OLD COLONISTS'
ASSOCIATION OF VICTORIA

February 8 2019

The Commissioners
Royal Commission into Aged Care Quality and Safety
ACRCProviderResponses@royalcommission.gov.au

Dear Commissioners

I am pleased to submit our contribution to the Royal Commission into Aged Care Quality and Safety.

The Old Colonists' Association of Victoria is a leading not-for-profit retirement village provider offering a continuum of care from independent living, assisted living and aged care in Victoria. Our four villages in Berwick, Euroa, North Fitzroy and St Helena are home to 500 older Victorians in need. OCAV is a dementia-friendly and age-friendly organisation.

Our aged care facility, Liscombe House provides accommodation and specialised care for our residents who are no longer able to live in an independent or assisted living environment. Our care approach at Liscombe House allows residents to move seamlessly from low to high care should their needs change to require more specialised care.

The 81-room residential aged care facility includes: 38 bedsits with their own ensuite facilities, one respite room, 12-bed dementia specific facility, and 30-bed high level care facility providing quality care for residents who have been assessed as needing high level care. The dementia-specific facility is staffed by carers who are trained in dementia care. Palliative care is provided on-site for residents, providing a familiar and comfortable environment for the resident and their family members.

As you will read, we are a small, flexible organisation with a proud heritage and a vision to build on our innovative person-centric approach to aged care.

Yours sincerely

Phillip Wohlers
Chief Executive Officer

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OLD COLONISTS'
ASSOCIATION OF VICTORIA

Submission to the Royal Commission into Aged Care Quality and Safety

PHILLIP WOHLERS
FEBRUARY 2019

GENERAL INFORMATION

Name of approved provider:
Old Colonist's Association of Victoria

Name of service or outlet:
Liscombe House; RAC 3257

Address of service:
339, St Helena Road,
St Helena, VIC 3088.

Contact officer:
Phillip Wohlers
03 94819300
phillipw@ocav.com.au

Ownership:
Old Colonist's Association of Victoria

Type of service provider:
Not for profit organisation

Type of service provided:
Residential care

Number of people receiving services as at 30 June 2018:
81

Number of full time equivalent direct staff as at 30 June 2018:
90

Specifically at Liscombe House:
65

Director of Nursing:
1

Clinical Care Coordinator:
2

ACFI Coordinator:
1

Registered nurse:
9

Enrolled nurse:
12

Personal care worker:
29

Allied health professional:
2 (Physiotherapist & Occupational therapist)

Diversional therapist:
3

Dietician:
1

Podiatrist:
1

Speech pathologist:
1

OH&S consultant:
1

Infection Control consultant:
1

ABOUT THE
OLD COLONISTS' ASSOCIATION OF VICTORIA (OCAV)

The Old Colonists' Association of Victoria is a leading not-for-profit retirement village provider offering a continuum of care from independent living, assisted living and aged care in Victoria. Our four villages in Berwick, Euroa, North Fitzroy and St Helena are home to 500 older Victorians in need. OCAV is a dementia-friendly and age-friendly organisation.

OCAV was established almost 150 years ago by a group of prominent Melburnians to ensure that older Victorians in need had somewhere secure and affordable to live, support when and if they needed it, and a community in which they felt engaged. Our mission remains unchanged. The need is greater than ever with an increase in single homeless women, a lack of affordable rental housing, limited public housing.

As a leading retirement village and aged care provider in Victoria, we work to provide affordable and safe housing for elderly Victorians in need, whether they live independently, or in supported or aged care living. Many of our residents have lived within OCAV villages for ten years and longer, maintaining relationships with friends and families.

We have a robust governance structure which includes a Care Committee. Members include: Judy Sharp (social worker) (Chair), Carl Wood (former health care leader), Prof Joe Ibrahim (gerontologist), Kathy Kirby and staff Phillip Wohlers (CEO), Shaaron Robilliard (Director of Nursing and Quality Manager), Karen Ernest and Roz Johnson.

OCAV is registered with the Australian Charities and Not-for-profit Commission.

ABOUT LISCOMBE HOUSE, OUR AGED CARE FACILITY

Liscombe House provides accommodation and specialised care for our residents who are no longer able to live in an independent or assisted living environment. Our care approach at Liscombe House allows residents to move seamlessly from low to high care should their needs change to require more specialised care.

The 81-room residential aged care facility includes: 38 bedsits with their own ensuite facilities, one respite room, 12-bed dementia specific facility, and 30-bed high level care facility providing quality care for residents who have been assessed as needing high level care. The dementia-specific facility is staffed by carers who are trained in dementia care. Palliative care is provided on-site for residents, providing a familiar and comfortable environment for the resident and their family members.

Through their close relationship with residents (because of our continuum of care approach), OCAV staff support residents to prepare for and transition into higher levels of care.

Liscombe House is fully accredited.

OUR OPERATING MODEL

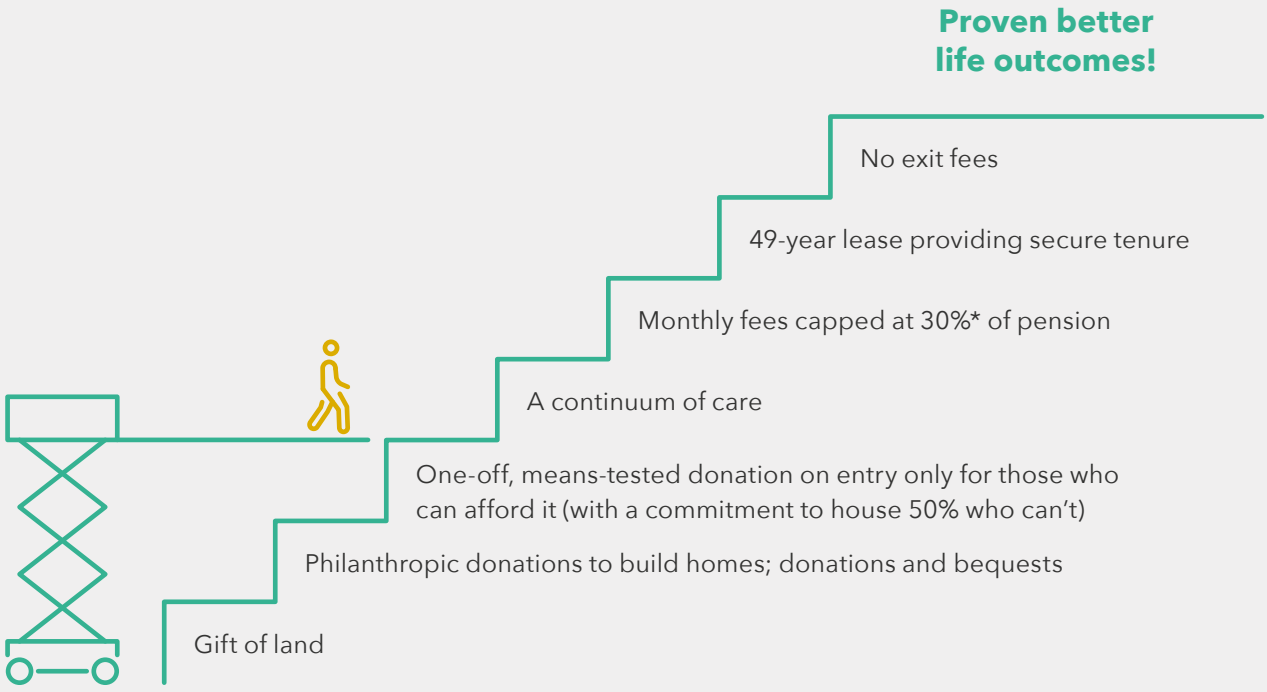
What sets OCAV apart from other retirement village and aged care communities is its unique and successful operating model which comprises philanthropic support, a one-off means-tested donation on entry from residents who can afford it, and the affordable monthly fees which is capped at 25 per cent of the pension. There are no exit fees. Every resident has a 49-year-lease providing secure tenure.

Embedded in the model is the commitment to provide at least 50% of housing to residents who cannot afford to contribute the one-off, means-tested donation on entry; treating all residents equally regardless of ability to pay the donation; and the commitment to the quality of life and dignity of the residents.

Even though the Federal Government residential care subsidy is received for each resident at Liscombe House, its aged care facility, OCAV receives no government funding for residents in independent and assisted living.

THE OCAV OPERATING MODEL

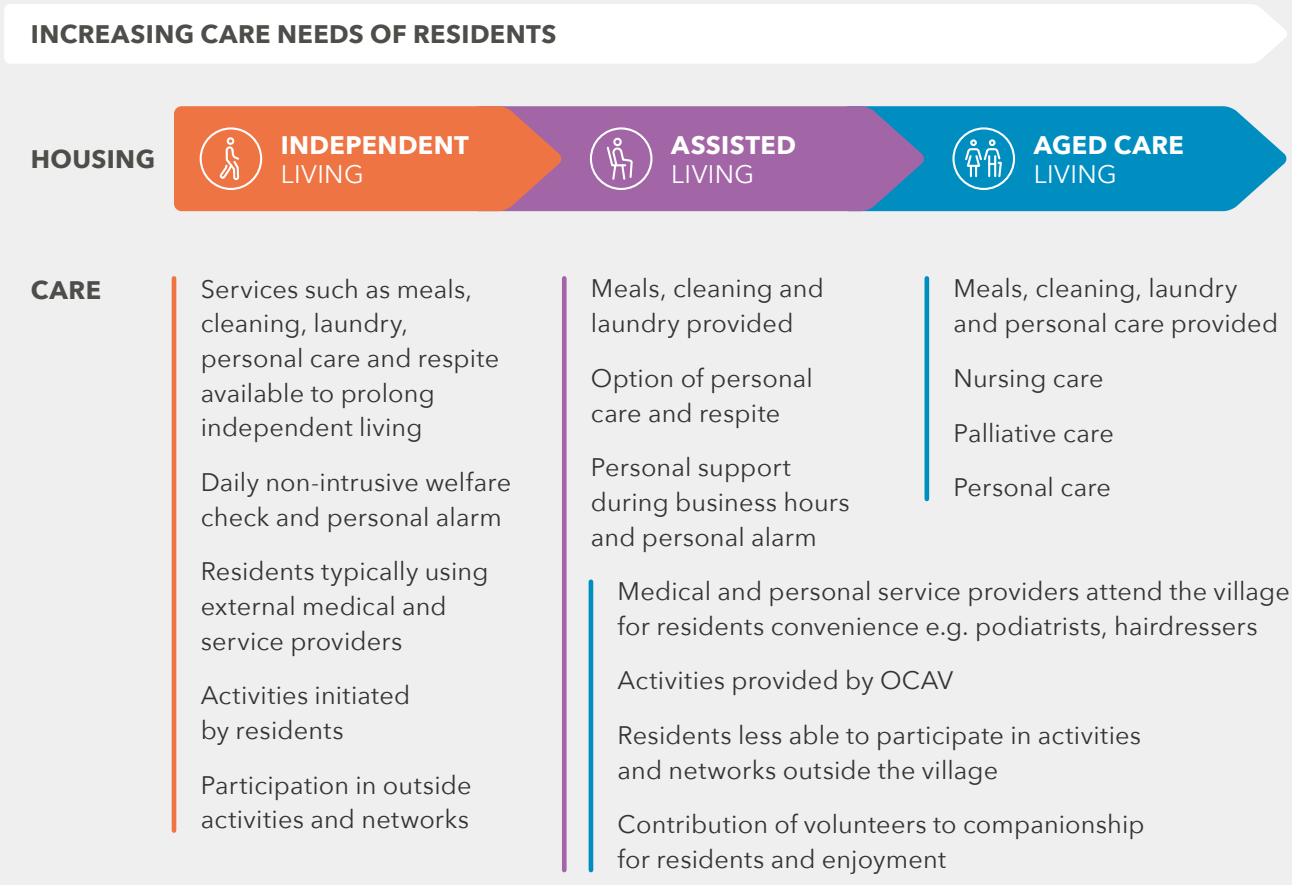
The operating model of the Old Colonists' Association of Victoria gives older people in need a lift on their way to better life outcomes.



OUR CONTINUUM OF CARE AND ITS BENEFICIAL IMPACT ON AGED CARE RESIDENTS

Through the model, all residents are able to access all levels of care as part of OCAV's continuum of care. This allows anyone coming into an independent living home to move into assisted living, if they need it, and then into Liscombe House, its aged care home, without extra cost.

These arrangements provide a great deal of peace of mind for residents and their family members, particularly given the complexity of ownership structures and fees of other retirement villages and some instances of unfair practices.



QUESTION 1

Since 1 July 2013, have there been any occasions when your service or outlet has provided substandard care, including mistreatment and all forms of abuse?

Yes

(b) If so, in relation to each such occasion:

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1. Compulsory reporting of Assault

- When did it happen?
  - 16/04/2014
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident.
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

2. Compulsory reporting of Assault

- When did it happen?
  - 09/04/15
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

3. Compulsory reporting of Assault

- When did it happen?
  - 21/04/2015
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department. OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

4. Compulsory reporting of Assault

- When did it happen?
  - 22/05/2015
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

5. Compulsory reporting of Assault

- When did it happen?
  - 27/1/2016
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

6. Compulsory reporting of Assault

- When did it happen?
  - 03/06/2016
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

7. Compulsory reporting of Assault

- When did it happen?
  - 08/08/2016
- What (in general terms) was the nature of the occasion of substandard care? :
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

8. Compulsory reporting of Assault

- When did it happen?
  - 29/11/2016
- What (in general terms) was the nature of the occasion of substandard care? :
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

9. Compulsory reporting of Assault

- When did it happen?
  - 1/12/2016
- What (in general terms) was the nature of the occasion of substandard care? :
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

10. Compulsory reporting of Assault

- When did it happen?
  - 04/01/2017
- What (in general terms) was the nature of the occasion of substandard care? :
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

11. Compulsory reporting of Assault

- When did it happen?
  - 16/10/2017
- What (in general terms) was the nature of the occasion of substandard care? :
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified
- Was the substandard care the result of a systemic failure?
  - No

12. Compulsory reporting of Assault

- When did it happen?
  - 14/11/2017
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified
- Was the substandard care the result of a systemic failure?
  - No

13. Compulsory reporting of Assault

- When did it happen?
  - 17/11/2017
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified
- Was the substandard care the result of a systemic failure?
  - No

14. Compulsory reporting of Assault

- When did it happen?
  - 30/12/2017
- What (in general terms) was the nature of the occasion of substandard care? :
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified
- Was the substandard care the result of a systemic failure?
  - No

15. Compulsory reporting of Assault

- When did it happen?
  - 11/01/2018
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
  - However, there is a now a new referral to DBMAS, and ongoing geriatrician involvement.
- Was the substandard care the result of a systemic failure?
  - No

16. Compulsory reporting of Assault

- When did it happen?
  - 21/03/2018
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department.
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified. All recommended behaviour interventions were in place. Behaviour management interventions were reviewed.
- Was the substandard care the result of a systemic failure?
  - No

17. Compulsory reporting of Assault

- When did it happen?
  - 30/05/2018
- What (in general terms) was the nature of the occasion of substandard care?
  - Resident hit another resident
- What action did your service or outlet take in response?
  - Both residents had diagnosis of dementia, not reportable to the department
  - OCAV followed its assault protocol, the resident was checked for injury, an incident form was completed, reviewed by the MO and the family was notified.
- Was the substandard care the result of a systemic failure?
  - No

18. Medication (Insulin) administered to wrong resident

- When did it happen?
  - 05/06/2018
- (What (in general terms) was the nature of the occasion of substandard care?)
  - Medication Management
- What action did your service or outlet take in response?
  - An Agency RN administered the medication and we followed protocol which is to: notify the relevant agency, and fax an evaluation form to the agency.
- Was the substandard care the result of a systemic failure?
  - No

(c) Provide a summary table showing the numbers of different areas of occasions of substandard card by year.

Area of care	2013- 2014	2014- 2015	2015-2016	2016-2017	2017-2018
Dignity					
Choice and control					
Clinical care	1	3	5	5	3
Medication management					1
Mental health					
Loneliness, disengagement, disconnection, boredom					
Personal care					
Nutrition					
Restrictive practices					
End-of-life care					
Governance/ management					

QUESTION 2

Since 1 July 2013, has your service or outlet received any complaints or had complaints made about them in relation to substandard care, including mistreatment and all forms of abuse?

2013: None

2014:

Aged Care Complaints Scheme, Case ID 158025

- When did it happen?
  - 13/06/2014
- What (in general terms) was the nature of the occasion of substandard care?
  - Clinical Care
- What action did your service or outlet take in response?
  - Improved documentation, falls risk policy and procedure reviewed, notification to family regarding clinical matters has improved. All areas surrounding complaint were resolved.
- Was the substandard care the result of a systemic failure?
  - No

2015:

Complaint by resident's relative about the care and standard of food for her sister, poor menu choices, cooking quality and presentation of food (including soft, minced and vitamised meals), poor staff communication to relatives, staff not washing resident's hair daily.

- When did it happen?
  - 14/01/2015
- What (in general terms) was the nature of the occasion of substandard care?
  - Nutrition
- What action did your service or outlet taken in response?
  - Upon investigation, it was discovered that complaints only emerged when a particular staff member was cooking. A review / audit of the menu choices, presentation and quality of food was carried out by a dietitian on 10/2/2015. Communication and care issues were discussed with RN and PCA involved, and counselled regarding the importance of reading and following up care plans for each resident. They were reminded to refer any clinical care questions to the RN / EN in charge. The RN was counselled regarding the importance of being aware of the resident / family care objectives / wishes. A sign has been put up resident's room requesting hair to be washed daily.
- Was the substandard care the result of a systemic failure?
  - No

Resident still not showered or dressed by lunchtime, daughter felt it was because there is not enough staff due to a compulsory training. Bathroom globe needed replacing- room in darkness for two days.

- When did it happen?
  - 30/3/2015
- What (in general terms) was the nature of the occasion of substandard care?
  - Clinical Care
- What action did your service or outlet take in response?
  - A discussion was held with the resident and daughter about the delayed shower. It was acknowledged that communication could have been improved. There had been training on the day but five staff were on the floor and had been attending other residents. The result of the discussion is that to avoid similar delays, the resident requested daily early showers, the request had been added into her care plan for staff to follow up. Electrician was called to fix the faulty connection on the day as the in-house maintenance wasn't able to fix it; the electrician attended on the next business day and fixed the connection.
- Was the substandard care the result of a systemic failure?
  - No

Resident's daughter has concerns about her mother's toileting and other issues possible associated with it. Also request for new key still not dealt with.

- When did it happen?
  - 19/6/2015
- What (in general terms) was the nature of the occasion of substandard care?
  - Clinical Care
- What action did your service or outlet take in response?
  - New toileting regime every 2hrly and CCC reminded staff of the need to adhere to the set toileting times. Key has been replaced.
- Was the substandard care the result of a systemic failure?
  - No

Kitchen staff needs to be aware of food consistency for residents on minced and moist diets.

- When did it happen?
  - 6/6/2015
- What (in general terms) was the nature of the occasion of substandard care?
  - Clinical Care
- What action did your service or outlet take in response?
  - Consultation was carried out between OCAV's food supervisor with the on-duty cook who realised her mistake. This prompted education sessions for staff with a competency. This was arranged with the nutritionist and completed on 23/07/2015.
- Was the substandard care the result of a systemic failure?
  - No

2016: Nil

2017: Nil

2018: Nil

(a) Provide a summary table in the following form, showing the numbers of different areas of occasions of substandard care by year.

Area of care	2013- 2014	2014- 2015	2015-2016	2016-2017	2017-2018
Dignity					
Choice and control					
Clinical care		1	4		
Medication management					
Mental health					
Loneliness, disengagement, disconnection, boredom					
Personal care					
Nutrition					
Restrictive practices					
End-of-life care					

QUESTION 3

Since 1 July 2013, what (if anything) has your service or outlet done:

All of the initiatives outlined below take into account the wide diversity of older Australians and the barriers they face in accessing and receiving high quality aged care services?

(a) High quality and safe services

Audits and surveys

- We have used Moving on Audit, an aged care residential audit tool program to review all OCAV standards of care: (see attached example of audit schedule). This allows us to benchmark ourselves against similar facilities. There have been no outstanding non-compliances since 2013.
- Consumer surveys conducted through Moving on Audits. Benchmarking has been carried out each year since 2013. In 2018 we received a 100% net satisfaction score (see attached copy).
- Relative feedback surveys have also been conducted each year, to good success. (See attached copy).
- We have had successful Australian Aged Care Quality Audits in 2013, 2015 & 18 and gained 44/44 outcomes each time.

Introduction of new peritoneal dialysis service

- Partnered with Austin Health home therapy team to deliver a Peritoneal Dialysis delivery; this service won an AACQA "better practice commendation – Dialysis in aged care award" in 2018. (See case study below.)

Introduction of management plans and programs

Since 2013, we have put in place a range of plans aimed at ensuring high quality and safe services. These are regularly reviewed and updated. We also conduct regular updates with staff and volunteers.

These include:

- An Infection Prevention Risk Management plan with an Infection control & prevention plan in place.
- OH&S program with a training manual handling team who mentor all staff
- Back Attack program put in place to ensure all staff understand how to protect their backs in order to lessen back incidents and to reduce falls among residents.
- Manual handling mentors provide ongoing training for all staff including skin integrity, correct posture and use of machines correctly and risk assessments
- Introducing a range of medication management improvements, the Leecare computer medication program, and a self-monitoring program.

Participating in national surveys

- Joined the Aged Care National Anti-Microbial Prescribing Survey in 2016 and have participated since

Introduction of new staffing and roles

- We have engaged two allied health staff to work daily from Monday to Friday to assist with exercise, muscle strengthening and pain management.
- We have introduced a Clinical Care Coordinator role to offer a service a Monday to Sunday service to improve on clinical care, monitor and continuously improve our KPIs.
- Extra staff have been put on for morning and afternoon shifts to look after the residents in the lounge room, and this has greatly increased social interaction and reduced the number of falls.

New equipment

We have introduced new equipment, thanks to philanthropic funding. This includes:

- Nine Wissner- bosserhoff beds to assist resident with in-bed mobility, automatic light and sensor alarm to improve resident's safety. Those beds helped to reduce falls.
- One bariatric bed.
- Acquired manual handling equipment, for example Sarah steady machines.

New programs

Through philanthropic funding, we have:

- Enhanced our music, art and pet therapy wellbeing program which is offered to all residents, with one on one therapy offered to palliative care residents.
- Introduced a weekend activity program, as well as offer regular outings which are decided with all residents.

Research programs

We have been participating in a research program to determine if increased dairy consumption in the elderly reduces fractures and preserves bone strength. The program is in conjunction with Austin Hospital and the University of Melbourne.

Case study: Introduction of a peritoneal kidney dialysis service

OCAV won a national better practice award for its innovative kidney dialysis service run from Liscombe House in late 2017.

The Australian Aged Care Quality Agency (AACQA) awarded OCAV in recognition of its commitment to continuum of care and support for a kidney dialysis patient who had to move from independent living within OCAV due to a rapid deterioration of his condition.

The AACQA said the service that OCAV provided was exemplary and demonstrated how true to its mission it was in providing care to its residents.

OCAV received the award for its care for a former resident who had been on home dialysis at OCAV's Leith Park village for three years as part of a pilot program involving the Royal District Nursing Service.

In September 2016, the resident, who had chronic kidney disease stage 4, deteriorated rapidly, and was no longer able to live in his independent unit because he required peritoneal dialysis every night while he slept. Following careful consideration and with the training and support of Austin Hospital, OCAV cared for the resident on dialysis at its Liscombe House aged care facility from October 2016 through to his death in February 2017.

OCAV's nursing team worked with the multi-disciplinary and home-therapy teams at the Austin Hospital in the setup of the dialysis service. The home therapy unit at Austin hospital offered their full support and 24-hour backup/call service, and provided relevant education and competency testing for staff. Home therapy organised for the peritoneal dialysis equipment and solutions to be provided through Baxter Health Care.

Until the resident's death, there were only three dialysis patients living in aged care facilities in Victoria. OCAV is offering the service for other older Victorians in need.

(b) Person centred care, greater choice, control and independence

We are committed to person-centric care, and have been since our foundation over 150 years ago. Our funding model and continuum of care approach enables this to be rolled out for each resident.

Dementia Wellness program

- The development of a template called "All about me "to briefly explain what is important to resident and their life choices and values (see case study).

Choice, control and independence

- We have a robust Advanced Care Planning program in place that enables residents to have their choice, control and independence regarding the care. We have trained staff who initiate conversations and provide information to residents and their families about setting up their advance care directive which ensures their values and beliefs are followed.
- All residents have access to a complaints' system.
- We have a pharmacy box in place which ensures consumers can pay their own accounts, and can liaise directly with pharmacists.

Codesign programs

Where possible, we codesign services and programs with residents. An important example of this is our nutrition service where nutritionists work closely with residents and staff at our aged care facility to ensure food on the menu not only complies with nutritional standards, but also is enjoyable for residents to eat.

A nutritionist assesses every resident who comes to Liscombe House at St Helena, so that a meal plan can be developed. This involves examining a person's capacity to swallow, weight issues or other health considerations also their likes and dislikes. The nutritionist, and often a speech pathologist, is also called in if the person's health and wellbeing changes and a resident loses their appetite or has difficulty swallowing food of a certain consistency.

The external nutritionist does an annual review of all residents to ensure the diet they receive meets their unique and often changing nutritional needs and meets the requirements of the Australian dietary and industry standards.

Volunteers

We have 180 volunteers who assist our consumers in many ways in their daily lives, enabling them to maintain their independence and a quality of life.

Men's group

A fortnightly men's group has been established providing a comfortable, social environment for men to feel included. Purposeful projects are co-designed with the men and the activities' coordinator.

In 2018, the Men's Group renovated the Men's Shed and are now working on a range of projects.

Case study: What's Important To Me?

The 12 people in our specialised dementia unit staff each have their own story board which has been designed with help from the resident and their families.

The simple storyboards, titled, what's Important to Me, are colourful and full of photos and images. They are used by all staff to learn more about the residents and better understand who they are.

Staff are encouraged to use the information even to casually chat to a resident. The storyboards are an extension of the thorough lifestyle assessment that is done for each resident within hours/days of coming to Liscombe House. The assessment covers their physical, mental and emotional health issues as well as other key lifestyle factors including religious, cultural and spiritual needs.

The What's Important To Me stories explore positive aspects of the resident's life rather than just focussing on the limitations of their living with dementia.

(c) Engagement with families and carers on care-related matters:

Our engagement program is extensive and includes:

Carers

- Hand overs each shift to all care staff, computer access for all staff at the bedside.
- Tool box education which is given to all staff when new residents enter our facility or for existing residents with new care needs.
- Clinical Care Co-ordinators being available on all morning shifts to discuss care needs
- A Registered Nurse is available on every shift for any discussions.
- Day to day consultation with residents and their families to develop a person centred care plan.

Families

- **W**e have regular family meetings to discuss changes to clinical conditions and GP visits.
- We have three a monthly care plan consultation with residents and families where staff consult resident / representative to provide information about current care needs and encourage to raise any issues / concerns they may experience.
- We produce a regular resident/ relative newsletter and for more immediate advice, we send email notifications.
- We have an annual Family Fun Day.
- Care specialists, for example in wound and skin or continence management, are available to discuss concerns with families.

(d) To deliver aged care services in a sustainable way, including through innovative models of care, increased use of technology, and investment in the aged care workforce and capital infrastructure?

Our engagement program is extensive and includes:

Innovation

Our innovations include:

- We have introduced a mentoring system to train staff and colleagues in correct manual handling procedure. The Back Attack mentors also conduct a risk analysis on every resident to develop safe operating procedures as part of a safe and person centred care program.
- We have introduced registered nurse student placements in partnership with Latrobe University. This has included overseas students in 2017 and 2018 (see case study in Question 8).
- We are introducing an outdoor exercise park at Liscombe House (see case study in Question 8).

Increased use of technology:

- We have started a Virtual Reality program (see case study in question 6).
- We have acquired more technology including Wi-Fi access for all residents, staff and visitors throughout Liscombe House, I Pads for staff use, upgraded computer stock and software to enable better time response to maintenance request, hazard management, and recording of and monitoring of supplier contracts. The latter includes a modernised system for day to night continence pads.
- We are using the Leecare medication program which has decreased the number of medication incidences and improved the monitoring of medication administration.

Investment in aged care workforce:

Over 2719 training hours were delivered through the year with all staff enrolled in Aged Care Solutions, an online program endorsed by the Australian Nursing and Midwifery Foundation. This provides learning on different topics each month. In addition, we have invested in:

- training all nurses and some care staff on peritoneal dialysis
- delivering PEPA paid training for palliative care
- Paying for study days for nurses and PCAs in wound management, diabetes and identifying a deteriorating patient.
- We have replaced the older rostering system with a faster, more efficient and transparent system.

Capital infrastructure:

We have invested in:

- Upgrading an outside courtyard which is used by all aged care residents and family
- We have refurbished rooms to maximise resident use; every room has its own ensuite
- We have upgraded consumer sitting rooms with new arm chairs and suitable flooring.
- We have installed additional air-conditioning for eleven bedrooms
- We have upgraded the kitchen in our dementia specific unit.
- We have put in place block out blinds in ten rooms and awnings in eight rooms as part of our climate change program
- We have acquired a bus to provide transportation for residents' outing and activities

QUESTION 4

As at 30 June 2018, did your service or outlet provide services to people younger than 65?

No.

QUESTION 5

Does your service or outlet experience difficulties in accessing health care for care recipients? If so, indicate what these difficulties relate to (indicate all that apply): primary care (i.e. GP services); hospital care; follow-up care for people discharged from hospital; mental health care; palliative care; dental care; other health services (e.g. podiatry); pharmaceutical services, including medication reviews; other (please specify).

OCAV prides itself on close relationships with its health care partners which is the main reason we do not experience difficulties in accessing health care for its consumers, except for dentistry at times.

Liscombe House is serviced by:

- Four GPs who visit the facility four times in a week and who are easily accessible by phone;
- Three geriatricians;
- Two physiotherapists who attend Monday to Friday;
- Visiting monthly dietician visit, visiting podiatrist,
- Access to outreach team at the Austin hospital;
- Alpha dental services visits arranged with family as required;
- Speech pathologist;
- Supply pharmacy and a pharmacist attached to facility who attends the Medication Advisory Committee meetings;
- Consultant pharmacist visits three times each month, and more often if needed to conduct Resident Medication Management Reviews;
- Banksia Palliative Care Services and Dementia Support Australia; and
- Good support from the Locum GP service when needed.

However, we do from time to time experience difficulties in accessing timely information from hospitals when they refer consumers to Liscombe House without ACAT assessments in place. This consequently has funding and care implications for OCAV's aged care facility. This is easily remedied by improving communication and ensuring silos are removed.

The hospitals need to play a role in ensuring potential consumers have the appropriate information and that ACAT assessments are in place before referring.

QUESTION 6

(a) What further changes (if any) could your service or outlet make to provide services of higher quality and greater safety and to improve individual outcomes?

OCAV continues to find ways to improve its person-centric service and programs for consumers through innovation and commitment of staff, volunteers and, increasingly, philanthropic support.

Our primary aim is to provide quality safety and care for all our residents, at whatever stage of care they are at. We aim to keep people out of hospital for as long as we can, as is evidenced in our case study on Peter Stock (see Question 3).

There are a range of changes that we could pursue if funding was made available. These include:

Palliative Care:

In 2018, we palliated 19 people at Liscombe House. Part of this success is attributable to the training program. Ten staff have completed external training in areas such as the palliative approach or looking at the terminal care pathway with Banksia and Northern Hospital; five staff have completed Advance Care Planning at the Austin Hospital, and one staff member has completed a train the trainer program in Advanced Care Planning.

In order to extend this, we are actively pursuing funds to refurbish a room in Liscombe House to cater for families and friends of palliative care residents

Reducing falls and balances among residents, and supporting staff

Through philanthropic funding, we have been gradually replacing beds with Wissner- bosserhoff beds. We currently have 10 beds (one is a bariatric bed). These beds are fitted with a light source, bed sensor and inbuilt bed mobility aid; they come with a safe sense remote control, good bed mechanics to improve transfers and re-positioning have greatly reduced falls out of bed.

To date, thanks to the introduction of these beds, together with falls and balance training, as well as our Back Attack program, the number of falls at Liscombe House has decreased significantly.

We continue to seek funding to replace all beds at Liscombe House.

We are also seeking funding for more technological interventions such as floor sensors, for example an Elsi Smart Floor Monitoring System.

Dementia management

We are continually looking at new ways to support our dementia residents better. A recent innovation has been the start of a Virtual Reality experience trial (see case study below).

One initiative that we would like to introduce if we are able to access funding is Paro, the robot seal for dementia care and management of Behavioural and Psychological Symptoms of Dementia.

Case study: Virtual Realitity Experience.

OCAV has trialled Virtual Reality technology to deliver an experience to aged care residents in Liscombe House. The trial involved six residents and some staff members. The results were positive. Underwater scenes were used to deliver an extraordinary experience for each individual. Residents talked about the day for some time after and still do.

Reactions from this initial activity was encouraging to staff involved. As a consequence, and through funding from philanthropy, we have purchase a mobile kiosk which we can use not only in our aged care facility but in our other villages, and particularly with assisted living residents.

The device is unique as it is moveable allowing it to be taken to a resident. It is user-friendly, requiring people with VR knowledge to operate it. It is not invasive as the mask is light and very comfortable. The concept is simple in design by not needing any interaction. Residents sit and view the experience, keeping it less complicated.

Introducing this technology to an elderly person has been both challenging and exciting. It is challenging when trying to explain what the experience is, or will be to individuals. Finding the most suitable experiences has challenges as far as contextualising it to the person, this point is ongoing.

We will use the technology as part of a research trial, in conjunction with La Trobe University, which will look at behaviour and reactions before, during and after involvement with VR. Feedback will be in the form of a questionnaire which will ask relevant questions relating to the experience. This will be gained from both residents and staff.

We anticipate that this experience may help divert behaviours, bring back lost memories, create new ones and when in a group setting, add a social element in talking to each other of what they went through. As important as this is to residents, it will be encouraged that staff can also experience scenarios, helping them understand what residents see and react to. The future ideas may include interacting with families who can record messages, short videos that loved ones can view and feel as if they are with them.

We have been able to introduce the concept seamlessly because of our continuum of care model and our person-centric approach to care. We know our residents and their interests (see Question 3.)

QUESTION 7

What changes (if any) to the interface between the aged care system and primary health, acute care and disability services and relevant regulatory systems would assist your service or outlet to provide services of higher quality and greater safety?

Liscombe House is well supported with great networks which we have taken time and care to establish over the years.

However, there are several ways in which the systems can be improved that would make a difference to the provision of higher quality and safety.

These include:

Improving Personal Care Worker Certificate III

Recommendation: Re-examine entry level qualifications and career pathways.

Education and training requires change to better focus on practical skills and known competency gaps. OCAV believes that there should be a re-examination of entry-level qualifications, and career pathways, along with recognition of the full range of competencies required to enable Australia move toward living well models of care and recognise the benefits of integrated care.

There also needs to be a greater focus on career pathways that take into account the ongoing need for part-time work in what is a heavily female dominated sector, with women making up 84 percent of the workforce.

The 2013 audit of registered training organisations highlighted that 90 per cent of aged-care courses did not comply with training standards under the Australian Qualifications Framework.

We recommend more support and funding for training from the government and better regulation for all training schools of the content and assessment in the Certificate III course for personal carers.

Encouraging people to take up careers within aged care

Recommendation: Value PCAs for the potential they bring to the industry.

Currently staffing costs are the main outgoings for any aged-care facility. This is not just about funding but also attracting potential people into the workforce, as well as better training and education.

Due to limited funding and pressure to meet profit targets, managers employ personal-care attendants (PCAs), rather than nurses. This creates both the potential for poor work standards but also a problematic perception: currently PCAs are not valued or recognised for their contribution, and the potential they bring to the aged care industry.

At OCAV, we encourage PCAs to begin their enrolled nursing qualifications while with us, and have strong links to hospitals such as the Austin for smooth transitioning.

Recommendation: Do NOT put in place nursing staff ratios.

Rather than nursing staff ratios, we believe the focus should be on the quality of outcomes through better models of care.

Good quality care can be delivered with PCAs working alongside enrolled nurses, carers and volunteers.

We also believe that aged care providers are in the best position to know the care needs of each consumer, and tailor care accordingly. This person-centric approach mirrors government policy, and also ensures judicious use of limited funding.

QUESTION 8

What other changes (if any) to the aged care system would assist your provider to provide services of higher quality and greater safety to Australians, including to people with disabilities residing in aged care facilities and to the increasing number of Australians with dementia?

Implement past review recommendations

Recommendation: Implementation of recommendations from past reviews would assist both aged care providers and consumers.

There have been 29+ reviews into aged care over the past few years. These have well-considered recommendations which have not been implemented.

We urge the Royal Commission to review these recommendations and, where appropriate to embrace them into this report.

We also urge the Royal Commission to define the kind of care that is needed for the future, as well as what the nation appears to want, and then to clarify how the current model needs to change (see below). This, together with a review of past recommendations, should influence decisions about improving the aged care system in Australia.

Funding:

The model

Recommendation: Change the funding instrument and model to drive best practice, take account of changing demographics, an increasing ageing population and increasing incidence of co-morbidity and chronic disease.

Currently funding is based on the concept of a low care resident – a dying concept.

This has come about due to changing future demographics, and current government policy of wanting consumers to 'age in place' (i.e. in their own home) more consumers are entering aged care facilities often with high risk and high care needs, and too late. Care for high need and high risk consumers within aged care is not being recompensed properly.

The increasing acuity of residents in Aged Care and the ability for Aged Care facilities to care for them are decreasing the resource and financial pressures on Hospitals. Funding needs to take account of this reality, and better forecasts are required to ensure aged care providers are effectively funded.

Cuts to funding have had huge impacts over recent years; for example, changes to medication funding are a clear demonstration that operators are not necessarily paid for the care they provide. This, in turn, as evidenced through media stories, has forced a small but significant number of operators to cut corners.

An improved funding model will allow certainty for providers to invest further in their aged care offering.

Recommendation: Increased funding is required to train and educate all staff working inside aged care – from nursing staff to maintenance.

Given the changing demographics of Australia, it is vital to ensure all staff are trained and educated about ageing, aged care, and the needs of older people. This includes cross cultural training and education, training in the needs of LBQTI elders, and others.

While aged care providers receive funding for training, it is not sufficient to cover all current necessary training and to address future needs.

A better educated and trained workforce will lead to improved aged care and peace of mind for consumers and their families or guardians.

Workforce planning and skills mix modelling are emerging as an essential cross-industry competency given the changing requirements of residents entering a higher level of care, and an ageing workforce.

Care planning and profiling people to inform models of care is also an emerging area. These care models emphasise the relationship between staff and consumers, with a focus on quality of life, rather than purely clinical care.

Aged care needs to be prepared for: an increase in the number of people living with dementia, with a multitude of chronic diseases, and diverse cultural and linguistic backgrounds. Ageing in aged care will mean more than medical interventions, it will mean promoting preventive health measures – including therapies such as art and music.

Recommendation: National approach to pay and conditions.

We recommend a national approach taken to pay and conditions which includes benchmarking pay against comparable industries and understanding the variations in pay across the industry in addition to the other factors that are equally important as part of employment arrangements.

We believe there should be a better alignment of employee engagement factors to help attract and retain people to the industry.

The following areas are crucial to ensure an aged care workforce that is skilled and able to adapt to changing circumstances: end of life planning, advanced care planning, social care, the changing requirements of older people many of whom are and have been independent and are unlikely to be ‘easy’ aged care residents.

At an administration and leadership level, staff will have to have improved business management skills, have access inside or outside the aged care facility to risk management assistance, strong financial and accountability assistance, and HR and IT assistance.

Governance

Recommendation: Greater clarity is required between which level of government is responsible for aged care and seniors.

Much more clarity is required about which level of government is responsible for aged care and seniors. Currently funding is siloed between federal, state and at other levels of government which does not create an efficient system. The impact on aged care providers is not just about funding but also a rise in red tape and reporting requirements. Governance needs to be streamlined.

Aged Care Quality and Safety Commission

Recommendation: The Aged Care Quality and Safety Commission should work with aged care providers to ensure continuous improvement.

We understand that the role of Aged Care Quality and Safety Commission is to audit aged care providers and to ensure standards are kept and raised.

However, as the revised Commission is still in its early stages, we believe that there is room to extend this duty of care to working with aged care providers to ensure and support continuous improvements rather than having a focus on highlighting mistakes.

This would ensure a more robust and proactive Aged Care Quality and Safety Commission which, in turn, will ensure improvements for consumers, and enable aged care provided to better achieve their goals.

Dementia

Recommendation: Increase government funding to enable aged care providers to better manage the consumer with dementia at all stages of the disease process.

Dementia is not a normal part of ageing but incidence increases with age, with almost one in 10 people over 65 with the condition, increasing to three in 10 aged over 85. It is the second main cause of death in Australia and the leading cause of death for women.

As can be seen in our answer to Question 1, the majority of incidences of 'substandard care' that we have experienced are due to dementia, and the interaction of residents with other residents. These type of incidents are likely to increase among all aged care providers as the number of people affected by dementia rises.

At Liscombe House, we have a dementia-specific unit where specially trained staff work closely to support our residents. We do not use restraints. We currently have three residents highly affected by dementia each requiring their own carer. We provide this one-on-one support at our own cost. As with many other aged care providers, we cannot keep pace with the reality of dementia with the current level of funding, and this has to be acknowledged by government.

Dementia friendly organisations

Recommendation: Funding for dementia-friendly organisations, as defined by Dementia Australia, should be made available.

Currently the focus of government funding dementia is focused on treatment as well as research into treatment.

Becoming a more 'dementia- friendly' nation will improve the quality of care and safety offered to consumers, and support to their family, friends and guardians by aged care providers.

We recommend that funding should be made available to enable aged care facilities to upgrade and modify buildings to become dementia-friendly, education for all staff, volunteers, families and interested consumers, and to introduce innovative programs and practices that support consumers at whatever dementia stage they are at.

This recommendation is made as a result of our being a dementia-friendly organisation, and understanding first-hand the complexities that arise from caring for people with dementia. We do not believe in the 'gated' community approach that is embraced by the current dementia-specific trend.

Training

Recommendation: Funding should be made available for staff remuneration while attending dementia training.

Much more clarity is required about which level of government is responsible for aged care and seniors. Currently funding is siloed between federal, state and at other levels of government which does not create an efficient system. The impact on aged care providers is not just about funding but also a rise in red tape and reporting requirements. Governance needs to be streamlined.

Innovation

For research into new ways of support

Recommendation: Increased funding and support for innovation within aged care should be made available.

Currently many of the innovations that OCAV is putting in place to ensure aged care consumers have robust care, enabled to live independently within their own limits, have opportunity to interact with other consumers to withstand loneliness and social isolation are carried out at our own cost.

As a small but flexible aged care provider, we are taking part in different trials – including Dairy Needs of Aged Care Residents, Virtual Reality, and Exercise for Older People – with renowned university and medical research institutes. This however comes at a cost for us as research funding rarely covers the administrative costs of aged care staff involved in trials.

Further, we encourage staff, volunteers and residents to propose innovative ideas that improve the services we provide, and the care and support we offer. Many ideas are unable to be followed through due to a lack of funding.

Access to a pool of small and large grant funding for innovation would be beneficial in advancing small and large scale innovation.

Case Study: OCAV and National Ageing Research Institute Active Ageing Project.

Since receiving funding from Perpetual Trustees, OCAV and NARI are about to start a research program that is aimed at incorporating regular exercise into our aged care residents' daily routines.

OCAV is building an outdoor exercise park in the grounds of its Leith Park retirement village, where Liscombe House is base. The park includes installation of soft-fall flooring and modified equipment designed to improve balance, flexibility, strength and coordination.

NARI's researchers will create an exercise program tailored for Leith Park's elderly residents. Physiotherapists will train residents in using the equipment and be on hand for support when needed.

Findings will be shared within Australia and internationally.

Workforce innovation

OCAV is innovative in its approach to providing workforce opportunities to staff, whether it is through training or new services, which ultimately benefit our residents and contribute to a broadening pool of potential part time and full time employees.

One of our approaches to promoting aged care as a career is our collaboration with La Trobe University.

Case Study: Holistic approach central to OCAV's care model.

OCAV has linked with Singapore's Nanyang Polytechnic to offer a month long aged care placement for nursing students. The overseas student placement program is managed by La Trobe University.

The placement has given the six Singaporean students a great insight into a different way of caring for the elderly, and built cross cultural understandings at the same time. While clinical care is similar to that offered in Singapore, the other programs offered at OCAV, such as diversional therapy and recreational activities do not happen in Singapore facilities.

The students noticed that apart from the emotional benefits, the activities and diversional therapy means the residents are more active and participate in things, rather than just sit in chairs. In Singapore, the care of the elderly happens in a much more medical setting.

The six students rotated around the aged care facility, spending time in the high care, low care and dementia units fine-tuning their clinical practices, wound dressing, use of equipment, and knowledge of compliance and regulations.

The experience is a win-win for OCAV's residents and staff. La Trobe ran education programs during the month of the students' placement and OCAV staff attended when possible. The sessions covered issues such as behavioural management, clinical compliance and the progression of Alzheimer 's disease.

MOA BENCHMARKING

Residential Care Audit Schedule 2018

Standard	Code	Audit or Survey Title	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Outcome 1	A-01	Continuous Quality Improvement										A-01		
Outcome 2	A-02	Regulatory Compliance	A-02											
Outcome 3	A-03	Education and Staff Development								A-03				
1.4	A-1.4	Comments and Complaints				A-1.4								
1.4.1	A-1.4.1	*Care Recipients Feedback Survey*					A-1.4.1							
1.4.2	A-1.4.2	*Relatives Feedback Survey*								A-1.4.2				
1.4.1	A-1.4.1.1	*Food Satisfaction Survey (optional)*											A-1.4.1.1	
1.5	A-1.5	Planning and Leadership					A-1.5							
1.6	A-1.6	Human Resource Management						A-1.6						
1.6.1	A-1.6.1	*Staff Feedback Survey*		A-1.6.1										
1.7	A-1.7	Inventory and Equipment			A-1.7									
1.8	A-1.8	Information Systems							A-1.8					
1.9	A-1.9	External Services								A-1.9				
2.4	A-2.4	Clinical Care									A-2.4			
2.5	A-2.5	Specialised Nursing Care Needs										A-2.5		
2.6	A-2.6	Other Health and Related Services						A-2.6						
2.7.1	A-2.7.1	Medication Governance	A.2.7.1											
2.7.2	A-2.7.2	Medication Clinical Practice								A-2.7.2				
2.8	A-2.8	Pain Management											A-2.8	
2.9	A-2.9	Palliative Care					A-2.9							
2.10	A-2.10	Nutrition and Hydration			A-2.10									
2.11	A-2.11	Skin Care					A-2.11							
2.12	A-2.12	Continence Management					A-2.12							
2.13	A-2.13	Behavioural Management				A-2.13								
2.14	A-2.14	Mobility, Dexterity and Rehabilitation			A-2.14									
2.15	A-2.15	Oral and Dental Care		A-2.15										
2.16	A-2.16	Sensory Loss										A-2.16		
2.17	A-2.17	Sleep												A-2.17
3.4	A-3.4	Emotional Support			A-3.4									
3.5	A-3.5	Independence												A-3.5
3.6	A-3.6	Privacy and Dignity		A-3.6										
3.7	A-3.7	Leisure Interests and Activities							A-3.7					
3.8	A-3.8	Cultural and Spiritual Life						A-3.8						
3.9	A-3.9	Choice and Decision Making									A-3.9			
3.10	A-3.10	Resident Security of Tenure and Responsibilities										A-3.10		
4.4	A-4.4	Living Environment											A-4.4	
4.5	A-4.5	Work (Occupational) Health and Safety							A-4.5					
4.6	A-4.6	Fire, Security and Other Emergencies							A-4.6					
4.7	A-4.7	Infection Control & Waste Management				A-4.7								
4.8.1	A-4.8.1	Catering Services Audit								A-4.8.1				
4.8.2	A-4.8.2	Cleaning Services									A-4.8.2			
4.8.3	A-4.8.3	Laundry Services						A-4.8.3						
All	LGBTI	LGBTI Audit - Rainbow Tick Self Assessment (optional)									LGBTI			
Monthly Quality Indicator Collection														

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Australian Government
Australian Aged Care Quality Agency

Consumers' Experience of the Quality of Care and Services: Aged Care Homes

Liscombe House

RACS ID: 3257

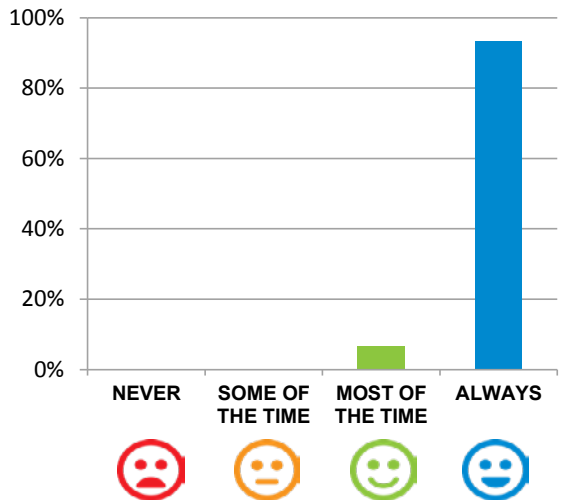
Reaccreditation Audit Date: 14 August 2018 to 15 August 2018

An audit team from the Australian Aged Care Quality Agency visited the aged care home for re-accreditation purposes and spoke to at least 10 per cent of the people who live there. Those we interviewed for this report were randomly selected*. The results are presented in this report which will help you understand the experience of consumers living in the home. It should be read alongside the accreditation audit report on the home available at the Quality Agency's Accreditation Report Search page at http://www.aacqa.gov.au/publications/reports. For more general information on aged care, visit www.myagedcare.gov.au.

* Number of consumers interviewed: 14
Number of representatives interviewed: 1

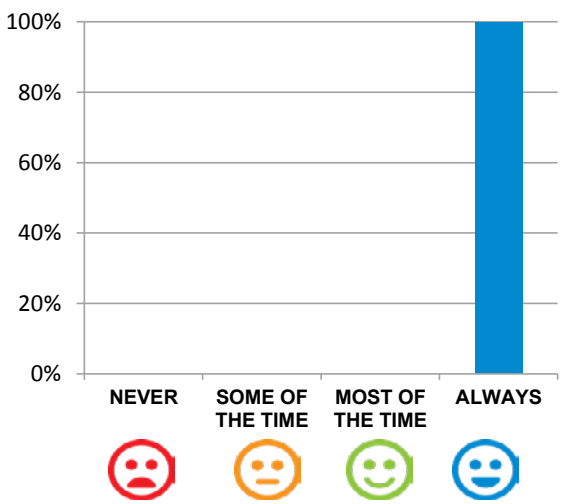
What is your experience at the home?

Do staff treat you with respect?



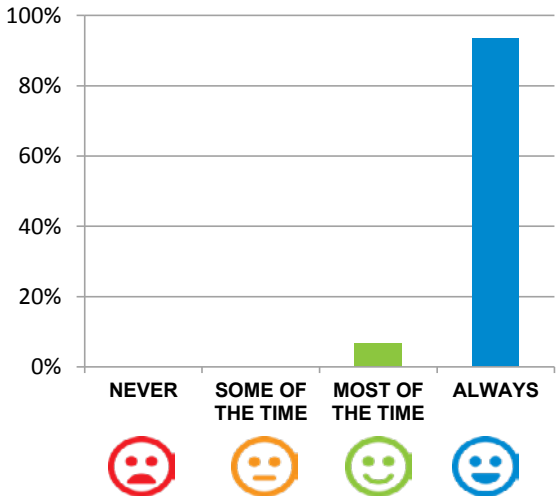
100% of responses were: most of the time or always

Do you feel safe here?



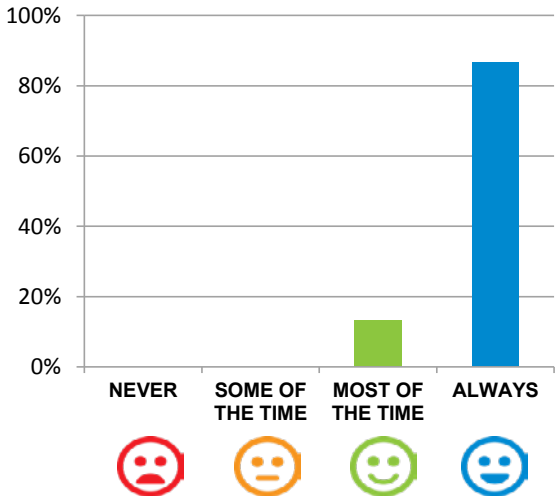
100% of responses were: most of the time or always

Do staff meet your healthcare needs?



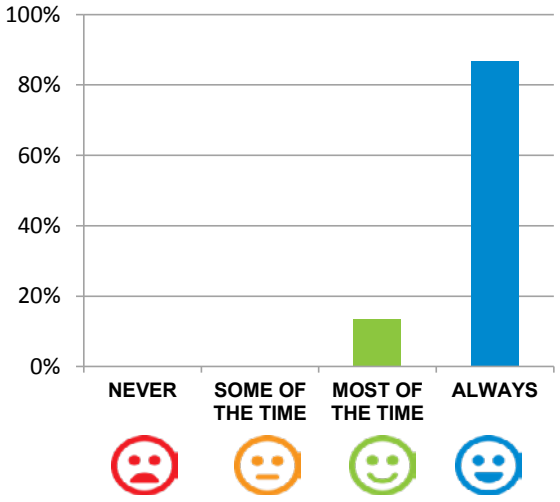
100% of responses were: most of the time or always

Do staff follow up when you raise things with them?



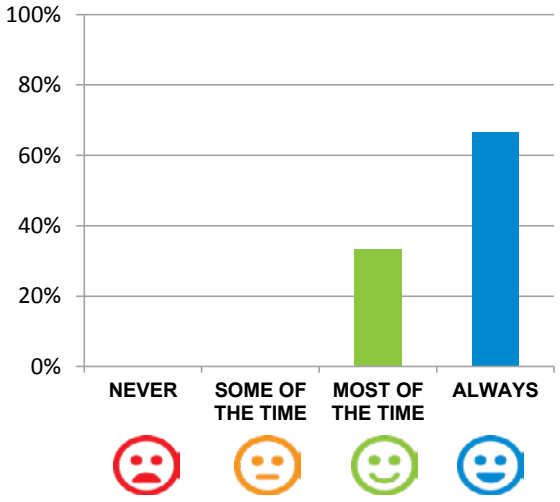
100% of responses were: most of the time or always

Do the staff explain things to you?



100% of responses were: most of the time or always

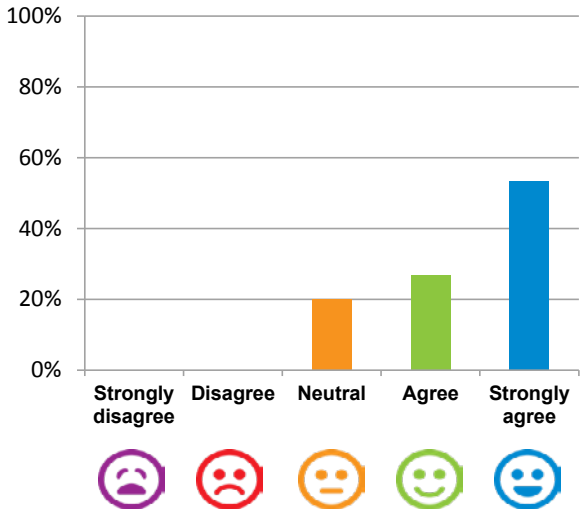
Do you like the food here?



100% of responses were: most of the time or always

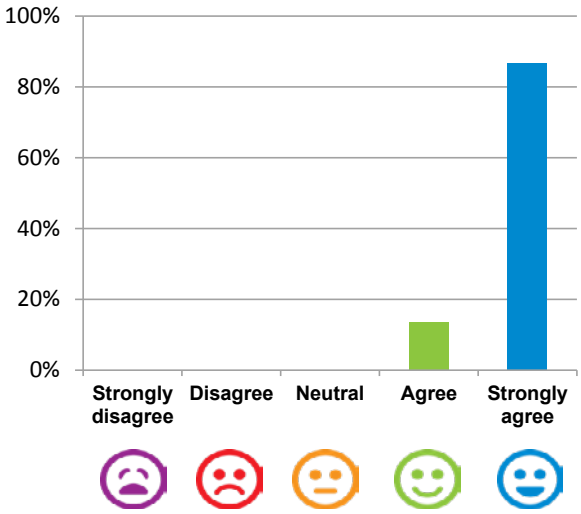
Do you agree with these statements?

If I'm feeling a bit sad or worried, there are staff here who I can talk to.



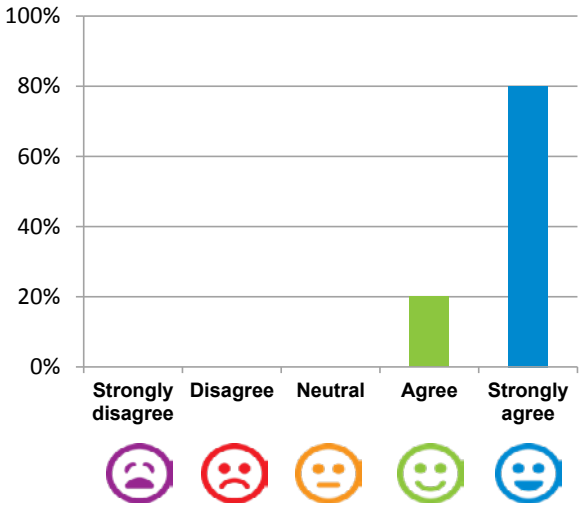
80% of responses were: agree or strongly agree

The staff know what they are doing.



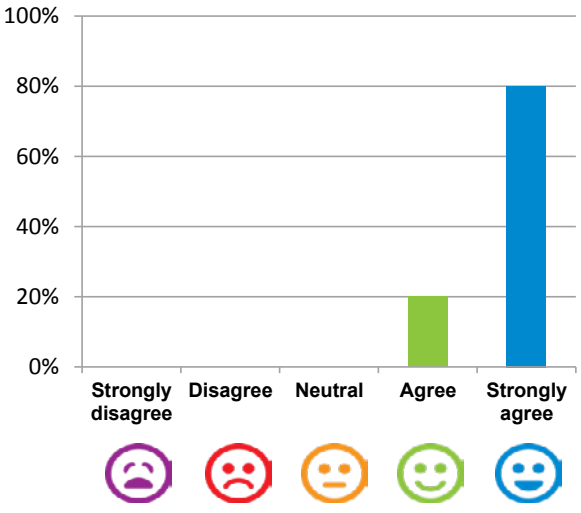
100% of responses were: agree or strongly agree

This place is well run.



100% of responses were: agree or strongly agree

I am encouraged to do as much as possible for myself.



100% of responses were: agree or strongly agree

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