

**Supplementary
Submission
No 21a**

**INQUIRY INTO REGISTERED NURSES IN NEW SOUTH
WALES NURSING HOMES**

Name: Mr Des Hartree

Date received: 19/08/2015

GENERAL PURPOSE STANDING COMMITTEE NO3

Inquiry into registered nurses in New South Wales nursing homes

17 August 2015

Dear Sir,

I would like to add supplementary information to my original submission #21 on 16/07/2015. This late supplement is due to such a short submission period.

RN's 24/7 PUBLIC ENQUIRY – supplementary comments

1. Irene my wife for 55 years who I love dearly has stage 6 - 7 dementia and is unable to do anything for herself ie walk, talk, toilet, dress, can't even turn over in bed, relies on assistance – no – everything has to be done for her. She is in a wonderful, caring Not For Profit “**community**” High Care “Nursing Home” since 6 December 2013. This is now her home. (I will not use the bureaucratic term “RESIDENTIAL AGED CARE FACILITY” which is so impersonal reminds me of another politically correct term correctional facility ie “jail”).

I HAVE BEEN WATCHING MY WIFE SLOWLY DIE FOR THE PAST 5 YEARS.

The first 2 years while Irene was not so bad we chased our bucket list, four months in Tasmania, four months in WA, A trip to QLD, 2 trips to SA and a cruise. Irene was by this time unable to safely travel, I became her 24/7 carer. Irene was a wanderer so I had her fitted with GPS. We built a granny flat on our youngest daughter's house so our daughter could help.

As it became more and more demanding, I obtained help, assistance from Baptist Care mainly for showering and personal care which was much appreciated.

On the 5th December 2013, I “hit the wall” could not speak, could not stop the tears, could not stop shaking, was not even capable of calling 000 for help. Doctor said, both to hospital or Irene must have respite care to allow me to recover and the rest is history, Irene became ill while in respite care as per my submission and was never able to return to our Granny Flat.

I now spend 4 – 5 hours each day at the Nursing Home, I feed Irene at Lunch and dinner and, over the months I have befriended many of the staff as it is a family type environment between staff, residents and the regular visitors and volunteers. In late April one of the RN's for whom I have enormous respect appeared to be upset and distressed, thought she must be having problems at home so as a friend I asked if there was anything I could do to help. Her answer surprised me, “nothing wrong at home but I am concerned about the security of my job”. Why? “They are going to take RN's out of Nursing Homes and I will lose my job”. Who told you that? “The Union”. Unions often cry wolf and exaggerate, you are one of the most experienced RN's in the place and nobody would be stupid enough to take RN's out of Nursing Homes.

2. That night I did research on the internet and for the first time realised that 24/7 RN coverage in nursing homes was at risk, so I immediately wrote to the minister with my concerns assuming the information I had was incorrect. The response some 5 weeks later confirmed my worst fears, but it was ok because it was Canberra's fault.

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My next step was to contact an MLC who had been helpful previously and in talking to his office the question with out notice was formulated. You already know the rest of the story, and here we are and I thank you for establishing this Public enquiry.

3. Since I received the Ministers response, I have spent much of my spare time, Irene is still my priority, either talking to people about the proposal to make RN's an option for Nursing Homes at operators discretion or carrying out local and overseas research into this and related subjects.

4. I have collected over 1600 signatures for the Registered Nurses and Midwives Association Petition. As I have collected these signatures I have heard many stories of empathy and wonderful support at various Nursing Homes and Hostels, I was amazed at the dozens of stories of abuse, cover ups, lies, neglect and straight out rudeness at some facilities, which line up with media exposes at some facilities and specific instances, and it would appear that very little has been learned from these instances even when coroners were critical. Instances of proven cover ups lies, false death certificate but it is ok as they retained their 100% accreditation making current accreditation a meaningless joke.

It appears that the only outcome is that the whistleblower, an AIN who told the police the truth, which was backed up with CTV footage confirming lies and a cover up, was sacked.

I am also concerned that nothing that is reported by the media or comments from coronial enquiries which are probable only the tip of the iceberg are being embraced, no change. **We appear to have developed a culture of denial.**

Over the past 20 years there have been many enquiries into aged care facilities Nationally, or at state level, generally with similar recommendations – very little has changed, why are the academics, the bureaucrats and our elected representatives not listening.

My worst criticism is aimed at the media, who are aware of the problems, have researched the problems (often at public expense ie ABC), have received significant public feedback of further failures of care. Failures that stay hidden, Reporters have the information, they have the ability, and resources to continue their investigative reporting, even advocacy, to achieve positive change. As an example, Margot O'Neil did a wonderful expose on late line which resulted in some 20 responses that I am aware of, most of which were negative but worthy of follow up in their own right, but have been unable to find follow up stories or any changes within the industry from original story. **I believe these reporters have a civic responsibility.**

5. During my research I came across numerous submissions and papers prepared by a Dr Michael Wynne who appears to be very anti corporatisation of medicine (he blames the death of his son on corporatized medicine and I understand two doctors were subsequently barred and the organisation kicked out of Australia) Dr Wynne is pro Not For Profit Community based Aged Care Facilities – Nursing Homes.

I have a history of the good doctors activities as he has tackled suspect or even corrupt organisations as they have tried to enter and ply their trade in Australia. Dr

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Wynne has made a number of submissions to various enquiries including “Australia’s experience with health reform – are there lessons for Canadians” presented in October 2004 in Edmonton Alberta in Canada which details some of the problems experienced in Australia and the USA Dr Wynne also made a detailed 58 page submission to the Productivity Commission Inquiry in 2010.

Dr Wynne was not happy with the draft report which opted for corporatisation of aged care in Australia. Dr Wynne responded to the enquiry, reluctantly accepting the change to corporatisation and he offered a number of suggestions so that problems experienced overseas would not be replicated in Australia.

There is I believe strong evidence that the Dr’s response was not even read (which would be an enormous indictment and puts into question to me the validity of the whole enquiry) as on page 9 of 31 of the response is what I believe at best is a cry for help or at worst a suicide note quote **“As a potential octogenarian, I am depressed by this draft report. There seems less and less prospect of an easy exit and more likelihood that I will linger on to 85 and go into a “residential care facility”.**

Here I will be confronted by choices others will make and vulnerable to the staffing problems this report fails to adequately address.

I will have to carefully consider my options while I still have the option of determining my own exit. Once in a facility options like that will not be readily available. I will look at the financial and other costs to my family and the prospects that life in such a facility will have sufficient meaning to justify it”.

I would expect that anyone who read this quote would immediately have alarm bells ringing, No alarm bells, no read.

6. The United Kingdom has recently accepted they had a problem in the NHS (National Health system which includes the various levels of aged and home care), unnecessary deaths, abuse, cover ups, lies, neglect and straight out rudeness at some facilities, combined with denial and an accreditation system that did not highlight or quantify the problems, experts were ignored and the fix was more paper work, less staff so all the hurt was felt at the front line care and nursing front.

NHS developed a poor community image and staff were frustrated which added to the front line substandard care being reported.

Robert Francis QC with his Francis QC report identified the problems and introduced massive change including thousands of extra nurses and care aides so that patients and residents were actually nursed and cared for not just paper report entries. He introduced meaningful KPI to measure outcomes and put \$ values on instances or flagged items (failures) eg class 2 pressure ulcer (bedsore) 12 extra days in hospital cost approx \$12,000, fall without major injury 2 extra days in hospital \$2000, urinary tract or bladder infection 5 extra days in hospital \$5000 etc, also made all facilities post their staffing rosters in advance and then made them measure their own performance to the rosters.

They started to think outside the square of past experience and are reporting positive results. The public, the administrators and authorities now have a meaningful way of comparing and monitoring real performance.

Maybe we don't have to reinvent the wheel just tweak it and adapt it for Australia's diverse metropolitan, unique rural and remote requirements

7. LLLB (Living Longer Living Better) may sound good and has some good features, but combining Low Care and High Care under one umbrella is stupid, (one shoe will never fit all).

I understand that Hostels were originally established to house students at school or for workplace accommodation or a low cost option for people who could no longer look after themselves in a home environment and required minimal assistance like cooking and washing done for them and some assistance with day to day living tasks. When their health failed so they could no longer cope with basic lifestyle activities like bathing dressing, feeding themselves or were bedridden then they were transferred to hospitals where they occupied acute care facilities.

This was a waste utilising a \$1000/day resource so sub acute hospitals were established (Nursing Homes) without all the expensive behind the scene facilities, this could be done for say \$200 per day, but as it was still considered a hospital environment, there was no charge for entry as it was a substitute for acute care hospital admission and showed massive savings to the state.

Low Care Residents paid a "bond" or participation fee without any equity to enter the hostel which was refundable when they left and an assumption that the incoming resident would pay the refunded "bond" (a ponzie scheme a derivative of the illegal pyramid scheme). Low Care resident also paid a daily fee approximately 80% of their pension for meals and house keeping, cleaning etc.. High Care residents did not pay the Bond but paid a higher daily fee something like an extra \$35.00 per day.

The High Care Resident also received a government supplement which was meant to pay for the extra nursing and care requirements of the High Care resident this often did not happen as most of this money was required to service the debt which resulted as no "bond" was paid by a new High Care resident.

For the hostels this was a problem, they needed the "bond's" to cover their working capital costs or overdraught.

Historically Hostels preferred to take on low care residents, because they came with a bond and community care and support expectations was lower. The operators would then as soon as possible have residents re assessed to High Care, which meant a \$52 to \$209 daily supplement which was supposedly to cover additional staffing to enable the facility to give appropriate quality care.

The very successful government initiative to keep people in their own homes, by making available subsidised home help significantly reduced government costs and gave people better outcomes by staying longer in their own homes, this means

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people are older and sicker and will normally be classified High Care before being considered for acceptance into a home.

Hostels and Nursing Homes were now seen as a liability, some closed others went bankrupt, the ponzie scheme failed as they ran out of new bond paying residents, as they always do and will. Understand the Federal Government has had to pay out some \$24,000,000. As they guarantee residents bond money.

A new approach was needed and the suggestion of a bond on High Care Residents was apparently floated and adopted, initially the suggested bond was a flat \$100,000 with supposed 20% of placements to be lower or no bond. This is where the 40/60 operators equity claim apparently originated.

Once the decision to have a bond on High Care, (that is replace a failed relative small ponzie scheme with a much broader ponzie scheme), - still no equity - the scene has been set to perpetuate with federal government blessing a derivative of an illegal practice.

Bonds are now required for entrance to a High Care Facility, LLLB set the rate at 50% of the median house price, which is short sighted for several reasons, in Sydney the median house price is \$1,000,000, which relates to \$500,000 bond, if you go to the country, median house prices could be \$400,000 or lower, a bond of \$200,000 or less, so nobody is going to build in low median priced areas, cost of a new facility is approximately \$200,000 per bed so in Sydney the operator basically makes a 100% plus profit on investment and he has almost unfettered access to this money meanwhile no new facilities will be built in many needed locations. If a bond is paid then it should be held by the government (as is the case with bonds on home rentals) and it could be loaned at low interest rates but under normal commercial conditions to builders of new or upgraded facilities. This means the government controls the flow of capital to areas where facilities are required, not where operators will make the most money.

8. Like you, I have taken the time to read all 158 submissions, and like you I have researched various aspects of selected submissions, I have absolute empathy for #91 Mission Australia who deserve our thanks and appreciation for their dedication to the poorest of the poor, more importantly they deserve special federal financial support, why can't these people have equal access to basic care including access to RN's on a regular and continuing basis I understand this is not their problem it is ours, once again, one shoe does not fit all sizes.

I also understand some of the problems that affect the not for profit groups in rural areas as they transition from Low Care to High care and I believe if we look outside the square of past experience, we can find acceptable solutions but not while we have the financial model under LLLB which is skewed towards the for profit organisations who can cherry pick the more lucrative market segments and walk away from the rural and fringe areas, perhaps the bonds needs to be centralised and then each bed receives a figure ie \$200,000 dollars so the rural areas and outer suburbs get a fair go or perhaps the High Care payment could be linked to the bond,

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lower the bond the higher the High Care subsidy, conversely the high end is lowered to level the playing field eg without statistical oversight could be if you pay a \$200,000 bond then max high care subsidy would be \$300 per day, but if the bond is \$500,000 then maximum High Care subsidy would be \$100 per day (watch the screams)

9. The large for profit operators keep crying poor, however, available data contradicts that claim. As an example Japara which was a private company that went public with 46% of its shares in April 2014 raising some \$450,000,000 at \$2.00 per share, some 16 months later, 5 August 2015 they were trading for \$2.77 per share with many brokers advising – buy – not a bad profit.

In the first 6 months Japara had an after tax profit of \$15,800,000 (this is approximately the cost of an additional RN plus 2 AIN's, 24/7s in each of their 39 nursing homes, or a new 156 bed facility per year and represents approximately \$7,900 annual after tax profit from each resident. Japara's chief executive is reported as indicating, that the majority of the increase in profit came from additional ACFI funding as they had increased average government funding from \$167.41 per resident per day in July 2014 to \$177.16 in December 2014. They also advised that a further 800 residents 20% were eligible for reassessment which would further increase profits (nothing about improving care ratio's), Japara announced a 5.5c interim dividend and expect to pay 10.5c for the full year. **Every dollar paid to shareholders is a dollar less for nursing or front line care**

10. We can resolve the problems and even improve outcomes, but first we have to accept that we have a problem and develop a way forward. We may need to think outside the square of past experience

Dr Flynn who started the Royal Flying Doctor had a problem and he took to the air. We could possibly resolve our rural RN shortage using Hex fee repayment reduction to compensate or possibly use the system that encouraged young newly qualified teachers to go to rural and remote areas for a limited time frame, we could encourage young rural students to take up nursing with reduced HEX fees if they return to a rural area.

12 QUESTION Where is Dr Wynne, Has he passed away due to natural cause, has he exited at his own hand, has there been any foul play as he has attracted enemies among dodgy corporatist, or, after 20 years of fighting denial, incompetence bureaucracy, Governments, and questionable ethics of some corporate's, has he just given up?

13 COMMENT I believe Dr Wynne is correct, Nursing Homes are a public service that should not be corporatised but put in the hands of local communities, Alternatively, let's corporatize the Armed services, the Public Service or even parliament, all would be just as silly

- 14.RECOMMENDATIONS.
- A We must accept we have a problem
 - B We must have RN's 24/7 in High Care environments
 - C We need a royal commission as many of the issues are federal not state such as LLLB shortfalls, Bond levels and their secondary effects, Low Care, High Care and the "ponzie" funding model.
 - D We need a KPI system that measures outcomes
 - E We need to implement recommended changes not just leave them for the next enquiry
 - F We should look at revised UK NHS system from staffing notification to KPI and accreditation
 - G Should revisit Dr M Wynne's recommendations and push his community model.

I wish to thank you for permitting me to make this supplementary submission