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• THE INQUIRY PROCESS

On 31 October 1996 the Legislative Council of the New South Wales Parliament passed the following motion:

1. *That the Standing Committee on Social Issues inquire into, and report on, the state of nursing homes in New South Wales and in particular:*

    a) *the extent to which the dignity, privacy, confidentiality and other rights of residents are protected;*

    b) *the effect of transferring the responsibility and management of nursing homes from the Commonwealth to the State Government;*

    c) *the likely impact of the introduction of entry fees and the increase in user-fees for nursing home residents;*

    d) *the adequacy of supported hostel-type accommodation to meet the needs of independent ageing persons;*

    e) *the use of existing capital infrastructure to expand services for the aged; and*

    f) *the impact on the aged community of the decision of the New South Wales Government to close the Office on Ageing and create the new Ageing and Disability Department.*

2. *That the Committee report by Monday, 30 June 1997.*

On 27 May 1997, the Legislative Council passed a motion extending the Committee's report-by date to 30 September 1997. This reflected the impossibility of the Committee completing by 30 June the site visits and extensive consultations necessary for an Inquiry of this depth, complexity and public importance.

However, given the imminence of the Commonwealth's changes that were the subject of some of the Terms of Reference, the Committee thought it essential that an Interim Report be released on the original report-by date. That Report, which was tabled on 30 June 1997, forwarded 55 recommendations, many of which are included in this final Report.

During the course of the Inquiry the Committee received 91 submissions, heard formal evidence from 28 witnesses and held briefings with 12 people. In addition to hearing evidence at Parliament House, Committee Members made site visits to residential aged care facilities in Sydney's eastern suburbs (Waverley) and inner west (Summer Hill) in

addition to five rural towns (Cessnock, Baradine, Trangie, Walgett and Warren). This allowed the Committee to gain an understanding of the operations of nursing homes, hostels and Multi-Purpose Services and to talk to residents, relatives, staff and management. Committee Member, the Hon Elisabeth Kirkby, MLC visited hospitals and residential aged care facilities in West Wyalong, Temora and Coleambally in rural New South Wales.

During the course of the Inquiry, the Committee also travelled to Wudinna and Elliston in South Australia, to compare and contrast the model of Multi Purpose Services on the Eyre Peninsula with those in New South Wales.

• PRINCIPLES UNDERLYING THE REPORT

The Committee believes that the provision of aged care in New South Wales, and any negotiations regarding the future provision of aged care, needs to be underpinned by some clearly articulated principles.

The paramount principle is that older people in New South Wales are valued members of our society. The Committee notes that there has been some debate in recent times about the 'costs' associated with an ageing society, and believes this is quite often a grossly unfair and simplistic debate which does not take into account the substantial contribution to society which many older people have made over a very long period, and continue to provide.

The Committee also believes that older people have the right to respect and autonomy, and to be supported to retain their autonomy. Respect for older people as equal citizens should not be diminished on account of frailty or cognitive impairment.

In addition, the Committee believes that older people should be provided with opportunities to maximise their participation in society for as long as they choose, and with choices about care options when these choices need to be made. To that end, services need to be developed so that the opportunities and choices for older people are in fact real, and not just developed in ways which suit service planners or providers.

The Committee believes that older people should have the right to contribute to the development of policy and programs which are aimed to support them, and provided with the means to do this. This Committee received submissions from a number of older people, and heard evidence from a range of consumers and their advocates during the course of this Inquiry.

These principles have underpinned the approach of the Committee in its conduct of this Inquiry, and the Committee has striven to reflect these in the recommendations it has made. The Committee strongly believes that the planning and provision of services which support older people should also be underpinned by a similarly articulated set of principles.

• DEVELOPMENTS SINCE THE TABLING OF THE INTERIM REPORT

In the time since the tabling of the Interim Report of this Inquiry on 30 June 1997 there have been a number of developments in regard to the policy and planning for aged care. These include the:

- passage of the *Commonwealth Aged Care Act, 1997* in June by the Senate, providing for the commencement of a significant component of the reforms as of 1 October 1997;

- tabling of the Senate Community Affairs References Committee's Report on Funding of Aged Care Institutions;

- securing of additional funds for concessional residents after much lobbying from the Uniting and Catholic Churches;

- announcement of funding rates for the Resident Classification Scale;

- release of details regarding the prudential arrangements for accommodation bonds; and,

- progress continues on the quality assurance process, scheduled to commence as of 1 January 1998.

Policy developments in this time which will also impact on aged care in New South Wales include: the Health and Community Services Ministerial Council (HCSMC) meeting in Cairns in late July 1997, which included agenda items on the impact of the *Commonwealth Aged Care Act, 1997* on States and Territories (initiated by New South Wales) and a revised discussion paper on the possible transfer of aged care to the States and Territories; and continued negotiations on the Commonwealth-State Housing Agreement, Disability Agreement and Health Care Agreement (formerly known as Medicare Agreement).

This final Report incorporates these developments and reflects on their impact for aged care in New South Wales.

• STRUCTURE OF THE REPORT

The remainder of the Report is structured as follows:

Chapter One, *Aged Care in NSW: Setting the Scene*, examines the policy and administrative context within which aged care sits in NSW.

Chapter Two, *Ensuring Quality Services: Current Arrangements*, examines the current safeguards of residents' rights, and highlights the important workforce issues which need to be addressed if quality care for residents is to be achieved.

Chapter Three, *Ensuring Quality Services: New Arrangements*, considers the ways in which residents' rights will be protected through the examination of the quality control regime proposed by the Commonwealth's accreditation system, complaints mechanisms and prudential arrangements for the accommodation bonds.

Chapter Four, *Residents with special needs*, addresses the needs of particular sub-groups of residents whose needs are not well met, and whose rights will continue to be compromised under the new arrangements. These include people with dementia and mental health needs, people of diverse cultural and linguistic backgrounds and indigenous Australians, people who only require accommodation and social support, and younger people with disabilities who live in aged care facilities.

Chapter Five, *Financing Aged Care*, considers the current (pre -1 October 1997) and future (post - 1 October 1997) funding arrangements for residential aged care, in particular the new system of funding the upgrading and maintenance of aged care facilities by the imposition of accommodation bonds, and discusses the need for a review of sustainable financing options to meet the long term care needs of older people in the future.

Chapter 6, *Impact of Reforms and Future Directions*, addresses the impacts of the *Commonwealth Aged Care Act 1997* on the NSW Government and related services, including regulation of aged care, and the effect of the Commonwealth's proposal to transfer the responsibility and management of residential aged care to the State Government. The Chapter also considers how existing services can be expanded to provide more responsive and innovative accommodation, care and support for older people both now and in the future.

CHAPTER ONE:

AGED CARE IN NEW SOUTH WALES: SETTING THE SCENE

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The Committee has been made aware of a number of key policy and administrative issues which affect the planning and delivery of aged care services in New South Wales. These include the absence of a clear agency to lead the policy development and planning for aged care in New South Wales, and the lack of a policy framework at both the national and state levels to provide direction for policy makers, service providers and consumers. In addition, the Committee has considered the impact of the closure of the Office on Ageing and the creation of the Ageing and Disability Department on the provision of aged care in New South Wales.

1.1 STRUCTURAL IMPEDIMENTS TO AGED CARE IN NEW SOUTH WALES

The Committee believes that there are a number of structural impediments to ensuring that older people in New South Wales have equitable access to affordable, quality aged care services which are responsive to their needs. The Committee believes that this stems primarily from the lack of a lead agency in New South Wales and an overarching ageing policy framework to meet the current and future needs of older people.

1.1.1 THE NEED FOR A LEAD AGENCY FOR AGED CARE IN NEW SOUTH WALES

Throughout the course of its Inquiry, the Committee has become increasingly aware of the fragmented nature of the administration and delivery of aged care programs, which is in part driven by the lack of a central lead agency which can pull the elements together and provide strategic direction for aged care in New South Wales. Responsibility for aged care falls primarily between two departments: firstly, the Ageing and Disability Department (ADD) which has primary responsibility for the Home and Community Care Program, the NSW Aged Care Policy Framework, NSW Action Plan on Dementia, and NSW Seniors Card program; and secondly, the NSW Health Department which funds acute and post-acute services, community nursing, psychiatric care and State Government Nursing Homes and long-stay beds in rural and remote hospitals. Both Departments jointly work on issues of common interest, for example the NSW Healthy Ageing Strategy which is currently being developed but, on the whole, work on quite separate pieces of the aged care system.

The Committee believes that this fragmentation affects the delivery of services to older people, and precludes the development of linkages between elements of the aged care system (eg. between community and residential care) and between other related service systems (eg. acute hospitals, mental health teams, transport etc.). It also limits the capacity of New South Wales to take a leadership role in regard to aged care, to articulate a clear vision for services for older people in New South Wales, and engage pro-actively with the Commonwealth in dialogue over the *Aged Care Act, 1997* reforms.

The Committee believes it is important that there be a single lead agency for aged care in New South Wales, and that this should be the Ageing and Disability Department, with the Minister for Aged Services responsible for aged care matters. The Committee received evidence that ADD has recently established a distinct Ageing Policy Unit within the Strategic Policy and Planning Division, and also established an advisory committee on aged care matters comprising key stakeholders (ADD Submission - 8 September 1997). The Committee believes that these changes will enable ADD to assist the government to articulate a clear vision for meeting the current and future needs of older people in New South Wales.

The Committee's opinions were also shaped by the strong objections to the inclusion of aged care within a health care framework which were put to them. The Committee heard that previous consultations held by the then MLC, the Hon Patricia Staunton, also confirmed this perspective:

> *the support for aged and community care not being held within the health portfolio was immense. It surprised me how widely that view was held around the table, which consisted of 30 or 40 representatives of different organisations* (Moore, Evidence - 8 September 1997).

Much of this evidence was provided to the Committee in relation to the proposed COAG reforms, where it was made quite clear to the Committee that any transfer of aged care funds should be kept quite separate to funds provided through health care agreements. The Committee also heard that ageing should not be regarded as a health issue, but a normal part of life, and incorporation of aged care within a health framework could 'medicalise' the ageing process and further disempower older people.

As noted above in the discussion of principles which have been the foundation of the process of this Inquiry, the Committee is of the strong opinion that aged care should be provided to people in a way which promotes the independence of individuals and maximises their participation in social life. A 'social' model of care includes providing care for people in their own homes for as long as possible and people chose, and the development of policies and programs which support this goal. The principles of the Healthy Ageing Framework which the Government is currently preparing should also be extended to those who require care or are in receipt of aged care services. **It is the clear preference of older people to remain living in their own homes; this is also a more cost-effective option for Government.** The Committee is concerned that if responsibility for aged care was placed with the NSW Health Department then the emphasis will be on the higher care need end of the aged care spectrum, with limited development of programs and policies for those at the lower end of the care spectrum. This is already reflected in the current regulatory role which NSW Health has, which is related to nursing homes only and does not include hostels.

RECOMMENDATION 1:
The Committee recommends that the total responsibility for aged care in New South Wales rest with the Minister for Aged Services, and through the Minister, the Ageing and Disability Department, including responsibility for all aged care policy, planning and related program funding, and that the Department be adequately resourced to take on this role.

1.1.2 THE LACK OF A COHERENT AGED CARE POLICY

The main thrust of this Inquiry has predominantly been on the way in which accommodation, care and support needs of older people are currently being met, and on the administrative and policy changes which have occurred or been proposed. Therefore, much of the Committee's deliberations have focussed on those older people who have relatively higher levels of care needs, for which the residential aged care sector provides. Throughout the course of the Inquiry, however, the Committee has had reinforced the fact that residential care is not a discrete entity, but forms part of a broader, more complex system of care for older people. This broader system includes both community and residential care, and is closely related with acute, primary and mental health care; accommodation; transport; pharmaceuticals; and legal and advocacy services. Currently, linkages between residential and community aged care are not strong; this is even more so in the case of linkages between these other services. What has become increasingly clear to the Committee is that changes to one element of this complex and interrelated system will have significant implications for other elements.

There is no national aged care policy which allows for planning for services across the continuum of care and which provides linkages with other related accommodation, care and support services. The Committee has heard that this is a key reason why the Commonwealth has been able to implement significant changes to the residential aged care system without due consultation or consideration of the impacts on other elements of the aged care and related systems. The main mechanism for collaborative planning is through the Health and Community Services Ministerial Council (HCSMC). However, the Committee understands that a decision has been taken at the July 1997 meeting that the meetings will no longer be convened on a regular basis. The Committee is concerned that the absence of any regular forum in which aged care issues can be discussed nationally will lead to further fragmentation of aged care services and national inconsistencies in service provision.

RECOMMENDATION 2:
The Committee recommends the Minister for Aged Services negotiate with the Commonwealth Minister for Family Services to develop a National Aged Care Strategy, including the establishment of a sub-group of the Health and Community Services Ministerial Council.

RECOMMENDATION 3:
The Committee recommends the Minister for Aged Services take up with relevant State and Commonwealth Ministers the need for regular meetings of Ministers on matters in relation to aged care planning and provision.

RECOMMENDATION 4:
The Committee recommends the Minister for Aged Services charge the Ageing and Disability Department to develop a NSW Aged Care Strategy which is consistent with the principles and directions established at the national level (as per Recommendation 2).

1.2 AGEING POLICY IN NEW SOUTH WALES: THE OFFICE ON AGEING AND THE AGEING AND DISABILITY DEPARTMENT

In April 1995 the NSW Office on Ageing (which had been operating within the Premier's Department) was closed and the Ageing and Disability Department was established, with staff and programs transferred from the one body to the other.

According to a briefing provided to the Committee by the Director-General of the Ageing and Disability Department (ADD), the Government's rationale for the change was that the creation of the new department upgraded both disability and ageing issues, so that a department was responsible for ageing and disability policy, planning and funding. The Government believes that this removes the conflict of interest that arises when one body is responsible for funding, implementing programs, providing services, and monitoring the success of programs.

The Department told the Committee that there has been no negative impact on the lives of older people or their services (Woodruff, Briefing - 12 December 1996). The staff from the Office on Ageing were transferred to the ADD, so there was no loss in staff or expertise. The corporate objectives of the Office on Ageing and the Ageing and Disability Department are very similar. The agenda of the Office on Ageing ranged across a number of portfolios and Departments and included issues of employment, discrimination, transport, finance, health and aged care, health and wellbeing, urban design and safety, housing, age issues consultation and 'life long learning' (NSW Government, 1993). Similarly, the Ageing and Disability Department seeks a "whole of government" approach to aged issues such as healthy ageing, accommodation and care, community education, transport, dementia care and elder abuse (Ageing and Disability Department, 1996).

The Committee heard some support for the establishment of the Ageing and Disability Department. The Council for Intellectual Disabilities submitted that:

> *the establishment of the ADD is a major step forward in the development of disability issues in New South Wales ... [and] was extremely important in establishing a necessary and critical funder/provider split with the Department of Community Services* (Submission 67).

And the Consultative Committee on Ageing believes that:

> *there may be some advantages to considering the needs of older people and people with disabilities jointly, provided that equivalent resources are directed to each sector* (Submission 79).

The fear that greater weight is given to disabilities than ageing policies and programs is reiterated by other individuals and organisations. Comments to the Committee included:

> *Ageing within ADD seems to have little influence and to have lost the focus that the Office on Ageing developed* (Submission 59);
>
> *We are not criticising the endeavours of Ageing and Disability Department staff, but their attention is more than fully taken up with disability services and to a lesser extent with aged care service delivery issues. Community perception is that aged services have been disadvantaged by this change* (Submission 36); and
>
> *... the Ageing and Disability Department has a much higher focus on disability and less so on the aged...* (Submission 65).

The Committee was told that the Government acknowledges concern by both the aged community and the disabled community that one of the sections will gain dominance over the other in terms of government focus. However, the Government believes these fears to be unfounded (Woodruff, Briefing - 12 December 1996).

Others oppose the Ageing and Disability Department because they believe it fails to recognise that the requirements of ageing people differ from those of disabled people. Submissions noted, for example:

> *Ageing is not a disability, the care required is quite different* (Submission 50); and

> *Despite certain similarities in the needs of older people and disabled people, the differences are sufficiently significant to warrant two separate portfolios* (Submission 66).

The Council for Intellectual Disabilities explained that linking ageing and disability together in one department created difficulties because the services required for each were different:

> *Services for aged people are generally based on a maintenance model, that is, maintaining the current status of people. In comparison, services for people with an intellectual disability are based on a developmental model and make the assumption that people will develop new skills and increase independence* (Submission 67).

The symbolic implication of a Department which links Ageing and Disability together was a key concern of many aged people and their advocates.

One aged care worker noted:

> *Unfortunately the new Ageing and Disability Department, by name alone, may infer that the NSW Government believes that ageing and disability are always related. The fact is only a small number of our elderly have any disability ...* (Submission 17).

A number of submissions were unhappy with the linking of ageing and disability. Statements by aged advocacy groups, aged persons, and those working in the aged care sector include:

> *Given that only some aged people are disabled, we believe it is more appropriate for the Department of Ageing and Disability to be separated into two distinct agencies. Disabled people are not necessarily aged and aged people are not necessarily disabled* (Submission 64);

> *The creation of the Ageing and Disability Department was seen by many older people as reinforcing the negative stereotype of aged or ageing* (Submission 65);
>
> *The symbolic association of the ageing process with disability has understandably been criticised by the community - this is as much an issue as concern about the distribution of resources* (Submission 79); and
>
> *There is no doubt that older people and organisations which represent them remain extremely concerned about the decision, both because they consider it inappropriate to link ageing issues with disability issues, and because they are concerned that ageing issues do not receive adequate attention and priority within ADD* (Submission 82).

The Ageing and Disability Department, and the NSW Government as a whole, were criticised by a number of individuals and groups for failing to develop a healthy ageing policy.

Dr John Ward, a geriatrician with the South Eastern Sydney Area Health Services, noted that:

> *The major weakness of the new Ageing and Disability Department is the absence of any programs to promote healthy or successful ageing* (Submission 10).

The Ethnic Communities' Council of NSW added:

> *The focus of the ADD on the needs of the frail aged, and those with a disability, tended to further disadvantage the majority of older people who are independent and well. ... [T]he anticipated increase in the number of people aged 60 years and over ... requires government to look at the needs of the well aged within a framework that raises the status of older people, facilitates the development of opportunities, encourages participation and utilisation of skills* (Submission 65).

The Committee notes that the NSW Government is currently developing a Healthy Ageing Strategy. The Strategy, which is being jointly developed by the Ageing and Disability Department and NSW Health and in conjunction with key stakeholders, will take a whole of government approach to services and programs for older people. The Strategy is expected to include issues around aged care (community and residential) and be driven from the perspective of maximising the independence of older people and giving them a choice to continue to be involved and to be productive members of society. The Committee looks forward to the finalisation and implementation of the Strategy.

Throughout the course of its Inquiry, the Committee has become increasingly aware of the limitations of its Terms of Reference, which focussed predominantly on the high care end of aged care (provided in nursing homes). **The Committee is aware that it is only a minority of older people who end up living in nursing homes (7%).** The Ageing and Disability Department pointed out in its submission that the Interim Report of this Inquiry had an overly biomedical/clinical approach to aged care, and that aged care needs to be considered within the broader policy context of healthy ageing (ADD, Submission - 5 September 1997). These comments support other expressed views which have been detailed previously about the way in which aged care should be viewed, and in particular where responsibility for aged care should be located within the NSW Government.

In the time that has passed since the Department was established, several organisations which initially were wary of the change have observed its operation and now feel that a return to the previous structure is unnecessary. The Combined Pensioners and Superannuants Association of NSW (CPSA) submitted that they had:

> *objected strongly when the Office of Ageing was closed and the new Ageing and Disability Department was created because the Association believed that there would be a diminution of Government policy on ageing issues* (Submission 71).

However, they noted that since:

> *the establishment of the Ageing and Disability Department the CPSA has seen that there have been genuine attempts at ensuring that the needs of older people are recognised within Government* (Submission 71).

The NSW Council of Social Service also submitted:

> *Given the significant amount of time, energy and resources that have gone into the new department and the establishment of its regional structure to date, NCOSS does not support major changes such as the re-establishment of an Office on Ageing* (Submission 81).

The Committee concurs that dismantling the Ageing and Disability Department now would be time consuming and expensive. The grouping together of Ageing and Disability in one Department was insensitive, and creates the public perception that ageing people are disabled, and, with hindsight, it would have been better to create an effective bureaucratic infrastructure that avoided this association.

The perceptions outlined above have also been reinforced by the recent work undertaken by the Ageing and Disability Department in its review of its Strategic Plan. The review process included conducting focus groups with a number of key stakeholders both internal and external to the Department and one of the key findings was that there is a view that ADD has not achieved what was expected for older people

and in ageing. In its submission to the Inquiry the Department noted its concern about these findings, and highlighted the measures which are being put in place to address these matters. These include:

- *a proposal to form a separate Policy Unit on Ageing;*
- *taking a more proactive role in responding to and monitoring the* Commonwealth Aged Care Act, 1997*;*
- *increasing the HACC program budget by $10.676m in 1997/98, taking the total HACC budget in New South Wales to $250.939m;*
- *the development of a NSW Healthy Ageing Strategy, currently being considered by Government;*
- *representing New South Wales on the National Healthy Ageing Task Force, a draft National Healthy Ageing Strategy is about to be released;*
- *ADD is responsible for funding and administering the NSW Aged Care Policy Framework, to which the Government has committed $4m over three years. This includes managing the NSW Dementia Action Plan; and*
- *a proposal for United Nations 1999 International Year for Older People is being prepared for the Government's consideration* (ADD Submission - 5 September 1997).

While the Committee accepts that there are significant aged care related responsibilities of the Department, it is aware that there are a number of structural impediments which limit the role of the Department in respect of older people. The Department's submission notes that:

> *Despite its best intentions to establish an influential portfolio and department with these responsibilities for ageing and disability, it has not been realised for older people because the Minister does not have substantial legislative or funding responsibilities* (ADD Submission - 5 September 1997).

Whereas the Minister for Aged Services has funding responsibilities in excess of $650m for disability services, and responsibility for the *Disability Services Act*, there is nowhere near the commensurate level of responsibility for funding for aged care, nor is there any legislation for aged care for which the Minister for Aged Services has sole responsibility (apart from the HACC agreements) (ADD Submission - 5 September 1997).

As noted earlier, there are a number of pieces of legislation which cover elements of the aged care system:

> *At the moment we have a bit of legislation in Fair Trading, a bit in Ageing or Youth and Community Services and a bit in the Private Nursing Homes Act* (Fisher, Evidence - 8 September 1997).

The Committee heard that the fragmented nature of legislation for aged care posed a risk for consumers (Fisher, Evidence - 8 September 1997) and seriously impacted on service planning and provision; it would appear that in New South Wales the approach to management of the 'bits' of the aged care system is as 'bits', and there is limited or no integration of service planning or provision.

In its submission to the Inquiry the Ageing and Disability Department describes an integrated system as one which includes health, accommodation, care and support covering:

> *(1) Health Services which are State funded and provided through Area Health Services including hospital and community based health services, day hospitals and centres, rehabilitation and extended care services, post acute care, community based palliative care services, mental health and psychogeriatric services, dementia specific residential facilities, carer support and education, health promotion and early intervention, respite and clinical research and education;*
>
> *(2) Aged Care Assessment Teams;*
>
> *(3) Community Care including HACC, Community Aged Care Packages, Commonwealth Respite for Carers; and*
>
> *(4) Residential care including nursing homes - State and Commonwealth, hostels, and long term respite provided in these facilities* (ADD submission - 5 September 1997).

As noted previously in this Chapter, the Committee believes that there is a need for an aged care strategy which articulates these linkages, and provides a clear agenda for aged care activities in New South Wales. The development of such a strategy should be consistent with the Healthy Ageing Strategy which is currently being developed and for which consultations are expected next year. However, the Committee heard that while the consultations are planned, there are fears that 'in some ways the real hard issues about community and aged care will not form part of that debate because it is a big political player' (Moore, Evidence - 8 September 1997). The Committee would be concerned if this was the case, and strongly supports a comprehensive debate which involves government agencies as well as stakeholders.

RECOMMENDATION 5:
The Committee recommends that the Minister for Aged Services and the Minster for Health ensure that the consultations on the NSW Healthy Ageing Strategy include a comprehensive discussion on the provision of aged care services in New South Wales.

The development of a comprehensive aged care framework would also provide the basis for a review of relevant legislation, including consideration of whether there needs to be a single Aged Care Act in New South Wales which encompasses the elements of the other aged care related legislation.

The Committee believes that the lead agency for undertaking this review of aged care in New South Wales should be the Ageing and Disability Department.

RECOMMENDATION 6:
The Committee recommends that the Ageing and Disability Department conduct a review of relevant aged care legislation following the development of a NSW Aged Care Strategy (as per Recommendation 4) and provide advice to government on whether the interests of older people, service providers and government would be better served if there was a single NSW Aged Care Act developed.

1.3 CONCLUSION

The complexity of needs which face older people poses many challenges to service planners and providers. Without clear direction at the policy and administrative levels, the Committee believes that the delivery of care to older people will remain fragmented, and older people will be at risk of missing out on receiving the accommodation, care and support services they need, when they need it, and in ways which meet their particular needs.

The closure of the Office on Ageing and establishment of the Ageing and Disability Department initially appeared to have resulted in a reduced focus on aged care in New South Wales. However, the Committee received evidence that the Department has now emerged with a strong vision for aged care in New South Wales, and has the capacity to take on a lead role in co-ordinating and planning for aged care in this State. The impediments to doing this lie in the lack of a clear legislative basis and consequent Ministerial responsibility, and also the lack of a coherent framework which sets the direction for aged care services nationally as well as in New South Wales - Recommdentations 1 - 4 in this Chapter address these issues. The Committee believes these issues must be addressed if older people in New South Wales are to receive the accommodation, care and support services they need both now and in the future.

CHAPTER TWO:

ENSURING QUALITY SERVICES: CURRENT ARRANGEMENTS (PRE 1 OCTOBER 1997)

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Residents of aged care facilities are people who generally have physical or cognitive impairments which result in their need for access to 24 hour nursing and/or personal care. A significant proportion are affected by varying degrees of dementia. As is common with people who are institutionalised, residents are unlikely to be assertive or to complain when their rights are infringed or their care is inadequate. In order to protect the rights of individual residents it is vitally important that adequate mechanisms are in place to maintain and regulate the care and service provided on their behalf, and to ensure that community and residents' expectations are fulfilled.

In the 1970s and 1980s, the condition and treatment of nursing home residents became a public issue. Media stories publicising dramatic cases of neglect and sub-standard care of residents were common. A number of Government inquiries and reports were undertaken on the financing and standards of nursing homes. One of these was the Senate Select Committee on Private Hospitals and Nursing Homes in 1985 (Giles Report, 1985).

The Giles Report found that the regulation of nursing homes was inadequate to ensure uniformly high standards of care and that the regulations failed to monitor issues relating to the quality of life of residents. It further noted that complaints mechanisms were unsatisfactory and difficult to access, that there should be more frequent and more thorough inspections of facilities, and that there were insufficient sanctions available for enforcement of standards (Giles Report, 1985).

A Commonwealth-State Working Party on Nursing Homes was subsequently established, and this resulted in 1987 in the gazettal of the Nursing Home Outcome Standards under Section 45D of the *National Health Act, 1953.* The 31 Outcome Standards form the basis of the quite complex current regulatory framework for nursing home standards (Braithwaite, 1993: 3).

2.1 THE PROTECTION OF RESIDENTS' RIGHTS

This section discusses the current system of safeguards. However, the current system will change as of 1 October 1997. A new accreditation system will commence on 1 January 1998, and is discussed in Chapter Three.

The regulatory regime for nursing homes is made up of several components. At the Commonwealth level, nursing home proprietors are guided in their dealings with and care of residents by the Outcome Standards, Charters of Rights and Responsibilities, and Residential Agreements. Under New South Wales legislation, the *Nursing Homes Act, 1988* and the *Nursing Homes Regulation, 1996* provide additional requirements. Local Government building codes are also applicable.

2.1.1 COMMONWEALTH OUTCOME STANDARDS

The focus of Commonwealth standards monitoring is on the desired outcomes rather than the processes (ie: the practices) or the structures (resources, physical and organisational settings) of nursing homes. That is, the standards monitoring examines how well the nursing home is attaining prescribed goals rather than the way it seeks to achieve them (Braithwaite, 1993: 9).

There are 31 Nursing Homes Outcome Standards and these seek to regulate both the quality of life of residents and the quality of care (Commonwealth Department of Human Services and Health, 1993). The Outcome Standards are grouped into seven categories:

- health care - which includes the right to choice of doctor, individualised care, informed choice of treatment, clean and healthy skin, adequate oral health care, and adequate nourishment and hydration;

- social independence - which includes freedom to come and go, to maintain friendships and receive visitors, manage own financial affairs, religious and cultural freedom;

- freedom of choice - including choosing bedtime and rising time, bathing time, clothing and freedom to complain to staff, proprietors, consumer organisations or government bodies;

- homelike environment - including having personal possessions, homelike decor, and security;

- privacy and dignity - which includes staff attitudes, modes of address, the right to private space, privacy in bathing and toileting, and confidentiality of records and information;

- variety of experience - including organised activities, freedom not to participate; and

- safety - including the right to take risks, design of the building, minimal use of restraints, fire standards and emergency procedures.

It is important to note that these Standards are **minimum** standards, and do not reflect high quality care.

The Commonwealth Standards Monitoring Teams initially aimed to make visits to nursing homes on a two-yearly cycle. In reality, however, most homes are visited much more infrequently, and the Monitoring Teams instead focus on making frequent visits to homes which are known to be in breach of standards (McFee, Briefing - 12 December 1996). The homes are given 24 hours' notice of the initial visit. The two-member teams talk to residents, Residents' and Relatives' Committees, relatives and

staff, and use their own observations to determine the extent to which the minimum standards are met. Each of the 31 Outcome Standards is assessed as being met, requiring action, or requiring urgent action (Law Reform Commission, 1994: 43).

Where the Standards Monitoring Teams find breaches that require action or urgent action, they hold discussions with the Director of Nursing and the Proprietor. The nursing home is provided with an extensive written evaluation, and given 30 days to create an action plan to meet all standards. This action plan may be published with the Standards Monitoring Report if the proprietor desires it (Braithwaite, 1993: 117).

Unannounced follow-up visits are made to determine if the standards have been subsequently met. The follow-up visits do not re-check all Standards, merely those previously determined to be requiring action or urgent action.

The Standards Monitoring Reports are sent to service providers, staff representatives, the Residents' and Relatives' Committee and government agencies. They are also made available to the public, upon request.

The Commonwealth does not have a separate body to enforce sanctions against nursing homes which have failed to meet standards. It is up to Standards Monitoring Teams to "actively recruit support from staff with management and enforcement responsibilities to do something about a recalcitrant nursing home" (Braithwaite, 1993: 50). This contrasts with the standards monitoring in the United States which involves a separate enforcement system. In that system, an automatic suspension of government benefits for new admissions to a nursing home occurs if the same deficiency is found on three consecutive visits, or if the deficiency is not corrected within three months (Braithwaite, 1993: 88).

Under the current Australian system, a home which has a low standards compliance score is labelled a home of concern (Gregory, 1993: 27). The list of homes deemed to be a home of concern is not made public, as they are subject to confidentiality provisions in the *National Health Act, 1953* (Horin, 13 May 1996).

Continued breaches of standards may result in the Minister declaring non-compliance with Outcome Standards. Sanctions for non-compliance include suspension or withdrawal of funding. The most common sanction is that the Commonwealth benefit is not paid for new residents admitted into the nursing home after the facility has been deemed not to comply. The final sanction, revocation of approval, effectively closes the facility (King, Evidence - 5 May 1997). The Minister's decision to declare a nursing home as non-compliant can be appealed by the proprietor to a Standards Review Panel (Law Reform Commission, 1994: 80).

In practice, however, sanctions are infrequently used. The Braithwaite Report noted that, though enforcement is better than it was, "there is still a need for further strengthening of the enforcement effort to make it credible" (1993: 88), and that the authorities "continue to tolerate nursing homes persisting in chronic non-compliance for months and years" (Braithwaite, 1993: xv).

Currently, no sanctions are applied unless there is a very low score, or if the nursing home is "so demonstrably bad that action would be incontestable" (Gregory, 1994: 26). This has created an industry perception that action will not necessarily be taken against sub-standard homes (Braithwaite, 1993: xx). The Committee was told that, in New South Wales at any one time, there are usually 20 or 30 "homes of concern". Of these, an average of ten homes have been formally declared as failing to comply with standards each six months. Perhaps two or three of the declared homes would have financial sanctions imposed, while others may have nursing advisers appointed (McMahon, Evidence - 5 May 1997). However, some homes have been under declaration for two to three years without any financial sanctions (Chadwick, Evidence - 6 February 1997).

Only one nursing home in New South Wales has been closed by the Commonwealth in recent years. Closing a nursing home is a serious step, and one which may be against the interests of the residents, who would have to find another bed in an environment of chronic under supply. Rather than closing down a home, the Department has preferred to negotiate with the proprietors and managers to remove themselves or sell up under threat of closure or financial sanctions. This allows for the facility to continue operation under new owners and managers (McFee, Briefing - 12 December 1996).

The problem of non-compliance may be exacerbated by the lack of effective competition in the nursing home industry. The number of nursing home beds is restricted by the Commonwealth government. With occupancy rates close to 100%, and most areas having waiting lists for beds, nursing home proprietors can expect to fill their beds regardless of the standards of care (Gregory, 1994: 35-6). Because this is a closed supply market, there is no incentive to encourage the provision of quality care. As Gregory notes, if market forces worked in the case of nursing homes, occupancy levels would be low in nursing homes that have low standards monitoring scores, but this is manifestly not the case (Gregory, 1994: 25).

Limits on the number of nursing home beds were originally put in place by the Commonwealth to reduce the number of nursing home residents and to shift the balance away from residential care to community care, a less expensive option for government and the preferred option for consumers. The Committee recognises that the regulation of numbers of residents is appropriate to avoid a return to the high rates of institutionalisation of aged people.

In its Interim Report the Committee surmised that this objective could be met equally well if the restrictions on bed numbers were to be removed, so long as numbers of residents approved for residential aged care remain restricted. If the numbers of approved beds were to increase, providers would be required to compete for approved (subsidised) residents. To that end, the Interim Report recommended that the Commonwealth Government remove restrictions on bed numbers while retaining limits on numbers of approved residents for residential aged care facilities.

The Committee has since received evidence that this approach would not necessarily work. In the first instance, there is no way to restrict the number of approvals for entry into a residential facility; approvals are based on the needs of the client rather than any quota. This is why some areas have lengthy waiting lists for aged care facilities. The Committee was also told that removing the restrictions on bed numbers, or places, could have some negative consequences, and may in fact not assist in ensuring quality care is provided or reducing waiting lists for nursing home care. The Rev Harry Herbert told the Committee that:

> *The theory is that it would drive all the bad operators out of business and leave only the good ones. However, such a system could have other impacts. You could imperil the financial stability of the good operators* (Evidence - 8 September 1997).

Rev Herbert continued:

> *It might lead to an over-investment in the nursing home industry. If a large number of beds are available and some of them are unfilled, that does not mean that those operators would simply fall by the wayside, They might mount high-intensity and perhaps successful campaigns to fill their beds. .... We need to think carefully about increasing the possibilities of that on the grounds that competition will somehow help weed out the bad operators* (Evidence - 8 September 1997).

The Committee also heard evidence that there is the potential for growth in the number of unfunded hostels as a result of closure of facilities which do not meet the certification standards, and that there are already a number of these operating which are not licensed and in which the rights of residents are being compromised (Fisher - Evidence 8 September). The Committee is concerned whether unused capacity of an over-invested industry might lead to an increase in alternative uses of these facilities (ie. unlicensed/unfunded hostels or boarding houses). However, the Committee believes that further examination of the likely consequences of increased bed numbers should be included in the planning for the National Aged Care Strategy, as proposed in Recommendation 2 of this Report.

2.1.2 COMPLAINTS MECHANISMS

Complaints about nursing home standards can be made to the Commonwealth Department of Health and Family Services, and it has a phone hotline. Unannounced inspections may be made as a result of phone complaints. Complaints can also be made to Commonwealth standards monitors (McFee, Briefing - 12 December 1996). The Complaints Officers and the Standards Monitoring Teams operate independently of each other. The Department received 277 complaints about nursing homes in 1995 (Minister for Family Services, Answer to Question on Notice No 74, Australian Senate Hansard for 20 June 1996).

Some have argued that there is an inherent conflict of interest in having the same body responsible for supervising standards and receiving complaints. Suggestions for overcoming that conflict include establishing a new body, independent of the Department, for the purpose of receiving complaints; or allowing the Commonwealth Ombudsman to deal with user complaints (Law Reform Commission, 1994: 60).

2.1.3 CHARTER OF RIGHTS AND RESPONSIBILITIES OF NURSING HOME RESIDENTS

In addition to the minimum standards, the *National Health Act, 1953* and the *Aged or Disabled Persons Care Act, 1954* contain schedules which set out Charters of Rights and Responsibilities of Nursing Home Residents. Charters have a role in educating about rights and responsibilities, and have a symbolic value.

The Charter of Residents' Rights and Responsibilities contains a broad statement of consumer rights. This includes:

> *the right to quality care, information, dignity and respect, personal privacy, freedom of speech, consultation, complaint mechanisms, and personal independence* (Law Reform Commission,1994: 35).

They also set out the responsibilities of nursing home residents. These responsibilities require the resident to respect the rights of other residents and staff, and to look after their own health as far as possible.

A copy of the Charter is in Appendix 7 of this Report.

2.1.4 RESIDENTIAL AGREEMENTS

Residential agreements are written contracts between the nursing home and the resident. Nursing homes must offer residents a Commonwealth-approved model agreement. If they do not, a notice is issued from the Department to notify the proprietor that they are still required to operate in accordance with the terms of the agreement.

The contents of the agreement include rules of service, charges, and the circumstances which permit ceasing of service. The resident's right to privacy, freedom from abuse and discrimination and the right to participate in decision making are also included in the model residential agreement (Law Reform Commission, 1994: 36).

Residential agreements are different from charters because they are legally enforceable, and the focus is on an agreement between an individual and the nursing home. Residential agreements can be useful in the event of a dispute, as they can form the basis of negotiations. However, enforcement through the legal system is an expense beyond the reach of many, if not most, nursing home residents. A further problem is that confused elderly residents may not understand the contract, although relatives may be informally involved in assisting and advising the resident.

2.1.5 CONSUMER GROUPS

The Commonwealth funds an independent advocacy service in each state. Nursing home proprietors are obliged to allow entry of advocates, and to assist them in meeting residents. This is a condition of funding for nursing homes. The role of the advocacy service is to provide residents with information, advise them of their rights, assist them with making complaints, and to provide referrals to other bodies. The Commonwealth-funded advocacy service in New South Wales is The Aged-Care Rights Service (formerly known as The Accommodation Rights Service).

2.1.6 STATE REGULATION OF STANDARDS

The State government regulates nursing home standards through its nursing home licensing provisions under the *Nursing Homes Act, 1988*, and the *Nursing Homes Regulation, 1996*.

All nursing homes in New South Wales must obtain a licence from NSW Health. It should be noted, however, that the Commonwealth regulates the distribution and numbers of nursing home beds. Nursing home licences are processed by the Private Health Care Branch of NSW Health. Licence conditions are spelt out in the 1996 Nursing Homes Regulation. These standards are more input focussed than the Commonwealth standards, and stipulate administrative processes (such as the keeping of records and registers), structural aspects (such as furnishing and equipping of wards, kitchens, common rooms, maintenance of buildings, fire safety) and staffing requirements. The New South Wales licensing standards also incorporate the Commonwealth Outcome Standards verbatim *(NSW Nursing Homes Regulation, 1996*, No 420, under the *Nursing Homes Act, 1988)*.

Following the issuing of a licence, the facility is subject to inspections by state health workers, under sections 44 (1) and 45 (1) of the *Nursing Homes Act, 1988.* The inspectors are now called "nursing supervisors" and their inspections initially were to

occur on a biennial basis (Woodruff, Briefing -12 December 1996). In recent times, however, the approach has been to take a risk management approach, with inspections concentrating on nursing homes which are considered to be a higher risk. The NSW Health inspection reports are not publicly available.

The Ageing and Disability Department, through the *Community Services Act,* has responsibility for licencing hostels, although these are currently exempted.

The final component of State regulation relates to investigation of complaints. The NSW Health Care Complaints Commission (HCCC) receives complaints concerning breaches of nursing home licencing conditions and the professional conduct of staff in all nursing homes in New South Wales. A phone hotline is advertised in the White Pages. Between January 1992 - June 1996, the HCCC received 111 complaints about nursing homes. HCCC informed the Committee that the majority of complaints concerned clinical standards and quality of care (Submission 70). The sources of these complaints are residents and relatives, staff of nursing homes as well as the Health Care Complaints Commissioner and residency rights groups (Wilson, Evidence - 12 May 1997).

There are several sanctions available for use by the State against nursing homes in New South Wales which breach regulations. NSW Health issues section notices for breaches of licensing conditions. Proprietors are given a time period for compliance to be achieved, after which the licence holder can be prosecuted.

Breaches of several sections carry penalties of fines of up to 20 penalty units ($500) including: failure to make repairs or alterations to buildings; overcrowded facilities; and failure to have a registered nurse on duty at all times (McFee, Briefing - 12 December 1996).

Cancellation of a licence is possible under the Act if the licence conditions are violated or there is a breach in "reasonable standards of resident care". The licensee must be given 14 days notice, be given a chance to respond in a submission, and may appeal to the District Court. However, like its Commonwealth counterparts, NSW Health is reluctant to withdraw licences because it creates a further problem of finding alternative beds for existing residents.

Dr Andrew Wilson, Director, Clinical Policy and Practice, NSW Health explained to the Committee:

> *... We try to avoid the situation of actually forcing a withdrawal of licences because it actually results in a sudden loss of service* (Wilson, Evidence - 12 May 1997).

Dr Wilson also noted that the majority of nursing homes respond favourably when problems are identified, and work with the Department to overcome them. Cancellation of a nursing home licence has not occurred within the last two years (Wilson, Evidence - 12 May, 1997).

2.2 PROTECTION OF RESIDENTS' RIGHTS AND DIGNITY

2.2.1 IS THE CURRENT SYSTEM EFFECTIVE IN PROTECTING THE RIGHTS AND DIGNITY OF RESIDENTS?

In 1996 the *Sydney Morning Herald* ran a series of articles exposing allegedly substandard care and facilities in the nursing home industry in New South Wales. Allegations included residents being left in pain for hours, overuse of chemical restraints and lack of safe environments. The *Herald* reported that, of the 149 homes targeted for full inspections by the Standards Monitoring Teams, more than half failed to provide a safe environment for residents and almost one third of the homes failed to meet six or more of the Outcome Standards (*Sydney Morning Herald*, 13 May, 1996). The Commonwealth Minister for Family Services informed the Senate on 20 June 1996 that only one-third of nursing homes in New South Wales meet all the minimum standards (Minister for Family Services, Answer to Question on Notice No 74, Australian Senate Hansard, 20 June, 1996).

The Committee sought further details about the incidence of New South Wales nursing homes' non-compliance with each of the individual Outcome Standards. This information was not immediately available because the Commonwealth Department of Health and Family Services apparently does not collate such information as a matter of course. The information which was subsequently provided to the Committee by the Department listed 207 nursing homes in New South Wales (around 43%) which have failed to meet all 31 Outcome Standards at full inspections prior to 30 January 1997. There was no indication as to whether the homes had subsequently met standards or whether they had been the subject of sanctions.

The Committee is concerned with the lack of data collected by the Department of Health and Family Services about compliance with Outcome Standards. It is at a loss to discern how the Department can assess the efficacy of the Outcome Standards and the enforcement of the standards if it does not maintain current data indicating levels of compliance. Further, the Committee notes that it would be useful for data to be collected on the progressive implementation of the accreditation system and reported breaches once the accreditation system is established, so that its strengths and weaknesses can be reviewed, allowing modifications where appropriate.

RECOMMENDATION 7:
The Committee recommends that the Minister for Aged Services approach the Commonwealth Minister for Family Services to ensure that the Commonwealth Department of Health and Family Services collects data concerning breaches of accreditation standards and publishes them annually.

The Committee is concerned that up to one-half of nursing homes in this state do not meet the minimum standards, and this suggests that enforcement is inadequate. It is the Committee's understanding the Outcome Standards represent not the ideal, but the minimum standards expected to be met by facilities in order to obtain Commonwealth funding.

While the Committee commends the negotiation-based approach, it is apparent that too many homes continue to operate in breach of the Commonwealth Standards. As changes have been proposed in the regulatory system of Australian nursing homes, it would be futile for the Committee to make recommendations for changes to the current regime. However, the Committee urges the Commonwealth Minister for Family Services to ensure that the new accreditation based system of standards incorporates a workable set of sanctions, and that these sanctions are applied when breaches occur.

The Committee acknowledges criticisms that the Outcome Standards reports make conditions appear worse than they are. Because even minor infringements of a standard can result in an "action required", failure to meet all standards is not necessarily indicative of bad care. Some proprietors also complain that the monitoring of individual standards is subjective (such as the standard requiring a "homelike" environment), and that the decisions on particular standards are not consistent between inspectors. This latter criticism was refuted by the Braithwaite Report, which examined the consistency of decisions and found that "the process accomplishes a high degree of consistency and validity of ratings" (Braithwaite, 1993: 76). There were some exceptions, with consistency problems identified for the continence management standard, the sensory losses standard and the undue noise standard (Braithwaite, 1993: 76).

Evidence received by the Committee from relatives of residents suggest that there are residents whose rights to privacy, dignity and confidentiality are violated in some nursing homes in New South Wales, in spite of the structures set up to prevent this. Most of the submissions from relatives of residents emphasised that they wished their submission to be confidential, as they were reluctant to openly criticise a facility.

The Committee notes, however, that standards of care in most nursing homes are high, and that nursing and personal care staff are generally caring, committed professionals. It is also true that it is the nature of Inquiries such as this one that individuals are usually only driven to make a submission in order to raise a complaint, rather than to give praise, and that this can give a distorted picture of the standards of care.

2.2.2 RESIDENT CARE AND DIGNITY

The Committee recognises that it is difficult to balance the rights of the individual and the realities of communal living. As the Council for Intellectual Disability noted in its submission:

> *The loss or reduction of personal privacy is the most immediate and obvious effect of moving into a facility. This particularly raises issues in nursing homes, as there is considerably more chance that the person will have to share a room with at least one or possibly several other people* (Submission 67).

Many of the problems of loss of privacy and confidentiality are related to the design of nursing home buildings, particularly the older buildings which commonly have four residents in one room.

The Centre for Education and Research on Ageing submitted that:

> *Despite the best of intentions, many nursing homes remain antiquated in their design and decor. One is often left to question how true privacy and dignity can be maintained in environments where elderly people's worlds have so dramatically decreased to a small bed area in a room shared by six other people* (Submission 78).

A former aged care worker noted:

> *You eat, sleep and perform the most intimate chores with strangers. Your possessions are now what you are able to fit in a small wardrobe and a bedside table* (Submission 83).

For couples, there is the additional problem that:

> *rooms which cater for married couples are also rarely available in nursing homes which also causes distress for residents and their families. There is little privacy available to maintain a marital relationship. It is generally assumed older people are asexual* (Submission 54).

In other instances, it was actions of staff and management which breached residents' rights to privacy and dignity. An ex-staff member of an aged care facility noted that the following practices occurred:

> *The withholding of private mail ... [and the denial of] the basic rights of residents being able to make telephone calls from the public phone without such calls being reported to management and residents chastised* (Submission 76).

A relative reported that:

> *when he visits his 57 year old demented wife she is more often than not dressed in clothes other than her own and it makes him very sad to see her in dresses and cardigans that are far too big* (Submission 77).

A relative of another nursing home resident submitted her observations of nursing home care in that particular facility:

> *My mother was in a four bed ward with an ensuite, but I never once saw anyone in that room helped to the toilet. They were put on a commode next to their bed because it was easier for the nurses. The residents were encouraged to buzz if they needed assistance, but the buzzers were either out of reach or unplugged or turned off...* (Submission 37).

She further noted:

> *On more than one occasion I found [my mother] still waiting for her morning shower at 12 o'clock. When I questioned this, I was told that the reason was due to the fact that they were short staffed on that particular day, or she wasn't on the shower list for any particular nurse. On one occasion I was asked to assist with her shower, because there weren't enough nurses. How embarrassing this must have been for my mother* (Submission 37).

The daughter of another resident was distraught when the following incident occurred at her mother's nursing home:

> *I walked into her room to find her sitting in a chair with her skirt slightly up, so I could see that she had no underwear on. A nursing assistant came in and I said, "mum has no underwear on". She stood mum up and lifted her dress to inspect for herself. Mum was in a four bed ward. One of the ladies in that ward also had visitors, so besides mum's dignity it wasn't a very pleasant experience for the people in that room* (Ilbery, Evidence - 21 April 1997).

Professor Brodaty, a psychogeriatrician who makes frequent visits to nursing homes, told the Committee:

> *I often see people in their room, sitting on a commode, in a state of undress, or people actually using a commode as I walk in to see one patient* (Evidence - 21 April 1997).

One confidential submission to the Committee detailed the treatment of a resident in a nursing home-type bed of a small country hospital, as observed by the resident's daughter:

> *Our father was soaked to the arm pit, lying on a urine soaked sheet ... The top sheet and blanket were wet too. There was no [continence] pad to keep him dry* (Submission 18).

Upon complaining of this treatment to a registered nurse, the daughter was told by the nurse that they had been instructed to just use the sheets.

Another relative of a nursing home resident documented her complaints to the home concerning care of several residents, including:

> *Mr B - after having a fall and breaking his hip was admitted to Port Kembla hospital. When admitted he was found to be malnourished, he had an appalling skin condition, his hair was encrusted to his head and he also had an ulcerated mouth ... On occasions when Mr B would not go into the dining room for meals, he was not given meals at all* (Submission 72).

This submission noted that there were several occasions where "residents who have been admitted to hospitals [from this facility] have been found to be malnourished".

The submission further documented:

> *Denial of Care to Mr F - Mr F has diabetes ... and was told [by staff] that he did not need to have his sugar levels tested as he could get AIDS or Hepatitis, therefore no monitoring of his diabetes was conducted* (Submission 72).

The author of this submission, who wishes to remain anonymous, followed the usual complaints process, including complaining to staff, management, the Commonwealth Complaints Unit and the Accommodation Rights Service. The author felt that only the latter organisation made any attempt to investigate fully and improve the situation in that facility, and that complaints to management of the facility resulted in intimidation and ill-treatment of the resident.

The daughter of another resident submitted that her father, after admission to a nursing home, suffered from ulcers and an abscess of the mouth. She felt that this was a result of failure of the nursing home staff to brush her father's teeth, and noted that:

> *my father had been in the nursing home for quite a period of time and I was most surprised to find that some staff thought he had false teeth [when he did not]* (Submission 73).

2.3 WORKFORCE ISSUES

A number of witnesses and submissions made the point that quality of care is very much dependent on attitudes and training of staff. One service providers' organisation submitted "staff attitudes make a fundamental difference to the atmosphere of a nursing home" (Submission 15).

A submission from Berriquin Nursing Home commented that:

> *We can provide a homelike environment but without staff who accept the philosophy of residents' wishes and needs being paramount, success will never be achieved* (Submission 26).

Clearly the attitudes of staff is an area of service that is very difficult to regulate. The Committee believes that qualifications and training are crucial in ensuring that staff have an understanding of the needs and rights of elderly residents.

The Ageing and Disability Department noted that:

> *(I)t is also important that management has a clear philosophy and understanding of carer needs, to support staff in their work* (Submission, 11 September 1997).

The Committee believes it is important that facilities are staffed by adequate numbers of qualified nurses: either registered or enrolled nurses. This is imperative if quality care is to be provided for those residents of aged care facilities who have high nursing care needs, including palliative care needs.

However, the Committee also recognises that for the majority of older people their care needs do not need to be delivered in a clinical setting, and therefore advocates the adoption of a social model of care: just because people are old does not mean they are sick.

Neither Commonwealth nor New South Wales legislation currently regulates specific staff-resident ratios or qualified-unqualified staff ratios. Other states have, or in the past did have, such regulations. The *NSW Nursing Homes Regulation, 1996* states in Section 15 that:

> *(1) The nursing and personal care staff of a nursing home must at all times be sufficient in number, and have appropriate experience, to perform the nursing duties necessary for the proper care of residents*

(2) *The sufficiency of nursing and personal care staff is to be determined in accordance with the Principles for the Classification of Nursing Home Patients and Repatriation Nursing Home Patients.*

The Principles classify residents according to the amount of care needed, though they do not codify a specific staff-resident ratio, or set requirements relating to a qualified staff - unqualified staff ratio. The last survey by NSW Health on staffing ratios in private sector nursing homes was done in 1992, and its findings are incorporated in Table 1.

TABLE ONE

STAFFING MIX IN NEW SOUTH WALES NURSING HOMES

YEAR	REGISTERED NURSES	ENROLLED NURSES	ASSISTANTS-IN-NURSING
1980	34.8%	9.2%	56.0%
1992	31.7%	10.5%	57.8%

Source: NSW Health, Private Sector Nursing Workforce, unpublished.

As can be seen in Table One, in 1992, less than half of the nursing and personal care staff in nursing homes were qualified, and this has slightly decreased since 1980.

The Committee is concerned at the lack of uniform criteria for staff working in residential aged care sectors. For example, there are no qualifications required for Personal Care Assistants or Assistants-in-Nursing, and, under current award conditions, Assistants-in-Nursing must undergo only 12.5 hours of on-the-job training each year (Fredericks, NSW Nurses' Association, Personal Interview, 21 May 1997).

Of particular concern to the Committee is the fact that there are no requirements for Registered Nurses to have specific gerontological training. Registered Nurses are often in leadership positions in aged care organisations, including being charge of other less qualified or unqualified staff. The Committee is aware that there are a number of aged care organisations in New South Wales which have a strong training culture, and other personnel practices which support the provision of high quality care. However, from the Committee's perspective, it is a concern that this is not more widespread.

The Committee believes that the aged care industry should work toward developing a holistic training framework, which is driven from the perspective of a social model of care and which also includes relevant clinical care elements. The Committee notes that the Commonwealth has established a Residential Aged Care Workforce Review Committee to report on how to meet the workforce requirements of the aged care

industry (Aged Care Structural Reform - Fact Sheet 20, June 1997). The Committee is not aware of any formal mechanism by which the NSW Government is involved in this process. The Committee believes it is important to include the State and Territory Governments in this process, as well as community care providers, particularly given the erosion of boundaries between residential and community care which has occurred over the last decade, and which needs to continue to ensure a more cost effective aged care system which is driven from a community care perspective.

RECOMMENDATION 8:
The Committee recommends the Minister for Aged Services request of the Commonwealth Minister for Family Services to include State and Territory representatives on the Residential Aged Care Workforce Review Committee, and extend the Terms of Reference to include community aged care services.

The Committee recognises the inherent difficulties in education and training of staff working in residential aged care facilities, in particular Assistants in Nursing and Personal Care Staff, due to the large proportion of part-time and casual workers, the low levels of education and the low levels of English language skills. In addition, the Committee understands that there is often a high turnover of staff, which could be a result of staff feeling unsupported in their work. To that end, it is important for all levels of staff working in aged care services, including management, to understand the issues of caring for frail older people. The Committee is of the strong belief that it is unacceptable for frail and ill elderly people to be cared for largely by untrained staff. The Committee is encouraged to see that the Accreditation Standards which are being developed by the Commonwealth address a number of these concerns. The Standards include staff training on medication management, palliative care, complex nursing care needs, issues relating to sensory loss.

The criteria for the Human and Resource Management Standard include policies and practices which provide:

- *for recruitment, orientation, training and education to be conducted and documented;*

- *that all staff have their performance formally reviewed on a regular basis, giving consideration to performance, training, education and other developmental issues; and*

- *that staff training and education needs are identified and acted upon. Staff are encouraged to pursue relevant ongoing education and training and progress is monitored* (Criteria d, f and g HFS Draft Standards for Aged Care Facilities, 3 June 1997).

However, given the length of time within which facilities have to be accredited (three years), the Committee believes it is important that the NSW Government monitors the implementation of standards. The Committee believes there are a number of strategies which could be undertaken to improve the training and education of staff in aged care facilities, including the development of an industry training framework for staff, which guides the industry in staffing and training priorities and best practice in training for the needs of the workers and management in the industry. The Committee believes that development of an industry training framework should be in the context of the Aged Care Strategy (as per Recommendations 2 and 4 of this Report) and in conjunction with key stakeholders such as the NSW Nurses' Association, NSW College of Nursing and consumer groups. In particular, the Committee is concerned to see that issues of privacy and dignity, and residents' rights, are incorporated into any industry training framework.

RECOMMENDATION 9:
The Committee recommends that the Ageing and Disability Department include in the NSW Aged Care Strategy (see Recommendation 4) the development of a New South Wales aged care industry training framework, which builds on the work of the Commonwealth's Residential Aged Care Workforce Review Committee, and includes community care workforce issues.

The Committee notes that there are a number of training programs currently available to Assistants-in-Nursing in New South Wales. The NSW Nurses' Association is confident that all Assistants-in-Nursing in this state have access to a training program, including those in rural areas (Illisse, Personal interview, 16 June 1997).

Prospective Assistants-in-Nursing can access a 12 month traineeship or a three month pre-service training program, the latter of which involves 10 weeks course work and two weeks work experience. A pilot program for existing staff to undertake a certificate of accreditation has recently been successful, and will be available to all Assistants-in-Nursing by October 1997. Rural areas have access to the program through distance learning, on-the-job training and Area Health Nurse Educators. Each of these programs are known as level three certificates, equivalent to 320 hours of study.

A level two certificate, known as Care of the Ageing is available through TAFE. Care of the Ageing is an 8-10 week course. A two week, level one certificate is also available in various facilities in New South Wales, but it is not accredited.

In its response to the Interim Report of this Inquiry, NSW Health noted that:

> *(I)t is recognised that Assistants-in-Nursing have an established role in health care delivery, particularly in the provision of aged care* (Submission, 11 September 1997).

The Committee is concerned, however, that existing aged care programs, such as the Care of the Ageing course noted above, may have an overly medical or clinical approach which would be inconsistent with the social model which this Committee believes should drive the provision of care for older people: that is, a model of care directed to supporting people in the community for as long as possible, and when that is no longer possible, providing care in a way which maintains the dignity and autonomy of older people. In its response to the Interim Report of this Inquiry, NSW Health advised the Committee that a review of training programs for Assistants-in-Nursing has recently been undertaken (Submission, 11 September 1997). Any review of course materials should take into consideration the findings of this Review.

RECOMMENDATION 10:

The Committee recommends that, as part of the development of a New South Wales aged care training framework (see Recommendation 9), the Ageing and Disability Department work with relevant stakeholders and the NSW Vocational Education and Training Accreditation Board (VETAB) to review existing accredited or approved aged care programs to ensure that they are driven from a social model of care perspective, as well as including the relevant clinical components.

RECOMMENDATION 11:

The Committee recommends that all nursing and personal care staff in New South Wales residential care facilities be trained to an Assistant- in-Nursing Course Certificate III level by the year 2000 and that a range of programs be made available to ensure equitable access to training.

The Committee notes that under the current system there are mechanisms in place to ensure appropriate staff mixes. Under the CAM/SAM funding arrangement the Commonwealth provides funding to nursing homes for nursing and personal care using the Care Aggregated Module (CAM). Each resident is classified based on their care needs, and facilities are funded accordingly. The funds are validated by the Department of Health and Family Services, so any CAM funds which were not spent on nursing or personal care are required to be repaid to the Department and must not be kept as profit. This reduces the incentive to cut costs by using cheaper staff.

Under the changes proposed by the Commonwealth, CAM and SAM funding will no longer be separate, and care related funding will not be validated. Several witnesses and submissions have expressed apprehension about the likely effects of the proposed changes. They are concerned that these changes will result in providers seeking to

reduce staffing costs and increase profits by employing more Assistants-in-Nursing rather than Registered or Enrolled Nurses, resulting in diminished quality of care (for example, Moait, Evidence - 5 May 1997).

The Commonwealth expects that appropriate staffing mixes in aged care facilities will be ensured through the standards for accreditation which require that services employ appropriately qualified and skilled staff to meet the needs of their residents. In order to meet the quality accreditation standards services will need to show:

- *a staffing mix which meets the care needs of their residents;*
- *the recruitment of appropriately skilled staff;*
- *the continued development of staff skills; and*
- *the provision of adequate opportunities and resources for supervision and on-the-job training* (Aged Care Structural Reform - Fact Sheet 20, June 1997).

The Committee is concerned that the accreditation process will not guarantee appropriate staffing mixes for residents, which witnesses feel will be compromised as a result of the abolition of a validated system of CAM funding for personal and nursing care. In its Interim Report on this Inquiry the Committee noted that the erosion of qualified staff can be averted in New South Wales through an amendment to the *NSW Nursing Homes Regulation, 1996* in respect of the licensing conditions contained therein. Licensing conditions should be altered to include a staff-resident ratio and a staff mix ratio.

The response to the relevant recommendation in the Interim Report has indicated that reform of legislation for these purposes should not proceed. NSW Health noted:

> *It is inappropriate to prescribe staffing ratios for health care settings in legislation as it excludes flexibility in planning and responsiveness of planning to changing service needs, demands, resident acuity and changes which are currently underway across the health and community services sectors* (Submission - 11 September 1997).

The NSW Nurses' Association also noted that:

> *Directors of Nursing at a local level must have flexibility and the resources to adjust their staffing needs to the current acuity of the residents* (Submission - 28 August 1997).

The Ageing and Disability Department cautioned against legislating for staff ratios and mixes:

> *The question of reform of NSW legislation must be considered in the context of the system as a whole* (ADD - 11 September 1997);

and

> *(t)he inclusion of nursing staff on staff may not always be necessary and should be determined according to the level of care required* (ADD - 11 September 1997).

The Committee believes, however, there are still significant concerns that the abolition of the validation of the CAM/SAM components will lead to compromised staffing profiles in aged care services, and is concerned that the accreditation process will not adequately pick up on these issues. To that end, the Committee believes staffing profiles and resident care should be monitored.

RECOMMENDATION 12:
The Committee recommends that the Ageing and Disability Department include in its monitoring of the impact of the *Commonwealth Aged Care Act, 1997* information which will reflect the quality of care for residents and appropriate staffing profiles.

2.4 MEDICATION USE AND RESTRAINT PRACTICES

The Psychotropic Committee is very concerned that there appears to be a high incidence of the use of medication in aged care facilities in NSW. A report in the Medical Journal of Australia (Vol 163, July 1995) concluded that:

> *The percentage of residents in Central Sydney nursing homes who were taking neuroleptics, hypnotics or anxiolytics is among the highest reported from geriatric institutions around the world. Prescribing practices in Australian nursing homes need to be reviewed* (cited in Submission 57).

The Committee understands that one of the chief reasons for prescribing such medication is to control behaviour of people, in particular people with cognitive impairments. There is also a concomitant high incidence of physical restraint used for such residents.

The impact of the over-use of medication for purposes of restraint on residents and their families is significant, as one relative noted:

> *My father [who had Alzheimer's Disease] was sedated without any consultation with me. He had never been prescribed sedation in his life, and it was totally uncalled for. My father was beginning to be "out of it" most of the time ... and it took some stern words from me and a change of doctor before I could get this stopped* (Submission 80).

The extent of the problem was acknowledged in a briefing provided to the Committee by the Ageing and Disability Department. Ms McFee told the Committee:

> *Public attention has been focused recently on the use of psychotropic medication in nursing homes. Aspects of Commonwealth and State legislation, regulatory apparatus and accountability mechanisms have been thought to be inadequate to protect the rights of residents to ensure best clinical practice in this area. Medical attention has highlighted the ease of reliance by nursing home operators on the use of psychotropic medication as a simple and inexpensive way of managing difficult behaviour, rather than developing other appropriate behaviour management strategies* (McFee, Briefing - 12 December 1996).

The Committee notes that some actions have been taken recently to reduce over-medication. A NSW Ministerial Taskforce on the Use of Psychotropic Medication in Nursing Homes was established to examine the problem and to form recommendations. This Taskforce has recently reported to the Minister for Health, who has called for public comment. The recommendations of the Taskforce are included in this Report as Appendix Five. The Committee endorses the recommendations of the Taskforce Report and urges their implementation as a matter of urgency.

The Australian Pharmaceutical Advisory Council (APAC) has recently published a report entitled Integrated Best Practice Model for Medication Management in Residential Aged Care Facilities (1997). This document is the result of the work of the APAC Working Party on quality use of medicines in nursing homes and hostels, and, it is hoped, will assist residential aged care facilities in achieving more appropriate levels of use of prescribed medication (Australian Pharmaceutical Advisory Council, 1997). The Advisory Council's recommendations can be found in this Report as Appendix Six. The Committee endorses the guidelines and recommendations contained in the APAC Report.

2.5 CONCLUSION: ARE RIGHTS PROTECTED?

With a combination of Commonwealth Outcome Standards, Charters of Rights and Responsibilities, Residential Agreements and state licencing standards, nursing home residents are currently protected by a very comprehensive system of safeguards. The current system has successfully raised the standards of care and quality of life of most nursing home residents, and has been assessed as being inexpensive and fair.

However, despite this, there remains some aspects of care which are not provided satisfactorily.

The Commonwealth has addressed the protection of rights of residents through a number of mechanisms outlined in the *Commonwealth Aged Care Act, 1997* including the accreditation standards, revised complaints mechanisms and increased capacity of services to raise funds to improve service provision (through the Accommodation Bond scheme). The effectiveness of these will not be clear for several years.

It is therefore important that the NSW Government continue to monitor the impact of the reforms on the rights and care needs of residents. Whether this is done in the context of continued legislative involvement, such as the *NSW Nursing Homes Act*, or through the review process of the *Commonwealth Aged Care Act, 1997* which the Commonwealth must undertake (and States participate in) is a decision the Government needs to make.