Issues Paper

Aged Care Quality and Safety Royal Commission Response – July 2019

Background

Gippsland PHN's vision is for a measurably healthier Gippsland. Our objectives include;

- Increased efficiency and effectiveness of medical services and other primary health services
- Improved coordination of care to ensure patients receive the right care, in the right place, at the right time
- Improved health outcomes for people with chronic disease and those patients at risk of poor health outcomes

Gippsland PHN relies on strong evidence and data together with crucial input from primary health professionals and the community to make decisions. We listen to, and work with, communities to make sure funded services meet their expectations.

Issue description

This issues paper documents Gippsland PHN's response to the Aged Care Royal Commission. It should be read as an attachment to the Gippsland PHN online submission form (DOC/19/10124).

Relevant data

Quantitative

An overview of available data for Gippsland related to aged care is provided in Table 1. The Gippsland PHN needs assessment[1] identified other relevant data that helps build the bigger picture of aged care in Gippsland:

- The population over 65 years is increasing faster than any other age group in Gippsland.[2]
- Life expectancy among males in Gippsland is low (78.4 years) compared to Australia (80.4), while female life expectancy is 83.0 compared to 84.6 in Australia.[3] Life expectancy in Latrobe is even lower for both males (76.9 compared to 80.3 in Victoria) and females (82.2 compared to 84.4 in Victoria).
- The top ambulatory care sensitive conditions among people aged 60 years or older were diabetes complications (29%), chronic obstructive pulmonary disease (12%), inflammation of the kidney (12%), congestive heart failure (11%) and hypertension (10%).[4]
- Gippsland has 77.1 residential aged care places per 1,000 people 70 years or older, compared to 80.1 for Victoria as a whole.[5]

[1] Gippsland PHN current needs assessment; https://www.gphn.org.au/populationhealthplanning/assessment/
[2] Victoria in Future 2016; https://www.planning.vic.gov.au/land-use-and-population-research/victoria-in-future-2016
[3] AIHW, My Healthy Communities; www.myhealthycommunities.gov.au/
[4] DHHS, Victorian Admitted Episodes Dataset (VAED), analysed using POLAR Explorer
[5] AIHW, GEN Aged Care Data; https://www.gen-agedcaredata.gov.au

Table 1. Selected aged care indicators across Gippsland.[6]

Indicator	Bass Coast	South Gippsland	Baw Baw	Latrobe	East Gippsland	Wellington	Victoria	Australia	Data source	Currency
Age pension recipients % of people 65 or over	69.8%	63.2%	66.5%	73.2%	70.0%	67.9%	63.2%	63.6%	Social Health Atlas of Australia	2017
Aged care residential places	474	288	532	941	536	517			GEN Aged Care data	2018
Anticholinesterase medicines, aged 65 years and over, age-standardised rate per 100,000 people	7,323		9,077	5,933	9,079	12,154	14,027	12,650	Australian Atlas of Healthcare Variation	2013-14
Antidepressant medicines, 65 years and over, age-standardised rate per 100,000 people	190,656		207,660	214,050	195,907	201,773	194,225	196,574	Australian Atlas of Healthcare Variation	2013-14
Antipsychotic medicines, aged 65 years and over, age-standardised rate per 100,000 people	19,039		24,105	22,068	23,547	23,271	29,797	25,788	Australian Atlas of Healthcare Variation	2016-17
Anxiolytic medicines, 65 years and over, age-standardised rate per 100,000 people	32,489		37,553	38,928	27,500	36,006	42,664	37,695	Australian Atlas of Healthcare Variation	2013-14
HACC clients aged 65+ per 1,000 target population	1,245	1,240	973	837	1,295	947	738		Victorian Local Government Profiles	2014-15
Number of GP attendances in aged-care homes, per person								16.6	My Healthy Communities	2016-17
Population 65-74 years	16.1%	14.1%	11.8%	10.4%	16.7%	11.9%	8.6%		Census of Population and Housing	2016
Population 75+ years	11.6%	9.6%	8.4%	8.1%	11.6%	8.4%	7.0%		Census of Population and Housing	2016

High compared to Australia, top 25% of PHNs/SA3s/LGAs

Low compared to Australia, bottom 25% of PHNs/SA3s/LGAs

* Data for Gippsland South West SA3 (includes Bass Coast and South Gippsland LGAs)

[6] See Gippsland PHN web site for more detail; https://www.gphn.org.au/populationhealthplanning/resources-2/

Qualitative

Gippsland PHN commissioned Health Issues Centre (HIC) in 2018 to conduct intercept conversations© using a combination of digital tools and in-person interviews to gather sentiments about the barriers to health and social care service access by people aged over 65 years. The consultations explored the views of residents in the Gippsland region, comprising the six Local Government Areas: Bass Coast, Baw Baw, South Gippsland, Wellington, Latrobe, and East Gippsland.

Key findings[7] included:

- **Loss of capacity and incremental decline** - The loss of both physical and cognitive capacity was a major concern for people aged over 65. Many people indicated the impact their declining health and capacity had on their personal identity and emotional wellbeing.
- **Identity** - A number of people indicated a struggle to maintain their own identity as they age. This was commonly linked to the realisation of their diminishing physical and mental capacity. Negative interactions with health services and other environments exacerbated rather than addressed this problem.
- **Empathy and validation** - Many respondents were scathing in reporting personal experiences where they believed they had been patronised or treated as unreliable witnesses to their own lived experience. Health and social service providers' inability to demonstrate empathy and validation was a key barrier to health and social care.
- **Communication of clinical information** - A number of consumers including those diagnosed with dementia as well as those with high cognitive function, were concerned about doctors not taking the time to explain their diagnoses, reasons for treatments and treatment instructions.
- **Gender** - In some instances, the 'traditional' role older women undertake as the nominated carer of family members, and 'housewife' responsible for upkeep of the home, extends to their responsibility to access home care and health services for themselves and on behalf of their husbands.
- **Access logistics** - A number of logistical barriers were frequently identified as major inhibitors to accessing health and social care services in rural areas. These barriers included: long waiting times for GP and other clinical appointments; cost of services and travel; distance and transport to and from services; reduced access to technology including phones and internet; and dependence on temporary accommodation nearby to services.
- **Carer support** - Responses from adult children of ageing parents highlighted the burden of responsibility on families to provide care for people in advanced stages of health decline and dependency.
- **Spiral of Decline & Withdrawal** – HIC identifies six stages of declining capacity and low self-esteem, reinforced by interactions with health services that fail to empathise and validate experiences of ageing, leading to health crisis and further loss of capacity. The Spiral indicates critical intervention points for health and social service providers.

[7] Health Issues Centre (2018). Consumer Perspectives: Ageing Residents' Access to Health Services in Gippsland. https://www.gphn.org.au/wp-content/uploads/2019/03/Health-Issues-Centre-Consumer-Perspectives-Ageing-Residents%E2%80%99-Access-to-Health-FINAL.pdf

Advisory groups input

The below input from members of the Gippsland PHN Advisory Groups (Clinical Councils and Community Advisory Committee) is gratefully acknowledged.

- Transition into residential aged care for a widowed or single person over 65 years often results in reduced social interaction, particularly where family or friends do not live geographically nearby. Family and friends rely on aged care facilities, and the staff within them, to help maintain the connection, but this requires sustained effort from staff. For example, if the resident has hearing difficulties, this can exacerbate already declining social contact as they may not hear phone calls and may stay in their room. Allowing and enabling social isolation without active interventions can be viewed as a form of neglect and can certainly hasten deterioration of the resident's health and wellbeing.

- Physical condition can deteriorate rapidly with loss of weight and muscle due to limited exercise and possibly poor nutrition. Exercise and recreational opportunities are limited due to lack of appropriate trained staff to organise and deliver, and/or no appropriate spaces within the residences. Group or facility activities are often linked with morning and afternoon tea and are low impact craft, music or social (e.g., bingo) rather than activities focused on physical movement.

- Aged care facility staff often do not have adequate cultural and aged care training. Hearing and vision loss are common in older people, however lack of regular screening and checking of hearing and vision can lead to staff misunderstanding about residents' behaviour and potentially misdiagnosis. There is a need to improve cultural awareness and respect for the older person, and training and retraining needs to occur for all staff to ensure that this is not undermined by the “busyness” of facilities and their staff. There also needs to be appropriate training and support around end of life, for all staff and volunteers. Such incidents need to be recognised and training, support and counselling mandatorily offered to staff known or suspected to be experiencing such.

- Aged care staff should be aware of multiple psychosocial factors that may be impacting an older person's health, such as addiction (gambling, alcohol, drugs). The care team that supports an older person must work together and be inclusive of the older person and their family/carers to achieve goals. For example, if a psychosocial issue is identified by the general practitioner and a referral made to an allied health professional, follow up monitoring and review must be undertaken. A biopsychosocial model of health should always be applied within aged care to ensure appropriate diagnosis and treatment.

- People aged under 65 years who are living in aged care residential facilities are not receiving the appropriate assistance. Aged care providers need to have a much better knowledge of the National Disability Insurance Scheme (NDIS) access pathways, and where NDIS can help. For those people living in nursing homes who are aged under 65 years, this can be wide ranging and include things such as support workers to take residents out for social events, to continence aids, better wheelchairs, alternative accommodation, assistive technologies to improve communication and access to media.

- There is apparent disparity between the access to, and level of, appropriate care packages for people living with disabilities in residential aged care facilities depending on their age. Some experiences have suggested that the My Aged Care system is a “poor cousin” of the NDIS and people aged over 65 years living in residential aged care are not accessing an equitable range of assessments, access to support workers, resources and programs to those of NDIS recipients.

- Night staff, public holiday and weekend staff of residential aged care facilities are often not adequate to provide coverage if there is a crisis and may lack an appropriately trained supervisor. For some reason, possibly financial based, or due to residents being asleep (supposedly) or inactive at nights and to visits to and from family and friends on weekends, there appears to be the idea that people do not need the same level of care at these times.

- Volunteers are too often used to fill gaps in the Aged Care system and they may not have the training and experience required to address issues which arise for the resident and may not be able to communicate with those in management in an informed, experienced and appropriate way to act as good advocates. Training is not offered to volunteers at an appropriate level to address such issues.

- Access to professional health services are best delivered in the residence, such as: medical, dental, audiology, vision, physiotherapy, chiropractor, massage, social work, psychology and mental health. These services often need to be accessed outside of the facility and there is never enough staff to enable this to occur. Friends and family are also not always able to manage such support due to their own health, fitness, work and other activities/responsibilities.

- Inappropriate staffing numbers can lead to families, friends, volunteers or other residents providing simple help to residents, such as eating, accessing bathroom, connecting or re-connecting telephones and electrical items. In worse case situations, the resident will go without this assistance.

- Aged care staff must be kept informed and updated regarding residents' rights and be encouraged and supported to advocate for the resident. Poor treatment is not acceptable under any circumstance.

- Attracting quality aged care staff requires a quality career path to attract the best candidates to this area. Improved career pathing and subsequent aged care staff numbers are likely to lead to an improved workplace experience.

Gippsland PHN priorities, investments and activities

Gippsland PHN has identified people aged over 65 years as a priority population.[6] Training and information for health professionals to best support their patients who are aged 65 years and over is an ongoing commitment.[8]

There is strong investment by Gippsland PHN across the region to provide accessible services. These include: mental health, primary health, after-hours care, and indigenous health.

An example of a specific response to improving mental health services for older people is being piloted by Foster Medical Centre. They are developing a model of care to support and manage residents in aged care settings to increase access to psychiatry services and improve their mental health outcomes and experiences. The objectives for the pilot are to:

- Target residents with a diagnosed mental illness or who are assessed as at risk of mental illness if they do not receive services.
- Create a therapeutic community inclusive of psychosocial adaptive interventions to maintain mental wellness during pre-admission and early post-admission into Prom Country Aged Care.

[6] See Gippsland PHN web site for more detail; https://www.gphn.org.au/populationhealthplanning/resources-2/
[8] Gippsland PHN Aged Care; https://www.gphn.org.au/programs/aged-care/

- Identify components for system level change within residential aged care facilities supportive of a positive transition experience.

Analysis and recommendations

This paper represents Gippsland PHN's response to the Aged Care Royal Commission. The Gippsland region has a high proportion of people aged over 65 years, with growing numbers projected. However, services are not necessarily keeping time with the increasing needs of an ageing population. Contributions from members of Gippsland PHN advisory groups, along with an overview of quantitative and qualitative data, has led to the following recommendations for consideration:

- A coordinated care team approach should be adopted at the outset for people identified with complex and/or co-morbid physical/mental/social issues. The patient and their family/carers must be involved at all stages, and all parties consent to terms of the care model.
- There must be mandatory cultural training for all aged care facility staff, including administration and amenities staff, and visiting health professionals.
- Differential diagnosis must be considered consistently for aged care residents.
- Residents be supported and encouraged to participate in tailored exercise sessions, focusing on sustaining or improving mobility.
- Aged care facility staff habitually check and increase the volume on residents' phones. It is a simple measure that could help residents stay connected with family and friends.
- Aged care facility residents are supported by staff to access supervised Skype sessions to enable geographically distant family (and friends) to have "face time". This could be a shared facility, in a media room for example, or just a laptop brought to their room.
- Communication between aged care facility staff and families of residents can be improved. There should be a communication plan developed upon entry to the facility, with agreed roles and responsibilities by staff and family members. Regular updates by staff should include mental health issues as well as physical/medical updates.
- Residents are given access to daily newspapers to help keep informed about current affairs.
- Staffing ratios need to be addressed per high needs, moderate needs and low needs, they need to be adequate, manageable and have a view to quick response times and health and safety for both staff and residents.
- Residential aged care facilities need to demonstrate activities to support any residents aged under 65 years' relating to NDIS.
- There should be fairness and equity across the NDIS and My Aged Care programs for residents of aged care facilities living with disabilities.
- More frequent quality and safety checks of residential aged care facilities by Department of Human Services (DHS) and a culture of higher expectations within DHS. Increased surveillance would need to be balanced against potential increased bureaucratic burden.
- An aged care workforce development strategy needs to be developed which includes recruitment, training and retention.
- A greater focus on mental health as a component of a full biopsychosocial approach to assessment, treatment and monitoring.
- Increased access to specialist and allied health care within the residence, and utilisation of telehealth models to support face to face care.