COMBINED PENSIONERS AND SUPERANNUANTS ASSOCIATION OF NEW SOUTH WALES INC.

Founded 1931.
Representing pensioners, superannuants and low-income retirees.

Consumer Protection Awards – 2002, 2003

28 July 2004

Our Ref: GFA.045
ASC.020

Submission to the Senate Community Affairs References Committee

Inquiry into Aged Care

Introduction

Combined Pensioners and Superannuants Association of NSW Inc (CPSA) is a non-profit, non-party political membership based association representing the interests of pensioners of all ages, superannuants and low-income retirees. It has around 150 branches and affiliates with a combined membership of over 12,500 throughout NSW. Although it is based in NSW CPSA represents its membership and broader constituency at both state and federal levels.

CPSA takes an interest in issues to do with aged care because a large number of our members and constituents are older people and, therefore, likely to need the services of residential aged care or Home and Community Care (HACC) service providers. In addition, because the association represents all pensioners, younger people in nursing homes who are on the Disability Support Pension (DSP) are also part of the constituency we represent.

The Inquiry into Aged Care has very broad terms of reference. CPSA appreciates that the Senate Community Affairs References Committee is taking what looks like a comprehensive approach to aged care. CPSA also appreciates the opportunity to respond to the issues raised and will do so under the specific headings listed in the terms of reference and make further comments as are relevant.

CPSA, Level 3, 25 Cooper Street, Surry Hills NSW 2010
Phone: (02) 9281 3588 Country callers: 1800 451 488 Facsimile: (02) 9281 9716
Email: cpsa@cpsa.org.au Website: www.cpsa.org.au ABN: 11 244 559 772

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

The *Review of Pricing Arrangements in Residential Aged Care: Final Report* (2004) conducted by Professor Warren Hogan included an analysis of the current situation regarding aged care workforce issues:

"The residential care sector faces significant workforce issues that need to be addressed in the near future if the quality of care in residential care services is to be maintained. These issues include:

- the general shortage of trained nursing staff, which is greater in the residential care sector than in other areas of the health system;
- specific barriers to recruitment, retention and re-entry to the aged care workforce;
- the ageing of the aged care sector's nursing workforce;
- differences between the states and territories in the regulatory frameworks governing training, medication management and employment conditions; and
- the changing profile of consumers of residential aged care services, with its implications for the nature and extent of the demand for future services and the composition and skills mix of the workforce."

Using figures from the Australian Institute of Health and Welfare (AIHW), Hogan demonstrates that the total number of nurses employed in the sector from 1994 to 1999 has declined by 17.8 per cent.

There are alarming shortages of nurses in Australia's health sector overall. However, it seems to be most critical in the aged care sector. Indeed, a 14 April 2004 media release from the NSW Nurses Association, responding to the Professor Sue Richardson and Associate Professor Bill Martin's survey *The Care of Older Australians: a Picture of the Residential Aged Care Workforce* (February 2004), revealed that approximately one in ten residential aged care facilities did not have enough personal carers with the

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most basic qualifications – let alone enrolled and registered nurses. In fact, according to Richardson and Martin:

"In sum, the typical worker is female, Australian born, aged about 50…is likely to be a Personal Carer [PC]…The data suggest that a quarter of PCs and close to one in five nurses have to be replaced each year – by their current employer, if not by the whole industry."

It is a serious concern that the residential aged care sector is so reliant on workers with only the most basic qualifications. That is not to cast aspersions on their commitment or the way they do their job. The problem is that they only have training up to TAFE Certificate III level. By comparison, Registered Nurses (RNs) have a four year degree in nursing including completed subjects in their professional specialisation and possibly postgraduate qualifications as well. PCs cannot offer the same level of care as fully qualified nurses. And the industry appears to be employing PCs in ever growing numbers.

Wage disparity between aged care nurses and their colleagues in public hospitals is a major reason for the shortage of nurses in the aged care sector. Staff shortages are problematic in all areas of nursing. In aged care nursing the shortages will be greater because aged care nurses are seriously lagging behind their colleagues in regard to pay. The Australian Nursing Federation (ANF) in an 18 June 2001 media release drew attention to the issue with the finalisation of Western Australia's public sector nurse-wages agreement that year. According to the ANF:

"Some aged care nurses now earn more than $100.00 per week, or $5000.00 per year, less than their equivalent colleagues in a public hospital or State Government nursing home. Many others are more than $50.00 per week or $2,500.00 per year behind their public sector colleagues. The wages slide has created a nationwide nursing shortage in the aged care sector in the last two years and the capacity of the industry to provide residents with a safe, sustainable nursing skills mix is seriously at risk."

It is not only the pay that is a problem. Poor working conditions appear to be a factor as well (and indeed tend to go hand-in-hand with poor wages). Richardson and Martin make this point:

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"Only 11 per cent overall are permanent full-time employees, with this highest percentage for Registered Nurses (at 18%) and lowest for PCs (at 8%). The most common form of employment was permanent part-time. This accounted for over two-thirds of workers…About 13 per cent of the workforce said that they were employed as casuals and a similar proportion said that they were not entitled to paid sick leave…Recently hired workers were much more likely to be on casual contracts [36 per cent]."

It is a worrying trend that recently hired workers are being hired on a temporary basis. Casual employment is insecure and is unlikely to foster a loyalty towards the employer. When an employer hires a casual s/he seems to be saying "here is a gap I need to fill" rather than "I need a real professional to join my team". The employee, in accepting a casual position, seems to be saying "I need the work" rather than "here is a professional team I want to join." In other words, casual employment means employer and employee have minimal interest in the other's well being and generally don't have a long term commitment to each other (although some casuals are sometimes employed for extended periods when they should be given permanency).

Permanent, preferably, full time employment of staff is important for the residents of aged care facilities. It gives them a sense of being settled and subsequent well-being. They like staff to have a chat with them (aside from other residents, staff are often their only company) and to be familiar with their needs. Understaffing and rotating staff undermines residents sense of feeling at home. You cannot establish a rapport with a nurse who is rushed off his/her feet and is not likely to be employed the following week.

The solution to the understaffing problem is likely to be long term. The Hon Julie Bishop, MP, Minister for Ageing, did announce $877.8 million package over 4 years to improve the wages of aged care sector workers. As long as the money is specifically targeted to achieve those outcomes then it is a good start (although Paul Sadler from Aged and Community Services Association of NSW and ACT estimated that the aged care funding package from the 2004 Budget is too little to allow providers to give aged care nurses parity with public hospital nurses).

A more fundamental problem, however, is the low status of "female" occupations (Richardson and Martin show that 94 per cent of workers in the sector are women). Aged care is a predominantly female occupation

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that involves the care of people in advanced old age. This combination gives it a low social status. It is not going to be easy to address that problem given that it relates to profound socio-economic factors outside the Australian Government's direct control. Nevertheless, in regard to long-term policy initiatives, there needs to be a strategy that will enhance the status of women and older people if aged care nursing is to overcome its systemic problems including staff turnover.

(b) The performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

(i) Assessing and monitoring care, health and safety;

(ii) Identifying best practice and providing information, education and training to aged care facilities;

(iii) Implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.

The performance and effectiveness of the Aged Care Standards and Accreditation Agency leaves much to be desired. Part of the problem is that the Agency is not set up to directly control residential aged care facilities. The Agency is, according to their website:

"…an independent company limited by guarantee, established under the Australian Securities and Investments Commission, and subject to the *Commonwealth Authorities and Companies Act 1997*. It is the body established by the Commonwealth Government as the accreditation body under the *Aged Care Act 1997* (http://www.accreditation.aust.com)"

This set up removes them from direct responsibility for residential aged care. Indeed, the *Aged Care Act 1997* deregulated the aged care industry giving more powers to proprietors. Proprietors receive subsidies from the Australian Government in return for service provision. However, they are allowed considerable leeway in terms of how services are carried out. The Agency merely accredits nursing homes and hostels on a classification scale leaving residents and their families to make choices based on that assessment. Unfortunately, the choices are not necessarily made freely – waiting lists for nursing home care means people often need to take what

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they can get. In fact, according to a 1 June media release this year from the Health Services Union of Australia (HSUA) over 20,000 people were waiting for a place in aged care facilities in NSW and ACT.

The Agency's own publication *The Standard (Winter 2004)* reveals serious problems with the accreditation process:

"Receiving a full, three-year period of accreditation is no mean feat, especially when your home has been identified with serious risk and multiple non-compliant outcomes just eight weeks before…staff who assessed the conditions at the [Juninga Centre] home were shocked. Frontier Service's staff Caroline Phillips and Sharon Davis identified extensive problems with clinical care and management systems, and staff morale was low after the home received negative coverage in the local press…Problems with nutrition and hydration had been identified before the Agency's visit, when staff observed residents having difficulty eating meals. A visiting speech pathologist had reviewed all residents and made recommendations. These recommendations were not acted on, and the advice was not recorded in residents' care plans."

The account goes on to illustrate how the home went "from serious risk to full, three year-year accreditation in eight weeks."

The article is clearly an attempt to vindicate the Agency's accreditation processes and to show how a bad situation can be rectified. What it really shows is how appalling it is that a facility could degenerate to such a poor state and still receive accreditation by turning the worst aspects around in a short period. What is to prevent the facility, like various others that have barely met accreditation standards, from slipping back to its former state?

A recent report on dental health in aged care facilities ABC Radio's *The World Today* was not exactly a glowing testimony to the way accreditation is carried out. Professor John Spencer from the University of Adelaide's Dental School referring to a survey conducted by the university said:

"We found that those people in nursing homes developed new dental decay at around two-and-a-half times the level of their similar aged older adults living in the community. The gum disease was certainly sufficiently severe that some teeth were being lost because they were simply mobile through gum disease…Those people that were developing the most new

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dental decay had the most restricted range of foods in their diet and seemed to be among those that had the greatest weight loss across the one year that we followed these residents in the nursing homes."

(http://www.abc.net.au/worldtoday/content/2004/s1148849.htm)

If older people have better dental health partly as a result of living outside residential aged care facilities it is an indictment of the accreditation process. Part of the problem with the process is that assessors do not have appropriate training. The Agency's website states:

"Audits are conducted by teams of quality assessors. All assessors have completed an approved training course and are registered as aged care quality assessors with the Quality Society of Australasia (QSA)."

QSA's training courses for aged care assessors run for 5 days and appear to have no pre-requisites apart from a willingness to learn. It may be that assessors have previous qualifications but that doesn't seem to be guaranteed. The courses are presumably of a high standard but 5 days does seem too short to guarantee assessors will be trained to make appropriate assessments of aged care facilities' standards.

Aged Care Assessment Teams (ACATs), which assess the level of care older people need when they can't manage at home without assistance (and which may mean they have to enter a nursing home), are made up of doctors, nurses, social workers and other health professionals. Why shouldn't the teams assessing nursing homes consist of already qualified professionals including nurses, building inspectors, fire safety inspectors and accountants? CPSA acknowledges the level of involvement by professionals in the accreditation process. Obviously the Directors of Nursing (DONs) and nursing staff must interact with assessment teams. The issue is that the assessment teams themselves do not have the level of qualifications we would like to see.

Occupational health and safety standards and building standards are extremely important considerations in the assessment process. Building inspectors and fire safety inspectors could provide the level of expertise to guard against existing problems when it comes to bringing facilities up to scratch.

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CPSA is extremely concerned about the level of neglect and abuse reported to occur in residential aged care. For instance, in 2000-01 the Complaints Resolution Scheme recorded 7,240 calls nationwide. In addition:

"Ninety eight percent of the complaints accepted were associated with the provision of aged residential care services. Relatives lodged the majority of complaints (54%), however, some fifteen per cent of complaints were made by staff and eight per cent by residents themselves."

More detail is available from the website of the Office of the Commissioner for Complaints (http://www.cfc.health.gov.au/docqa/qa_crsperf.htm).

If only eight per cent were registered by residents it does indicate that intimidation could be a factor here. Nursing home residents have to put up with any possible retribution. Relatives do not. In other words, the number of complaints from residents could be "the tip of the iceberg". Nonetheless, no matter who is lodging the complaint it does seem that the number of legitimate complaints is far too high. It would be interesting to compare the number of complaints lodged by parents against the NSW Department of Education and Training in regard to schools. CPSA suggests that if accepted complaints were similar in number to those lodged against aged care providers there would be a public outcry.

The accreditation process, as it stands, does attempt to identify best practice and provide information, education and training to aged care facilities. This is spelt out in the Agency's *Charter of Commitment to Service Quality*. It also provides self-assessment packages and other education packages aimed at ensuring service providers are able to meet accreditation standards. But whether the providers actually reach those standards or the standards of best possible practice is a different issue. The problem lies in enforcement. While aged care providers cannot do what they like and must adhere to legislation and accreditation guidelines, there is not the same degree of Commonwealth accountability as, for example, the NSW Government's accountability for the state of its public hospital system.

Warren Hogan stated in *Review of Pricing Arrangements in Residential Aged Care: Summary of the Report* (2004):

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"Financial accountability and report is generally undeveloped and prudential arrangements require improvement. This is not to say that all of the industry exhibits these characteristics – there are a number of entities, particularly the major religious organisations, which have highly professional administrative and financial arrangements. However, the majority of the industry comprises small entities, often partnerships or sole traders, having limited appreciation of the need for management and financial skills."

A report in *The Sydney Morning Herald* (21 July) by Nick O'Malley was even more scathing:

"Accounting standards in the aged care industry are so inconsistent that it is difficult to calculate its revenue let alone prove it cannot afford to pay rises for staff…A professor of accounting at the University of NSW, Bob Walker, told the commission that 15 financial affidavits the industry is using to defend itself from a nurses' pay claim were so 'muddled for accounting purposes as to be meaningless'."

In other words, the industry is not accountable for every cent it spends. This seems somewhat different from the situation of organisations receiving funding through the Home and Community Care (HACC) Program or other government grants. It seems also different from what the situation should be for anyone who supports best accounting practices. However, by not accounting for every cent that is spent the industry is doing nothing illegal. The problem stems from the *Aged Care Act 1997* which does not require more rigorous standards.

This is not only the opinion of CPSA. In the survey *What do Nurses Think about Aged Care: a Report on Nurse Perceptions about the Aged Care Sector* (September 2001):

"70% of aged care nurses think that accountability for funds management is a problem and 81% of nurses in the public sector hold the same opinion of aged care managers. This view is held by all nursing categories across all sectors and particularly among nurses with between 16 and 30 years experience."

The survey goes on to state that:

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"Up until the Commonwealth Aged Care Act was implemented in 1997, the funding of aged care facilities was achieved through a system of quarantined funds that related to the provision of professional and personal care known then as the Care Aggregate Module or CAM, and another aspect of the funding to pay for accommodation and hotel services, known then as the Service Aggregate module or SAM. An acquittal provision accompanied this system and any money that was not used for the defined purpose was returned to the government."

The abolition of this system paved the way for the inevitable:

"With the removal of the acquittal provision through the Commonwealth Aged Care Act (1997), there was no longer an inbuilt system of checks and balances to ensure that government funding for the aged care sector is in fact inadequate."

So, if nurses themselves and consumer groups are united in criticising the accreditation process under the *Aged Care Act 1997*, it may be time for the Commonwealth to consider better legislation that will ensure accountability on the part of the industry.

The current accreditation process at the present time seems too lax and too administratively burdensome at the same time. The laxity has been described above particularly in relation to financial accountability. Administratively, the accreditation process calls on nurses to provide information to the assessment teams when they visit aged care facilities. This means they have to be away from their patients. This is especially onerous in aged care facilities which are chronically understaffed. It is particularly important to have Enrolled Nurses (ENs) with advanced qualifications and Registered Nurses (RNs) available to attend to patients needs as they are the only staff qualified to administer medications. When they are not on hand the patients cannot have their needs attended to.

Again, the main problem seems to be with the legislation governing residential aged care. If the *Aged Care Act 1997* did not give so much discretion to the providers then it would not be necessary to have teams come out to do spot checks and take up the time of the staff. This, of course, would mean a fundamental change in the way aged care services are delivered. However, if a fundamental change is needed then it should be implemented. After all, we are talking about some of the most

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vulnerable people in our community. They deserve no less than first class health care like everyone else.

(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 arrangements

Residential aged care facilities are inappropriate places for younger people who have different needs to those for whom residential aged care places have been designed. *Younger People with Disability out of Nursing Homes: a Discussion Paper* (September 2002) by NCOSS et al is a detailed introduction to the issue. The paper highlights a number of serious concerns. For instance:

"There is grave concern that residential aged care facilities are not obliged to respond to the changing needs of younger people with disability, either via monitoring and reassessment or development of an Individual Service Plan as required of disability services by the [*Disability Services Act 1993*]. It is possible that any focus on the cognitive, behavioral and social needs of a younger person with a disability occurs only when problems arise for the provider due to the person's expressed behaviours. For example, the nature of the disability of the younger person (eg: alcohol related dementia) may cause additional problems if there is no access to any age-appropriate social life, no appropriate mechanism for sexual expression, no peers to talk to or to share interests with."

Residential aged care facilities can also be inconveniently located compared to community care. This problem is particularly poignant for families who find themselves with little choice but to be cut off from their loved one because no disability service is available.

In addition, residential aged care facilities are set up primarily to deal with issues relating to people at the end of their lives. This is what the nurses and other professionals in nursing homes and hostels are trained for. Younger people with a disability, whose life expectancy could be decades, need the professionalism of community workers, social workers and nurses specifically trained to serve their needs. Such professionals are generally not found in such facilities.

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Finally, younger people in nursing homes, through no fault of their own, contribute to extend waiting lists for places. An action plan involving both state and federal governments is needed to address this issue which is creating difficulties for younger people with disabilities and frail older people alike.

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

The Home and Community Care (HACC) Program is described as follows on its website (http://www.hacc.health.gov.au/index.htm):

"The Home and Community Care (HACC) Program is a central element of the Australian Government's aged care policy, providing community care services to frail aged and younger people with disabilities, and their carers. The aims of the HACC Program are:

- to provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers; and

- to support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential care."

It can be problematic in terms of the extent of the client base. As mentioned above HACC services are there for frail older people, people with disabilities and their carers. This means the program must serve a clientele with a variety of complex and differing needs. This can be done if the program has adequate funding. However, it does not for several reasons.

First of all, older clients and younger people with disabilities are living longer than in previous decades. A frail older person aged 80 years may live to 90 years and a person aged 30 years with a permanent, but not terminal, disability, can live many decades.

Also, as in the case of residential aged care, HACC services need to use current funding to deal with waiting lists. This in turn means informal carers (non-professionals caring for relatives or friends outside residential aged

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care or other institution settings) are having more responsibility placed on them without much chance of respite.

CPSA's *Submission on the Review of Community Care* (2004) states:

"CPSA recommends a 20% increase in funding for HACC services each year until the current high level of unmet need amongst older frail people, younger people with disabilities and their carers dissipates. Furthermore, the Commonwealth should carefully map areas where community care has clearly defined access points before committing much-needed funds to the development of Regional Access Centres.

Until access to community care is solely on need, programs like the HACC Program are failing in their objective to prevent the premature or inappropriate admission of people to aged care facilities."

The last point spells out the value of HACC services. Clients with access to these services don't have to enter hostels or nursing homes before they should. This takes the pressure off residential aged care waiting lists and, because older clients of HACC services still maintain a certain degree of independence, it means there is less expense for government (and hence taxpayers) – residential aged care facilities, like hospitals, need large amounts of funding for building upkeep, staff pay, food and administration systems. It makes economic sense as well as being of benefit to the client to be able to remain at home as long as possible.

It would also be worthwhile putting more resources into promoting HACC services so the general public has an idea of what is available so they can make an informed choice. An advertising campaign would also be useful in that people would start to understand what the choices are in regard to services before they need them.

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

CPSA is concerned about several issues in this regard:

- The effectiveness of hospital discharge plans

CPSA, Level 3, 25 Cooper Street, Surry Hills NSW 2010
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- The willingness of hospital staff to consider the desires of elderly patients

- The ability of residential aged care facilities to care for convalescing patients

- Whether elderly convalescing patients can access adequate services at home

The current situation in regard to hospital discharge planning can be ad hoc at best. This is not simply the opinion of CPSA. According to Ros Bragg (formerly of NCOSS) in *Earlier Discharge – Monitoring the Outcomes of Hospital Discharge* (December 2002):

"A key concern for NCOSS has been the lack of effective monitoring of the outcomes of hospital discharge. NCOSS has received consistent reports of consumers being discharged home without adequate community care services available. NCOSS has also received regular reports of community care services receiving referrals which they are unable to meet, whether because they are made at short notice, are outside their target group, or because the agency has already closed its books."

These gaps in service delivery make hospital discharge a difficult process for younger people. How much more difficult for a frail 80 year old? NSW Government policy of early discharge (in order to free up beds as soon as possible) can result in patients being released from hospital in the early hours of the morning. While it is important to make hospital beds available, particularly for very acute cases, the process should not take place when there are gaps in service delivery – especially for the most vulnerable patients. In some cases the patient's family may not be available so an older person may not have a relative who can care for them while community services are put in place.

In other words, a seamless discharge process is vital for the health and well being of older patients. This is something the Australian Government, state governments and non-government health service providers need to continue to work on to ensure older patients do not find themselves back in hospital due to systems failures.

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CPSA hopes this submission will be taken into account regarding all aged care issues dealt with by the Senate Select Committee. In addition, we have made specific recommendations (see page 16).

Yours faithfully
Combined Pensioners and Superannuants Association of NSW Inc

per June Gabriel
State Executive Member

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Recommendations

1. The trend towards deprofessionalisation in the aged care industry must be halted.

2. Aged care nurses in all states should have their pay brought into line with their colleagues in the hospital system.

3. The growth of casualisation in the aged care industry must cease.

4. A comprehensive strategy to promote aged care nursing as a career should be worked out between government and universities.

5. The *Aged Care Act 1997* should be abolished.

6. The Aged Care Standards and Accreditation Agency should be abolished and aged care be brought under direct control of the Department of Health and Ageing.

7. New legislation in place of the *Aged Care Act 1997* should be modelled on legislation governing the public hospital system.

8. The Australian Government and state governments need to establish a timeline and a comprehensive strategy, in consultation with the National Advocacy Alliance for Young People in Nursing Homes and other interested community organisations, to relocate younger people currently living in nursing homes to more appropriate settings.

9. The Home and Community Care (HACC) Program should receive a 20 per cent funding increase each year to meet the needs of its target groups and be comprehensively promoted as a service.

10. The Australian Government, state governments and interested community organisations need to implement a strategy to fill any gaps in the discharge process of older people going from hospital to aged care facilities or the community.

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