CARING FOR OLDER AUSTRALIANS

PRODUCTIVITY COMMISSION DRAFT REPORT

COMMENTS

PART 1 – DRAFT RECOMMENDATIONS

I support the draft recommendations almost unreservedly and hope that the final recommendations will be implemented as presented.

I am mindful of the successful protests in 1997 against the plan that entrants to high-level residential care should pay bonds. A well designed and consistent system was hacked about, leaving a significant gap in funding with adverse effects for many, including those in high-care.

Those who paid bonds subsidised those who did not, a form of taxation without representation that rational nursing home providers were practically forced to impose.

I hope that this does not happen again.

DRAFT RECOMMENDATION 1.4

Making accommodation bonds equivalent to periodic accommodation charges is needed, so that the resident can choose the most convenient method of payment, without financial consequence. How does this ensure that the **size** of accommodation payments reflects the cost of supply?

Publishing the accommodation charges is also desirable, but how can it ensure that the charges are reasonable for the accommodation offered? The potential consumer needs **comparative** information about the charges of a range of care facilities, with a listing for each of how many rooms there are at various prices. This is a job for the Australian Seniors Gateway Agency to co-ordinate.

- I believe that government must approve the amount charged for accommodation, room by room if need be.

- Charging what is fair for the accommodation offered is a large conceptual leap from the previous method, which for some providers was to charge the maximum amount that could be raised, subject only to the rule that residents must keep $38,500.

- Some residents paid bonds for entry to residential care that were significantly more than the value of their accommodation. They should get the option to transfer the excess bond amount to the Australian Pensioners Bond or elsewhere.

DRAFT RECOMMENDATION 1.7

Sharing rooms with strangers can be an unhappy arrangement on group tours where the parties are outside all day, are younger, in good health and better able to tolerate the quirks of a room-mate. These arrangement are temporary.

Hospitals put public patients into single rooms at times and flexibility could be desirable also in residential aged care. Residents with dementia or those with large powered wheelchairs may not make suitable room-mates.

DRAFT RECOMMENDATION 8.2

Post Hospital Care

For hospital patients eligible on age or other grounds for federal community care, a provisional ACAT assessment while in hospital could permit the immediate post-hospital support provided by State or Territory governments to be chosen so as to merge seamlessly with federal government permanent help later.

Access to Health Care

The integration of community and residential care might extend to nursing home residents some of the help now available in the community. Many in residential care do not get help from volunteer drivers, so cannot get dental treatment, X-rays, physiotherapy or other needed health care, let alone have outings for psychological benefit.

Providing mobile dental vans to visit the aged in community and residential care (and the disabled) would be an enormous benefit.

Consumer Advocacy

Help to navigate the range of care options as suggested in Draft Recommendation 8.2 is most desirable. I want consumer advocacy services to be extended generally, as described in Part 2.

DRAFT RECOMMENDATION 12.2

I strongly oppose abolishing the Office of the Aged Care Commissioner. Instead, the Commissioner should be given determinative powers.

Government policy to reduce the number of appeal bodies is understandable. Even some of the providers who made submissions were daunted at the idea of dealing with the Administrative Appeals Tribunal. For residents and their families, the AAT is essentially out of reach, and this would be so even if an Aged Care Division of the AAT were established. Resistance might not be rational, but it would be real.

Appeals against decisions of the proposed Australian Aged Care Regulation Commission complaints handling area would in practical terms not be possible, perpetuating the frustration expressed by many under the current system, where the Complaints Information Scheme has the final say.

Removing complaints handling from the Department proper will not improve the quality, or the perceived impartiality of the investigations, or restore confidence among clients.

An accessible appeal system with a generous time allowance for lodging appeals is imperative.

DRAFT RECOMMENDATION 12.3

How satisfied are consumers and potential consumers with the quality care assessments currently published?

DRAFT RECOMMENDATION 12.6

The accountability principle needs to be asserted that funds supplied by government for a certain purpose must be **used** for that purpose and that **evidence** of this must be provided. This has not always been so in the aged care world.

The proposed arrangements can make it clear how much is provided for care and how much for help with accommodation and living expenses for those who need financial support. This can be reported to government and also to residents.

A possible outline for monthly statements to residents is given in Annex 1. The government deserves to get credit for its contributions, which are now not known to residents.

DRAFT RECOMMENDATION 12.7

I strongly oppose this recommendation. In these days of computerised accounting and electronic communication, why is there a problem?

Providers should report to those who lend them bond money what they have done with it, as verified by an independent auditor. With residential bonds, the residents do not get even an implicit report of well-being through the punctual payment of agreed interest.

Even residents who decide to play safe and pay for their accommodation periodically instead of by a lump sum can still be badly affected if, for whatever reason, a nursing home collapses.

Providers must satisfy government as to their prudence and probity, but government apparently did not react to warning signs until too late several years ago when nursing home staff complained about non-payment of their superannuation. A significant percentage of the citizens of every country do not trust their government to get things right. The more people who have information, the more who can sound an alarm if things are going sour.

To make it as proposed an **opt-in** situation puts the resident in a supplicant position and offence could be feared or taken at the implication of lack of trust.

This information should be seen as a **right**. Whether residents want or understand the information is immaterial. At the very least, the arrangement should be an **opt-out** one.

This recommendation does not appear to sit well with the aspirations of Draft Recommendation 4.1.

PART 2 – OTHER COMMENTS

ADVOCACY

Choice of Care

Draft Recommendation 8.2 suggested extending advocacy services to help people choose the care they need.

Financial Help

There were references in submissions to "negotiating bond amounts". I suspect that negotiations occurred only if potential residents could not raise the named amount, or if there was a financially informed helper. In most instances, it would be so unequal a contest that 'negotiation' is not the right word. Many residents would have paid the asked price without realising that negotiation was possible.

Government setting of bond amounts and other charges would be a great improvement, but in cases where the resident cannot meet the total, there should be assistance from an advocate. Centrelink staff could be helpful intermediaries.

This is perhaps the easiest area for advocacy, because government can set charges and Centrelink evaluate ability to pay. There are ascertainable facts with clear decision paths.

Compulsory Involvement

There are circumstances where advocate involvement should be **compulsory**.

People should not have to move from their own home to a nursing home, to another nursing home, or to a dementia unit **anywhere**, without someone to support them **absolutely** from when the move is first proposed. Even experts do not always get it right the first time.

There could be other situations where the views of others are to be imposed against the wishes of an aged person, who should not stand alone against those with power. Families may not be equipped to help, or may not want to.

Those actively in the work force may not grasp how indomitable and frightening they can seem to the frail aged, who may also have dementia or be institutionalised.

HUMAN RIGHTS

Human Rights Commissions have no jurisdiction over nursing home residents. Instead, human rights are the responsibility of the Department of Health and Ageing, who supervise providers who may have breached them. It is not good practice to give the Department the final say on what amounts to being its own work and the same would apply to the Australian Aged Care Regulation Commission.

If residential aged care and community care are brought together, both should have human rights protections. It should not be left to the interpretation or goodwill of providers.

Liberty

We do not imprison those with mental illnesses, nor do we force medication on them. We need full medical consideration and perhaps court orders if we try to impose these conditions even temporarily on the mentally ill. What is more, the diagnosis of mental illness is in the first place is made by doctors and psychologists with lengthy special training.

Those alleged to have committed criminal offences are not punished unless they have been tried and found guilty.

Wars have been fought in the name of liberty, but we imprison our elderly citizens without trial because they develop an inconvenient illness.

Attempts to improve the behaviour of a 'problem' resident by administering mood-altering drugs may be well-intentioned, but can make the situation worse. Drugs are not trialled on the old, let alone those known to have brain damage. The full adult dose can be disastrous.

There are no formal protections to ensure that the best solution is to lock people up in what is euphemistically called "secure accommodation." Fellow residents can cause the new environment to be anything but secure!

Security of Tenure

A move is stressful for people of any age. For the aged, learning and adjusting to a new environment is not easy, especially if dementia is involved. An **imposed** move, however, can be heart breaking.

There is no security provided in the current legislation for imposed moves **within** a facility, except between low and high care. There are legislative protections against imposed moves **between** facilities, but they can be circumvented.

Most imposed moves are triggered by behavioural problems and the target residence will be a dementia unit. Providers desperate to prevent harm to others can see the solution as removal forthwith of a problem resident. Full protections should apply whenever a provider initiates a departure and an advocate whose sole purpose is to help the resident should be involved from the first.

The nursing home blames the resident when a situation disintegrates and can be judgemental and righteous. The nursing home has all the documentation, written from its point of view. There would rarely be awareness that attitudes, behaviour or incompetence of nursing home staff probably contributed to the crisis.

Rushed (or unsuitable) staff may be rough with residents, but it is the reaction of the residents that is reported 'in the book'. Fear of physical hurt, in particular, is almost a guarantee of difficulties in dealing with a resident. An advocate might be able to find out what happened and have the decision reversed and practices changed.

If a resident's condition is claimed to be beyond the nursing home's capacity to cope, perhaps some compensation should be paid to the resident, whose expectations have not been met? Nursing homes were aware that dementia could develop, but the resident alone suffers the consequences.

Risk Taking

In ordinary society, in community care, and among the mentally ill, however much we may deplore some of the choices made, the assumption is that people are free to take risks if they so choose. But not if you live in a nursing home. If you have dementia, it is almost certain that you will be locked away "for your own safety", on duty of care grounds. Protests by you or your family will not count.

'Duty of care' as sometimes interpreted in practice, deprives people of their human rights. The concept needs to be examined.

Fairness of Records

The resident has no protection against statements that may be untrue, even defamatory. Allegations may be made and contribute to the resident's reputation among the nursing home staff, who may as a result treat the resident unpleasantly.

The resident or his family may know nothing about the comments and have no chance to defend or deny. The first family knowledge of adverse comments may arrive when they are used punitively.

Accuracy of Records

For decades members of the public have had access to records concerning them and the right to correct mistakes. It is overdue that nursing home residents (or those receiving community care) get the same rights to check the accuracy of their records.

The proposed Australian Seniors Gateway Agency will reduce the potential for errors and their multiplication, as proliferation of record systems reduces, and it could provide a convenient way of data checking.

At present, if information is recorded wrongly, the information is likely to be quarantined to that particular provider. Once information is published through whole systems, it will be extremely difficult to correct all the destinations unless the systems are linked and can be updated electronically.

A system is needed where the subject of records is automatically sent for checking a copy of information recorded, and then a copy of the result of fixes, which often take several tries!

DUPLICATION OF EFFORT

Paperwork and documentation use time that would better be spent in direct care of residents. I see two ways to reduce the workload:

- As proposed by many, use electronics to record and transmit information about the condition and needs of residents. Work on a system for interchanging information between hospital and nursing home has begun. It is wonderful that a start has been made, but the progress work I've seen was on a manual system, not an electronic one.

  Daily reports, care plans, incident reports or transfer forms would be more easily created if based on well-designed electronic forms and they would certainly be easier for busy people to read.

- Instead of each nursing home (or group) designing its own forms, there could be centralisation. The Department, or some delegated organisation, could prepare the forms.

Much of the work has already been done. If a sample of nursing homes supplied records of what they now do (with names removed from individual records), a draft amalgamation of each type of document could be prepared and distributed for comment and trial. Nursing homes could be asked also to provide samples of any other records that were unusual, to ensure that the software catered for all cases.

Information already provided by the Department, such as advice on prevention or treatment of pressure sores, could be designed so that selections for particular cases could be made and incorporated into the resident's care plan.

Transfers between residential care establishments, community or respite care or hospitals would be facilitated by direct useability of records.

With community care joining the system, the multiplicity of record keeping systems must be rationalised. It makes sense that all use the same software, even for internal purposes.

The research proposed in Draft Recommendation 13.1 would be made much easier if common systems, rather than just linked systems, could be used.

A similar tactic could be used so that systems for achieving ends or preventing problems could be centrally produced and modified as needed by each user. Consumers would like to know that the conclusion that "systems are in place" used by Accreditation and CIS staff, would become irrelevant. If everyone has been supplied with the systems, the emphasis would shift to where it always should have been, that is, on whether the systems are actually put into practice.

At June 2010 there were 2773 aged care facilities with 163,000 permanent residents. It is not surprising that providers complain of paperwork and government demands if (except perhaps for providers who own more than one facility) all are separately trying to deal with the same problems.

AGED CARE FUNDING INSTRUMENT

Under ACFI, daily funding amounts are laid down for each resident for the levels of help needed in the three areas of Activities of Daily Living, Behaviour and Complex Health Care. Some submissions found that the weightings given to the three areas needed revision.

I support the proposal from submission 327 p15 that the ACFI, after needed modifications, could be used to calculate staffing needs. ACFI ratings give not only the level of financial help needed by the resident, but reflect the time each resident needs for staff at carer or nurse level. Summing these would give an objective measure of how many staff are needed and at what level

The disappearance of staff/resident ratios and the vagueness on staffing requirements in the 1997 legislation may suit providers, but staff and residents have been seriously dissatisfied and instances of serious understaffing have been reported.

A SUGGESTIONS SCHEME

The Department doubtless has a Suggestions Scheme for its staff, and nursing homes must supply an accessible suggestion box, but I propose that Suggestions should become a formal part of the Departmental structure and functioning. Many of the cases sent to the CIS must be motivated by the wish to bring about improvements, but there is no other mechanism to achieve this.

Ministerial replies, whether written or in person, fall into a pattern, where whatever the complaint, suggestion or question, the sender is told of everything good done in the portfolio in the past few years, however irrelevant, or however well-informed the sender appears already to be. The actual complaint, suggestion or question may not be addressed at all.

I propose a Suggestions Scheme for the whole aged care sector, feeding into policy development and practical advice. It would be located in the Department, not near the Complaints or Accreditation areas, so that objectivity would be perceived and achieved.

The main point of a Suggestions/Improvements area would be that ideas that now must be funnelled through a complaints scheme, or fall into the void of Ministerial correspondence, could reach staff whose job is to consider the ideas and initiate processes for evaluating and implementing them.

Working together to improve conditions for the aged and those who care for them has to be preferable to an adversarial arrangement.

CONTINUOUS IMPROVEMENT

Critical incident reporting is an important way to detect and fix problems and prevent recurrence. It is a vital part of the desired continuous improvement process, but it was reported that there is reluctance to use the method lest documenting things that went wrong could be used punitively.

The roles of assisting, but also examining are not compatible. Providers cannot be expected to consult Departmental experts to solve a problem that has arisen, if they fear that information they supply might be used against them. Sending information as a suggestion could feel safer and help others.

The Department sends information to nursing homes about subjects such as how to deal with outbreaks of gastro-enteritis, or current best practice on pressure sore prevention and treatment.

I was told that the Department can write to individual nursing homes about a legislative requirement of which they are in breach, but cannot prevent new breaches by sending a circular to all nursing homes reminding them of the requirement. If true, it is a serious restriction on the Department, and not in accord with the continuous improvement demanded both by the legislation and by common sense.

A newsletter several times a year could report developments and describe problems that had been encountered. Reminders as to the intent of legislation and spelling out what interpretations are not in keeping with its intent or are plain unacceptable could be beneficial.

EFFICIENCY

I doubt the applicability of efficiency goals to community or residential aged care. The most efficient way to transfer a resident from A to B is to dump her in a wheelchair and push. This is incompatible with maintaining resident physical fitness, independence and dignity. Funding should allow for enough staff time to wait while residents do things for themselves or finish eating a meal.

Providers who cope claim that this happened because they are more efficient and this may be so. But the ‘efficiency’ may have derived from geographical or economic factors, overcharging on bonds, or excluding applicants who need not or cannot pay bonds.

M Edeson

ANNEX 1

A possible monthly report to residents

PAID BY	**Resident**				**Government**	**TOTAL**
FOR	**Derived from Bond** $	**Daily Fees** …*.days* *@ $..../day*	$	Total $	$	$
Accommodation (Room, use of premises)						
Hotel Services (Food, linen, cleaning)						
Personal Care (Help to dress, bathe, use toilet, walk, eat, drink)						
Health Care (Give medications, treatments, dressings, prevent problems)						
Total for *month, year*						
Additional Services *Hairdresser* *Newspaper* *Pharmacy* *Other*						
TOTAL paid by resident						

Information in *italics* in the table above would be supplied as applicable.