Productivity Commission Report on Aged Care

Comments:
The Draft report is commended for addressing most major concerns with aged care provisions. However we would suggest additions at three levels:

Firstly, we are unable to locate any reference to those elderly community members with mental problems, apart from some references to dementia. We urge an addition to draft recommendation 9.3, which addresses the needs of remote and indigenous people, to include provision for the special needs of those with mental problems which can manifest in a number of ways and makes the inclusion of such people in group situations thwart with potential problems. It is difficult for such people to live easily and harmoniously with others and it makes the role of carers so much more difficult and demanding. Yet these people have needs that should be provided for. The upheaval necessitated with entry to an aged facility is often a most traumatic experience for the elderly patient, can be quite destabilising and lead to ongoing mental problems. We believe the final report should address the needs of those with mental problems.

Secondly, the draft report makes little mention of an area presently causing considerable difficulty in the operation of aged care facilities and this is the matter of remuneration for staff of homes. Draft recommendation 11.2 makes mention of the need to pay competitive wages to nursing and other care staff. At this time aged care homes have great difficulty in recruiting suitable staff, particularly nursing staff whose salary scales are far behind those paid to hospital nurses.
As well, paucity of funds means that care administrators often are forced to choose less qualified staff at lower cost in order to balance budgets. We hear stories of just one qualified nurse being available to attempt to meet the emergency needs of many care patients; and other staff without suitable skills being then co-opted into roles which should be filled by fully qualified staff.
Many of the problems identified in the attached papers by Neville Lester stem from inadequate and insufficiently qualified staff.

Thirdly, while the draft proposals look at financial provisions, it is our belief that problems of finance will continue into the future. Somehow sufficient resources must be made available and if we see these largely coming from government sources, we doubt that this will be able to meet the growing need that research suggests we will be required to address. Just as it is now government policy to have all contribute to their retirement incomes through compulsory superannuation, we believe some scheme whereby the needs of the elderly are addressed through their working lives should be put in place. This might take the form of an extra one or two percent lifting of contributions to superannuation, generating sufficient funds over a working lifetime to meet initial aged care home entry costs.

Dick James,
Tasmanian Division President,
Association of Independent Retirees.

ASSOCIATION OF INDEPENDENT RETIREES (AIR) LIMITED

TASMANIAN DIVISION HARG

DISCUSSION PAPER

" THE NEED FOR INDEPENDENT AUDIT TO DETER ABUSES IN AGED CARE FACILITIES"

Background:

The August 2010 meeting of the Health and Aged Care Research Group (HARG) of the Tasmanian Division expressed concern at the apparent increase in abuse both by neglect and by direct physical means, that has been reported to have been experienced by recipients of high care in some Aged Care facilities. Members of the group are aware of these reports from personal observations of family and friends and from widely publicised press reports that occur from time to time. The group requested that this paper be prepared to stimulate discussion as to whether AIR should advocate for some form of audit by Government agency to ensure that care provided to residents is always of acceptable quality.

It is accepted that the Aged Care industry operates under severe cost pressures. Not everyone can afford to pay the total cost of being provided with comfort, care and the necessities of life during declining years, particularly when infirm and incapacitated by age. Funding measures in place for not-for-profit facilities reportedly provide only the means to provide basic services and in less wealthy parts of the country contributions from accommodation bonds and support from the local community are insufficient to improve the situation. Management of 'for-profit' facilities is by definition required to ensure that expenditure is as low as reasonably possible.

Shortage of funding is seen as the major contributor to abuses by neglect of residents and AIR has asked in pre-election and pre-budget submissions to Government for funding methods to be reviewed. This discussion does not deal with funding problems.

The Nature of Abuse:

Everyone is entitled to be treated with respect and to maintain their dignity. Old people who have been forced to leave their own homes, are bereaved, separated from family and their usual social contacts, and who are failing in health and mobility are especially vulnerable. Often their mental capacity is weakened. When admitted to an Aged Care facility they should be made as comfortable and welcome as possible in the new environment full of strangers. They and their family expect that this will happen. Unfortunately this is not always so. The following are some of the abuses which the HARG group is aware have occurred or are occurring. Some are isolated instances. Some are not. Most result in loss of dignity. Most cause distress.

- Shortage of qualified nurses on site. The proportion of qualified nurses to other care staff is often dramatically low. The facility will operate for extended periods during the day or over weekends without a qualified nurse on site.

- Unqualified and sometimes incompetent staff are left to cope.
- Unavailability of professional medical assistance at critical times.
- Overcrowding, with incompatible people in close proximity.
- Inclusion of dementia sufferers and younger mentally impaired people with aged-care recipients.
- Over-sedation of some patients as an alternative to direct care.
- Food which is inadequate, unappetising, or of doubtful nutritional value.
- Inadequate supervision and assistance to patients when eating.
- Inadequate and infrequent monitoring of patients' personal comfort and hygiene, especially in relation to bodily eliminations.
- Infections, illnesses, and dental problems remaining untreated for unacceptable periods.
- Inadequate supervision of infirm patients specifically to forestall falls and accidents.
- Actual physical abuse as a means of 'discipline' or 'punishment' by unqualified or ignorant staff.

The Need for Audit Inspection:

While many family members and other visitors to residents of an Aged Care facility have recognised abuses and deficiencies such as those listed above, it seems that comparatively few complaints are received. There may be many reasons, among them the following:

- Family members feel guilt about their mum or dad being in care, and in denial that the care is less than it should be.
- They may accept that the Facility is doing the best it can with the funds available to it, so a request for improvements is unreasonable.
- There may be no alternative to having the person in the situation , or alternatives might not be acceptable to family members – so better not to rock the boat!
- There may be a heartless 'Out of sight, out of mind!' attitude.
- There is always a fear that complaints, formal or otherwise, will result in some form of backlash which will not be to the resident's benefit.

If overseeing the provision of quality care is left to families, abuses continue. It is necessary to consider overseeing by an independent authority.

What Form Should the Audit Take ?

The right for family to know that their relations in a care facility are receiving appropriate and non-abusive treatment must be balanced by the right of the Facility to carry out its prescribed activities without undue and unnecessary interference. In this regard random inspections could be targeted at suspected offending institutions rather than across the board, with regular, less intrusive inspections of others.

If an appropriate authority already has the power to conduct random and unannounced inspections of a facility with the specific role of assessing its quality of care and

detecting abuse, should AIR enquire as to its effectiveness? If an existing power is not effective, or if no such power exists, should AIR advocate for an effective system?

Where to from here?

Should we have someone authoritative talk to HARG members at our next meeting to advise whether our concerns are already being addressed and if so with how much success?

If then the Tasmanian HARG wants this matter to be taken further this paper should be adapted and expanded and presented to the Board of AIR as a submission for development of a formal policy seeking to ensure that the quality of care provided is subject to monitoring by an authority with the power to enforce its recommendations.

Neville Lester 15/8/10

ASSOCIATION OF INDEPENDENT RETIREES (AIR) LIMITED

TASMANIAN DIVISION HARG

DISCUSSION PAPER

"HEALTH CARE IN TASMANIA – THE PATIENT'S VIEWPOINT. WHY ISN'T IT HEARD?"

Background:

The August 2010 meeting of the Health and Aged Care Research Group resolved that this paper should be prepared as a preliminary to a wider discussion on deficiencies in the treatment received by patients in the various levels of health services with a view to placing before Government (and anywhere else it is relevant) the views of patients, past and present, and their experiences and assessments, so that these can be considered seriously in planning changes or improvements to the particular service.

There is a perception that when a review is being undertaken, whether for a treatment system, a small change to a local clinic, or for design of a new or upgraded hospital, that the consultation process includes obtaining constructive input from "job owners" and "stakeholders" but not from the experienced end-users - who are the patients. Thus the new feature or system is designed to incorporate suggestions from administrators, accountants, doctors, nurses, service union members, and others involved in the provision of health care. And the systems analysts, engineers and architects then produce designs that suit the contributors.

The result of processes like this can be seen in systems that flow more smoothly for the operators but may be inconvenient, or even demeaning, for patients, and in buildings that are convenient for nursing and medical staff but are destructive of comfort and dignity for patients.

The Problems:

If asked patients could draw reviewers' attention to a number of factors which distress patients. The list that follows are examples drawn from members' own experiences.

- Patients spend large intervals of often boring, sometimes anxious, time waiting. This is endemic at all levels and in all types of health care. Systems should be reviewed to cut the waiting time, and waiting rooms should be made pleasant and comfortable. To wait in corridors at emergency wards and clinics is particularly unacceptable.
- The practice in some clinics to require all patients for treatment or consultation at a session to arrive at the same time is deplored. Patients feel as if they are being treated like sheep waiting outside a shearing stand. Staging appointments and keeping patients informed of delays would assist.
- Diagnostic processes often take time, several consultations, and delays between referrals. Anxiety increases if dates cannot be set for the next stage. It is important that the patient always has access to information explaining

delays. There is often a reluctance to impart such information, which should be the patient's right.

- Placing members of the opposite sex in the same hospital rooms is degrading. Members have reported several distressing experiences resulting from this practice. It occurs in some hospitals despite beds being available, or rooms being empty in other parts of the same ward. A fabric screen does not provide privacy or protection of personal dignity.
- Hospital rooms with openings but no door to a corridor may be convenient for staff, but do not allow for quiet undisturbed sleep. Curtains help little especially when pulled open quickly and noisily.
- Noise and light levels at night in hospital wards are often very high. Staff should be encouraged to wear soft-soled shoes, to speak quietly especially at shift change times, or when tending a patient in a multiple bed room, and to avoid slamming doors. Lighting should be minimised. Patients' television (sound and light) should be monitored to minimise annoyance to others.
- A patient's whereabouts and progress through a process in hospital should be the specific responsibility of a nursing staff member. One patient reported being taken from a ward in a wheelchair for tests in another part of the hospital, being left in a corridor by the attendant - "It won't be long mate."- and sitting without magazine, medication or information through a lunch hour and a long time afterwards before his presence or absence was queried.

Discussion and Recommendation:

This paper does not criticize the actual standard of medical treatment, or the quality and dedication of nursing. It seeks rather to highlight matters of personal consideration which can be easily improved . Importantly it hopes to bring about an appreciation of patients' personal feelings and their wish for increased levels of consideration of these feelings. All patients are entitled to be, and expect to be, treated with respect and dignity.

It is recommended that this paper be considered by the Tasmanian AIR Health and Aged Care Research Group as the basis for a submission to the Tasmanian Government seeking that the views of patients be taken into appropriate account.
It is also recommended that the paper should be commended to the Board through the National HARG for consideration of action in other Divisions.

HARG, AIR, Tas