15 September 2010

Ms. Sue Macri
Assistant Commissioner
Caring for Older Australians Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Attention: Mr. Troy Podbury
Research Manager

Dear Ms. Macri,

Thank you once again for the opportunity to meet with you and other Commission representatives on 20 August 2010 to discuss our joint submission to the *Caring for Older Australians* inquiry. We were very impressed with the level of engagement with the topic on the part of all the Commission staff that were present.

As requested, attached is a supplementary submission that attempts to address the additional issues that arose out of our meeting. The process of preparing the paper, together with our two previous submissions, served to highlight the complexity of the subject matter and the difficulty in exploring each issue, despite many pages of discussion. We hope therefore that we have been able to assist the Commission in preparing its report to government.

Once again, we would be more than happy to meet with you to provide any clarification or further detail that you might require.

Yours sincerely,

ROB HANKINS
Chief Executive
ECH Inc.
Parkside SA 5063

RICHARD HEARN
Chief Executive
Resthaven Inc.
Malvern SA 5061

KLAUS ZIMMERMANN
Chief Executive
Eldercare Inc.
Wayville SA 5034

SUPPLEMENTARY SUBMISSION TO PRODUCTIVITY COMMISSION INQUIRY

CARING FOR OLDER AUSTRALIANS

ECH INC., ELDERCARE INC., RESTHAVEN INC.

SEPTEMBER 2010

What is good about the current system – what don't we want to lose?

- Most Australians expect government to use their taxes to support them in various ways throughout their lives: through education, health, telecommunications, transport systems, defence of the country etc. The expectation in relation to aged care is no less and there is a presumption in most if not all of the submissions, including our own, that government will continue to provide. A fundamental question for the Australian electorate and future governments therefore is whether this will indeed continue to be the case. Certainly we would argue that the current role of the Australian Government in aged care should be retained and suggest this be reflected in the Commission's report. A separate but related question is how the revenue is raised: through consolidated revenue measures or some form of insurance, or a combination of public and private funding. Regardless of the outcome, the principle of 'user pays' should form part of any new policy.
- The existence of a clearly delineated legislative framework ensures accountability and defines rights and responsibilities. Irrespective of shortcomings in the current legislation and regulation, the fact that aged care is legislatively based is a strength of the current system.
- The fact that residential aged care policy and funding is centralised (in the Department of Health and Ageing) results in greater consistency across the country and the same should eventually extend to community care with the Commonwealth assuming full responsibility for aged care from 1 July 2011. State and Territory Governments should play no part in the funding or administration of community aged care once the Home and Community Care program becomes part of the suite of Commonwealth programs.
- A strength of the current community care system is the ability of service providers to build relationships with individual clients. Seamlessness within and between service systems is as much about relationships as it is about access. The role of case-management is an important aspect of a service provider's care coordination role and therefore the two should not be separated in the development of any new service delivery models. Older people do need information that clearly outlines what is available to them and in connecting with the service system but any such external services should not supplant or act to undermine the legitimate case-management (or service coordination) role of service providers. In the current community care climate (e.g. where Consumer Directed Care is being considered) we are starting to turn the role of case manager around to be more about mentoring or supporting an older person to direct their own care. It is really about terminology: the 'case manager' can still play this key role by being a single point of contact: a provider of information, an adviser.
- The quality of aged care services in Australia is unquestionably very high. Instances of poor care have been rare. While the accreditation and quality standards have directly contributed to improvements in care across the board, their administration has lost some focus in recent years as the continuous improvement and compliance aspects have dominated the thinking. An expectation of unending continuous improvement in all aspects of care and service is *non sequitur* and the compliance regulations are out of all proportion to actual risk and performance. We need to retain or return to the educative, developmental orientation of accreditation and standards that was first evident in the early 2000s.
- In terms of funding and service provision, there is a degree of flexibility in the current system that should not be lost. For example, despite the limited range of and disparities between funding levels, care packages in their various forms can be tailored to the needs of the individual should a service provider choose to do so (within the limits of the total funding). There is, for example, no legislative impediment to a service provider pooling care package funding and cross-subsidising high-end users from low-end user funding, or offering a Consumer-Directed Care type model of service. While advocating for an

entitlement system, the level of funding available to each individual should be notional, as it is now, to allow funds to be applied flexibly across groups of consumers with varying and variable needs. Further to this, unlike residential care where co-payments and residents' capacity to pay is assessed independently, no such legislated system of consistency in fees exists in community care. This means the pool of funds available to a group of clients is diminished or enhanced in an unpredictable manner, depending on the ability or inclination of individuals to contribute co-payments. Clients who do pay, inevitably cross-subsidise those who do not or cannot pay. The question of a just and equitable funds distribution mechanism in relation to co-payments in community care has not been explored in a practical sense to date.

- Respite and carer support services are valued components of aged care and have the potential to be more highly integrated to better balance the need for service providers to both care for the care recipient and help the carer to get the most from their respite.
- Day Therapy Centres (DTCs) and programs have largely been overlooked in consideration of better 'connectedness' between the health and aged care systems. Modern programs consist of much more than mere therapy treatments, as important as they are. More services and programs now happen off-site (in general community facilities, private practices and commercial gyms for example) and act to reconnect many older people with their local community, thereby combating issues of social isolation and loneliness, lack of activity and interests etc.
- The Community Visitors Scheme is a small but highly effective program that should be retained and expanded.
- Transition Care has had varying degrees of success but overall, has been effective in streaming many older people away from residential aged care and in a surprising number of cases, returning people home with little or no formal support.
- Multipurpose Services have been very effective in delivering aged care to rural and remote communities where traditional funding models would have been unviable.

How does Australia compare internationally?

International comparisons are often difficult to make but anecdotally at least, Australia is regarded as having one of the best aged care systems in the world. This is perhaps best interpreted in an overall sense rather than a consideration of any one aspect of aged care. For example, several countries have become well known for particular service delivery models or funding mechanisms:

- Norway for its Teaching Nursing Homes;
- the Netherlands for Humanitas;
- Japan's Long-Term Care Insurance;
- Sweden for Smart Homes; and
- health care organisation, Kaiser Permanente in the USA for its approaches to health and wellness.

However, it is fair to say that in Australia, almost every form of care and service is available, or potentially available, to the entire older population, with a markedly high level of quality and affordability. It is Australia's rigid program and funding structures that have resulted in fragmentation of the service delivery system and stand in the way of more flexible, tailored, developmental responses to individual client needs and preferences.

The aged care system of the future should draw on the best overseas examples and adapt them to local circumstances. Along with other initiatives proposed in our own and others' submissions, they should form a core part of the system in ways that are not simply a series of add-ons as has been the case in the past.

Linkages between the approach to regulation and political risk and the implications for the sustainability of policies in the future

We accept the reality of governments having to manage the political risks inherent in their programs. Enough has already been written and said about the rather glib approach to current regulation of aged care but we still need to find a balance between the perceived political risk and the reality. A consistent government attitude to managing the risks has been an attempt to simply control the aged care system at very close quarters and at every turn. A more arms length approach, based on a more realistic view of aged care and a risk tolerant mindset, might go some way towards achieving the right balance. The establishment of an independent complaints authority and a panel of approved accrediting authorities are among recommendations made in submissions. Interactive relationships between authorities and services providers and greater transparency in decision-making would also be effective means of mitigating risk. The government's expressed wish to enter into a closer 'Partnership' arrangement with the Charitable sector around service delivery may be a way of further developing the 'trusted relationship' that needs to exist between funder and service provider.

The repeated addition of regulation upon regulation has been triggered by a small number of isolated, albeit serious, incidents involving potential danger or actual harm to older people in care. The reluctance of government to ease off on the degree of control it seeks to exert over all service providers may be connected to minority but persistent interest group accusations that instances of neglect or poor care are more widespread than they believe have been 'exposed' through the accreditation and complaints systems. In any case, government needs to develop more realistic expectations of care and services to older people and reflect that understanding in the standards, accreditation and compliance regimes. Better public education about what to expect of aged care services, the actual cost and the respective roles and responsibilities of management, staff and families is a critical component in changing the over-regulation of aged care.

It is essential that service providers are accountable and they 'care' well for vulnerable older people. The way that is achieved in a potentially more collaborative way should be seriously explored to create a new paradigm for regulation. The level of 'adverse events' in hospitals is on the scale of war casualties yet nobody has ever suggested any be closed or even sanctioned as a result. The current zero tolerance attitude and all or nothing approach to dealing with aged care services is very unsettling and in the longer term, unsustainable. Even in the case of the worst examples of poor care in residential care facilities there were those residents and family members who did not want the facility to close and indeed, were quite satisfied with the care. Most people prefer to see problems rectified and improvements made rather than harsh sanctions being applied, or worse, the dislocation of their family members and service closures. Even when single adverse events hit the media and/or where closure may be warranted, it should not be a trigger for further regulation of the industry as a whole.

The government needs to accept the reality of such situations arising and manage the risks through a range of supportive and educative, as well as regulatory, measures aimed at service providers, residents/clients, families, advocates, the media and the public at large.

Comparisons of the cost of providing care and current income

1. **The cost of care of a high care resident at admission (based on statistics regarding residents at admission), including a comparison using public sector wages**

   Refer to Attachment A. (acute care cost comparison to follow)

2. **Comparing the cost of care of some potential clients against ACFI categories**

   Not all behaviours are a result of diagnosed illnesses or conditions; some are just related to personality traits, or simple stubbornness in response to particular situations. However, the ACFI does not recognise non-diagnosed behaviours.

   ACFI is also based on a medical model of clinical care and does not reflect more holistic lifestyle considerations. Necessary staff responses to issues such as loneliness, sadness and feelings of isolation (as opposed to depression) are not recognised, nor is the management of chronic conditions.

ACUTE CARE	AGED CARE
Less paperwork	More paperwork
Less care planning	More care planning
Clinically higher risk but with access to doctors and nurses	Clinically complex but less support from GPs and nurses
Pharmacy on site	No pharmacy on site – added responsibility for RNs

Workforce and service quality implications of introducing minimum qualifications for care workers

- A significant section of the carer workforce would be excluded if minimum qualifications were introduced. It would also be a mistake to assume that simply introducing minimum qualifications would lead to significant improvements in care and service. Our view is that it is better to recruit unqualified staff with the right attitude and then train them, or support them to obtain formal qualifications, than simply accept people because they have a Certificate 3 qualification for example. There needs to be better screening of course applicants and not just the use of courses to rush people into approved training for other purposes (such as an alternative to Centrelink benefits). This 'sheep dip approach' undervalues the role of care workers in aged care.
- Aged care requires above average numeracy and literacy skills to comprehend procedures and comply with documentation requirements. Current Australian residents and new migrants with lower literacy skills but with the right values and attitudes should be given the opportunity to upskill progressively from pre-qualification mode through to formal qualifications. The industry needs to have more input to curriculum development though to ensure that qualifications such as the Cert. 3 are genuinely competency-based and more relevant to the real world of service delivery.
- While the RTO sector is regulated there is great variation in the quality and competency levels of graduates. There is a national training framework with defined learning outcomes but the number of core competencies/units in each course varies significantly. The actual course time can vary from a couple of weeks to six months full-time,

depending on credit transfers and recognition of prior learning. Much more consistency is needed through, perhaps, the introduction of a national curriculum and audits of RTO courses.

- The workforce is ageing and will continue to do so. Younger people and men are not currently being attracted to the aged care sector. Older workers are also not being attracted. The potential impact of minimum qualifications on these under-represented groups should be considered.
- On the other hand, an organised pathway for school leavers remains an important option with respect to young people and qualifications they may consider. Perhaps one suggestion is a form of trade certificate training as part of Years 10 – 12 for students interested in aged care as a future work place. We understand that Norway may have some sort of pathway system for involving high school students.
- There is an image problem for school leavers in relation to working in aged care – and probably for men. The introduction of minimum qualifications might help in this respect by adding an element of educational status to the work but it should not come at the expense of unqualified workers. The issue should be about defining the scope of practice for staff and groups of staff, while encouraging and providing opportunities for training and career progression.
- Student nurses/physiotherapists/doctors would need to be exempted as they would not have the required minimum qualifications without some kind of recognition of their current study and they are an important resource while they study.
- The issues around minimum qualifications and registration bodies need careful consideration to ensure we do not eliminate key sources of the workforce, both today and in future years where there will be higher demand. We believe the emphasis should be on competency levels of those who work in aged care as against minimum qualifications.

What in the current policy environment has led to increased competency based training and the benefits this offers compared to non-TAFE RTOs?

If there has been an increase in in-house competency-based learning (CBL) and training, it may be a reaction to the variability in quality and competence of graduates of external training courses. In other words, service providers may be using CBL approaches as a safeguard measure to ensure their workforce is in fact competent, regardless of whether individual care workers have a Cert. 3 or not. It is also likely to have been a natural progression in workforce training policies as a result of the impact of accreditation and quality standards and the drive for continuous improvement.

Another factor may be the simple fact that the aged care sector has grown quickly and substantially, resulting in service providers responding by having to train more staff in-house.

CBL and other approaches to in-house training are likely to remain, irrespective of improvements in external courses and certainly for unqualified staff.

Issues related to employment of CALD staff (who generally have limited English skills) and their ability to effectively operate within the current accreditation system

- Employment of CALD staff, particularly more recently arrived migrants, does create an increased stressor on providers because additional funding and support for their integration into the Australian work environment is not readily available. The Aged Care Standards are rigid in relation to expectations of staff and no allowance is made for their transition to the Australian workforce in terms of staff competencies and capabilities under the Accreditation Expected Outcomes.
- Accreditation Agency assessors can exhibit little understanding or allow little or no leeway in accommodating a CALD staff member's difficulty in articulating an understanding of the myriad of policies and procedures that they face in residential aged care for example. The lack of funding for integrating and supporting CALD staff means that the additional costs are borne by service providers. For example, providers are encouraged to support CALD workers with additional training, increasing literacy skills, education in Australian workplace cultures and providing creative solutions to poor English literacy.
- This additional burden has two important elements: the impact on regular staff in orientating and supporting CALD staff with reduced English and different approaches to work generally; and the impact on management who must adjust and accommodate practices for CALD staff within current resources and in the shadow of potentially negative assessments by the Accreditation Agency.
- There can be cultural subtleties in language and gestures that can alienate staff who are recently arrived migrants. There can even be cultural clashes between groups which add a new complexity to the workplace and pose new management challenges in maintaining quality service delivery. Recently arrived (younger) African or Asian staff can have difficulty in relating to residents of older European/post WWII cultures, for example.
- Service providers are increasingly reliant on a CALD workforce. We don't have an intrinsic problem with this but many newly arrived migrants tend to be less work-ready generally and therefore more expensive to induct and maintain in the workplace.
- Some workplaces are also becoming overly reliant on recruiting CALD personal care staff. Residents generally cope well with this but a better balanced workplace would reflect the broader community and the profile of residents. There is a growing imbalance in aged care, particularly in residential aged care, which only serves to highlight the difficulty in attracting staff.
- Aged care requires a lot of documentation. Poor English comprehension skills affect some CALD employees' capacity to contribute to documentation requirements. This has a resulting impact on the quality of their input and/or on their peers, which can lead to accreditation-related risks for the service provider. In turn, the risks must be managed through special additional efforts.
- We are fortunate to have a CALD workforce available to aged care. Without it there would be a significant labour shortage with resultant gaps in rosters and the workforce more generally. Some CALD employees are more highly qualified in their home countries and adjusting to a role as a (lower status) care worker can be very challenging. The boundaries of work/client relationships and interactions are sometimes not well understood.

Flexible approaches to workforce/management practices to address specific staff shortages (for example substituting ENs for RNs on certain night shifts)

The current aged care workforce is bound by restrictive industrial and legal parameters that have developed over time and as a result of understandable concerns about workers' rights and remuneration, as well as protecting the integrity of certain professions and disciplines. Governments have added further restrictions to protect care recipients from harm through formal safeguards regarding, for example, administration of medications. These constructs have largely been designed from the perspective of the particular profession or employment category. A new modern, flexible workforce would be designed with the interests of the care recipient as the starting point.

Changes are needed that address how people want to live in residential aged care or receive services at home; changes that enable them to have a better quality of life. Currently the focus of the Accreditation Standards and the funding for residential care is based on the clinical aspects of care that can only be addressed by health professionals. This focuses attention on the traditional medicall model of aged care and is not moving the industry forward to the type of support people want. Health professionals clearly have a place in aged care but a great many older people have service needs and lifestyle preferences that are not clinically based. We have changed the building requirements for and style of residential aged care facilities so they look less like hospitals but we have not changed the style of care that occurs within the building. Clinical care still dominates the thinking and can only be performed by health professionals.

In the community, the family assist to monitor the health and well being of the client but once they are under the care of a formal service provider the quality standards and funding requirements tend to dictate the involvement of health professionals at some level; if not, they prescribe the types of permissible service outputs.

Simple substitution of employee classifications is not the solution to the call for a more flexible workforce. Rather, it is about a consideration of the older person's care and quality of life requirements and desires and then a re-engineering of the work and duties accordingly. The way residential aged care work is currently defined, structured, performed and judged is locked in a traditional medical/clinical model and the bulk of community care (HACC) is menu-driven.

Flexible approaches to workforce/management need to be based on a rethink of the way in which work is done; what needs to be done; then who might be able to do it; and prioritising the best groups of staff to do the right kinds of work. It is about analysing the work and not necessarily the jobs/roles and then thinking about what skills are needed to do the work. By breaking down the various tasks and functions into their respective competencies and knowledge requirements, they can then be matched with whoever is most suitable – or the work can be divided between those who are suitable in some areas and not suitable in others.

This kind of flexibility is more focused on the work required to provide support and service to a resident/client and less focused upon a designated position (RN/EN/Physio etc). If we start with 'what does the client need?', we can then match the need to a skill to meet this need – and then look to see who has this skill or should have this skill or should receive education to develop this skill.

In tandem with this (for practical reasons) providers could do a skills audit of the aged care staff and map what they have the capabilities to do; match these to the needs expressed by

clients; and then find the best matches and gaps. From this, we are likely to find that groups other than RNs have competency and potential competency to do some of the tasks currently undertaken by RNs, thus relieving them of these tasks and freeing them to do different tasks and other functions.

This kind of thinking matches well with the national competency based training framework for health services and also with the undergraduate programs for nurses.

Exploring the regulation of retirement villages within a framework of targeting regulation to those most at risk

Contrasting position between retirement villages and other accommodation options (supported services, caravan parks etc)

We have commented in part at least on these issues in our previous submissions but to add, some older people living in some retirement villages may be more vulnerable financially than others. Retirement village operators are often holding considerable amounts of residents' funds (albeit in trust) and should be subject to robust prudential arrangements. In this respect, there may be a case for more consistent State/Territory regulation of the industry - but in the context of housing provision, not aged care services.

Retirement villages, supported accommodation facilities, caravan parks and independent living units are all forms of housing or accommodation for older people. They differ markedly in terms of style, amenity, density and age and frailty of resident but they are not aged care services. We agree that vulnerable or 'at risk' residents should have their interests protected but through the appropriate housing-related mechanisms.

Any care and services available to residents are likely to come from government-funded providers, not the village operator (unless they are one and the same). Regulation of the care is (or in the case of HACC, will be) legitimately the province of the funding body, namely, the Commonwealth, under the *Aged Care Act 1997*.

The need for the current inquiry and subsequent policy process to address both long and short term issues and the relative imminence of some problems

Continuing to cling to traditional models and thinking is not moving the sector forward and is limiting its ability to be competitive and offer real choices for the consumer. There will be those organisations comfortable with traditional approaches and some that will want to go to the other extreme and offer "resort" living in an aged care facility. The market will vote with its feet but to do that there needs to be reform that ceases to constrain organisations within the medical model of aged care.

It is evident from the submissions to the *Caring for Older Australians* inquiry and all that has preceded it that the Commission needs to give its attention to the longer term but, once again, some problems are with us right now and need immediate attention. As stated in our Initial and Summary submissions, funding is a critical issue for both residential and community care and programs. Low rates of indexation and rising costs have combined to force down direct contact hours. What is needed now is:

1. an immediate injection of interim funding, including for community aged care, to make up the shortfall brought about by the decision to only index funding by 1.7% in 2010-11;
2. independent determination of the actual cost of care and an appropriate indexation formula;
3. the charging of accommodation bonds for residential high care and increasing the maximum accommodation charge and supplement to levels that reflect the cost of building within a localised market context.

ATTACHMENT A

A day in the life of and the cost of caring for a high care resident

Resident Profile

Based on several factors identified by the Australian Institute of Health and Welfare[1] as being typical of residents at entry, our resident is an 85 year old woman born in Australia from a non-indigenous background. She had been living alone in a unit in the Adelaide metropolitan area since she was widowed nearly 10 years ago. Her only income is the fortnightly Centrelink age pension of $644.20.

Twelve months ago she sold her unit for $270,000 and has now been admitted to a dementia specific wing with a high ACAT. Her daughter visits regularly but her son lives interstate. After the sale of her home she has a total cash balance of $284,000 from which she earns about 3% in income or $327.69 per fortnight. This income has resulted in her age pension being reduced to $552.97 per fortnight.

Her combined fortnightly income is $880.66

On admission an asset test revealed she is liable to pay an Accommodation Charge of $26.88 per day. This is charged each month in arrears and contributes towards the cost of her accommodation.

On submission of the Resident Entry Record, the Department of Health and Ageing advises the provider and the resident of the basic daily fee and the income-tested fee chargeable to the resident.

Each month the provider charges her a basic daily care fee of $38.20 per day, indexed twice yearly in March and September. This cost forms 84% of her pension. The basic daily care fee contributes to her living expenses like meals, laundry, heating and cooling.

As our resident is deemed by the Department to have sufficient income, she is required to help contribute to the cost of her care through an income tested fee. This has been calculated at $1.90 per day.

These charges combined come to $937.72 per fortnight which is more than our resident's fortnightly income requiring her to use her cash investment to cover the difference and pay for things like social outings, hairdressing, newspapers, pharmacy items, telephone calls and some lifestyle activities.

Total contribution provided by our resident is $66.98 per day (Accommodation Charge $26.88 + Basic Care Fee $38.20 + Income-tested Fee $1.90).

The Australian Government contributes to her care needs by means of the Aged Care Funding Instrument (ACFI) which assesses the need for care across three domains: Activities of Daily Living; Behaviour; and Complex Heath Care. Our resident has a score of Medium, High and Low respectively which allocates $107.98 per day to the facility. The amount of subsidy payable by the Government is reduced by the amount of the income tested fee, reducing the Government's contribution to the cost of care to $106.08 per day.

[1] AIHW, *Residential aged care in Australia 2007-08: a statistical overview* (June 2009)

The Australian Government also provides a Conditional Adjustment Payment of $9.45 per day to support training and improvements in corporate governance and financial management practices.

Total income provided through government funding is $115.53 per day.

Total income to the facility is $182.51 per day.

Total cost of care and housing of this resident has been calculated at $299.44 per day (see below).

As a result, there is a shortfall in income of $116.93 per day for this particular resident.

Diagnosis

The Aged Care Client Record (ACCR) indicates our resident was diagnosed with hypertension and osteoarthritis by her GP. She experiences ongoing severe pain.

She also has a diagnosis of Alzheimer's Disease. The GP made a provisional diagnosis of depression and care staff completed a Cornell Scale for Depression; the score was 16.

Care Related Needs

Activities of Daily Living

Our resident rises each day at 0800. She has a diagnosis of osteoarthritis. By mid-afternoon she has stooped posture, requiring rest and analgesia.

Our resident forgets to use her frame and has episodes of unsteadiness increasing her risk of falling. Need to maintain optimal mobility whilst maintaining safety.

One staff member is required for all toileting tasks. Our resident is unable to sequence tasks in the correct order. Physical assistance is needed to ensure she is positioned on and off the toilet with clothing adjustments. She often wanders when needing to use a toilet as she forgets where hers is located and goes looking for one. Scheduled toileting times are 0800, 1000, 1400, 1800, 2100 and 0400. She cannot state her need for the toilet. However, staff are able to recognise her need from her body language.

Her preferred hygiene time is 0830 – 0900. She requires one staff to assist with all hygiene tasks. Due to arthritic pain she has limited dexterity. She is also unable to comprehend how to begin or complete tasks and requires ongoing instruction. Full assistance is required for undressing/dressing, washing, drying, drying hair, deodorant, clothing selection, and nail care. Teeth are cleaned after every meal which requires one staff for all dental tasks. Staff collect and set up all equipment for her; staff place paste on brush and hand it to her, and rinse the brush on completion. Staff prompt her to clean her teeth and sometimes physically brush her teeth for her when required.

One staff member is needed to set her up for all meals. Breakfast and morning tea is in her room; all other meals are in the dinning room. She needs to be escorted to the dining area as she forgets meal times. All utensils require positioning and staff pour all drinks. Each course is given one at a time to avoid confusion and mixing foods together. Continual prompts and cues are needed to start eating, finish eating and to remain at the table during meals. Staff have to place the utensils in her hand.

Assistance is required to ensure post meal hygiene needs are met. Staff need to ensure she has adequate hydration between meal times and must place the cup in her hand.

Our resident's normal sleep time is 2130. At home she used to wake and wander from room to room in an agitated state. To reduce the risk of disturbed sleep/wakefulness and wandering, she is engaged in activities during the day, with two resting periods in between. Staff set her up to watch television before bed, fit an incontinence aid, give her a warm drink, heat pad and gentle massage and offer pain relief. Later settling times and spending individual time with her can help achieve an uninterrupted sleep. As a precaution, a sensor mat is employed in case she does wake and rise from bed. Staff need to ensure curtains are closed in her room and mirrors are covered as she tends to hallucinate and sees a man who she thinks will hurt her or take her belongings.

ADL Score: Medium

Behaviours

Our resident lacks awareness of self, others, place and time. She is disoriented and has unrealistic perceptions and a reduced ability to concentrate. She has short term memory impairment and is unable to recall significant past events. She has a visual deficit and wears glasses during the day. She has diminished hearing related to ageing but no hearing aid is worn. She has difficulty finding words, and has difficulty finding the correct word to use in right context.

Without appropriate management, our resident will wander frequently day and night, often up and down the hallways, and potentially into other residents' rooms. She has entered her neighbour's room in the past and tried to pull her out of bed. She has also climbed into bed with the same resident. She will attempt to abscond if she sees anyone entering through the main door.

Our resident will sometimes verbally and physically refuse to participate in activities of daily living. She has excessive suspiciousness, verbal accusations and delusional thoughts that are expressed and can lead to significant disturbance of others. She becomes paranoid and hallucinates if exposed to reflective surfaces such as mirrors and windows. She believes a man lives in them and that he is trying to hurt her and take her belongings.

She constantly fidgets and is unable to keep still when seated. She is constantly getting up and down. She also tries to hide items such as her handbag and purse as she thinks a man is trying to take it from her.

Our resident becomes very anxious and sometimes cries. She becomes upset with her family for events or actions she has misconceived and at times searches or requests to see certain members of her family. She has a diagnosis of depression and has a rating of 16 on the Cornell Scale for Depression.

Staff need to monitor behaviour routinely, documenting timing of behavioural changes, increasing confusion and/or hyperactivity, identifying behaviour triggers and intervene when needed. Staff need to move her to a quiet environment during periods of extreme agitation. Staff often need to distract our resident with an

alternative activity and reinforce appropriate behaviour by spending additional time with her when calm.

Staff will take her on daily walks in the garden as part of her exercise routine; retrieve her purse from her main hiding places; after breakfast, set up a simulated presence therapy session using digital images of her home and family; engage her in purposeful activity related to culture (e.g. tidying her room with the cleaner as she used to work as a cleaner herself); and allow for appropriate resting periods.

Staff need to be attentive to non-verbal physiological symptoms which may result in our resident becoming physically aggressive as a coping mechanism for wanting a change in environment: too hot, too cold, over-stimulated, hungry, thirsty.

Staff need to maintain a consistent routine and environment, respond promptly to calls for assistance, always setting a timeframe and sticking to it.

Behaviour Score: High

Medication and Complex Health Care

Our resident requires care staff to administer her medication which takes 10 minutes over a 24 hour period. Timing was performed as a requirement of the funding tool. This time does not include preparation of medications such as dispensing, crushing or recording of medication administered. This takes 19 minutes over a 24 hour period.

Our resident is unable to recognise medications and is unable to remember when or how to take medications. Staff need to place tablets into a pill cup and give one tablet at a time with a drink. She will only drink filtered water and will not drink water from the tap. Staff need to prompt and cue resident to place the tablet into her mouth and ensure each tablet is swallowed. Our resident often refuses medication and becomes agitated which requires staff to distract her or to try again in a few minutes time.

Our resident has ongoing arthritic pain in her left shoulder, neck and knees. Pain worsens when she is in a lifter. Heat and massage are effective treatments but she often refuses oral analgesia. Physio treatment and exercises are scheduled twice a week. Massages are provided each morning and tubigrips are applied to both knees. A heat pack is applied at night. Staff need to offer analgesia, monitor diet, bowels and skin integrity. Pain often results in depression, anger and frustration, increased agitation and fixation on limitations.

Medication and Complex Health Score: Low

Lifestyle Related Needs

Our residents has chosen a number of lifestyle activities coordinated and supervised by a Lifestyle Coordinator and assistant. Staff need to assist with orientation around the facility, especially returning to her room.

Her Lifestyle Choice Monthly Calendar is as follows:

Sun 2PM Sunday – Fun Day,

Monday 11AM and 2PM - Move it or lose it

Tuesday 11AM Catholic Communion and 2PM - Singalong

Wednesday 11AM - Reminiscing and 2PM - Exercise Group followed by table games

Thursday 11AM and 2PM Sensory Stimulation – Cooking

Friday 11AM - Mental Stimulation – Quiz 2.00PM - Community Church.

Monthly - Bus Outings

Our resident also uses the site hairdresser on a fortnightly basis. This is charged and deducted from her bank account monthly. Newspapers, telephone calls and pharmacy costs are also charged and deducted monthly.

NB the cost of care includes activities and processes that are not funded through the ACFI, such as Lifestyle activities and what we have termed the Non-Resident time of a process (or non value add) such as crushing or melting medication.

Policy issues

1. As the ACFI subsidy (particularly for Behaviours) and other income is insufficient to cover the cost of accommodating and caring for this resident, the provider must have other strategies in place to offset the cost, such as:
    a. access to low care bonds of a sufficiently high number and value;
    b. keeping the number of such residents to a minimum or not accepting such residents into care; and
    c. achieving efficiencies in the care plan such as less frequent or less intensive monitoring and assistance; increased non-nursing staff hours to RN hours; and fewer lifestyle activities.

2. If the provider was able to take a bond from high ACAT admissions, it would be in a better financial position and so would the resident. On a $250k bond, the provider would have an additional $31 per day and the resident would keep her full pension and would not have to pay an income tested fee. Similarly, if she sought financial advice and invested the proceeds from the sale of her house appropriately she would keep her full pension and avoid the income-tested fee.

Cost of Care

The aged care funding instrument is a tool for measuring the need for care. It does not measure the care need provided. The resident's day outlined below is based on timings and observations from real life business process maps. This provides a measure of the cost of care provided to our resident.

TIME	Activity (requiring assistance)	**Resident time** (use actual time from BPM's)	Total min	Total $	**Non-Resident time** (use actual time from BPM's)	Total min	Total $
730	Take medication	RN - administer meds	2	$ 1.66	Handover, RN stocks trolley, dispensing, preparing, and recording meds.	5	$ 4.14
800	Get out of bed	1 x Carer - full assistance	5	$ 1.92	Handover & care plan, picking up and storing mechanical lifter.	2.5	$ 0.96
805	Go to toilet	Carer - full assistance	4	$ 1.53	Wash hands	0.5	$ 0.19
815	Have breakfast in room	Carer - supervise and prompt	6	$ 2.30	Pick up trolley, deliver breakfast	2	$ 0.77
845	undressing / dressing, washing, drying, dry hair, deodorant, clothing selection, dressing, physio directed tubigrips, nail care, oral hygiene.	Carer - full assistance	15	$ 5.75	Sluice room, wash hands, documentation	7	$ 2.68
915	make bed	Carer - full assistance	3	$ 1.15	Put laundry in bins. One for SA linen / one for resident clothes	1.5	$ 0.57
930	neck massage from therapy aid	Therapy aid - full assistance	10	$ 3.83	Documentation	2	$ 0.77
1000	Go to toilet	Carer - full assistance	4	$ 1.53	Wash hands	0.5	$ 0.19
1015	morning tea	Carer - supervise and prompt	2	$ 0.77		0	$ -
1030	Doctor Visit	RN - accompany doctor	10	$ 5.43	Documentation, clinical meeting	5	$ 2.71
1100	Lifestyle activity - mental stimulation: Quiz	Lifestyle co-ord & lifestyle assistant	20	$ 8.33	Design / organise program	10	$ 4.50
1200	go to dinning room	Carer - supervise and prompt	3	$ 1.15		0	$ -

TIME	Activity (requiring assistance)	**Resident time** (use actual time from BPM's)	Total min	Total $	**Non-Resident time** (use actual time from BPM's)	Total min	Total $
1230	lunch and medication	Carer - supervise and prompt. RN administer meds	4.5	$ 1.96	Carer helps serve lunch. RN stocks trolley, dispensing, preparing, and recording meds. RN orders meds / faxes pharmacy	4.5	$ 2.36
1300	clean up after lunch & oral hygiene.		8	$ 3.07	Wash hands	0.5	$ 0.19
	1 hour gap. Residents watch TV in sitting room, sit outside, etc	Carer intervene	0	$ -		0	$ -
	Wandering x 2 instances	Carer intervene	10	$ 3.83		0	$ -
	Verbal x 1 instance	Carer intervene	5	$ 1.92		0	$ -
	Physical x 1 instance	Carer intervene	5	$ 1.92		0	$ -
1400	Go to toilet	Carer - full assistance	4	$ 1.53	Wash hands	0.5	$ 0.19
1400	Lifestyle activity - Church	Carer help with orientation	3	$ 1.15	Design / organise program	10	$ 4.50
1500	Physio visit	Physio, therapy aid and RN	48	$ 35.34	Documentation	2	$ 1.09
1530	Afternoon tea	Carer - supervise and prompt	2	$ 0.77	Carer prepares thickened drink and delivers	2	$ 0.77
1540	Daily walk	Carer - supervise	20	$ 7.67		0	$ -
1600	Rest Period – watch TV						
1700	Dinner and medication	Carer / RN	5	$ 2.23	Carer and RN handover, RN stocks trolley, dispensing, preparing, and recording meds. RN orders meds / faxes pharmacy	6	$ 3.10
1745	clean up after dinner, oral hygiene and get ready for bed.	Carer - full assistance (2x Carer assist in bed)	18	$ 6.90	Wash hands	0.5	$ 0.19

TIME	Activity (requiring assistance)	**Resident time** (use actual time from BPM's)	Total min	Total $	**Non-Resident time** (use actual time from BPM's)	Total min	Total $
1800	Go to toilet	Carer - full assistance	4	$ 1.53	Wash hands	0.5	$ 0.19
1810	Therapy - cleaning	Carer - supervise	20	$ 7.67		0	$ -
1830	Heat pack	Carer - prepare and apply	5	$ 1.92		0	$ -
2030	Warm drink / Watch TV	Carer - supervise and prompt	5	$ 1.92	Carer prepares warm drink and delivers	2	$ 0.77
2100	Go to toilet	Carer - full assistance	4	$ 1.53	Wash hands	0.5	$ 0.19
2130	Go to bed	1 x Carer - full assistance	5	$ 1.92	Picking up and storing mechanical lifter	0.5	$ 0.19
	SLEEP		0	$ -		0	$ -
2430	Call out for Nurse, in pain / can't sleep	RN - checks / administer PRN meds	11	$ 9.12	Carer and RN handover. RN - dispensing, preparing, recording meds	6	$ 4.59
	SLEEP		0	$ -		0	$ -
400	Go to toilet	Carer and RN - full assistance	9	$ 5.95	Wash hands	1	$ 0.64
	SLEEP		0	$ -		0	$ -
			279.50	**$135.20**		**72.50**	**$36.44**

Cost of Residential Care Unbundled

Cost of Care Summary

Resident Time	289.5 min per day	$135.20
Non Resident Time	72.50 min per day	$ 36.44
Medical Supplies (organisational average)		$ 4.60
Total Cost of Care		**$176.24 per day**

Hotel Services Summary

Labour	$ 26.00
Food, Cleaning, Laundry Supplies	$ 23.00
Utilities	$ 5.40
Total Cost of Hotel	**$ 54.40 per day**

Management Services Summary

Admin Labour	$ 13.00
Other Labour (Quality, OHS, Training)	$ 3.70
Admin expenses	$ 15.00
Total Cost of Management	**$ 31.70 per day**

Accommodation Summary

Depreciation	$ 26.10
Repairs & Maintenance	$ 11.00
Total Cost of Accommodation	**$ 37.10 per day**

Total Cost of Residential Services	**$299.44 per day**

Unbundled Services Income versus Expenses

1. Aged care wages

Service	Income	Expense	Shortfall
Care Services	107.98	176.24	(68.26)
Hotel Services	38.20	54.40	(16.20)
Management Services	9.45	31.70	(22.25)
Accommodation Services	26.88	37.10	(10.22)
	182.51	**299.44**	**(116.93)**

2. Acute care wages comparison *

Service	Income	Expense	Shortfall
Care Services	107.98	187.62	(79.64)
Hotel Services	38.20	54.40	(16.20)
Management Services	9.45	31.70	(22.25)
Accommodation Services	26.88	37.10	(10.22)
	182.51	**310.82**	**(128.31)**

*** the above tables only compare care staff costs between aged care and acute care, not any differences in administrative or other staff (e.g. gardeners and laundry staff)**