Productivity Commission 2010.
Submission: TLC Aged Care

TLC Aged Care wishes to provide feedback and make recommendations regarding the future direction of Aged Care.

Getting the right care from our system when and where it is needed

1. Supply and demand – ACAR
   The supply and demand of aged care is very much a local issue. In some regions the supply of beds is oversubscribed leading to providers having occupancy at levels below where the government funding is geared toward. In other areas we experience near full occupancy and have waiting lists. The ACAR process could be improved to take in to account current occupancy levels, in conjunction with predicted need to ascertain whether existing over supply could accommodate anticipated demand. Additionally it would appear more economically viable for existing providers to be approached in areas of need to extend if possible exiting facilities to take advantage of infrastructure, i.e. kitchens, laundries etc rather than replicating in new facilities.
2. Partners in care - Broad partnerships exist with many stakeholders. Of most importance are The Department of Health and Ageing as well as Medicare, the accreditation and compliance agencies with which we deal. More will be discussed in relation to these bodies.
   Other partnerships with acute providers exist. For TLC an agreement with Southern Health exists in relation to the Transitional Care Program. In many respects this is a broadly commercial agreement, which provides some guaranteed occupancy within one of our homes. Issues do exist at an operational level, however we feel the relationship and the service provided is of benefit to the community and health sector at large in moving care recipients to a more appropriate setting to make the transition back to a home environment. However, despite the significant financial commitment made for the provision of Transitional care by the acute sector, the Aged care sector, relative to the funding received gets a much smaller proportion which does make it difficult to justify the provision. It would be of advantage to introduce some guidelines around pricing to encourage the aged care sector to enter into transitional care.
   We have significant partnerships with suppliers, catering, cleaning, Allied health, and information technology organisations all providing expertise to in areas that are not our core competence. These providers are carefully selected and with some we have developed long term partnerships.

3. Special needs and care challenges – ACEBAC – currently provides money for research to ensure best practice and care needs are met. This however is limited and it would be of advantage to the Aged care sector to have

access to research funding to ensure best practice in areas such as dementia, Alzheimer's as well as other burdens of disease.

4. Increasingly we are meeting the needs of bariatric residents which require additional or different equipment in our homes, and education for our staff both from a dietary and OH&S perspective.
5. Mental health issues and the associated challenging behaviours are also broadly impacting on our aged care settings. The intersection of mental health aged care and the conflicting regulatory requirements we must meet sometimes leads to a situation in which we have no choice but to breach legislation. This is discussed in more detail below.

A sustainable system and financially viable services

1. Capital needs of the sector – Over time there has been a change in government priorities regarding funding such that high care funding has been directed to the residential services and low care funding directed towards the provision of community based services. As a result the capital needs of high care needs to be addressed to respond to the change in policy. Currently, bonds for high care residents are only possible in the presence of extra services licences. There exists a cap in the number of ES licences that can be applied for and we are now experiencing a situation whereby the levels set for certain LGAs have been reached. This has created a problem whereby the need for high care beds is not being addressed by approved providers because they are not able to generate capital funding through the collection of bonds. This creates a significant risk to the delivery of residential high care in the future. The significant capital outlay associated with the construction of an aged care facility, and the time frames set by the ACAR process require an upfront investment – re planning, land, and other construction related consulting fees. An extension of the time made available to construct or an agreement in principle prior to expenditure may be a way of enticing investment and ensuring construction. However recent valuations of residential aged care facilities have been lower than the overall cost of construction leading to an effective short term issue for banking covenants, and also business returns on investment.
   Take up of Extra Service – as discussed above extra services is the mechanism by which Approved Providers can ask for a bond from residents entering high care. As residents are becoming older and sicker before entering care, the ability for AP to 'sell' Extra Services is becoming increasingly difficult. A number of residents and their families are reluctant to pay for services which they don't believe they will use for the purpose of entering high care. It is recommended that the term Extra Services be changed to something different or alternatively be discontinued and replaced with a system consistent with that of low care in relation to charges i.e. accommodation charge is discontinued and a bond is charged.
   An alternative title if an Extra Services model is to remain could be 'Priority Access' which could work like this:

- A bond is charged, include the ability for periodic payments which exists currently
- No Extra Services fee is charged
- Clawback to government which would be lost under this proposal is replaced with a proportion of bond over and above retention.

2. Meeting recurrent costs – cost of regulation, operations, care. Grant funding for research, productivity and technology. CAP covers operations
   Larger groups have the ability to exploit the economy of scale they posses and the centralised infrastructure to invest in improvements, incurring a shorter, "project" cost for a longer term financial benefit.
3. Choice and flexibility
   Users have limited choice and flexibility in regards to aged care. The current heavily regulated environment requires a reasonably standard service to be provided, with extra services being the only area within which a regulated degree of flexibility can be provided. Lifestyle programs are the other major source of flexibility that many homes provide, this coupled with fabric of the building in many respects resemble the choice offered to prospective residents, normally restricted to a geographic area. An unbundling of services and a much publicised ability for a broader user pays system could provide more choice for residents, an additional income stream for providers, leading to a more individualised service to be offered.

Regulation

1. Level and scope of regulation – the current regulation is burdensome and includes finance audit to justify funding, accreditation, mandatory reporting, at risk wandering legislation, police checks, health professional registration and associated compliance and adherence with CIS complaints regulations. It is also consider that the complaints commissioner is a toothless tiger. Consolidation of compliance bodies is required. There are examples of where the Department work in conflict with the Accreditation Agency in relation to compliance and the company has had first hand experience of where The Department has issued a non compliance where the Accreditation Agency has not for the same issue. The complexity of having differing authorities and decision making processes is confusing for the industry and invalidates the decision making process of the system.
2. Keeping people at the centre – With a heavy compliance focus it is at times difficult to focus on individual needs whilst meeting the onerous regulatory compliance. With a punitive system adherence to compliance can override the need of the individual.

   Consideration of other special needs residents such as bariatric, Alzheimer's and dementia residents is an example of where the care provided from a clinical view point keeps the individual at the centre. However it would appear in some respects the emotional spiritual and less

tangible aspects of keeping the resident in the centre is more difficult to achieve.

The following case demonstrates the difficulty some approved providers are faced within the context of trying to comply with 'The Act'. The company was issued with a breach based on not maintaining security of tenure, however if the resident remained living in the aged care facility a breach would have been issued under a different section of the Act – "damned if you do, damned if you don't"

Mrs. Molly B is a 49 year old married woman with 2 teenage children. She was admitted to a TLC Aged Care home with a diagnosis of early onset dementia in January 2009 four years after diagnosis. On the first day of admission Molly activated the fire alarm. Within one week Molly was refusing assistance with all ADL's and was observed to be lying on the couch "giving birth" ie panting, bearing down and screaming. This occurred on average once per week. There were no triggers identified. Molly was referred to Aged Persons Mental Health Team (APMHT) however due to Molly's age APMHT were unable to accept the referral and they attempted to find a service that could assist. No service was identified and APMHT did visit as Molly's behaviour had become increasingly aggressive especially toward other residents. APMHT transferred Molly to hospital for assessment and for a functional review. It was identified in hospital that Molly had a high sensitivity to a number of the psychotropic medications. Her medication regime was reviewed. Molly remained in hospital heavily sedated due to her aggressive behaviour and returned to the home 3 weeks later. Molly's behaviour again became increasingly violent. APMHT were called and Molly also recommended under the Mental Health Act on the 22/5/09 and returned to the home on 9/6/09. Over an 8 month period from admission there were 73 incidents of aggression. These aggressive incidents included injury to both residents and staff. Staff sustained a black eye, bruising, scratches and bites. 6 residents also were injured and sustained bruising, skin tears from scratches and skin tears from bites and one resident had a clump of hair pulled out. None of these residents provoked these attacks. In August 2010 there was an increase of aggressive incidents and Molly's sister informed the manager that Molly's husband was seeing another woman and was no longer visiting Molly as regularly. A number of strategies by the home to support Molly and minimise aggressive behaviours were used. On nine separate occasions concerns were expressed by staff to APMHT that Molly was not able to be managed and that the safety of other residents and staff was at risk. Molly's GP was also approached on several occasions staff requested that Molly be transferred due to the risk she posed to others. These requests were met with resistance. The GP was guided by APMHT. The catalyst occurred on Sunday 6th September 2009 when Molly walked up to a picture frame on the wall punched the picture frame causing the glass to break when family visited. APMHT was again contacted who were unable to assist but said they would contact her psychiatrist who later called and said he was unavailable for 3 days. Clinical Services Manager contacted Executive Operations and informed of incident.

Executive Operations recommended that Molly be recommended under the Mental Health Act and CSM to contact GP and arrange transfer to hospital. GP supported transfer to hospital however did not want to recommend Molly despite her being a danger to others. Molly continued to be specialled. An ambulance was contacted to transfer Molly to hospital. Molly was transferred via ambulance to Hospital tests were done and the hospital called to say that due to her behaviours they were unable to manage her and were sending her back. The Hospital advised that APMHT were involved in her care and that the home was unable to accept her back as unable to ensure the safety of other residents, staff and family members. Executive Operations notified the Department of Health and Ageing of the situation and requested advice and also spoke with the General Manager Victoria and Tasmania Aged Care Accreditation Agency and discussed situation. Everyone agreed that it was not safe for Molly to return to the home however not to accept her back was a breach of security of tenure. The Hospital called to say that they were specialling Molly and advised that they considered that it was not appropriate to return her to the home given how aggressive and unmanageable her behaviours were. They had held a meeting and were waiting for APMHT to attend a case conference. Executive Operations contacted DON at Hospital and offered to pay for staff to continue to special Molly until appropriate accommodation could be arranged. The Clinical Services Manager contacted six other homes to discuss ongoing care and accommodation. Two stated they had no beds and the remaining four refused due to her aggressive behaviour. Molly's husband then submitted a complaint to the Complaints Investigation Scheme. Investigation followed and outcome was:
"TLC Aged Care breached its responsibilities under the Act. The issue related to Security of Tenure – Part 2, Division 1.23.6 of the Aged Care Principles: and acknowledged that the home had undertaken appropriate actions to remedy this breach and the case is finalised.
Recommendations: -

1. Current review of the Aged Care Act in relation to Security of Tenure and take into account safety of other residents and staff in instances where their safety is at risk due to the behaviour of another resident.
2. Determine where younger residents in aged care fit in relation to at risk behaviours
3. Early notification to discharge resident to more suitable care

Molly was eventually transferred to a psycho geriatric facility where her family report that she remains heavily sedated

3. Managing risk and regulation – accreditation, CIS, conflicts with each other. The example above outlines the risk management sometime required; as is clear in this instance it is clearly a harm minimisation approach that is required.
   Risk management from a regulatory view point, requires significant time and attention. Accreditation, "support visits", CIS investigations, as well as staffing, financial and other risks all associated with the aged care sector

requires a focus on risk to ensure compliance with the Aged Care Act 1997 and other regulations. The risk of sanctions and the highly publicised non compliance registers all add to the sectors focus on managing risk to ensure compliance to regulation. Given the ability to have a support visit or CIS investigation at any time the issue of risk management is always on the mind of management of aged care facilities. Perhaps a more supportive and less punitive approach would lead to a better outcome. Providing guidance and advice, which could be considered support, may assist providers with additional information to provide a better service as well as a longer term need for less compliance based investigators.

Workforce

1. A skilled high quality workforce that cares – unregulated workforce, shortage of nurses, no parity with pay compared to the acute sector.
   Within the broader aged care sector the ability for the church and charitable sector and the not for profit providers to access a significant tax free component of income for each employee as well as other benefits such as tax free restaurant dining furnishes these sectors with significant advantage over the private sector providers. Creating equity between public and private providers would lead to a more equitable split of staffing across the broader aged care sector, and remove an advantage to a percentage of the sector that has existed for a significant period.

2. Workforce sustainability, recruitment and retention
   Part Time staff – on average staff within our work force work ½ EFT. This creates an administrative cost related to the number of employees. The ability for part time staff to receive a tax free component of income for more than one employer would also attract staff in the sector to part time work (i.e. work for two employers and receive close to 35K tax free in a year!)
   Turnover and recruitment – it is difficult to attract staff to aged care, which often requires the use of external recruitment agencies to act on behalf of the provider to attract staff particularly for more senior roles, facility managers and above.
   Sustainability – with a shrinking and ageing work force there is a need to utilise technology to reduce the need for staffing. The private sector has already discussed does not have the ability to offer staff the benefits the church and charitable and not for profit sector. Consistency would allow market forces to determine where staff chose to work in the absence of the benefits only a portion of the sector can offer.