

A Daniel's Shield Initiative

**A Focus Point Planned
for
National Nursing Home Initiative Week
- 15th to 21 August -**

Our Purpose

To initiate and promote the development of Residential aged care that is
Community Based
Community Assessed
Community Monitored
Providing

A safe, home like and family-friendly environment created and maintained by the residents, extended families, friends and local community and funded by and in collaboration with the Australian Federal Government

This document is a draft only of

A Suggested Framework

for a Community Based

Monitoring and Assessment System

for Residential Aged Care in Australia

**You Can Contribute to Effective Change in Australian Aged Care
By**

- Reading this document carefully
- Discussing it with others – set up discussion/work groups
- Passing it on or emailing it to as many people as possible

provide your feedback and all opinions and suggestions to

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Or email us at daniels.shield@gmail.com

by November 30th 2009

You can download this document from our website at www.danielsshield.org

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Key to Abbreviations

CRCC	Community Residential Care Committee
AD's	Appointed Delegates
DOHA	Department of Health and Ageing
ACSAA	Aged Care Standards and Accreditation Agency
CEC	Community Executive Committee
ACSAA	Aged Care Standards and Accreditation Agency

Stakeholder

Every voting Australian citizen is a *stakeholder* in this vital area of the Australian community.

This definition of *stakeholder* applies in all usage of this word throughout this document.

No corporate or government body can dictate what is to happen as it is the responsibility of the Minister who must ultimately answer to the public on all matters pertaining to the provision of aged care in Australia.

Federal Government

The primary and determining legislative authority in aged care provision in Australia to remain the relevant departments within the elected Federal Government

The Role of the Federal Government will be to

Provide	a legislated framework to develop and facilitate the implementation and management of a community based monitoring and assessment model for Residential Care Facilities in Australia.
Work	in cooperation with independent community based residential care facility monitoring and assessment committees (CRCC'S – Community Residential Care Committees)
Take	ultimate responsibility for all aspects of care provision within residential care facilities including provision of adequate levels of funding to maintain quality care and the provision of a high standard of relevant staff training

The Federal Government - Department of Health and Ageing (DOHA) would be responsible for

1. Establishing geographically defined residential aged care service areas across Australia.
(Defined areas currently already exist in the public domain via the DOHA website.)
2. Researching the above areas to determine which community groups and community leaders are active in each. Liaising with local councils and members of the established community groups to facilitate the appointment of a **Community Residential Care Committee (CRCC)** See pg. 4)
 - Delegating legislated authority to the **CRCC's** to source and appoint appropriate local community members as paid **Appointed Delegates (AD's)** to undertake monitoring, assessment, advocacy, mediation and complaints resolution roles in the residential care facilities within their designated geographical areas.
3. Developing appropriate reporting and administrative processes for the **CRCC's** and AD's to perform all required functions within the legislated framework.
4. Development of both a *selection criteria* for **AD's** and initial and ongoing training programmes relevant to the needs of the **AD's** in cooperation with the **CRCC's**.
5. Adequate funding to all levels of aged care provision, including management, supervision, monitoring, assessment and continuous improvement programmes. (There will be expenses incurred by the **CRCC** and payment of these need to be levied as a joint responsibility of all stakeholders, including the Government and local Councils to ensure ethical money management)
6. Continuing standard three yearly Accreditation visits to provide Federal approval for funding purposes.
7. Legislating that liaising with the **CRCC** and **AD's** and utilization of their documented records be mandatory in the *Accreditation* and/or *Complaints Investigation Scheme* processes
8. Providing to the public all outcomes of all accreditation and complaints' processes in a prompt/timely, transparent and easily accessed format .

Community Residential Care Committees (CRCC's)

The role of The Community Residential Care Committees (CRCC's) will be to

Ensure	the local community, including those residing in aged care facilities, has a viable voice and is empowered to effectively influence and control the environment and <i>quality of care</i> within the aged care facilities in their geographical area.
Source	and appoint appropriate community based, remunerated, personnel – Appointed Delegates (AD's See p. 5) .
Manage	and supervise AD's work performance and function for AD's
Provide	all necessary support to AD's including initial and ongoing training and administration and be the required first point of contact in communication lines between AD's and the DOHA

Appointment Process of Community Residential Care Committees (CRCC's)

DOHA to liaise with local councils and source active local community groups and/or community leaders.

For example: Local Councils, Lions, Rotary, Apex, Quota, CWA, religious groups etc

DOHA to enlist the assistance and cooperation of these councils and groups/leaders to select a **committee** of appropriate, local community members from their ranks **and/or** from independent, local community members – **Community Residential Care Committee (CRCC's)** .

- The **CRCC** would have a legislated minimum membership number, a minimum quorum and a minimum number of required meetings per year.
- These committee positions would be voluntary with legislated policies governing tenure of position and authority capacity within the committee structure. Any person who has a vested interest in the local residential aged care industry would be ineligible. Eg Freemasons, church officials etc, business suppliers to the industry etc

The Community Residential Care Committees (CRCC's) would be responsible for

1. Resourcing **from the local community** suitable nominees that fulfill all *selection criteria* (as set by the DOHA in cooperation with the **CRCC's**) to be appointed as **paid Appointed Delegates (AD's)** to undertake assessment, monitoring, advocacy and dispute resolution etc roles within the local residential care facilities. All nursing home documentation will be available to the appointed **AD's**. Legislated privacy restrictions would need to be amended to facilitate this access. (Number of **AD's** to be determined from the size of designated geographical area and the number of facilities in the area.)
2. Ensuring **AD's** receive initial and ongoing necessary and appropriate training
3. Ensure provision of all necessary support required by the **AD's** to perform their job requirements
4. Acting as the **intermediary** between the **AD's** and the **DOHA** in relation to all areas of **AD's** functions, including performance appraisals, role development, remuneration and expenses.
5. Collaborative development with **DOHA** of performance appraisal tools and continuous role improvement action plans for **AD's**.
6. Monitoring and assessment of performance appraisal tools and continuous role improvement action plans for the **AD's** and reporting findings back to **DOHA** .
7. Mediate between facility management and/or residents and stakeholders and the **AD's** in the event of complaints or concerns about the performance and/or actions of the **AD's**.
8. Mediate in facility complaints issues that have remained unresolved following mediation undertaken by the **AD's**.
9. Refer complaints that remain unresolved following mediation by both **AD's** and the **CRCC** to the **DOHA** Government *Complaints Investigation Scheme* or other appropriate entity for resolution.
10. Follow up all complaints issues until a satisfactory resolution is reached as per an effective quality assurance measuring tool

Community Appointed Delegates (AD's)

Role of the Appointed Delegates (AD's) will be to

Maintain	a close affiliation with the local community and the residents of the care facilities and continually research to understand their <i>coal face</i> issues,
Ensure	ensure that all stakeholders in the residential care facilities in their locally designated area are empowered to contribute equally to the creation and maintenance of a care environment that is safe, homelike, family friendly and open to the community
Monitor and Assess	the quality of care being provided within each facility and ensure that all statutory Standards are upheld
Mediate	between stakeholders where concerns or complaints exist to a point of mutual resolution.
Report	outcomes of all monitoring and assessment and complaints' processes to the relevant statutory authorities and the CRCC's

The Appointed Delegates (AD's) would be required to

1. Meet all requirements of the *selection criteria*
2. Undertake initial and ongoing training to enable them to fulfill the responsibilities of their role
3. Undertake regular weekly/fortnightly visits to the residential care facilities within their designated district and become familiar with all operational aspects of each facility and develop effective communication lines with all residents and other stakeholders.
4. Consult with all stakeholders and generate cross-sectional communication within the entire structure of the home. (horizontal as well as vertical communication lines to be created.)
5. Undertake the varied functions of the *Aged Care Accreditation and Standards Agency* and the *Complaints' Investigation Scheme* investigators. Effectively, by using current **DOHA** and **ACSAA** measuring and assessment tools and by having frequent site contact, **AD's** will assess, monitor, advocate, and mediate on behalf of all stakeholders.
6. Submit monthly audits and reports resulting from all monitoring, assessment and complaints' processes undertaken to the relevant government entities (ACSAA, CIS, Quality and Compliance etc).
7. Follow up on all report and audit recommendations and take necessary further action where necessary
8. Facilitate a general meeting of all stakeholders to select a **Residential Care Facility Committee (RCFC)** (See Page 6)
9. Chair monthly **Residential Care Facility Committee (RCFC)** meetings.
10. Meet with facility Provider/Managers to present Minutes of the **RCFC** meetings and
 - a. Table *Required Action Forms* created at the **RCFC** meeting and time frames for completion
 - b. Present *Stakeholder* concerns or complaints from the **RCFC** meeting and facilitate resolution plans including any necessary advocacy and mediation required between management and complainants
11. Follow up on all *Required Action Forms* to completion and in cases of non compliance further the complaint through the relevant government/statutory entity and the **CRCC**. *This follow up to continue until compliance is achieved.*
12. Disseminate Minutes of **RCFC** meeting to all registered stakeholders.

Residential Care Facility Committee

This **Residential Care Facility Committee (RCFC)** will meet monthly and have a legislated structure, membership, function and authority. It will replace the currently mandatory residents' meeting that has no specified format, function or power.

No staff or management personnel will attend.

Members will be elected at a **General Residents' Meeting** of all stakeholders, will come from the following groups and will be limited in number:

- Govt/Local community appointed delegates (**AD's**)
- Residents with required competency levels – eg not with severely limited communication abilities. These representatives should be nominated by other residents friends and **AD's** at a **General Residents' Meeting** and **not by management**
- Families and friends of residents
- Guardianship or Public Trustee representatives where applicable * See page 7

(Workable numbers of each representative group above needs to be determined.)

Role of the Residential Care Facility Committee (RCFC)

To provide a safe forum where all facility stakeholder issues can be discussed and addressed fully, authoritatively, efficiently and with transparency.

The Residential Care Facility Committee (RCFC) will be required to

1. Meet monthly with an **AD** as chairperson
2. Follow all requirements of a legislated meeting process
3. Discuss all aspects of care provision within the home.
4. Minute the meeting.
5. Create **Required Action Forms** to present to Management to remedy any areas of concern
6. Contribute suggestions for Continuous Improvement within the facility
7. Initiate and provide positive incentives to reward all commendable aspects of care provision by any stakeholder
8. Organise annual **General Residents' Meeting** to nominate and elect the **RCFC**.
9. Organise extraordinary **General Residents' Meetings** if required.

Other Important Relevant Issues for consideration and public discussion:

Volunteering in Residential Care Facilities:

Residential Care facilities are “homes” by legal definition. Community access and volunteering is an essential component of quality aged care.

Growing and concerning limitations and prerequisite demands are being placed on volunteers to the aged care industry.

These have resulted from a number of complex issues including but not exclusively:

- a. Fear of litigation
- b. Work place health and safety requirements
- c. Perceived interference by volunteers in internal facility matters by staff and management
- d. Bullying tactics where volunteers are perceived as a “threat” to the status quo

The reduction of excessive restrictive legislation and internal management policies in facilities will need to be addressed for the successful introduction of community based care.

Quality training and recruitment

Issues of concern raised with *Daniel’s Shield* by management, staff, public, families and friends of care recipients are many. They *include* but are not exclusively:

- a. Inadequate training provision and requirements for Personal Carers and Assistant Nurses.
- b. Inadequate monitoring and assessment of students on placement
- c. Inadequate follow up of outcomes of aged care education provision and subsequent excessively high turn- over of staff in the industry
- d. Inappropriate personnel being trained for the industry. It is a vocational industry. It requires compassionate, caring staff with a genuine empathy for the frail and infirm in care.

Management, staff, residents, families and friends of residents – all have complained of the general decline in standard of personnel being placed into the industry.

It is common to hear Director’s of Nursing complaining of Centrelink unemployed people presenting at their doors and stating that they have been told that the only place they will get work is in a nursing home!! This is not an infrequent occurrence.

The employment of a rapidly growing number of staff that cannot speak English has been reported. The obvious concerns here are not racist but related to the communication barriers between non English speaking staff and frail elderly with hearing, sight and cognitive impairment.

Guardianship Issues

A growing and major concern about the varied state guardianship entities is being registered with advocacy and community groups around Australia.

The criticism is that their interventions are often unwarranted and intrusive and fuelled by family conflicts. Family dysfunction in today’s society is increasing and this in turn is creating increased opportunity for the involvement of the statutory guardianship entities.

Staff and families report that residents under guardianship orders are not visited nor their care monitored or assessed by anyone from the varied state guardianship offices. This gives the facility management unfettered power over the residents without any accountability. The guardianship and the facilities often override the concerns and reasonable requests of family members and significant others in the residents’ lives.

Guardianship from a distance does not work. This is not acceptable. The responsibility for the care of these people must be not only allocated to the guardianship entities but taken actively by them with set protocols for regular visitation and ongoing assessment of the needs of the client and the quality of care being provided.