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Speech by Adam Graycar:

"Nursing homes and hostels review"

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AUSTRALIAN ASSOCIATION OF GERONTOLOGY

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# NURSING HOMES AND HOSTELS REVIEW

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Profound changes are foreshadowed for Australia's nursing homes. The Commonwealth has recently brought down the Nursing Homes and Hostels Review and in at least one State, South Australia, the State Government has a Ministerial Task Force on Nursing Home Accommodation. It is clear and apparent that policy considerations of some considerable magnitude are being considered and will continue to be considered.

There are numerous operators in the nursing home industry. The largest cost input comes from the Commonwealth Government and Commonwealth decisions are of significant interest to the State Governments, to Local Governments, to private and voluntary sector operators, to local communities, to families and relatives, and most important of all, to the residents of nursing homes.

Some policy issues of fundamental concern addressed in this paper are:

- Overall Philosophy
- Quality of Life
- Staffing Standards
- Assessment
- Interstate Differences
- Costs, and who should bear them.

The looming explosion in social care poses formidable challenges for policy makers in the gerontological arena. Policies, programs and services that reflect the interests of our older population, families of older people, workers in the aged care industry, and the community at large (taxpayers) would ideally exhibit characteristics of equity and efficiency, accessibility and accountability, and most elusively of all, wide acceptability.

There is no shortage in Australia of detailed reports comprising a litany of solutions and suggestions of how to develop most suitably the services required to support our older population. The key policy issues seem to me to be:

- How to cater for an increasing old-old population that almost certainly will put greater pressure on our nursing home beds, while at the same time implementing growth control principles.
- How to provide that population with appropriate professional support which will have to be accompanied by a more relevant orientation, almost certainly involving substantial attitudinal change among nursing home administrators and personnel.
- How to develop policies within a dynamic system of Federal/State relations, a system in which responsibilities are not clearly defined and in which political and fiscal factors shape decisions, often to the great consternation of those who are closest to the care being dispensed — the providers and the recipients.

- How to fund high quality services, and determining what proportion of the cost should be borne by governments by the individuals, by their families or by service providers.

Our residential care system which provides sheltered and supported accommodation for disabled people both young and old, is on the verge of significant and monumental change. The Commonwealth Department of Community Services has made admirable moves in identifying the strengths and weaknesses in the present system, gathering vast amounts of data, and considering sympathetically and humanely how people requiring residential care can live with dignity and have services appropriate to their needs.

The changes mooted in the system are based on the principles of reducing the number of institutional beds, providing better community support so that people are not unnecessarily institutionalised, providing appropriate assessment to ensure that the services received by people match their needs and, if institutionalised, ensuring that their rights are maintained, that the services they receive are appropriate, and are geared towards enhancing and maximising their life chances.

In South Australia we have a ministerial task force on nursing home accommodation and in our interim report we highlighted how the State Government might respond to likely changes. We recommended that staffing levels needed urgently to be examined to ensure that the level of care is not compromised. As the States set but do not pay for the staffing levels, we have to work jointly with the Commonwealth, present unimpeachable evidence and demonstrate political negotiating and bargaining skills.

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 steamlining of the inspection system, linkages with community care, the establishment of a joint complaints mechanism and most inportantly, 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.

In our recent task force meetings we have been grappling with factors leading to dependency of nursing home residents, means of alleviating those dependencies and means of identifying the feasibility of setting standards which focus on quality of care outcome for residents instead of just concentrating on inputs.

In our analysis we have identified about 22 factors contributing to dependency among nursing home residents. We have broken them into four categories: those reflecting broad societal values and conditions; those individually centred and based; those pertaining to nursing homes in general; and those pertaining to particular nursing homes. By breaking them down in this way we can identify how to go about finding an appropriate policy target and point of intervention. For example, lack of privacy and powerlessness of residents applies in all institutional settings, while low staff morale, poor management or poor staff education applies in some nursing homes but are not universal phenomena. To address these issues we have been exploring a quality assurance program focusing on structure, process and outcome.

If the elderly in our nursing homes are not to be devalued, one would expect that changes may need to be made to programmes to reflect the philosophies, aims and objectives of nursing home services. Once a person is admitted to a nursing home, the proprietor accepts a 'duty of care' and is, therefore accountable for the quality of care. Furthermore, if acceptable quality measures are not adhered to, the proprietor can be held negligent in a court of law. State Governments can act to ensure suitable settings in which the care is provided, and the framework within which the carer works. Developing a process to facilitate and optimise the setting and framework is a policy exercise.

professional as well, can you see me at morning tea, and I'll get your names and pass them on to those who decide the Nobel Prize.

We have problems of both a planning and delivery nature in both our home care and residential care programs. At a conference in Adelaide a couple of months ago my theme was who plans and who delivers. I made the point that in aged care, many of those who plan don't know much about delivering, and many of those who deliver do so without effective communication with those who plan. I'm sure you can all relate to that, wherever you sit in the aged care industry.

When we examine who plans and who delivers we find a complex situation where side by side we can identify science and mumbo jumbo, self interest and altruism, skill and clumsiness, and power and authority. We find stereotypes and prejudices, knowledge and ignorance, compassion and indifferent disregard often co-existing, sometimes competing, yet always there.

Many of those who plan don't know much about ageing and many of the deliverers are too battered, too harrassed and too poorly managed to cope. What keeps the system going however, is goodwill. There is tons of goodwill in aged care and for a time will overcome the management crises which I'm sure you can all see. Without the goodwill our system would be hopeless and irredeemable. But goodwill is no substitute for education. I want to put forward some ideas later on developing excellence in planning and delivering in aged care.

We have seen enormous gains in the 1980s, but there is enormous economic and ideological pressure to limit those gains. Aged care costs money. There is no way to say it doesn't. Families are not able to provide the skilled and demanding care associated with some of the dependencies of age. Nor can untrained and unskilled do-gooders. Yet how often have we heard naive politicians and community leaders suggest that families should do more. How often have we heard the evangalists who preach normalisation say that all that frail elderly people need is a homelike environment and a smile. It is easy to pass the buck to families, or as some normalisers do, wish away the dependencies - dismiss them with a magic wand and hope they float away. We need a realistic orientation to our older population.

If as is planned the number of nursing home beds is reduced to 40 per 1,000 persons aged 70 or more, and if HACC services meet their stated objectives, then it follows that the reduced number of nursing home beds will, of necessity, be filled by people who are considerably more dependent than many of the people in nursing homes today. There will be no place in Australia's nursing homes for people who are not highly dependent and who have not been assessed as such. Their disabilities and dependencies will require good professional and other support to ensure that their needs are met and so they can be maintained at a quality of life that is deemed appropriate.

It is important to recognise that nursing home residents are among the most powerless, most isolated and most dispossessed in our society. Many of these people are unable to organise and lobby on their own behalf. Most people in nursing homes will be there because they have chronic multiple diseases resulting in progressive disability and impairment, and these realities must be recognised in policy and planning.

It is poor planning to contemplate that undereducated and poorly skilled people can provide the support required within formal services. Yet all too often we hear from people who do not have an adequate knowledge base that any kindly person can deliver the care required. When we look at our nursing home population which is powerless, dispossessed and vulnerable it would be grossly deplorable if they were to receive care largely from untrained people and hope that an advocacy system would bring into line those who don't deliver very well. Often the reason that care providers do not deliver very well is that they have not been educated to deliver well, and those who plan do not understand the structure of the target group nor how its needs might be met.

After many months of anguish those of us concerned with the quality of care in nursing homes were pleased that the Commonwealth put out a thoughtful package that increased the hours of care for some categories and made a commitment, among other things to better training, needs based funding, respite care, better assessment and consumer rights.

Provision of 27 hours, 23.5 and 20 hours for the top three categories should, I am advised, cater adequately for the dependency profile as it now exists. According to the release this should cover 60% of nursing home residents. As you know morale among hands-on service providers is very low as they feel they have to deal with stone age conditions amid a rhetoric which says we have left the stone age behind. There have been questions about the adequacy of the resident classification

instrument, but the fair and reasonable thing to do is to monitor the process, as the Commonwealth has very sensibly suggested, for twelve months and not make any premature judgements. We need to make our judgements on the basis of rigorous, well informed and well developed research processes.

The outcome standards have been set, signifying a move from custodial to holistic care. SAM and CAM have been debated ad nauseum, though many would say that the consultation process has stretched relationships between government and providers a bit thin. The validity of the RCI is being questioned and the standards monitoring teams are on their way. The last three years have been traumatic - traumatic since the benefit freeze was imposed in Victoria and South Australia. That was the attempt to punish those who wanted to have higher standards but not the way the Commonwealth saw it.

Then came the normalisation thrust.

A group of visionaries, with little background in aged care have learnt a few funny words, organised a few intense, but shallow workshops and presto, discovered a new philosophy of aged care.

If we strip away some of the absurd jargon, they are advocating what many of our good professional practitioners have been doing for ages - and doing well. We don't need the rigidity and utter conservatism that has characterised normalisation.

My Office has had numerous complaints from nursing home residents and their relatives and from staff working in nursing homes which have gone down the normalisation path. What I object to is the imposing on older people without consultation the values of those who have no experience in aged care, and whose perceptions have been developed by attendance at expensive evangelical courses, masquerading as education workshops.

The industry breathed a collective sigh of relief, when on May 3 Mr Staples, the Federal Minister for Aged Care announced that the evangelists in his department would no longer try to dictate their dogma to the industry.

In our residential system we have to have a commitment to excellence. We can't just go for a warehousing philosophy, and work we have done in South Australia has identified the need for a more highly educated, and not a more poorly educated care force in residential care.

The South Australian Ministerial Task Force on Nursing Home Accommodation 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. This program is already underway, developed and aministered by the Nurses Board of S.A. We recommended appropriate training for qualified nurses to equip them better to provide top quality care. This is presently being addressed by the Commonwealth. 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 recommend streamlining of the inspection system, linkages with community care, the establishment of a joint complaints mechanism and significantly, that quality assurance programs be implemented in all nursing homes.

As I said

It is poor planning to contemplate that undereducated and poorly skilled people can provide the support required within formal services. ~~Yet all too often we hear from people who do not have an adequate knowledge base that any kindly person can deliver the care required. When we look at our nursing home population which is powerless, dispossessed, and vulnerable, it would be grossly deplorable if they were to receive care largely from unqualified people and hope that an advocacy system would bring into line those who don't deliver very well. Often the reason that care providers do not deliver very well is that they have not been educated to deliver well, and those who plan do not understand the structure of the target group nor how its needs might be met.~~

The Commonwealth's commitment to better education and training is welcome. It is not just the number of hours that is important, but the quality and skill of the staff delivering those hours. Our dependency profiles are such that aged care requires more than well meaning amateurs. I know I speak for many in saying that in the area of education the Commonwealth has a long way to go. Education is too important to leave to those with only a little learning. Following his April 21

statement of $2.75 million for gerontic education I am looking forward to the Minister's announcement about a new-look education process for aged care.

Many of our planners have an inadequate knowledge base. Many of our managers know a lot about running a facility, about the nitty gritty of funding, of meeting impossible targets and deadlines, of dealing with the complexities of the governmental and communal environment in which aged care operates. Where they're light on, it seems to me is in dealing with their staff and in some cases with their residents.

We have a situation where burnout is an evident characteristic among many care delivery staff, where staff morale is low and communication is all one way. We have stone age views of power and authority where all too often a female care deliverer gets a whack on the head from a male manager wielding a stone axe while espousing jargon that indicates he has left the stone age behind.

In the ageing industry many of the managers are managing multi-million dollar facilities, employing dozens and sometimes hundreds of staff. The managers feel pushed, pressured and pummelled from all sides and all they have to fall back on is goodwill and a strong desire to do the right thing. What they often do not have are the management and personnel handling skills so absolutely necessary.

Those doing the hands-on work often do not understand the planning process which results in their daily activities. Being

separate from the planning process can contribute to burnout. Burnout involves the loss of concern for the people with whom one is working. In addition to physical exhaustion (and sometimes even illness), burnout is characterised by an emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients or patients. The professional who burns out is unable to deal successfully with the overwhelming emotional stresses of the job, and this failure to cope can be manifested in a number of ways, ranging from impaired performance and absenteeism to various types of problems (such as alcohol and drug abuse, marital conflict, and mental illness).

We don't have data on the extent of burnout in aged care in Australia. The literature says it comes from not being able to achieve one's goals. Then tension is always there if the management processes are not adequate, and managers can limit burnout by better participatory goal setting and time management, variety at work, developing special interests and activities, changing or adapting to distressing events etc.

Commonwealth planners concerned with the implementation of outcome standards should pay particular attention to burnout, especially given the strong correlation between unsatisfactory goal achievement and burnout. A very high set of standards and expectations have been set, and without good management and appropriate resource allocation, burnout, and its highly undesirable consequences could well be looming as an ongoing and expanding problem.

One way of pre-empting and limiting burnout is through the development of quality assurance programs. Quality assurance shows people where they are going and whether they're meeting goals. Good quality assurance - a concept and process widely used in all industries shows problem areas and deficits in the system. Quality assurance is a way of ensuring that favourable outcomes are occurring within a facility. Quality assurance simply means that quality, a degree of excellence, is assured, that is, positively declared and guaranteed. It lays a rigorous basis for setting goals and achieving outcomes. Quality assurance is a planned and systematic approach to monitoring the care provided (or service being delivered) that identifies opportunities for improvement and provides a mechanism through which action is taken to make and maintain these improvements. Many improvements can be achieved at little or no cost, but to be worthwhile, resources do have to be available to implement identified improvements.

The Commonwealth has given managers an incredible challenge by saying "we don't want to know about inputs, we just want first class outcomes - go for it." I think this is a little simplistic.

Clearly and unequivocally, quality of care outcomes result from inputs, in particular from structure and process. There is a need for a quality assurance program, of which outcome standards are one aspect.

It is necessary to point out the difficulty in relating the outcomes of care to the process of care. If only the outcomes are measured, without examining the process of care and the structure of the service or organisation, one cannot know what caused the favourable or unfavourable outcomes. Therefore, only an evaluation that encompasses structure, process and outcome has the potential for impact on the quality of care.

It seems to me that the Commonwealth has a problem with this. It has a commitment to only one part of the process, and may be trying to gloss over the rest.

Quality assurance provides a planned and systematic approach to monitoring and evaluating care standards. It is an important professional and management tool, something to significantly assist those of us wishing to provide relevant care in the 1990s.

The ageing industry, one of Australia's largest industries has come a long way in the last decade or two. It has moved very quickly from the stone age to the high tech age, and this has brought a lot of tensions. The squabbles and mistrust, anguish and tensions which have characterised the politics of ageing over the past few years have to stop if we want our outcomes to be effective - older people being needed and fed, as the song says. What I have tried to put forward is a recognition that 64 year olds play a stronger advocacy role, that primary health care has a place, especially in middle age, that home care services focus on accessibility and effectiveness, and that

better education, better staff management and quality assurance will provide better outcomes.

Policy issues in the ageing arena involve structuring an environment which responds effectively, efficiently and compassionately to a demographically changing elderly population. We all have a responsibility, organisationally and collectively to set the structures and processes to achieve excellent outcomes, and thus our deliverers will deliver well and the main beneficiaries will be the target population - elderly people who will feel valued and respected, and in turn our whole society will benefit and be enriched.

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