ST Johns Village Inc. Submission "Caring for Older Australians"

Background

St John's Village commenced with the occupancy of the 31 Self Care Units in 1969 and has strived to continuously improve services to residents in North East Victoria.

This facility has been providing residential aged care services since 1976, pre-dating the *Age Care Act 1997,* and certification and accreditation requirements.

The *Trustees of the Anglican Diocese of Wangaratta* is the approved provider for the provision of residential aged care services at St John's Village.
.
The low care facility 'The Hostel' was constructed in 1976 as a 74 bed low care facility. It was developed in stages and extended with the completion of McDonald House, a 16 bed dementia unit, as the final stage, bringing the total number of places to 90.

The original high care facility a 30-place 'Nursing Home' was constructed in 1995 and extended in 2002, to provide an additional 15 high care places and 15 dementia care places.

The development of The Terraces commenced in 1998 and in 2010 has reached 147 units. Stage 2 is under construction and will eventually provide a total of approximately 200 units for retirement living accommodation.

St Johns Village provides aged care services to 387 Residents and employs 210 staff, has a turnover of $15 million dollars, which is a major employer in the Community.

WORKFORCE

In rural Victoria, aged care is constantly challenged in engaging quality staff.

The aged care industry encouraged the Nurses Board to introduce a new level of clinical nurse care to support a desperate need for nurses to deliver care. Division 2 nurses with medication endorsement were introduced so that aged care providers would be able to at least administer medication when a registered nurse was not available. Division 1 nurses mainly work in an acute setting and aged care facilities only attract those RN's that have had enough of the hospital system and gravitate to aged care. We were able to capture Division 2 medication endorsed nurses because they had a role to play in aged care. In more recent times the acute sector has accepted Division 2 medication endorsed nurses and it has now impacted on our ability of delivering quality care.

The training of Registered and Enrolled Nurses does provide a broad, but limited, exposure to aged care in the curriculum. Problematical in the exposure is that aged care is not considered to be a speciality and many students consider aged care to be 2nd rate to acute care, of little importance and not the desired field of clinical acumen, however, gerontic nursing has the requirement for the registered nurse to be a skilled clinician with the ability to triage, assess and refer in the absence of medical support and adhoc service provision by medical practitioners. The emphasis on this requirement is not evident with students and is extremely disappointing

There are opportunities to qualify nursing students to Personal Care Attendant level during the first year of their university studies, but this process is hampered by the minimal requirement of aged care workers to possess a Certificate III in aged care. The nursing student is required to present current academic qualifications and pay for a certificate of attainment to enable the students to gain employment and practical 'nursing' exposure as well as provide aged care with a valuable human resource.

Consideration also needs to be given to funding aged care providers in providing traineeships, where students at Certificate III or IV in Aged Care are employed in facilities and paid to undertake practical skills in a super numerary role, whilst undertaking studies. St John's Village has trialled this model by engaging long term unemployed persons and working in partnership with Regional Training Organisations to qualify them to Certificate III in Aged Care. The results have been very rewarding for both the organisation and the individual. We have a highly efficient employee at the end of the course who understands aged care and can deliver quality care from day one.

FINANCIAL VIABILITY

The financial results of the 2009 Bentleys National Aged Care Financial Survey, indicates signs that the aged care industry viability is deteriorating.

Results show average profits have halved in the past three years to less than 5% and more than 40% of providers are running at a loss.

Rural providers are the greatest hit where more than 50% are operating at a loss, compared to 37% of the metropolitan providers.

St John's Village has sustained losses in providing residential care for the last eight years.

The Commonwealth pricing model does not reflect the real cost of operations and capital required, to provide Residential services.

The Commonwealth Government's recent announcement to provide residential care providers with a 1.7% increase to resident fees and subsidiaries is a real concern, when the national CPI increase was 2.9%.

Aged care providers in the rural sector will all be facing salary and wages and oncosts increasing 3% to 3.5% to ensure we reward our staff appropriately and maintain staff. Salary and Wages accounts for 75% or our operating budget.

Other utilities such as rates are to rise 6%, insurance 3.4%, light and power increasing to 3.5% and water 29.5%.

The aged care sector has had to endure no increases to the conditional adjusted payments in the last two years. Government has cut in half the aged care annual funding instrument from 4% to 2%, which has made delivery of aged care very difficult.

The short term solution to the financial viability issue is annual indexation that reflects the real cost of aged care, and a capital operation system that allows residents who have the means to be able to choose how they contribute towards their accommodation costs.

Government needs to re-introduce an indexed conditional adjusted payment. This will support aged care providers in the provision of quality care.

Rural aged care providers are the hardest hit, according to the 2009 Bentley survey, the rural viability supplement needs to be incremented to support the rural providers.

Whilst the ageing population cannot be reliant on Government funding, a user pay solution should also be considered where people contribute towards aged care services through a superannuation scheme. A percentage of the employer contribution is to be specifically set aside for aged care services.

The other long term solution is to allow the health insurance industry to provide coverage for residential aged care services. This will need Government incentives to encourage people to contribute as provided in the current health insurance schemes.

We are confronting a growing ageing population and we need to facilitate a responsible approach both at Government and consumer level.

QUALITY AGED CARE

Introduction of care in the home has seen a real shift in residential aged care services.

Currently there is a model that silos residents into low care and high care classifications. This model then introduces various care requirements and differing consumer charges. For example, we have bond charges in low care and accommodation charges in high care. Cost of care services are different, for example, a resident in low care pays for allied health services compared to a resident in high care where facilities pay for the allied health services.

Facilities classified as high care are required to have a differing work force, for example, more nurses, which does not assist high care providers, in providing more flexible care driven needs.

By abolishing low and high care facilities greater flexible care could be provided and be funded in a more flexible and consistent manner. Residents would be expected to pay based on their financial capacity not by what level of care they are classified in.

The aged care sector also has capacity to support our health system where we can care for sub acute residents that require care and support following medical procedures/interventions. This model of care frees up acute hospital beds and reduces our health costs, as aged care operates at a lower cost per day than a hospital.

Aged care, like the entire health system, is heavily reliant on the medical practitioner. There is an ever increasing demand placed on them both in providing medical support and their need to provide quality data that underpins to Aged Care facilities funding. Without a medical diagnosis, the aged care providers are not funded for certain behavioural / medical components. Therefore, there is a heavy reliance on the GP to duplicate documentation not only in the aged care facilities documentation systems but also their own to enable diagnoses and treatment modalities to remain current to reflect the actual care needs of the aged care client. As in all rural areas GP's are a limited and ageing and accordingly we need to support our GP's by providing Aged Care Nurse Practitioner roles.

A recent study by Caroline Lee, CEO of Leecareplus, into Aged Care Nurse Practitioners (ACNP) has identified many great outcomes for the resident and aged care providers. ACNP are well recognised internationally, however, introducing this role in Australia is still in its infancy.

The study concluded that the Nurse Practitioner provided a holistic aged care specialist nursing service

Significant improvements in the residents function and social status were demonstrated and resident and representative satisfaction levels with the care provided by the aged care facility where significantly increased

The results also demonstrated that the ACNP interventions were of high quality, led to improvement in resident health outcomes, improved resident quality of life and reduced hospitalisation. This is achieved by intervening in a timely manner when residents required relief of their physical and psychosocial symptoms through targeted interventions and one on one specialist medical attention.

The study concluded that there is a real need for ACNP in residential aged care and Government should support, assist in facilitating and transitioning the practitioner's role into the aged care arena. General Practitioners also believed ACNP also provided a high level of quality care in collaboration with GP's and other allied health professionals.

REGULATORY COMPLIANCE

Aged care providers are significantly regulated with various regulations and acts that are a mandatory requirements. In addition there are compliance auditors that ensure regulations are met.

To deliver aged care, providers are required to meet all 44 standards set by the Commonwealth and administered by the Aged Care Standards Agency on tri annum basis. In addition, Government also mandates at least two support contact visits each year, where facilities are visited unannounced.

The challenges of the site visits also include the individual auditors perception of what is the required acceptable outcome and what is required to demonstrate the outcome as rarely do two auditors from successive visits view the same outcomes in the same light.

Should the facility encounter an issue where the resident/carer is unhappy about the service provided, they have the right to report their concerns to the Commonwealth Investigation Service (CIS). In fact CIS can receive reports from any person that has a concern about the care provided at an Aged Care Facility. They can be family, visitors, staff or any other person that calls. All calls are then investigated and facilities are subject to unannounced visit/s from CIS Investigators or a phone call requesting documentary evidence to be provided within the requested time frame.

Facilities will then receive a written report identifying whether the facility is found either compliant or non-compliant within the Aged Care Act and regulations. The letter will then report on where the facility is found to be non-compliant and detail expected actions within a given time that is to be evidenced back to the Commission.

The CIS then informs the Aged Care Standards Agency that they have investigated a complaint and the Standards Agency then presents to the facility for a support contact visit, unannounced to address systems related to the incident and again facilities will be found either compliant or non-compliant and systems will need to be reviewed.

In a recent incident, the Agency came to investigate our facility that resulted from a CIS complaint. They reviewed systems relating to the incident and found the facility compliant with the initial breach as identified with the CIS however, they then decided to widen their scope of audit and reviewed another module of clinical care systems and found the facility non compliant with need to review its policy and procedures.

The facility is required to respond to such agencies and respond to required actions. This all takes significant time and resources to respond to and is over regulated.
Pressure on staff due to inadequate funding and the insufficient staffing makes the likelihood of errors more common, reducing and leaving the industry often to criticism.

If this same case scenario occurred in the acute health care system, the ramifications of the regulatory bodies inspections and scrutiny would not have been comparable. Accreditation in this facility is Mandatory but in Hospital acute health it is not mandatory but voluntary. All systems require regulation, but Government needs to enable the provider sufficient funding to improve the access, equity and quality of care for all aged persons.

There is an urgency to care of our older Australians in the present and to ensure we sustain such services into the future and so we ask the Commission to address the real issues indentified in this submission.

Yours sincerely

The Right Reverend John Parkes
Bishop of the Anglican Diocese of Wangaratta
and
Board Chairman
St Johns Village Inc.