

High Care Residential Aged Care Facilities in Victoria

Consultation Paper

July 2000

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Part A

1 Overview

1.1 Introduction

Over 36,000 older Victorians are residents of Commonwealth-funded residential aged care facilities, of whom just under half are in high care residential care facilities. The Commonwealth Government funds, regulates and sets standards for high and low care facilities.

In 1995 the previous Victorian Government removed the State regulatory framework for nursing homes. At the time, it was argued that the State regulatory framework duplicated the Commonwealth's role.

The Victorian Government believes that the community expects all levels of Government to work co-operatively to promote the well being of residents living in aged care facilities.

Through this paper the Victorian Government wishes to stimulate discussion about positive action that can be taken to promote a greater sense of confidence among older people and their carers about residential aged care services.

The Victorian Government believes that people living in residential aged care facilities are entitled to feel secure that they will receive the services they need and that they will be treated with dignity and respect. This paper and the consultations with the community is aimed at promoting these objectives.

The Victorian Government is committed to effective community consultation. Before introducing any regulation it wants to ensure that all stakeholders are able to comment on the Government's approach. The Government is committed to listening to the advice that it receives and acting only when it has fully considered the views of the community. Consultation and dialogue with the community will drive the Government's policy responses to the issues raised in this paper.

This Consultation Paper indicates the key areas where input is sought, raises questions for discussion and provides background information to individuals and organisations interested in participating in this process.

1.2 Terms of Reference

The Victorian Government believes that older Victorians should receive high quality care from whichever service provider is delivering the care they need (whether that is in a residential aged care facility or in their own home).

The Victorian Government believes that the current Commonwealth regulatory framework has a number of gaps and that if they are addressed it should lead to improvements in quality of care. The Victorian Government wishes to consult the community regarding regulation of high care residential aged care facilities (formerly known as 'nursing homes') and addressing gaps in the Commonwealth Government's regulatory framework for those facilities. The introduction of State regulations for

high care facilities will need to support rather than duplicate the existing Commonwealth systems and processes.

The Victorian Government's policy 'A New Partnership—Labor's Plan for Older Victorians' states:

Regulations and Information

Labor recognises that one of the best ways of ensuring that Victorians receive the highest quality in residential care is to ensure that they are fully informed about the operational capacity of their facility.

Victorians deserve the right to know about the number of staff employed by their facility as well as the qualifications of the staff.

Labor will restore State regulations for aged care facilities in Victoria, including patient/nurse ratios.

Labor will require nursing home providers to better inform residents and their families of the numbers and qualifications of staff.

To capitalise on the expertise of stakeholders in this area, the Victorian Government is seeking input to the development of State regulations from a range of individuals, peak organisations and people with knowledge of the residential aged care sector.

The Commonwealth Government is the primary funder and regulator of residential aged care services. Residential aged care services are provided in the private, not-for-profit and public sectors. The primary stakeholders in residential aged care are the residents themselves. There are a number of other key stakeholders involved. These include:

- Providers of residential aged care.
- Staff of residential care facilities.
- Families, friends and carers of residents.
- Older people generally.
- Governments and government agencies responsible for administering the relevant legislation.
- Aged care assessment services.
- Aged care advocates.
- Medical practitioners and allied health professionals.

Each of these stakeholders is concerned to ensure that older Victorians receive the best possible quality of care in residential aged care facilities.

1.3 Scope and Focus of this Consultation Paper

This Consultation Paper is divided into two parts:

Part A identifies the areas where the Victorian Government is seeking input in this consultation process on the introduction of State regulations for high care residential care. Part A asks key questions to stimulate discussion and ideas in these areas.

Part B of the paper provides background information about the residential aged care system, including:

- An overview of the current government regulation of residential aged care facilities in Australia, with particular emphasis on the situation in Victoria.
- An overview of current regulatory approaches to residential aged care in the other States and Territories of Australia.
- A discussion of recent international trends in the government regulation of residential aged care overseas, using the United States of America, the United Kingdom and Denmark as examples.
- An overview of the recent history, at both Commonwealth and Victorian levels, of the regulation of residential aged care.

The focus of this Consultation Paper is on the provision of high care services in high care residential aged care facilities. There is also, however, some discussion of low level residential aged care facilities (formerly known as 'hostels') and of supported residential services, in order to provide a wider context to readers.

It is intended that any policy responses following from this consultation process will not duplicate the Commonwealth's role, but will focus on positive responses at the State level to the problems identified. The rights, interests and well being of residents should guide the process and the responses.

1.4 Other Current Initiatives

It should also be recognised that there are a number of current initiatives under way which aim to improve the quality of care received by residents. These include:

- **The Aged Care Issues Forum**—initiated by a group of stakeholders, including consumer organisations and aged care industry bodies, and aimed at developing a united policy agenda to achieve better care outcomes for residents.
- **The Commonwealth National Strategy for an Ageing Australia.**
- **The Commonwealth's Ministerial Forum on Compliance and Regulation**—initiated by the Commonwealth Government, involving some stakeholders and aimed at improving the quality of care through, among other things, the development of an industry code of practice.
- **The Commonwealth's Two-Year Review of Aged Care Reforms**—the final report by an independent consultant due for release in mid 2000.
- **Various initiatives on aged care workforce issues and planning**—including the attraction and retention of qualified staff to aged care.

Readers of this Consultation Paper should be aware that some of these initiatives may affect the issues raised in this paper.

1.5 Process for Making Submissions

The Victorian Government is seeking a broad range of views on the specific questions and issues raised in this Consultation Paper. The views of stakeholders will be used to inform the development of Victorian Government policy responses, particularly in the areas outlined in Section 1.2 and Section 2.

Input can occur in the following ways:

- By direct written submission in response to this Consultation Paper

or

- Attending consultation forums to be held in metropolitan and regional locations

or

- By representation of views through the members of the Ministerial Advisory Committee on Nursing Home Regulation.

1.5.1 Ministerial Advisory Committee on Nursing Home Regulation

The Minister for Aged Care has established a Ministerial Advisory Committee to provide input to this process. Membership of the Ministerial Advisory Committee includes representatives of carer and consumer organisations, health professionals and industry associations. A list of members of the Committee is in Appendix 10.1.

1.5.2 Direct Submissions

Submissions can be made directly to the Department of Human Services in response to issues raised in this Consultation Paper. They can be made in writing or verbally.

An advertisement placed in the press provides details of the dates and locations for verbal submissions.

1.5.3 Written Submissions

Written submissions must be received by DHS no later than **Friday 4 August 2000**. Receipt of all submissions will be acknowledged. Submissions should be no longer than 15 pages and should include a copy of the pro forma providing summary details about the submission. Any confidential or sensitive material in the submissions should be clearly marked “confidential”.

Submissions should be sent to:

Ministerial Advisory Committee on Nursing Home Regulation Aged Care Unit Department of Human Services PO Box 4057 Melbourne 3001
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Copies of the pro forma for submissions can be obtained via the Department’s internet site at **www.dhs.vic.gov.au** or by phoning **9616 8152**.

1.5.4 Verbal Submissions

Individuals, organisations and other stakeholders also have an opportunity to provide verbal submissions to members of the Ministerial Advisory Committee.

Appearances for verbal submissions will be scheduled and people wishing to make a submission will need to contact the Department of Human Services on 9616 8152 to be allocated a time. Verbal submissions should be limited to a maximum of 15 minutes for individuals and 30 minutes for peak organisations. A pro forma will also be available for people making verbal submissions to complete.

A small number of focus groups will also be held to seek the views of particular groups and will supplement advice and information provided in verbal submissions.

1.6 Process Following Submissions

At the conclusion of the public consultation process, the Ministerial Advisory Committee will consider the views of stakeholders. Based on this feedback, the Committee will report to the Minister for Aged Care on options for Victorian Government policy responses.

As the Victorian Government currently does not currently have the power to regulate Commonwealth-funded residential aged care services, the Victorian *Health Services Act* will require amendment for regulations to be re-introduced.

Prior to the introduction of regulations, a Regulatory Impact Statement will be drafted in accordance with the legislative requirements for new regulations. This process would occur after the consultation process has been completed and the Committee has reported to the Minister for Aged Care. The Regulatory Impact Statement will outline the reasons for the introduction of regulations, the costs and benefits of the proposal and discuss implementation issues. The Regulatory Impact Statement will include a copy of the draft regulations and will be released for public comment. The Regulatory Impact Statement cannot be released until the amendments to the Act have occurred.

2 Questions for Consideration

This section canvases gaps in the current Commonwealth regulatory approach and seeks comments on possible responses by the Victorian Government to develop State regulations to address these areas. It also explores, and seeks comments on, other areas where a positive policy response may be developed.

A brief overview of the residential aged care system is included in Part B of this paper. Readers without a working knowledge of the existing Commonwealth regulatory regime and terminology may find it useful to read Part B of this paper before they read and attempt to respond to the issues raised here.

2.1 Introduction

The Commonwealth's current regulation of residential aged care (see Section 4) is highly structured and complex, attempting to cover all elements of the system,¹ including the promotion of 'a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals'.²

While there are numerous issues in the delivery of residential care, many are not in areas over which the State Government has control. It also needs to be stressed that many issues are complex and multifaceted and that regulation (in isolation) is not a total response.

Consideration of options for State regulation also needs to take place in the complex operational environment where revenue streams for providers are heavily constrained and Victorian providers are faced with revenue pressures due to factors, such as the equalisation of to national funding rates for high care facilities. In this environment, it is important to bear in mind that any additional requirements should try to minimise any undue diversion of resources by providers towards compliance costs at the expense of direct care delivery. It is also important to avoid direct duplication of (or conflict with) existing Commonwealth requirements.

The Commonwealth is the primary funder of residential aged care facilities. Development of any State regulations will need to take account of the Commonwealth funding framework. This issue is also one that will be addressed in the Regulatory Impact Statement.

2.2 Staffing

The Victorian Government's policy refers specifically to:

1. The introduction of regulations including nurse/resident ratios for residents of high care facilities, and
2. Better informing residents and their families of the numbers and qualifications of staff.

The introduction of State regulations is intended to support rather than duplicate Commonwealth requirements. While the Commonwealth's current regulation of

¹ See the objects of the *Aged Care Act 1997* in s 2-1(1).

² Section 2-1(1)(b), *Aged Care Act 1997*.

residential care covers a broad range of areas, the Victorian Government is concerned that the two areas identified are not adequately addressed by the Commonwealth.

2.2.1 Staffing Levels and Qualifications—Current Requirements

Currently the Commonwealth legislation *does not* prescribe:

- The numbers of qualified nurses in high care residential aged care facilities (either at all or relative to numbers of residents).
- The levels of qualifications of nursing and personal care staff.
- The numbers and qualifications of all other staff (including allied health workers, domestics, etc) and the appropriate skills mix necessary to ensure quality outcomes for residents.

The Commonwealth's *Aged Care Act* (1997) requires only that the approved provider 'provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question'³ and 'maintain an *adequate number of appropriately skilled staff* to ensure that the care needs of care recipients are met'.⁴

The Commonwealth's current Residential Care Standards and the Accreditation Standards made under the Quality of Care Principles also do not specify or prescribe any staffing numbers, staff/resident ratios, staffing qualifications or skills mix. These matters are left to the discretion of the provider, so long as the provider ultimately meets the relevant care standards, as assessed by the accreditation auditors.

2.2.2 Staffing—Previous Commonwealth Requirements

During the period from 1 October 1997 up to and including 20 August 1998, the Commonwealth's Quality of Care Principles were prescriptive about high care nursing services required in a residential care facility. The main change which took effect from 21 August 1998 was to remove the requirements for on-site qualified nurses and particular ratios of qualified nurses to particular numbers of high care residents. Details and a comparison with the existing requirements are contained in the box below.

Quality of Care Principles

1 October 1997—20 August 1998

Requirements:

Nursing services (Schedule 1, Part 3, Item 3.8)

Twenty-four-hour on call access to care by a qualified nurse, or by appropriately trained staff under the supervision of a qualified nurse, if there are one to three high care residents any of whom are assessed as requiring nursing services.

Twenty-four-hour on-site care by a qualified nurse, or by appropriately trained staff under the supervision of a qualified nurse, if there are four to seven high care residents, any of whom are assessed as requiring nursing services.

³ Section 54-1(1)(a), *Aged Care Act 1997*.

⁴ Section 54-1(1)(b), *Aged Care Act 1997*; emphasis added.

Twenty-four-hour on-site care by a qualified nurse if there are eight or more high care residents.

Nursing procedures (Schedule 1, Part 3, Item 3.9)

Technical and nursing procedures carried out by a qualified nurse, or other appropriately trained staff, under the direct to indirect supervision of a qualified nurse on a sessional or regular basis.

21 August 1998—Current Requirements

The requirements in items 3.8 and 3.9 (listed above) were removed and replaced by the following requirements (in a new item 3.8) for the provision of 'nursing services' for residents receiving a high level of residential care:

Initial and ongoing assessment, planning and management of care for residents, carried out by a registered nurse.

Nursing services carried out by a registered nurse, or other professional appropriate to the service (for example, medical practitioner, stoma therapist, speech pathologist, physiotherapist or qualified practitioner from a palliative care team).

Services may include, but are not limited to, the following:

- Establishment and supervision of a complex pain management or palliative care program, including monitoring and managing any side-effects.
- Insertion, care and maintenance of tubes including intravenous and naso-gastric tubes.
- Establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters.
- Establishing and reviewing a stoma care program.
- Complex wound management.
- Insertion of suppositories.
- Risk management procedures relating to acute or chronic infectious conditions.
- Special feeding for care recipients with dysphagia (difficulty with swallowing).
- Suctioning of airways.
- Tracheotomy care.
- Enema administration.
- Oxygen therapy requiring ongoing supervision because of a care recipient's variable need.
- Dialysis treatment.

Prior to the introduction of the Commonwealth Aged Care Act on 1 October 1997, the Commonwealth funding system for nursing homes required that certain components of the funding received by providers were spent directly on resident care. The funding targeted the employment of direct nursing and personal care staff and had to be accounted for by the provider to the Commonwealth.

In Victoria, there were also enforceable requirements for particular staffing levels in what were then nursing homes under State industrial awards and State legislation. Further detail on staffing requirements prior to the introduction of the Aged Care Act can be found in Sections 8 and 9.

2.2.3 Staffing—Issues for Consideration

While there are no existing requirements for the staffing mix in high care residential aged care facilities in Victoria, there is a significant shortage of trained and qualified staff (including nurses).⁵ This means many providers of high care facilities find it extremely difficult (if not impossible) to attract qualified staff in some circumstances.

These shortages are the result of a number of factors including the difficulties in attracting trained and qualified nursing staff to work in high care facilities and the difficulties in retaining them. This impacts on the maintenance of professional standards, which, in turn, affects the retention of staff.

Considerations in re-establishing staffing ratios include the practicalities of compliance, monitoring and enforcement in an environment where ‘ageing in place’ is an endorsed Commonwealth Government policy, and determining the appropriate staffing and skills mix in any individual facility. These issues should not be considered in isolation but be factored into discussions on development and implementation of any staffing ratios.

In determining staffing levels and staff/resident ratios the following should be considered:

- Types of staff—nursing, personal care, allied health, domestic.
- Costs of particular staffing levels.
- Workforce and labour market issues.

In attempting to achieve an appropriate skills mix to provide high quality care to residents, consideration should be given to:

- The needs of residents including:
 - ◆ Frailty
 - ◆ Dementia
 - ◆ Intellectual disability
 - ◆ Diagnosed mental illness

⁵ The Nursing Workforce Survey was conducted by the Australian Nursing Federation (Victorian Branch), the Deans of Nursing and the Australian College of Nurse Management Inc. It showed that in 1999, 57.6 per cent of aged care facilities had vacant nursing positions and 55.6 per cent of facilities employed unqualified staff to counter the shortage of qualified nurses, with the greatest shortage being in respect of RN Division 2 nurses.

- ◆ Cultural and ethnic background
- ◆ Young disabled
 - Age group range of 11–100 plus.
- The balance of:
 - ◆ Appropriate clinical care
 - ◆ Home-like environment and
 - ◆ Resident lifestyle.
- Staff qualifications and training:
 - ◆ Base-line qualifications
 - ◆ Special aged care training requirements
 - ◆ Continuing training of staff
 - ◆ Refresher training for staff
 - ◆ Supervision of staff.
- Scheduling of staff.

Comments are sought on the following questions:

1. Do you think there are gaps in the Commonwealth legislation in relation to staffing? If so, what are they?
2. What sort of staff or staffing mix do you see as being essential in high care facilities?
3. How do you think the State Government should regulate staffing in high care facilities? How detailed should any regulations be?
4. If the State Government does adopt staffing ratios for high care facilities only, what do you think this will mean for residents needing high care services in low care facilities?
5. If you are an operator of a high care residential care facility, how would you manage a staffing ratio in an environment where 'ageing in place' is being encouraged?
6. What do you think would be the best way of enforcing (that is, monitoring compliance with, and imposing sanctions for breach of) State staffing regulations?
7. What sort of sanctions do you think could be imposed for non-compliance with any State staffing regulations? (Remember that the Victorian Government is not the primary funder of residential aged care facilities.)

2.3 Provision of Information from Providers to Consumers

The provision of comprehensive high quality information to potential residents and their families about the services offered in individual facilities is important to allow consumers to make an informed choice about which facility they enter. While consumer choice is limited by Government restrictions on the number of available beds, the availability of information which gives clear information on the full range of services available in each facility should assist consumers in their comparison of available facilities and over time put increased consumer pressure on providers to meet their needs.

The Commonwealth requires providers to make certain information available to residents entering high or low care facilities, but there are no requirements for the provision of information about staff numbers, staff/resident ratios or staff qualifications available in a particular facility.

Under the Commonwealth Aged Care Act, approved providers of residential aged care facilities are required to give information to residents entering low or high care about:

- The resident's broad human and civil rights and obligations under the Charter of Residents' Rights and Responsibilities, or under Part 2 of the *User Rights Principles* (which cover access of authorised people to the facility to investigate and assist in the resolution of complaints, security of tenure, access by representatives, access by advocates and community visitors, and the rights in the Charter) and
- If the resident has not entered a resident agreement, information should be provided on the levels of care and services to be provided, policies and practices about fees, the period of respite care where relevant, security of tenure, assistance to find alternative accommodation, the internal complaints mechanism, and the resident's responsibilities. These matters are mentioned in s 59-1(1)(b)-(h) of the Act.⁶

Comments are sought on the following questions:

8. What sort of information about staffing levels, ratios and qualifications do you think a high care residential care facility should be required to provide to prospective and existing residents and their families and representatives?
9. Do you think there is any other critical information a high care residential care facility should be required to provide that is not currently covered by the requirements of the Commonwealth?
10. What do you think is the most efficient and useful way for information to be provided from your perspective (as a carer, resident or provider)?
11. What effects or outcomes do you think there will be if the State Government does introduce regulations in relation to the provision of information about staffing to residents and their families?
12. What do you think would be the best way of enforcing (that is, monitoring compliance with, and imposing sanctions for breach of) State regulations about the provision of such information?

⁶ Section 23.16, User Rights Principles.

13. What sort of sanctions do you think could be imposed for non-compliance with any State information regulations? (Remember that the State Government is not the primary funder of residential aged care facilities.)

2.4 Consumers Information and Complaints Resolution

In addition to the areas identified in the State Government's policy, there are several areas where a State role (not necessarily regulatory) may be considered to support the Commonwealth requirements for high care residential aged care.

2.4.1 Consumer Information (Apart from that Provided by Residential Care Facilities)

While a broad range of information on residential care is available from a variety of sources, there is a concern that the information provided by the Commonwealth Government, Aged Care Assessment Services, consumer/carer organisations or other advocacy services should be accessible, of high quality and consistent.

Areas where improved provision of information could be considered include:

- Guidelines on what to look for in a residential care facility.
- Specific consumer information on particular residential aged care facilities and vacancies in particular areas.
- Information relating to financial matters.
- Information provided in languages other than English.
- Information on residents' rights.

Some of the initiatives that are being undertaken to address these gaps elsewhere in Australia and overseas are discussed in Part B (Sections 6 and 7) of this paper.

Comments are sought on the following questions:

14. Do you think there are some aspects of residential aged care where consumer information could be improved?

15. If so, what are they and what improvements are required?

2.4.2 Complaints Resolution

Another area where it has been suggested that the Victorian Government may be able to support the Commonwealth's residential aged care system is in the handling and resolution of complaints about particular aspects of the high care residential care being provided.

The current two-tier complaints resolution system under the Commonwealth's Aged Care Act is discussed in Section 4.13.

The Commonwealth Aged Care Act establishes an external complaints mechanism in the Victorian office of the Commonwealth Department of Health and Aged Care.⁷ The Complaints Resolution Scheme (CRS) can receive complaints about an alleged breach of a provider's responsibilities which the complainant thinks is unfair of which makes the complainant dissatisfied with the service.

In the course of developing this paper, a number of stakeholders raised concerns about the effectiveness and timeliness of the external mechanism and the enforceability of any determinations made by a Complaints Resolution Committee.

Any State regulations about complaints resolution must consider the most appropriate form of enforcement and recognise the predominant role of the Commonwealth.

Issues to be considered therefore include:

- The benefits for consumers that would arise from State regulation in this area.
- The potential for duplication or unnecessary overlap of complaints systems, leading to wastage of public resources and the resources of providers.
- Any difficulties for providers in (potentially) responding to two sets of complaints systems in relation to one set of issues.
- Potential confusion for complainants, especially where complaints extend over two jurisdictions (that is, care issues under the Commonwealth system, staffing issues under the State system).
- The jurisdiction of the existing Commonwealth-funded advocacy service (which receives no State funding).
- The potential for 'buck passing' between two Government complaints systems, with a potential result that some complaints may not be addressed either at all or effectively.

Comments are sought on the following questions:

16. Are there any gaps in the Commonwealth complaints system and what are the appropriate responses?

17. Are there any other options for complaints resolution?

2.5 Acknowledgment of Broader System Issues

During the course of consultations on the development of this Consultation Paper, stakeholders raised a number of issues, most of which lie within the Commonwealth's area of responsibility. While these issues have been acknowledged below, it is proposed that they would be best addressed through a collaborative Commonwealth-State approach.

These broader issues include:

⁷ The Complaints Resolution Scheme (CRS) is commonly called an 'external' complaints mechanism, to distinguish it from the internal complaints resolution mechanism required to be established in each residential aged care facility.

- An improved definition of ‘quality of care’ through benchmarking.
- Better access to care appropriate for people with dementia.
- Better access to care appropriate for people without cognitive impairment.
- More appropriate care for younger people with disabilities.
- The need for culturally appropriate care.
- Better access to respite care.
- The impact of ageing in place on residents’ access to residential aged care facilities, on the homelike environment in low level residential aged care facilities, on the quality of care provided in low level residential aged care facilities to residents assessed as requiring high care services, and on the Commonwealth’s planning ratios.
- Concerns with the accreditation process.
- Constraints on the release of information by the Commonwealth to other agencies.
- The complexity and length of resident agreements.
- The need for adequate resourcing of advocacy services.

Another broad issue within the responsibility of the State Government, was also raised, relating to the administration of medications in residential aged care facilities.

2.6 Stakeholder suggestions for further Government involvement

Consultations with stakeholders in the course of the development of this Consultation Paper also raised some suggestions about the further role of the State Government in improving the quality of aged care, especially in high care residential aged care facilities. Feedback is also sought on these suggestions:

- The establishment of a “centre of excellence” in Victoria, with strong international links, to focus on the development and delivery of education and training activities for nurses, other care workers, medical, paramedical and allied health professionals and ancillary support workers in the aged care sector. Ideally, the centre would operate in conjunction with an “ageing in place” facility; research, develop, evaluate and refine models of best practice, develop guidelines and quality of care benchmarks and provide practical education and training placements.
- State high care residential aged care facilities to link in with ongoing research and training, providing opportunities for staff from facilities in other sectors to enhance their skills and knowledge through temporary placements. Refresher courses for former registered nurses and other workers returning to aged care after some years of absence could also be provided by facilities.
- State funded research could be carried out in all sectors on, amongst other things:
 - critical staffing issues, such as skills mix, and staff/resident ratios
 - the development and implementation of “family friendly” policies and practices to encourage consultation with, and participation by, unpaid carers of residents

- exploring and trialing good practice in clinical care,⁸ innovation in care models,⁹ and quality of care indicators

all with the object of maximising the quality of care and life of residents.

- The development of a mentoring program. For example, where an innovative and effective care model is developed and implemented successfully in a particular facility, that facility, with appropriate funding, could assist the development and implementation of similar models on other facilities.
- That the Victorian Department of Human Services operate a “Good High care Residential Care Program” (or similarly named program), where best practice facilities in all sectors could be formally and publicly recognised each year and given an award. In doing this, the Government would be actively promoting a more positive image of residential aged care and encouraging best practice in the industry.

Views are sought on the following questions:

18. Do you have any comments on the suggestions outlined above?

19. Do you have any other suggestions for State Government responses to improve the quality of care provided in high care residential aged care?

⁸ For an example of an innovative model for clinical care (funded by the State Department of Human Services) which could be built upon and extended further, see Bundoora Extended Care Centre, *A model for provision of enhanced medical care to nursing homes*, June 1998.

⁹ A current example of such work is the model developed for quality of long-term care for Aged Mental Health Services (the Life Improvement and Functional Enhancement (LIFE) Program) at the Merv Irvine Aged Psychiatry Residential Facility. Development of the model was commissioned and funded by the Department of Human Services. Its implementation was carried out in conjunction with the Bundoora Extended Care Centre. The model was evaluated (via State funding) by the Centre for Applied Gerontology at the Bundoora Extended Care Centre (*Development and Evaluation of the Life Improvement and Functional Enhancement (LIFE) Project*, Occasional Paper No Four, July 1999).

Part B

3 Aged Care —Overview

3.1 ‘Aged Care’ Described

‘Aged care’ means, and has the objective of, the care and support of older adults in need of services because of particular disability, illness, frailty, cognitive impairment or other vulnerability.

The provision of care and support for older people can occur formally or informally, on a paid or voluntary basis, in a number of settings, including:

- Access to community-based services.
- Through government-subsidised, or private, packages of care delivered in the older person’s home to delay entry to or substitute for residential care.
- Through informal services provided in the older person’s home by unpaid carers (who are often, but not necessarily, relatives).
- Formal residential care.

A minority (approximately ten per cent) of older people enter residential care. Most older people maintain reasonable health and independence in their own homes, sometimes supported by other forms of care.

At an ideal level, the objectives of aged care extend beyond basic care, support and accommodation services, to:

- The protection of older people from abuse, neglect or exploitation.
- The enabling of older people to retain as much autonomy and independence in, and as much control over, their lives as practicable.

3.2 Forms of Residential Aged Care—Overview

Most formal residential aged care in Australia is funded and regulated under the Aged Care Act (Cwlth) and the Aged Care Principles 1997 (Cwlth) by the Commonwealth Government, and comprises low and high care residential aged care facilities. Other forms of residential aged care also exist and are regulated to some extent by the States and Territories.

In Victoria, supported residential services (SRSs) provide accommodation and support for people including, but not limited to, older people. SRSs are regulated by the Victorian Government under the *Health Services Act 1988* (Vic), which is administered by the Department of Human Services. SRSs receive neither State nor Commonwealth funding.

Retirement villages, intended predominantly for the accommodation of people over 55 years of age, are regulated to some degree at State level under the *Retirement Villages Act 1986* (Vic). This legislation is administered by Consumer and Business Affairs (Victoria), and complements the Commonwealth’s aged care legislation in relation to

low and high care residential aged care facilities (which, along with independent living units, serviced apartments and SRSs, may fall within the statutory definition of 'retirement village').

3.3 Characteristics of Residential Aged Care

The defining characteristic of residential aged care is the combined provision of care and accommodation to an older person by paid workers (and sometimes unpaid workers) in a setting other than the older person's own home. Such care and accommodation is provided in return for monetary payment by each resident.

Residential aged care involves a communal environment where the rights of any individual resident must be balanced against the rights of other residents and of staff. For an older person, used to a more individualistic lifestyle, the entering of such a communal environment may be confronting. It may (although ideally it should *not*) mean a decrease in individuality, privacy and dignity. For some, it may engender feelings of 'homelessness' and despair at being out of control of their own lives.¹⁰

Another important characteristic of residential aged care is the inherent structural power imbalance between:

- Residents and their representatives (for example, unpaid carers, relatives)
- and
- The providers (including staff) of the residential care facilities.

A resident (or their representative) usually has little choice about whether to enter high care residential aged care and only limited choice about which particular facility to enter. The demand for places generally exceeds the supply, especially in Victoria where there is a lower proportion of high care beds per people aged 70 years and over compared to most other states and territories.

The need for high care placements, in particular, often arises during health crises and residents and their representatives may have to deal with a variety of conflicting emotions (eg guilt, sorrow, separation trauma). The ability of some families to comprehend sufficiently the details of a complex system (even when provided with full information) may be limited or skewed by such emotions. The capacity of families to make rational and informed decisions about care placements may therefore be significantly compromised. In addition, most residents (and their representatives) will only become involved in the system a limited number of times. The providers, by comparison, have an expertise and body of knowledge built up over time and repeated transactions.

Because of complex care needs, residents (and their representatives) are dependent on the continuing goodwill of those providing care and accommodation services. Residents may, routinely and of necessity, experience various daily living activities (such as showering, toileting and continence management) in ways that would be humiliating and invasive for many of us.

Many residents, especially at a high level of dependency, have some form of cognitive impairment (for example, a form of dementia) which increases their vulnerability and dependency, and reduces their ability to enforce their rights. Such residents may be at risk of exploitation and abuse.

¹⁰ Carboni, Judith T, 'Homelessness Among the Institutionalised Elderly', *Journal of Gerontological Nursing* (1990) Vol 16, No 7, pp 32–37.

Some residents (and their representatives) fear retaliation or retribution from those upon whom they depend for services, should they complain or otherwise attempt to enforce their rights.

Residents and their representatives have little bargaining power either at the point of entry to, or within, a system which, while still highly regulated by government, is encouraged by that same government regulation to include some market-based and 'user-pays' elements.¹¹ The relatively weak bargaining position of residents (and prospective residents) and their representatives is exacerbated by (in some cases) a lack of accurate, clear and understandable information about:

- The care and accommodation provided by individual facilities
- The rights, entitlements and obligations of the various stakeholders

and

- The long-term implications of some of the financial and legal arrangements entered into.

Even a regulated system will only work equitably where both consumer and provider are able to transact on an equal level with similar bargaining powers. Where there is:

- A reasonable balance between demand and supply
- Provision of accurate and understandable information to the consumer
- Consumer choice

and

- Effective redress of problems with no potential retribution

transactions may be conducted on an essentially equal basis.

Where those factors do not exist or are seriously flawed or compromised there is no equality of bargaining power.

From the provider perspective, a system can also be seen as inadequate and anti-competitive where, as in aged care, governments control the number and the allocation of available places, and governments constrain the capacity to raise and expend revenue.

From a resident perspective, the imperfections in the system justify positive current and future regulatory intervention by governments to protect those (the residents and their representatives) who are at most disadvantage. The style and content of any current and future regulatory intervention is crucial, as is its effective enforcement. Regulation must not have the effect of creating or perpetuating unwarranted financial and administrative burdens and disincentives to providers or potential providers.

¹¹ For example, in the Commonwealth's system, the payment of accommodation bonds and charges by residents, and the absence of a ceiling on the amounts of accommodation bonds that may be paid—although other safeguards do exist to protect low income people (see further at Section 4.8).

4. Commonwealth-Funded Residential Aged Care Facilities

4.1 Introduction

Over 36,000 older Victorians live in Commonwealth-funded residential aged care facilities.

These facilities provide eligible older people with accommodation and high and low level care services, depending on the assessed care needs of each person. Assessments are performed by Aged Care Assessment Services (ACASs), and an assessment of a potential resident as needing either low or high care is an essential prerequisite to entry. Younger people with disabilities may also be eligible for entry into residential care.

High care generally includes the provision of nursing services, personal care services and assistance with other daily living tasks, to older people. Low level care is targeted to older people who require assistance with personal care and other daily tasks, with (if necessary) a degree of nursing care.

Under the Commonwealth Government's policy of 'ageing in place',¹² high care services may be provided, to people assessed as needing them, in low level residential facilities.¹³

Entry by eligible people to aged care facilities is on a permanent or long-term basis or for short-term respite.

All Commonwealth-funded high and low level residential aged care facilities in Australia are regulated and funded under the Aged Care Act (Cwlth) and the Aged Care Principles 1997 (Cwlth). State regulation may also be applicable, in particular under the Retirement Villages Act (Vic) and, in the recent past, under the Health Services Act (see further at Section 9). Other State and Local Government regulations apply in some areas.¹⁴

Funding for residential aged care facilities also comes from the financial contributions made by residents (recurrent daily care fees, accommodation charges and accommodation bonds: see further at Section 4.8).

¹² 'Ageing in place' is not defined in the Commonwealth's aged care legislation. It seems to mean, however, the provision of care and support services in places where older people prefer to live. It includes the provision of community care to people in their own homes, and is intended to minimise the need for people to transfer to different forms of accommodation, while still providing them with the appropriate levels of care and support.

¹³ As at 31 March 2000, 2,071 residents were receiving high care services in low care residential facilities in Victoria - 14.8 per cent of all people (14,006) living in low care residential facilities at that time. Also at 31 March 2000, 1,207 residents were receiving low care services in high care residential facilities in Victoria (6.9 per cent of a total 17,562 people living in high care facilities) (Department of Health and Aged Care, RCS Appraisals as at 31/03/00, RCS Statistics Update, Table (d)).

¹⁴ For example, State regulations continue to apply to Commonwealth-funded residential aged care facilities under the Drugs, Poisons and Controlled Substances Act and associated regulations. Local Government regulations in areas, such as building requirements, fire safety and under the Food Act also apply to residential aged care facilities.

Accommodation in residential care varies. In high care facilities, accommodation may be in a single room in the service, or in a room shared with another person or with more than one other person. Other areas (for example, bathrooms, sitting rooms, dining rooms) are used communally by residents. In low level facilities, accommodation is usually a single bedroom or bed-sitting room with an en suite bathroom. Other areas (for example, dining rooms, sitting rooms) are used communally.

The legal basis of a resident's tenure is a licence (usually set out in a written residence agreement).

Commonwealth-funded residential aged care is operated by providers in the private-for-profit, not-for-profit and public sectors.

4.2 Background to the Current System

From 1996 to 1997 the Commonwealth Government developed a new regulatory regime which commenced on 1 October 1997. The Aged Care Act and the Aged Care Principles bring former Commonwealth-funded hostels (now low care residential aged care facilities) and nursing homes (high care residential aged care facilities) together in one legislative package, in an attempt by the Commonwealth Government to implement a seamless and integrated system of aged care (residential care, flexible care and community care).

These reforms have introduced significant changes in relation to:

- Terminology.
- Capital funding arrangements.
- Resident fees.
- The resident classification system.
- Requirements for building certification.
- Quality assurance and accreditation.
- Internal and external complaints and dispute resolution mechanisms.
- Abolition of targeted streams of funding for nursing homes.
- Removal of a requirement for providers to acquit funding (that is, to spend funding as targeted by the government and to account regularly to government on expenditure).
- The introduction of the concept of 'ageing in place'.
- A single funding system for high and low level facilities.

As part of these reforms the Commonwealth Government withdrew most government capital funding from high care facilities. The new system also saw the Commonwealth introduce a new user charges regime which focused more strongly on residents' capacity to contribute to the cost of their care, while retaining substantial government recurrent funding in the form of recurrent subsidies.

Soon after its commencement in October 1997, the intended integrated system was affected by significant Government policy changes, primarily in relation to the

replacement of accommodation bonds in high care facilities with accommodation charges and changes to the Prudential requirements for bonds.

4.3 Application and Objects of the Aged Care Act 1997

The Aged Care Act applies to all Commonwealth-funded residential aged care facilities (as well as to Commonwealth-funded flexible and community care) throughout Australia, whether run by the private-for-profit sector, the government sector or the non-government not-for-profit sector. No distinction is made in the application of the Act (as it was under the former legislation) between government and non-government facilities. The Aged Care Act also applies to unfunded places operated by an approved provider where an unfunded place is occupied by people assessed by ACAS as needing low or high care aged residential care services.

The objects of the Act include:

- The promotion of a high quality of care for residents.
- Ensuring accountability of providers for providing care.
- The protection of residents' health and well-being.
- The facilitation of access.
- The provision of respite.
- Effective national planning.
- The promotion of ageing in place.

4.4 Commonwealth's Role

The Commonwealth's role is to:

- Plan and allocate residential (as well as community and flexible) aged care places.
- Approve providers.
- Approve the recipients of aged care services.
- Provide financial support by paying recurrent subsidies for the provision of aged care and by paying grants for other matters connected with the provision of aged care.
- Prescribe the fees payable by residents towards the cost of their own accommodation and care.
- Prescribe standards of accommodation and care and other responsibilities of approved providers towards residents, with sanctions for breach.
- Provide for the rights and responsibilities of residents.

4.5 Responsibilities of Approved Providers

To receive recurrent subsidies, a provider must be granted approved provider status.

The broad responsibilities of approved providers in relation to the aged care services they provide through their aged care facilities are set out in detail in Chapter 4 of the Aged Care Act and are about:

- The quality of care provided
- The user rights of residents and
- Accountability for the care that is provided.

Sanctions may be imposed under Chapter 4 on approved providers who do not meet these responsibilities.

Numerous other obligations, not so directly relevant to the quality of care and the rights of residents, are also imposed on approved providers under the legislation by the Commonwealth Government.

4.6 Income Streams for Approved Providers

Providers of residential care facilities receive income from several different sources:

- The Commonwealth, through the payment of recurrent residential care subsidies and other subsidies and payments.
- Residents, through the payment of recurrent fees, and accommodation charges or accommodation bonds.
- State Government top-ups (for public sector residential care facilities only).

Providers have flexibility in how these funds are used to meet best the care needs of residents, subject to the requirement that accommodation bonds and charges be used in the first instance (where necessary) on building improvements and developments. There are currently no Commonwealth requirements for acquittal of funds.

4.7 Residential Care Subsidy and Resident Classification

The recurrent funding provided by the Commonwealth is called a 'residential care subsidy' and is paid to providers on a monthly (in advance) basis, in relation to each approved resident.

The level of recurrent subsidy paid for each resident is linked to the resident's assessed level of care need. That is, a facility receives the highest level of subsidy in relation to a resident assessed with the highest level of care needs. Resident care need level is determined by use of the Resident Classification Scale (RCS). This scale is used for residents in both high and low level facilities. An eight-point scale is used with '1' indicating the highest level of care is required. In general, a person classified from level eight to level five inclusive requires low level care; a person classified from level four to level one inclusive requires high level care.

Historically, Victorian high care residential aged care facilities have tended to have a higher proportion of residents with very high care needs compared to other States.

The Commonwealth's Funding Equalisation and Assistance Package is having a significant impact on the subsidy levels paid to providers. The key impact of this policy will be a real funding loss for Victorian providers over nine years. Prior to the introduction of funding equalisation, Victorian providers had received one of the highest subsidy rates in Australia, reflecting the higher costs of service provision in this State.

A further impact on the funding of residential care is in the indexation of Commonwealth subsidies. The current indexation arrangements do not take into account real cost movements which will result in a further loss in real terms for

providers if Commonwealth indexation adjustments do not keep pace with cost increases faced by providers.

4.8 Fees, Charges and Bonds Payable by Residents

Residents are liable to pay a number of fees and charges. Fees vary depending on whether the resident is a non-pensioner, full pensioner or part pensioner, and on the date of the resident's entry.

4.8.1 Fees

Resident fees, which contribute towards the cost of care, include:

- **Basic daily fee.** This fee applies to residents in both high and low level residential care, whether entry is for permanent or respite care, unless granted hardship status. For a full or part pensioner the amount of basic daily care fee is based on 85 per cent of the maximum single age pension. Pensioner supplement (formerly rent assistance) is paid direct to the residential aged care facility, not the resident, by Centrelink. Residents of extra service facilities pay an additional extra service component.
- **Income-tested daily fee.** This fee may apply to residents who are non-pensioners or part pensioners and who entered high or low level residential care on or after 1 March 1998. It is paid in addition to the basic daily care fee. Centrelink is responsible for the income-testing and the Department will advise the relevant provider and the resident of the additional amount payable. Some low level residents who entered hostels before 1 October 1997 may be paying 'variable fees' (essentially income-tested fees) calculated under the former Commonwealth legislation by the provider.

4.8.2 Accommodation Bonds

Residents entering low level residential aged care and extra service high care residential care on or after 1 October 1997, other than concessional¹⁵ residents, will usually be asked by the approved provider to pay an accommodation bond (known under the former system as an entry or in-going contribution). An approved provider may only seek an accommodation bond where the service is certified. Division 57-A of the Act provides the basic rules about accommodation bonds.

¹⁵ A 'concessional' resident is one who, at the time of entry, was

- (1) Receiving an income support payment (for example, an age pension); and
- (2) Had either not owned a home for at least two years, or, if a homeowner, the home was occupied by the resident's partner or dependent child or by a carer (who had lived there for at least the past two years and was eligible to receive an income support payment), or by a close relation who had lived there for at least the past five years and was eligible to receive an income support payment; and
- (3) The value of the resident's assets was less than 2.5 times the basic age pension (currently an amount of \$24,000), not including the value (or 50 per cent of the value if owned jointly with a partner) of the resident's home (if a home is owned).

Concessional residents cannot be charged an accommodation bond. The Commonwealth Government has planned for a national concessional resident ratio of 27 per cent of residential care places.

4.8.3 Accommodation Charges

All residents entering high care residential care facilities on or after 1 October 1997 (other than pre-existing residents of high care facilities who transfer to other high care facilities on or after that date—known as ‘charge exempt residents’) will usually be asked by the provider to pay a daily accommodation charge (for a maximum of five years) on top of the daily care fee (and any additional income-tested component).

The maximum amount of daily accommodation charge payable is \$12.00 per day for residents who are neither ‘concessional’ nor ‘assisted’ residents,¹⁶ and \$6.00 per day for an ‘assisted’ resident. ‘Concessional’ residents cannot be charged accommodation charges.

4.9 Agreements

The Commonwealth is encouraging the entry of residents into legally enforceable, written agreements with providers in relation to their accommodation and care. The Aged Care Act sets out the requirements for the content of those agreements.

4.10 Quality of Care and Accreditation

Part 4.1 of the Aged Care Act sets out the responsibilities of approved providers for the quality of care provided to residents. Providers must:

- Provide the relevant care and services specified in the Quality of Care Principles 1997.
- Maintain an adequate number of appropriately skilled staff to ensure that care recipients’ needs are met.
- Provide care and services of a quality consistent with the rights and responsibilities of care recipients set out in the Quality of Care Principles.
- Comply with either the Residential Care Standards (before a facility is accredited) or the Accreditation Standards (on and after accreditation)—both of which, amongst many other things, require compliance with all other relevant Commonwealth, State and local legislation.
- Where the care is provided through a flexible care service, comply with relevant Flexible Care Standards (if any).
- Comply with any other responsibilities set out in the Quality of Care Principles.

The Quality of Care Principles specify the care and services for residential care facilities (Schedule 1) and set out the Accreditation Standards (Schedule 2) and the Residential Care Standards (Schedule 3). There are not yet any Flexible Care Standards.

Auditing and monitoring of facilities for the purposes of ongoing risk management and accreditation is carried out by the Aged Care Standards and Accreditation Agency (the Agency). This is an independent body established by the Commonwealth under the Aged Care Act in 1998. It is overseen by a Board comprising representatives of the various stakeholders in residential aged care.

¹⁶ An ‘assisted’ resident is defined in exactly the same way as a concessional resident except in relation to the relevant level of assets at the time of entry: an amount equal to four times the basic age pension amount.

All facilities must be accredited by 1 January 2001. If a facility is not accredited by that date, Commonwealth funding will be withdrawn.

The accreditation decision is made by the Agency, which takes account of:

- Whether the facility has met the Accreditation Standards.
- The obligations of the facility under the User Rights Principles.
- The prudential requirements for accommodation bonds.
- The concessional resident ratios.
- Whether the facility is certified or is likely to be certified in the near future.

The Agency must refer to the Department the names of providers in whose facilities the Agency considers there are serious and systemic problems and where residents are at risk. The Department will consider whether the imposition of sanctions is warranted. Conversely, the Department may refer to the Agency the names of providers about which complaints of a serious and systemic nature have been made to the Complaints Resolution Scheme, for ongoing monitoring and risk assessment by the Agency.

4.11 User Rights of Residents

Part 4.2 of the Aged Care Act sets out the user rights of residents, and the mirror responsibilities of approved providers to residents. Failure to meet these responsibilities may lead to sanctions being imposed on providers under Part 4.4 of the Act.

The general user rights responsibilities of approved providers of residential care relate to:

- Compliance with the rules about accommodation bonds and accommodation charges.
- Compliance with the rules about residents' fees.
- Compliance with the rules about respite care booking fees.
- Charges for services or care outside that required to be provided under the Quality of Care Principles.
- Compliance with the provisions for residents' security of tenure, both within the facility and in relation to leaving the facility.
- Compliance with the rules about extra service agreements.
- The requirement to offer each resident a resident agreement and, if the resident wishes, to enter that agreement.
- Compliance with the rules about residents' personal information and confidentiality.
- The establishment within each service of an effective internal complaints resolution mechanism.

- Allowing access to people acting for or advocating for care recipients, and to community visitors.
- The identification of accommodation charge exempt residents and the refund to them (or their estates) of the amounts of any accommodation charges paid by them.
- Compliance generally with the user rights provisions of the act and the User Rights Principles 1997.

The responsibilities of approved providers are detailed further within Part 4.2 and within the User Rights Principles.

The Charter of Residents' Rights and Responsibilities (essentially identical to the charters for residents of hostels and nursing homes under the former Commonwealth legislation) is Schedule 1 to the User Rights Principles. As under the former system, it sets out in very broad terms and language the many rights (and the fewer responsibilities) of residents. These rights (and the mirror responsibilities of approved providers) are picked up throughout the Aged Care Act and the various Principles in (generally) more precise and enforceable terms.

4.12 Accountability for the Care that is Provided

Part 4.3 of the Aged Care Act sets out the responsibilities of approved providers with respect to their accountability for the aged care provided through their facilities. Approved providers must, amongst other things:

- Comply with the requirements of the Aged Care Act in relation to keeping and retaining records relating to the facility.
- Comply with any conditions to which the allocation of places is subject.
- Properly conduct appraisals of residents in relation to their care needs.
- Comply with the Accountability Principles 1997 (which relate primarily to access to residential care facilities by certain authorised people).

4.13 Complaints Resolution

One of the specific responsibilities of an approved provider of a residential aged care facility is to establish an internal complaints mechanism for the facility and inform residents about it. The approved provider is to use the mechanism to address any complaints made to the provider by a resident (or representative) about the facility or the care services. The Department's manual, *Standards and Guidelines for Residential Aged Care Services*, provides more (non-binding) detail as to what is expected from such a mechanism (for example, confidentiality; speediness, etc).

Chapter 3 of the Committee Principles 1997 deals further with complaints. Anyone may complain to the Complaints Resolution Scheme (CRS) in the Department of Health and Aged Care about an alleged breach of a provider's responsibilities which the complainant thinks is unfair or which makes the complainant dissatisfied with the service. Such a complaint may be made whether or not any attempt has been made to resolve the issue through a provider's internal complaints mechanism.

If it accepts the complaint, the CRS will assess it and facilitate the escalating levels of complaint resolution, being:

- Negotiation between the parties.

- If the complaint is not resolved, mediation (if both parties agree) by an independent, professional mediator.
- If the complaint is still not resolved, and if at least one party wishes to continue, a determination hearing by an independent four-member complaints resolution committee, which has the power to make binding decisions.
- If one of the parties decides to appeal the decision of the committee within seven days of receiving it, a review (which does not involve a re-hearing) by an independent determination review panel.

4.14 Sanctions

Part 4.4 of the Aged Care Act sets out the consequences of non-compliance by an approved provider. Sanctions may be imposed by the Secretary of the Department. Certain procedures, also set out in Part 4.4, must be followed (except where there is immediate or serious risk to residents) if sanctions are to be imposed. The Sanctions Principles 1997 also deal with matters relevant to the sanctions process.

A range of sanctions may be imposed, depending on the particular circumstances, including:

- Revocation or suspension of approval of the approved provider.
- Restriction of the approval of the approved provider.
- Revocation or suspension of the allocation of some or all of the places allocated to the approved provider.
- Prohibition on the further allocation of places.
- Revocation or suspension of extra service status.
- Prohibition of the grant of extra service status.
- Revocation or suspension of the certification of a residential care service.
- Prohibition on the charging of accommodation bonds or the accrual of accommodation charges.
- Requiring payment of some or all of any grants paid by the commonwealth to the approved provider.

The remainder of Part 4.4 deals mainly with the procedure for imposing sanctions; and when sanctions will cease to apply.

5 Supported Residential Services

5.1 Introduction

This discussion of supported residential services (SRSs) is primarily for the purpose of illustrating the approach of State regulation of residential care services.

SRSs vary widely. Some offer quite luxurious and expensive 'motel-type' rooms with en suite bathrooms for frail older people; may (but not necessarily) be located within a retirement village complex; and may also be known as serviced apartments. Other SRSs provide more basic 'pension-only' bedrooms (often shared) in a house or complex for frail older adults and people with intellectual and psychiatric disabilities. All SRSs provide communal facilities for residents.

SRSs are primarily regulated by the Victorian Government under the Health Services Act and the Health Services (Residential Care) Regulations 1991. The Victorian Department of Human Services administers the legislation. These regulations are currently under review.

The Retirement Villages Act (Vic) will also apply where an SRS meets the definition of 'retirement village'. Advice from the Commonwealth Department of Health and aged Care indicates that Commonwealth aged care legislation also applies to a person assessed by an Aged Care Assessment Service as needing low or high level care if that person is in an unfunded SRS bed operated by an approved provider of Commonwealth aged care services.¹⁷

SRSs receive neither Commonwealth nor State funding. They are essentially funded via the recurrent fees payable by residents.

Both the private-for-profit and not-for-profit sectors own and operate SRSs, although the private sector owns and operates the majority.

The legal basis of an SRS resident's tenure is a contractual licence (supported by a written residential statement).

5.2 Regulation under the Victorian *Health Services Act 1988*

Under the Health Services Act, all SRSs must be registered with the Victorian Department of Human Services. The period of registration is usually for three years with options for renewal. Registration may be subject to specific conditions being imposed on the proprietor by the Department.

The Health Services (Residential Care) Regulations also set out standards for the care of residents. These standards are monitored by regional SRS advisers from the Department of Human Services. Where there is a breach of the Regulations or of the Act the ultimate sanction available is revocation of licence.

Other levels of sanctions include:

- Prosecution
- Ministerial censure

¹⁷ See Department of Health and Family Services, *Service Provider Newsletter*, No 2, May 1998, p. 4.

- Suspension of admissions
- Variations of conditions of registration
- Refusal to renew registration.

The Health Services (Residential Care) Regulations also require that each resident of an SRS have a service plan (also known as a care plan), to ensure adequate care, developed and reviewed in consultation with the resident. Personal care staff, any health service provider and the resident must have access to the service plan.

The proprietor of an SRS is also required by the Health Services (Residential Care) Regulations to take reasonable steps to:

- Provide both facilities and staff to enable residents to participate in a range of activities and recreation
- Provide privacy for residents
- Assist residents' mobility.

The Health Services (Residential Care) Regulations impose only minimum staffing levels. Nevertheless, they require that a person must be employed as the personal care coordinator. Often, the proprietor takes on that role. From 1 January 2001, the Regulations will prescribe minimum qualification levels for personal care coordinators.

Nothing in the health services legislation, or elsewhere, regulates or prescribes the fees payable in SRSs by residents.

Complaints and dispute resolution are covered by the legislation. The proprietor of an SRS must nominate a person or people to deal with any complaints from residents. The legislation does not prescribe any particular complaints resolution process. However complaints are dealt with, the process must be explained to the residents, must be confidential and appropriate records must be kept by the proprietor. The proprietor is also obliged to take reasonable steps to ensure that any residents who do complain about the accommodation or services are not adversely affected (that is, do not suffer retribution) by reason of complaining.

SRS residents also have access to 'community visitors'. The community visitor scheme is coordinated through the Office of the Public Advocate and utilises volunteers. The Health Services Act empowers community visitors to:

- Inspect SRS premises and facilities
- Enquire about the care provided to residents
- Question staff and residents and inspect records.

Other forms of external complaints resolution processes available to residents include the Health Services Commissioner Victoria and Department of Human Services regional SRS advisers.

There is no specifically funded, independent advocacy service for SRS residents. However, the community visitors scheme is intended to fulfil this advocacy role.

6 Overview of Current State-Based Regulatory Approaches in Other Australian Jurisdictions

6.1 Introduction

This section provides an overview of the State-based regulatory approaches in the other Australian States and Territories. It concentrates on State-based regulation of care and accommodation provided in Commonwealth-funded residential aged care facilities. State-based regulation (where it exists) operates in conjunction with the current Commonwealth regulatory framework.

State-based retirement villages legislation also affects residential aged care facilities in a number of States. The operation of retirement villages legislation is not included in this discussion as it focuses on contractual and real property transactions, and does not deal with care issues. Nevertheless, retirement villages law comprises an additional regulatory and administrative layer for providers.

The following chart summarises the various approaches of the other Australian States and Territories.

Table 1 Summary of Various Approaches of the Other Australian States and Territories

State	State Regulations	Staffing Ratios
New South Wales	✓	
Queensland		
South Australia	✓	✓
Tasmania	✓ (State Minister has agreed to allow current licensing to expire in 2000)	
Western Australia		
ACT		
Northern Territory	✓	

6.2 New South Wales

Nursing homes operated by the private sector in New South Wales are licensed and controlled under the *Nursing Homes Act 1988* (NSW) and the *Nursing Homes Regulation 1996* (NSW). The legislation is administered by the New South Wales Department of Health which carries out its role in close cooperation with the Commonwealth and is consistent with the approach of the independent national Aged Care Standards and Accreditation Agency. **Hostels** are not covered by State regulation.

The licensing standards regulated by the New South Wales Department are very detailed and include:

- The design and construction of nursing home premises.
- Facilities and equipment.
- Staffing, including qualifications of staff members, number of staff and duties.
- Operational matters, including administration and support services.
- Clinical records, including access by residents to, and confidentiality of, those records.

The regulations covering staffing include general requirements that ‘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’ (with the determination of ‘sufficiency’ based on any Commonwealth requirements). Similar requirements exist in relation to domestic and maintenance staff. There are no specific ratios for staffing.

Fees are charged for licensing and there is a complaints process that can be accessed.

6.3 Queensland

Since 1 July 1998, **nursing homes** are not required to be licensed and are not regulated by the Queensland Government. This is the result of a 1997 review under National Competition Policy of the former Queensland legislation relating to nursing homes (and to hostels): the *Health Act 1937* and the *Health (Nursing Homes) Regulation 1982*. As a result of the review it was decided to allow the Health (Nursing Homes) Regulation to expire on 1 July 1998 under the automatic expiry provisions of the *Statutory Instruments Act 1992* (Qld).¹⁸ The head of power contained in the Health Act remains intact.

The previous Queensland regulations covered both **nursing homes** and **hostels** in all sectors and were detailed and prescriptive in areas, such as building design, use of the premises, safety requirements, and staffing arrangements.

6.4 South Australia

Nursing homes and **hostels** in both the private-for-profit and not-for-profit sectors in South Australia are covered by State regulation because they come within the definition of ‘supported residential facility’ under the *Supported Residential Facilities Act 1992* (SA).

The Act provides specifically for the rights of residents, covering matters including resident contracts, service plans and disputes.

The Regulations prescribe the standards of care for residents as well as setting fees for licence applications by proprietors, building standards and staffing arrangements.

Minimum staffing levels that must be maintained at a **nursing home** are also prescribed in the Regulations. While they do not include specific staff to resident ratios, they do include a number of specific as well as more general requirements, as follows:

¹⁸ Personal communication, Aged and Community Care Reform Unit, Queensland Department of Health, 20 January 2000.

1. **In a nursing home where there are not more than 16 people who require nursing care:**
 - A registered nurse must be on duty and another nursing staff member (registered nurse, general nurse (supervised) or a nursing home assistant) must be on close call at all times, provided that during the night shift a registered nurse may be on close call if there is another nursing staff member on duty during that time.
 - An adequate number of nursing staff members and therapists must be employed to ensure the proper care of the residents.
 - There must be sufficient domestic staff members to maintain the premises in a clean condition, to prepare, serve and clear away meals and to maintain adequate laundry and linen services.
2. **In a nursing home where there are more than 16 people who require nursing care:**
 - Two nursing staff members, at least one of whom is a registered nurse, must be on duty at all times.
 - An adequate number of nursing staff members and therapists must be employed to ensure the proper care of the residents.
 - There must be sufficient cleaning staff members on duty to maintain the premises in a clean condition, to prepare, serve and clear away meals and to maintain adequate laundry and linen services.

The South Australian Regulations, with the exception of the staffing requirements, also apply to **hostels**. If a supported residential facility is not a nursing home but nevertheless provides nursing care, the proprietor must ensure that the staff of the facility includes a registered nurse.

6.5 Tasmania

Private-for-profit and not-for-profit **nursing homes** (and **hostels**) fall within the definition of 'private medical establishment' in the *Hospitals Act 1918* (Tas) and come within the Tasmanian licensing and monitoring system.

However, a review of the Hospitals Act, as it applies to the residential aged care industry, has recently been undertaken in Tasmania. The Tasmanian Minister for Health and Human Services has approved the following recommendations of the review:¹⁹

- That the requirement for facilities providing accommodation for the aged be withdrawn from the definition of a 'private medical establishment' as contained in the Hospitals Act 1918, thereby removing the need to license these facilities.
- That the provision of supported accommodation be monitored and, if warranted, consideration be given for a review to determine the need to develop alternative arrangements and the most effective framework for the administration of those arrangements.

It is expected that the Tasmanian Parliament will deal with this matter later in 2000.

¹⁹ Personal communication, Department of Health and Human Services, Tasmania, 7 February 2000.

Despite the fact it is probable that residential aged care facilities will be removed from the application of the Hospitals Act shortly, it is still useful to examine briefly that existing licensing and monitoring system.

Once licensed, a private medical establishment is subject to regulations which may, amongst other things, prescribe requirements with respect to the site and situation of any building or structure. The regulations focus on the physical nature of private medical establishments. Matters covered by other State legislation (for example, fire safety, medication issues) are not included in the licensing conditions. While the State Minister has a duty to inspect private health establishments, there appears to be no regular ongoing monitoring system after initial inspections of licensed premises.

6.6 Western Australia

Currently, private and voluntary sector **nursing homes** are required to be licensed at State level under the *Hospitals and Health Services Act 1927 (WA)* and the *Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987 (WA)*. They fall within the definition of 'hospital' within the terminology of the Act, and 'private hospitals' (including private nursing homes) are required to be licensed under the Act and the Regulations.

Where a licence is granted, the Commissioner of Health may impose such terms and conditions on the licence as they think fit. Such conditions may, amongst other things, specify:

- The maximum numbers of patients that may be treated at any one time

and

- The number and categories of nursing and other staff, the kinds of nursing and other care that shall be provided or available, and the periods or times at which they shall be available.

The Regulations, amongst other things, may:

- Prescribe the fees payable for a licence application or licence renewal.
- Provide for the conduct, good management and staffing of private hospitals.
- Provide for the establishment and keeping of registers containing such information as may be prescribed.

Under the current Regulations the licensee must ensure:

- That the director of nursing, or in that person's absence, a responsible person holding approved qualifications, is at all times present at, and in charge of, the private hospital.
- That constant attention is given to the hygienic and proper storage, preservation, preparation and serving of food in the private hospital (with more detailed duties in relation to food and diets).
- That an adequate number of suitable refuse containers is provided in the private hospital for the holding of general refuse.

However, the requirement that the licensee provide certain qualified staff does not apply to 'private hospitals' that are **nursing homes**.

The Western Australian Government has recently agreed that reforms are to be made to the licensing of private **nursing homes** (and aged care **hostels**).²⁰ The reforms are yet to be implemented but they are expected to be in place by late 2001. Once implemented, private **nursing homes** will be exempt from State licensing requirements if those facilities are regulated as residential aged care facilities under the Commonwealth's aged care legislation.

6.7 Australian Capital Territory

There are no specific Australian Capital Territory laws relating to the control of **nursing homes** and **hostels**.

6.8 Northern Territory

Nursing homes in the Northern Territory (other than public sector facilities) are licensed and controlled under the *Private Hospitals and Nursing Homes Act 1981* (NT).

The Act provides for the replacement of the manager, the duties of the manager (including ensuring that a registered nurse is on duty at all times), annual inspections with capacity for service of written notice on the licensee requiring specified repairs, alterations, additions or improvements to the premises or equipment, or specified changes in the management.

Anyone may make a complaint to the Chief Medical Officer against a licensee. On receipt of a complaint, the Chief Medical Officer may authorise an inquiry into the complaint and a written report on the findings.

Regulations may provide for, amongst other matters:

- The minimum qualifications required of nursing staff employed in a nursing home.
- The duties of nursing staff.
- The ratio required of nursing staff to patients.
- The minimum standards of accommodation required for patients.

No regulations have, however, been passed in the Northern Territory.

²⁰ Health Department of Western Australia, *Licensing Information Bulletin*, October 1999.

7 Identification of Overseas Trends

7.1 Introduction

This section provides information about the government regulation of aged care facilities, especially nursing homes, in the United States of America, the United Kingdom and Denmark. The focus of the discussion is on quality of care, staffing and information issues. The discussion is illustrative only. It should be remembered that each of these countries differs from Australia in terms of, amongst other things:

- Social structures and values.
- Demographics.
- Government systems generally.
- Government planning and regulation of health and aged care systems.
- Dependency levels of residents of aged care facilities.

7.2 The United States of America

7.2.1 Introduction

Nursing homes in the United States of America (USA) are regulated by federal and state laws. The centrepiece is the *Nursing Home Reform Amendments Act 1987* (NHRA Act). Regulations under this legislation were implemented by the Department of Health and Human Services in 1995.

The NHRA Act sets out the quality of care and quality of life required in skilled nursing facilities or nursing facilities (nursing homes) which receive Medicare and Medicaid funding (which is in relation to most residents in USA nursing homes). The legislation prescribes standards of care, with provision for surveys of facilities, the rights of residents and grievance procedures.

The federal Government and the states share the responsibility for the quality of care and life of the 1.6 million residents (mostly older people) who live in the 17,000 nursing homes certified as eligible for Medicare or Medicaid funding.²¹ Much of the implementation and enforcement of the provisions rests with state governments. This is implemented via an agreement and funding arrangement between the federal government and each state government. State agencies, for example, have responsibility for certifying homes as eligible for Medicare or Medicaid payment. They conduct surveys to monitor the standards of care, implement a complaints investigation process and oversee the education of nurse aides. Most funding for these programs is provided by the federal government with state agencies receiving \$210 million in 1999.

Most States have other laws applicable to nursing homes, additional to the federal law.

Since the introduction of the 1995 regulations there is evidence that the health and safety of residents has improved:

²¹ Enhanced HCFA Oversight of State Programs Would Better Ensure Quality, General Accounting Office Report to the Special Committee on Ageing, November 1999, p. 7
<www.gao.gov//main.html>

- Over-use of anti-psychotics is down from 33 per cent to 16 per cent.
- Appropriate use of antidepressants is up from 12.6 per cent to 24.9 per cent.
- Use of physical restraints is down from 38 per cent to 15 per cent.
- Use of indwelling urinary catheters is down nearly 30 per cent.
- Use of hearing aids for residents with hearing problems is up 30 per cent.²²

However, significant problems remain in the USA nursing home industry:

Despite the passage of the Nursing Home Reform Law of 1987, residents still face numerous problems, including neglect and abuse in nursing home facilities because of the failure of facilities to fully implement the law and inadequate enforcement of the federal nursing home standards... According to the Health Care Financing Administration (HCFA) 75 per cent of the 5,600 facilities inspected since the new federal enforcement system took effect July 1, 1995, were found out of compliance with federal standards.²³

In 1998 President Clinton announced a nursing home initiative to implement a number of reforms to address the problems. These measures focus on improving the survey process (monitoring or assessment) and tougher enforcement and sanctions processes.²⁴ The discussion below focuses on existing USA requirements in relation to staffing, staff/resident ratios, staff qualifications and information provided to residents and family members.

7.2.2 Staffing Requirements

The USA legislative package makes a number of references to staff qualifications. There are, for example, general requirements about the need for professional and qualified staff.

Under the NHRA Act nursing services and specialised rehabilitative services, medically-related social services, pharmaceutical services, dietary services and dental services must meet '...professional standards of quality...' and '...be provided by qualified persons...' The facility must employ, on a full-time, part-time or consultant basis, professionals necessary to carry out requirements under the regulations and the professional must be licensed, certified, or registered in accordance with state laws. The regulations require that 'the facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care'. 'Sufficient staff' means sufficient numbers of licensed nurses and other nursing personnel '... on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans... '.

²² Statement of Michael Hash, Deputy Administrator, Health Care Financing Administration, before the Senate Special Committee on Aging, July 1998, p. 2
<www.hcfa.gov/testmony/1998/nurs1.htm>

²³ National Citizen's Coalition for Nursing Home Reform, News Release, 30 June 1999, p. 1
<www.nccnhr.org/Updates/applauds_clint.htm>

²⁴ Statement of Helene Fredeking, Senior Advisor, Divisions of Outcomes and Improvement Center for Medicaid and State Operations, Health Care Financing Administration before the Senate Special Committee on Aging on Nursing Home Staffing, 1/11/99, p. 1
<www.hcfa.gov/testmony/1999/991103.htm>

A skilled nursing facility must also ‘...provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least eight consecutive hours a day, seven days a week’. Exceptions may be made, for example, in rural areas where the supply of skilled nursing services may not be sufficient to meet the needs of individuals, provided there are alternative arrangements to meet the medical and nursing needs of the residents. The facility must designate a registered nurse to serve as the director of nursing (DON) on a full-time basis and a licensed nurse to serve as a charge nurse on each shift. The DON can serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents

In addition to nursing care, a nursing home ‘...must employ a qualified dietician either full-time, part-time or on a consultant basis’ as well as ‘...sufficient support personnel competent to carry out the functions of the dietary service’.

Activities must be directed by a qualified, therapeutic specialist or an activities professional who is licensed, registered or eligible for certification by a recognised body (such as an occupational therapist or occupational therapy assistant) or has other relevant experience or training recognised by the State.

In addition, the facility must comply ‘...with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility’.

Further, each facility must ‘...designate a physician to serve as medical director’ who is responsible for ‘(i) implementation of resident care policies; and (ii) the coordination of medical care in the facility’. A nursing home with more than 120 beds must also employ a qualified social worker with relevant experience of working with individuals in a health care setting.

The NHRA Act also requires the training of nurse aides. A nurse aide ‘...means any individual providing nursing or nursing-related service to residents in a facility who is not a licensed health professional, a registered dietician, or someone who volunteers to provide such services without pay’. Aides used on a temporary basis must be qualified and those used on a permanent basis must be qualified if employed for more than four months. Being ‘qualified’ means being competent to provide nursing and nursing related services and the completion of a training and competency evaluation program approved by the State. A nurse aide training and competency evaluation program must consist of no less than 75 hours of training covering a specified curriculum and at least 16 hours of supervised practical training. The training of nurse aides must be under the general supervision of a registered nurse with at least two years of nursing experience and at least one year in long-term care.

Each state must establish a registry of nurse aides. The registry must set out specific information about each nurse aide, including any finding by the state survey agency of abuse, neglect, or misappropriation of property by the individual. This information can be disclosed to any person requesting it. The registry must also remove the name of any nurse aide who has not performed nursing or nursing-related services for 24 consecutive months, unless the entry included findings of abuse, neglect, or misappropriation of property.

7.2.3 No Specific Staff/Resident Ratios

The USA legislative package does not provide for specific nursing staff/resident ratios or a minimum number of hours of care for each resident per day. There are limited specifications for skill mix as outlined, but these are not tied to any staff/resident

ratios, except for the minimum requirements in relation to the presence of a registered nurse and the requirements about DONs.

The role of establishing specific staffing requirements is left to the individual states and most have minimum standards whether in law or policy. Adequate staffing has increasingly become of significant concern, and over the last two years approximately two thirds of the states have passed new laws or set up a process for researching and evaluating the issues of adequate staffing.

In 1990 the Department of Health and Human Services was required to conduct a study and report to Congress (Special Committee on Aging, USA Senate) within two years on supervisor/care-giver/resident ratios and to make recommendations as to what was appropriate.²⁵ That research was not completed at that time. It is currently being completed by a conglomerate of research organisations on behalf of the Health Care Financing Administration (HCFA) within the Department of Health and Human Services and it is expected that a report will be submitted to Congress in July 2000.

The research is to determine:

1. If minimum nurse staffing ratios are appropriate; and if appropriate:
2. The potential cost and budgetary implications of minimum ratio requirements
and
3. If there are nurse staffing ratios that strongly determine optimal resident outcomes.

Data is being collected for 1996 and 1997 from most of the nursing homes in the states of Ohio, New York and Texas—a total of 2,700 homes caring for 243,000 residents.²⁶

No doubt this large-scale research will be of considerable interest to a number of countries and states, including Victoria, when it becomes available in July 2000.

If staff/resident ratios are mandated in the USA as a result of the current inquiry, it appears there will be a problem in recruitment of qualified nurses, given the current shortage in the USA (as elsewhere).²⁷

7.2.4 Information Requirements

The USA legislation requires that each resident must be informed orally and in writing about their rights and obligations. Eligible residents must be given information about prescribed services to which the resident is entitled and services which are charged to the resident. Residents must be informed orally and in writing of their legal rights, including contact details for advocacy groups, the state survey body, ombudsman (that is, advocacy) program and other relevant bodies, as well as information about complaints procedures.

Other information requirements include in relation to health status and medical condition, clinical records, the right to accept or refuse medical or surgical treatment, and to execute an advance directive.

²⁵ National Citizens' Coalition for Nursing Home Reform (NCCNHR)—Federal and State Minimum Staffing Requirements, October 1999 Draft, page 1. NCCNHR website:
<www.nccnhr.org/advocate.htm>

²⁶ Department of Health and Human Services, *HCFA/ABT Study and Report to Congress on Appropriateness of Minimum Nurse Staffing Ratios*, Terms of Reference, Health Care Financing Administration (HCFA).

²⁷ Westlaw, *Nursing Homes*, Vol 49, Issue 1; p. 2.

As part of the Clinton Administration's reforms to assist consumers in choosing a nursing home, information kept on the Health Care Financing Administration's website (which makes available state survey results about individual homes), now includes information about prevalence of bedsores, incontinence and other relevant health conditions. Consumers can compare nursing homes on various criteria and do a search by county or postcode. The website also includes a 'Guide to Choosing a Nursing Home', a publication that takes consumers step by step through the selection process including questions to ask, a checklist, contacts and resources.²⁸

7.3 United Kingdom

7.3.1 Introduction

There has been considerable activity in the United Kingdom (UK) over the last couple of years in the long-term care industry. A Royal Commission on Long-Term Care for the Elderly was established in 1998 'to examine short and long-term options for a sustainable system of long-term care for elderly people, both in their homes and in other settings...'. A report was presented to Parliament in March 1999.²⁹ The matters covered are not directly relevant to the issues of immediate importance in Victoria.

The current regulatory structure of nursing homes (developed in a piecemeal fashion since 1948) has also received attention. Serious gaps have been identified. For example:

- Local authority nursing homes are at present exempt from the enforcement of regulations.
- Responsibility for regulation is shared amongst a number of authorities.
- The *Registered Homes Act 1984* and regulations provide little detail in respect of the standards required.³⁰

A White Paper, *Modernising Social Services*, sets out the British Government's commitment to protecting vulnerable people through standards and monitoring systems. The Centre for Policy on Ageing (CPA) was given responsibility for producing the Nationally Required Standards. A document, *Fit for the Future? National Required Standards for Residential and Nursing Homes for Older People*,³¹ (the Consultation Document) sets out the changes which include a proposal for more '...robust, measurable and enforceable...' National Required Standards and the establishment of Commissions for Care Standards at a regional level for the regulation of care services.

The Consultation Document was issued in September 1999 and a final document is due to be published soon. The Care Standards Bill 1999, which makes provision for a new, independent regulatory body for a number of services including nursing homes, is currently before Parliament. In England the regulatory body will be known as the National Care Standards Commission.

²⁸ Health Care Financing Administration, Press Release 14 December 1999, pp 2-3, <www.hcfa.gov/news/pr1999/p991214b.htm>

See the HCFA's consumer website at <www.medicare.gov>

²⁹ *With Respect to Old Age: Long-Term Care—Rights and Responsibilities*, A Report By the Royal Commission on Long-Term Care, March 1999 <www.officialdocuments.co.uk/document/cm41/4192/4192.htm>

³⁰ United Kingdom, Department of Health, *Fit for the Future? National Required Standards for Residential and Nursing Homes for Older People*, Consultation Document, Department of Health, 1999, pp 103-4.

³¹ Available at <www.open.gov.uk/doh/quality.htm>

7.3.2 Staffing Requirements and Ratios

The difficulties of establishing staffing standards is recognised in the Consultation Document:

Fixed ratios might help ensure that minimum levels of care are provided and the health and safety of residents and staff safeguarded. But rigid ratios of qualified to unqualified staff may not be sufficiently flexible to meet varying needs and could create significant organisational and operational problems for care homes. A better approach might be to link staffing directly to such factors as the layout of the home, the purpose of care and the assessed needs of residents, using a recognised assessment tool. This approach would require further work to establish such a tool, prior to implementation of any possible future standard in this area.³²

Part of the difficulty relates to the proposed application of the standards to a range of residential and nursing homes.

Currently, there are some requirements in place in the UK and the recommendations in the Consultation Document build on these. The approach includes a general requirement that ‘...staffing levels and skills mix are adequate to meet the needs of the residents in the particular home in question’.³³

More specific minimum baseline standards are proposed. The CPA has recommended a ratio of one third qualified nurses to two thirds untrained staff. Approximately 46 per cent of nursing homes do not currently meet this ratio and inspection reports have shown that insufficient qualified staff has led to serious consequences for residents³⁴.

The proposed minimum staff requirements are:

- An RN or medical practitioner in charge of the facility.
- Two care staff on duty at all times.
- Staff/resident ratios of:
 - ◆ 1:5 residents am
 - ◆ 1:7 residents pm
 - ◆ 1:10 residents night
- One third of staff to be registered nurses.
- Ancillary staff based on:
 - ◆ 3.5 hours per resident per week for laundry and domestic staff
 - ◆ 2.5 hours per resident per week for catering staff.³⁵

Beyond the minimum requirements, each nursing home agrees, in conjunction with the Registration Authority, on staffing levels and skills mix. The agreement is subject to annual review. The matters to be considered when establishing levels and skills of staff are:

³² Consultation Document, Department of Health, 1999, pp 8–9.

³³ Consultation Document, 1999, p. 68.

³⁴ Consultation Document, 1999, pp 8 and 110.

³⁵ Consultation Document, 1999, pp 70–71.

- Resident numbers
- Categories of residents
- Dependency levels of residents
- Needs of individuals set out in care plans
- Aggregated needs of resident population as a whole
- Size and layout of home
- Form of care delivery
- Peak periods of activity during the working day.³⁶

Induction and training requirements are also proposed.

Nursing homes are also obliged to provide a notice setting out staffing in the facility and for this to be available in material provided to potential residents as well as residents and members of the public on request.

It is recognised that a move to one-third registered nursing staff would require 61 million pounds additional funding, if adopted. This is not the only concern, however, as the minimum obligation would require 7,000 additional nurses and, with a shortage of qualified staff in the UK, there will be difficulties recruiting staff.

The King's Fund, an independent health care think-tank in the UK, is also conducting a national inquiry on care and support workers providing care to vulnerable adults. The questions being addressed in this research are:

1. What problems are there in the quality of care and support provided to vulnerable adults, and what are the reasons for these?
2. To what extent will these problems be resolved by new arrangements for regulation and training?
3. What further recommendations might be made for strengthening arrangements to ensure good quality services?
4. What are the features of good practice in the provision of high quality care and support, and what skills and characteristics of care workers are associated with such practice?

This study will also be of interest, particularly in relation to staffing issues and quality of care. Consultations are currently taking place and the King's Fund will report by December 2000.³⁷

7.3.3 Information Requirements

Requirements relating to information provision received attention in the Consultation Document, as well as in a report by the Office of Fair Trading, *Older People as Consumers in Care Homes*.³⁸

³⁶ Consultation Document, 1999, p. 69.

³⁷ Personal communication with King's Fund, United Kingdom, 18 April 2000.

³⁸ October 1998, available at <www.oft.gov.uk/html/rsearch/reports/oft242.htm>

In 1997 the UK Office of Fair Trading ('OFT') identified four areas of concern to care home consumers: information, contracts, financial issues and complaints mechanisms. In relation to information the concern was whether potential residents were given sufficient information to enable them to choose the best home, and if appropriate information was given from the outset about what specific services were included in the fees. The OFT invited feedback from residents and relatives as well as relevant government bodies and authorities, and conducted a survey of residents to ensure they had a voice in the process. The OFT was aware of the pending changes to the regulatory scheme and framed recommendations in such a way so that they could be considered in the legislative changes. There are a number of recommendations that are relevant to the provision of information, but most of these relate to current requirements under Australia's aged care legislation.

There are some existing UK requirements in relation to information and the Consultation Document builds on these. A primary obligation in relation to the provision of information relates to the requirement for a nursing home brochure and prospectus. The brochure must include information about fees, services, terms and conditions of residence and a contract. Specific information is required about a number of aspects of the nursing home, such as the number and size of rooms, choice of shared accommodation and specialist staff employed. Where a home claims to meet special needs, information is required about matters, such as care practice, physical layout and design, and food and its preparation.

7.4 Denmark

7.4.1 Overview

Denmark follows the welfare state model but, compared to other Nordic countries, has given a greater role to the private sector.³⁹ The system in place for aged care is based on a different model of care to that developed in Australia.

The current provision for nursing home care probably stems from a policy developed as early as the 1970s to enable older people to remain at home as long as possible. At that time, institutional care focused on the most disabled, and large nursing homes (200 residents) were built to benefit from the economies gained in the employment of professional staff. Later in the 1970s a National Commission on Ageing was established and it finally reported in 1982. Developments in the 1980s built on the recommendations of the Commission which had focused on the need for all benefits and services to support the autonomy of the elderly. In 1988 a new law came into effect and prevented the construction of institutional-type nursing homes. Existing nursing homes were to be replaced by apartments for older people and, in the seven years to 1994, 12,000 nursing homes were replaced with 20,000 new dwellings with approximately 8,200 of these offering nursing services. Alongside the move to a non-institutional setting for nursing care, extensive home care services were established.⁴⁰ Through the 1990s the nursing home system was also gradually changing to one where accommodation and services could be purchased separately.

To maximise the rights of residents, each resident's room is considered to be their private dwelling and the resident decides what care is required from staff. Residents pay rent and additional charges for other services received in the home. To address the increasing demand for accommodation and care of those with dementia, a number

³⁹ Organisation for Economic Cooperation and Development, *Caring For Frail Elderly People—Policies in Evolution*, Social Policies Studies 1996, p. 121.

⁴⁰ *Caring For Frail Elderly People—Policies in Evolution*, pp 121–122.

of experimental housing schemes have been set up. One example is the 'sheltered unit' of six to eight people, within a larger home, employing specialised staff who plan each day based on the needs of the residents. Some offer day care and some 24-hour accommodation.

It is clear that the boundaries between nursing homes and other forms of residential living are not as clear in Denmark as in other countries.⁴¹ This system provides food for thought for those who advocate greater levels of community care and creative housing options for older people.

⁴¹ Kane, R A, Kane, R L Kane and Ladd, R C, *The Heart of Long-Term Care*, 1998, Oxford University Press, p. 271.

8 Commonwealth Regulation of Residential Aged Care Before October 1997

8.1 Introduction

The residential aged care system in Australia underwent ten years of staged reform between 1985 and 1995. These reforms responded to some graphic reports (including from Parliamentary committees) in the early to mid 1980s of serious neglect and abuse of frail older people in nursing homes (as high care residential aged care facilities were then called) and other institutions.⁴² It was also a response to the growing realisation that Australia had, as it still does, a rapidly ageing population.

During this period, the Commonwealth Government sought to change the balance of nursing home and hostel places, so that fewer people were inappropriately placed in nursing homes, and introduced a planning benchmark to guide the allocation of new places. One of the results of the introduction of this system was that the Commonwealth was able to control the number of new places allocated.

8.2 Nursing Homes

Prior to the 1997 reforms, two (sometimes overlapping) systems of regulation of nursing homes under both the *National Health Act 1953* (Cwlth) and the *Aged or Disabled Persons Care Act 1954* (Cwlth) were in place. In Victoria, state regulations were also in place for nursing homes until 1995 (see at Section 9).

8.2.1 Non-Government Nursing Homes

The Federal Government had in place, under the National Health Act, a regulatory system of:

- Approvals-in-principle and approvals of operators.
- Assessments, approvals and classifications of nursing home residents.
- A system for determining the numbers of beds (including beds in state government nursing homes) in each state and territory and in each nursing home.

This system enabled the Federal Government to control the growth of nursing homes. A complex regulatory system for respite care formed part of the overall system.

Not-for-profit organisations and local government bodies operating nursing homes could apply to the Federal Government, under the Aged or Disabled Persons Care Act, for grants towards capital works costs incurred or to be incurred in respect of the nursing homes. Such grants would be made subject to conditions imposed by the relevant Minister under a capital funding agreement.

⁴² For example, McLeay, L, *In a Home or at Home: Accommodation and Home Care for the Aged*, Report from the House of Representatives Standing Committee on Expenditure, AGPS, Canberra, 1982; Parliament of the Commonwealth of Australia, *Private Nursing Homes in Australia: Their Conduct, Administration and Ownership*, Report by the Senate Select Committee on Private Hospitals and Nursing Homes, AGPS, Canberra, 1985.

Private-for-profit operators and state Government operators were not eligible to receive such capital funding. Operators of 'exempt' (now known as 'extra service') nursing homes⁴³ in any sector were also ineligible for Commonwealth capital funding.

Each non-government nursing home was required to be approved by the Federal Government under the National Health Act in order to operate as a nursing home and to receive recurrent government funding.

Once approval-in-principle had been granted, a proprietor could then apply for approval of the premises as an approved nursing home, in order to receive recurrent funding.

Recurrent subsidy agreements between the non-government service providers and the relevant federal Minister contained a number of general and other conditions, including 'outcome standards' (see further below) which were expected to be met by each non-government approved nursing home in return for the recurrent funding.

The level of recurrent funding received by each non-government approved nursing home depended, in part, on the assessed care-needs/dependency level of each eligible resident. Older people were assessed for residential care eligibility by an Aged Care Assessment Service. Once eligibility was established and the person was admitted to a residential aged care service, a more detailed assessment was undertaken by facility staff. Residents were assessed against the Resident Classification Index (RCI) which was divided into five classified levels of dependency in nursing homes: '1' being the highest level of dependency; '5' being the lowest level. The higher a resident's dependency, the higher the level of recurrent subsidy received by the nursing home in relation to that resident.

As well, 'top-up' extensive care benefits could be paid under the National Health Act to non-government approved nursing homes where extra financial assistance was required—for example, in order to employ registered nurses.

Recurrent funding was segmented to target different aspects of running a nursing home. One segment, the 'Care Aggregated Module' (CAM), funded the salaries and wages of nursing and personal care staff. It took into account the varying industrial award rates in each state and Territory. It also took into account the different assessed care needs of each resident, and was indexed quarterly. Providers were obliged to report regularly to the Department on the acquittal of CAM funding. CAM funds not spent on nursing and personal care were recoverable by the Government.

Where an approved nursing home did not comply with certain ongoing conditions, its approval could be suspended under the National Health Act. This meant that sanctions could be put in place to suspend the payment of recurrent subsidy to the facility. For residents admitted after such a declaration was made, the proprietor was still obliged to charge only the standard fee.⁴⁴

It was illegal under the National Health Act for a nursing home provider to charge any form of capital entry contribution to a resident.

⁴³ Exempt nursing homes were a minority of non-government nursing homes, approved by the Federal Government under the *National Health Act* to charge higher (but still regulated) fees to residents than non-exempt homes could. In return, residents of exempt homes could expect to receive a higher quality of accommodation and care services.

⁴⁴ The statutory minimum resident contribution (or fee) in nursing homes was 87.5 per cent of the sum of the maximum single age pension and rent assistance, regardless of a resident's actual income, calculated on a daily basis.

Approvals were subject to a series of conditions that included:

- Maximum number of beds.
- Fees charged to respite care residents occupying absent permanent resident's bed.
- The offering to a new resident of a resident/provider agreement, substantially in the form determined under s 40ABB of the National Health Act, or, if the resident chose not to enter the agreement, compliance by the provider with any Ministerial requirement consistent with the Charter of Residents' Rights and Responsibilities (see below).
- Limit to fees charged and extra charges.
- Information relating to the nursing staff and personal care staff.
- Entry of authorised people (departmental standards monitors) in order to ascertain compliance with the outcome standards.
- Entry of residents' advocates.
- Provision of nursing home care to satisfy the outcome standards.
- Any other conditions determined by the minister for the purpose of providing for the needs, welfare and interests of the residents of nursing homes.

The National Health Regulations prescribed the services 'of a kind provided in a nursing home'. These services included, but were not restricted to:

- The provision of goods to assist residents to move themselves (for example, crutches, wheelchairs).
- The provision of assistance in the activities of daily living of residents (for example, help with bathing, showering, eating, dressing).
- The provision of meals of adequate variety, quality and quantity.
- The performance of nursing procedures.
- The provision of assistance in obtaining health practitioner services.

Approved non-government nursing homes were required to provide nursing home care and services at a level sufficient to meet the outcome standards. Under the legislation, certain consequences (for example, suspension or revocation of funding) could be imposed on non-government nursing homes not complying with the outcome standards.

The outcome standards were jointly developed by the federal and state Governments. The standards focused on positive care *outcomes* for residents, rather than on any inputs that might be required to reach those outcomes. By regulating in this way, the Federal Government hoped to have built a degree of flexibility and autonomy into the aged care system, such that the proprietor, director of nursing and staff of any individual non-government nursing home could decide how, within the funding constraints, the outcomes could best be achieved in that home.

One of the conditions to which non-government nursing homes were subject was compliance with the outcome standards. Monitoring was undertaken by Standards Monitoring Teams (SMTs). Providers were required to allow the SMTs entry at any reasonable time.

Publication of the eventual standards monitoring reports was intended to promote greater public awareness about the quality of care and the quality of life within non-government nursing homes; and to promote greater public accountability of nursing home providers.

Where there was serious and persistent non-compliance with the outcome standards, sanctions could be imposed in order to protect the interests and the welfare of the residents. Sanctions included a Ministerial declaration that a nursing home had not satisfied the outcome standards along with a determination that no Commonwealth benefit was payable. Sanctions also included, where residents were seen to be seriously at risk, suspension or revocation of the nursing home's approval. Revocation of approval was seen as a sanction of last resort, given that the inevitable consequence would be the closure of the relevant nursing home (and the dislocation of the residents).

In practice, the Federal Government rarely exercised its power to impose sanctions. Instead it relied, where outcome standards were not met, on the practice of SMTs' negotiating with nursing home providers about action to be taken to redress areas of non-compliance.

Where a nursing home provider believed they had been treated unfairly in an outcome standards compliance report, the provider could request an independent review from a Standards Review Panel.

Despite the introduction of new aged care legislation by the new Federal Government on 1 October 1997 (see Section 4), the Department only ceased its standards monitoring function on 30 June 1998 (with new Residential Care Standards in place), at which time the responsibility for assessing compliance with standards was taken over by the independent Aged Care Standards and Accreditation Agency.

The Federal Government also published 'design principles' for nursing homes, to encourage the nursing homes, in their physical characteristics, to 'support the provision of care to provide maximum independence and support for the lifestyles of residents'.⁴⁵

A major influence on the Federal Government's approach to nursing homes was the 'Ronalds' Report', published in 1989.⁴⁶ This report identified issues relating to the protection and promotion of residents' rights. Key initiatives in the Ronalds' Report, and acted on by the Federal Government from 1990, included:

- The development of a Charter of Residents' Rights and Responsibilities in both Commonwealth-funded nursing homes and hostels.
- The development and implementation of a model agreement to be offered to each nursing home resident by the provider.
- The establishment of a complaints unit in each state office of the relevant federal Department.
- The establishment of independent, Commonwealth-funded advocacy services in each state and Territory to take up grievance issues on behalf of residents of both

⁴⁵ Department of Community Services and Health, *A Home by Design: Nursing Home design Principles*, 1989, AGPS, Canberra.

⁴⁶ Ronalds, C, *Residents' Rights in Nursing Homes and Hostels: Final Report*, 1989, Department of Community Services and Health (Cwlth), AGPS, Canberra.

hostels and nursing homes, except in New South Wales, where such an advocacy service already existed.

- The establishment of a community visitors scheme to support nursing home residents at risk of isolation otherwise.

A major acknowledged deficiency of the reform program was the inability and lack of capacity of the complaints units to deal adequately with complaints and to resolve disputes with finality. In 1996 an independent evaluation, funded by the Federal Government, of the complaints mechanism found that:

- The existing complaints mechanism often left many complainants and service providers dissatisfied with both the outcome and processes.
- Complaints were interpreted and acted on only within the outcome standards monitoring framework.
- The complaints mechanisms in place did not comply with the Australian Standard on Complaints Handling (AS 4269—1995).⁴⁷

A 1994 review by Gregory of the structure of nursing home funding found significant deterioration in nursing home capital stock (that is, the physical buildings and facilities) and major deficiencies in capital works.⁴⁸ Some nursing homes were found to be fire hazards. The review also found, amongst other things, that the funding system did not provide incentives for maintenance of good quality nursing home stock.⁴⁹

8.2.2 State Government Nursing Homes

State Government (or 'public') nursing homes were, in Victoria, partly funded under State legislation: the *Health Services Act 1988* (Vic). See Section 9 for discussion of State regulation.

Recurrent funding for state Government nursing homes was also received from the Federal Government under s 47 of the National Health Act, but at a discounted rate. The State Government committed to providing top-up funding to negate the effect of the Commonwealth discount in the public sector.

The fee structures for residents in public sector nursing homes were the same as for those in the non-government sector.

After a transfer of state nursing homes to the non-government funding system, completed by 1 July 1994, state nursing homes were subject to the same Commonwealth outcome standards and monitoring provisions as non-government nursing homes. Residents of public sector nursing homes also had access to the Commonwealth complaints processes from this date.

No capital funding of state Government nursing homes was available from the Federal Government under the Aged or Disabled Persons Care Act.

⁴⁷ Elton, B and Associates, *Evaluation of the Residential Aged Care Complaints Handling Mechanism, 1996*, Department of Health and Family Services (Cwlth), Canberra, p. 7.

⁴⁸ Gregory, R, *Review of the Structure of Nursing Home Funding Arrangements, Stage 2, 1994*, Department of Human Services and Health (Cwlth), AGPS, Canberra.

⁴⁹ Op cit, p. 3.

8.3 Hostels

Commonwealth reforms to the hostel sector began in 1990, with:

- The extension of recurrent funding under the Aged or Disabled Persons Care Act to the private-for-profit sector (previously, recurrent funding had been available only to not-for-profit operators)

and

- Programs for the management and care of hostel residents with dementia.

The Federal Government also continued to provide capital funding to 'eligible' hostels (that is, excluding those run by the private-for-profit sector) under the Aged or Disabled Persons Care Act.

Further reforms to hostels continued from 1991, with increased Government subsidies (where available); new resident assessment mechanisms; and increased funding for hostel staff training.

Once recurrently funded, hostel operators entered into recurrent subsidies agreements with the relevant Federal Minister, under which a number of general and other conditions (including outcome standards) were imposed on the hostels in return for the funding. As in nursing homes, the level of recurrent funding was based on five assessed care-need levels of residents.

Other reforms initiated by the Federal Government in relation to nursing homes also applied to hostels, including:

- Standards monitoring.
- The requirement that hostel residents be offered a residence agreement (complying with the general conditions of funding).
- The development of a charter of hostel residents' rights and responsibilities.
- The establishment of residents' advocacy services in each state and territory (other than in New South Wales where such an advocacy service already existed).
- The establishment of complaints units in the state and territory offices of the relevant Commonwealth Department.

Included in the Commonwealth's general conditions of funding of hostels were provisions regulating residents' entry contributions and ongoing fees.

Unlike for nursing homes, hostel operators could charge in-going residents a capital entry contribution, of any amount, subject to each resident being left with a minimum amount of assets after payment (2.5 times the annual age pension—in current terms an amount of \$24,000). Certain amounts (the calculation of which was based on both the original amount paid and the period of residence up to a maximum of five years) were able to be retained by hostel operators from the lump sum entry contribution. Hostel operators were also entitled to receive the interest earned on the investment of the entry contributions. There were no federal controls or protective mechanisms in relation to how entry contributions were safeguarded. On death or departure, the balance of each resident's entry contribution was refunded to them (or the estate) within certain timeframes required under the general conditions of funding.

The Commonwealth made provision for access to hostels for 'financially disadvantaged' residents by requiring that a percentage of the total places be allocated for access by this resident group and prohibiting the charging of an entry contribution.

Ongoing fees were also the subject of the Commonwealth's recurrent funding agreements with hostel operators. Where a resident's income was equal to or less than the maximum single age pension, then the maximum fee payable was 85 per cent of the sum of the maximum single age pension and rent assistance, calculated on a daily basis. Where a resident's income exceeded, even by one dollar, the maximum single age pension, then 'variable fees' (or income testing) applied within certain capped limits, so that the resident paid higher fees.

9 Victorian Regulation of Nursing Homes and Hostels Before 1995

9.1 Introduction

Until 1995 the Victorian Government had a minor role in the regulation of nursing homes and hostels under the Health Services Act. Principles contained in the Victorian regulations were consistent with the Commonwealth's Charter of Residents' Rights and Responsibilities.

The discussion of state regulation that follows relates only to the historical situation *prior to* the repeal of the relevant nursing home and hostel provisions in that Act in 1995 by the *Health Services (Amendment) Act 1994*.

9.2 Overview of the Regulation

Under the Health Services Act state regulations were made for nursing homes and hostels about:

- Requirements about safety, cleanliness and hygiene and the standards of care in health service establishments.
- Requirements about the welfare of people accommodated in or receiving health care or other services from health service establishments, including but not limited to matters of personal hygiene, nutrition, comfort, privacy and respectful treatment.
- Requirements for staffing of health service establishments, including but not limited to appointments, numbers, qualifications, rostering and staffing arrangements.
- Monetary penalties for breaches of the regulations.

The proprietor of a nursing home was required to ensure that the minimum number of nursing staff provided was for:

- Day and evening shifts: one registered nurse for each ten residents or fraction of ten.
- Night shifts: one registered nurse for each 15 residents or fraction of 15, and that not less than one-third of the nursing staff on duty on each shift were registered general nurses.

State standards monitoring teams regularly inspected facilities that fell under the Regulations. One of the difficulties in coordinating this function with the Commonwealth was the lack of information the Commonwealth was able to provide about which facilities would be inspected. This resulted in some facilities being inspected by both Commonwealth and State inspection teams within a short period of time. As Commonwealth standards monitoring became more vigorous, the State monitoring role slowly phased down and ceased with the repeal of the State regulations in 1995. Where possible, the Commonwealth and state teams worked together to monitor any concerns about the standards of care in residential facilities.

10 Appendices

10.1 Members of the Ministerial Advisory Committee

Ms Colleen Pearce (Chair)	Uniting Care Victoria
Ms Mavis Smith	Victorian Health care Association
Ms Edith Morgan	Older Person's Action Centre
Ms Margaret O'Callaghan	Older Person's Action Centre
Ms Maria Bohan	Carer's Association
Mr Brian Fitzpatrick	ANHECA—Vic
Mr John Brooks	ANHECA—Vic
Ms Marion Lau	Ethnic Communities Council
Ms Mary Barry	VAHEC
Ms Pauline Feegan/Kairsty Wilson	HSUA
Ms Hannah Sellers/Jill Clutterbuck	ANF
Ms Robyn Fuller	Broughton Nursing Home
Ms Patricia Reeve	Council on the Ageing
Fr Joe Caddy	Catholic Social Services
Ms Mary Lyttle	Residential Care Rights
Ms Margaret Gaskin	ACAS
Ms Beth Wilson	Health Services Commissioner
Dr Gerald Segal	AMA
Ms Elizabeth Butterfield	Carnsworth Nursing Home
The Hon Jenny Lindell	MP Member for Carrum
Ms Lynette Moore	Alzheimer's Association of Victoria
Mr Russell Williams	Department of Health and Aged Care

Ms Sandra McCullough was appointed as a consultant to the Ministerial Advisory Committee.