person know? Will this be legislated and if not, how will it be enforced?

Conceptual references such as 'dignity of risk' are not widely understood by the general public and have potential for ambiguity and/or being superseded by other contemporary practices. For example at 3.2.5: *The provider supports the older people to live the best life they can, including by exercising dignity of risk.* It needs to be clear that this expectation relates to the risk of the person and not others, such as workers. For example, it is not appropriate for an older person to decide that their preference is not using a lifter for transfers, when a lifter is required for the safety of staff assisting with the transfer.

4. How satisfied are you with the outcomes and actions set by the revised Quality Standards for the focus areas listed below?

Valuing people and caring for people from diverse backgrounds

This will be dependent on the expectations of providers and how well it is monitored. Cultural safety is extremely important. Health practitioners regulated under the National Law (registered nurses and enrolled nurses) learn about cultural safety as part of pre and post registration education. Delivery of culturally safe care is embedded in the *Registered nurses standards for practice*. However, many care workers would not have received any education in cultural safety. Providers must be expected to demonstrate:

- How they educate unregulated workers to contribute to the provision of culturally safe care?
- How they determine the recipients of aged care feel culturally safe?
- Continuing professional development for all workers in the delivery of culturally safe care?

Similarly, the reference to *trauma aware and healing informed care* (Standard 1, Action 1.1.2) which are specialised approaches to care. How will providers ensure their workforce is skilled in identifying trauma and delivering this type of care and will the provision of such care be measured?

Supporting people with dementia

In 2022 there are an estimated 487,500 Australians living with dementia. Of these approximately 65% live in the community. Sixty eight percent of people living in nursing homes have moderate to severe cognitive impairment.[3] This population requires specialised care, particularly those with behavioural issues who require higher levels of care and surveillance. There remains a lack of staff (both regulated and unregulated) with expertise in dementia management. While the revised Aged Care Quality Standards recognise the need for services for people with dementia, they pay little or no attention to ensuring the workforce is educated and skilled in caring for this group. Given that the delivery of care to this vulnerable population is dependent on adequate numbers of appropriately qualified and skilled workers, Providers must be required to demonstrate what they do at an organisational and individual level (as part of person-centred and individualised care) to ensure workers are supported to work with people who have dementia.

Clinical care of older people

In 2017 – 18 in Australia, 50.5% of people had 2 or more chronic health conditions.[4] The ANMF recognises the increasing number of people over 65 living in nursing homes and the community who have complex and chronic health conditions and/or cognitive decline. Given the incidence of such conditions, it must be recognised that the provision of aged care services should align with the provision of health care rather than with the NDIS. This is especially important when considering transitions, comprehensive and continuity of care between aged care and health facilities and the community.

5. Do you think the revised Aged Care Quality Standards apply well to care and services being provided to older people in the following contexts:

Residential aged care facilities: Although aspects of the revised Aged Care Quality Standards can be applied to residential aged care facilities there are significant shortfalls and gaps in the proposed standards as outlined in this submission that need to be addressed.

Their home: Although aspects of the standard can be applied to in home aged care delivery, there are significant shortfalls and gaps in the proposed Standards as outlined in this submission that need to be addressed.

6. Are there opportunities to make the revised Quality Standards more meaningful and empowering for older people?

Words such as *meaningful* and *empowering* are concerning. These are vague terms and should be used with caution when referring to one of the most vulnerable groups in Australian society. Attention is drawn to the frequent use of terms such as *home like environment, de-institutionalization* and *ageing in place* when discussing the aged care sector which has provided the impetus for the significant diminution of skill mix and the resultant safety and quality failures so well detailed in the final report of the Royal Commission.

While the ANMF welcomes the increased focus on input from the person receiving aged care services, further emphasis needs to be placed on those who do not have decision making capacity, especially given the increasing percentage of people living with dementia and their carers. Acknowledging and addressing the needs of this population is critical for those without a next of kin or a self-appointed substitute decision maker. The prevalence of elder abuse in Australia remains high with findings that one in six older Australians experience some form of abuse. Those with poor physical or psychological health and with higher levels of social isolation are more likely to be elder abuse victims as well as a group likely to be receiving aged care services. Elder abuse can be:

- Psychological (11.7%);
- Neglect (2.9%);
- Financial (2.1%);
- Physical (1.8%); and
- Sexual (1%).[5]

How will the Standards ensure that people without decision making capacity have their needs met and are safe from abuse? The true test of the revised Aged Care Quality Standards will be in how effectively they protect the most vulnerable, those without a voice. This will require strong legislation and a regulatory authority with the will and power to act when providers do not deliver the outcomes expressed through the revised Aged Care Quality Standards. Given the lack of information about the Act, the Regulatory Model or an implementation guide, this is difficult to predict.

7. Are there any outcome statements or actions that could not readily be demonstrated by Providers?

Please see Question two which outlines the ambiguity in a number of the revised Aged Care Quality Standards and expresses the need for a constructive alignment in describing the standards and the expectations of Providers. Adoption of the format used by in the NSQHS Standards would increase the clarity regarding the link between the Standard and outcomes and the expectations of Providers.

8. Are there any additional outcome statements or actions beyond those in the revised Quality Standards that should be included?

The ANMF recommends the inclusion of two additional Actions and revised wording at 5.4.1 to better reflect the Outcome statement.

The Provider ensures assessment and planning systems:

a) *Are developed in partnership with the older person and their representatives and professionals involved in their care;*
b) *Regularly identify clinical risks and chronic conditions, particularly on commencement, at transitions of care and when there is a change in diagnosis, behaviour, cognition or mental or physical condition;*
c) *Includes development of holistic care plans, including for acute exacerbation of chronic conditions;*
d) *Include ongoing review and re-assessment at regular intervals and as the older persons needs change.*

9. As a Provider, what guidance documents and/or supports would you need to aid implementation of the revised Quality Standards?

The new implementation guide should be available to further explain the Standards, including the expectations of providers.

10. Overall, do you think the revised Aged Care Quality Standards are an improvement on the current Aged Care Quality Standards?

The ANMF is supportive of the revisions to the Aged Care Quality Standards and acknowledges the improvements made. However there is a need to evaluate the revised Aged Care Quality Standards in the context of the new Aged Care Act, Regulatory Model and implementation guide. For this reason the ANMF recommends that the revised Aged Care Quality Standards be viewed as an interim measure with a full review when the Act and Regulatory Model are finalised.

It is the view of the ANMF that aged care is health care and should be aligned with the ACSQHC and the NSQHS Standards rather than with the Standards developed for the NDIS.

The World Health Organisations constitution states that health *is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*.[6]

A definition supported by the Australian Institute of Health and Welfare (AIHW). [7] Further to this, the social determinants of health demonstrate the impact of non-medical factors on the outcomes of people's health. Such determinants include access to health services, social inclusion, food security, housing and basic amenities and the environment.[8] People accessing aged care services do so due to incapacity, injury, recovery, frailty, disease, or an inability to perform the activities of daily living, all of which relate to a person's health. Additionally, the increasing levels of chronic and complex conditions suffered by those living in aged care facilities and in the community require clinical assessment monitoring. It is for these reasons the ANMF considers aged care to be health care.

Given that aged care exists within a context of health, it follows that the services provided and the Standards should align with the NSQHS Standards which are well established and have a proven record of applying and assessing health care delivery. This alignment will reflect and reinforce that all Australians have a right to high quality health care regardless of the setting or context in which they find themselves. There is little evidence to suggest that the revised Aged Care Quality Standards should align with those developed for disability services, especially given the ongoing Royal Commission into violence, abuse, neglect and exploitation of people with disability with the final report not due until 2023.

11. Please provide any other feedback on the revised Quality Standards.

Workforce as a separate, standalone standard

The workforce is the backbone in the delivery of services and provision of support to those requiring aged care. This has been recognised through the recent legislation requiring registered nurses to be onsite and on duty in residential aged care facilities 24 hours per day and that nurses and care workers spend a mandated amount of time with each person receiving care per day. In order to deliver care, nurses and care workers require fair and safe working conditions and remuneration, appropriate levels of staffing, ongoing professional development, education and support and providers who understand their scope of practice or role. This should be articulated under a workforce standard.

To improve continuity of care and assist in the recruitment and retention of skilled and experienced aged care workers, the Aged Care Quality Standards must include clear expectations of providers in relation to worker safety and wellbeing. Aged care workers experience the highest rates of serious injury of any industry[9] with the majority being physical injuries related to the physical transfer of people and psychological injuries arising from occupational violence, aggression and bullying. Work Health and Safety (WHS) laws require that risks are eliminated so far as reasonably practicable or minimised where elimination is not possible. Reasonably practicable should be clearly defined and not include the personal preferences of the person receiving care. Workers should be consulted at each stage of risk

management process in accordance with legislation and receive work health and safety training and education appropriate to their role, including incident reporting and management.

Outcome or action statements relating to the safety and wellbeing of older people, should be reviewed and those that should also include workers be identified. For example, outcome 4.1a has numerous references to the safety and wellbeing of the older person and the ANMF believes this should include the worker.

In outcome statement 4.1a *Where equipment is used in the delivery of care and services or given to the older person by the provider, it is safe and meets their needs,* it should also include ***and the needs of workers***.

4.1a Action b) *discusses with the older person, any environmental risks and options to mitigate these.* The ANMF suggests*, discusses with the older person* ***and workforce****, any environmental risks and options to mitigate these.*

4.1b Outcome statement, *Equipment provided by the provider is safe, clean, well-maintained and meets the needs of older people would be more appropriate if it read Equipment provided by the provider is safe, clean, well-maintained and meets the needs of older people* ***and workers****.* There are numerous other examples throughout the document where workers should be included.

Aged care regulation has historically failed to deliver proper care outcomes. One of the main reasons for this has been the inability or unwillingness of governments and some providers to ensure that the funding is spent on the care for which it is intended. No funding model or system of aged care regulation will be complete or effective without measurable actions including demonstration of minimum shift by shift staffing requirements, modern awards and enterprise agreements and transparency to show the public that requirements are being met.

The Productivity Commission's Aged care employment study report [10] identified digital care platforms as likely to increase the number of gig-economy workers providing direct care. It is unclear whether these workers will be brought under the scope of regulation, and if so, how these revised Standards will fit this model. To future-proof these Standards, urgent consideration will be needed in this regard.

For the reasons outlined above, the ANMF strongly recommends that workforce sits as a separate standard within the revised Aged Care Quality Standards.

Additionally, the revised Aged Care Quality Standards must clearly define the workforce as separate from the provider. Currently this is not the case. The workforce must also be recognised as a separate audience for the revised Aged Care Quality Standards.

Definitions

Governing body and provider

There are several definitions throughout the revised Standards that are problematic.

The term *governing body* is used often, for example *the intent of Standard 2 is to hold the governing body responsible*. If the governing body is responsible, who is legally accountable, is this the Board members or the provider? If it is the provider that retains ultimate legal responsibility then this should be clearly articulated, for example, *The provider, through its appointed governing body is responsible,* wherever the Board is mentioned.

A further example at 5.3.3 states, *the provider documents existing or known medicine allergies at the commencement of care and when changes occur.* This wording is problematic and again raises the question, who is the provider? *Medicine management systems ensure existing or known medicine allergies are documented at the commencement of care and when changes occur,* may be clearer.

Workers

The definition of workers requires expansion to ensure providers and others understand the professional scopes of practice (of regulated workers) or roles (of unregulated workers). For example care workers who are not regulated under the National Law do not have a scope of practice and do not administer medicines. Providers should not expect registered nurses to direct care workers to undertake a task that is not within their role.

Medicines management

A major cause of confusion in medicines management, is the difference between 'prompting', 'assisting with medicines' and 'administering medicines'. These terms have very different meanings when used in the context of medicines management and the ANMF strongly recommends that a clear definition for each is included in the revised Standards and suggest the following:

Prompting - the person is assessed as being able to self-medicate and is in control of their medicines. Their independence requires support.

Prompting of medicines is reminding a person of the time and asking if they have or are going to take their medicines. The person is still in control of their medicines and may decide not to take them or to take them later. Prompting can be useful when a person knows what medicines to take and how to take them but may simply forget the time.[11]

Assisting - the person is assessed as being able to self-medicate and is in control of their medicines. Their independence requires assistance.

A person may be able to retain control of their medicines but need assistance with simple mechanical tasks. Assisting with medicines can include: bringing packs of medicines to a person at their request so that the person can take the medicines; opening bottles or packaging, including pre-packaged dosage systems (blister packs) at the request and direction of the person who is going to take the medicine; reading labels and checking the time at the request of the person who is going to take the medicine; ensuring the individual has a drink to take with their medicines.[12]

Administration - the person is assessed as unable to safely manage their medicines though prompting or assistance.

If a person cannot take responsibility for managing their medicines, any of the following will constitute administration of medicine: deciding which medicine(s) have to be taken or applied and when this should be done; being responsible for selecting the medicines; giving a person medicines to swallow, apply or inhale, where the person receiving them does not have the capacity to know what the medicine is for or identify it; giving medicines (even at the request of the person receiving care) where a degree of skill is required to be exercised to ensure it is given in the correct way.[13]

To ensure understanding by providers and workers in aged care, it must be clearly stated that care workers can prompt or assist with medicines when directed and supervised by a registered nurse. Only registered nurses or enrolled nurses can administer medicines. This will also assist Providers to meet correct staffing skill mix requirements.

Infection prevention and control

4.2.1 a) states that the provider *identifies an appropriately qualified and trained infection prevention and control lead.* This must state that the lead is a registered nurse who is appropriately educated, resourced, qualified and supported. The outcome statements and actions at 4.2, infection prevention and control, must specify that the provider is responsible for supporting education and ongoing professional development for workers. Providers should also be expected to ensure systems are in place to guarantee the provision and maintenance of adequate and appropriate personal protective equipment to maximise the safety and wellbeing of older people and workers.

Accountability

The governing body must demonstrate they have the necessary skills, experience and credentials to identify financial and clinical risk relative to the older person.

Registered and enrolled nurses are accountable for their professional scope of practice and must be consulted regarding matters where their practice will be impacted.

Technical Nursing

The ANMF recommends removing the sections at 5.4.4 titled Technical Nursing and the list of clinical interventions. This terminology is outdated and demonstrates a lack of understanding regarding the nursing process. The check list of high risk, clinical interventions suggests a reductionist view of care and does not reflect the person-centred approach to which the revised Standards and nurses aspire. It would be more helpful to speak about the provision of nursing care, stating that registered nurses working in aged care settings, provide holistic, person-centred care, determining the needs of the person according to comprehensive assessment and planning.

Transitions of care

The ACSQHC acknowledges that safety issues exist during transitions of care.[14] The ANMF notes within the revised Aged Care Quality Standards, there is no clear definition of *transition* nor is there acknowledgement of the high level of risk associated with transitions of care, either into or out of a facility. Further, there is no clear expectation of evidence-based requirements for care provision leading up to or following a transition. The provider must ensure that there are systems in place for the safe transfer of information between appropriate health practitioners/health professionals. This communication pathway must work in both directions. The provider must accept the duty of care associated with transitions and demonstrate that safe processes and systems are in place, including defined responsibility and accountability for communication at transitions of care that ensure the safety of the person.[15]

High risk situations related to transitions of care include medicine safety. Older people are more likely to be prescribed multiple medicines. Over 90% of people receiving care in nursing homes are prescribed more than four concurrent medicines, with an average of 9.75 medicines prescribed per person.[16] This is exacerbated when communication between health practitioners is uncoordinated and/or where there are no systems in place to ensure the transfer of essential information between health care providers and practitioners. The risk of hospitalisation or re-hospitalisation due to medicine errors increases for those experiencing transitions of care and who are prescribed high risk medicines such as anticoagulants, antipsychotics, hypoglycemic agents or taking many medicines.[17] It is for these reasons that the Outcome 7.2 should sit within Standard 5 and align with the NSQHS Standards.

CONCLUSION

Thank you for this opportunity to provide feedback on the revised Aged Care Quality Standards. Whilst the ANMF appreciates the urgent need for reform to the Aged Care Quality Standards, it also acknowledges other reforms that are underway, namely the new Aged Care Act and Regulatory Model. Viewing the revised Aged Care Quality Standards in the context of these fundamental pieces of work will be essential to determining how each will inform the other. The ANMF assumes that further review and revision of the Standards will occur following the new legislation and completion of the Regulatory Model.

In summary:

- It is the view of the ANMF that aged care is health care and that the Aged Care Quality Standards should align with the NSQHS Standards which are well established and have a proven record of applying and assessing evidence based health care delivery;
- The ANMF recommend a separate standard addressing workforce to ensure accountability by providers especially given the recent legislation for nurses to be onsite and on duty 24 hours per day with appropriate safe staffing levels and mandated care minutes;
- Providers need to be clear about what is expected of them in order to meet the Standards. This could be achieved by constructively aligning standards and outcomes using a format such as that adopted by the ACSQHC in the NSQHS Standards;

There should be revision of ambiguous language throughout the document. Expansion of definitions related to the workforce will also assist with clarity.

REFERENCES

[1] Royal Commission into Aged Care Quality and Safety (2021) Final Report: Care, Dignity and Respect, Volume 1 Summary and Recommendations. Available at https://agedcare.royalcommission.gov.au/sites/default/ files/2021-03/final-report-executive-summary.pdf

[2] Royal Commission into Aged Care Quality and Safety (2021) Final Report: Care, Dignity and Respect, Volume 1 Summary and Recommendations. Available at https://agedcare.royalcommission.gov.au/sites/default/ files/2021-03/final-report-executive-summary.pdf

[3] "Dementia Prevalence Data." Dementia Australia, 2022, https://www.dementia.org.au/information/statistics/prevalence-data.

[4] "Chronic Conditions and Multimorbidity." Australian Government, 2022, https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity

[5] Australian Government, Australian Institute of Family Studies (2022) Elder abuse research, retrieved from https://aifs.gov.au/projects/elder-abuse-research

[6]World Health Organization. "Preamble to the Constitution of the World Health Organization as Adopted by the International Health Conference." New York: WHO, 1946.

[7]Australian Institute of Health and Welfare. "What Is Health." Canberra: Australian Government, 2022. https://www.aihw.gov.au/reports/australias-health/what-is-health.

[8] World Health Organization. "Social Determinants of Health." Geneva: WHO, 2022. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

[9] SafeWork Australia, Work Related Injury and Disease Key WHS statistics, 2020, accessed online 30/8/2021 at https://www.safeworkaustralia.gov.au/book/work-related-injury-and-disease-key-whs-statistics-australia-2020

[10] Productivity Commission. *Aged Care Employment.* (Melbourne: Australian Government Productivity Commission, 2022). https://www.pc.gov.au/inquiries/completed/aged-care-employment/report

[11] The Care Inspectorate (2015) Prompting, assisting and administration of medicines in a care setting: guidance for professionals. Available at: https://hub.careinspectorate.com/media/1595/prompt-assist-administer-medicines-in-a-care-setting-guidance.pdf

[12] The Care Inspectorate (2015) Prompting, assisting and administration of medicines in a care setting: guidance for professionals. Available at: https://hub.careinspectorate.com/media/1595/prompt-assist-administer-medicines-in-a-care-setting-guidance.pdf

[13] The Care Inspectorate (2015) Prompting, assisting and administration of medicines in a care setting: guidance for professionals. Available at: https://hub.careinspectorate.com/media/1595/prompt-assist-administer-medicines-in-a-care-setting-guidance.pdf

[14] Australian Commission on Safety and Quality in Health Care. (2017). Safety Issues at Transitions of Care: Consultation on pain points relating to clinical information systems. Australian Commission on Safety and Quality in Health Care.

[15] Australian Commission on Safety and Quality in Health Care. (2017). *Safety Issues at Transitions of Care: Consultation on pain points relating to clinical information systems.* Australian Commission on Safety and Quality in Health Care.

[16] Sommers, M; Rose, E; Simmonds, A; Whitelaw, C; Calver, J; Beer, C. 2010. “Quality use of medicines in residential aged care.” *Australian Family Physician* 39 (6): 413–416

[17] Department of Health and Aged Care. 2022. *Guiding principles for medicines management in residential aged care facilities*.