Submission to:

SENATE INQUIRY INTO AGED CARE

July 2004

From: Royal District Nursing Service
31 Alma Road
ST KILDA VIC 3182

ABN 49 052 188 717

Telephone: (03) 9536 5222

Signed: .....

Dan Romanis, Chief Executive Officer

Overview of Royal District Nursing Service (RDNS)

RDNS is a not for profit charitable organisation incorporated under Corporations Law and a Registered Funded Agency under the Health Services Act.

RDNS provides a 24-hour home nursing service seven days a week from twenty regional centres strategically located throughout Melbourne metropolitan are and the Mornington Peninsula.

RDNS response to the Terms of Reference of the Senate Inquiry into Aged Care

RDNS comments focus on the first and latter three items within the Terms of Reference only.

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

The $101.4 million commitment over four years for workforce training and education is a very positive contribution to the longer term, but does not address the immediate issues of staff shortage.

Wages for nurses working in many areas of the aged care sector are lower than those applied to the acute and community sectors and need to achieve some parity in order to retain nurses and improve recruitment in aged care facilities.

Introducing 400 new nursing undergraduate places over 3 years is insufficient to address the critical chronic nursing workforce shortage. Significantly greater numbers of places will be needed to make any impact on the general nursing workforce numbers let alone in the less popular area of practice in aged care.

Increases in capital funding for improvements to aged care facilities would not only be of significant benefit to residents but would also assist in providing better working conditions for staff and therefore foster improvements in workforce recruitment and retention.

(c) The appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions, are met under current funding arrangement.

RDNS is increasingly providing care to young people with chronic degenerative diseases such as Motor Neurone Disease, Muscular Atrophy, Multiple Sclerosis and Cerebral Palsy who are being supported at home by ageing parents. In most instances

these clients eventually require residential care, often when their parents become frail and/or infirm or when the level of HACC services available can no longer adequately meet their changing needs.

RDNS experience in caring for younger people with disabilities who are living in aged care facilities has identified the following issues:

- the loss of independence and hence the level of dependency appears to be proportional to the increase in the level of institutionalisation of the young person
- there is a lack of trained staff to understand the needs of young people as opposed to the treatment and care of the older residents with specific needs such as dementia and this leads to a tendency to treat all residents the same. For example menus and meal times, recreational activities and a lack of privacy do not take into consideration the needs of a younger resident.
- Facilities frequently demonstrate a lack of consideration of the younger person, as do 'house rules' such as the visiting rights of friends and relatives which must be conformed to by all residents regardless of age or degree of disability.

RDNS staff visiting young people with disabilities living in aged care facilities often observe behavioural problems associated with institutionalisation, boredom and need for a measure of independence. Often staff at these facilities are not able to provide the emotional and developmental support required for these younger people to reach their potential. It is not uncommon for the younger person to develop the custom and culture of the aged care facility or strike out against the rules and find themselves being transferred through a series of residences.

The placement of younger people with disabilities in a setting that has not been designed to meet their characteristic needs shows little consideration for their self esteem and quality of life.

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

Current HACC programs are already experiencing levels of unmet need and these are set to escalate with the rapid growth in the aged population and concurrent decrease in the availability of informal care. The majority of older people no doubt prefer to remain in their home with the support of a range of community services rather than be placed in residential aged care. Resources available to HACC programs must grow at least in parallel if even the current quality and access to HACC services is to be maintained.

Some specific points in relation to the provision of HACC services are:

- Whilst not, perhaps, immediately relevant to this Term of Reference item, RDNS experience would suggest that the multitude of funding sources and programs which have developed to address the healthcare needs of the elderly is often confusing and difficult to navigate from a client and (sometimes) provider perspective. Just one example of the resultant clouding in service provision is the Department of Veterans Affairs (DVA) funding for veterans care. In Victoria, HACC funding supplements that

which comes from DVA for provision of nursing care to veterans. Thus in providing this care a service provider such as RDNS effectively faces two sets of accountability requirements which due to a lack of standardisation increases the weight on administrative workloads at all levels.

- Eligibility criteria for HACC service entitlement have continued to be heavily based on subjective decision making. Whilst an element of flexibility will always be desirable, the looseness of interpretation between service providers and across HACC service types has led to inequity of access to services. A strengthening of HACC eligibility criteria and standardarisation of interpretation across services is essential to ensure that the increasingly scanty spread of funds across the growing aged population is equitably distributed.

- It is widely acknowledged that support of the frail aged in the community is highly dependent on the commitment of informal carers. The rapidly growing aged population is already placing increased pressure on a diminishingly available number of informal carers and this gap will only widen in the future. Without building the community services needed to support frail aged people who are without informal care networks to draw on, the demand for residential and acute care will continue to spiral.

- Evidence of insufficient resources in HACC services have been noted by RDNS. For example:
    - Lowering in the levels of care being provided to Linkages (community options) clients. Nursing care is often considered by case managers to be too costly resulting in the inappropriate allocation of care to personal care attendants without full consideration of the impact of this on the client's condition.
    - Waiting lists for clients to receive Community Aged Care Packages – particularly in ethno-specific programs.
    - Waiting lists for clients to be assessed by Aged Care Assessment Services.
    - Clients receiving insufficient hours of personal care, shopping, food preparation and respite.
    - Equity of access to HACC services is challenging for clients residing in rural areas and the outer urban regions which are frequently growth corridors. These people also face the lack of public transport, proximity to informal care in the form of family and neighbours and general and specialised health services. Clients with CALD backgrounds living in isolated communities face even further stress in accessing appropriate community services.

- There is a need to review the HACC 'no growth' areas of Palliative Care, Rehabilitation and Post Acute Care. Already growth in demand for these services without the corresponding matching of funding increase has resulted in cross subsidisation from within existing HACC funding. This misrepresentative circumstance will no doubt continue and escalate without consideration and response.

(e) the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

Despite recent efforts within the acute sector to provide more appropriate arrangements when discharging elderly clients from acute care back into the community setting, significant problems exist. The quality of discharge planning in the acute setting is erratic and frequently fails to recognise the needs and issues faced by clients on their return to their homes. This often leads to distress for clients and their families and even readmission to acute care, an event that may have been avoided with better planning and communication between the acute and community services.

The introduction of mandated protocols for communication between the acute setting and following-up community services may offer some means to begin addressing this issue. The implementation of the Service Coordination Tools as a vehicle for referral between HACC services in Victoria has generally resulted in better coordination of multiple community service providers in the delivery of a HACC client's care. Standardising and formalising of referral protocols between the acute and community sectors may bear similar fruit and prepare the ground for even more sophisticated future communication processes such as the electronic exchange of information.

The immediate phase of post acute care delivered in the home throws up many anomalies and challenges for community nursing services. Generally this phase of care is the funding responsibility of Post Acute Care programs but often inadequate resources are allocated to meet the true needs of the client at this stage of their recovery. A practice exists of PAC funding only being made available to support the period between hospital discharge and the date when HACC funded nursing service is available to commence care provision, rather than the period of PAC funding being based on an assessment of the client's potential period of need.

The Hospital Admission Risk Projects (HARP) in Victoria are another example of funding resting in the hands of the acute sector but with an aim of maintaining HACC clients within the community. These projects aim to reduce acute sector care costs but do not adequately provide the additional funding for this purpose to the key community services who are integral to the achievement of the goal.

The acute sector objectives and strategies must be a part of the planning of HACC services as increasingly there is a shift towards mutually exclusive goals. Greater collaboration between the acute and HACC sectors would achieve more effective outcomes in the planning of services.

CONCLUSION

RDNS appreciates the opportunity to inform the Senate Inquiry Into Aged Care, of our observations and perceptions of the significant challenges that now and will in the future impact on the delivery of effective and efficient services to Australia's ageing population.