

20 August 2010

Caring for Older Australians
Productivity Commission
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Productivity Commission Inquiry: Caring for Older Australians

Aged Care Crisis (ACC) welcomes the opportunity to respond to the Productivity Commission public inquiry, 'Caring for Older Australians'.

ACC is an independent group of Australian citizens. Members of our group are engaged with the aged-care sector in a variety of ways – as health professionals, as consumers of services and as volunteers.

The web site www.agedcarecrisis.com seeks to provide a strong consumer voice to aged care. The by-line is 'where little voices can be heard'. The site provides accessible information on many aspects of aged care, access to topical journal articles and an opportunity for site visitors to express their views and concerns.

ACC believes that reform of aged care is long overdue. Daily correspondence to our web site – mostly indicating grave concerns about the current system of care - confirms this view.

We make the following general comments.

- Shortcomings in the current system of aged care are leading to widespread lack of confidence within the broader community.
- Frail older people across Australia are at risk because aged-care providers are not required to adhere to mandated minimum staff/resident ratios.
- Consultation with independent consumer groups on all aspects of aged care should be paramount. For too long the voice of the aged-care consumer has been neglected.
- We draw attention to the current reliance on the market economy for the provision of care to a significant proportion of frail, older Australians. This increasing dependence is creating serious problems within the sector. In particular, the pressures associated with cost cutting are driving many of those staff who seek to provide humanitarian and personal empathic care out of the sector.
- ACC asks that there be real transparency, accountability and disclosure in all aspects of aged care.

We note that the Issues Paper encourages those making submissions to this Inquiry to raise any relevant aged-care issues. This submission, therefore, takes a broad approach.

ACC has contributed to various inquiries, reviews and consultations - including the following:

- Review of the Aged Care Complaints Investigation Scheme (October 2009)¹
- Review of the Residential Aged Care Accreditation Process for Residential Aged Care homes (July 2009)²
- Inquiry into Aged Care Amendment (2008 Measures No. 2) Bill 2008³
- Aged Care Amendment (Security and Protection) Bill 2007⁴
- Inquiry into Older People and the Law (2006)⁵
- Elder Abuse Prevention Project (2005)
- Inquiry into Aged Care (June 2004)⁶

ACC⁷ has played a unique and pivotal role in examining events and trends within the aged-care sector. We have taken the time and effort to gather scattered information and compile it⁸ for critical examination. We have published articles from the coal face⁹ and created a forum¹⁰ where participants can tell of their experiences and comment critically. We produce a periodic newsletter¹¹.

ACC draws attention to the loss of human rights that so often occurs at the end of life – when it is far too easy for individuals to lose their social identity and the rights of citizenship once they enter the pressured world of the aged-care home. None of us should become merely a ‘feed’ or a ‘toilet change’ and all of us must work to ensure that the human rights of frail, aged people are upheld in every respect.

On behalf of ***Aged Care Crisis***,

Lynda Saltarelli and Linda Sparrow.

web: www.agedcarecrisis.com

¹ Review of the Aged Care Complaints Investigation Scheme (October 2009): www.health.gov.au/internet/main/publishing.nsf/Content/ageing-review-cis.htm

² Review of the Residential Aged Care Accreditation Process for Residential Aged Care homes (July 2009): www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-accreditation-review-submissions.htm

³ Inquiry into Aged Care Amendment (2008 Measures No. 2) Bill 2008: www.aph.gov.au/Senate/committee/clac_ctte/aged_care_amend_2008_measures_no2

⁴ Aged Care Amendment (Security and Protection) Bill 2007: www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/2004-07/aged_care_security_protect/

⁵ Inquiry into older people and the law (2006): www.aph.gov.au/house/committee/laca/olderpeople/index.htm

⁶ Inquiry into aged care (June 2004): www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/2004-07/aged_care04

⁷ Aged Care Crisis Centre: www.agedcarecrisis.com

⁸ The Column: www.agedcarecrisis.com/the-column

⁹ Your Stories: www.agedcarecrisis.com/your-articles

¹⁰ Letters and feedback: www.agedcarecrisis.com/yoursay

¹¹ ACC Newsletter: www.agedcarecrisis.com/subscribe

Submission

Productivity Commission's Inquiry: Caring For Older Australians

Aged Care Crisis
www.agedcarecrisis.com
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1 Government roles and responsibilities

Aged Care Crisis (ACC) is deeply concerned about the conflict of interest inherent within our aged-care system. The Department of Health and Ageing (DOHA) has a multi-faceted role which includes the funding and regulation of aged care, providing policy advice to government as well as applying sanctions to those aged-care homes which are not compliant with standards.

Furthermore, DOHA, through the Complaints Investigation Scheme (CIS), investigates complaints about its own operations and can (and has) reversed the decisions of the Complaints Commissioner who oversees the operations of the CIS and reviews cases on request.

ACC has analysed the interdependencies of the CIS, the Aged Care Standards and Accreditation Agency (the Agency) and the Office of the Aged Care Commissioner¹² and DOHA. Although all three bodies have distinct roles, final decisions regarding regulation and compliance ultimately rest with DOHA.

This issue of conflicted interest was raised as a matter of concern in Professor Merrilyn Walton's Report¹³ following her review of the CIS.

Additionally, the Commonwealth Ombudsman's submission¹⁴ to the CIS review stated:



... If the Aged Care Commission is to be both truly independent and perceived as such emphasis must be given to those things that impact on independence. Its resources should not be subject to Departmental control, it should have a clear direct line of reporting to the Minister and to the public and consideration should be given to whether it should pick up more of the CIS role...

Commonwealth Ombudsman

¹² Transparency in aged care: www.agedcarecrisis.com/transparency-accountability-disclosure/transparency-in-aged-care

¹³ Review of the Aged Care Complaints Investigation Scheme (PDF 793 KB):
 [www.health.gov.au/internet/main/publishing.nsf/content/6E29D85E65EF32FACA25770300036CB1/\\$File/ReviewCIS21009.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/6E29D85E65EF32FACA25770300036CB1/$File/ReviewCIS21009.pdf)

¹⁴ Submission by the Commonwealth Ombudsman - Review of the Aged Care Complaints Investigation Scheme
 ombudsman.gov.au/docs/submissions/Submission+on+Aged+Care+Complaints+Investigation+Scheme.pdf

2 Transparency, accountability and disclosure

ACC notes that the community has been promised greater transparency in all spheres of government¹⁵. Although various reviews and inquiries have recommended this, there is little evidence of such transparency within the aged-care sector¹⁶.

Aged-care providers receive billions of dollars of taxpayer funding. There should be full disclosure as to how that money is being spent. As well as providing increased transparency for consumers, such disclosure would undoubtedly encourage improvement in residential aged-care services.

Here are some things that people don't know when they are trying to locate a suitable aged-care home:

- What is the staff/resident ratio?
- What do staff rosters show about levels of resident care within the home?
- Do residents get permanent assignment of staff?
- Is a registered nurse always available on-site?
- What is the number and nature of substantiated complaints levelled against the home – and how have those complaints been resolved?
- What is the number and nature of non-compliances or breaches as a result of *unannounced visits* – and what has the provider done to address them?
- If a bond payment is required, would it be a \$50,000 bond or a \$1,000,000 bond, for example?
- Does a dietician plan menus for residents? Are special diets provided for those who need them?
- How are residents and families involved in treatment / care plans?
- Are resident support groups encouraged - and run independently by family members?
- What is the availability of health professionals?
(*eg doctors, geriatricians, dentists, dieticians, podiatrists, speech therapists, etc*)?



... Any complaint scheme requires transparency in its processes to engender trust from all the parties as well as the community; when complaints reside in the organisation responsible for overall quality of the services (*that may be subject of complaints*) there is incentive to limit data about complaints, the main areas complained about and the problems in the public arena...

*Professor Marilyn Walton*¹⁷

¹⁵ Ministerial Statement - Restoring Integrity to Government (Senator John Faulkner – 4 December 2008): www.senatorjohnfaulkner.com.au/file.php?file=/news/VAYCKHXIYU/index.html

¹⁶ Transparency in aged care: www.agedcarecrisis.com/transparency-accountability-disclosure/transparency-in-aged-care

Can I please see mums records? (Rodney Lewis – Legal Issues Columnist for ACC): www.agedcarecrisis.com/legal-issues-column/can-i-please-see-mums-records

¹⁷ Review of the Aged Care Complaints Investigation Scheme (PDF 793 KB):

[www.health.gov.au/internet/main/publishing.nsf/content/6E29D85E65EF32FACA25770300036CB1/\\$File/ReviewCIS21009.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/6E29D85E65EF32FACA25770300036CB1/$File/ReviewCIS21009.pdf)

3 Accreditation

ACC believes that the critical role of education and the establishment of exemplar processes and practices within aged-care homes must be separate from the roles of oversight and regulation. The latter roles would be better accomplished by a body independent from the industry. This would address a number of other conflict of interest situations – such as the ones noted below.

3.1 Accreditation: conflicting roles

The Agency, as it is currently structured, has two conflicting roles - a regulatory function and an educative function. While it is beneficial to have a co-operative body assisting aged-care homes improve the quality of care provided, it is problematic when that body also performs a monitoring and assessing role and publishes the results of those assessments within the aged-care market place. Such a conflict of interest cannot be sustained and acts against the well-being of frail people in residential care.

Some facilities prepare for site audits or assessments with the help of outside contractors. Clearly, if the same contractors are retained by both the facility and the Agency then there may be an even further conflict of interest as the contractors are effectively working for two masters.

An example of this is where one consultancy, whose core business is in providing "*quality and legislative compliance services*", openly markets its links as an assessor, advertising its experiences as an assessor with the Agency. This might be seen by some as an implication that accreditation can be purchased.

We can envisage a situation where assessors working in a director's company would fear for their own jobs when assessing the aged-care homes owned by a colleague of a director – or when the reverse situation existed.

Some members of the Board of the Aged Care Standards and Accreditation Agency are active participants within the aged-care industry. A body charged with the important role of monitoring vulnerable people should not be governed by those who are, or are connected with, the subject of the oversight process. Even if there is no bias *there should not be a perception of bias*.

3.2 Measuring processes – and not the delivery of care

The current accreditation system does not adequately measure the delivery of care to frail Australians in our aged-care homes. The Agency concentrates on processes rather than on measurable adverse events. These often remain hidden.

Measurable levels of real care (performance) such as bedsores and weight loss are not recorded nor reported publicly. Instead the Agency refers to "indicators" and looks at whether processes are in place to prevent and treat these failures in care. Their success in doing so is neither evaluated nor reported. While these processes are important for improvement they are not the measures of performance which inform regulators, citizens or researchers.

Until it is recognised that the accreditation process (as it now stands), and the ability of a home to deliver compassionate and professional care to residents, are two fundamentally different things, then aged care will remain in the chaotic state that it is already in.

It is now possible for an aged-care home to pass accreditation and yet still provide poor care. We see many examples of this in incidents highlighted in the media¹⁸:



I have concerns about the level of nursing care and I believe that there is inadequate clinical input from RN (registered nursing) staff. I have discovered medication errors and have visited on two occasions in the last three weeks, in the morning, to find that only one RN was in the building which cares for 150 residents ...

Dr Bromberger

3.3 Undue emphasis on documentation

The most common criticism of the current accreditation system relates to the undue emphasis on documentation. ACC receives much feedback about the inadequacy of a system that depends on what is written rather than what is actually done.

A system which takes staff time away from residents in order to complete a myriad of bureaucratic tasks fails both residents and staff. Currently, documenting the minute details of a person's life seems to have become more important than actually helping them live their lives. Documentation and the keeping of records is an important part of care – as is developing well-formulated care plans. However, the current system is out of balance and the staff time spent on documentation rarely, if ever, appears to result in improved care.

For example, using staff resources to document and update resident classifications does not normally result in the provision of extra carers, nurses or other staff.

Much has been written in recent times about the malnutrition experienced by nearly 50 percent¹⁹ of nursing home residents. ACC questions the point of documenting a person's weight, diet and food intake in detail if there is neither the time, nor resources, to provide nutritious, tempting meals or the assistance required to encourage and assist residents to eat them.

3.4 Reports on homes: the Agency

Family members wanting to make informed decisions about a residential aged-care placement for their loved ones are often unable to do so. The vast majority of reports published on the Agency website are the cyclical, three year Accreditation site audits. These are the reports of planned visits, performed at a convenient time and after the homes may have spent months preparing for the audit.

Such reports tell us that the management of the aged-care home knows what it is supposed to do but gives little information about what happens on the other 1,093 days of the cycle. They may be nearly three years out of date for those seeking information about prospective homes.

¹⁸ Brisbane based [Dr Jenny Bromberger speaks out](#) (*Courier Mail*, 9 December 2009)

¹⁹ Residents in aged care facilities malnourished (Dietitians Association of Australia – 22 March 2010)
www.daa.asn.au/files/media%20releases/March_2010/MR-Aged%20Care%20Malnourished_March10.pdf

Research shows that 65 per cent of residents stay less than three years in residential care and, of those, 42 per cent stay between one and two years²⁰. As a result, many residents will enter and exit a facility without ever taking part in an accreditation audit. In other words, the quality of care they receive will not be assessed while they are alive to benefit from any improvement made as a result of the assessment.

Information arising from other activities carried out by the Agency, such as support visits, contacts, unannounced visits is not available. For example, if a non-compliance is found during an unannounced site visit, these details are not publicly disclosed nor subject to public scrutiny.

In order for frail, aged people to achieve full protection, the community must be able to see what the company or provider is capable of when no one is watching - not just when they have been given time to prepare for an inspection and not simply after providing a response to an adverse finding in order to stay in business.

Of the nearly 8,500 visits and/or reports made to an approximately 3,000 aged-care homes by the Agency and by DOHA in the 2007-2008 year, only the 517 accreditation reports were made publicly available. Approximately 90% of information is withheld from public scrutiny²¹.

3.5 Missing: responses by providers

The *Aged Care Act 1997*²² stipulates that a home's response to an adverse finding be made publicly available. In spite of this requirement, and contrary to the intent of the *Act*, responses can be made in a form which is not actually available to the public.

The Agency seems to openly encourage this practice within the sector. **The recent analysis by ACC, *Aged Care Report Card for 2007-2008*²³, revealed that not one single response was available for the year 2007-2008.** How a home responds to an adverse report is a critical part of understanding the practices and policies of that facility.

The publication of all relevant information is an essential part of achieving transparency. Privacy is an important consideration, but should not be used as an excuse or barrier to transparency and accountability – or as a way to protect those who are unable to protect themselves.

3.6 Missing: consumer input

Research has shown us that hospitals are safer and better when the consumer voice is heard. ACC asks why this does not occur in aged care and calls for more consumer input at all levels within the sector.

The accreditation process should be made much more consumer friendly – in particular by including consumer/carer advocates on every audit panel. Furthermore, managers of aged-care homes should ensure that there is an active resident/family member committee which is fully supported and not patronised.

²⁰ Residential aged care in Australia 2007–08 (*Australian Institute of Health and Welfare*)
www.aihw.gov.au/publications/age/age-58-10709/age-58-10709.pdf Table 3.9

²¹ Transparency in aged care: www.agedcarecrisis.com/transparency-accountability-disclosure/transparency-in-aged-care

²² *Aged Care Act 1997 - Accreditation Grant Principles 1999: 9.1 Publication of original decisions (2)*:
www.comlaw.gov.au/comlaw/management.nsf/lookupindexpagesbyid/IP200400954?OpenDocument

²³ Aged Care Report Card: www.agedcarecrisis.com/aged-care-report-card

ACC draws attention to the Community Visitor Program managed by the Office of the Public Advocate (OPA) in Victoria²⁴. Under this program, trained, volunteer members of the community make regular, unannounced visits to both government and privately funded residential accommodation facilities.

Under the provisions of the relevant legislation, community visitors are permitted open access to all documentation regarding residents, as well as all parts of the home and free discussion with residents.

The value of these unannounced visits is well documented in the Community Visitor's Annual reports²⁵. We urge a closer scrutiny of this system of community visiting which provides a further degree of monitoring of an aged-care system that is critical to the well-being of us all.

3.7 Missing: review of the accreditation process

In May 2009, DOHA announced a review of the accreditation process. The review received 147 submissions from a range of stakeholders. DOHA has not published those submissions on its website.

ACC had hoped that the review report would have been released in time for those making submissions to the Productivity Commission's Inquiry "Caring for Older Australians" to be informed by its findings. Fourteen months should have allowed this to occur.

3.8 Provider nomination of assessors

ACC is of the view that scrutiny of individual aged-care facilities requires independent assessment with well-defined and targeted expectations.

It appears that aged-care providers are currently able to influence the accreditation process in two ways. Firstly, an aged-care provider is able to nominate candidates (up to three) for a place on the assessment team which can, and sometimes does, consist of a single member. Secondly, an aged-care assessor must be approved by aged-care providers - a case of the accreditor being accredited by the accretee. As already stated, ACC calls for the inclusion of consumer advocates on all assessment teams.

3.9 Timing and preparation for inspection visits

ACC receives numerous complaints from aged-care workers and from the families of residents about the extensive notice given to providers prior to a site audit. As already noted, such advance notice does not give inspectors the opportunity to accurately review the life of the home on a daily basis²⁶. Families do not want to know how homes perform on special occasions. They are interested in having knowledge of day-to-day care.

Elaborate preparations are made by some providers prior to inspection. Staffing rosters are sometimes changed. In some instances, extra furniture is hired; fresh towels and linen are readily supplied.

²⁴ Office of the Public Advocate – Victoria: www.publicadvocate.vic.gov.au

²⁵ Community Visitor's Annual Report 2009: <http://bit.ly/bV8Qb0>

²⁶ The visitors are coming: www.agedcarecrisis.com/accreditation-a-nurses-perspective

For example:



... At my mother's nursing home, the week of accreditation was bizarre - the place was crawling with 'volunteers' (*staff off-duty with volunteer badges on*); putting on an outdoor barbeque for residents who haven't felt sunshine for the previous three years and probably won't again.

New furniture graces the hallways with elaborate artificial flower arrangements, while true volunteers who come daily (yes, daily) to feed at least six residents because they feel the need to help feed these people while the food is hot ...

We also draw attention to the fact that, to our knowledge, evening or weekend visits rarely occur – the very times where homes are known to have extremely low, even dangerous, staff resident ratios. **If visits at these times do actually occur, this information is not disclosed in published reports on the Agency's website.**

ACC welcomes the increased number of unannounced inspections but notes that some prior warning is given of these too.

Providers are also able to nominate “no go” dates and can block dates to give homes time to prepare for these unannounced inspections.

3.10 Inspections: lack of consistency

ACC believes that there is a lack of consistency in relation to inspections. We understand that such consistency is hard to achieve when inspections are occurring across Australia. However, it is difficult for the community to be assured of the quality of our aged-care homes when inspections of the same facility by different teams have widely differing results. We are aware of several instances where this has occurred.

For example, we note that the Agency site audit performed during the 9-11th September 2008²⁷ awarded a mice-infested home full accreditation. Only after adverse media attention did the Agency investigate the same facility in April 2009, which revealed mice plague conditions existed for months *prior to the site audit in September 2008*²⁸.

²⁷ Accreditation Agency site audit performed on 9th-11th September 2008:  <http://bit.ly/cLGlaw>

²⁸ Agency report of the investigation in April 2009:  www.agedcarecrisis.com/images/stories/KaringalNursingHome_ReportMouseInfestation.pdf

4 Complaints Investigation Scheme (CIS)

The current Complaints Investigation Scheme is the third complaints scheme for Australian aged care. Like the others, this one is embedded in DOHA. It is managed by the Office of Aged Care Quality and Compliance (OACQC). ACC believes that the current complaints scheme is as ineffective as the previous two.

ACC receives much feedback from complainants stating that their views are not heard and that evidence provided indicating mismanagement or neglect is often disregarded. This view has also been reinforced in the Aged Care Commissioner's Annual Report²⁹ and the recent review of the CIS.

ACC notes that the various conflicting interests affecting the DOHA have been mentioned by Professor Merrilyn Walton who chaired last year's review of the current complaints investigation process³⁰.



...it's very difficult for the department because it has so many conflicting interests
Professor Merrilyn Walton

A further issue is that it is possible for a home to breach responsibilities as an approved provider, as well as having serious complaints substantiated against the home, and yet avoid any public scrutiny. Under the current system, after a complaint has been investigated and found to be valid, aged-care homes are simply required to agree to make some amendments to policies and procedures.

Consumers need to be fully confident that the current scheme, and any future scheme, will protect the residents of our aged-care homes. Publishing the findings of the investigations of complaints is a critical part of providing that protection.

The CIS generally fails to provide any remedy to individual complainants or to resolve issues for residents. This is because it deals primarily with systemic defects in process and breaches of standards.

A resident may have suffered injury, their health may have been seriously affected or perhaps they may have been wrongly restrained. In such cases the CIS is entirely incapable of providing any satisfaction. An ordinary person with full rights would be entitled to seek redress and compensation. Frail aged residents have no such rights, despite the *Aged Care Act* inferring otherwise.

While residents still have their legal right to make a claim, there is scarcely a recorded case anywhere in Australia of such a claim being made. This is hardly surprising when they are fully dependent upon the very person or corporation responsible for their injury, and are faced with litigation that is financially and emotionally draining - even to the strongest among us.

²⁹ Aged Care Commissioner – Annual Report (2008-2009): www.agedcarecommissioner.net.au/pdf/08-09-annual-report.pdf

³⁰ Review of the Aged Care Complaints Investigation Scheme (Prof. Merrilyn Walton) – October 2009: www.agedcarecrisis.com/ReviewCIS21009.pdf

It is true that residents still have their legal right to make a claim, but considering the situation in which they live, fully dependent upon the very person or corporation which may have been responsible for their injury, faced with litigation which is financially and emotionally draining even to the strongest among us, it is little wonder that there is scarcely a recorded case anywhere in Australia of such a claim being made.

Frail aged residents in aged-care homes are not able to exercise their basic legal rights like other Australians. The community should find ways to bring legal resources to them when they are unable to travel, pay for, or otherwise have recourse to their rights. A possible way forward would be the accreditation of local and legally qualified people to act as arbitrators in appropriate cases.

Numerous reviews and audits have exposed the current, as well as previous Complaints Resolution Schemes as deficient and flawed³¹. These reports also reveal that aged-care staff who report neglect and abuse, remain largely unprotected.

4.1 The role of state-based advocacy groups

ACC notes the under-reporting of complaints in aged-care homes, as some complaints are made and resolved with relevant state-based advocacy organisations.

An analysis of the state-based advocacy organisations' websites indicates a lack of fulsome information. Information relating to their advocacy activities and the latest annual reports were either unavailable or difficult to access at the time of writing this submission. An exception was the Elder Rights Advocacy (ERA) organisation based in Victoria, which provided some useful information in their annual report regarding their activities³².

At the time of writing this submission, we note that ARAS³³ in South Australia provided some valuable information in their submission regarding their activities.

Whilst each advocacy group operates independently and may have its own specific state programs, there should be accurate and consistent information provided on the web sites of each state advocacy organisation. This would enable consumers to readily access information relevant to that state.

5 Aged Care Commissioner

The Aged Care Commissioner³⁴ oversees the operations of the CIS. Consumers may appeal against a decision or the way in which a complaint has been handled by the CIS. Although the Aged Care Commissioner can review the decisions made by the CIS, he/she has no power to overturn decisions. In some instances, DOHA has ignored the concerns of the Aged Care Commissioner³⁵.

Furthermore, ACC asks that careful consideration be given to the appointment of the Aged Care Commissioner. Not only should there be no conflict of interest in the appointment of those charged with ensuring our aged-care system is fair and equitable, but that there should also be the *perception that no conflict of interest occurs*.

³¹ Elderly abuse prompts Govt measures (ABC 7.30 Report – 15 Mar 2006): abc.net.au/7.30/content/2006/s1592672.htm

³² Elder Rights Advocacy (ERA) Victoria – Annual Report 2008-2009:
www.era.asn.au/pdf%20files/reports/RCR%20annual%20report%202008_2009%20web%2020.pdf

³³ Aged Rights Advocacy Service Inc (S.A.): www.pc.gov.au/data/assets/pdf_file/0019/100936/sub137.pdf

³⁴ Aged Care Commissioner website: www.agedcarecommissioner.net.au

³⁵ Thanks for the advice, but... (The Senior – 26 November 2008): www.agedcarecrisis.com/news/3345-thanks-for-advice-but

For example, it is essential that those who are adjudicating complaints about aged-care homes are not involved, and never have been involved, in the management or the ownership of aged-care homes.

It is of great concern that, according to the most recent Aged Care Commissioner's Annual Report³⁶, there has been an overemphasis on the documentation provided by aged-care providers and not enough on evidence provided by complainants. This view is substantiated by feedback from respondents to ACC. For that reason the Commissioner's power and authority is illusory.

6 Fear of retribution

Many of those who are dissatisfied with their care, or the care of a loved family member, fear that making a complaint will jeopardise their well-being or that of their relative. Staff who report deficiencies within the system or draw attention to incidents of neglect or abuse are frightened that they might lose their employment, have the number of shifts they work reduced or suffer other punitive consequences. ACC is aware of several incidents where this has occurred. Many staff choose to stay silent when they do, in fact, see the mistreatment of residents.

ACC is of the view that this is a critical issue which must be addressed as a matter of urgency. We note that when complaints are not dealt with early they are often compounded and relationships within the aged-care home deteriorate. We urge that much more be done to achieve resolution when issues are first identified.

7 Private equity in aged care

The primary focus of market listed entities is profitability. This is the reason that they enter the aged-care sector. Private equity groups now own a majority of private-for-profit nursing homes in Australia. These groups are aggressively focused on short term profitability. They are motivated to squeeze the system for profits so that they can sell and leave the sector³⁷.

Within this setting, managers distant from the coal face, make top-down financial decisions with little understanding of the consequences for the residents for whom they are ultimately responsible.

Caring for old, frail and vulnerable people is labour intensive. It requires an adequate labour force consisting of individuals who are well-trained and devoted to the task. Sadly, it is often those staff who seek to provide humanitarian and personal empathic care who leave the sector in frustration with their inability to provide that care when the prevailing culture of the home relates to cutting costs.

³⁶ Aged Care Commissioner - Annual Report (1 July 2008 – 30 June 2009):
www.agedcarecommissioner.net.au/pdf/08-09-annual-report.pdf#page=42

³⁷ Aged care money may be heading in wrong direction (The Age – 17 Sep 2007): <http://bit.ly/dDaoUW>

7.1 Private for profit: is care better?

A preliminary examination³⁸ of a sample of accreditation results in Australia suggests that when the differences between rural and urban results are taken into account, for-profit entities have a four times increased likelihood of failing at least one of the accreditation standards when compared with religious and community not-for-profit homes.

Although an increasing number of private-for-profit homes have entered the sector, there has been little, if any, hard data published by either DOHA or the Agency as to the quality of care provided by these homes – in comparison with those run by charity, community organisations and state governments.

Further support for the need for this evaluation to occur is provided by evidence of serious problems in private equity aged care homes in the USA resulting in government enquiries and tightened legislation³⁹.

7.2 Private for profit: simple as ?

The Australian community has seen the problems associated with the collapse of the privately owned ABC Learning Centres and how public funds were used to keep many of these centres viable. Yet we seem to have learnt very little from this⁴⁰.

There have been several recent instances where, as happened in the ABC Learning Centres⁴¹, aged-care homes have had to close because of mismanagement and lack of financial viability.



A frail grandmother failed to stave off eviction from her aged-care hostel despite a video plea posted on YouTube⁴². There are other examples of this occurring⁴³.

These closures have had detrimental consequences for frail, vulnerable people at the end of their lives. Being forced to transfer to another home, can be disorienting and traumatic at a time when stability and consistency are all important.

Caring for people who are at the end stages of life is a community responsibility. It should not be a means of creating profits for fund managers and distant shareholders at the expense of the care residents should be receiving.

³⁸ Aged Care Report Card: www.agedcarecrisis.com/aged-care-report-card

³⁹ More Profit and Less Nursing at Many Homes Sunday, 23 September 2007 10:00 *The New York Times*: Charles Duhigg: www.agedcarecrisis.com/news/2264-more-profit-and-less-nursing-at-many-homes

⁴⁰ Lessons of failed ABC Learning Centres ignored (ACC Media Release – 19 June 2009): <http://bit.ly/ck6AcV>

⁴¹ Private equity and the Australian aged care sector (ABC Radio National – 25 Sep 2007): <http://bit.ly/9jqiem>
ABC learning collapse is a policy failure (Crikey – 7 November 2008): <http://bit.ly/bFkUKi>

⁴² Dee Derrick's desperate YouTube message falls on deaf ears: <http://bit.ly/bfLAzH>

⁴³ Residents kicked out – Debt forces nursing home closure (22 December 2009): <http://bit.ly/dhSREq>
Berwick Village Aged Care shutdown (16 December 2009): <http://bit.ly/cy0arH>
Care home shut down (21 May 2009): <http://bit.ly/arZbeD>
Lifecare collapse's bitter taste (10 February 2008): <http://bit.ly/bhnsYH>

7.3 Residential aged care buildings

Currently, the entity owning the actual physical asset of the nursing home (bricks and mortar) has virtually no responsibility or accountability for the adequacy of the care provided at the facility. This has resulted in the actions (or inactions) of the landlord affecting the quality of care within the home.

Lack of security of tenure⁴⁴ adds additional stress to residents and their families at a time when stability is essential for their well-being.

For example, at times there may be restrictive clauses in the lease agreements that effectively prohibit the approved provider from making needed upgrades or renovations consistent with aged-care regulations. Other restrictive lease practices might make the implementation of physical or structural changes so onerous financially that it becomes prohibitive for the approved provider to even consider such changes.

8 Probity of aged care providers

ACC is concerned that there is no public disclosure when entities apply for approved provider status. Members of the community are neither encouraged, nor given the opportunity to object, to a particular provider or to supply information which might be extremely pertinent.

Giving those with knowledge, or with the time and interest to do research, the opportunity to provide additional information would minimise the risk that unsuitable providers might end up caring for frail and vulnerable people.

8.1 Approved provider status

The government has claimed that providers of aged care must be assessed to see that they are suitable before they are granted “approved provider” status. It has recently become clear that this is not the case⁴⁵.

Dr. Wynne has highlighted the fact that once a group attains approved provider status, that status can be transferred to any unsuitable individual or company that buys the holder of approved provider status. No assessment is required. This status becomes a commodity which is clearly of considerable commercial value to a company whose suitability may be questionable.

Probably very few of the private equity groups, banks and wealthy individuals who have taken control of our for profit nursing homes by acquisitions have had to gain approved status in their own right.

⁴⁴ At 111, oldest Aussie faces eviction (2 July 2006): <http://bit.ly/93f7dt>

⁴⁵ Dr Wynne: Will BUPA seek approved provider status? (Well, actually NO): www.corpmedinfo.com/bupa_approval.html

DOHA confirmed this in writing to Dr. Wynne on 20th February 2008 stating:



... As you are aware, an organization which acquires a controlling or significant interest in an organization that already has Approved Provider status is not required under the *Aged Care Act 1997* to apply for Approved Provider status. BUPA, therefore was not required to seek approval from the Department of Health and Ageing ...

*Dr Wynne – Responding to DOHA*⁴⁶

This is a glaring loophole in the regulations and places frail and vulnerable citizens at risk of exploitation by unscrupulous commercially focussed entities with little knowledge of the requirements of the frail aged or interest in anything other than the potential profitability of the sector.

Although some changes were made in December 2008⁴⁷, they have not properly addressed the issue as companies can still buy into the nursing home sector without having to seek approved provider status in their own right. In other words, the recent changes have been inadequate in dealing with the protection of frail and vulnerable citizens.

9 Accommodation bonds

The total value of bonds (*or the new industry favoured terminology “refundable accommodation deposits”*⁴⁸) held by aged-care homes is at \$8 billion (as at 30 June 2009). The Audit Office states that this figure is growing at about 25 percent a year. Accommodation bonds have increased from an average of \$58,400 per bond in 1998-99 to new bonds now averaging over \$190,000 each. This is an increase of 325% over 11 years.

ACC, along with most stakeholders in aged care, agrees that a secure and reliable method of funding of aged care must be attained. The first step in doing this must surely be to gain full knowledge about how current government subsidies are actually being spent as a basis for further deliberation. The second step is to consider all possible methods of funding.

If a further extension of accommodation bonds is to be considered then it is crucial that we have clear and concise legislation to protect consumers. This is currently not the case.

Most families are astounded to find that there is no limit as to the amount aged-care homes can charge, other than taking account of the assets of residents.

⁴⁶ Dr Wynne - Responding to DOHA: <http://bit.ly/9ScJxA>

⁴⁷ Dr Wynne: Overview of the Aged Care Amendment (2008 Measures No. 2) Bill 2008 Provisions: www.corpmedinfo.com/agereport2008.html

⁴⁸ Beware the “Grand Plan” for Aged Care (CPSA): www.cpsa.org.au/VOICE/article.php?id=521

The situation is now quite common where families are being forced to liquidate valuable long-standing assets in order to pay unreasonable bonds when their family member may only be a resident in a high-care home for a short period of time.



... I am sure we would think it very strange if we went into Harvey Norman to buy a heater and the salesperson asked us how much money we had before he answered the question ...

*Submission No. 58*⁴⁹

9.1 Are they *really* guaranteed?

When an accommodation bond is taken by an approved provider, the provider is obliged to issue a guarantee to the resident, confirming intention to repay when the resident no longer needs the service.

The term itself is misleading since a guarantee properly understood, involves three parties. In the case of a business loan for example, there is the borrower, lender and another party of substance, like a bank, or in cases of private loans, an adult or parent, as guarantor. The guarantee in this case is merely a second promise to repay the bond. The first promise is contained in the accommodation bond agreement itself.

Although the government is entitled to recover its losses through a levy upon other providers, the Australian National Audit Office⁵⁰ indicates this has not yet occurred, leaving taxpayers to pay.

As already stated, we have a similar situation with the spectacular collapse of ABC child care centres. Can (and should) taxpayers afford to keep paying for failed operators?

Not only are the residents' financial interests compromised by failed operators, but hard-working staff lose their entitlements due to collapsed providers.

This is yet another reason why the full transparency, accountability and disclosure of operators and funding must occur. A recent report by the Australian National Audit Office⁵¹ deplored the inadequate monitoring of \$8 billion in bonds lodged by nursing home residents.

Most consumers are unaware that the critical trigger for the guarantee system to operate is the occurrence of an insolvency event as defined under Section 6 of the *Bond Security Act*⁵².

The fact that an aged-care home has been placed into administration does not fall within the definition of an 'insolvency event' for the purposes of the Act. Should an insolvency event occur, recovery of the bonds still requires some vigilance, as previous consumers have unfortunately already discovered⁵³.

There have been several examples of companies that have mismanaged resident's funding as well as staff entitlements⁵⁴.

⁴⁹ Submission 58 (name withheld): www.pc.gov.au/data/assets/pdf_file/0009/100134/sub058.pdf

⁵⁰ Protection of Residential Aged Care Accommodation Bonds (Australian National Audit Office – 10 September 2009): www.anao.gov.au/uploads/documents/2009-10_Audit_Report_5.pdf

⁵¹ **Aged care residents may recover accommodation bonds – but not yet** (Slater and Gordon – 27 May 2008): www.agedcarecrisis.com/nursinghomes/accommodation-bonds

⁵² The Scheme is administered under the *Aged Care (Bond Security) Act 2006* and the *Aged Care (Bond Security) Levy Act 2006*: comlaw.gov.au/comlaw/management.nsf/lookupindexpagesbyid/IP200613906?OpenDocument

⁵³ Take heed – 2 years in the life of... www.agedcarecrisis.com/yoursay/2566-take-heed-2-years-in-the-life-of

⁵⁴ Aged care nurses face uncertain future (ABC news – 11 May 2010): <http://bit.ly/aYsqGv>

9.2 Cherry picking and bounty hunting

ACC is concerned about the increasing number of their correspondents who report that aged-care proprietors are rejecting some potential residents in favour of those who are able to pay larger accommodation bonds.

ACC notes that aged-care placement consultancies are being offered incentive payments to attract prospective residents with assets; and that staff are similarly rewarded for negotiating the largest possible accommodation bonds from them. The higher the amount procured from the family members/residents, the larger the bonus.

These practices may explain the difficulty some families experience when trying to locate a suitable bed – preferential treatment is given to a resident who has a capacity to pay a large bond. Such practices exploit the vulnerability of families at a time of great stress.

ACC also ask that the Productivity Commission require DOHA to publish bed availability on the Aged Care Australia website (Aged Care Home Finder)⁵⁵ – this would be easy and quick to implement as providers already have access to provide information on this website about their facility.

10 Staffing issues

10.1 Missing: doctors and geriatricians in aged-care homes

Aged-care residents, particularly those in high care, need ready access to a doctor – perhaps more than any other members of society - yet there is a shortage of doctors who regularly visit aged-care homes. Ideally there should be a team of doctors with an interest in aged care working under the supervision of a geriatrician. They should be responsible for the care received and supervise and intercede when problems occur. Furthermore, visiting clinicians need a suitable, private area to examine and treat patients.

ACC notes that the Australian Medical Association has been vocal about these deficiencies⁵⁶ and therefore adds a further voice to stress the importance of this issue.

While providing evidence at a recent coroner's inquest, one concerned clinician, Dr Tideman, made the point, that the support for nursing home patients by general practitioners in South Australia is simply not adequate.

⁵⁵ Aged Care Australia – Aged Care Home finder
www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/aged+care+home+finder?OpenDocument&type=1

⁵⁶ More aged care beds welcome, but medical care for older Australians ignored – 1 Aug 2010: ama.com.au/node/5916

Dr Tideman expressed the view that:



... It's deplorable, in my view; absolutely deplorable that we are not in this State able to provide good general practitioner services that don't rely on locum services to our residential aged care. And therefore the acute setting – the acute hospitals, like my hospital – then becomes the first line for sick elderly patients who do not need to be in a hospital and, in fact, care can be compromised by them coming into a hospital⁵⁷...

Dr Tideman

10.2 Poor access to Allied Health Services

For many older persons, a small functional gain can mean a significant improvement in quality of life. Greater access to services such as physiotherapy, speech pathology, dietary advice, music therapy and occupational therapy must occur if we are serious about providing high level, holistic care.

Correspondents to our website regularly report the rapid deterioration of their family member's functionality after they are admitted to an aged-care facility. Hard-pressed care staff, for example, are generally unable to spend the time assisting with mobility. Many residents, who are able to walk on entry to a facility, soon lose this ability. Physiotherapy services, for example, not only focus on mobility but provide oversight and support to less trained staff.

Recently some publicity was given to the benefits of music therapy for people at the end of life. Yet very few homes provide this important service⁵⁸.

10.3 Staff resident ratios

Many people who contact ACC are shocked to learn that there are no mandated minimum staff/resident ratios in aged-care homes across Australia. The *Aged Care Act 1997* has little to say about staffing. In fact, only two lines are allocated to this, the most vital aspect of care provision: *that there must be "an adequate number of appropriately trained staff"*.

As a direct consequence of this lack of required standards in staffing, managers who are under pressure to meet their profit targets, do so by reducing staff – putting frail older people at risk.

ACC has been informed of ratios as low as one carer to 80 residents. We have mandated staffing levels in childcare centres, kindergartens, schools and hospitals. They, too, cater for people with different levels of need in different locations, but still manage to set a safe, minimum staff to client ratio.

This lack of mandated minimum staff/resident ratios has seen the exodus of experienced nurses from aged-care homes – particularly private-for-profit homes. Those staff who remain find that they can no longer meet their responsibilities to residents in the available time and resident care is compromised.

⁵⁷ Finding of inquest by Mark Johns, State Coroner (South Australia) - 3 June, 2010: www.courts.sa.gov.au/courts/coroner/findings/findings_2010/Promnitz_Aileen_Dawn.pdf

⁵⁸ Alzheimer's and dementia: the power of music (ABC Radio National – 2 April, 2010): www.abc.net.au/rn/nationalinterest/stories/2010/2859359.htm

Prior to the introduction of the *Aged Care Act 1997*, a fixed percentage of funding received by owners of aged-care homes was dedicated to care - including the salaries of nursing staff⁵⁹. Funding could not be diverted to non-care staff, to capital maintenance or to profit. This requirement was removed under the *Aged Care Act 1997*⁶⁰.

10.4 Adequately trained staff

In every hospital coronary care or intensive care unit, staff specially trained in that area, ensure that high standards of care are maintained. The same principle should apply in aged care. More specialty trained staff are urgently needed within the sector. To be effective, this commitment to training must encompass continuing education and ongoing professional development.

ACC is dismayed to see the continuing reduction in the numbers of registered nurses who work in aged-care homes. More and more homes now rely on having a registered nurse on call rather than on site. This is despite the fact that the level of care needed by residents is higher than ever before.

It is also of considerable concern that the sector now relies, to a large extent, on the employment of inexperienced carers, some of whom have poor English language skills and who are unable to communicate effectively with residents. ACC believes that all those employed to care for frail vulnerable people should be able to fully understand the training they are given and the instructions from supervisors. They must also be able to read and understand case notes and care plans and accurately write these themselves, when required.

10.5 Parity with the acute sector

ACC draws attention to the lack of salary parity between those nurses who work in aged care and those within the acute sector. It is well known that, on average, aged-care nurses receive 20 percent less pay than their colleagues in acute care. This inequity is one of the prime reasons for the current staff shortages in aged care and the reliance on agency and casual staff – with detrimental effects on the quality of care received by residents. People at the end of life require skilled and consistent care – not piecemeal and makeshift staffing arrangements.

10.6 Poor clinical care

The ongoing reduction in the numbers of registered nurses has had a significant impact on the quality of care being provided in aged-care homes. This is one reason why residents must be placed in hospital when they require treatment for even minor complaints. ACC receives much feedback from carers about the increased responsibilities that they are given and for which they may have no, or insufficient, training⁶¹. Correspondence published in [Appendix 2: Feedback](#) is evidence of this.

⁵⁹ Pensioners respond to nursing home crisis: (APSF, 3 April, 2000): <http://bit.ly/bGVC14>

⁶⁰ Aged care deregulation by stealth (The Australian, 8 March, 2000): <http://bit.ly/aLnU06>
Nurses in the Aged Care System (Dr Wynne) – re: **Deregulation**: www.corpmedinfo.com/nh_nurses.html

⁶¹ A failure of care – elderly patient loses leg after undetected break (*The Sunday Mail*, 25 July 2010): <http://bit.ly/d2WiKF>

11 Technology in aged care

Health and aged care have been poor cousins in the spread of technology. They have languished behind for far too long. Doctors are still required to type in, or hand write notes - a system that makes it difficult to collect and analyse information. We live in an era of WIFI, touch screens, buttons and sliders. There are screens you can write on in long hand. Most health professionals and carers use a wide range of technology as part of their daily life at home – computers, iPads, eReaders, digital Phones and TVs. Yet, at work in aged care, modern technology is largely unavailable.

Every activity and pill given can be recorded by touching a button, a value by using a slider and any qualifying comments can be written in long hand and attached. A time code ensures an accurate record and changes will also be time coded. Record keeping becomes accurate and collection and analysis can be done automatically.

Simple call lights can send on and off signals to a computer and be logged. This is one of the most sensitive measures of care, particularly when set against the tap on the screen recording what was done in response. It is simple to do.

This is all information that any nurse manager would want to help organise staff and supervise care. It is the sort of information that any oversight body would require. Not once a year random observations but a day-by-day record of what is happening, collected, correlated and reported.

None of this is rocket science. It is here now, affordable and practical. It simply needs to be developed and applied.

There are currently systems in place to collect data from aged-care providers. An improved, centrally managed online system should be developed in order to provide the benefits listed below.

1. **Prevention of the duplication of IT efforts and money.** This would save the outlay on individual and expensive bespoke systems, as well as ensuring uniformity and consistency of data collection.
2. **Minimum effort for all staff working in the sector.** A global system would mean that any staff working or moving location within the aged care sector would already understand how to use the system - leaving more time to care for residents.
3. **Reliable data and statistics.** Reliable data relevant to aged care is currently lacking. This system would enable the collection of data into a central system – thus producing some meaningful statistics and information about people residing in aged-care facilities across Australia. This could also be used to inform studies and research.

12 Ageing in place

In 1997, the Federal Government introduced its “ageing in place” policy which allows residents of low-care homes to remain within that home – even when their care needs have been assessed as high care. ACC supports the rights of frail residents to stay in a home to which they have become accustomed. However, feedback to our site indicates that there are many instances where this policy is being exploited. People with high-care needs require enough staff to provide this higher level of care. Too often this does not happen and staff struggle to maintain the level of care required by these high-care residents.

13 ACAT: assessments

Australian Government expenditure in 2008-09 for the **Aged Care Assessment Program (ACAP)** was \$74.5 million, which included recurrent funding for Aged Care Assessment Teams (or ACATs). In 2008-09, 116 Aged Care Assessment Teams operated nationally, to assess the care needs of frail older people and help them to find services to meet their care needs. A person must generally be assessed by an ACAT before they can access aged care services provided under the *Aged Care Act*.

13.1 When “high care” really means “low care”?

ACC are aware of instances where an Aged Care Assessment Team (ACAT) has assessed a resident as “high care” - only to have this decision overruled by the approved provider and re-classified as low care.

There may be, in some instances, a significant appeal for assessments to be made that produce an outcome which necessitates payment of an accommodation bond. Under current legislation, nursing homes can only request bonds from low care residents or high care extra service.



... DOHA reinforces there is no actual requirement in the *Aged Care Act 1997* for the assessment to be done by an ACAT under the ACAP. Accordingly, the Provider has the final say, not the ACAT assessment team!

The fact that the Department’s budget funds 116 ACATs⁶² across Australia and they are intended to make the final assessments independently, is apparently no longer of importance to DOHA.

Perhaps though, they should tell the Parliament they have abandoned the idea of independent assessment before they next ask for money under ACAP?

What a relief for taxpayers. No more ACAPs – its do-it-yourself for Providers! ...

*Rodney Lewis, Legal Issues Columnist, Aged Care Crisis*⁶³

⁶² Report on the Operation of the *Aged Care Act 1997* – 1 July 2008 – 30 June 2009:

[www.health.gov.au/internet/main/publishing.nsf/Content/05554311F10CBEC3CA25767800189A30/\\$File/ROACA09.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/05554311F10CBEC3CA25767800189A30/$File/ROACA09.pdf)

⁶³ Aged Care Crisis - Legal Issues Column (Rodney Lewis): www.agedcarecrisis.com/legal-issues-column

14 In-home care

ACC supports the increased provision of 'home-based' services for frail, aged people. One of the major issues is the current lack of supervision to ensure that the care provided is of an adequate standard.

Furthermore, the practice of an original contractor sub-contracting care⁶⁴ to another group whose staff may not have the required training places some frail aged at risk and is of great concern.

14.1 Community Aged Care Packages (CACPs)

In 2008-2009, the government spent \$479.7 million on CACPs. As at 30 June 2009, there were a total of 40,195 CACPs being provided to frail older people who choose to remain living at home with support, and who would otherwise be eligible to receive at least low level of residential care.

There were also 6,514 **Extended Aged Care at Home (EACH)** and **EACHD (EACH Dementia)** packages for people with complex needs requiring high level care and who have expressed a preference to live at home. The EACH program is worth approximately \$43,000, and the EACHD is worth nearly \$48,000 a year. The Government spent a total of \$256.3 million on EACH and EACHD packages for 2008-2009.

These care packages are allocated to approved providers, yet there is no accountability or statistical data available as to how many hours have been actually delivered to care recipients. There is no evaluation and no mechanism to determine how effective the dollar allocation has been or how satisfied consumers and their family caregivers have been.

14.2 The issue

The ACC is aware of serious concerns about the operation of the various aged care packages in the community. It has been in frequent communication with one member of the community who investigated these matters when he found that only \$15,000 of the \$48,000 EACH package allocated for his mother's care was being spent on that care⁶⁵.

He indicated to ACC:



... the best I could ever manage was \$15,000. Now, administration, case management and contingency costs claimed the \$33,000 on paper, but in reality I don't think so. Most of that money goes into what I deemed to be a "residual" that remains with the organisation and I think a lot of organisations maintain... and by law - as I understand it - organisations can retain any leftover money. It doesn't go back into consolidated revenue...

George Vassiliou

His request to administer the funds himself was initially denied but he persisted and eventually discovered that he was able to secure the care his mother needed – more than double what she would otherwise have been given through a pilot scheme run by an approved provider.

⁶⁴ Untrained workers put aged at risk (The Courier Mail, 21 June 2010): <http://bit.ly/biAQ01>

⁶⁵ Aged care warrior takes on the system (ABC Radio – National Interest, 8 Aug 2008) www.agedcarecrisis.com/news/3061-aged-care-warrior-takes-on-the-system

He paid a 10 per cent administration fee to the provider (the fund manager), which handled the money, and one hour a month of case worker fees. The rest went to pay the person who cared for his mother

ACC believes that, while the exact figures are impossible to obtain, the concerns are well founded and urges the Productivity Commission to closely examine the expenditure on community packages to determine how these funds are spent, and to set in place a system that establishes accountability, transparency and community oversight of funding and care as integral components of the services.

ACC is particularly concerned that:

1. Funds intended to relieve pressure on aged-care homes by caring for older people at home are not being used for that purpose – resulting in some individuals seeking residential care.
2. That funds allocated for care are being diverted into profits or else to fund other activities.
3. There is little transparency in regard to the way the money is spent and minimal, if any, oversight of the quality care provided.

14.3 The residual

The provider is not required to hand back unspent moneys. Any money left over remains with the provider as profit. Our informant supplied us with DOHA's response to his concerns about this:



Approved providers of community and flexible care under the *Aged Care Act 1997* are paid a subsidy in respect of each allocated Community or Flexible care place for which there is an approved care recipient receiving care. By definition a subsidy is a contribution towards the cost of providing care. Other contributions might include fees paid by care recipients or other funds available to the organisation.

Approved providers may be charitable or for profit services. The Government **does not mandate levels of profitability** but instead expects providers to deliver the appropriate levels of care according to the needs of care recipients.

*Extract letter to George Vassiliou from Department of Health and Ageing⁶⁶
11 August 2008*

The residual may be seen as an incentive for providers. Whether that incentive is reinvested into the organisation or taken out as profit or redirected to other activities is not known.

It is disappointing that, to date, DOHA has shown little interest in finding ways to ensure that the majority of the funding is directed to its prime purpose – that of providing the care that enables frail older people to remain in their own home. The retaining of the residual impacts on the quantity or standards of care provided. In addition, the funding of community organisations like the Aged Rights Advocacy Service Inc⁶⁷ (ARAS) that assist families and residents when they are dissatisfied about the services provided has been progressively reduced - forcing them to reduce staff.

Sadly, many community groups that depend on government funding have learned not to rock the boat by being pro-active and criticising the system for fear of further reduction in funding.

⁶⁶ Letter to George Vassiliou from DOHA – 11 Aug 2008: www.agedcarecrisis.com/DOHA-Letter_11Aug2008.pdf

⁶⁷ ARAS (Submission no. 137): www.pc.gov.au/data/assets/pdf_file/0019/100936/sub137.pdf

14.4 Waiting for care

ACC understands that making arrangements to meet with clients and their family caregivers takes time, but finds it unacceptable that a professional organisation can take up to three, and sometimes more than, three months to set up a program of care. There are some questions that should be asked relating to the intent of this delay. The concept of the residual is a likely factor driving organisational thinking to keep as much of the fund un-allocated or unspent at the end of the reporting period. This then becomes part of the 'residual'. Ostensibly, the residual should be used for training of staff and improving organisational access to equipment. But how many dollars are allocated to these claimed uses?

Once again, the lack of transparency and disclosure leaves consumers and taxpayers wondering how their monies are being spent.

14.5 Subcontracting or outsourcing care

We understand that, in most cases, the care is not actually provided by the recipient of the funds. Instead it is subcontracted to another group that employs staff to provide the care. They in turn take their profit from the \$15,000 remaining before employing those individuals who actually do the work and who are often paid at very low rates.

14.6 Consumer Directed Care (CDC)

"Consumer Directed Care"⁶⁸ (CDC) of aged care in the community is a misnomer. It should be "Provider Directed Care" as the consumer has very little input into management or control of the money.



Under the *Act* only Approved Providers with an allocation of either Community Care or Flexible Care places can receive subsidy for these programs.

Extract letter to George Vassiliou from DOHA⁶⁹ - 11 August 2008

ACC is not aware of any major funding for agencies to promote consumer control. The larger agencies and fund holders are the drivers of this concept. Inevitably what happens is that rules are developed that suit their interests. The system therefore, is very much one sided.

This focus on the needs of providers is widespread as is shown in the recently released Community Care Charter 2009. Aged-care advocacy groups have complained about the lack of input into the completed charter⁷⁰. A recent letter to the Prime Minister highlighted the issues consumers confront with the current system of CDC⁷¹.

⁶⁸ Consumer Directed Care (CDC) in Australian Government Funded Community Aged Care (page 16): www6.health.gov.au/internet/main/publishing.nsf/Content/ageing-cdc-demonstration.htm

⁶⁹ Letter to George Vassiliou from DOHA – 11 Aug 2008: www.agedcarecrisis.com/DOHA-Letter_11Aug2008.pdf

⁷⁰ ARAS - Submission no. 137: http://www.pc.gov.au/data/assets/pdf_file/0019/100936/sub137.pdf

⁷¹ Letter to the Prime Minister from George Vassiliou – 19 Aug 2010: www.agedcarecrisis.com/yoursay/4062-letter-to-pm-consumer-directed-care

It disturbs ACC that, in a system which empowers the providers rather than the community, DOHA expects the disempowered recipient to negotiate administration fees with the provider. The higher the administration fee, the less care can be provided.⁷²

ACC urges the Commissioners to review Dr Wynne's submission⁷³ where a range of suggestions were made which would bring a real balance of consumer direction and input into aged care.

14.7 Conclusion

A true CDC system should focus on the care and provision of support for individuals and their family caregivers. Reduction of unnecessary administration and case management is an imperative. Family caregivers desire more dollars going to direct care.

For example, case managers could be employed by groups such as the Aged Rights Advocacy Service Inc (ARAS). If the Commission advises the creation of a community based organisation, along the lines suggested by Dr Wynne, then this body would be well placed to do this. The same organisations would be able to monitor the provision of the services.

15 Retirement villages

We note that this is covered in detail in Dr Wynne's submission and web site, as well as various other submissions to this and previous inquiries⁷⁴. We urge the Commissioners to review laws to protect consumers from unfair practices, which are well documented in the media, Dr Wynne's website⁷⁵, court transcripts and more recently, on our web site⁷⁶.

⁷² (CDC) in Australian Govt. Packaged Care Programs 2010-2011 – Information on CDC Packages: <http://bit.ly/dBjA1U>

⁷³ Dr J.M. Wynne - submission 368: www.pc.gov.au/data/assets/pdf_file/0016/101914/sub368.pdf

⁷⁴ Retirement villages in Australia (Dr Wynne): www.corpmedinfo.com/retirevillages.html

Submission 89: Neville Carnegie: www.pc.gov.au/data/assets/pdf_file/0013/100372/sub089.pdf

Village victims - ABC - Stateline (9 July 2010): www.abc.net.au/news/video/2010/07/09/2949825.htm

Retirement villages: Good or bad? (Neville Carnegie): www.agedcarecrisis.com/retirement-villages

A tale of two retirement villages (Neville Carnegie): agedcarecrisis.com/retirement-villages/a-tale-of-two-retirement-villages

⁷⁵ Retirement Villages in Australia – Dr Wynne: www.corpmedinfo.com/retirevillages.html

⁷⁶ Retirement Villages – Good or bad? – Neville Carnegie: www.agedcarecrisis.com/retirement-villages

Recommendations

16 Recommendations

1. Funding, roles and responsibilities

- (a) That a full and independent analysis of the cost of care, including community care, be carried out in order to set appropriate benchmarks to guide the level of aged-care subsidies provided by the government.
- (b) That the departmental roles of funding and providing aged care be independent from the role of complaint investigation, monitoring and oversight of aged-care homes.
- (c) That a separate and fully independent body carry out the role of complaint investigation, oversight, evaluation and regulation.
- (d) That the accreditation agency continue its educational role, working closely with providers to ensure that the processes and procedures required to maintain high standards of care are in place.

2. Transparency, accountability and disclosure

- (a) That there be regular, systemic reporting of the work of the CIS to the general public.
- (b) That there be full transparency and disclosure about all aspects of aged care - including how government-funded aged-care subsidies are spent. Consumers should have access to all information relating to the operation of aged-care homes and to all aspects of the care provided.

3. Accreditation, oversight and regulation

- (a) ACC recommends a full review of the accreditation and monitoring of aged-care homes with a view to separating the processes of education and oversight. The following further recommendations are suggested as key points of focus for such a review.
- (b) That the system of accrediting aged-care homes be reviewed with the purpose of focussing less on written documentation.
- (c) That the standard of care that is actually delivered be measured.
- (d) That each audit panel has a consumer representative.
- (e) That every aged-care home has a residents' committee which is **independent and fully supported by the management of the home and** where residents and family members can contribute to the policies and practices that occur within that home.
- (f) That extensive warning not be given prior to the regular cyclical audits carried out by the Agency or for visits by any other oversight body.
- (g) That the standards measured reflect current community standards and are based on measurable outcomes relating to the actual care and health of residents.
- (h) That weekend and night inspections of aged-care homes occur on a regular basis – and that the timing of visits be recorded in reports.
- (i) That no warning be given prior to unannounced inspections.
- (j) That the results of all visits be published and remain available so that consumers have ready access to all relevant information and do not have to rely solely on the reports of cyclical, three year audits which are very often out of date.
- (k) That providers be required to publish their response to adverse findings.

Recommendations

4. Complaints Investigation Scheme (CIS)

- (a) That the body which investigates complaints be independent from the Department of Health and Ageing.
- (b) That activities undertaken by state-based advocacy organisations be documented and incorporated into the Annual Report of the Operation of the *Aged Care Act 1997*.
- (c) That there be full disclosure about all **substantiated complaints** made against a home and how those complaints were resolved.
- (d) That there is a system available under the *Aged Care Act* by which residents have recourse to appropriate compensation when they have been injured or have suffered some loss because of something the Provider or its employees have done or have not done.
- (e) That all complaints (both those submitted to the aged-care home and those submitted to the CIS) should be registered via a central call centre or a designated web site and allocated an ID number.

5. Aged Care Commissioner

- (a) That the Office of the Aged Care Commissioner be independent from the DOHA and that recommendations by the Commissioner be actioned.
- (b) That there should be no apparent, or perceived, conflict of interest evident in the appointment of the Aged Care Commissioner.

6. Fear of retribution

- (a) That full protection be provided to those who report neglect and abuse in aged-care homes.

7. Private equity in aged care

- (a) That all data regarding the performance and quality of care in homes owned by private-for-profit groups be compared with those run by charity and community organisations and made publically available.

8. Probity of aged care providers

- (a) That **all parties** who seek to have any part in both owning and managing an aged-care home be required to submit to the full approved provider process.
- (b) That, where there are expressed concerns about the suitability of a provider and yet approval is, in fact, granted the rationale for this decision be made public.
- (c) That approved provider status not be subject upon purchase.

9. Residential aged care buildings

- (a) That there be an increased focus on the landlord as well as the approved provider, that all lease provisions and other aspects of ownership are transparent and that lease agreements are compliant with conditions of participations and breaches are addressed.

10. Bed allocation (licenses)

- (a) That the names, details and business record of every applicant for aged-care beds and approved provider status be made available on a website in order to allow feedback to DOHA from community members.

Recommendations

11. Accommodation bonds

- (a) That bond amounts, like other retail items, be set and stated up front.
- (b) Consumers should not be subjected to bond disparity of hundreds of thousands of dollars when paying for the same item/service.
- (c) That there be full disclosure of all aspects of accommodation bonds and that related accessible information be made freely available.
- (d) That providers be fully accountable for the safe management of accommodation bonds and that there be full disclosure on how and where the bond money is invested.
- (e) That the Government apply the provider levy to repay accommodation bonds and not use taxpayers' monies to refund unpaid bonds.
- (f) That any payments/percentages/bonuses made to either internal or external consultants for procuring accommodation bonds from prospective residents be declared to that resident and be publicly disclosed.

12. Staffing issues

- (a) That all residents of aged-care homes have access to the full range of allied health services necessary for their basic health and well-being, including physiotherapy, occupational therapy, music therapy and dentistry.
- (b) That the *Aged Care Act 1997* be amended to require safe, mandated minimum levels of staffing.
- (c) That all aged-care homes be required to have a registered nurse on duty at all times.
- (d) That all aged-care homes be required to invest in ongoing staff training.
- (e) That aged-care nurses receive salary parity with those nurses who work within the acute sector.

13. Technology in aged care

- (a) That a centrally developed and managed online system for all aged-care homes be implemented.

14. Ageing in place

- (a) That further checks should occur to ensure that residents with high care needs who remain in low care homes as part of the 'ageing in place' program actually receive the extra care they need.

15. ACAT: assessments

- (a) That provider input should not predominate when assessing eligibility for high care subsidies for residents.

16. In-home care

- (a) That data be made available as to the hours of care actually delivered to clients who receive packages for in-home care.
- (b) That there be full disclosure of all administration costs associated with in-home care.
- (c) That sub-contracting in-home care not be permitted.
- (d) That quality assurance measures be put in place for all in-home care and that all staff who supply that care be required to have set minimum qualifications.
- (e) That every recipient of care (and/or their family carer) be supplied with a detailed 6 monthly statement of account detailing the expenditure of the funds allocated to their care. .

Recommendations

17. Consumer Directed Care (CDC)

- (a) That when the CDC model of care is implemented then special care be taken to ensure that all parties have equal participation in working out the specific arrangements.
- (b) That funds be allocated to Advocacy organisations to promote this model of care as an option and to assist in the implementation and that further funding be made available to educate potential consumers about the model as well as the requirements for it to function effectively.
- (c) That consumers and their family caregivers wishing to take up the CDC model of care have an orientation program provided at time of assessment.
- (d) That the CDC model have a framework developed so that minimum standards are adhered to for the provision of support to the frail older person as well as to the care staff employed.
- (e) That in order for a true CDC model of care to become fully operational then legislation be changed to allow for funds to be directly transferred into consumer bank accounts.

Recommendations

17 In conclusion

ACC believes that caring for frail, older people is a collective responsibility which guards and protects the welfare of one of the most vulnerable groups in our society.

This view is at odds with current policies whereby aged-care services are open to the market economy, and frail old people become customers who, in theory, but not in reality, are able to pick and choose from a range of commercial providers. We therefore deplore the current move towards placing the well-being of our family members at the mercy of market forces.

However, if Australians facing the end-of-life are, in fact, to be placed in the hands of corporations and private equity firms, the very least they can expect is to have rigorous systems in place to ensure their physical and financial protection. This is currently not the case.

It is our view that a review of the *Aged Care Act (1997)* and related principles is long overdue.

We are aware that Dr Michael Wynne is making a submission⁷⁷ in regard to providing greater community involvement and participation in aged care – which we also support. The whole community has a stake in a system that cares and protects vulnerable people at the end of life. One that lurches from crisis to crisis leaves everyone wanting.

ACC would like to acknowledge Rodney Lewis⁷⁸, our Legal Issues Columnist, for his advice and contributions to our submission.



It is time now for the reform of aged care. The solutions required are not rocket science.

They include the meaningful involvement of politicians and health bureaucrats with consumers and relevant health professionals.

They include looking again at the framework for policy – our aged-care legislation and related principles.

And most importantly, they include acknowledging that the care of vulnerable people at the end of life is a responsibility that belongs to all of us.

Aged Care Crisis

⁷⁷ Dr J.M. Wynne - submission 368:  www.pc.gov.au/data/assets/pdf_file/0016/101914/sub368.pdf

⁷⁸ Rodney Lewis (Legal Issues Columnist - Aged Care Crisis): www.agedcarecrisis.com/legal-issues-column

Recommendations

18 Appendix 1: Links

Below are a series of links to articles which demonstrate the significance of the issues raised in this submission.

- **Beware the Nursing Home Industry's 'Grand Plan'** (CPSA - 19 July 2010):
(Combined Pensioners and Superannuants Association of New South Wales Inc. [CPSA]):
www.cpsa.org.au/MAIN/srelease.php?id=176
- **Oh no! Not another aged care inquiry – but this time it might really matter:**
(Dr Wynne) www.corpmedinfo.com/agereport.html
- **Aged care deregulation by stealth** (The Australian, 8 March, 2000): <http://bit.ly/aLnU06>
- **Pensioners respond to nursing home crisis:** (APSF, 3 April, 2000): <http://bit.ly/bGVC14>
- **Australia's ageing aged care system** (ABC Radio National - Peter Mares): 29 May 2009
www.abc.net.au/rn/nationalinterest/stories/2009/2583237.htm
- **Nursing Home Transparency:** www.agedcarecrisis.com/nursinghomes/transparency
- **Ageing Bonanza:** www.agedcarecrisis.com/nursinghomes/ageing-bonanza (Dr J.M. Wynne)
- **Elephant in the room:** www.elephantintheroom.com.au
Elephant In The Room is a nationwide awareness campaign on behalf of The Australian Wound Management Association (AWMA) that seeks to draw attention to the serious problem of chronic wounds a condition that affects of 270,000 Australians today.
- **Regulating nursing homes: The challenge of regulating care for older people in Australia**
(John Braithwaite, BMJ 2001):
 www.anu.edu.au/fellows/jbraithwaite/documents/Articles/Regulating_Nursing_2001.pdf
- **Behind open doors – A Construct of Nursing Practice in an Australian Residential Aged Care Facility:**
[PhD -Anita De Bellis, Lecturer, Flinders University, South Australia]:
 catalogue.flinders.edu.au/local/adt/uploads/approved/adt-SFU20061107.122002/public/02whole.pdf
- **Elderly abuse prompts Government measures** (ABC 7.30 Report – 15 March 2006):
www.abc.net.au/7.30/content/2006/s1592672.htm
- **End of the line** (ABC – 4 Corners, 1 June 2009): www.abc.net.au/4corners/content/2009/s2584582.htm
The ABC's 7.30 Report has exposed the Complaints Resolution Scheme as deficient and flawed. The report also revealed that aged-care staff who blow the whistle on neglect and abuse, remain largely unprotected. ([Feedback forums](#) to 4 Corners program)
- **Consumer participation in accreditation - Resource Guide** (Consumer Focus Collaboration)
 www.healthissuescentre.org.au/documents/items/2008/08/226136-upload-00001.pdf
- **Dear Minister Roxon:** www.agedcarecrisis.com/yoursay/3908-dear-minister-roxon
The following letter was sent by a concerned daughter whose mother currently resides in a nursing home, to Minister for Health and Ageing Nicola Roxon, in an effort to raise their concerns about lack of staffing ratios and skilled staff working in aged care, as well as the lack of care. As well as providing a first hand view of these issues, the author has also provided some practical views on resolving those issues. The following is only an excerpt:
- **Visiting is vital:** www.agedcarecrisis.com/visiting-is-vital

19 Appendix 2: Feedback to Aged Care Crisis

Please note that the following extracts of emails and letters are a small collection only, sent to Aged Care Crisis from:

- Daughters, sons and relatives, who have personal experiences with residential aged-care facilities and hospitals within Australia
- Staff training, working, or who have been disillusioned with aged care within Australia and have since left;
- Staff working in aged-care homes across Australia and who are concerned about the current accreditation process.



Lack of information

“ The Minister for Ageing announced on the 1 July 2009 that a new register was available on the Department of Health and Ageing website which displays the number of non-compliances found for each aged-care facility. This initiative however, does not reveal any of the breaches found by the Department of Health and Ageing's Aged Care Complaints Investigation Scheme (CIS), the main body to whom complaints are made.

I only found this out when I found that my mother's Hostel, which had a finding of 3 breaches of the *Aged Care Act* against it by the CIS in May 2009 following a complaint of mine, showed a clean record on the new website register.

I find this particularly concerning for prospective aged care residents and families who are deciding on options for the best care



What I find on my “unannounced visits”

“ On my last three visits (last 3 days) I have found my mother lying on the floor of her room or bathroom and crying. Her door was closed and no-one in sight.

She was wet - I initially thought perhaps from the bathroom floor, but no, **her continence pad was so full with urine it was pulling her clothes down.**

Her hearing aid had been plugged in her ear with no battery and her hair hasn't been washed for 10 days now. This is what I find with my unannounced visits.



Cold, wet and soaked in urine

“ I visited my mother tonight and on her blue princess chair, in the bathroom, was a pillow she had obviously sat on all day. The pillowcase was drenched in urine. I had a pillow protector on it and when I took it off, I found that the urine had soaked through into the pillow as well. I took the whole lot home to wash as well as one of her sheepskins to have dry cleaned. It was disgusting.

To think that she had to sit in that all day long is really revolting. To leave someone like that and then to leave that pillow in her bathroom is just awful. It stunk badly. So humiliating for my mum. How uncomfortable to sit in urine like that all day, especially during winter. It is just cruel. It is unacceptable in our society to allow this to happen. It is inhumane.

Tony Abbott said the Liberals would throw money at Aged Care by opening more beds. That makes me sick. More beds for more people to endure more inhumane care? It is just not good enough.

Feedback**Rights of family to see information**

“ We've had a devastating blow with the death of our mum just 3 days after she entered a nursing home. She had only been there three days when she was rushed back to the hospital with a broken arm!!!!??

Mum was able to tell me details of what happened, that she'd asked for help to move back a bit in her chair, and *"they had me by the arms when I heard the snap"*. After the procedure carried out at the hospital, she died in her sleep that night – we are satisfied that the hospital only tried to help her in a terrible situation.

Our issue is only with the staff at the nursing home, and the fact she got a broken arm in the first place. When we went there the following day, we were unsuccessful in obtaining a copy of the “incident report” – or any other paperwork for that matter.

Mum is now with the coroner as we've agreed to an autopsy so we can get some answers about her death. We just don't know if we'll ever be sure what happened at the nursing home, how her arm was broken, what she went through before she arrived at the hospital for help, whether the staff who lifted her were at fault, or if negligence at the nursing home brought about an early death.

**Can we please have some useful information?**

“ YES please. Bring on a "My Nursing Home" that details all complaints, all results, all menus, all falls, all infections, all staffing, everything. I would rate the ACF my Mum had to endure for 2 weeks with a 0/10.

Absolutely diabolical even though they looked good on the outside and promised the world on the inside. And never delivered any of it.

Menu was nothing like we were told; no staff; staff yelling at people; unhappy dementia patients crying to be allowed to go home, no activity other than TV blaring all day in one big space.

**Nursing home owners should be more accountable**

“ It is to Australia's shame that frail old people are given no assistance to live out their lives in a way that is respectful.

At my Mum's nursing home I was shocked that no one was ever asked what they wanted to eat. It was dumped in front of them. No menu as only one choice for all at meal times, EXCEPT at accreditation time. No wonder they dropped like flies, choking on the smallest piece of food.

One died of gangrene. How? In Australia? I expect things like that on a battlefield. Not in an Aged care place that is supposed to have nursing homes. Mum got a bed sore and that was shocking. And they did not even tell me until it was too late. And when they took her to hospital, so she could die there they did not even tell me she was there until the next morning. By which time I had 10 minutes to get up there to say good bye. Bring on a My Nursing Home and make the owners more accountable.

**Selling off aged care**

“ It is obvious to me that farming out the care of the very young and/or the very old as a profit-making activity is just asking for trouble. And we have just seen that trouble with the collapse of the ABC Learning Centres. Now we all have to pay more to bail them out.

We pass over tax-payer funds to corporates and then watch them create huge facilities in order to cut costs and then see the inevitable cutting back on staff. And there is hardly a protest. And it is not only that it is risky business - it is also immoral.

Caring for people who are at the end stages of life is a community responsibility. It should not be a means of creating profits for the shareholders of big corporations.

Feedback

““ Food

““ **Dying to eat:** Earlier this year, my friend was contacted by the (Nursing Home) doctor to say her mother had stopped eating and drinking and prepare for the inevitable. My friend went down to see her mother....it was lunch time, so she fed her. No coercion, no force - mother ate at her own pace ... ALL the meal. She did the same at dinner. So, why had she stopped eating and drinking? She hadn't, they'd just stopped feeding her because *it took too long*. Please don't get me wrong, I know from experience she can take an average 30 minutes, and the staff are totally pulled out. But to allow her to starve, that's criminal.

““ **How many (nursing home) inspections take place at 'dinner time' at 4pm** - when the bread and butter and cup of tea are handed out with nothing else until 7am the following morning?..."

““ **Food for residents was locked with a padlock in a fridge** because the owner felt (the staff) would steal the milk, margarine or jam...hungry residents couldn't get a snack after 7.30pm when kitchen staff went off duty..."

““ **Eating is one of the few pleasures left** to some elderly folk and where are the inspectors at the vital times. Why should the residents be fed at 4pm so staff can go home and not cost extra in wages? Ask anyone if they eat their dinner at 4pm - not bloody likely..."

““ If I had not gone in at meal times my father would have starved to death.

““ **Searching for... food:** My mum had a tiny piece of omelette for dinner last night. Tasteless with nothing with it. At least the poor residents in the dining room had a piece of white toast with theirs to fill them up.

I was so appalled I stalked the corridors trying to see what everyone else was eating. I came across a trolley with ham and salads. I STOLE a plate!!! I cannot believe the levels I am forced to go to. It was the first bit of fresh vegetables she'd had in two years!! She loved it!! Can you imagine a bit of grated carrot, cucumber or a piece of beetroot after so long? Unimaginable luxury!

Do we have mum in the cheapest nursing home in Australia? No, probably one of the most expensive with all the extras! Unfortunately, we forgot to get a contractual agreement that the food was actually well balanced and nutritional!.

““ Lack of skilled staff

““ My latest example of the mess that aged care staffing is in is when a frail, diabetic patient I know was given pavlova for a dessert. Might as well have given her rat poison!

Fortunately a family member was present at the time and disaster was avoided. But it is sad when families can't depend on reliable systems being in place to ensure compliance with dietary needs and preferences. Evidently, mistakes such as this are not uncommon at that particular facility.

Having your father, mother or spouse in care is stressful enough without feeling that you have to be there every minute of the day to ensure safe and reliable care.

““ Medications

““ Not only are unregulated staff providing the majority of care for sicker residents with often multiple & complex conditions, but are also being allowed to hand out drugs. I was taught that you NEVER gave a drug unless you knew its' use, interactions, side effects etc. To do so, otherwise, was considered unethical. Drugs are not lollies!

As an RN in aged care for 20 years all I've seen is a decline in the quality of staff. Sorry to all those unregulated care workers out there, but you are NOT nurses. You have been used as a cost cutting measure in a failing system which in the not too distant future will be unsustainable.

Feedback



Onerous paperwork and missing staff

“ I am an RN and have been working in aged care for 32 years now. I trained to be a nurse and I so want to be the nurse that a patient/resident deserves...but it isn't possible...not with the way aged care facilities are run now.

The role of the RN is now endless paperwork justifying why we need x amount of dollars for the care of these patients/residents etc and the care that I was trained to provide is carried out by carers most of where I work, are untrained. These are persons who have come from working in supermarkets for example and thought they would give aged care "a go".

I am supposed to mentor and supervise these 'carers' and be accountable for their actions, who after 1 days orientation and 2 buddy shifts are let loose on the floor! This has been happening because we are so desperate for staff where I work that its almost like we will take on anyone just to give us 'hands on deck'.. In all fairness...we also have carers who are absolutely dedicated and very experienced but they are few in our staff.

I left my job last year because I couldn't cope any longer with the demands and expectations of me...I have always been a very capable and organised, responsible and dedicated nurse...I love caring for the elderly but my sanity and health were at stake. I took 6 months off and am now back working in the same place. There has been no improvement.

The facility has expanded and they are admitting more residents and we are still working with the same staff ratio...I've reduced my hours this time...to keep my sanity intact and have had to take the attitude *..its just a job* because it was my genuine caring and concern for these people that nearly done me in last year...its a very sad situation for both patients/residents and staff.



Staffing issues

“ If the government really knew what it was like to be worked like a horse for the said \$16.20 per hour, they would have to feel shame.

I have just resigned from a state of the art facility, it has a beautiful facade, but all that glistens is not gold, believe me. Seems they may have slightly overspent on the facility, so now have to cut back on staffing to keep within their budget, which isn't too difficult, as staff are hard to come by anyway.

As stated, why would anyone want to study for the paltry wages they receive after? Simply anyone can walk into aged care, it appears the only 'qualifications' necessary are the ability to work like a slave, shut up, and do as you're told. Most places do ask for Aged Care Cert.111 'or working towards it', which means diddle squat. There's no point in families complaining, what are they going to do? Move their loved one to another facility that's in the same position? The whole situation is absurd, and if it wasn't so appalling, it would be laughable.



Paperwork updated prior to Accreditation

“ I work in an Aged Care Facility in where management have passed all staff on their competencies without staff actually demonstrating the competencies to management.

Observation charts have been filled in at Accreditation time when they were not actually attended at time they were suppose to be attended. Some charts were filled in for previous 3 months.

Staff are expected to come to work early so as to complete their work on time and management are aware of this. I have spoken to staff and informed them that if they or a resident sustain an injury then Work Cover will not cover them as they are not actually rostered on duty and management will continue to work short staffed as staff are scarred of losing their jobs if they refuse.

If staff make a complaint management deal with them by cutting their hours of work back. Some staff rely heavily on their hours to support their family.

Feedback



Staff member – there is a crisis in aged care

“ I am a Recreation Activity Officer (RAS) at a (large) nursing home. This home has a mixture of hostel and nursing home accommodation. I work two 6.5hr days per week for \$17 per hour (care service employee grade 2 + 3% negotiated in an AWA 2007). I have been given new tasks with out being trained for them and then yelled at by the RN for asking questions.

I have been expected to run from one end of the facility to the other doing two tasks at once. I am appalled to find out from your site and the official accreditation site that there is no Australian legal staffing levels ratios in nursing homes and that management can cut staff at their discretion as long as their paperwork looks good and no-one says anything out of turn when the accreditation visitor calls.

I am expected to bring the dedication and skill of a psychologist to the assessment of residents for the lifestyle section in their files. From this I must work out the resident's problems and needs and write a care plan for their leisure requirements. After that I have to evaluate whether it is working and adjust it if it is not! My two page job description actually includes that I must "conduct therapy sessions to improve residents' mental and physical well-being".

I have a Masters of Art Therapy and this is their cheap way of trying to get my expertise for next to nothing. I read in the Feb 2008 newsletter "The Standard" put out by the accreditation agency that "*Creativity proves valuable in dementia care*". This article is about the use of art therapy in quality dementia care. I have not got a hope in hell of getting the management where I work to employ me and pay me as an art therapist.

Yet if they did I would really have scope to help people. There's the crunch! The recreational staff have it easy compared to the personal care staff and the nurses but still it is bad economics to reduce the staff in any section if resident well-being is the main criteria. The fact that the new funding instrument ACFI appears to give more funding for more frail residents means that the less frail ones are the losers.



Two staff for 80 residents?

“ I have just worked one of the worst shifts in my career as a Registered Nurse. I work for a large nursing agency and work in a wide variety of aged care facilities. I am an experienced RN, I have a certificate in Gerontology and a Masters Degree. I am getting so sick and tired of seeing aged care facilities cutting staffing to the bare minimum and in so doing risking the health of the residents they are supposed to be caring for.

I was rostered for an evening shift 1530 to 2200. I was appalled to discover that for eighty residents in hostel care there was only one carer and myself for the shift, in fact the carer worked 1630 to 2130. The hostel is spread over two floors and has "cottages" out the back. How on earth are two people supposed to care for this many residents?

I noticed that some residents required their medications crushed and highlighted on their medication chart was "choking risk." There was no one in any of the dining rooms to supervise the meal - only the kitchen staff. One may ask if a resident can choke on medications wouldn't it be fair to assume that eating would pose a greater risk?

My question is - how the hell do these places get accredited? I was running all evening in a vain attempt to get the medications out as near as possible to the correct time. It was impossible, the best part of eighty residents all ordered medications at the same time. By the time I had finished the tea time medication round, it was time to start the supper round, speaking of which the residents didn't get any.

Two people can't provide good care for almost eighty residents, all I could do was administer medication, that's all I did. I didn't have a meal break and left thirty minutes late feeling that I had done a terrible job. I'm writing this at 0154, as I cant sleep thinking about it.

“ “ Accommodation bonds – who can you trust?

“ “ I would strongly urge all family members of residents in aged care to be vigilant with obtaining frequent account statements in regards to accommodation bonds and trust accounts despite your rapport with management and staff.

This situation (nursing home collapse) arose out of the blue like a slap in the face.

Complete trust and faith was placed in this company and its directors, trust and faith which at the time did not seem illogical since they had been granted approved provider status by the Government.

If you cannot trust providers approved by your own Government, who can you trust?

“ “ Continence

“ “ we managed to find enough pads from our secret stashes to last through the night for the current 90 residents ..."

“ “ they are literally wet from head to toe and require bed strips. I can tell you it is bloody distressing to watch an elderly woman's face crease with distress and humiliation and state, 'Oh this is awful, this is just terrible' ..."

“ “ at my work have for the past week HAD NO adult wipes (like baby wipes to wipe dirty bums), no blueys, and are on to our last packet of gloves and they are large and hard to work in. There have been many issues with care, INCONTINENCE AIDES and lots of agency staff...one of the nurses actually bought her own in for the residents.

“ “ Missing: Consulting room for medical practitioners

“ “ Many Aged Care Homes have a range of facilities. These include some form of catering as an alternative (and for visitors to purchase food) and hairdressing. Usually there some craft facilities and social/entertainment areas for guests as well as residents. There may well be others at different homes.

One rare but necessary facility which seems to be missing is a consulting room for medical practitioners when they visit patients who are residents of homes. A consulting room would allow privacy, provide more appropriate surroundings and include some relevant equipment.

It has to be questioned when this facility is not available. Medical care is a very high priority for many residents of nursing homes and few can travel out to get it. Therefore it makes sense to, in some way, to ensure quality and timely care is available within the home once the medical practitioner arrives. To illustrate the point, standard equipment such as scales, stethoscope, sphygmomanometer, desk, chairs, lighting and an eye chart could be simply, easy and neatly provided in a small space.

As well, privacy for consultations (scheduled or emergency) is ensured. Copies of records could also be retained there so a locum called at short notice would have full access to relevant records – also, the records could then accompany residents who are taken by ambulance for urgent, specialised medical treatment and alleviate the need to intimately question residents who may not be able to provide appropriate answers.

Does the nursing home your relative lives in, or the nursing home you are considering for a loved one (or even yourself) have this needed facility?