Frontline Aged Care Solutions
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Inquiry into Caring for Older Australians
Productivity Commission
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Submission to the Productivity Commission
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Caring for Older Australians

It is considered an important event in aged care today, to have the opportunity to respond to this comprehensive and thorough draft report. Frontline Aged Care Solutions have made some significant trails in the leadership of aged care management in recent years and offers the following for consideration and review.

The ever-increasing statistics of the older population in Australia are well documented and is an issue that reflects some discourse in the care and health sectors. Hand in hand with the greying of Australia are aged associated lifestyle and care issues, which eventuate in the end of life process. These issues can be as different as the life journeys of the individual.

Key issues are listed below:

1. **Access and equity based on fair assessment** should begin with a review of Aged Care Assessment Team (ACAT) and the development of a nationally accepted set of valid and evidence based assessment tools. The Productivity Commission's (PC) "one stop shop" and national gateway is supported and should have industry stakeholders and consumer input for design and practicality.

All future aged care systems and services need to recognise the particular needs of Aboriginal and Torres Strait Islander people, people from Culturally and Linguistically Diverse (CALD) backgrounds, people living in rural and remote locations, people who are homeless and other special needs groups such as, the forgotten Australians and gay lesbian, bisexual and transgender groups that are not recognised under the current *Aged Care Act 1997*.

2**.** The professional recognition and establishment of practice for the role of the **Geriatric Nurse Practioner (GNP)** to assist General Practitioners (GPs) and families with increasing complexity of care needs for individuals in the following;

- High quality assessment
- Medication reviews
- Wound management advice
- Central practice in communities
- In direct support of the nursing homes
- Medicare funded item numbers
- Case management and care conferencing

3. **Support for families and informal carers** should be considered an area that requires a marked improvement for families to gain access to available government assistance or a transfer of subsidies to provide for care in the home. A change to the guidelines and criteria for carer's pensions in Centrelink would pay dividends. Nationally, there should be free access to family supports and training programs that have been demonstrated to save their costs very quickly. Counselling and education with ongoing support can reap long lasting dividends in enabling family carers to support their elder people (particularly those living with dementia) at home longer. The ability to have access to a Geriatric Nurse Practioner would be a touchstone in community services.

- The major alternative to residential care is home care, and this requires more support for families and an increase in community services. The subsidies on current offer need to be reviewed and increased to meet the market and industry expectations for the services carried out. The current programs are restricted by their allocations boundary and don't cover the costs for quality care services.
- A day respite and therapy centre licence should be available for service providers in communities for families to gain access during working hours. Access to subsidies included.
- The provision for a pilot program of funded transitional care beds at 1.5x the rack rate for a normal residential bed. The program is for transitional assessment and rehab that will assist an elder person from the acute setting (hospital) through transition in rehabilitation programs run by Residential Aged Care Facilities (RACFs), in order for the person to return to independence or give them a choice of a home care program. This would encourage closer collaboration between the ACAT and service provider.
- The application of home care services should not be restricted by program entry boundary, but centred on care needs that are formally assessed under a national standard of valid assessment forms.
- The establishment of a specialist elder care medical centre attached to the service provider's RACF, for the use by community to gain access to a GP, GNP, basic medical care, wounds management, incontinence management, and case conferencing with a multidisciplinary health team.

4. **Residential Care** – Clearly there will be a major financial impost to meet the projected growth and estimated need of residential beds and community care places. It is estimated that to maintain current levels of residential care, a thousand new beds will have to be introduced each month through to 2050. The current funding arrangements for service providers is extremely lacking in order for them to provide the quality in care that is needed, and demanded by consumers.

Access Economics estimated that the costs of dementia alone will rise from 0.8% to over 3% of GDP by 2050. Alternative models of care, and better instruments of funding need to be developed, and the burdens of regulatory compliance need to be reduced and in some areas removed. This compliance in many cases is duplicated and triplicate, waste productive time and create workplace barriers to better care outcomes.

The RACF is the perfect service provider to establish a medical specialist centre at the premises for the local GP medical centre to operate from and specialise in the services to the elderly.

The RACF could have the ability to establish collaborative and specialist services on sit designed to meet the needs of the elderly in and around its community. This medical centre has the ability to provide the following services:

- Case management
- Medication reviews
- Wounds dressings
- Post acute follow up
- Allied health
- GP
- GNP
- Diabetics clinics
- Dental hygiene
- Closer ACAT collaboration

The RACF as a service provider should be able to work in collaboration with all stakeholders and have a better service that reduces hospital visits, manages the care and conducts review and accurate assessments.

There are other models of residential care that do not involve institutions such as, having small group homes or having a team of carers servicing a cluster of home units. Providing better age in place programs for the Retirement Villages sector, and increasing the choice of service access.

Removing the current system of separating high and low care would not benefit the resident or provider, and clouds the accuracy of assessment and validation for funded care services that may be needed.

Funding arrangements for accommodation should be classed as “rent” that is paid to the service provider by the recipient and separated from the services of care.

Accommodation charges “rent” to be decided by providers on styles and standards of rooms and facilities...at no cost to government.

Improved access to capital funding for the assistance in building and extending current services.

A strong commitment from the Department of Health and Ageing (DoHA) to provide accommodation and care for those who are socially and economically disadvantaged, however this cannot be achieved with the current concessional supplement.

The current supplement is currently grossly inadequate and should be increased to better align with equivalent levels of bonds or charges that residential care providers are receiving from non concessional residents and if so better.

Improved and increased funding allocations that reflect the actual cost of care and health services, and a user pays stream of allocation in services.

A funding provision for localised and allocated General Practioner in the RACF on top of user choice. Or GNP in place and in collaboration

5. **Acute Hospital Care** of elderly people and those with dementia is a pressing and growing issue. People with dementia do poorly in hospital. They have a greater length of stay that is costly, they have more falls, they become delirious and require sedation and specialising and their outcomes are poorer.

In summary, elderly clients and people with dementia are costly for the hospital system and hospitals are not set up to deal with people with dementia.

The solution to this is the recommendation (above) of the establishment of an elder care medical centre on site of the RACF. Better training in aged care and dementia for the acute nursing staff.

Closer collaboration and communication will occur between the acute settings and these centres. This will include the ability to use transitional beds to assesses and rehabilitate.

Service providers will have added value to the service and families can gain faster better access to specialised care, advice, and information.

6. **Delivering care to the aged — workforce issues** are of a major concern if the growing sector is to provide quality services and care.

Key issues are not limited to:

- Wages
- Skills mix
- Formal qualifications
- Training standards
- The use of immigrant staff
- Culture and diversity
- Clinical leadership

First and foremost is the issue of qualifications and skills mix of direct care staff. Direct care workers that are employed for professional services should be holding a minimal qualification of cert III in community care, aged care, and disability work as a mandatory compliance.

The qualification should have a skills mix that reflects the nature of the duties performed and be based in the nursing process (which it currently is not). Staff attending to residents in high care areas should have a nursing discipline qualification, as the complexity of this work is undeniable.

A Nursing Registration should be established for licensed vocational nurses that hold the cert IV in nursing with a gerontic nursing care. This nurse can be registered and be able to be held accountable under the Nurses Act. This nurse will be able to perform the complex and diverse workloads demanded in High care nursing homes. This would increase the attraction for skilled nurses domestically and internationally, to move into aged care.

Wages will need to be adjusted to match those of the nursing counterparts in public and acute nursing settings. The work levels of aged care assistant nurses are extremely demanding and the pay structure does not reflect the workloads involved, nor the skills needed to deliver care in these complex scenarios. The wages of Registered staff in aged care is desperately in need of adjustment to match the acute setting.

Service providers will gain the benefit from an increase to the subsidies paid for services that is being suggested in this PC report, and in turn will be able to meet wage demands. The resident will be able to expect a standard of quality care. The industry will start to attract the skilled workforce it requires. The workers will feel valued and this is all in line with the goals for better care.

Currently the workforce is heavily populated with staff from CALD backgrounds, which are not congruent with the culture of the elder Australian. Communication barriers are a major

problem, and heavy demands on compliance and paperwork is distracting from care and service delivery. Recruitment selection and induction needs to be formalised and monitored, and accountability needs to be assured.

Multi Disciplinary Health Team Leadership in aged care is primarily the responsibility of the registered nurse (RN) and clinical governance and clinical leadership are included in the role of the RN in aged care setting. RNs need new delineated pathways for entry and careers in gerontic nursing.

Courses designed to meet the skills gap being experienced the RN in aged care. Leadership and management training, communication, conflict management and counselling are very important skills for the RN in aged care settings. Geriatric Nurse Practioner is a specialised skill that should be implemented in the RACF and the community. This GNP is the optimum pathway for the Clinically focused RN. The alternative pathway being senior management.

Gerontic Nursing should be recognised as a specialised field and skill set for aged care. The qualifications from direct care workers and junior nursing staff should be more easily articulated into gerontic specific qualification for registered nursing. The ability to attract overseas-qualified nurses also needs to be simplified and the International English Language Testing System (IELTS) needs to be reviewed. The IELTS test is currently preventing the transition of nurses from English speaking countries such as the Philippines, into Australia to be utilised in aged care.

The structure of the workforce in aged care should be reviewed. Currently the skills required to meet the tasks in community services, is blurred and not congruent with those needed in low care and high care settings. Many care staff are being used in multi service areas without being multi skilled and properly trained.

The implementation of the training nursing home is a great idea that is needed and will require considerable federal government support. The funding for such programs can come from superannuation schemes. Private organisation such as Frontline and the Australasian College of Care Management, deserve to be consulted.

7. **Stigma** – is a huge issue. Not only is there a stigma about ageing, there is stigma about mental health and about dementia. Stigma exists around aged care, residential care and the neglect and abuse. These stigmas need to be addressed as learning and development issues within the community. An older person with conditions of illness, dementia, depression or other mental health suffers a great deal of stigma. Nursing home staff and care workers are also suffering stigma.

A national awareness campaign would be helpful in reducing this and would lead to earlier diagnosis and treatments, better approaches to managed care, improved feelings about the end of life process and planning the care of family loved ones and individuals.

Kind regards

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