ANHECA SUBMISSION

About ANHECA

The Australian Nursing Homes and Extended Care Association (ANHECA) is a national organisation representing some 800 providers of residential and community aged care services across Australia. The Association has as its major objective the support of its membership through a range of activities geared towards ensuring the provision of quality residential and community care services for the Australian Community. Set out below is a statement of the vision, mission and objectives of the organisation and its federated state membership organisations.

Our Vision

ANHECA strives for, and is committed to, excellence in residential care within a financially viable environment.

Our Mission

Our Mission is to ensure that Australia achieves and maintains an efficient and effective world-class residential care industry for all its peoples, through:

- the development and presentation to governments and the community, of achievable and cost-effective aged care policies;
- a forum for Members and their State constituencies for debate and resolution of issues impacting upon aged care service provision; and
- representation of Members and their State constituencies to government, stakeholders, and others interested in the Australian aged care industry.

Our Goals

The Vision and Mission of ANHECA will be delivered through a focus on goals and outcomes, including strategic direction and policy planning, partnerships with members, stakeholders and the community, and the fostering of research.

Our Goals are:

- **An appropriate commercial and regulatory framework**
  Ensuring system structures allow residential care service providers to achieve a viable commercial return consistent with market forces and independent of ownership structure
- **An appropriate residential care funding scheme**
  Ensuring the funding scheme is based on sound commercial practices,

standard accounting practices, and equal treatment of all aged care service providers.

- **Longer-term strategies**
  Creating strategic direction and longer-term strategies for the development of the broader residential care industry.

- **A consensus national policy on aged care**
  Encouraging and facilitating national policy that is agreed by industry and all political parties.

- **An enhanced image of the Association and the Residential Care Industry**
  Forging a progressive approach to industry issues, and expanding and improving communications with Government and other industry stakeholders.

- **Research**
  Developing strong working relationships with Government, political parties, universities with an interest and focus on aged care issues, and other stakeholder organisations, to research issues affecting members' interests, and developing a relevant information base on which policy decisions can be made.

- **Outcomes that meet Objectives**
  Ongoing critical assessment of Association performance using indicators that reflect policy development, and effective representation of members' interests to Government and other stakeholders.

ANHECA Members

ANHECA is owned and funded by its members.

Members are the autonomous State Associations. State Members are:

- ANHECA (New South Wales)
- ANHECA (South Australia)
- ANHECA (Tasmania)
- ANHECA (Western Australia)
- The Aged Care Association of Victoria Inc
- Aged Care Queensland

ANHECA State Members provide residential care in High and Low Care facilities (nursing homes and hostels), as well as a range of retirement villages, independent living facilities and community-based services.

TERMS OF REFERENCE - A

The adequacy of current proposals, including those in 2004-05 budget in overcoming aged care workforce shortages and training.

ANHECA has been highly supportive of many aspects of the 1997 aged care reforms. However, one aspect that has always caused difficulties has been the single Commonwealth subsidy across all state and territory jurisdictions, which fails to recognise the considerable variations between states and territories in the cost of salaries and wages. As salaries and wages represent approximately 70% of residential aged care outlays with little opportunity to vary income to reflect costs the sector is generally unable to match salary and wage rates being paid in other parts of the health system.

This lack of synergy between actual subsidy and actual state based workforce costs makes it extremely difficult for residential aged care to pay a competitive wage rate. This is particularly relevant when looking at the registered nurse and enrolled nurse workforce as these staffing classifications have traditionally had a direct comparison between the aged care sector and other parts of the health system.

Registered Nurses

Registered Nurses are an integral component of residential care, particularly nursing homes. As the frailty and dependency of residents receiving care within the sector continues to grow, the number of registered nurses required in the sector is going to expand as a proportion. If the number of persons requiring care matches the Australian demographic over the next thirty years, the gross number of registered nurses required for the system is also going to grow by a similar proportion. This is likely to lead to the demand for registered nurses in the residential care sector growing by as much as two hundred and thirty per cent during the next thirty years.

There is already severe competition for the nurses who are available in the health system and as the age profile demographic of the registered nurse workforce in residential care indicates that many of the existing nurses will be approaching retirement age over the next five to ten years there is an urgent need to ensure that sufficient numbers of suitably qualified registered nurses can be recruited into the sector in the future.

One of the major reasons given for registered nurses leaving the residential care sector or declining to enter the sector is the sheer volume of red tape required of registered nurses working in residential care. Many existing staff enjoy residential care work and provide devoted and professional care to their residents, however indicate on a regular basis, a high degree of frustration with the excessive red tape they are required to maintain to satisfy government requirements in respect of the validation of the appropriate resident classification for the RCS funding scheme, accreditation,

documentary detail which often focuses on minutia rather than systemic review and a complaints resolution scheme, which tends to provide no procedural fairness to the staff in residential care facilities.

ANHECA has estimated that there is approximately four million registered nurse hours wasted per annum in completing unnecessary red tape in the residential care sector. That between Departmental staff activities and residential care staff activities, approximately $90M per annum is wasted. ANHECA accepts that residential aged care is a substantial budget outlay by government and that there needs to be suitable accountability provisions to ensure the appropriate expenditure of those outlays. ANHECA also accepts that our resident population is a group of the frailest most dependant persons in our society and that we need to ensure they are being protected and receiving appropriate care. However, ANHECA does not believe that this level of waste is acceptable and more particularly does not believe that it is acceptable to create the negative workplace environment for registered nurses that currently exists.

ANHECA believes that it is essential to generate a higher profile for the residential care sector amongst the nursing profession. The first step in achieving this significant attitudinal change will be to remove as far as is possible, the unnecessary red tape that currently exists within the system.

The workforce survey undertaken by the National Institute of Labour Studies clearly indicates that the registered nurse workforce is the most dissatisfied in residential care and it is this group that causes the most difficulty for aged care providers in attraction and retention.[1] It is therefore necessary for us to concentrate on the reasons why nurses are not finding aged care attractive and to overcome those issues.

The introduction of a registered nurse undergraduate scholarship scheme for rural and remote students in the 2002-03 budget has proved highly successful. It is yet to be demonstrated that the nurses who have joined this scholarship program will in fact stay in residential care. The expansion of this program by the federal government in the 2004-05 budgets to a national scheme is highly commended.

One difficulty with the scholarship programme is the lengthy timeframe involved. It will be five years before the first graduates actually are available and hopefully working in the residential care sector. There is no assurance that these particular undergraduates will commence and or remain in residential care later in their careers. This does not mean that the project is not welcome, it certainly is, it is one significant step among many that will need to be undertaken to ensure that adequate nurses are available to residential care in the future.

[1] The Care of Older Australians: A picture of the Residential Aged Care Workforce (Feb 2004) National Institute of Labour Studies, Flinders University, Adelaide

ANHECA believes that there is a real need to raise the profile of aged care nursing and the professional attitude of nurses towards aged care nursing.

That the standing of nurse education within the university environment needs to have a much stronger focus and the recognition in the nursing profession that aged care nursing is a legitimate subset of a nurses career, will all over time improve the status and standing of aged care nursing.

The undergraduate nursing curriculum at each university must recognise aged care as a speciality. It must be studied in the third year of the undergraduate program with all other specialities. During clinical placements for the first year student in an aged care setting, students tend to be allocated with aged care workers which clearly demonstrates the nature of the work that a care worker undertakes, however generally does not give the student a strong feel for the more highly skilled clinical role of the registered nurse in the aged care setting.

There is a need for the role of the registered nurse in residential care to be re-examined with a view to enhancing the existing role. All state jurisdictions should permit the employment of nurse practitioners within the residential care setting, with the nurse practitioner having an enhanced clinical role so that this person could supplement the workload of general practitioners, who in many instances are in short supply in residential care services.

Medical Practitioners

The provisions of Medicare Plus in providing for the Comprehensive Medical Assessment and the creation of GP panels are welcomed by the sector as a step in the right direction to improve the attractiveness of the sector to general practitioners.

ANHECA is concerned that only 16% of GPs provide a regular services to nursing homes. A regular service is defined as providing more than fifty occasions of service per year.

This lack of medical support in residential care facilities places a greater load on registered nurses and often leads to unnecessary admissions to the acute hospital sector.

Another provision in the budget may provide some relief over time. The allocation of funds to enhance the e-commerce and information technology capabilities of the Department of Health and Ageing and the sector could significantly improve the medical service regime in residential care. If GPs were able to access resident files from their own desktop PC and communicate with facility staff regarding resident care electronically it would make servicing residents a more attractive and efficient proposition for general practitioners.

Enrolled Nurses

As more pressure is placed upon the residential workforce, particularly the registered nurse workforce in the future, due to growth within the sector and the changing Australian workforce profile, it will be essential that residential care be able to access and train enrolled nurses (Division 2) to undertake much of the routine clinical work.

One of the greatest frustrations for residential care over the last ten years has been the difficulty in enhancing the role of enrolled nurses so that the enrolled nurse could undertake medication management. Negotiating this arrangement with the various state based nursing registration boards has been a long and tedious process.

The budget provision to support 1500 additional vocational training places per year to assist enrolled nurses to expand their skills in medication management is highly supported.

The role of the enhanced enrolled nurse in the residential aged care facility of the future will become fundamental and of primary importance in quality care delivery. It is essential that as many enrolled nurses as possible undertake the education to allow for the enhancement of their role to incorporate medication management so that the best possible utilisation of registered nurses can occur and that sensible and rational work practices can evolve based upon the capabilities of the various categories of staff.

There must be a clear and simple career path articulation between the enrolled nurse and the registered nurse. It is important that a career pathway is available for unskilled staff that decides that they would like to become a nurse and commence the enrolled nurse education and then wish to advance to a registered nurse. This is already available to enrolled nurses, however needs to be reinforced and clearly demonstrated to future employees that this is a career path option to a person interested in a long term nursing career.

General Staff

ANHECA believes that there is a need for the sector to be supported in improving the language skills of general staff in many parts of the country. General staff positions within aged care are often an attractive work environment for new migrants to Australia. Many new migrants lack adequate English language skills.

The budget provision to provide 2000 additional places to assist aged care workers participate in Workplace English Language and Literacy programmes is a welcome initiative.

There is a general desire in the industry to adopt, as far as is possible, the objective of raising the qualifications of all care staff to vocational training

certification three level. Though this may not always be possible it is nonetheless a laudable objective for the sector to pursue.

The budget provision of an additional 4,500 vocational training places per year to assist aged care workers to undertake vocational educational and training is most welcome

TERMS OF REFERENCE – B

The performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

1. **assessing and monitoring care, health and safety;**
2. **identifying best practice and providing information, education and training to aged care facilities; and**
3. **implementing and monitoring accreditation in the manner which reduces the administrative and paperwork demands on staff**

Since the implementation of the 1997 Aged Care Reforms, ANHECA has been highly supportive of the whole concept of accreditation and the quality-improving framework for the sector. ANHECA believes that the introduction of the accreditation system has had a profound effect upon residential aged care and has driven a significant improvement in the quality of services, but more particularly, led to the adoption within residential care services of the systematisation of quality improvement systems within organisations leading to services incorporating these systems within their day to day service delivery framework.

In that context, ANHECA believes that the overall concept of accreditation has been positive, though this interpretation is only supported by observation and anecdotal response to service performance during accreditation Rounds One and Two.

At the same time it is recognised that it is difficult to produce formal evidence of the impact of accreditation on the quality of service provision. Residential care services provide a range of services, the type of which it is difficult to measure in a quantifiable format.

The Aged Care Standards and Accreditation Agency (the Agency) has to date, not produced any material, which would provide the sector or the community with any level of assurance that the overall intention of accreditation in improving service quality has been achieved.

Nor has the Agency provided any evidence of consistency and inter rated reliability of the performance of assessors and the outcomes achieved between assessor teams within states and nationally. ANHECA believes that the Agency needs to apply resources to the development of a substantially improved data mining and reporting capability, which would have the capacity to report on assessors and audit outcomes at an individual, regional, state and national level.

ANHECA believes that the existing arrangements in respect of accreditation administration whereby the Commonwealth has created its own company, limited by guarantee, as a monopoly provider to the residential aged care

sector, is an inefficient and less than effective method of providing accreditation services to the residential care system.

ANHECA believes that a more appropriate methodology would be to bring residential care accreditation services within the Joint Accreditation Service-Australia and New Zealand (JAS-ANZ) framework. JAS-ANZ would be responsible for accrediting a number of quality improvement organisations, which are capable of undertaking quality improvement services for the residential care sector. This system would have many similarities to the accreditation scheme recently introduced by the Commonwealth Government in respect of Disability Employment Services. At Attachment B is the ANHECA position paper in respect of accreditation for the residential aged care sector, which sets out the proposed structure that could be introduced for residential aged care as well as a brief summary of the JAS-ANZ service regime.

ANHECA believes that there is within the current scheme, considerable confusion regarding the respective roles of the Agency, the Department of Health and Ageing and the Complaints Resolution Scheme administered by the Department of Health and Ageing. The current arrangements regularly take the Agency out of the role of being the quality improvement body and force it into the role of being the compliance monitoring body. ANHECA contends that these two roles are incompatible and that the Agency needs to be one or the other, not both.

ANHECA believes that the Agency could clearly be an organisation along with others that are accredited with JAS-ANZ to undertake the quality improvement services for residential aged care and that the Department of Health and Ageing has responsibility for compliance monitoring and complaint resolution investigation.

An open contestable quality improvement environment would also provide a further benefit to the residential care sector. Many providers of residential care are also providers of community aged care packages; home and community care programs, retirement villages, independent living units and a variety of other community based and residential programs for the elderly and others. In the current scheme there are various requirements from various government agencies about accreditation arrangements or management decisions about utilising a variety of accreditation/quality improvement services which mean that large providers of aged care services, both community and residential can have five different quality improvement schemes operating across their various services.

ANHECA believes that providers of various care services, residential and community should be able to rationalise the current plethora of accreditation type services and adopt a common quality improvement framework across all service types. This would have the added benefit of better integration across these programs as well as an enhanced management outcome for providers.

The Agency's system of identifying best practice in the sector and endeavouring to educate the industry through the Agency's newsletter and a

small number of seminars, though useful is considered to be less than optimum. This is due in part at least, to the Agency wearing the two hats of compliance and quality improvement. Other quality improvement organisations are able to advise individual services about quality improvement and apply those recommendations specifically to the service. This type of support can be provided during general contacts, which are meant as a support visit not a formal audit. ANHECA sees no difficulty with an agency that purely has quality improvement as its objective, undertaking this role. However, an organisation that also has a large compliance role is not able to effectively do this as the industry will not seek advice and support from an organisation, that the next day can be 'inspecting' its services and ensuring compliance.

ANHECA believes it is essential that the current system be restructured and that the quality improvement organisation be JAS-ANZ accredited and that those organisations who provide quality improvement services to the sector be enabled to expand those services across the whole continuum of community, aged care and residential services and that quality improvement organisations that are accredited with JAS-ANZ not be obliged to undertake a compliance monitoring role at the same time.

ANHECA does not believe that the current accreditation system does in any way assist the sector to reduce administrative and paperwork demands on staff, in fact, the reverse. Because the Agency is so focused on the minutia of day to day activities and not on systems improvement, it is forcing residential aged care providers to focus on forms and ticking of boxes, rather than ensuring that the quality systems work effectively for overall service improvement and that the systems bring failures to the attention of management immediately they occur.

ANHECA believes that an adoption of the JAS-ANZ accredited, contestable market service regime would return the quality improvement service for the residential care system, to a systems focused regime. This would have the effect of reducing paperwork obligations on staff, as it would clearly separate out the quality improvement processes that have a systemic focus from the compliance monitoring activities being undertaken by the Department of Health and Ageing.

TERMS OF REFERENCE – C

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 illnesses, or specific conditions and met under current funding arrangements.

There is not doubt that the residential aged system funded by the Federal Government is in the main, structured to service the community that the name describes; aged persons. However, what is our definition of aged and what is our definition of young? An arbitrary separation of ages could be as follows:

- Young is aged less than 30
- Youngish is 31 to 50
- Older young is 51 to 65
- Young older is 65 to 75
- Old is 75 to 85
- Very old is 85 plus

It is merely one attempt to define or put an aged description around definitions of young and old. It may not be definitive but it does help to lay some parameters around the matter under discussion.

Young People

As state governments have withdrawn their support for residential accommodation for young people with various disabilities including brain acquired injury, multiple sclerosis and other disabilities, there has been only one substantial program left standing to support individuals in this situation, that is the residential aged care system.

Admissions to the residential aged care system of people in the young, youngish, and older young categories are often problematic. The needs of these groups are often very different to the old and very old persons who are accommodated in residential care. The socialisation and accommodation requirements will vary considerably from mainstream aged care. Though the complaint often focuses on the needs of the young and youngish group for appropriate accommodation. Placement of a young/youngish person in an aged care facility can often be highly disruptive to the young old, old and very old residents in the facility.

Residential aged care is in the main, not appropriately staffed to adequately service younger people with different needs. The appropriate response, if the Commonwealth Aged Care Program is to continue to provide services for persons under 65 who are residents due to a non-age related illness would be to specifically set aside small units of 12 to 15 residents to accommodated in co-located appropriate housing, young/youngish persons with appropriate staff, rehabilitation services, and social activities. These services should be clearly identified and appropriately funded either by state health departments

or a specific allocation within the Commonwealth Residential Care Program. It is currently estimated that there is approximately 6000 people in the residential care program who fit this category of being a young/youngish person accommodated in an aged care setting. Assuming that all 6000 existing young/youngish persons were catered for in an identifiable unit co-located with existing residential care services, there would be a requirement to construct something in the order of 400 x 15 bed units across the country and to identify these clearly as beds set aside for younger persons.

The Commonwealth and States would need to reach agreement on how this capital cost would be met and how the ongoing operational cost of servicing the 6000 beds would be met.

Dementia

Certainly residential aged care is experiencing substantial growth in the number of cases of dementia amongst residents in high and low care and an increasing number of residents who suffer from some form of mental illness especially depression. Though there has been work, especially that undertaken by Alzheimer's Australia, looking at the projected future numbers people effected by Alzheimer's, it is generally accepted that approximately 60% of residents in residential care suffer mild to severe dementia, there has been no work undertaken to consider the real cost of providing residential services to those with dementia or with behavioural or other difficulties.

ANHECA believes that prior to the implementation of a dementia and palliative care supplement which is proposed as part of a revised funding scheme from July 2006, a substantial review needs to occur regarding the actual cost of providing such services. While the top subsidy payable to a level 1 resident in residential care is $118 per day, the average payment for an acute sector palliative care service can be as high as $430 per day. There is great difficulty reconciling these two quite separate figures. It is essential therefore, for government to look at the true cost of providing an effective palliative care program and an effective dementia program and to incorporate that cost provision within any revised residential care subsidy framework.

TERMS OF REFERENCE – D

The adequacy of home and community care programs in meeting the current and projected needs of the elderly.

In considering the needs for the elderly in home based programs, it is suggested that any review needs to look at the coverage from community aged care packages, home and community care programs and a variety of other state and federally funded programs which target service provision in the home environment.

It is difficult to determine, given the number of programs, the adequacy of the current systems and whether or not they meet the projected needs of the elderly.

There is no doubt that the current funding levels will need to track very closely the projected demographic, aged specific changes that will occur over the next fifty years.

There is also no doubt, that the desire of the elderly is, wherever possible, to remain in their homes and to retain their independence. Governments both state and federal, and of all political persuasions have for sometime seen the benefit of supporting such programs and have endeavoured to expand the various home based programs to meet the growing demand.

One area of possible improvement is that of regional transport services to assist home based recipients of care to attend social and community functions. Though taxis are available to meet this need, those with very little income find taxi service a disadvantage. In addition, where a home based person requires assistance or support to attend for a medical service or some other activity, finding someone to assist in this process is often difficult.

TERMS OF REFERENCE – 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.

The first issue to be dealt with under this heading is the lack of consistency that currently exists between hospitals, area health services, state health departments and the residential care system. There needs to be a common process for assessment and transfer of patients from the acute setting to residential care and of residents of residential care to the acute care setting.

In addition, the acute sector needs to become far more vigilant in its service regime to the elderly. It is not appropriate and indeed it is a clinically inferior service to expect to admit and discharge the old and very old in the same timeframe as a young person. It is extremely poor service to discharge a confused dementia impaired old person to home or to a nursing home late at night or because there are a shortage of beds in the acute sector over the weekend.

The acute sector makes very little provision to care for those with dementia and will often invoke service regimes eg: raised bed sides and high beds which are simply considered inappropriate in the residential care setting. In addition, on entry into the acute sector, a person who is dementia affected and has a tendency to wander will often be left unattended and unescorted for considerable periods of time.

These are not acceptable situations, however do represent a selection of existing problems covering the interface between acute and residential care.

There is a substantial need for the development of transitional arrangements, utilising much of the existing expertise that resides in residential care facilities, to provide a nursing home type environment for persons who require ongoing support but not the fully fledged acute care services delivered in an acute hospital.

This would have the benefit of relieving some of the bed occupancy strain that currently exists in the acute sector and as well provide for improved communication and clinical transfer information between the two sectors.

Various reports have been written in recent years looking at the interface between the two sectors and how this might be improved. [2]

ANHECA believes there is significant scope to improve the communication between the acute and residential sector through the adoption of advanced

[2] 'Mapping of Services at the Interfaces of Acute and Aged Care' Consultancy Report to the Australian Health Minister's Advisory Council Working Group on Care of Older Australians, Anna L Howe, Richard Rosewarne and Janet Opie, Applied Aged Solutions Pty Ltd, June 2002.

information technology systems and the integration of other heath specific information technology systems to assist in the communication channels between the two sectors. It is essential, that a patient being transferred from acute to residential care have information forwarded at the time of the transfer, detailing recommended medication regime, any diagnostic results and any suggested treatment regime that should be applied to the resident in the future. Similarly, a resident being transferred from the residential sector to the acute sector should have information forwarded to the hospital at the time of transfer detailing the problems and giving an up to date copy of the resident's medical record to avoid unnecessary duplication on presentation to the hospital.

The growth in the age demographic in Australia over the next thirty years means that these issues are not going to diminish. In fact without some solutions they will inevitably escalate. Provision of programs such as Pathways Home and transitional beds in residential care provide some of the solutions. Innovative programs evolving at various acute/residential interface locations around Australia are proving valuable solutions to these problems.

The real issue relates to providing the incentives to take these various pilot type programs and converting them into mainstream services offering alternate solutions wherever demonstrated service improvement and enhanced systems efficiency is achieved.