INTRODUCTION

This paper is a combined effort from an approved provider's networking group. This group has been meeting for the past five years, every 2 months. The purpose of the group is to share ideas and discuss how to deal with issues in the aged care environment. The members of this group is by invitation only and consists of approved providers of small to medium size organisations. The group is made of the following approved providers:

APPROVED PROVIDER	NUMBER OF BEDS REPRESENTED
Carrington Aged Care	260
Huon Healthcare	301
Burton Healthcare Pty Ltd	60
Parkwood Aged Care Services Pty Ltd	252
Desilva Health Care Pty Ltd	70
Norsan Pty Ltd (Park Lane)	164
Milford Hall Pty Ltd	60
TOTAL BEDS	**1,167**

The group selected issues that affect the operations on a day to day basis. The points are brief and can be discussed fully, if required. The main issues contained in this paper are:

- Regulation – Resident Tenure
- Regulation – CIS
- Supply and demand – bed vacancy
- Capital needs of the sector – bonds in high care
- Workforce requirements – flexibility around legislation
- Meeting recurrent costs – CPI increase
- Choice and flexibility – consumer pays for extra care

REGULATION

- Resident tenure to be more flexible to assist in the removal of residents that are not, or are no longer suitable for aged care (dangerous to self / dangerous to others). Increasing need for psycho geriatric care – mainstream aged care does not have the skills nor the funding to cope with this type of resident. The resident must be moved on quickly so not to put other residents at risk. This situation can also lead to detrimental effects of a facility, with security issues for other residents, security of staff and issues with attracting new potential residents and or their families.

  See Appendix One: Case Study

- Establishment of a totally independent commission and investigation system from Department DoHA. Complainants should be made to register their contact details with the relevant authority (which would then be verified) so that the complaints legitimacy can be captured, feedback issued and additional information sought, if necessary. Each complainant's details to remain anonymous (by request) to the Approved Provider and confidential to the relevant authority. A complainant's register could assist the resolution of vexatious and nuisance complaints and the considerable expense that Approved Providers incur in simply defending themselves. Investigators to have appropriate training which can be guided by DoHA.

  The present CIS does not provide closure for complaints. This results in long-running, time consuming and often unresolved complaints. This further creates an unhealthy damaging relationship between the provider and the resident and/or family member (consumer). The CIS needs to recruit people, who are trained to liaise with the Approved Providers, to assist with resolving complaints/disputes in an effective and timely manner that is acceptable to all parties involved. We need an appeal process to the Aged Care Commissioner, where the Commissioner's decisions can overturn the decisions made by the CIS. The present system does not allow for an effective appeals process.

SUPPLY AND DEMAND

- Cost of bed vacancy. Competition is good for the industry however there is considerable expense associated with building a new aged care service and the Approved Provider needs to service the debt. Legislation regarding bond payment terms and options is too flexible in favour of the resident.

  Recommendation

  - Prudential and bond arrangements to remain unchanged so that bonds can off set the bank interest and/or interest be earned on bonds if servicing no debt.
  - Consider changing the time allowed for a resident to lodge an accommodation bond.
  - Extend the time frame within which the accommodation bond should be refunded.
  - Government to fund empty beds ($50 per day) over a time period to assist with servicing the debt of building.

- If the market were to be deregulated in a way that removed the Government control of bed licenses (i.e.: allowed for more aged care facilities to be built more freely). The industry is not robust enough financially to manage supply changes with a likely outcome of further occupancy falls and who will pay for that, i.e. could decimate the industry.

CAPITAL NEEDS OF THE SECTOR

- Combine low and high, and just have residential care with bonds. Statistics show that low care will diminish over time. This allows capital funding for high care facilities to renovate and provide a better facility for the older Australian.

  ACFI funding to remain status quo but to be indexed. Bonds see section on supply and demand.

  Therefore no requirement for ACAS Teams in the acute sector. ACAS teams can be dissolved and this critical funding can be put back into Aged Care. Placement Coordinator employed by Approved Provider, use E-Health to access patient history to determine suitably for Aged Care.

- If deregulating part of the industry by removing bed licenses, some form of compensation to current approved providers to be taken into consideration. To include those approved providers that have purchased bed licenses outside ACAR rounds (current market value $40,000 per bed) and the cost of bed licenses via bed rounds is also expensive.

- Concessional ratio – to be monitored across all facilities, the ratio to be based on demographics. The extra services facilities to be exempt from the concessional ratio.

WORKFORCE REQUIREMENTS

- Reduce the reliance of using Registered Nurses, regulation to be more flexible in providing different models of care. Paying good money to RN's who are incompetent but facilities have to have them there due to legislation requirements.

- The enrolled nurse has now taken the role of the registered nurse, the PCW now does the role of the enrolled nurse but needs more clinical expertise, especially in the area of observations. Extra module of training to up skill the PCW which also offers a career path and then reduces reliance on the registered and enrolled nurse.

  Education and training organizations need to reach a higher standard of knowledge and skills rather than churning out poorly qualified nurses and PCW's that need retraining once entering the workforce at the expense of the Approved Provider.

- Staff wages to be in parity with the acute sector and cost of living (to be appropriately funded), needs to attract the Y Generation to the aged care industry. See "meeting recurrent costs" for how to pay for this.

- Without immigration or BIGGER Australia "aged care" would not have employees.

MEETING RECURRENT COSTS

- Linking in with workforce requirements aged care to become more sub-acute (aged care takes funding from public sector). The facility brings in specialist RN's from hospital (like "hospital in the home" for wound, palliative care) and this is either funded as extra care from the acute sector, consumer pays and / or it could extend into ACFI and be funded accordingly without changing too much.

- Funding to deal with specialist needs such as mental diseases and substance abuse. By 2020 mental health, including depression will become the largest health issues facing Australia. Aged care staff not skilled in this area. Funding to come from acute for social workers to assist and deal with difficult families/residents.

- Longer term approach to making funding in Aged Care more sustainable. Appropriate and adequate indexation. COPO annual funding adjustments do not reflect the increasing cost of healthcare and the model needs to be revised to take into account the Health Price index. Funding should be adjusted in line with the aged pension and daily fees every six months.

  CPI is 2.9%, yet the Minister for Aged, Justine Elliot only gave the Aged Care Industry a 1.7% increase in subsidies. Providers are forced through their EBA, to give staff a 3 - 4% pay increase each year over 4 years. Wages equates to approximately 70% of total expense of Aged Care Facilities. This has a drastic negative impact on our profit margin which is diminishing annually. The Aged Care Industry is struggling to maintain quality care to our residents and to attract and retain quality experienced staff.

CHOICE AND FLEXIBILITY

- If a family wants to pay for extra carers then they have the flexibility to have this. The Department's standing on this states that if an extra carer is provided the facility must pay for it and cannot ask the family. This would occur more in high care where you have residents not suitable for aged care – refer to the first point under 'Regulation' and the need for resident to have specialized care. What level of care does Government want and be prepared to pay for and then let the Approved Provider's work the rest out with the resident i.e. flexibility to charge.

APPENDIX ONE
CASE STUDY

78 Female Resident transferred to facility from another Nursing Home (closed down) on 4th June 2009.

Resident presented at facility with Facial Herpetic, Neurolgia, Stress Incontenent, BA Incontenent, Dementia. Continued behaviors from admission:

- Wandering
- Intrusive
- Verbal
- Aggression
- Distressed

Family do not want resident medicated for behaviors

June 2009
Under GP review commenced on Risperidone for behaviors. Family visits infrequent

August 2009
Request made to family to personalize room to offer resident some form of resemblance – request not taken up. Family meeting as family not happy with medications being administered. Family meeting arranged with GP.

Family visits still infrequent and always take the resident to her room and stays there for entire visit. Questioning GP's orders.

October 2009
Request change of GP due to medications being prescribed. Family refuse to sign care plan

Family meeting arranged with new GP.

Family request to be called at any time of day in the event behaviors become unmanageable – Calls made on numerous occasions remain unanswered.

November 2009
Family again questioning medications.

GP reviewing behaviors with Geriatrician and recommended referral to APATT for review. Family agree to review.

December 2009
Dementia Consultancy Service to review to determine best medication regime.

DCS reviewed and advised of strategies / interventions to commence.

January 2010
Family complaining re verbal altercation with fellow co-resident, family member advised would not be held responsible for his actions if this was to continue.

Facility instigated further discussions with GP, Dementia Consultancy Service. Geriatrician reviewed and possibility psycho geriatric ward would be better suited.

Family agree to recommencement of Risperidone for behaviors.

March 2010
Behaviors increasingly difficult to manage and distress of resident instigated further review by GP/Geriatrician. Recommendation is for Dementia Specific and arrangements would be required for ACAS Reassessment.

Family meeting with GP/Facility – Family concerned regarding how much input they would be able to have if moved to another facility.

Family consent received for ACAS Reassessment as long as family can be involved in the process.

ACAS Assessment completed and recommendation for admission to psycho geriatric ward for full assessment and review – family declined.

April 2010
Discussions with APATT team – finding resident difficult to assess due to inadequate medication therapy and discussed further at a family meeting.

Request by facility to walk with resident to different environments when at the facility – this has not been acted upon by the family.

Psycho geriatric team continuing discussions with family.

May 2010
Facility meeting with family and agreement reached for resident to be correctly assessed by a psycho geriatric team.

Resident transferred to facility for review at end of May 2010.

Resident at psycho geriatric facility for one night and facility contacted by family demanding return immediately. Discussions with psycho geriatric facility advise family abusive, making misleading claims, offered complaints forms and refused, abusive during discussion with medical staff where all discussions with family had to be halted.

Family member making abusive telephone calls to facility, reported to police.

End May 2010, family issued letter advising 14 days notice to seek alternative accommodation.

Facility provided alternative accommodation details for three facilities where dementia specific was provided.

All facilities have not been followed up, citing distances and inability for husband to visit.

Contacted by Complaints Investigation Scheme as family have contacted and made several complaints in regard to care provided to their mother by the facility. Ongoing investigation as family continue to raise varying issues during all conversations with CIS.

June 2010
Follow up letter issued to family to request meeting re facility wait listing for dementia specific.

Contact made by Elder Rights as complaint received. Closed off without further investigation required.

July 2010
Meeting held with family to gain details of facilities waitlisted for resident – provided details of facilities waitlisted – confirmed. Facilities are of more distance than those provided in the initial discussions.

Family advise they have sought legal advice regarding the letter to request the need for the family to seek alternative accommodation, however family advised this was not successful as everyone was reluctant to pursue.

Resident has continued behaviors requiring one on one care. Family are continuing to delay the transfer to an appropriate dementia specific facility for the benefit of their loved one. Family continue to visit infrequently or provide support to the facility in the day to day management of the resident. One of the residents family members continues to display inappropriate verbal abuse at times to the staff at the facility and has been advised the appropriate authorities will be called if this behaviour continues. Case still ongoing as of this paper being submitted.