CHAPTER THREE:

ENSURING QUALITY SERVICES:

NEW ARRANGEMENTS

(POST 1 OCTOBER 1997)

CONTENTS:

The Commonwealth is currently in the process of reforming the quality assurance system for residential aged care facilities. Like the current system, the new system will include a Charter of Residents' Rights and Responsibilities, and residential agreements. The major change to the system is the abolition of the standards monitoring regime, and its replacement with an accreditation-based system of standards monitoring. There are also changes to the funding of nursing homes - or residential aged care facilities, as they will be known - which may impact on standards of care. The following sections describe and comment upon these changes.

3.1 ACCREDITATION

The accreditation system of quality assurance, which the Commonwealth will introduce from 1 January 1998, has not been completely developed at this stage. What is known is that all residential aged care facilities will be assessed against the accreditation standards, which are currently in draft form only. The accreditation standards are being developed by a working group consisting of consumers, industry and Commonwealth Government representatives (no State or Territory Government representatives have been involved in the development of the Standards).

An Aged Care Standards Agency, administered by a Board selected by the Minister, will oversee the accreditation process (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 1, 1997). Only facilities which are accredited may charge accommodation bonds and receive Commonwealth funding (*Commonwealth Aged Care Act, 1997*, Division 37-1, p 129).

The Accreditation Standards and sanctions are outlined in Part 18.8 of the third exposure draft of the *Aged Care Act, 1997 Principles*. The Standards appear comprehensive and constructive. They are grouped into four categories:

Category 1	Health and Personal Care (including medical care, pain management, nutrition and hydration, skin care, continence management, behavioural management);
Category 2	Resident Lifestyle (including privacy, dignity, independence, leisure activities, cultural and spiritual life, decision-making);
Category 3	Safe Practice and Physical Environment (including infection control, fire safety, OHS); and
Category 4	Management Systems and Organisational Development (including human resource management, regulatory compliance and information systems).

The draft accreditation standards incorporate standards regulating both inputs and outcomes in most of the aspects of care which are regulated by the current Outcome Standards. The draft accreditation standards differ from the existing standards in several areas.

Some additional measures have been included. The most significant gain for the resident in Category 1 (Health and Personal Care) is draft standard (1.11), "evidence of involvement of specialist assessment and treatment where appropriate" for issues of behavioural management.

In Draft Category 2 (Resident Lifestyle), the significant gains are: expanded emotional support; regular reviews of leisure activities; greater support for cultural and spiritual observances; and the right to be free of harassment, retaliation and victimisation.

Draft Category 3 (Safe Practice and Physical Environment), expands and updates the present standards significantly in the areas of Occupational Health and Safety, and includes environmental services such as catering, cleaning and maintaining facility grounds.

Draft Category 4 is an entirely new category - Management Systems and Organisational Development. The purpose of this new category is:

> *to enhance the quality of performance under all standards in all categories, and should not be regarded as an end in themselves. They provide opportunities for improvement in all aspects of service delivery and are pivotal to the achievement of overall quality* (Draft Accreditation Standards, 1997).

The principle enunciated is that the

> *organisations' management systems are responsive to residents, staff and stakeholder needs and the changing environment in which they operate* (Draft Accreditation Standards, 1997).

This category includes the requirement that there be sufficient numbers of appropriately skilled staff, and that staff be encouraged to undertake ongoing education and training.

The draft accreditation standards also exclude some of the current Outcome Standards. In particular:

- the provision under Standard 1.1 that "residents are aware that they can choose and change their medical practitioner" is removed;
- current Standards 1.5 and 1.3, Pain Management, which require staff awareness of "verbal and non-verbal cues for pain or discomfort" and of "effective pain management practices" have been omitted;

- the new Palliative Care Standard 1.6 no longer includes specific reference to the carrying out of residents' wishes at their death, as elaborated in the current standard 5.6;

- Draft Accreditation Standard 1.7 (Nutrition and Hydration) does not mention that "snacks and drinks are available throughout the day" and "food is presented in a manner that is appetising to residents", as required by current Standards;

- current Standard 5.2 whose principle is that "private property is not taken, lent or given to other people without the owner's permission" has been deleted;

- Draft Standard 2.4, (Independence) has changes in emphasis which reverses the control over independence. The facility proprietors/care givers are now the ultimate arbiters of residents' independence, not the residents (who hold that right in the current standards). For example, assessment of each residents "needs and preferences" are replaced by assessment of "capabilities and restrictions". Although "needs" are mentioned in Draft Standard 2.4c, it is in terms of evaluating and documenting needs, rather than the current requirement under Standard 1.2 to "respect" and "consult" on residents' needs; and

- significant criteria deletions in the area of privacy and dignity are: "residents' wishes are carried out at their death" (5.6); and that "residents' private space is respected by (staff and) other residents" (5.3); Changes in these criteria include the previous "right to privacy" (5.3) being replaced by "needs for privacy". Likewise, "residents are enabled to undertake personal activities, including bathing, toileting and dressing in private" (2.5b), but privacy is no longer "maintained at all times", as in current standard, (5.3).

Accreditation of all residential aged care facilities is aimed to be completed by the year 2001. In the meantime, facilities must obtain interim certification if they wish to charge an accommodation bond. In order to obtain certification, facilities must also meet the requirements of any state laws and Commonwealth authorities in relation to building, equipment and care standards (Certification Principles, 1997: 73).

Facilities with unrenovated buildings exceeding 20 years of age, which are more than one storey, which do not meet any relevant state fire and safety laws, or which were not purpose built, may be required to undergo an assessment for certification. This assessment must be undertaken by a qualified person independent of the Department. The assessment determines whether the building and equipment meets State laws, is safe and secure, ensures privacy for residents, and allows access to public transport and medical care (Certification Principles 1997, Part 4, ss 12 - 14). Facilities which have not achieved accreditation after the transition period of two or three years will lose Commonwealth subsidies (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 1, 1997).

The Aged Care Standards Agency will have the task of inspections of facilities for the purpose of accreditation. It will make recommendations to the Department concerning substandard services (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 18, 1997b). As the Commonwealth Department of Health and Family Services remains the funder of services, it will be responsible, under the Aged Care Bill, 1997 for imposing sanctions.

The Committee is concerned that the accreditation system on its own may be insufficient to ensure a high standard of care in nursing homes. An accreditation and peer review approach usually emphasises the importance of market forces to control standards, believing that facilities with poorer standards, or which lack accreditation, will not be able to attract consumers.

Market forces are restricted in the nursing home industry by several factors. Perhaps most notable is that competition is restricted because of the fixed supply of beds. With waiting lists in most areas, even substandard homes are able to assume that they will be able to fill most, if not all, of their beds. It is the Committee's view that market forces cannot operate in a situation where supply is highly controlled and regulated and demand is inelastic.

The Committee also heard that, as most nursing home residents are admitted straight from hospital, there is often no time for them to assess the different homes before admission. In addition, the quality of care is not the only reason for selection of a nursing home. Other aspects which factor into choice include proximity to relatives and friends, retaining links to ethnic or religious groups, and availability of beds. In country areas in particular, the choice of nursing home is very limited, or even non-existent.

The Committee has reservations about the appropriateness of relying on the Aged Care Standards Agency to investigate and report on the aged care services funded with public monies. Although the structure and make-up of the Agency has not been finalised, at this stage it appears that there will be no Government or Departmental representative on the Board of the Agency. The Committee notes that the care of nursing home residents is a significant budget item, and believes that the Commonwealth should accept the responsibility to ensure that facilities receiving its funds are providing an adequate standard of care.

3.2 SANCTIONS

The *Commonwealth Aged Care Act, 1997* details the principles and processes for application of sanctions for non-compliance under the new regulatory framework. The Secretary of the Commonwealth Department of Health and Family Services can impose sanctions on an approved provider if that provider fails to meet its obligations and responsibilities in relation to the aged care they provide. These responsibilities relate to quality of care, user rights and accountability. Examples of such responsibilities include:

Section 54-1 (1) (a) - to provide such care and services as are specified in the Quality of Care Principles;

Section 54-1 (1) (b) - to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;

Section 54-1 (1) (d) - to comply with the Accreditation Standards made under section 54-2;

Section 56-1 (a) - to offer to enter into a resident agreement with the care recipient, and, if the care recipient wishes, to enter into such an agreement;

Section 56-1 (l) - to comply with the requirements of section 56-4 in relation to resolution of complaints (*Commonwealth Aged Care Act, 1997*).

Under the Act, there are a number of sanctions available, including revoking or suspending the provider's approval to provide aged care services, altering the conditions of the provider's approval, prohibiting the further allocation of places to the provider, revoking or suspending the extra service status of a residential care provider, prohibiting the charging of an accommodation bond, and revoking certification (Section 66-1, *Commonwealth Aged Care Act, 1997*).

A provider can avoid losing approval as a provider if she/he agrees to conditions specified by the Secretary, including:

i) providing, at its expense, such training as is specified in the notice for its officers, employees and agents;

ii) providing such security as is specified in the notice for any debts owed by the approved provider to the Commonwealth;

iii) appointment by the approved provider, in accordance with the Sanctions Principles, of an adviser approved by the Commonwealth to assist the approved provider to comply with its responsibilities;

iv) appointment by the approved provider, in accordance with the Sanctions Principles, of an administrator approved by the Commonwealth to administer an aged care service in respect of which the approved provider has not complied with its responsibilities;

v) transferring some or all of the places allocated to the approved provider under Part 2.2 to another approved provider; and

vi) such other matters as are specified in the Sanctions Principle (Part 4.4, Section 66-1).

There are steps which must be taken by the Secretary before sanctions can be imposed, starting with giving a notice of non-compliance, followed by a notice of intention to impose sanctions or a notice to remedy the non-compliance. If there is an immediate and severe risk to the residents, these steps can be omitted. Decisions to impose sanctions are reviewable under Part 6.1 of the *Commonwealth Aged Care Act, 1997.* This is an internal review mechanism: the review is performed by the Secretary - who also made the original decision. External review is available through the Administrative Appeals Tribunal (ss 85-4 and 85-5, *Commonwealth Aged Care Act, 1997).*

The Committee notes that the *Commonwealth Aged Care Act, 1997* provides a range of sanctions designed to encourage providers to meet their obligations and to force out providers consistently breaching standards and responsibilities. In allowing for providers to avoid revocation of approval by adhering to conditions imposed by the Department, the Act also provides a mechanism to ensure that a provider providing sub-standard care can be removed from an administrative and/or management position without a loss of services and the forced removal of residents. This avoids the traditional problem faced by regulators seeking to close down providers of sub-standard care.

However, the Committee is concerned that the standards and sanctions regime proposed under the Act does not overcome the deficiency of the current standards monitoring process: there is no guarantee that the monitoring body will be less tolerant of low standards than is currently the case. The Committee believes that the Department of Health and Family Services should maintain its responsibility for monitoring of standards, and a separate unit within the Department should be made responsible for imposing sanctions for breaches of standards. Such sanctions should automatically be imposed on repeat offenders.

3.3 COMPLAINTS MECHANISMS

The *Commonwealth Aged Care Act, 1997* does not detail the complaints mechanisms to be put in place under the new system; details will be contained in the subordinate legislation (the Principles). The Committee notes that under Section 56-4 of the *Commonwealth Aged Care Act, 1997,* providers are required to institute complaints mechanisms within their aged care facilities, and commends this.

The third exposure draft of the *Commonwealth Aged Care Act, 1997 Principles* provide for the creation of Complaints Resolution Committees. The Committee is independent of government, and is empowered to resolve complaints and to refer systematic or serious issues to the appropriate agency. The Secretary of the Department of Health and Family Services is empowered to negotiate complaints and arrange for mediation prior to referring a complaint to the Complaints Resolution Committee for resolution.

There is now general support for the establishment of this independent committee, overcoming earlier hesitancy arising from earlier exposure drafts which did not specify the mechanism which would be available for residents. The Ageing and Disability Department submitted:

> *ADD supports the creation of an independent monitoring agency which reports to the Minister and has the power to refer cases to the Minister to enforce sanctions* (Submission, 11 September 1997).

The Aged-Care Rights Service also submitted:

> *Overall, the system is an improvement on the existing framework for complaints handling and resolution* (Submission, 11 September 1997).

A number of witnesses and submissions have emphasised that any external complaints body must be independent of both the industry and the Department. The NSW Council of Social Service, for example, noted in its submission to the Committee that for the new system to be successful, it must have "a body separate to both funder and provider which is responsible for monitoring and individual complaints" (Submission 81).

While the Complaints Resolution Committee will be independent of government, the Committee was concerned that complaints must first be lodged with the Secretary of the Department. ADD submitted that it would prefer to see an independent body as the point of first contact (Submission, 11 September 1997).

RECOMMENDATION 13:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services change the complaints resolution process outlined in the third exposure draft of the *Commonwealth Aged Care Act, 1997* Principles, Chapter 3, Part 1: Committee Principles to provide for residents to have direct access to the independent Complaints Resolution Committee without first having to lodge their complaint with the Secretary of the Department of Health and Family Services.

RECOMMENDATION 14:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure the proposed accreditation-based system for quality control in residential aged care facilities embodies the following principles:

- an independent complaints body similar in structure to the Ombudsman's Office;
- the maintenance of the Commonwealth Department of Health and Family Services' role in monitoring the accreditation standards which are currently being developed;
- a separate unit within the Department of Health and Family Services to be responsible for imposing sanctions on facilities which fail to meet the accreditation standards;
- automatic application of the hierarchy of sanctions available under the *Commonwealth Aged Care Act, 1997* for facilities failing to meet the same standard on three consecutive visits; and
- public access to accreditation standards reports, including posting the accreditation inspection reports in the foyer of each facility.

The Committee believes that the accreditation standards themselves should contain, in addition to the existing standards, a strong statement concerning the rights of consumers to privacy, confidentiality, dignity, and independence; and individual standards that incorporate these principles.

3.4 PRUDENTIAL ARRANGEMENTS

The prudential arrangements which have been developed by the Commonwealth aim to protect the funds which residents have deposited as accommodation bonds, and ensure that residents can be certain that any outstanding bond amounts owing to them when they leave a facility will be repaid.

The *Commonwealth Aged Care Act, 1997* requires all facilities charging bonds to comply with the prudential arrangements. The arrangements include the establishment of an industry trust fund, into which all bonds will be deposited, and remain for the

duration of the resident's stay in care. Residents who pay a bond will have a separately identified account within the fund, from which retention amounts (up to $2,600 per year for a total of five years) will be deducted progressively each month. Compliance with prudential arrangements will be monitored by a government appointed, independent Scheme manager and will be part of the assessment of whether a facility should be accredited (Prudential Arrangements Information Kit - Fact Sheet No. 1, 29 August 1997).

Not all providers will need to subscribe to the Scheme; some State Governments, large churches or industry groups may operate their own arrangements as long as they meet legislative requirements and are as stringent as the general industry scheme. Accommodation bonds lodged with such agencies will also be guaranteed, but by the sponsoring organisation of that scheme rather than the industry guarantee fund.

It is expected that services will be able to borrow against the amounts which they have received as accommodation bonds and which are held in the trust fund. Their capacity to borrow will clearly be related to the overall size of the trust fund (such borrowings could be used to invest in any maintenance and upgrading of their facilities which might be necessary to achieve certification and accreditation).

The prudential arrangements have been generally welcomed by consumer groups as a means of ensuring that residents' monies are safe. The Aged-Care Rights Service submitted that:

> *(It) is relieved that the prudential arrangements are stringent and will require all monies from accommodation bonds to be held in trust* (Submission - 8 September 1997).

The Committee heard, however, that there are still some concerns about the signing of accommodation bond and fee agreements, in particular when people are not able to sign on their own behalf.

The Aged-Care Rights Service submitted that:

> *The definition of 'representative' under S.96-5 Commonwealth Aged Care Act, 1997 remains a concern....Our contention is that the definition (or lack) of 'representative' is too broad and may result in parties entering agreements on behalf of others without informed consent or legal standing* (Submission - 8 September 1997).

3.5 RIGHTS AND FUNDING

The Commonwealth's proposal to remove the distinction between CAM (Care Aggregated Module) and SAM (Standard Aggregated Module), and to remove the requirement to validate CAM funding may impact on the quality of care that residents receive in residential aged care facilities.

Under the current system, one of the components of Commonwealth funding is provided for the nursing and personal care of each resident, according to their care needs. This is CAM funding, and it can only be used for nursing and personal care. As previously noted, each service provider has their CAM funds validated by the Department: that is, their records are checked to ensure that funding provided for care was used for care. Any money that was not used for residents' care must be returned to the Department, so a provider cannot increase profits by spending less money on residents' care.

A number of witnesses expressed the belief that subjecting nursing care to the profit motive by removing CAM validation will result in an erosion in the quality of care in nursing homes. They argue that providers will be motivated to cut care related costs to increase their profits, and will do so by hiring less qualified staff, or fewer staff altogether (Moait, Evidence - 5 May 1997; Herbert, Evidence - 21 April 1997; and Johnson, Evidence - 21 April 1997). These concerns are also raised in Stage II of the Gregory Report, which notes that the success of standards monitoring to date has occurred in an environment where there is no financial incentive to reduce care costs (Gregory, 1994: 26). Professor Gregory concluded that a non-acquitted funding system would require more frequent and more stringent standards monitoring to ensure that it did not result in a diminution of the quality of care (Gregory, 1993: 32, 79). Recommendation 12 in Chapter 2 of this Report seeks to address the potential problem of a possible reduction in numbers of qualified staff.

Further details and comments about CAM funding can be found in Chapter Five.

3.6 CONCLUSION

While a number of details of the new care standards monitoring regime are still unknown, the Committee has concerns about some aspects of the proposals. The Committee notes with regret that a number of significant details of the care standards monitoring regime are still not available for comment. In particular, there is a potential for deterioration in care standards resulting from insufficient Government monitoring, and the proposed changes may exacerbate the trend of inadequate training of staff and a declining proportion of qualified staff. The Committee emphasises the importance of strong enforcement and independent complaints mechanisms in ensuring that standards of care in residential facilities are maintained.

CHAPTER FOUR:

RESIDENTS WITH SPECIAL NEEDS

CONTENTS:

The rights of discrete sub-groups of residents are at times overlooked in some aged care services and their specific needs are subsumed in the interests of uniform cost effective services. Younger residents are particularly disadvantaged, and many residents from small rural communities suffer from isolation from their families and lifelong community networks. Residents who have dementia and those with mental illnesses are also at a disadvantage. Residents from non-English speaking backgrounds can experience serious difficulties in obtaining sensitive and culturally appropriate care, as can indigenous Australian communities. In addition, the rights of people to sexual expression and relationships are limited within aged care services.

4.1 RESIDENTS WITH DEMENTIA

The Committee received much evidence about the needs of people with dementia living in residential aged care facilities and the extent to which their needs are not well met. Approximately 60% of nursing home residents and 28% of hostel residents have moderate to severe dementia (Rosewarne *et al*, 1997: 31).

The majority of people with dementia are cared for in mainstream areas, that is, where there is a mix of frail older people who are not cognitively impaired as well as those who are. A major research project which was undertaken by Dr Richard Rosewarne and a team from Monash University, and funded by the Commonwealth Government has found that around 10% of mainstream aged care facilities have a dementia specific area, most usually in a wing of the facility:

> *That is, the main facility has a wing alongside, an attached area, where staff can move in and out but the residents do not* (Rosewarne, Evidence - 8 September 1997).

The research focussed on the care needs of people with dementia who had challenging behaviours, and found that dementia-specific areas cater for those people staff find the most difficult to provide care for. However, in his evidence to the Committee, Dr Rosewarne noted:

> *The interesting thing about challenging behaviour and dementia is that most of the care is provided in the mainstream aged care system* (Rosewarne, Evidence - 8 September 1997).

It is therefore imperative that staff who work in residential aged care services are trained in dementia care and behaviour management (Submission 10). In the absence of trained staff, residents with dementia are often restrained, either physically, or chemically through the use of sedatives. It is often the case, according the Alzheimer's Association, that the:

> *use of psychotropic drugs as a form of restraint in the management of dementia [occurs] without the consent of the person affected or their guardian* (Submission 77).

The behaviour of residents with dementia can also be upsetting for other residents, particularly those who share rooms with people with dementia. One study of 2000 residents in nursing homes in Sydney found behaviour associated with dementing illnesses to include the daily manifestation of:

> *restlessness, pacing, constant calls for help, cursing and verbal aggression, and oft-repeated sentences [for 10% of residents]. Hitting, kicking, and biting were less common ... Few (0.5% each) were reported as making verbal or physical sexual advances daily or more often. Some 4% were said to scream or make loud noises at least once daily; about 2% screamed several times daily, and ... 0.45% screamed several times an hour* (cited in Submission 58).

Most of the residential aged care services are not constructed or furbished in a way which mitigates against some of these behaviours, and are not staffed by qualified staff with expertise in managing the behaviour of the dementia affected. This is regrettable because, as the Committee was told by one specialist:

> *... with good management programmes, with training of staff and judicious use of medication, for most of these people, we can make their lives, and the lives of those around them, much better* (Brodaty, Evidence - 21 April 1997).

Dr Rosewarne's research further demonstrated the need for appropriately trained staff, particularly when assisting the person with dementia with personal care or activities of daily living:

> *...the biggest issues was the challenging behaviour as a product of the resident and staff member and the activity they are trying to do. That interaction is important* (Rosewarne, Evidence - 8 September 1997).

Dr Rosewarne continued

> *... Not everyone with a high level of cognitive impairment and dementia has a challenging behaviour ... It is not as if residents have some characteristic which, no matter where we put them, means that they are challenging at the point eight level out of ten.... It depends on the way they are approached, their current disposition and what sort of activity you are trying to do. It is important for staff training to think carefully about all those issues* (Rosewarne, Evidence - 8 September 1997).

The Committee believes that there is an urgent need for dementia-specific training of all staff caring for residents with dementia. However, this training should not only include nursing staff but also includes the whole of the organisation. In its response to the Interim Report of this Inquiry, the Ageing and Disability Department noted:

> *Training in dementia should not be limited to nursing and personal care staff: management also need to be educated in the care needs associated with dementia, so staff can be supported. This is particularly important for the implementation of flexible work practices, which are fundamental to good care of people with dementia* (Submission - 11 September 1997).

Unfortunately, there are few organisations which provide this level of training for staff and management.

The Committee further understands that there are few dementia-specific training programs available, although most nursing, gerontological and aged care training programs include a dementia module. The Committee is aware that there are a number of training programs being developed as part of the $4m NSW Action Plan on Dementia, including for General Practitioners and hospital staff, but these will not specifically address the needs of people working in residential aged care services.

The Commonwealth currently provides a National Residential Dementia Training Initiative as part of the former National Action Plan for Dementia Care. Under this Initiative, all levels of staff in nursing homes, including management and ancillary staff, are able to access training programs which are provided by dementia educators contracted by the Commonwealth. In New South Wales the training providers are Alzheimer Education (West and Northern New South Wales) and the Hammond Care Group (East and Southern New South Wales and the Australian Capital Territory). Attendance in the program is voluntary and free of charge. There is a small amount of funding available to assist those services which cannot afford to send staff to the training, for example due to the cost of backfilling specialist staff in small facilities or due to the distances involved for rural and remote services. The training includes a train-the-trainer component to assist the continuation of dementia training at the local level into the future. The Initiative concludes in December 1997. An evaluation of the training is being undertaken by the South Eastern Institute of TAFE in Victoria, and the final report will be provided to the Commonwealth in March 1998.

The Committee understands that, as part of the monitoring process, an advisory group has been established by the NSW Office of the Department for Health and Family Services which includes industry representatives. One of the aims of the advisory group is to assist the development of a dementia training infrastructure within New South Wales which will continue dementia training beyond the life of the Initiative.

The Committee believes that a national program of dementia training should continue to be offered to all staff and management of residential aged care facilities. It is unclear at this stage what responsibility the Commonwealth will take in relation to the provision of ongoing dementia training. The Committee believes that dementia training will continue to be required in New South Wales in the future, and that this should be included in the aged care training framework discussed in Chapter Two of this Report.

RECOMMENDATION 15:

The Committee recommends that the Ageing and Disability Department take into account the findings of the evaluation of the National Residential Dementia Training Initiative, and any recommendations of the NSW Advisory Group for the Initiative in its consideration of an aged care training framework (as per Recommendation 9).

RECOMMENDATION 16:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ensure that Dementia Training is included in the training curriculum for aged care services, or any other training program being considered by the Residential Aged Care Workforce Review Committee.

RECOMMENDATION 17:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to determine what dementia training will be made available by the Commonwealth in the future.

RECOMMENDATION 18:

The Committee recommends that, should the Commonwealth not provide dementia training in the future, the Minister for Aged Services develop and implement a training program similar to that offered under the National Residential Dementia Training Initiative, or contract out for the development of such a program, and that the Commonwealth be approached to provide funding for such a program.

The Committee is aware that there are a range of dementia training materials which have been produced in recent years, in part stimulated by the funds provided under the National Action Plan for Dementia Care. In New South Wales a number of organisations received funding for Demonstration Projects for Best Practice in Dementia Care under the National Action Plan. However, the Committee is concerned that while there are many organisations which hold a variety of resources, often for specific target groups (eg. Alzheimer's Association holds information for carers, the Centre for Education and Research on Ageing has resources for care professionals), there is no one identifiable organisation to hold a broad selection of resources and which could ensure that materials on best practice in dementia care are widely disseminated. The Committee understands that a national Clearing House and Resource Centre was funded under the National Action Plan, based at Monash University, however funding for the project is now finished and the resources are no longer available. The Committee believes it is important that there be a similar central dementia resource centre which could market itself to residential aged care services and which could assist in the ongoing development of staff working in these services. This could be considered within the context of the NSW Action Plan for Dementia Care.

RECOMMENDATION 19:

The Committee recommends that the Ageing and Disability Department consider allocating funds from within the NSW Action Plan for Dementia Care to support the establishment and/or ongoing viability of a central dementia resource centre for staff and management of aged care services.

RECOMMENDATION 20:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ascertain the whereabouts of resources produced under the National Action Plan for Dementia, previously housed at the Clearing House and Resource Centre at Monash University, and the possibility of including these resources in the collection to be established under Recommendation 19 above.

While staff training is fundamental to good dementia care, Professor Henry Brodaty told the Committee that while most residents with dementia could be managed in mainstream facilities which have trained staff and good programs,

> *there is a residue, and the numbers are hard to say, who are not amenable to such good management and for them we need special dementia care units. This is a problem* (Brodaty, Evidence - 21 April 1997).

As noted above, there are very few nursing homes with dementia-specific care units. A dementia care unit is usually separate from the mainstream facility, usually in a wing, or secured-off area, and includes a number of design features which appear to enhance the lives of people with dementia, and assist staff in the provision of their care. The Committee heard that while:

> *A lot of research has been done in the area of design ... there is very little empirical evidence proving what is best* (Rosewarne, Evidence - 8 September 1997).

In the course of his research, Dr Rosewarne identified four key issues which were thought to be important in dementia design:

> *(1) Secure areas where people can wander and move from a main kitchen and living area and which are accessible (ie. not locked off);*
>
> *(2) Inclusion of a kitchen area which is incorporated into the model of care;*
>
> *(3) Dining and living rooms which are divided into smaller areas to accommodate small groups of people; and*
>
> *(4) A more open design, where there are no barriers to people trying to get through, over and around* (Rosewarne, Evidence - 8 September 1997).

The Committee believes that the thrust of these principles, which appear to be aiming at smaller, domestic style units, is also of benefit for people who are not cognitively impaired.

Many of the design features which Dr Rosewarne identified are included in dementia specific services which have developed in recent years in New South Wales. The Committee was informed that

> *New South Wales has some very fine examples of design which aim at enhancing the outcomes for people with dementia, including the work which has been undertaken by the Hostel and Care Program* (ADD Submission - 11 September 1997).

The Hostel and Care Program (HCP), which is part of the Home Care Service of NSW, assists organisations in developing aged care facilities, including dementia specific facilities. Under the NSW Action Plan on Dementia the HCP will receive funds to explore design issues for people with dementia, including in residential and community care settings, and disseminate the findings in a user-friendly format (ADD Submission - 11 September 1997).

The Committee was also made aware of a major consultancy on environmental design which was undertaken as part of the National Action Plan for Dementia Care, the findings of which have not yet been published. The Committee considers that, as design of facilities can work towards enhancing the lives of people with dementia, and as organisations consider renovations or rebuilding in order for their facilities to be certified, it is important that this information be made available as soon as possible.

RECOMMENDATION 21:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services make available the findings of the environmental design consultancy undertaken as part of the National Action Plan on Dementia Care.

In New South Wales there is another level of residential care which has been developed for people who have severe dementia who have extremely challenging behaviours, called CADE (Confused and Disturbed Elderly) Units. These units were established as a result of the deinstitutionalisation process which the mental health system underwent during the 1980's. Nine units were established in New South Wales, and the Units incorporate dementia-specific designs and have higher staffing levels and specialised programs to better manage residents' behaviours. CADE Units are funded at a higher rate than nursing homes: the comparative costs are $100 per bed day for nursing homes, and $200 per bed day for CADE units. The lack of suitable services to support or accommodate people with severe dementia who have challenging behaviours and live in aged care facilities often results in those residents being forced to be admitted to acute psychiatric or general hospitals inappropriately, at a cost of $300 - $400 per day (Brodaty, Evidence -21 April 1997).

The Committee understands that a review of CADE units was undertaken which has not yet been publicly released by NSW Health. Any consideration of future directions in dementia care for aged care services should take into consideration the recommendations of this review.

There are a range of developments in recent years in relation to the care and support of people with dementia in residential aged care services. These include the groundbreaking Rosewarne research (noted above), the Commonwealth's Psychogeriatric Care and Support Initiative, the Victorian Aged Care Assessment Review, the Victorian Taskforce on Dementia, and the Future Directions on Dementia Care which was prepared by the Reference Group for the National Action Plan for Dementia Care.

An overwhelming theme of these developments is the right of people to be supported where they are for as long as possible, and the need for appropriate service and system responses to be available to support them. It is clear that the majority of people with

dementia can be supported within mainstream services; some will require specialist care and support within a mainstream setting; a small percentage of people with severe dementia who have challenging behaviours will need specialist accommodation, care and support.

The Committee heard evidence that the Rosewarne research identified twelve elements of service development that need to be addressed if the above outcomes are to be achieved, including nine for the mainstream services and three which were more of a specialist and separate nature:

> *The findings suggested that there was a need to upgrade the general system but also to have some specialist parts* (Rosewarne, Evidence - 8 September 1997).

The mainstream elements include those issues raised above such as improved staff training and environmental design which results in a more homelike setting, as well as the inclusion of relatives/family in care planning and delivery, support to rural ACATs and General Practitioners through teleconferencing and telemedicine, and appropriate levels of funding for dementia care in the Resident Classification Scale (Rosewarne, Evidence - 8 September 1997).

In regard to specialist care, the Committee heard that the findings of Dr Rosewarne's research supported the need for specialist dementia/psychogeriatric services which were based in a community, rather than health system (Rosewarne, Evidence - 8 September 1997). The models of the Victorian Psychogeriatric Assessment Teams (PGATs) and the Commonwealth's Psychogeriatric Care and Support Units were considered useful models.

Both models provide specialist advice to mainstream and dementia specific services, particularly in regard to management of difficult behaviours. The Victorian model

> *operates like a psychogeriatric model but is more of a psychosocial model as it is not so medically focussed* (Rosewarne, Evidence - 8 September 1997).

Both the Psychogeriatric Assessment Team and the Psychogeriatric Care Unit models also have brokerage funds attached, which are used to provide short-term funding to meet specific needs of the client/s who have the challenging behaviours. The important thing to note about this model is that it supports the care of people in the mainstream services for as long as possible, and limits the need for specialist or high cost service provision:

> *It is not just about placement; it is about giving staff advice on management and then pulling out as needed ... and acts as the local resource team for facilities having difficulty with people* (Rosewarne, Evidence - 8 September 1997).

Dr Rosewarne noted that difficult people are not difficult forever, and concluded:

> *We believe that it is important for the service system to have resources that are available; flexible resources where you can pull them in and pull them out. It is another way of saying that you do not always have to build separate things for people who are difficult at a particular time* (Rosewarne, Evidence - 8 September 1997).

There has also been exploration of alternative models of accommodation and care for people with dementia in Europe, including cluster projects and group homes, which the Committee believes may provide important lessons for New South Wales. The Committee believes there are clear lessons to be learned from both national and international developments, and these should be incorporated into any national or State aged care strategy as recommended previously.

RECOMMENDATION 22:

The Committee recommends that when developing the NSW Aged Care Strategy, and contributing to the National Aged Care Strategy, the Ageing and Disability Department take into consideration developments in dementia and psychogeriatric care which have occurred internationally as well as within Australia, such as the cluster and group home models which have been developed in Europe.

The Committee understands that, as part of the recent Federal Budget, additional funding was provided for Aged Care Assessment Teams in New South Wales to continue to employ staff with psychogeriatric expertise, which was initially funded under the National Action Plan for Dementia Care. In addition, the NSW Action Plan has provided funds for Area Health Services to develop local area dementia plans. However, the number of psychogeriatric staff employed in area health services and on ACATs remains limited, and there is significant variability in the provision of comprehensive community psychogeriatric teams across the State. The Committee believes that it is important that New South Wales develop a comprehensive psychogeriatric network, and that this should form part of the NSW Aged Care Strategy recommended above.

RECOMMENDATION 23:

The Committee recommends that the development of the NSW Aged Care Strategy (see Recommendation 4) include the provision for a comprehensive network of community psychogeriatric teams.

RECOMMENDATION 24:

The Committee recommends that the Ageing and Disability Department and the NSW Health Department fund the establishment of a comprehensive network of community psychogeriatric teams, including funding for a budget-holding role which can be used for short-term interventions in community care settings and residential care services for people with challenging behaviours.

The provision of quality care for people with dementia is also dependent upon the amount of funding available to provide that care. The Committee is aware that there are a number of residential aged care facilities which already offer innovative management programs and environmental design to assist in the management and care of residents with dementia within existing funding levels, and a number which do so only by providing additional funding. The Resident Classification Scale which has been developed places greater weightings for dementia related care needs, including appropriate programs and environments. Dr Rosewarne participated in the group which oversighted the development of the scale, and told the Committee that services:

> *will not get separate infrastructure funding for a special dementia unit but will be able to use the funding they have to provide these options if they wish* (Rosewarne, Evidence - 8 September 1997).

The Committee has heard that, while the scale targets care for people with dementia more clearly, there are no additional funds to the aged care budget:

> *It should be remembered that all that has been done is to spread the same pot of money over nursing homes and hostels. Whether in the long run that is a big help we wait to see* (Herbert, Evidence - 8 September 1997).

The Committee is concerned that additional funding for dementia which the Commonwealth Government has promised may not result in improved care for people with dementia.

RECOMMENDATION 25:

The Committee recommends that the Ageing and Disability Department include in its monitoring of the impact of the *Commonwealth Aged Care Act, 1997* on the appropriateness of funding for people with dementia.

The Committee heard that it is difficult for carers of people with dementia to access appropriate respite care. Moving a person with dementia from familiar surroundings and placing them into residential care for respite can be quite unsettling for the person, and their inability to understand the changes or communicate their concerns to staff can result in behaviours which can make care difficult to provide. As a result, the Committee is aware that some residential facilities refuse to take people with dementia for respite on account of the disruption this causes for the resident and staff.

This is of particular concern to the Committee, as the stress of caring for a person with dementia is often a key reason why carers need to relinquish care and place the person with dementia into residential care on a permanent basis. The Committee believes that it is important for services to better understand the care needs associated with providing respite for people with dementia, and that this should improve if all staff receive adequate training in dementia care and management adopts responsive and flexible care practices (see Recommendation 18).

The Committee understands that the Alzheimer's Association Australia received funds under the National Action Plan for Dementia Care to conduct research on the particular respite needs for people with dementia and their carers. The report has not yet been released, and the Committee believes that this would be a resource to service planners who aim to provide appropriate and responsive services for people with dementia and their carers.

RECOMMENDATION 26:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services release the report prepared by Alzheimer's Association Australia on respite needs for people with dementia and their carers as soon as possible.

RECOMMENDATION 27:

The Committee recommends that the Minister for Aged Services negotiate with the Commonwealth Minister for Family Services to improve access to residential and day respite care in dementia-specific facilities and facilitate the development of more responsive and flexible models of respite care.

4.2 RESIDENTS FROM NON-ENGLISH SPEAKING BACKGROUNDS

Older people from non-English speaking backgrounds (NESB) are another group which can be disadvantaged in nursing homes. A right to maintain cultural identity, including practising religion, is encoded in the current Outcome Standards. However, not every home meets the Outcome Standards relating to cultural identity. Some homes, for example, have failed to provide ethnic food; others do not seek to support religious practices.

Specific problems for residents of non-English speaking backgrounds include difficulties in communicating with staff and other residents, and considerable trouble in voicing their complaints. Access to information in their native tongue may also be problematic, reducing their ability to make informed choices.

A particular difficulty for NESB residents is that many facilities fail to use professional interpreters. Instead, providers often rely on family members of residents, or bilingual staff, to undertake informal interpreting for medical assessments and other legal, medical and private matters. The Committee is concerned that this may infringe on the right to confidentiality for NESB residents.

The use of amateur interpreters also could cause mistakes to be made based on inaccurate translations. There is a potential for serious negative consequences when untrained interpreters are asked to translate technical legal and medical terminology. When negotiations for accommodation bonds occur, this need for professional interpreters to be used will be paramount.

RECOMMENDATION 28:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure that all residential aged care facilities with residents of non-English speaking backgrounds be required to provide the services of a professional interpreter or phone interpreter for all medical assessments, consultations and any negotiations concerning accommodation bonds or residents' fees where a resident needs such services to communicate effectively.

Adequate funding is needed to ensure that providers are able to meet the needs of NESB residents who have difficulties in expressing themselves or understanding English. The new Resident Classification Scale, which assesses the level of care needs of residents, should allow for higher funding levels for residents who have higher individual needs, including language-related needs.

RECOMMENDATION 29:

The Committee recommends that the Minister for Aged Services request that the Commonwealth Minister for Family Services ensure that the Resident Classification Scale recognises the additional resources needed to meet the needs of non-English speaking background residents with low levels of fluency in English, and that higher funding be allocated accordingly.

The NSW Clustering Service, which is funded by the Commonwealth Department of Health and Family Services, seeks to assist with meeting the needs of NESB residents. A key function of the Clustering Service is to create "clusters" of residents from particular cultural and linguistic backgrounds, so that they can be concentrated into specific nursing homes. This provides residents with opportunities for communication in their native language, and allows facilities to specialise in culturally aware care. The Clustering Service also offers cross-cultural training, encourages community - nursing home networking, and collects data about the numbers and placement of NESB residents and staff (Submission 9).

The Committee commends the NSW Clustering Service for its valuable services. The Clustering Service currently operates on an annual budget which, according to its manager, impedes the Service's ability to project its services over the medium term with any certainty (G Lee, Manager NSW Clustering Services, Personal Interview, 12 May 1997). The Committee is very concerned over the recent changes by the Commonwealth of funding to the Clustering Service. The Committee understands that the Service will need to tender against other organisations for future funding to support people of culturally and linguistically diverse backgrounds in residential aged care services. While the Committee is not opposed to competitive processes in the allocation of public funds, it considers that it is not appropriate in this case: there is limited expertise available in New South Wales to provide such a service and the introduction of competition for funds for this service may lead to reduced co-operation between services and fragmentation of the network which currently exists. The Committee believes that the Clustering Service should be funded on a five-year basis to allow medium term planning.

RECOMMENDATION 30:

The Committee recommends that the Minister for Aged Services support the NSW Clustering Service being funded on a five-year basis, and approach the Commonwealth Minister for Family Services to request this.

RECOMMENDATION 31:
The Committee recommends that the specific needs of people of diverse cultural and linguistic backgrounds who use aged care services be addressed within the NSW Aged Care Strategy to be developed under Recommendation 4.

4.3 SERVICES FOR INDIGENOUS AUSTRALIANS

The care needs of older indigenous Australians are quite distinct. Indigenous Australians have a shorter life expectancy and a higher incidence of illness and disability than other Australians, and make use of aged care services at earlier ages (Australian Institute of Health and Welfare, 1997: 4). Therefore, arbitrary age limits, such as those used by the Commonwealth in establishing planning ratios for aged care, are often inappropriate.

In addition, indigenous Australians tend to prefer community-based to residential services, consistent with their expressed desire to remain on the land and with their families in old age. The Committee has heard that in some country towns aged care facilities have been built for Aboriginal communities yet find that the facility is not used by the people of that community. It appears that the planning for and delivery of services for such communities was often undertaken without due consultation or consideration of the cultural appropriateness. However, the Committee understands that in recent years the Commonwealth has become increasingly more sensitive to the particular needs of Aboriginal peoples, and has been more flexible in its provision of aged care services to this population group.

In its response to the Interim Report of this Inquiry, the Ageing and Disability Department noted that:

> *there is only one successful example of (an Aboriginal Specific facility) in New South Wales, which suggests that people from Aboriginal and Torres Strait Islander communities require greater support from appropriate community services* (Submission, 11 September 1997).

The Committee received no submissions or evidence from Aboriginal communities on the specific needs of older Aboriginal and Torres Strait Islander peoples. It therefore believes it is inappropriate to report on this matter, without adequate information on which to proceed.

The Committee believes that the particular aged care or aged related needs of Aboriginal and Torres Strait Islanders should be considered more fully by policy planners and providers of aged care programs, in consultation with indigenous communities.

RECOMMENDATION 32:

The Committee recommends that the specific needs of indigenous Australians should be considered within the context of the NSW Aged Care Strategy to be developed under Recommendation 4, and developed in close consultation with indigenous Australian representatives.

The Committee understands that Aboriginal communities were consulted in the development of the NSW Action Plan on Dementia, and representatives continue to participate on the Reference Group oversighting the implementation of the Plan. A number of specific projects will be funded under the Plan which target Aboriginal communities, including community awareness and education for health workers about dementia. The major cause of dementia in the Aboriginal community is alcohol-related, rather than Alzheimer's disease as is the case with the general population.

4.4 RESIDENTS FROM RURAL AREAS

The most common problem for rural and remote areas is lack of local residential care services. As a result, it is not unusual for residents requiring nursing home care to be admitted into nursing homes hundreds of kilometres away, where it is very difficult for family and friends to visit, particularly those without cars.

The *Sydney Morning Herald* reported the case of Mr Don Cameron, who had lived together with his wife in a hostel in Bourke. As Mr Cameron's Alzheimer's disease progressed, he was temporarily moved into the local hospital, and finally was transferred to a nursing home at Forbes, five hours' drive away. Mrs Cameron is unable to visit her husband regularly, and their contact is usually confined to a phone call each Sunday (*Sydney Morning Herald*, 4 April 1997).

This situation is not an isolated incident. Due to small populations, people in rural and remote areas may have access to a hospital, a hostel, or a nursing home, but rarely more than one of these services. Some small country hospitals have set aside long term beds for nursing home type care, but they seldom are able to achieve the homelike environment required of nursing homes, and some lack diversional therapy or organised activities.

The Commonwealth has retained a $10 million capital program for the building and upgrading of facilities, a priority of which will be rural and remote communities.

Multi Purpose Services have sought to meet the needs of rural and remote areas. Multi Purpose Services (MPSs) are a joint Commonwealth-State initiative which provides different types of care under one administrative body and one funding structure.

The Committee has examined the delivery of services in MPSs in South Australia and in rural areas of New South Wales because of the potential of the model to expand the range of services offered in rural communities. A Multi-Purpose Service is a centre which integrates several different health and aged care services in one facility under one administrative and funding structure. A single MPS could offer acute care hospital services, nursing home and hostel care, as well as home and community care and ambulance services. Typically, an MPS builds on an existing service such as a hospital or hostel which is not financially viable on its own.

The MPS program seeks to overcome the problems inherent in the provision of health and aged care services to communities in rural and remote areas. Such problems include the small populations and low demand which make the provision of services costly on a per-person basis; fluctuations in demand which can threaten viability; difficulties in obtaining staff in remote areas; and distance from mainstream services.

The MPS program was piloted in New South Wales in 1992 with four MPSs, under a Commonwealth-State agreement. The four MPSs currently operating are at Braidwood, Baradine, Urana and Urbenville. Other states also have piloted MPSs. Funding is a mixture of Commonwealth and State capital funding, with recurrent funding being made up of State HACC and acute care funding, and Commonwealth Community Services funding (Lagaida, Evidence - 12 May 1997).

The potential benefits of the MPS model include:

- improved access to a range and mix of services;
- flexible use of funding to direct resources as required;
- reduced administrative costs as overheads are shared by the different services; and
- reduced capital costs as buildings are used for a number of services.

Multi-Purpose Services can also overcome the problem faced in many small communities with frail elderly people being forced to move to aged care facilities hundreds of kilometres away, or being accommodated inappropriately in long term beds of local acute care hospitals.

Submissions and evidence received by the Committee have revealed support for the concepts of MPSs. For example, the Uniting Church's Uniting Ministry with the Ageing told the Committee:

> *MPSs are an excellent way of trying to maximise the use of the resources in [a] town, because you actually get, as much as you can in small towns, economies of scale because everybody is working together and you can*

> *actually share administrative resources that otherwise you might have to duplicated in the different facilities, so I see enormous potential for MPSs* (MacDonald, Evidence - 21 April 1997).

Submissions received by the Committee reveal that there has been some resistance to the model of MPSs implemented in New South Wales.

The Aged Services Association (ASA) has been outspoken in its criticism of the MPS model in New South Wales. ASA does agree that for some communities, "an MPS is a sensible option" and supports the concept of MPSs. ASA's concerns with the NSW Government's approach to MPSs include:

> *... the absence of consulting with our industry, and secondly in the absence of being able to provide an explanation for the model that was chosen ... we have taken issue with the flexibility of the NSW Department of Health in implementing that particular model* (Frean, Evidence - 28 April 1997).

In particular, the New South Wales model of MPS involves Area Health Services taking control of what had previously been a community-managed facility. An official from NSW Health explained the organisational structure for MPSs in New South Wales:

> *In terms of the actual operation, for the individual MPS site [the auspicing body] is the area health service. But, in terms of the program for the establishing of an MPS site, it is the NSW Health Department* (Lagaida, Evidence - 12 May 1997).

Mr Lagaida gave evidence that there is community involvement in the setting up of the MPS, with community members forming an MPS development committee. However:

> *Once the MPS is established and up and running, the MPS then becomes part of the area health service's operation. ... The ultimate responsibility resides with the area health services. The reason for doing it that way is to ensure that there is an integration and proper planning of acute, aged care and community services* (Lagaida, Evidence - 12 May 1997).

Some communities are clearly unhappy about the prospect of losing management and control of aged care facilities, particularly where community fund raising has financed a large proportion of the existing facility's operation. The Committee received evidence that:

> *where a facility already exists in a local town ... if a community has done a lot of work and put together a local facility, they have raised money, they have bought and built this local facility, the Department of Health has been largely saying to them, in effect: Well, that's fine, if you want to have continued funding, we will continue to provide operational funding to you,*

> *but we will take this MPS over and in fact we'll take ownership of all the assets and they will now belong to the Health Department* (MacDonald, Evidence - 21 April 1997).

Mr MacDonald commented further:

> *... I see enormous potential for MPSs, but you have to go back to square one and start selling the whole thing again because it has been an absolute disaster the way the Department of Health has handled it* (Evidence, 21 April 1997).

Community run facilities are apprehensive of Area Health or Regional Health control. Teloca House at Narrandera submitted:

> *Under the current MPS Agreements, all management control of existing activities - such as participating Hostels and Nursing Homes - comes under the jurisdiction of the Regional Health Authority. From the experience of Urana [MPS], the former Hostel Management Board has no input to "day-to-day" operations of the Hostel, as such is now administered through the Greater Murray Health Board ... Consequently, we object to the current model for a MPS, which removes local management control to regional health authorities, and seek amendment to provide for local management committees to be elected by the local community rather than the need for "Ministerial" appointment of members* (Submission 12).

Teloca House also noted that the considerable contribution of volunteers who freely give their services for a community facility would be less willing to give time to assist a more distant regional health body.

The loss of community control of facilities is avoided in other States. The three MPSs in South Australia are incorporated bodies run by local communities. The Committee visited the Central Eyre Peninsula MPS in South Australia. The Board of Directors of Mid-West Health and Aged Care Inc, the body which runs the MPS, is entirely made up of nominees from the participating facilities and local communities. The Board is divided into sub-committees which examine such aspects of management as continuous improvement, women's health and community services. A full-time Chief Executive Officer is employed for day-to-day management.

Some communities and providers in New South Wales are also concerned about the services and care offered by MPSs. They are critical of the health focus of aged care in MPSs, and their lack of provision of other services needed by the aged population, such as housing, public transport and recreation facilities. One criticism of NSW Health's management of MPSs is that it treats aged care as a health issue.

The predominance of the health focus, including NSW Health's involvement in the MPS Program, may threaten the viability of the facilities, according to the Aged Services Association, because people will be unwilling to pay an accommodation bond to enter accommodation that has the atmosphere of a health facility (Frean, Evidence - 28 April 1997). It is also important to note that MPSs are not required to meet Outcome Standards, and thus there is no independent monitoring of the quality of care. The Commonwealth proposes that MPSs will be required to be certified and accredited under the new system.

With plans for up to 50 additional MPSs to be established in New South Wales over the next few years, some local communities and service providers are complaining that they have been pressured into accepting MPSs, have been threatened with closure of existing health facilities and have received misleading information. They would like to see a more flexible approach which would allow for the maintenance of community participation.

The Committee believes that while there are obvious advantages to the MPS model as a means of provision of aged care services in rural New South Wales, there are also significant barriers to their successful operation. These barriers are predominantly from the management structures dictated by NSW Health. The appointment of managers by the Area Health Service, and locating that management position within the Area Health Service, has removed the connection between the MPS and the local community. While the Committee heard that local MPS committees have been established to provide that link to the Area Health Service, the overwhelming feeling of some of these local communities is that their services have been taken out of their hands. This is of great concern to the Committee. Local communities in rural and remote areas have a history of pulling together to meet the needs of their communities. The Committee heard from a number of people about their community's effort and goodwill over many years, including fundraising activities and private donations, to ensure that the community had the aged care services it requires. The imposition of a manager appointed by the Area Health Service, and external to that community, meant that they no longer had control over the funds which they had raised, and created uncertainty about the use of those funds, and of any future funds which might be raised by the community. To remove the management of the MPS from the hands of local communities has been, for many, a rejection of their contribution to the aged care needs of their community.

The Committee considers that further consideration of the model should be done in the context of the NSW Aged Care Strategy as per Recommendation 4.

RECOMMENDATION 33:

The Committee recommends that the Ageing and Disability Department include in the NSW Aged Care Strategy to be developed as per Recommendation 4 of this Report a review of the Multi-Purpose Service model, including discussion of the most appropriate management structures for this type of service.

4.5 RESIDENTS WITH MENTAL HEALTH NEEDS

According to the Senior Staff Psychiatrist in Psychogeriatrics at the Royal North Shore Hospital, residents of nursing homes are not able to access the same degree of expert clinical attention and services as the wider community when they are suffering from a mental health problem (Submission 20).

Mental health problems are prevalent in the nursing home population, particularly clinical depression and anxiety syndromes. It is estimated that some 30% of nursing home residents suffer from depression (Submission 58). This depression can respond to treatment, but is often undiagnosed, or assumed to be a normal part of ageing, and left untreated (Submission 58). The Ageing and Disability Department noted that

> *Improved diagnosis of depression is also important because it can cause dementia-like symptoms and without proper diagnosis people can be labelled (as is often the case with people with dementia) and treated with less respect* (Submission - 11 September 1997).

Research undertaken by Dr Brian Draper of Prince Henry Hospital also indicates the link between depression and the high incidence of suicide rates among nursing home residents (ADD Submission - 11 September 1997).

As noted above in the discussion on the rights of people with dementia, residents who have a diagnosis of dementia can also have behavioural problems which could be assisted by specialist mental health or psychogeriatric services.

Despite the high level of psychiatric illnesses in nursing homes, there are few specialist mental health care workers to treat them. According to a survey published in the *Australian Journal of Public Health* in 1995, less than one half of the nursing homes in Sydney received visits from a mental health professional for an hour or more each month. Only 7% of facilities in the study received more than four hours a month of specialist care (cited in Submission 57).

It was further submitted to the Committee that:

> *Although a majority of area health services in New South Wales include comprehensive psychogeriatric services, some (especially in rural areas) do not, and most are not staffed adequately; most cannot provide an adequate service to nursing homes ...* (Submission 20).

The submission went on to suggest that the addition of one extra staff member per psychogeriatric team would suffice to meet the needs of most nursing home residents.

The Australian Health Ministers Advisory Council's Mental Health Working Group has commissioned a Scoping Study on Older People and Mental Health which focuses on the linkages between accommodation, treatment, care and support service systems.

However, the Committee understands that the Scoping Study Working Group has not met for over six months, despite work being underway on the Work Program which was identified in the first stage of the Scoping Study.

RECOMMENDATION 34:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ascertain the progress of the Scoping Study on Older People and Mental Health, and to request a meeting of State and Territory representatives to advance the work program and promote improved linkages between accommodation, treatment, care and support service systems for older people with mental health needs.

A common problem for residents who are able to obtain the services of mental health specialists is access to a private space for consultations. A psychogeriatrician told the Committee:

> *If I want to interview a patient - I am asked to see people if they are depressed or something was bothering them or when they have psychosis - it is very hard, usually impossible, to find somewhere private to interview the person. If there is an interview room, it is a long way away. There are three other people in the room; it is not fair to ask them to leave. The person I am seeing often isn't mobile. So it makes life tough* (Brodaty, Evidence - 21 April 1997).

This situation makes it very difficult for residents with mental illnesses to obtain professional help in a confidential manner. No one wants to discuss their problems while there are three other people in the room; this includes mental health as well as other health related problems. It is essential that a private interview room be made available at all residential aged care facilities, and that this room be centrally located.

RECOMMENDATION 35:

The Committee recommends that Minister for Health ensure that all residential aged care facilities in New South Wales be required to set aside a private interview room for residents to consult with health personnel, including mental health specialists. The private room should be located as centrally as possible to ensure that the less mobile residents are able to access it.

While most residents with mental illnesses or challenging behaviour can be treated in-situ, there are always a small number of residents who require care in specialised facilities. In previous times, elderly people with mental illnesses would have been admitted to psychiatric hospitals. However, with the policy of deinstitutionalisation, and the closure of many beds, other alternatives must be sought. Unfortunately, as previously noted, New South Wales lacks alternative facilities suited to caring for older people with challenging or disturbed behaviours. This not only means that older people who have a mental illness are denied appropriate care, but it creates disturbances in nursing homes and can be distressing for other residents (Submission 20). As was proposed in Recommendation 23, the development of an appropriately resourced comprehensive network of psychogeriatric community teams would also benefit older people with a mental illnesses.

The Committee was informed that the Report of the NSW Health Task Force on the Mental Health of Older People is due for release in October 1997:

> *The report's recommendations address a range of issues specific (to) dementia and recognise the current shortfall in long term care places in New South Wales for (people with) severe behavioural disturbances associated with dementia* (NSW Health, Submission - 11 September 1997).

The Committee looks forward to the publication of the Report of the Task Force.

4.6 RESIDENTS WITH PARTNERS

Residential services do not, in the main, include consideration of the rights of residents to sexual expression and relationships. While the Charter of Residents' Rights and Responsibilities stipulates that residents have a right to maintain personal relationships, it does not mention sexual relations. The Committee is concerned that it is frequently assumed that residents of nursing homes are asexual. Couples are often unable to share a room privately together. It was also submitted to the Committee that elderly gay or lesbian couples face discrimination because of their sexuality (Submission 44).

It is not uncommon for married couples in the same facility to be accommodated in separate rooms. It was reported to the Committee, for example, that a husband and wife in a facility in a town in rural New South Wales were placed in separate rooms against their wishes. In other cases, husbands and wives have been separated by many hours' driving time, as discussed earlier.

The Committee was informed that the third exposure draft of the *Aged Care Act Principles* does not include a right to sexual relations.

RECOMMENDATION 36:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to include in the *Aged Care Rights Principles* a specific reference to a right to sexual relations.

4.7 YOUNGER NURSING HOME RESIDENTS

The Committee heard disturbing evidence concerning the situation of younger residents of nursing homes. There are 929 residents of nursing homes in New South Wales who are under the age of 60 years. The most common disabilities of younger residents are acquired brain injuries (28.4%), intellectual disabilities (23.4%), neurological impairments (21.4%) and physical disabilities (21.2%) (Jacobsen, Evidence - 12 May 1997).

It was submitted to the Committee that nursing homes are an inappropriate place for younger residents. Nursing homes catering for older people focus on preventing the degeneration of the health and abilities of their residents. By contrast, the needs of most people with an intellectual disability are developmental or educational. Residents with disabilities require intensive developmental programs implemented by staff who have an understanding of the needs of intellectually disabled people and the skills to meet those needs (Submission 67). For residents with acquired brain injuries, there is a pressing need for rehabilitative services to allow them to develop their potential. These services are unavailable in many nursing homes.

The care and developmental needs of the intellectually or physically disabled and those with acquired brain injuries are very intensive and are more costly than caring for an aged or frail resident. The Committee was told that:

> *The per capita funding that is available under the disability program is far in excess of the upper level of per capita funding available as a subsidy in a nursing home ...*
>
> *... disabled residents of nursing homes, at something of the order of $77,000 per person, per year ... [while] the upper limit for funding in an aged care nursing home is more of the order of $45,000. ... It would be impossible to meet the disability standards of people at the high needs end of the spectrum without extending that level of dollar per capita ...*
>
> *... you could argue that the nursing homes that do accept [younger] people with very high support needs, in the absence of appropriate funding, will be forced into the position of [providing] ... something that is in fact substandard for those particular individuals* (Clark, Evidence - 12 May 1997).

A particular problem for younger people in nursing homes is that they can feel isolated, with few people of their own age group to communicate with, or who share their experiences.

One younger resident described her experiences in a nursing home to the Committee:

> *Because I have cerebral palsy I sometimes get spasms in my arms and legs. At meal times I am not allowed to sit with the other residents because they complain to the staff that I might kick or bump them ...*
>
> *... Most of the people I live with are old enough to be my grandparents, and I don't have anything to talk to them about. Most of them wouldn't talk to me anyway...*(McMinn, Evidence - 12 May 1997).

For many younger residents of nursing homes, there are insufficient activities to occupy them. Some nursing homes exclude disabled residents from their organised activities, and "do not support an individual's access to a range of community services and facilities" (Submission 38). Diversional therapy designed for frail, aged or dementing residents may not be appropriate for younger residents. As Ms McMinn commented:

> *We do have a diversional therapist who comes to the hostel, but the majority of her activities I cannot access because I am blind and I have a profound hearing loss, and you need to be able to walk, or maybe my hands are not good enough, or something....*
>
> *... Someone told me that I could stare at the walls, but I can't; I'm blind, and I can't see them ... If I had the opportunity to go to a day centre it would certainly make my life a lot better. ... then I would be with people like myself and of my age and I would have people to talk to or maybe someone to read my mail for me* (Evidence, 12 May 1997).

Residents of nursing homes are unable to access HACC and other State services such as day centres if they are resident in a facility with a diversional therapist because this would be considered "double dipping". The Committee recognises that cost constraints operate in the area of aged and disabled care, but it appears that younger nursing home residents are missing out altogether as a result of bureaucratic inflexibility.

RECOMMENDATION 37:

The Committee recommends that the Minister for Aged Services ensure that any impediments preventing residents of aged care facilities under the age of 60 years accessing Home and Community Care services and other State services be removed as a matter of urgency.

RECOMMENDATION 38:

The Committee recommends that the Minister for Aged Services approach the Commonwealth to make the financial arrangements necessary to ensure access of residents of aged care facilities under the age of 60 years to Home and Community Care services.

RECOMMENDATION 39:

The Committee recommends that the Minister for Aged Services and the Commonwealth Minister for Family Services resolve the issue of transporting residents of aged care facilities under the age of 60 years to day centres and other Home and Community Care services.

Younger nursing home residents are usually admitted into a nursing home because of the lack of other alternatives. According to the Council for Intellectual Disabilities:

> *At present people with an intellectual disability are entering nursing homes because of a lack of suitable alternative accommodation rather than because of any assessed need for nursing care* (Submission 67).

People with intellectual disabilities and neurological damage are better placed in supported accommodation in group homes, or living in their own flats with support services.

The Committee heard that a high level Accommodation Task Force has been established to consider the accommodation needs of people with disabilities and older people. The Task Force has established estimates of the costs of moving younger people out of nursing homes into the community. The Ageing and Disability Department submitted:

> *the Taskforce has estimated that approximately $55 million in capital funding and $30 million in recurrent funding would be required to address this problem at the lowest level estimate* (Submission - 11 September 1997).

The submission continued:

> *the NSW Government is unlikely to have the resources to address this problem in the near future* (Submission - 11 September 1997).

The Committee believes that the Commonwealth Government as well as the NSW Government should take responsibility for addressing the particular needs of younger people living in aged care services.

RECOMMENDATION 40:

The Committee recommends the Minister for Aged Services approach the Commonwealth Minister for Family Services to (1) develop a joint strategy to facilitate the transfer of the 929 younger people currently residing in aged care facilities out of these facilities into more appropriate accommodation options in the community, where possible, and (2) where this is not possible, ensure that younger persons receive the appropriate therapy and services they need.

The Committee understands the final report of the Accommodation Task Force is expected to be provided to the Ministers for Aged Services, Housing and Health in the near future. While it is inappropriate for the Committee to comment on the recommendations in that report, the Committee commends the Task Force for undertaking such an ambitious task, and it looks forward to more positive accommodation outcomes for older people and people with a disability as a result.

4.8 OLDER PEOPLE WHO HAVE ACCOMMODATION, SUPPORT AND SOCIAL NEEDS

The majority of this Report has focussed on people who require high levels of care and that part of the residential system which supports them. This section considers those people who do not have significant care needs, but require some accommodation and social support, and comments on how the service system best meets their needs, or doesn't, as appears most often the case.

People who require admission to a residential facility need to be first assessed by an Aged Care Assessment Team. One of the main reasons why people have historically entered hostels, or low care level aged care facilities, is because they have been assessed as requiring assistance with personal care needs and/or having accommodation, support and social needs which cannot be met in a community setting. Under the current (pre-1 October 1997) system, residents who mainly required social and accommodation needs, but not personal care, are classified as 'hostel level' residents and a Commonwealth subsidy is provided for those residents in this category who are Financially Disadvantaged Persons (FDPs).

The Commonwealth funding for hostel residents reflects the residents' assessed care needs. The lowest level of funding is for people who are assessed as requiring only hostel care, with no personal care (Submission 53). Hostel Care subsidies are currently

$2.95 per day for residents who entered the hostel before 27 April 1993, and $3.55 per day for those who entered thereafter (Department of Health and Family Services, November, 1996). The Personal Care subsidies range from $26.90 - $35.30 for FDPs and $23.40 - $31.90 for non-FDPs.

The practice in recent years has been to reduce the number of people approved for hostel entry. In the past three years, the proportion of Hostel Care classified residents has dropped from 45% to 30%. Approximately one half of these residents were Financially Disadvantaged Persons (Submission 46); in New South Wales there are approximately 5,000 such residents currently in hostel accommodation. At the same time, some hostel residents whose care needs have increased have remained in hostels rather than move on to nursing homes. Consequently, there is somewhat of an overlap between the most frail residents of hostels and the less dependent nursing home residents (Halton, Briefing - 12 December 1996).

The Committee received a number of submissions about the inadequacy of the current hostel system to meet the needs of this group of older people who require accommodation and social support, rather than personal care needs. The Manning Valley Senior Citizens' Homes commented:

> *the adequacy of supported hostel-type accommodation to meet the needs of independent ageing persons is poor and the situation is becoming worse and will continue to do so until the need for the "social" model hostels for independent ageing persons is recognised and purpose-built buildings are once again provided for that purpose* (Submission 41).

The Director of Nursing of Fairview Hostel in Moree submitted that, as hostel residents have been admitted with increasingly higher care needs, hostel accommodation "meets the needs for the dependent aged person but the independent person is now inappropriately placed" (Submission 50).

The Australian Catholic Health Care Association noted:

> *Hostels are increasingly accommodating more dependent residents and therefore access for Hostel Care consumers has been declining at a significant rate. ... Their need is for safe and secure accommodation, socialisation support and some supervision in their activities of daily living. ... Current Government policy is that people with essentially a housing need have this met through the public housing program. Whilst some hostel care residents may fall into this category, the majority are people who can no longer function while living alone and require some form of congregate housing for social support and security reasons* (Submission 46).

An aged care worker submitted that:

> *The resolution to keep consumers out of institutional care for as long as possible has also changed the social environment of hostel accommodation. Residents are more likely to have advanced dementia and/or high dependency needs. For the more independent residents this may compromise their living environment* (Submission 83).

Under the changes to the residential aged care system which the *Commonwealth Aged Care Act, 1997* will bring, older people who would previously have entered hostels for accommodation and social, rather than personal care, needs will no longer be eligible for a Commonwealth subsidy. These changes apply both to existing residents and prospective residents. The Commonwealth has assured existing Hostel Care residents that their security of tenure is guaranteed under the Outcome Standards, and that most hostels will be able to continue operation (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 16, 1997). However, new residents who need supported accommodation, but who do not have a care need, will have to seek other options in the aged care and housing sectors.

Submissions and evidence reveal a great deal of concern about the abolition of the Hostel Care subsidy. The Aged Services Association, for example, submitted that:

> *The effects of the Commonwealth removing Hostel Care funding without the provision of compensatory housing and care funding will be wide ranging. Those financially disadvantaged hostel residents currently receiving Hostel Care may, in some cases, become homeless. Increased pressure will inevitably be brought to bear upon State-funded services in the housing and community sector, and upon the goodwill of the church and charitable sector. It is critical that funding be made available to enable this group of people to access other forms of supported accommodation* (Submission 66).

Ms Betty Johnson from the Older Women's Network told the Committee:

> *there will be a group of people who thought that they had an opportunity for accommodation in a hostel who will no longer have that opportunity. Many of them no longer have it now. We think it is part of the reason for a rise in homelessness* (Briefing - 12 December 1996).

The Uniting Church submitted that:

> *this means that those people who have retained some level of independence, and who have previously been able to access some minor hostel care services, will no longer be able to take up places in hostels. The sector has expressed considerable concern to the*

> *government about this and has sought the advice of the government as to how it proposes that these people will be dealt with in the future* (Submission 53).

The impact on providers may also be significant: hostel service providers have accepted "Hostel Care" category residents approved by Aged Care Assessment Teams on the assumption that such care for residents who are financially disadvantaged will be assisted by Commonwealth subsidies. These residents will no longer be subsidised, and the proprietors will be expected to absorb the costs. One service provider noted that this will create financial difficulties for providers:

> *The Hostel Providers cannot provide care without the subsidy and the people concerned on basic pensions cannot afford to pay the increased fee ...* (Submission 16).

The Commonwealth believes that increased subsidies for other categories of residents - especially people with dementia - will make up this cost and the overall impact on hostel providers will be "minimal" (Commonwealth Department of Health and Family Services, Aged Care Fact Sheet 14, 1997b).

Some hostels may require existing Hostel Care residents to pay an extra amount equivalent to the Hostel Care subsidy. It has also been suggested that, notwithstanding the right to security of tenure guaranteed in the residential agreements, evictions may occur.

A representative of Combined Pensioners and Superannuants told the Committee:

> *I think the withdrawal of the hostel care subsidy will mean that people will have to leave hostels and they will not have anywhere to go ...* (Benson, Evidence - 12 May 1997).

The impact of the abolition of the Hostel Care subsidy was also considered by the Senate Community Affairs References Committee. In its Report on Funding of Aged Care Institutions, the Senate Committee notes that it:

> *believes that although these people are in hostels largely for social reasons the social isolation faced by many people living alone can be debilitating and hostel care of this type will often ensure that these people maintain a better state of health and are provided with a safer lifestyle than when living outside a hostel setting* (June 1997: 38).

The Senate Committee continued:

> *In the long term, providing this type of accommodation may also reduce expensive medical or nursing home costs in the future* (June 1997: 38).

The Committee believes that existing Hostel Care residents who are subsidised should have a level of subsidy maintained to ensure that they are not forced out of hostel accommodation.

RECOMMENDATION 41:

The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to review the levels of Commonwealth payments for existing and subsidised residents of hostels (or low care residential aged care facilities, as they will be known) who do not have personal care needs.

The loss of access to hostel care will have significant impacts on the need for accommodation and care services such as the Home and Community Care (HACC) program, public housing and boarding houses.

HACC services may be a suitable means to meet the needs of older people who have accommodation but would have entered a hostel purely to overcome isolation or inability to cook and clean.

In the Interim Report of this Inquiry the Committee noted that funding for HACC services is already inadequate to meet demands. The Interim Report noted that the Commonwealth has made significant cuts to the HACC budget, with the difference to be made up by an increase in user-fees, at the discretion of the States. New South Wales currently charges user fees for some HACC services, so that a total of 11% of HACC funding is now raised through service fees. User fees will be required to almost double to 20% if HACC expenditure is to remain at the same level following budget cuts (Ms Moore, Evidence - 6 February 1997). The Interim Report concluded that more independent older person is thus faced with a simultaneous loss of access to hostels and an increase in charges for HACC services, and recommended that both the State and the Commonwealth will need to increase funding for the HACC Program accordingly if needs are to be met.

In its response to the Interim Report the Ageing and Disability Department noted that HACC growth for 1997/98 has been confirmed as $5.871 million following agreement between the NSW Minister for Aged Services and the Commonwealth Minister for Family Services. An additional $4.805 million will go to existing service providers as 2% indexation, which equates to approximately 2.4% growth in funding and is close to the 2.7% that was recommended in the Commonwealth Government's Efficiency and Effectiveness Review of the Home and Community Care Program (1995:14-15). The total budget for the HACC Program in New South Wales is now $250.939 million (ADD Submission - 11 September 1997).

The Committee is pleased that there has been this level of growth in HACC funding, however, it believes it may still be insufficient to meet the increased demand for services which is expected to result from the removal of subsidies for people who

would previously have entered hostels for accommodation and social needs. The Committee understands that the impact of the *Commonwealth Aged Care Act, 1997* on the demand for HACC services will be included in the data collection project which ADD and NSW Health is establishing (this is discussed further in Chapter 6). Should this monitoring confirm the fears of the Committee that the demand will be far greater than supply, then the Committee believes that additional funds should be allocated to the Program.

RECOMMENDATION 42:

The Committee recommends that the Minister for Aged Services closely monitor the demand for Home and Community Care (HACC) services which is expected to rise as a result of the implementation of the *Commonwealth Aged Care Act, 1997* and, if demand is greater than the funds available, the Minister negotiate with the Commonwealth Minister for Family Services to secure additional funding for the Program.

The implications for public housing and boarding houses stems from the fact that those residents who formerly would have been eligible for a Commonwealth subsidy are those who are financially disadvantaged. Many of these people have little or no alternative means of support (Aged-Care Rights Service, Submission - 8 September 1997). The option of the private rental market is not a realistic one. The Committee notes that these changes are being introduced at a time when the State is facing reductions in subsidies from the Commonwealth under the Commonwealth-State Housing Agreement.

As noted previously in this Report (Chapter 2), there are concerns that there will be an increase in unfunded hostels or boarding houses:

> *We anticipate a growth in this type of accommodation, especially in buildings which have failed to gain Commonwealth certification and accreditation. Funded beds can be sold or moved leaving the accommodation for use by unfunded operators* (Aged-Care Rights Service, Submission - 8 September 1997).

The Committee is seriously concerned that some of these operators appear to purposely operate outside any legislation, leaving vulnerable residents without adequate protection.

These changes highlight the need for a comprehensive aged care framework, as recommended by the Committee in Chapter 1, which takes into account the planning and provision of services for older people across the community and residential care spectrum, and for improved debate on sustainable financing options for aged care.

The Committee understands that the impacts of the changes on the demand for public housing and boarding houses will be monitored as part of the data collection project being undertaken by ADD and NSW Health. Should this monitoring confirm the fears of the Committee that the demand for such services will increase, then the Committee believes that additional funds should be allocated to monitor and licence boarding houses and to provide public housing assistance for older people.

RECOMMENDATION 43:

The Committee recommends that if the monitoring of the *Commonwealth Aged Care Act, 1997* shows that there is increased demand for public housing and boarding houses as direct result of the Act, then the NSW Minister for Aged Services and the NSW Minister for Housing commence negotiations to secure additional funding under the Commonwealth/State Housing Agreement, and that additional resources are provided to monitor and licence boarding houses in New South Wales.

The Committee notes that while the removal of the Hostel Care subsidy will have immediate negative consequences, it may also provide an opportunity for serious consideration of alternative accommodation options for older people. This would be consistent with the discussions previously in this Report about the need to consider aged care from a community care perspective, and also about the need for debate on longer term sustainable financing of aged care. While in one sense the changes may provide an impetus to shift the balance of care from residential to community, the Committee notes that this needs to be accompanied by a commensurate shift in funds between the sectors, something which clearly has not occurred.

4.9 PEOPLE WITH HIGH CARE NEEDS

Throughout this Report the Committee has noted the importance of developing aged care from a community care perspective, and the need to shift the balance of care (and funding) to where most people prefer to have that care provided - in the community.

The Committee has received evidence, however, that people with high care needs are currently unable to access services they require, primarily because of the Commonwealth's aged care planning ratios. This is especially a problem in rural areas, where often there are insufficient community based services available to keep people with lower care needs in the community, therefore putting pressure on high care places.

The Committee is concerned that the provision of high care beds is not sufficient to meet the current and future demands for that level of care, and believes that there should be ongoing review of the appropriateness of the planning ratios, in particular the provision of high-care beds/places in rural and remote areas.

RECOMMENDATION 44:

The Committee recommends the Minister for Aged Services include a review of the appropriateness of the allocation of high care places/beds, in particular in rural and remote areas, in the review of the *Commonwealth Aged Care Act, 1997* and development of the National and NSW Aged Care Strategies.

4.10 CONCLUSION

It is clear that the care needs and rights of particular sub-groups of residents in aged care services are not well met.

The Committee believes that this situation arises primarily from the absence of any clear set of principles about the sort of care system we want for people, and how we provide that care. In addition, there is inadequate commitment to using the sanction mechanisms currently available against those organisations which deliver care which is outside of these principles (as discussed in Chapter 2 of this Report).

The Committee also heard that there are a number of structural issues which also need to be addressed, and which will require a commitment of governments to work together more closely to both develop more responsive and appropriate service models, and provide the adequate resources to fund these models. In particular the Committee notes this is needed for the enhancement of community psychogeriatric teams, the transfer of younger people out of aged care services to more appropriate accommodation settings, and development of alternative accommodation options for people who need accommodation and social support, rather than care needs.

The Committee notes that there are a number of mechanisms already underway in New South Wales to address these issues, including the Accommodation Task Force and the NSW Action Plan on Dementia, but it is concerned that the NSW Government must be vigilant and committed if the aged care service system in New South Wales is going to achieve improved quality of life and protection of the rights of people in residential aged care services.