BLUE CARE

Head Office

Submission to the Senate Community Affairs Reference Committee

Inquiry into Aged Care

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From:

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About Blue Care

Blue Care celebrated 50 years of care in 2003 and has grown to become one of Australia's leading not-for-profit providers of community and residential care services with 9000 employees and 250 centres throughout Queensland and northern New South Wales.

The organisation is best known for its home nursing service, Blue Nursing, which is conducted from 63 centres throughout the state. Last year the Blue Nurses travelled 10 million kilometres making over 1 million visits.

Blue Care also provides a supportive, safe and secure environment for residents through a range of residential aged care accommodation options. These include 1400 independent living units, 73 residential respite beds, and 90 residential facilities providing a total of 5182 beds across both low-care hostels and high-care nursing homes, many of which include special purpose dementia units.

The scope of Blue Care's community services is extensive. The organisation delivers approximately one third of Queensland HACC services, over 1000 Community Aged Care Packages and 60 Extended Aged Care Packages. A range of allied health services are also provided, in addition to 14 day therapy centres, and 57 respite centres. Blue Care runs all eight Commonwealth Carelink Centres in Queensland and auspices 11 National Respite for Carers Programs and Commonwealth Carer Respite Programs. Disability services, transport and home maintenance services are also provided.

Responses to the Senate Community Affairs References Committee Terms of Reference for the Inquiry:

(a) **the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training.**

Blue Care welcomes the Australian Governments' response to supporting training and education of the aged care workforce. However, we must acknowledge that it falls short of the recommendations made in the recent Hogan review

At a time when the projected percentage of people over 65 is estimated to increase by at least 75% over the next 20 years[1], a stable workforce in aged care is imperative. Yet, there is an emerging crisis in attracting and retaining skilled registered nurses to provide residential aged care. A decreased level of nursing staff has been identified as a major area of concern for all stakeholders, including residents, families, providers and peak bodies.

The Australian Nursing Federation received over 1,000 calls to their national aged care phone-in, with a major concern being inadequate staffing levels[2].

In addition, the national shortage of nurses and the wages gap between nurses working in the aged care sector and nurses working in the public hospital sector, which currently stands at 21.6% or $170.50 a week, is exacerbating staff recruitment and retention difficulties in aged care.

Recommendation

1. **Since 2001, commencing with the "Two Year Review of Aged Care Reforms" there have been at least four separate Australian Government sponsored publications which have contained recommendations on issues related to the aged care workforce shortages and training. We encourage (a) prompt translation of the recommendations of these reports into action and (b) the necessary funds to close the wages relativity gap.**

(a) **the performance and effectiveness of the Aged Care Standards and Accreditation in:**

(i) **assessing and monitoring care, health and safety**

Agency staff undertaking support visits and accreditation visits interview a cross section of staff, residents and families to assess all aspects of care provision and the impact this has on the health and well being of the resident. This process is beneficial because it allows Agency staff to hear first hand accounts of care delivery in a facility and enables a more comprehensive and realistic view of care delivery.

This positive aspect of performance is unfortunately offset by inconsistencies in the understanding and knowledge of different auditors when applying the standards to an aged care facility. It is important that there is a consistent approach to assessing and monitoring care and health and safety among auditors.

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[1] AIH&H; Australia's Health 2004, 356 – increase in population aged 65+, males +97%, females +78%.

[2] Australian Nursing Federation 2004, results of national aged phone-in.

Recommendation

2. **Validate Agency staff's ability to comment expertly and consistently on the Aged Care Standards**

(ii) identifying best practice and providing information, education and training to aged care facilities.

Some attempts have been made to identify best practice through the higher ratings award introduced in the second round of accreditation however this process in itself increases the burden on residential facilities to make this additional submission.

Comment from Director of Nursing of a Blue Care Residential Aged Care Facility

"Initially I felt I had an obligation to the staff to go for a merit award after all their hard work, but when faced with the additional work required for the submission, well, none of us could face it. Anyway, we know we provide good quality care!"

Recommendation

3. **That the best practice and merit be awarded as part of the accreditation process and not as an additional process.**
4. **That the showcasing of best practice initiatives be an ongoing process rather than at the end of an extensive round of accreditation.**

(iii) implementing and monitoring accreditation in a manner which reduces the administration and paperwork demand on staff.

The repetitive nature of the self assessment document substantially increases the burden of administration and paper work associated with accreditation. Worst of all, the burden of paperwork takes care staff away from their prime responsibility – caring for residents.

Recommendation

5. **Review and streamline the self assessment document.**

(b) the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements.

Young people in Residential Aged Care

Blue Care currently cares for 149 young people with disabilities in residential aged care. Without viable alternatives, young disabled people in residential aged care undoubtedly become institutionalized. The result is a decrease in the number of beds available for the aged in need and consequential problems with bed availability in hospitals.

Of the 149 young people with disabilities accommodated in Blue Care residential aged care facilities, over 70% of these people have a classification of RCS 1 to 3, representing a cost to the Australian Government of between $118.12 to $92.27

per day. A community based program would a offer more effective and efficient alternative.

Recommendation

5. **That the Australian Government support the five point plan for a Sustainable Future for Young People in Nursing Homes developed by YPINH National Advocacy Alliance.**

Residents with special need

The report from the Australian Institute of Health and Welfare[3] identified the increasing incidence of dementia and the impact on the population of residents in aged care facilities. People with dementia require more care and the current funding arrangements do not adequately meet the specialised high care requirements for this increasingly large group.

Decreasing staff numbers in facilities place restrictions on remaining staff to adequately deliver quality care to this group.

Funding arrangements preclude facility managers from bringing in skilled professionals as consultants to work with staff in designing special strategies to address residents with behavioural problems frequently seen in those with a mental illness and dementia.

Recommendation

6. **That the Australian government work with providers and dementia care specialists to ensure that the dementia specific supplement provides adequate funding to meet the unique needs of dementia clients.**

(c) the adequacy of Home and Community Care (HACC) programs in meeting the current and projected needs of the elderly; and

The Home and Community Care program (HACC), while providing valuable services to eligible clients, is not structured to provide a service that is responsive to changing needs of current clients, or the future needs of the elderly.

HACC is generally seen as catering for low level needs. However as people age and given that there is a clear recognition that clients have a preference to age in their own home, there is an increasing number of high need clients with low functional capacity accessing HACC services.

Blue Care is a major provider of HACC services in Queensland and in 2003-2004 provided approximately one third of all HACC services. Of those visits 73% of clients were receiving more than two HACC services. Blue care also provides 60% of Queensland nursing care under the HACC program and many of our clients have complex health care needs as well as requiring continued social support and maintenance. It is clear that the HACC service is providing care to an increasing number of high dependency clients and in many instances propping up Community Aged Care Packages (CAPS) and Extended Aged Care in the Home (EACH).

[3] Australian Institute of Health and Welfare. 2004

Currently HACC programs are funded for approximately 18 specific service categories which creates a service that is disconnected and often unresponsive to a client's changing needs. Under this funding model, a range of services in a geographic area may be offered by a number of providers with multiple points of entry. In Queensland alone over there are over 700 separately funded projects delivering HACC services.

Providing access, timely and appropriate services to clients is stifled by the complexity that this funding arrangement creates. This complexity is a burden to both the client and the service providers as they attempt to create a package of care that best meets the client's needs.

From a carer attempting to make changes to a HACC service.

"After my mother left hospital and came to live with me, only a few kilometres from her home, I called one of the providers to resume their service (Mum had been receiving services from two providers). After several phone calls, I was told I would have to contact another agency, as my home was now 'out of their area'. I rang the another agency only to be told I would have to wait two weeks for them to undertake an assessment before they could provide the service. Out of frustration, I rang a private agency that could start providing the service the next day It's as though the system is set up to deter people from using it!"

The current model results in a disjointed and sometimes illogical service with the client or carer required to liaise with a range of providers. In addition the providers themselves may not be aware of the other services being provided or they are often not kept up-to-date with changes to care.

HACC Qld have piloted and are now implementing the Ongoing Needs Assessment (ONI) with the aim of reducing the need for multiple assessments from the range of agencies and encouraging better sharing of information to create a seamless service. Yet the evaluation of the ONI pilot reported that 90% of agencies agreed that information *was already* shared[4]. Providing a consistent approach to documentation through the use of the ONI may impact on the quality and consistency of information shared however it is not the panacea for seamless and responsive care delivery.

Providers are not able to respond to changing trends in client demand without having to go through an extensive approval process which only decreases the ability of service providers to respond to demand or need. Community Options Packages (COPS) have the ability to move funding across services types by up to 25% and this capability can create a more responsive approach to client need.

From a Blue Care service coordinator

"The needs of the clients fluctuate depending on their circumstances at any given time. Therefore a service needs capacity to be able to use the funding for social support if that has the greater need and transfer back to using money for personal care or nursing if the need shifts to this area."

[4] Queensland Health 2003. Evaluation of the Implementation of the Ongoing Needs Identification (ONI) Tool for Tier 1 Screening in the HACC program, Final Report"

In Queensland service types are allocated for a specific number of "outputs" which is based on a unit cost that has been submitted by the provider and approved by HACC

From a Blue Care service coordinator

"Asking services to be flexible is fine however with flexibility comes greater call on after hours and week-end work. Given the current rigid output driven model, this model / approach does not allow for services to be flexible in their service delivery given the costs of after hours and week-end work and the unit cost the government is prepared to pay."

At one centre the demand for after hour services increased by 25% over only one year and this changing demand is not captured through the unit cost which is reviewed only every three years.

A lack of clear definitions and the incredible range of interpretation of the HACC guidelines and definitions impacts on the consistent approach to service delivery and client eligibility. Where definitions are open to interpretation, it is known that providers will "shop around" HACC area managers until they get an interpretation that suits their needs. While undoubtedly this creates flexibility, it also creates inequity of access to HACC services.

Comments from a Blue Care client

"As a HIV sufferer, I was told I was not eligible for HACC services. After I moved to Brisbane, my new case manager suggested I request HACC services. I contacted the HACC area manager that covered my new location and she said I ***was*** *eligible. I don't understand then why I couldn't get this service where I used to live?"*

The second round of HACC standards validation commences in a few months and our program coordinators are now preparing to complete the 56 page self assessment. Many providers will undertake this process with the knowledge that CAPS, EACH, DSQ services and NRCP services will introduce another program of standards validation. While providers support the need for best practice and continuous improvement, the requirement to demonstrate accountability again and again places an enormous administrative burden on providers.

Recommendation

7. **That the Australian Government work with State and Territory Governments and HACC service providers to modify the funding model that supports a more responsive approach to clients changing needs. Some options include:**
    i. **Decreasing the number of service types funded by rolling together funding for social support, personal care, domestic assistance, home respite and other like services types.**
    ii. **The domains of assessment and case coordination are integral to service delivery and should form a fundamental part of an episode of client care especially within nursing and allied health disciplines, not a separate service type.**

iii. **Allowing providers to shift funding across service types by up to 25% as for the Community Options Packages. (COPS).**

iv. **Work with providers to establish a consistent formula for unit cost.**

8. Provide a case management service that not just assesses client needs but assists the client to access a package of care that meets their distinct needs. Case management should be an ongoing service that continues to support the client as their needs change in the future.

9. Review definitions and guidelines to ensure consistent and clear approach.

10. Continue with community care review and provide an accountability framework that spans all community care programs.

(e) the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

In Queensland there is no formal provision for transition of the elderly from an acute hospital setting to aged care. Some district health services have attempted to create an interface at Emergency Departments by establishing programs to "intercept" the elderly prior to admission. However the success of these programs is measured by the rate of hospital avoidance, rather than the successful transition of these clients to their home.

Comment from Blue Care Community Nurse in North Queensland

"First hand experiences tell me there is a gap in relation to effective transition planning when an 80 year old gentleman can be discharged a 6pm at night with no call to the family and sent outside to wait for a taxi minus the shoes he went in with!"

Community services in Queensland are almost exclusively provided by the non-government sector in discussion and planning for a continuum of care. Although we are encouraged by this engagement, the eventual success will be measured by the number of referrals received and the absence of duplication.

Recommendation

11. Transitional programs need to be developed in a partnership with the Australian Government, State Health departments and the major non government community agencies with input from the district health services and divisions of general practice to ensure a consistent integrated approach with well established outcomes.

12. Provide post acute funding or funds for transitional care directly to community care services which will be responsible for the delivery of the services. These agencies will establish the programs using the expertise in community care service provision equitably to both public and private acute hospitals.