Caring for Older Australians

Productivity Commission

Issues Paper

May 2010

Verification documentation in Aged Care services

Dear Sir/Madam

I wish to take this opportunity of bringing to your attention the problem of the documentation necessary to achieve funding in all areas of aged care services.

I have recently retired from a long nursing career in aged care and have personal experiences that suggest that present documentation requirements are not only onerous but are positively detrimental to those for whose care they are designed.

I refer to the documentation necessary to obtain and retain adequate funding for the care of people in nursing homes and hostels in Australia. There are two areas in particular with which I have personal knowledge:

> Aged Care Standards and Accreditation for nursing homes and hostels (accreditation.org.au)
>
> Resident Classification Scale - RCS (aihw.gov.au/publications)

The Standards are designed to ensure that the care given to older persons in residential facilities funded by government is of acceptable – even excellent, standard.

The Resident Classification Scale is designed to ensure that the level of funding provided to residential facilities is appropriate to need.

These two objectives are just and fair, but the way in which justification is sought is onerous and inappropriate.

The documentation required to support the Standards and the RCS takes time and funds out of the system. It encourages corruption, has a negative impact on care provision and fails to provide the evidence that it seeks.

I will endeavour to illustrate these claims by anecdotal evidence gained during the course of my work as a consultant in aged care.

One of the issues at work has to do with the lack of education and understanding of the staff required to fulfill these requirements and the lack of education and understanding of the Assessors who review the results.

DISCUSSION

The craze for more and more documentation in a risk-averse corporate world has become ridiculous. It has been said that in law, 'Unless it is written, it never happened'. This is understandable, but the reverse is not true, 'If it is written, that does not mean that it happened'.

Care staff are producing more and more paperwork in an attempt to appease the Assessors. Assessors demand more and more paperwork in response to the atmosphere that this engenders.

Unfortunately, staff who are frightened of not understanding what is required of them sometimes become defensive, angry and often as a result of this, ineffective.

Unfortunately, many assessors do not fully understand their role and make ridiculous conclusions. Some enjoy the power and the process then becomes adversarial and destructive.

The combined effect of all this is detrimental to good care and retention of good staff. Nurses are, in the view of many of us, so concentrated on the paperwork that the resident/client takes second place. Excellent nurses, disgusted at the distortion of their role, go elsewhere. Proprietors and managers often assist in these aberrations, worried at a possible loss of funding and failure of their enterprise.

At the beginning of this raft of reforms, now more than 20 years ago, most of us in the industry were crying out for reform. Supervision of residential facilities was cursory and open to abuse. And abuse occurred. The situation was terrifying. Now it is not the same sort of terror, but terrible nonetheless.

I do not think history will forgive us for what is happening now. Legislators have used less than intelligent interventions and have not listened to the right advice. The industry has been spineless thus far in making intelligent representations that would limit the damage that is being done.

STORIES

The Resident Care plan.

This document is designed to describe the day to day needs of the resident/client/patient. It should be up-to-date at all times so that appropriate care is given.

As a result of the RCS, the care is often described in terms of the items specified by this document, thus ignoring other needs. (The RCS is a funding tool, and does not claim to list all possible needs).

The result is often a Care Plan of 20 or so pages. I often asked a classroom of student nurses to give a show of hands of those who read the care plan before providing care. Often, there is not one response. And those who do say 'yes' are lying I think. It is impossible given the time constraints they endure.

In addition, it is also impossible to keep such a document up to date for 30 or so people every day, which is the purpose of this plan.

I claim to be able to go into any nursing home in Australia, pick out a Care Plan at random and find error.

In one home, I discovered 3 care plans; one on the desk for the benefit of Assessors, one hidden in a drawer for Registered nurses to read and a piece of paper tacked to the inside of the wardrobe in a residents' room. This one proved to be the most accurate.

My mother's assessment documents for her care planning in a hostel was 35 pages long but had no place to show that she needed a daily blood test for diabetes.

Progress notes

These documents form a diary of the residents' daily life and are designed to give a picture of their status, and any changes in their condition requiring changes in care. I have seen such abuse of this tool as to make us all look ridiculous. In some cases, day after day, nurses describe in painful detail what the resident did, what the staff member did with, and to, the resident. All a doleful repetition of what happened the day before. I may say that the Assessors do not tell them to do so, it is an exercise in trying to cover all possibilities.

I had one occasion in which this repetition went on for 36 pages. So intent were the writers on getting it all down, that they failed to note that the resident had sustained a hip fracture during this period and was sent to hospital and later returned.

The effects of all this needless writing are many. One of the most serious of which is that nobody can read the result. It would take too long for common sense persons to persevere with. Doctors and other health professionals will no longer read nurses' account of what occurred in a residents' life.

The writing itself takes hours. Nurses mindlessly copy what has been written by the person before them and often this practice is endorsed by their leaders. It is better to be safe than sorry etc.

I once suggested to some nurses that they were writing too much and that is was not useful to the welfare of the residents. I was shouted at by the accountant/manager, afraid for his funding.

In a reading of the research papers on urinary incontinence, I discovered a care plan for incontinence written by some academics in America. It contained all possible areas of intervention with lucid explanations. Brilliant and brief. Readable. We showed it to assessors who rejected it because it was too short. Not enough words. I doubt that they knew more about urinary incontinence than I did. It seemed, and still seems that the search is for effort rather than usefulness.

As a consultant I talked to assessors and care staff and management. Care staff and management tended not to believe me when I showed shorter and easier way to write their documents as suggested by assessors. They seem, many of them, to have fallen into the trap of thinking longer and more is better. And I must say, that I believe that they are encouraged in this belief by some assessors. If I write a succinct report of a situation, it causes anxiety in staff.

Corruption

This situation causes me much sorrow. I am unhappy to see nurses corrupt the system and I am very sorry to see residents being compromised by corruption. There is little enough money provided for the care of our most vulnerable people without wasting it.

Nursing consultants are offering documentation forms designed to baffle Assessors. On the whole, they are very long, full of unnecessary detail requiring lots of responsive writing by staff and are miracles of obfuscation. Assessors admit they can't follow them, but can't disprove their validity.

And they are all very expensive. Managers are buying them because they believe they must use such documents, because they are afraid. I have had little luck in dissuading them.

One consultant is quoted as saying, "write what I tell you and you will pass" (Standards, RCS etc)

It is very common for the documents to bear no resemblance to the care actually provided.

A physiotherapist friend was sacked from her job because she refused to write of imaginary service provision.

There is an eighty year old nurse working in one home whose job it is just to write.

CONCLUSION

Reform is always difficult. However this has gone too far for too long. An opportunity exists at this time for a review and reform of the requirements of verification of quality and quantity of care in our residential facilities. Transfer of powers to the Commonwealth provides the perfect excuse.

I can hope that on that occasion if it occurs, that proper advice and research will be undertaken, and that a less extreme environment becomes the norm.

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