Speech by Adam Graycar:

"Nursing homes"

presented to the Private Nursing Homes Association, Wirrinna, South Australia, 1st October 1986

78(9) 1

as given

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PRIVATE NURSING HOMES ASSOCIATION

WIRRINNA

1ST OCTOBER 1986

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There are, in South Australia today, 118,000 people in their sixties, 72,000 people in their seventies, and 27,000 in their eighties and over, that is about 217,000 people over 60, and 100,000 over seventy.

As we look to the future, over the next 25 years S.A.'s population will increase by 27%; the population aged 65 and over by 67%; the population aged 75 and over by 118% and the over 85s by 225%.

85+ fastest growing group.
Dependencies at that age chronic not transitional

Age profile in AH. (Tables)

Table 1

Nursing Home Residents Per 1,000 Population Aged 65 and Over, by State, 31 December 1985

State	Age (years)						
	65-69	70-74	75-79	80-84	85-89	90-94	95+
	Rate per 1,000 ERP						
NSW	7.4	16.1	37.6	92.9	200.3	352.1	567.4
Vic	4.4	10.1	26.4	63.4	150.0	292.0	476.4
Qld	6.3	15.6	34.3	88.3	184.9	328.0	507.1
SA	5.6	13.6	34.7	84.2	200.8	352.9	494.4
WA	6.7	16.5	38.1	84.4	205.9	347.9	514.5
Tas	6.4	13.3	34.9	91.8	196.8	331.3	489.3

Source: Compiled from data supplied by Department of Community Services, Canberra and Australian Bureau of Statistics, Adelaide.

Table 2

Age Distribution of Nursing Home Residents as a Proportion of Residents Aged 65 years and Over, by State, 31 December 1985

(Rank:Highest =1)

State	Age at 31 December 1985										TOTAL
	65-69	Rank	70-74	Rank	75-84	Rank	85-94	Rank	95+	Rank	
NSW	5.9	1	10.6	3	39.7	3	37.4	5	6.3	3	100.0
Vic	4.5	6	8.8	6	38.5	5	41.5	1	6.8	1	100.0
QLD	5.3	=2	10.9	1	39.3	4	38.4	4	6.2	4	100.0
SA	4.6	5	9.5	4	38.1	6	41.4	2	6.4	2	100.0
WA	5.0	4	10.8	2	42.5	1	36.4	6	5.1	6	100.0
Tas	5.3	=2	9.3	5	40.8	2	38.9	3	5.7	5	100.0
All States	5.3		10.2		39.6		38.9		6.3		100.0

Source: Compiled from data supplied by Department of Community Services, Canberra.

Dramatic decline in mortality
last 15 years.

	85+		80-84		75-79	
	M	F	M	F	M	F
1971	236	194	144	101	97	6.
1984	204	156	116	74	77	42
Drop %	14	21	19	27	21	31

S.A. More older people
at every age group
over 65. Tables

Backdrop of fed/state
- Const'l - history
- residual powers

- arbitrary - eyes
teeth
ears

- funding
licensing } Calif/state

state | environ
& proces

ESTIMATED AGED 65 YEARS AND OVER AUSTRALIAN STATES

1985

← peek a boo

AGE	NSW		VIC		QLD		SA		WA		TAS		AUSTRALIA (Including Territories)	
	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%
65 - 74														
SERIES A	366·7	6·72	263·8	6·41	161·1	6·33	97·6	7·15	77·5	5·51	29·6	6·70	1007·6	6·41
SERIES D	366·6	6·72	263·9	6·41	161·2	6·32	97·8	7·17	77·5	5·50	29·6	6·72	1007·7	6·41
75 - 84														
SERIES A	172·4	3·16	132·5	3·22	75·9	2·98	46·0	3·37	39·7	2·82	14·0	3·17	484·3	3·08
SERIES D	172·3	3·16	132·5	3·22	75·9	2·98	46·0	3·37	39·7	2·82	14·0	3·18	484·3	3·08
85 +														
SERIES A	41·3	0·76	32·3	0·79	19·0	0·75	11·6	0·85	8·7	0·62	3·4	0·77	117·1	0·74
SERIES D	41·3	0·76	32·3	0·79	19·0	0·75	11·6	0·85	8·7	0·62	3·4	0·77	117·1	0·74
TOTAL 65+														
SERIES A	580·4	10·64	428·6	10·42	256·0	10·06	155·2	11·37	125·9	8·96	47·0	10·64	1609·0	10·23
SERIES D	580·2	10·64	428·6	10·42	256·1	10·05	155·4	11·39	125·9	8·95	47·0	10·66	1609·1	10·23
TOTAL 75+														
SERIES A	213·7	3·92	164·8	4·01	94·9	3·73	57·6	4·22	48·4	3·44	17·4	3·94	601·4	3·82
SERIES D	213·6	3·92	164·8	4·01	94·9	3·72	57·6	4·22	48·4	3·44	17·4	3·95	601·4	3·82

SOURCE: ABS CATALOGUE NO. 3222.0

PROJECTED POPULATION
65 YEARS AND OVER
AUSTRALIAN STATES
1991

A G E	NSW		VIC		QLD		SA		WA		TAS		AUSTRALIA (Including Territories)	
	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%
65 - 74 SERIES A	417·7	7·17	303·9	6·95	184·7	6·57	113·2	7·80	90·6	5·80	32·6	6·99	1159·3	6·84
SERIES D	416·1	7·15	303·9	6·93	184·7	6·42	113·4	7·85	91·5	5·75	32·7	7·11	1162·2	6·81
75 - 84 SERIES A	220·8	3·79	164·7	3·76	98·7	3·51	60·5	4·17	50·4	3·22	18·1	3·88	619·5	3·65
SERIES D	220·1	3·78	165·1	3·76	99·3	3·45	60·6	4·19	50·7	3·19	18·1	3·95	620·3	3·63
85 + SERIES A	52·1	0·89	41·1	0·94	24·3	0·86	14·2	0·97	12·4	0·79	4·4	0·94	149·5	0·88
SERIES D	52·0	0·89	41·1	0·93	24·3	0·84	14·1	0·97	12·4	0·78	4·4	0·95	149·5	0·87
TOTAL 65+ SERIES A	690·7	11·85	509·7	11·65	307·7	10·95	187·9	12·95	153·4	9·82	55·1	11·82	1928·2	11·38
SERIES D	688·1	11·83	510·1	11·64	311·3	10·82	188·1	13·02	154·6	9·72	55·3	12·02	1932·1	11·33
TOTAL 75+ SERIES A	272·9	4·68	205·8	4·70	123·0	4·37	74·7	5·14	62·8	4·02	22·5	4·82	769·0	4·54
SERIES D	272·1	4·67	206·2	4·70	123·6	4·29	74·7	5·17	63·1	3·97	22·5	4·89	769·8	4·51

SOURCE: ABS CATALOGUE NO. 3222.0

PROJECTED POPULATION
65 YEARS AND OVER
AUSTRALIAN STATES
2001

AGE	NSW		VIC		QLD		SA		WA		TAS		AUSTRALIA (Including Territories)	
	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%
65 - 74 SERIES A	432·6	6·73	323·1	6·74	199·4	6·12	114·9	7·28	109·9	6·02	32·9	6·56	1236·2	6·53
SERIES D	429·6	6·60	322·0	6·55	210·2	6·07	115·2	7·25	112·3	5·80	32·9	6·73	1246·8	6·38
75 - 84 SERIES A	278·9	4·34	206·5	4·31	127·5	3·91	78·3	4·96	64·1	3·51	22·0	4·38	788·4	4·16
SERIES D	277·0	4·25	207·3	4·21	130·9	3·78	78·5	4·94	65·4	3·38	22·3	4·56	793·5	4·06
85 + SERIES A	81·9	1·27	61·8	1·29	39·1	1·20	22·8	1·44	19·8	1·08	6·9	1·37	234·5	1·23
SERIES D	81·3	1·24	62·0	1·26	39·4	1·13	22·8	1·43	20·0	1·03	7·0	1·43	235·0	1·20
TOTAL 65+ SERIES A	793·4	12·35	591·4	12·35	365·9	11·24	216·0	13·70	193·7	10·62	61·8	12·32	2259·0	11·94
SERIES D	787·8	12·10	591·4	12·03	380·5	10·98	216·6	13·64	197·7	10·22	62·2	12·73	2275·3	11·65
TOTAL 75+ SERIES A	360·8	5·61	268·3	5·60	166·6	5·11	101·1	6·41	83·9	4·60	28·9	5·76	1022·9	5·40
SERIES D	358·3	5·50	269·3	5·48	170·3	4·91	101·3	6·38	85·4	4·41	29·3	5·99	1028·5	5·26

SOURCE: ABS CATALOGUE NO. 3222.0

PROJECTED POPULATION
65 YEARS AND OVER
AUSTRALIAN STATES
2021

AGE	NSW		VIC		QLD		SA		WA		TAS		AUSTRALIA (Including Territories)	
	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%	N (000)	%
65 - 74 SERIES A	695·4	9·47	520·6	9·75	363·5	8·97	182·0	10·44	213·2	9·31	54·3	9·97	2090·0	9·48
SERIES D	691·3	9·00	519·2	9·02	397·9	8·65	185·5	10·07	222·4	8·54	53·5	10·41	2131·9	8·91
75 - 84 SERIES A	347·5	4·73	258·2	4·83	178·8	4·41	90·8	5·21	101·0	4·41	26·4	4·85	1028·1	4·66
SERIES D	344·5	4·48	257·4	4·47	193·1	4·19	90·8	5·04	104·8	4·02	26·0	5·06	10440	4·36
85 + SERIES A	105·0	1·43	80·5	1·50	54·0	1·33	29·2	1·67	29·8	1·30	8·4	1·54	312·1	1·41
SERIES D	103·7	1·35	80·6	1·40	57·5	1·25	29·3	1·62	30·8	1·18	8·6	1·67	316·2	1·32
TOTAL 65+ SERIES A	1147·9	15·64	859·2	16·09	596·3	14·71	302·0	17·32	3440	15·03	89·0	16·35	3430·1	15·57
SERIES D	1139·5	14·84	857·2	14·89	648·5	14·09	301·7	16·75	358·2	13·76	88·2	17·17	3492·1	14·60
TOTAL 75+ SERIES A	452·5	6·16	338·7	6·34	232·8	5·74	120·0	6·88	103·8	4·53	34·8	6·39	1340·2	6·08
SERIES D	448·2	5·83	388·0	6·74	250·6	5·44	120·1	6·66	135·6	5·21	34·6	6·73	1360·2	5·69

SOURCE: ABS CATALOGUE NO. 3222.0

Response

, this warrants careful policy attention. Elderly people require a wide range of supports, mostly income support, but also health services, housing support, and social services, and residential support.

Responding to our older popln
is big business & big politics

To measure success or failure is tremendously different because the issues have to be seen against a backdrop of philosophical questions which discuss what government ought to do to whom, why and how. As things now stand the biggest expenditure areas go in aged care. The 9 billion dollars in age and veterans pensions is 1½ billion dollars greater than the defence budget. The amount we put into nursing homes and hostels equals our whole Foreign Affairs and Overseas Aid budget.

While we might be familiar with a range of policy, planning, and research techniques, answers to the perpetual questions, what works? what does not? who wins and who loses? how and why? what do we know and what do we not know? remain distant. After years of development and analysis 'we still have not, and probably never will, acquire the necessary methodological tools in most circumstances to produce unequivocal, non-trivial findings concerning social policy ~~problems.~~ This applies particularly in the ageing field where we have no unequivocal standards of what is right for older people. Operationalise ideas

with changing pop'n structure, with increase in dementia & other dependencies and with most older people living in community - including those with handicaps (82%) - incl (72% over 75), we often hear the call for families to play a greater role in care. Oh for the golden age, people often lament, when families did more for their older relatives than they do today. In reality there never was such a golden age when family care was more forthcoming than it is today. In general, people did not live long enough to become dependent, and work patterns usually meant that one worked until one died.

Now we are in a very different ball game. In giving people more time to live, science and medicine have also given them more time to die. When we look at our present capacity to solve problems it is apparent that we do our best when the problems involve little or no social context. We're skilled in coping with problems that are purely technical. We can send people to the moon, yet we can't find jobs for our young people; we can build in our big cities, gleaming skyscrapers with computer controlled talking elevators, yet we can't make traffic flow; we can keep people alive for twenty to twenty five years beyond retirement yet we can't always ensure that they can live those years in dignity.

changing times - chronic care

The solution however, lies in developing formal and bureaucratic mechanisms, not in informal and haphazard ones. It can be argued that family structure is able to deal with idiosyncratic events because it can define, as a result of its intimacy and small size, that which is to be valued and it can respond, where appropriate, with speed and flexibility. Bureaucracies within formal strucutres, on the other hand, are better equipped to deal with routine needs, and needs which require specialized knowledge or perhaps professional skills. Specialized institutions, ~~and I include the RDNS here~~ include all NIT industry are in the vanguard of dealing with our looming explosion of social care.

My task is to assist in the development & co-ordination of policies, programs & services (and is problematic)

I do this against a background of problems - some to be addressed by policies, some by programs, some by services - not all of which fall to you - but you are the end result of failure.

We have problems working out equitably and efficiently how to convert 40 years of earnings into over 70 years of life. We have problems with concepts like "double dipping", "tax treatments", "income and assets", "taxpayers' capacity", and so on.

We have problems in trying to alter the balance between the proportion of resources going into home care compared with that going to institutional accommodation.

We have problems with our transport systems which cannot cope with elderly people both with and without mobility limitations and thus confine too many people to home, magnifying their exclusion from fruitful community integration.

We have problems expecting families to play roles that are considerably in excess of their capacity to support older people, particularly those who are severely physically disabled or the burgeoning number suffering from some of the dementias.

We have problems with a health care system which has been in the political spotlight for most of the last 15 years and which is not sure how to handle the balooning costs, the changing technologies nor how to treat with appropriate respect, not only the clientele, but the many professionals who have always taken a back seat to and been patronised by doctors.

We have problems devising a set of home care services that are efficient, flexible, accountable, acceptable, comprehensive, accessible, co-ordinated and equitably allocated.

We have problems ensuring that those who choose to enter resident funded retirement villages have the appropriate legal protections and that those retirement villages meet suitable standards of design and accessibility.

We have problems providing suitable accommodation for the most severely disadvantaged - those 50,000 elderly people, three quarters of whom are women, who rent in the private market.

We have problems restructuring a nursing home system which seems to have lost its way as rising expectations of nursing home care have created a larger than warranted population anticipating ultimate nursing home admission. This is a billion dollar Government financed industry which strains basic concepts of equity, and leaves many people grossly unsatisfied.

I'm not a magician

There are important value questions about where the responsibility lies. Should individuals be responsible for their own health and welfare? How far must a situation deteriorate before government should step in? Should the state be primarily responsible for all risks? Should older people buy services in the private market? Should families care for their dependent members? What if elderly people have no family, or if their family does not have the willingness or the resources to play the caring role?

Important to diagnose clearly
~~understand clearly~~ — tennis ball

~~state~~ —

N.H. + Norfolk Review

SA sort

Endorsed principles – GBS £1000
Imp to speak same language – activity/hours

1) i.e. supported in accom. suitable to need –

2) inappropriate & unnecessary inst'l avoided.

3) skilful & comprehensive assessment mandatory

4) needs based planning backed by suitable inspection mechanisms

5) agreement between Council & Stakeholders on suitable care standards

6) continuing development of home care services to keep people at home for longer

7) No bed closures

Not in discussion with Council about funding details

but about staffing & care levels &

COMMONWEALTH/STATE WORKING PARTY ON STANDARDS

Noting the objective set in the review of Nursing Homes and Hostels of the phased implementation of a uniform national fee and benefit structure a Commonwealth/State Working Party has been established to report on:

- the quality of care objectives and minimum standards which should guide the development of staffing standards in nursing homes in respect of ordinary care and extensive care residents;

- the amount of personal and nursing care staff to be funded for ordinary and extensive care residents taking into account the amount of care currently being used for these purposes, the findings of the Rhys Hearn Consultancy and other empirical evidence and the cost of such provision having regard to the total resources available for aged care; and

- the factors which should determine the implementation of the proposed staffing standards including appropriate transition arrangements.

The Working Party should provide an interim Report on the progress made by the end of September together with an indication of the timescale for completion of the work.

MAY 1986

ATTACHMENT A

DRAFT TERMS OF REFERENCE FOR A COMMONWEALTH/STATE WORKING PARTY ON GERIATRIC ASSESSMENT

Noting the objective set in the Review of Nursing Homes and Hostels of a multi-disciplinary regionally based geriatric assessment network being jointly developed by the Commonwealth and the States, the Working Party is to

- further develop the broad guidelines given by the Review for geriatric assessment
- report on ways of monitoring the performance of the teams and the respective roles of the States and the Commonwealth in this - monitoring to include both resource efficiency of teams, and the percentage of aged people assessed and their outcomes
- recommend procedures for developing an information base available to the Commonwealth and the States
- provide advice on the elements of cost currently being met by the Commonwealth and the States and on the cost implications for the Commonwealth and the States respectively of expanding the geriatric assessment network
- recommend procedures for encouraging referrals to the assessment teams and for developing linkages with service providers.

MTF

Interim report

We had a number of recommendations relating to the provision of appropriate educational opportunities for nurse assistants to qualify, through accredited educational programs as enrolled nurses, and for appropriate training for qualified nurses to equip them better to provide top quality care. Given the role of the States in the industrial arena we recommended that definitions of non-nursing duties formally be agreed upon by all parties concerned and that as a general guideline, nursing care should only be provided by qualified nurses. We recommended streamlining of the inspection system, linkages with community care, the establishment of a joint complaints mechanism and most importantly, that quality assurance programs be implemented in all nursing homes.

These were not part of an unrealistic wish list, but rather part of a catalogue within the jurisdiction of State Governments which affect, for the better, we firmly believe, practices in nursing homes. We also examined the arbitrary, capricious and unwarranted freeze on benefit levels in South Australia and Victoria, but as that was beyond the State's jurisdiction our recommendation could only be that we protest vigorously, and gather more evidence to show the Commonwealth they were wrong.

· MTF current

working parties – quality of care!

MTF identifying dependency
TOP 8 ~~prob~~

↓

response – normalis ation
– professionalisation

WA-

structure
process
outcome

1. SOCIETAL

- Breakdown of extended family
- Attitude of client/relative - expecting dependency to be the norm
- Lack of mandatory assessment
- Political factors focussing on expediency rather than long term planning
- Self concept of some older people - and societal responses
- Existing range of community services and eligibility criteria

2. INDIVIDUAL

- Medical condition
- Mental state
- Financial circumstances

3. GENERAL INSTITUTIONAL

- Lack of Privacy
- Lack of Control
- Lack of Autonomy
- Lack of Rehabilitation
- Powerlessness of residents
- Staffing rosters - too many people
- Filling of beds immediately
- Burning bridges
- Excessive support (e.g. wheeling somebody to toilet rather than walking with them)
- Insufficient staff to practise high quality care
- Institutional neurosis

4. SPECIFIC INSTITUTIONAL

- Philosophy of nursing home - warehouse or home
- Staff morale
- Management by drugs
- Low job satisfaction
- Poor staff education
- Poor management - inappropriate care levels
- Low regard by some general practitioners of nursing home residents and staff
- Expression of rights by residents and residents' organisations

Paper prepared by Elizabeth Down

DRAFT

FACTORS CONTRIBUTING TO THE ALLEVIATION OF DEPENDENCY

In the Interim Report it was recommended (Recommendation 12) that quality assurance programmes be constructed. The following attempt at laying out systematically along quality assurance programme lines of structure, process and outcome, highlights one way of seeking to reduce dependency. While the focus is on care and support, in particular the interaction between staff and residents it should be pointed out that quality assurance can go a long way to reducing dependency but will not necessarily overcome attitudinal and environmental issues that sometimes appear intractable.

Factors which contribute to reducing dependency have been categorized under the dimensions of a Quality Assurance Program, structure, process and outcome.

STRUCTURE

This refers to the setting in which the care is provided - the framework within which the carers works.

1. Written statements of philosophy, objectives and aims of the agency

2. Written statements of philosophies, objectives and aims of specific care providers, e.g. medical service, nursing service, activity program, para medical services

3. Written policies, procedures and organizational structure to ensure the philosophies, aims and objectives are implemented.

   If one of the aims of the service is to provide holistic care, a written set of guidelines should exist, such as for example, the Department of Community Services "Quality of Care in Nursing Homes" document. Also policies should be formulated specifying nursing documentation, and including individualized nursing care plans to meet physical, social, emotional and spiritual needs.

4. Written job descriptions should be prepared for all staff.

5. Agreed upon and appropriate staffing levels will form the basis of quality care.

   If there are inadequate staff levels only tasks will be achieved and these will not allow the individual to maintain optimal, physical social and emotional function. There should be a mechanism developed which relates resident dependency to staffing levels and staffing ratios.

6. Agreed upon staff mix and agreed upon skill levels of staff. Staff who do not have the necesary knowledge and skills will perpetuate dependency, e.g. lack of knowledge of rehab. procedures and techniques, lack of paramedical services.

DRAFT

7. Environment - to reduce institutionalization and promote dignity, privacy and autonomy.

8. Staff Development Program to include orientation, in-service, on going education. This is essential to ensure a continued level of practitioners' competence, and to meet the changing needs of clients, the community and staff.

9. Development of staff performance evaluation tools.

10. Mechanisms for evaluation of staff job satisfaction and morale
    - turnover
    - termination interviews
    - staff meetings
    - meeting structure to facilitate participative management
    - absenteeism.

PROCESS

This refers to the activities by which care is provided; this focuses on the interaction between the recipient of care and the care providers.

1. Assessment/Reassessment

   This should be multi-disciplinary and include
   - medical condition / diagnosis / disability
   - nursing assessment
   - social / emotional functioning
     . self esteem, self concept, grief
     . sensory deprivation
     . depression
     . drug therapy - excessive
                    - interaction
   - attitude and expectations of clients / relatives

2. Client Autonomy

   - representation on management committees, and other organization committees
   - suggestion box
   - participation in care planning e.g. attend multi-disciplinary meetings
   - resident advocate?
   - external complaint mechanism

3. Staff Performance Evaluation

   A means of ensuring the organization and service is meeting its aim and objectives. The evaluation tool should reflect the requirements stated in the job description.

OUTCOME - TO COME.

DRAFT

DRAFT LIST OF POSSIBLE OUTCOMES (to be added to)

- The individual increases and applies knowledge related to health, and actual and potential health problems
- The individual engages in optimum activity, compatible with the ageing process.
- The individual experiences optimum comfort.
- The individual communicates effectively within a range compatible with the ageing process.
- The individual is protected from and free from injury.
- The individual achieves optimum sensory perception compatible with the ageing process.
- The individual achieves optimum mobility and body alignment, within a range compatible with the ageing process.
- The individual achieves and maintains optimum body temperature within a range compatible with the ageing process.
- The individual achieves and maintains a clean and intact integument, compatible with the ageing process.
- The individual maintains rest and sleep patterns to meet needs, within a range compatible with the ageing process.
- The individual achieves optimum mobility and body alignment, within a range compatible with the ageing process.
- The individual achieves and maintains optimal hydration and nutritional status.
- The individual achieves and maintains optimal cardio-vascular function within a range compatible with the ageing process.
- The individual achieves/maintains maximum respiratory function, within a range compatible with the ageing process.
- The individual achieves and maintains elimination within physiological limits, compatible with the ageing process.
- The individual maintains personal integrity, identity, autonomy and self esteem.

(1)