Australian Society for Geriatric Medicine (ASGM) Submission to Senate Community Affairs References Committee Inquiry into Aged Care

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

The measures in the 2004 budget that partly address the current acute workforce shortage in direct care staff in the aged care industry are welcome. The ASGM supports the increased number of places for training of personal care assistants and enrolled nurses. The modest increase in the number of places for education of registered nurses is also welcomed. However the ASGM remains concerned about the general level of training in the residential care industry. There is an overall dearth of specific geriatric training in most of the nursing, allied health and medical courses in Australia, despite the ageing of the Australian population and the need for such skills in the acute, subacute and residential care sectors. Postgraduate education for all professional groups is poorly developed and resourced. Health care in residential care is currently fragmented, poorly organized and does not foster cross disciplinary education within the aged care workforce. There has been no prioritisation of the general workforce into areas which will be affected by the ageing of the population (eg Community services, Residential Care, service industries). There are already widespread shortages of nursing, allied health and medical staff, and measures are urgently needed to attract and retain professionals into the area of aged care.

(b) The performance and effectiveness of the Aged Care Standards and Accreditation Agency in

(i) Assessing and monitoring care, health and safety.

In Residential Aged Care, the assessment and monitoring of care, health and safety of residents is a task that must be informed by high levels of expertise and evidence, and be underpinned by a suitable organisational framework. Residents are often unable to effectively participate in their own care, and families may be reluctant to complain or comment on care. They may be concerned that this will

affect the care of their relative, or they may feel that the staff are doing all they are able within the resources available. The current processes which rely on subjective impressions about standards of health care and safety have been repeatedly shown to be very unreliable. Nominating desirable aspirations is laudable. The presence of written policies and procedures is encouraging. Fortunately, the rare cases of extreme neglect under the current monitoring systems have been obvious. However, it is not until valid and objective health and safety indicators are established, and data is collected methodically, that reliable estimation and comparison of standards of health and safety become feasible. This should be our goal.

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

This also requires a planned and comprehensive approach. Australia is at the forefront of international research and practice in most fields of health care except residential aged care. We currently fail to collect even basic data about the health status of people in residential care, or about our existing health care practices and their outcomes in this setting. International residential care comparative studies do not influence practice. High quality health care for residents is achieved through the effective integration of skilled nursing with medical and allied health care. Effective integration of care and assurance of quality require the collaborative development, implementation, and assured adherence to multidisciplinary practice guidelines, and valid quality outcome indicators. A sectoral framework, with a mechanism for high standard multidisciplinary guidelines and the development of outcome indicators, is needed. Adherence to guidelines and achievement of outcomes require the generation of incentives through a quality-directed funding system, and an accreditation system that exhibits the professional expertise to engender the respect of nursing, medical and allied health clinicians.

(iii) Implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.

All health care processes, including quality enhancement and funding systems, need to be efficient as well as effective. Efficiency is also the product of evidence based processes that have been refined over time by international best practice. Ineffective activities that fail to produce essential outcomes are profoundly inefficient. Systems such as the internationally benchmarked interRAI (Resident Assessment Instrument) may appear complex when first examined, but in the long run are the most efficient since they achieve the desired outcomes. Accreditation and funding systems that promote defensive paperwork (ie the current system) are stressful for staff because they become distracted from providing productive resident care. The development of an entirely new system of residential aged care standards and monitoring for the Australian setting, without

reference to decades of international professional literature about health service quality, has been the equivalent of inventing a bright and shiny “square wheel”.

(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 illness or specific conditions are met under current funding arrangements.

This is a question about age and condition-specific care settings and care specialisation, versus “generic” care settings catering for a wide range of age groups, disabilities and illnesses. The important issues are

- lifestyle and care needs of younger people
- special and complex care needs of older people
- Commonwealth versus State and Territory responsibilities.

The ASGM’s is expert only in the needs of older people. Dementia is the single greatest cause for admission to residential aged care, and in Australia, geriatricians are the major specialists dealing with people with dementia and their families. Dementia results in a changing profile of cognitive, behavioural and ultimately physical impairments that require dedicated care responses at each stage. For example, people with late stage dementia may require the implementation of an appropriate palliative care model for these profoundly disabled people. People with milder dementia are best managed in a secure home-like environment. Those people in the intermediate stages of dementia often have behavioural symptoms that are frequently severe enough to require the assistance of mental health services.

The current funding arrangements represent an attempt to define a range and quantum of care inputs. The system is idiosyncratic by international standards and has been condemned by two recent Australian reviews. It is extraordinarily documentation intensive but fails to generate a useful care plan. It fails to adequately recognise the resources required for management of behaviours in intermediate stage dementia care and leads providers to “cherry pick” “easier and better reimbursed residents with high physical dependency. It creates financial disincentives for the provision of restorative care and rehabilitation. It fails to provide any framework or incentive for illness or injury prevention. It fails to provide any incentive to provide medical treatment on site rather than transfer residents with new medical problems to state funded hospitals. Appropriate and expert behavioural management, rehabilitation, illness and injury prevention, and on site acute and sub-acute medical care would all be cost effective to the Australian community, and preferred by most residents and their families. Current remuneration of specialized medical services and organization of public

hospital aged care services does not support the provision of this care within the Residential setting.

Acute care and palliative care in Residential Care have also not developed adequately because of the funding issues between State and Commonwealth Health Departments. Many patients would be more appropriately cared for in their Residential Care facility if the expertise of the medical and nursing and allied health services of the Public Hospital system were available to them. Pilot programs such as Hospital in the Nursing Home have not been extended to other areas. Funding for medical advice in writing Advanced Health Directives should also be explored.

The best researched international funding system is RUG III (Resource Utilisation Groups – 3rd Revision), which is derived from the interRAI suite. One of 7 funding clusters is automatically generated from a high quality care need and care planning assessment protocol.

The 7 RUG categories are: -

- reduced physical function
- behaviour problems
- impaired cognition
- clinically complex
- special care
- extensive care
- special rehabilitation.

Research in a number of countries confirms an intuitive impression of the utility of such a system.

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

Over the last 20 years, assessment and rehabilitation services have improved across Australia. This has allowed the discharge of frailer older people from acute hospitals back to their home in the community. However, this has resulted in an increasing demand on the Home and Community Care (HACC) sector to maintain older people at home. The ability of HACC services to provide assessment for targeted rehabilitation to older people has not been developed or funded. Many older people therefore continue to require community services, when they may have been more independent if they had access to assessment and rehabilitation. HACC services are often unable to prioritise those people who have recently been discharged from hospital services. There should be no

waiting list for HACC services. There is also a need for provision for case management and on going co-ordination for HACC clients.

Overall, the recent fourth National Hospitals Demonstration Program highlighted the need to further integrate HACC services with early discharge programs. Coupled with access of HACC services to assessment and rehabilitation resources should result in more seamless transition from hospital to home.

(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 ASGM understands that the Australian Government has planned the provision of 2000 transitional beds across Australia. The ASGM and its members look forward to working with government to develop this proposal to provide alternative pathways for older people who are ready to leave the acute or subacute settings but may benefit from such care before entering residential care or returning to the community.

There is great variability across Australia in availability of early supported discharge programs from acute hospitals and effective geriatric assessment and rehabilitation. This has been the mainstay of supporting transitions between acute, subacute, and residential care and in returning people to their own homes This variability has been highlighted in a recent report "Service Provision for Older People in the Acute - Aged Care System " which can be found at **http://www.health.gov.au/mediarel/publications/1bfinalreport.pdf**.The ASGM hopes that the Australian and State governments can work cooperatively to benchmark appropriate access to such services across Australia.

Such services will require considerable expansion of the currently available specialist aged care workforce and once again highlights the need to prioritise recruitment and retention of a skilled workforce.

Australian Society for Geriatric Medicine

145 Macquarie St

Sydney, 2000

Telephone 02 9256 5460

Fax 02 9241 3458

Email admin@asgm.org.au