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Aged care

The present situation

5.1 The population of Norfolk Island, in common with many small country towns on the mainland, is ageing more rapidly than most Australian communities. Already ten per cent of the population is over the age of seventy, and this percentage is likely to increase in the next few years. The Department of Veterans' Affairs report examined data from the 1991 and 1996 censuses, and concluded that the figures 'suggest a significant and increasing demand for aged care services in the years ahead on Norfolk Island.'[1]

5.2 In 1996 the Norfolk Island Government changed the rules for General Entry Permits, allowing them to be granted to people with sufficient means who wishe to retire on Norfolk Island.[2] Also, among the rapidly increasing number of tourists to the island the trend has been for older, often quite elderly, visitors. The impact of these trends is becoming more obvious each year, and the need for improved facilities for the care of the elderly has been acknowledged widely.

5.3 Evidence suggests that some people reluctantly leave the island as they age, in search of quality aged care, rather than end their days on the 'Verandah' at the Hospital.[3] The Committee was able to see first hand the unsuitability of the hospital environment for the frail elderly, some of

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1 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 21.

2 Commonwealth Grants Commission, *Report on Norfolk Island 1997*, p. 22.

3 Mrs Colleen Evans, CHAT, Submissions, p. 53.

whom had dementia. With just a curtain for privacy, with shabby, basic, hospital furniture and without the necessary physical security or full-time care by geriatric trained staff, it is not a destination of choice.

5.4 A witness to the inquiry described how the lack of home support services and alternatives to nursing home care contributed to both his parents being forced to become long-term patients in the hospital:

Case Study – Mr Rex Barrett [4]

Mr Barrett described the situation that led to both his parents being admitted as full-time residents of the hospital. His father became totally blind and suffered a series of strokes. His care put undue strain on Mr Barrett's mother, the main carer despite her age and advancing osteoporosis. Mrs Barrett eventually suffered two compound fractures of the spine as well as two strokes. Separate facilities for male and female patients meant that the elderly couple could not live together and Mr Barrett Snr, being the only male, was isolated.

Mr Barrett said that some of the longstanding concerns of elderly patients' relatives about staffing inadequacies had been addressed, with a substantial improvement in the last eighteen months, particularly since the DVA visit. However, he believed that 'the aged people of the community … are poorly served in terms of the value they get for the dollar that is spent.' Mr Barrett remarked that he and other relatives were impressed with the 'excellent recommendations' made in the RSL report on aged care on Norfolk Island, which focus largely on means to support the elderly to remain in their own homes.

Mr Barrett felt that a retirement village option, in which people buy a unit and a known percentage of the investment is returned to the family upon their death or departure, would be preferable to the situation his parents are in. A Commonwealth subsidy would increase the incentive.

5.5 The Norfolk Island Government noted in its submission to this inquiry that aged care was an area of growing need, and that it had commenced planning to meet the health needs of the elderly members of the community.

4 Mr Rex Barrett, Transcript, pp. 137-140

5.6 The *Aged Care Act 1997* (Cth) does not apply in Norfolk Island or to any other external territory. The Act provides the framework through which the Commonwealth gives financial support through payment of subsidies and grants for the provision of aged care and related matters. The Department of Transport and Regional Services observed in its submission that access to Commonwealth programs would help offset the limitations of Norfolk Island's health and aged care services.[5]

5.7 The Committee would encourage any changes to the Act that would allow the Norfolk Island community to access programs and initiatives designed to assist rural and remote communities in the provision of aged care, available on the mainland.

5.8 Recent involvement by the Department of Veterans' Affairs with projects for veterans has already been a catalyst for change within the local community. Ms Janet Anderson of the Department commented that the Norfolk Islanders were very receptive to DVA initiatives and were prepared to volunteer their own ideas. She believed that there was a very strong sense of working together during the analysis of the deficits in aged care on the island, with a considerable amount of learning on both sides.[6]

5.9 Cooperation with the Department of Veterans' Affairs has led to initiatives which have already made modest improvements in facilities for the aged, with scope and enthusiasm for further joint ventures.

5.10 The strong tradition of caring for the frail elderly at home has been affected by factors such as the increased participation in the workforce of mature women, traditionally carers of the aged, as well as the departure of many in the 20-40 age group to the mainland, pursuing further education and career opportunities.

5.11 Currently, the elderly who are too frail to look after themselves are cared for in the Norfolk Island Hospital as long term nursing care patients. They are attended during the day by one full-time nursing staff member and a part-time activities officer, but at night the aged care section is covered only by ward staff from the acute care section. The RSL report identified both a shortage of staff and a lack of knowledge and skills among the staff working with these patients. Elderly residents who are able to remain in their own homes are visited by the district nurse, although at present she is only employed for three half-days per week. There are no formal programs of home help, personal care or community transport.[7] Meals on wheels are available from the hospital kitchen but reports indicate that

5 Department of Transport and Regional Services, Submissions, p. 77.

6 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 151.

7 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 143.

'the wheels' must be provided by relatives of those being served, and that there is little demand for the service. The Red Cross runs a service, Telecross, telephoning people who live alone at a set time each morning.

5.12 The Department of Transport and Regional Services noted in its submission that the residential facilities, located in former public wards of the hospital, fall far short of the standards required and provided on the mainland. The DVA's observation was that there 'is no doubt that it is a relatively poor physical stock for the purposes for which it is currently being used'.[8] This situation does not appear to have been designed; rather, it has just evolved, with an increase in the number of elderly who cannot be cared for at home, the availability of surplus beds at the hospital and the fact that the only other option is to leave the island.

5.13 The accommodation lacks privacy and a homelike atmosphere as well as security for dementia patients. There have been none of the physiotherapy or occupational therapy services which are normally available to aged residents on the mainland, although this situation changed in mid-2001 with the appointment of a physiotherapist. Geriatric training is needed for both nursing and domestic staff at the hospital, and this should be addressed by the newly engaged aged care clinical nurse consultant. The Department of Veterans' Affairs believes that the hospital:

> tends to give priority to acute cases and places less importance on the work it does in aged care.[9]

5.14 Mr John Hughes of the Hospital Board advised the Committee in November 1999 that a prefabricated set of five units, the Mawson Units, was donated to the Norfolk Island Hospital some years ago for aged accommodation. Although located in the grounds of the Hospital this facility has not been used exclusively for aged accommodation and has been allowed to deteriorate. The RSL report recommended that the Norfolk Island Government should carefully consider the role and place of these one-bedroom, independent living units, as they represent aged and healthcare capital stock that is significantly under-utilised.[10]

5.15 Witnesses have said that some residents are noisy and have created a climate of fear. The Hospital Director advised in April 2001 that the five residents comprised five people with particular health needs. All had to negotiate a lease with the NIHE. One other unit for an elderly person has

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8 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 143.

9 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 143.

10 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 60.

been created in the former isolation unit which is located very close to the main building.

Facilities for war veterans

5.16 The Department of Veterans' Affairs meets the cost of medical treatment for entitled members of the Norfolk Island veteran community treated locally and on the mainland. The Department's submission in February 2000 stated that there were 148 veterans on the Island. Of these, 89 were over the age of seventy, which constituted a quarter of the island's over-seventy population. Fifty-five were entitled to health care benefits, forty-six of whom held Gold Cards, which means that the Department pays for any treatment the veteran or war widow needs.

5.17 As the Norfolk Island population ages, the number of individuals who are covered by DVA entitlements and programs will also decrease. This will result in a larger proportion of elderly Norfolk Islanders being required to fund their own health care, rely on the Island's welfare system or seek care on the mainland. There is bound to be an increased cost to the Norfolk Island Government, which will need to make accurate forward estimates in order to cope with its ageing, non-veteran population.

5.18 In 1998 representatives of the Department of Veterans' Affairs visited the Island to assess the needs of veterans as part of a review of aged care services commissioned by the Norfolk Island RSL sub-branch. As a result of that visit there has been a joint approach by the Norfolk Island Government and the Department to upgrade all facets of care for the elderly. The Department's representative said at the public hearing in Canberra that:

> we are providing a resource to the island, and the beneficiaries of that extend beyond the veteran community …we actually recognise the benefits which flow from our initiative into the broader community and accept that that is part of what we do. We are very pleased by that but, at the same time, we know that if we were not to invest, it would not happen.[11]

5.19 An advisory committee was formed, comprising the President of the local RSL sub-branch, the Minister for Health and the Director of the Hospital, to develop specific proposals by which the Department of Veterans' Affairs might assist in the development of better services for veterans on the Island. As this Committee no longer exists, it may be helpful if the new

11 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 147.

aged care clinical nurse consultant (ACCNC) and a representative of the RSL or an officer in the Administration are designated to assist in liaising with the Department, to ensure that valuable opportunities for joint aged care projects are not lost. There is a great need for continuity in this area.

5.20 The RSL report implied that there were other areas where funding could be provided, but it will be necessary for the Norfolk Island Government and the RSL to approach the Department. For example, DVA could be approached for funding support to set up a community based aged care and dementia services support program, using the CACP model (Community Aged Care Places). Although recurrent funding would not at present be provided, given the present high numbers of entitled veterans on the Island a case could be put by the Government and the RSL for consideration of this. Ongoing costs of such a program for non-entitled veterans and the general population would need to be met by a combination of service charges and/or government subsidy.[12]

5.21 Other programs which might attract capital or seeding grants include the Joint Projects Program (for projects designed to help veterans maintain and improve their independence and quality of life), the Community Care Seeding Grants Program (for new or existing projects in community care and respite care) and the Healthy Lifestyle Encouragement Grant. The Committee wishes to stress the continuing importance of the RSL report and the many valuable recommendations it makes.

5.22 As a result of the original advisory committee's proposals, the Department of Veterans' Affairs offered financial assistance for the employment of a geriatric nurse supervisor and a physiotherapist for twelve months, as well as the purchase of a suitable vehicle. The funding takes the form of a 'service development incentive payment' or seeding funding, made under a variation of the current agreement for the provision of hospital and other health services.

5.23 The Committee was advised in April 2001 that a geriatric nurse supervisor, or ACCNC, had been selected and was due to commence duty in May. The ACCNC was selected for the ability to take charge of the aged care services both in the hospital and the community. As the coordinator for aged care services the ACCNC should be able to identify, coordinate and promote existing facilities, as well as develop other facilities for which there is an obvious need. An important part of this role will be to provide specialist training in aged care nursing, especially in the care of patients with dementia. Close liaison with a future community health coordinator,

12 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 68.

medical staff and the district nurse will be essential to develop this important role fully. The Hospital Director advised that the ACCNC will be responsible for establishing an Aged Care Services Steering Committee.

5.24 A physiotherapist was also selected and was due to commence duty in June 2001. The physiotherapist was chosen for the ability to devise and conduct therapy programs for the aged in residential care as well as fitness programs to enhance the wellbeing and independence of the elderly who manage to live at home. Since the intention, demonstrated by DVA funding of fifty per cent of the salary for a further two years, was to attract a physiotherapist who would stay for several years, the selection process took into consideration the ability to establish a sustainable private practice using the existing facilities at the hospital and an interest in doing so.

5.25 The RSL recently established the White Oak Day Club for veterans and other elderly residents. The DVA informed the Committee of other initiatives that have been taken up with enthusiasm:

> We have a fairly extensive range of literature on various issues in relation to health promotion which we have already made available to the island … The sorts of issues we are talking about for older populations are improving or maintaining fitness levels, diet and dentition – things like that which might not necessarily occur to everyone but which are vitally important in maintaining a level of wellness amongst an aging community. It is an area where we are keen to do some more work.

5.26 The DVA also conducted extensive home safety assessment programs: HomeFront, and the Rehabilitation Appliance Program (RAP), over a period of two weeks.

5.27 Other main areas of need identified in the recommendations of the report commissioned by the RSL are:

- professionally staffed therapy services and programs (the appointment of an experienced and enthusiastic physiotherapist will assist greatly in this area);[13]
- access to DVA health promotion and carer support programs;
- improved quality of residential aged care services provided by the hospital,[14] and support at home by community-based care services (including respite, dementia care, carer support and day therapy)[15]; and

13 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, pp. 47-48.

- a Norfolk Island Government contract for home and community-based care services to a 'group with proven expertise'.[16]

5.28 The Department of Veterans' Affairs submitted that its ability to enable access by the veteran community on Norfolk Island to health and other care services was restricted by the realities of limited access to professional staff, and the resource constraints of the NIHE and the Norfolk Island Government. To meet its commitment to the veteran community, the DVA requires an enhanced and more integrated model of health and aged care services, both residential and community-based.

5.29 The RSL report identified the lack of any trained therapy staff on the island as a major deficit, given the major financial, social and therapeutic benefits of patients returning to their community as soon as possible after treatment. [17] Having qualified therapy staff on-site would mean that the periods of extended rehabilitation required for stroke, hip and knee replacement and cardiac patients would be reduced significantly. Rehabilitation on the mainland is much more expensive because of travel and accommodation costs, and can cause extended separation from family members.

5.30 Given that attracting suitably qualified staff is difficult, the RSL report proposed a solution based on working with a therapy services team from the mainland who could provide both post acute rehabilitation as well as aged services therapy. A team consisting of a counsellor, occupational therapist or physiotherapist could be contracted to provide services on rotation of one team member every three months, which would ensure some continuity through communication with team members who know each other. The cost savings from patients being returned from the mainland earlier could be used to offset the cost of the therapy service.[18]

5.31 The Department made it clear that it uses privately as well as publicly provided services for veterans. It has offered support in designing a suitable residential facility, and the RSL report emphasised the advantages of attracting private investment and involvement in both the construction of facilities and the provision of specialist geriatric services. Its policy is to access mainstream health services for veterans wherever possible:

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14 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 49.

15 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 57.

16 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 56.

17 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 47.

18 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 48.

> These are both in the public and private not-for-profit and private for profit sectors. We enter into fee-for-service contracts with local providers who can satisfy our requirements in terms of accreditation, quality standards and cost as well.[19]

5.32 The Department added that clarification by this Committee of the responsibilities of the Commonwealth Government will influence decisions made by the Department regarding the nature and scope of its role in supporting the veteran community on the Island.

5.33 The RSL report is an extremely useful document which should provide valuable assistance to the Norfolk Island community as it examines and develops its aged care services as part of the new health strategy. The Committee strongly recommends that ongoing responsibility for liaison with the Department should be formalised.

Ageing in place

5.34 This is a concept of aged care that is increasing in popularity. It reflects the wishes of most elderly people to remain in their own homes, within a community of people they know well. It is the Department of Veterans' Affairs' policy to support ageing in place for as long as possible, taking into consideration the needs of the home based carers. The dilemma on Norfolk Island is that the infrastructure support to allow that to occur is relatively poor.[20]

5.35 The RSL report recommended that the Norfolk Island Government should consider developing a range of community support services similar to HACC (Home and Community Care) services, to enable the frail elderly (and disabled people) to remain in their own homes.[21] As mentioned above, seeding funding may be available through the Department for a variety of initiatives. The Report noted that:

> The value of such services in keeping aged people in their own homes and out of institutions is widely recognised as a superior approach for the patient and family and more cost effective than institutional based care.[22]

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19 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 142.

20 Ms Janet Anderson, Department of Veterans' Affairs, Transcript, p. 149.

21 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 62.

22 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 63.

> Such programs need not cost the government very much at all as most potential users indicated that they would be happy to pay for services. They just need somewhere to be able to ask for this sort of assistance, a kind of one stop shop for such services.[23]

5.36 These services should be flexible and tailored to the needs of individuals. HACC services on the mainland include home cleaning, cooking, laundry, shopping, home maintenance and repair, respite care, assistance with showering and dressing, community nursing, food services, day care centres and other social support. The value of employing a community health services coordinator who would identify, promote and coordinate all services that already exist, particularly those offered by service clubs and volunteers, has already been discussed in Chapter 4. In the interim, these kinds of initiatives could possibly be examined and undertaken by the new aged care clinical nurse consultant, in conjunction with the proposed Aged Care Services Steering Committee.

5.37 The RSL report recommended that the hours of the district nurse be extended. This would allow the nurse to organise more health education and health promotions activities as well as help more of the elderly to remain independent in their homes.[24] There is an important role for the district nurse in the implementation of services necessary to maintain those with borderline independence in their homes. Dr Fletcher confirmed that the hours, three half days a week, were 'a bit inadequate'.[25]

5.38 Although Norfolk Island is small, transport for those without access to a private car is difficult. This can lead to social isolation and associated problems, especially for the aged. Dr Fletcher commented that:

> There is no bus service or taxi service to speak of on the island, so elderly people who are alone, even though it may only be five miles from the centre of town, are generally pretty isolated.[26]

5.39 For many people on the mainland, 'ageing in place' begins with a decision to move into a community such as a retirement village while they are still relatively young and active, with the energy to take up new interests and make new friendships. Such communities within a community can be an ideal place for people as they become less mobile, especially when accommodation for different levels of independence is an integral part of

23 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 63.

24 *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 62.

25 Dr Lloyd Fletcher, Transcript, p. 41.

26 Dr Lloyd Fletcher, Transcript, p. 41.

the design of the 'village'. People can move to an assisted lifestyle without moving away from friends and activities that they value.

Alternative residential facilities

5.40 There could be a role for private enterprise in providing aged care, either through an investment partnership or entirely provided by a private organisation. Professor Gaston felt that Norfolk Island was a place which could be quite attractive to investors, either local or off-shore. A quality older citizens' village with accommodation for different levels of independent living, built close to the hospital, could combine private and public health services:

> to enable residents "to age in place" within a communal environment, with medical, recreational, health promotion and emergency facilities within easy reach.[27]

5.41 Such facilities, which are designed with recreational facilities to attract the 'young elderly', may combine one or two bedroom units for fully independent living with hostel and nursing home-type accommodation within the same complex. As people age they have the option of moving to assisted living within the same community which removes much of the trauma of enforced relocation.

5.42 The Committee believes there could well be scope for a partly or fully privately funded initiative such as this. Evidence suggests that the motivation and means to build a privately funded older citizens village already exist on Norfolk Island. The Government Gazette No. 20, of 11 May 2001, indicated that plans for a private village, consisting of ten two-bedroom self-care units for residents had been submitted for approval to the Planning Board. However, there is no indication the proposal includes any communal or recreational facilities or facilities for assisted independent living.

5.43 Older property owners could be encouraged to sell their homes to younger islanders to raise the money required to invest in a place in an attractive community facility. Ms Denise Quintal made a proposal along similar lines when speaking to the Committee during its visit to Norfolk Island:

> maybe the local [elderly] islanders who own homes could consider selling their homes to youth on the island on a pay-back scheme.

27 Professor Carol Gaston, Submissions, p. 62.

> … we could be distributing the home to a young family and the aged person could then move into the hostel and they would be paid money – just like a mortgage – that could actually be used to pay for their aged care. It would keep the homes within the family units of Norfolk Island.[28]

5.44 Another option, suggested in the RSL report, was the acquisition of a suitable house near the hospital for a group of elderly people, with a personal care assistant. This could provide a home-like atmosphere, companionship, assistance with daily care as well as the security of ready access to medical backup:

> Provided that the house was not too far away and linked by telephone and call bell to nursing and medical assistance, it could be a good model of aged care services delivery.[29]

5.45 The opportunity to acquire a large house, easily adapted to accommodate six or more elderly people with a live-in assistant, presented in August 2000. This dwelling was located a few minutes walk from the main hospital building and had large, attractive gardens, views and many bedrooms, as well as large rooms suitable for communal use. The proposal to buy the house was supported by the Hospital Board but the Norfolk Island Government, although agreeing with the concept in principle, was not able to fund the purchase.

5.46 In May 2001 the house was still for sale. The Committee believes that the price and terms for this property represented good value as well as an opportunity to address the urgent problem of aged accommodation within the Hospital. However, such a decision is constrained by the present uncertainty about the timetable for replacing the Hospital.

Possibilities for short-term action

5.47 Even if immediate action were taken to plan and build a new aged care facility, the situation for those already living in the Hospital and those who are barely managing to cope in their own homes cannot wait. Urgent measures are needed to improve the quality of life of those already living in the hospital, as well as to assist people to continue living in their own homes rather than have to move to the mainland or into the Hospital.

28 Ms Denise Quintal, Transcript, p. 102.

29 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 49.

5.48 There was a delay in implementing the three initiatives proposed by the Norfolk Island Advisory Committee and approved by DVA, namely, the proposed geriatric nursing supervisor, physiotherapist and the vehicle. Each of these initiatives, now activated, will make significant and immediate improvements in health services for the aged. The Committee hopes that future joint initiatives will not experience similar delays.

5.49 Expanding the hours and responsibility of the district nurse could be undertaken immediately, and could be seen as a logical place to start in the push to make ageing in place a reality. The acquisition of a new vehicle and its use to transport small groups of elderly people to the Day Care club, to appointments or even to the supermarket, will rapidly reduce their social isolation and increase their independence and wellbeing.

5.50 Ideally aged care and acute care should not be combined since aged care generally suffers when the two are in competition for staffing and funding. The RSL report documented that this has been the case in the Norfolk Island Hospital although recent staff rostering has endeavoured to keep one staff member on duty in the aged section by day. The DVA Report recommended that in order to recognise aged care as one of the core services of the NIHE, a separate cost centre should be established in the NIHE chart of accounts to reflect this.[30]

5.51 The Committee expects that the ACCNC will organise other improvements in aged care, such as staff training and an examination of underutilised existing facilities. It awaits future developments with interest.

Recommendations

Recommendation 18

5.52 **The Committee recommends that the Commonwealth Government extend the Aged Care Act to cover Norfolk Island, to enable the Norfolk Island Government to access existing programs and initiatives designed to assist rural and remote communities.**

30 Richard Tate Health Consulting Group, *A Study of Aged HealthCare Needs for Entitled Veterans, Norfolk Island*, December 1998, p. 50.

Recommendation 19

5.53 **The Committee recommends that, in order to enable elderly people to remain living in their homes for longer, the Norfolk Island Hospital Enterprise:**

- **increase the district nursing hours, and involve the district nurse where appropriate in the design, implementation and coordination of services necessary to maintain aged persons who are borderline independent in their homes;**
- **in consultation with appropriate staff, examine, prioritise and implement the generally low cost services recommended by Department of Veterans' Affairs, such as respite care and carer support, which would assist people to remain in their own homes;**
- **examine the feasibility of involving service clubs in Home and Community Care-type services, such as house cleaning and maintenance and shopping; and**
- **extend home assessment and accidental fall prevention services to all elderly Norfolk Island people.**

Recommendation 20

5.54 **The Committee recommends that responsibility for routine medical consultations for the aged residents in the hospital be devolved from the general practitioners to the aged care clinical nurse consultant or nurse practitioner.**

Recommendation 21

5.55 **The Committee recommends that the Norfolk Island Hospital Enterprise allocate sufficient funds to ensure that the existing physiotherapy and hydrotherapy facilities at the Hospital are maintained at optimal levels.**

Recommendation 22

5.56 **The Committee recommends that responsibility for liaison between the Norfolk Island Government and the Department of Veterans' Affairs be formalised, in order to take maximum advantage of the benefits available through relevant DVA programs.**

Recommendation 23

5.57 **The Committee recommends that, pending the construction of a new hospital or alternative aged care facility, the Norfolk Island Hospital Enterprise take immediate steps to improve the nursing home facilities within the Hospital by:**

- **establishing a separate cost centre and 24-hour staffing allocation, so that aged care does not lose out to the demands of acute care;**
- **enhancing the perceived status of caring for the nursing home patients, including increased staffing levels and training in geriatric care, in particular the special needs of dementia patients;**
- **improving security for dementia patients by fencing part of the hospital grounds; and**
- **providing privacy for residents, and an attractive and comfortable environment for aged care within the hospital.**

Recommendation 24

5.58 **The Committee recommends that the Hospital Enterprise consider for the future accommodation of elderly people with limited independence either:**

- **a suitable shared house, near the hospital; or**
- **purpose-built, dedicated nursing home and hostel places located within a Multi Purpose Service facility.**

Recommendation 25

5.59 **The Committee recommends that the Norfolk Island Government investigate the possibility of a fully or partly private sector funded retirement village to provide a variety of accommodation for people with differing levels of independence, as well as facilities for social and physical activities. Support for the idea of residents' investment should be canvassed.**