SUBMISSION MADE TO THE

SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE

INQUIRY INTO AGED CARE

MADE BY TANDARA LODGE COMMUNITY CARE INC SHEFFIELD TASMANIA

August 2004

EXECUTIVE SUMMARY:

The Municipality of Kentish is a unique position in terms of services offered for health and aged care. Its major town (Sheffield) is located 30 minutes out the Regional Centre of Devonport, but the region includes some of the most remote areas of Tasmania (including Cradle Mountain). It covers 1,100 sq kilometres, with a population of 5,500 spread throughout the region. A total of 60% of the population live outside the major towns of Sheffield, Railton and Wilmot.

Tandara is the sole provider of health services located in the region, providing residential care, community care, primary health services, community housing and transport.

Tandara Lodge Community Care Inc carries out the following functions on behalf and for its local community:

1. Provides Residential care for the frail aged, dying and young disabled in the local community, in order for them to be able to stay amongst their community in their time of need.

2. Provides housing for the disabled and disadvantaged in the community.

3. Provides the Regional Health Program for the region, with over 18 different primary health services.

4. Provides Community Care through the Community Aged Care program.

5. Provides other social and health related services, such as meals on wheels, etc.

6. Provides leadership in the community by partnering with other community-based organisations, to offer other non health services to the community.

The organisation is governed by a Board drawn from the local community.

The conclusions in this submission are drawn from the operation in a rural North West Tasmania facility. While other areas of Australia may not have similar issues as this region does, the submission reflects the outcomes of the current aged care system in this region.

Therefore, given our experience in the community and the role played, we make the following conclusions in relation to Terms of Reference:

1) The measures included in the 2004 budget are inadequate to recruit professionally trained registered nurses into rural areas. People in these areas are denied access to higher education due to distance and family circumstances. This can be overcome by the use of Distance Education for Registered Nursing degrees.

2) The performance of the Aged Care Standards and Accreditation Agency has been successful in monitoring care standards. However, in the areas of best practice and reduction of paper work, they have not been effective.

3) Young people with a disability are not appropriately accommodated in an aged care setting, however, young people with a life limiting illness are provided with a high level of care in an aged care setting.

4) The Home and Community care programs are completely inadequate for the requirements of the community, with over 75% of eligible people missing out on services.

5) Currently there are no arrangements in place for the transition of elderly people from the acute hospital settings to an aged care settings or back into the community.

The above conclusions result from the inability of Governments (both State and Commonwealth) to co-ordinate services in these areas.

Therefore, for any real impact to be made in these areas, there has to be a "true partnership" between the Commonwealth and State Governments and the providers of Aged and Community Care. Until, there is a formal process in place that will direct the appropriate funds, programs will never be delivered in a manner that will meet the growing needs of the community.

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POINTS OF CLARIFICATION FROM CONCLUSIONS:

1) The measures included in the 2004 budget are inadequate to recruit professionally trained registered nurses into rural areas. People in these areas are denied access to higher education due to distance and family circumstances. This can be overcome by the use of Distance Education for Registered Nursing degrees.

This statement reflects three main issues facing North West Tasmanian rural aged care providers.

The first is the level of qualified staff to service the requirements of the Aged Care Act. The second is the lack of facilities, which allow staff to study, particularly for Registered Nurses. Thirdly, the budget allocates more money to the area of Vocational Education and Training (VET), which is already amply covered by the current system operating in TAFE and Schools (as VET centres.)

In discussions with the Dean of the School of Nursing at the University of Tasmania, he expressed the view that the recruitment of Registered Nurses is not about the number of places currently being allocated through universities, but rather the lack of retention of Nurses. Many graduates do not enter nursing or are retained within the area they are trained in (i.e. Tasmania). This would indicate that perhaps the "wrong" people are being trained? Retention of nurses is the main reason for a shortage of suitably qualified staff in rural areas, such as the North West of Tasmania.

Currently, many mature aged, care workers are excluded from being able to enter registered nurse education due to the course not being offered by distance education. In a recent survey undertaken by Aged and Community Services Tasmania, well over 150 care staff indicated they would be prepared to undertake registered nurse education, if it was offered by distance education. The main reasons for this were:

1 The ability to remain in employment and within the local community where they live.

2 The ability to stay with their families whilst undertaking their degree.

3 The ability to obtain employment at their local facility once they complete their degree.

The results indicated that nearly all people surveyed would be retained within the aged care system, and not change profession or move interstate.

Therefore, the problem not addressed by the 2004 budget is the retention of properly trained staff, due to the lack of availability for staff to obtain education through distance education. Until there is funding for distance education for registered nurses, then the shortages will continue and become more acute in the future.

The other issue arising from the budget is the misallocation of funds towards programs that will not improve the overall level of skill in the workforce. There is an attitude within the Health and Ageing Department that they know what the sector needs, and therefore allocates funds to projects that show no demonstrable improvement in skills. They would be better placed to offer funds and seek projects where the providers set out their training needs, which are not tied to strict and inappropriate criteria.

POINTS OF CLARIFICATION FROM CONCLUSIONS:

2) The performance of the Aged Care Standards and Accreditation Agency has been successful in monitoring care standards. However, in the areas of best practice and reduction of paper work, they have not been effective.

The Aged care Standards and Accreditation Agency is only able to monitor the care standards for residents currently living in residential care facilities. There are three reasons for this:

1 The standards and associated outcomes, as set out in legislation, are only care based, with all areas focusing on resident care.

2 The Standards and outcomes are not designed to focus on any other area of business practice, but rather what the effect will be for the resident.

3 The assessors are therefore care based, and not able to, or do not, understand the fundamentals of business practice and other issues surrounding the operation of an Aged Care facility.

While there is an attempt to "judge" leadership, human resources, etc, the Standards are inadequate and the assessors are not equipped to be able to make suitable assessments of these areas and therefore concentrate on the main area of their training - resident outcomes.

A specific example is that a facility must have a mission and vision statement. Unfortunately, just having a mission and vision statement does not mean that the facility is of a high standard. Due to the lack of skill of the assessors, they are unable to identify if the mission and vision does equate to practice throughout the organisation. Most organisations have mission and vision statements, such as HIH, Ansett, etc. Having a mission and vision statement does not in any way indicate the facility is able to manage itself on an ongoing basis. There have been many examples of organisations obtaining high standards in their accreditation visit, and very shortly after running into financial trouble and having to be either sold, taken over, or had sanctions applied.

However, in the area of monitoring care standards, the Agency has been able to do this and do it well, as this is the area of expertise of the assessors.

The ability of the Agency to provide information, best practice and education has been poor, with very limited success. The introduction of the Aged Care channel, has been a waste of Government money. These funds would have been better focused on direct educational projects.

In regard to paper work, the Agency has increased the amount of paper work, as they require more information on resident care and systems. Every undertaking of the Aged Care facility has to be documented in order for it to be identified, proven and "ticked off " by the Agency as occurring. So, rather than reduce paper work they have significantly increased it.

The other issue involving the Agency and paper work relates to their requirements for documenting resident care. Their requirements are often at odds with the requirements of the Department of Health and Ageing, Validation Officers. The Validation Officers, who validate the claims of a facility for their Resident Classification Scale funding, require nursing notes and care plans to be different to that required by the Accreditation Agency. This merely generates more paper work, rather than less. There is no co-ordination between the two bodies on a common system that could to be used.

POINTS OF CLARIFICATION FROM CONCLUSIONS:

3) Young people with a disability are not appropriately accommodated in an aged care setting, however, young people with a life limiting illness are provided with a high level of care in an aged care setting.

The long term placement of young people (those aged under 45) in Aged Care facilities is not appropriate. It is not appropriate for a number of reasons, which includes, the nature of their social requirements, the type of personal care delivered and the ongoing emotional and physical needs of younger people.

The notion that younger people are those under the age of 60 is incorrect, with many people in their 50's being appropriately accommodated in aged care facilities, where the above issues are of a lesser concern.

However, where a younger person has a life limiting illness (such that their stay will be medium to short term), then accommodating them in an Aged Care facility is often a better option to other options that are available. These people should not be accommodated in the acute sector and should remain at home until such time that their care needs increase to a level that the family and/or care staff are not able to cater for their ongoing needs.

In this situation, where a younger person requires a high level of care towards the end of their life, then an Aged Care facility is an appropriate place. This is due to the resources and systems being in place to care for the younger person in an environment which is both medically suitable and as home like as possible. It is also often within their local community, amongst friends and relatives.

Therefore, there has to be a distinction made about when placement is appropriate and an avoidance of a solution where "one size fits all".

POINTS OF CLARIFICATION FROM CONCLUSIONS:

4) The Home and Community care programs are completely inadequate for the requirements of the community, with over 75% of eligible people missing out on services.

There are serious flaws in the current system for providing Home and Community Care (HACC) and Community Aged Care Packages (CACP's) in our region.

The main problem area for this region is in the provision of HACC services. The central issue is that consumers are unable to gain access to relevant services, and therefore miss out on essential care.

The underlying reason why services are not provided where there is demand is that the planning and targeting of services for consumers by State Health does not accept demonstrated need for services in a region, unless existing service providers highlight that need.

There has been a demonstrable need in the region for an increase in community care services, but we are continually told by State Health that there is no demonstrated need for 'additional' care in the region. Their conclusion is based on reports received from existing HACC providers in the north west of Tasmania, who are supposed to service the Kentish region, but who in reality, provided limited scope of services and do not provide a comprehensive service to meet the needs of the community.

Dealings with the HACC unit of the Tasmanian Department of Health and Human Services have led to several conclusions about the prospects of achieving services for those in need in the region. These include:

1 The Department only consults with current HACC consumers and service providers when seeking to establish demand for planning purposes (an admission personally made by representatives of the Unit) – thereby excluding information available from (we estimate) around 75% of people who are eligible for HACC services, but who never receive them.

2 As such, new services are not considered, unless a proposal comes from existing providers.

3 Until recently, the Department has never consulted with consumers in the region (by their admission).

4 The situation would be far more equitable if those people in need in the region were unsuccessful in seeking community care services because they failed to demonstrate a higher priority for their needs than did others in need elsewhere in Tasmania.

5 But, the demand demonstrated in various applications – based on real people who meet required criteria - is not recognised by the Department and, therefore, is not taken into account when priorities are set.

Associated with the lack of services with HACC, is the lack of Community Aged Care Packages (CACP's) available. The current ratio for low care beds in the region is well under the required amount, but this has not been compensated for by additional CACP's. This has led to a large backlog of people waiting for a low care bed, and at the same time being unable to access CACP's. The logical step would be to allow the low care licenses to be "interchangeable" with CACP's, so people who cannot get a low care place can at least have access to Home Care through CACP's.

POINTS OF CLARIFICATION FROM CONCLUSIONS:

5) Currently there are no arrangements in place for the transition of elderly people from the acute hospital settings to an aged care settings or back into the community.

Neither the Commonwealth nor State Governments has provided any transitional funding or support in the region for those who require either aged care or home care, after an acute episode in the local hospitals.

This is despite efforts from local providers, over the past four years, to provide ways in which elderly patients can be transferred to aged care facilities for rehabilitation or home with home care support.

Ideally, any elderly patient should be able to receive rehabilitation services prior to leaving the acute sector, but this is not available. There is also a policy of not allowing elderly patients in acute beds to go directly to an aged care facility, unless it is for permanent placement.

The ideal outcome for an elderly patient who has had an acute episode is for a period of respite with rehabilitation.

The current system does not allow this. Firstly, the Commonwealth will not allow the patient to take respite in an aged care facility for, say, a period of 2 weeks (directly from hospital). Secondly, State Health will not fund the necessary rehabilitation services required by the patient, so they can recover and go home.

Therefore, the following scenario is common in the region:

1 Mrs. Jones is 80 years of age, lives by herself and manages with some Home help every two weeks.

2 Mrs. Jones has a fall at home and fractures her leg.

3 Mrs. Jones goes to hospital, where they operate on her leg.

4 Mrs. Jones stays an extra 2 weeks in hospital longer than she should, with no rehabilitation, because she cannot go home (there being no support at home).

5 Mrs. Jones is then sent home with the same level of home help as before, but with a community nurse visiting each day.

6 Mrs. Jones leg has not healed properly and after 1 week at home, she falls again and breaks her hip.

7 Mrs. Jones ends up back in hospital, where they are not prepared to operate, and she is listed for high care placement.

8 Mrs. Jones then stays in hospital for another 6 to 8 weeks waiting to be admitted to an aged care facility.

9 Mrs. Jones gets permanent placement after 8 weeks, but is frail and requires a high level of care.

10 While in hospital Mrs. Jones contracts a staph infection, and now has to be isolated at the aged care facility.

POINTS OF CLARIFICATION FROM CONCLUSIONS:

Mrs. Jones is now costing the Commonwealth Government, on average, $ 45,000 per annum in aged care funding, merely because the services from the acute sector to the aged care sector or home care are non existent. On top of this is the cost of the hospital stay, which, at an average cost of $ 600 per day is $ 42,000. This is a cost to State Health.

What should have happened to Mrs. Jones was:

1 Mrs. Jones has a fall at home and fractures her leg.

2 Mrs. Jones goes to hospital, where they operate on her leg.

3 Mrs. Jones is transferred to a "step-down" facility (within an aged care facility) 5 days after her operation and is given rehabilitation services, such as physiotherapy, etc.

4 Mrs. Jones has the rehabilitation for a period of 4 weeks, and then goes home when she is able to perform basic duties.

5 During the time of her rehabilitation, an Occupational Therapist works with Mrs. Jones to properly fit out her home and provide various aids for her to manage at home.

6 Mrs. Jones goes home and is able to manage by herself, with the home help recommencing.

The cost for the above services over the period would be approximately $ 11,000, one off cost, as opposed to a cost of $ 42,000 for hospital bed days and an ongoing cost of $45,000 per annum for her high care placement.

However, both levels of Government are unable to provide the funds or the will to make the above occur.

It is understood that some other States do have a system, which allows for rehabilitation, but not in our region or the majority of Tasmania.

Currently there are over 26 patients waiting in a local acute hospital for an aged care bed, with the likelihood of at least half being able to rehabilitated through the above process and put back into the community.

CONCLUSION:

The current system of providing workforce funding, checking standards for our elderly, the appropriateness of having younger people in aged care facility, the adequacy of home care and the lack of transitional arrangements, underpin current issues surrounding the health and aged care systems.

In reality, the standard of care for both health and aged care is of a superior quality, when compared to other systems, particularly those overseas. The level and quality of care is not the issue that the health and aged care systems face.

The issues expressed in this submission are about two levels of the health and aged care systems, which are in need of reform, both at funding and policy level.

The first level is that of the use of funds within programs, where there is no accountability and problems exist between the State and Commonwealth Governments, as to who is going to fund what part. Until there is a level of agreement between the Commonwealth and State Governments on this, then nothing will be achieved. This also applies to the issue of Registered Nurse education, where both Governments have the responsibility for funding and making the system work.

The second level involves policy and who delivers which services to whom. There are two different systems being applied, with the Commonwealth preferring to "out source" most of its services (largely in aged care), while the State prefers to deliver its own services. This breeds a natural clash between the State and the Commonwealth, as the Commonwealth does not trust the State to use its funding in an appropriate manner.

The Commonwealth would prefer to purchase services, while the State has its hands both in the health system and around it. Finally, until there is some agreement between the State and Commonwealth about how services are to be funded and made accountable for the funds, the issue of "cost shifting" will be central to decisions made about services offered to the elderly, now and into the future. The outcome of this tension between Governments for the elderly will be a denigration of services in coming years.