AUSTRALIAN NURSING FEDERATION (SA BRANCH)

December 12, 2002

Alex Stock
Ageing Inquiry
Ageing.reps@aph.gov.au

Dear Alex

RE: SUBMISSION TO THE INQUIRY INTO LONG-TERM STRATEGIES TO ADDRESS THE AGEING OF THE AUSTRALIAN POPULATION OVER THE NEXT 40 YEARS

Please find attached the response of the Australian nursing Federation (SA Branch) to the Inquiry.

We would be happy to clarify any of the issues raised or discuss our response further. Please contact Rob Bonner (rob@sa.anf.org.au) at this office in the first instance.

Yours Faithfully

Lee Thomas
Secretary

Australian Nursing Federation (SA Branch)

SUBMISSION TO THE INQUIRY INTO LONG-TERM STRATEGIES TO ADDRESS THE AGEING OF THE AUSTRALIAN POPULATION OVER THE NEXT 40 YEARS

Introduction

The Australian Nursing Federation (SA Branch) is the largest professional organisation and the industrial association for the state's Registered and Enrolled nurses. In addition the ANF offers membership to persons delivering aspects of nursing care to clients in the aged care sector who are not Registered or Enrolled nurses. The ANF (SA Branch) currently has over 9,000 members.

The ANF plays an active role in advocating for nurses and the wider community in relation to access and quality of health services and takes a social view of health which requires attention to factors that lead to health impacts such as wealth, age, access to education, employment housing etc.

In addition to its Professional and Industrial Advocacy roles the ANF (SA Branch) is also a Registered Training Organisation and funds a shared academic post with the Flinders University.

In terms of issues associated with the ageing of the population the ANF (SA Branch) interests relate primarily to the impacts on requirements for health and aged care services as well as the effects of an ageing nursing workforce.

As targeted by this inquiry key areas of escalating spending growth are health, aged care and aged pensions. The implications this has for nurses and the complex health environment in which they work from the perspective of the ANF (SA Branch) are as follows.

Changing nature of health care provision in South Australia

The Generational Health Review[1] (GHR) in South Australia is proposing a population health outcome model of service delivery that seeks to achieve an equitable health outcome for all community members. It clearly identifies the need for a reorientation to the way in which health services are funded and organised. They argue a population based model should be used to ensure those areas with the greatest health needs receive the appropriate funds. This has significant implications for the role of aged care service providers and the role of nurses working within the aged care sector. An emphasis on primary prevention programs, a strong primary health care system, changing the profiles and roles of hospitals and an appropriate and flexible workforce are key planks in GHR strategy for change.

[1] Generational Health Review South Australia Discussion paper October 2002 www.dhs.sa.gov.au/generational-health-review

This model will, without doubt, place a greater emphasis on health service provision to the majority from within the broad community base rather than acute hospitals. Furthermore when combined with the current push for 'ageing in place'[2] and high quality community based service provision for older people[3]the availability of suitably qualified health workers becomes all the more imperative. The GHR also alludes to new and flexible health worker roles. Like the international picture illustrated through the current NHS Plan in the UK[4], Nurses are considered to be a vital part of the solutions to health in the western world. The risk exists however that nurses could be replaced by generic health workers or unregulated careworkers in an effort to supply a band aid short term solution to current crises of nursing workforce (to be discussed in-depth later in this submission) thus further contributing to role erosion of the Registered and Enrolled nurses. The long term implications of immediate strategies must therefore be considered given nurses play a significant role in the development of initiatives that foster healthy and active ageing, promote lifelong learning and continued valued participation in and support of communities by older people. That is effective Community building sustainability.

Nurses and care workers who deliver aspects of nursing care are the largest group of health workers who provide care and support services for older people and will continue to do so in the future. Therefore the views of nurses, and the impact relevant issues have for nurses, have the potential to have significant impact on older people and their needs both now and well into the future. The Senate Community Affairs Reference Committee's Inquiry into Nursing (Patient profession: Time to care 2002) reported recently and the ANF (SA Branch) would support the following recommendations as facilitating strategies for long term growth for nurses and for best outcome potential for older people in their care. These are consistent with the findings of the SA Department of Human Services Recruitment & Retention plan and the Commonwealth commissioned Recruitment and Retention of nurses in residential aged care (CDHA 2002) and parallel outcomes of the National Review of Nursing Education (NRNE 2002).

Recommendation 7: That research be undertaken to examine the relationship between health care needs, nursing workforce skill mix and patient outcomes in various general and specialist areas of care, with a view to providing "best practice" guidelines for allocating staff and for reviewing quality of care and awarding accreditation to institutions.

Recommendation 34: That Commonwealth and State Governments promote and support the development and introduction of Nurse Practitioners across Australia as a viable component of healthcare services.

Recommendation 37: That State and Territory nursing regulatory authorities develop a framework for the regulation of unregulated healthcare workers.

Recommendation 38: That the relevant State and Territory legislation be amended to provide that unregulated healthcare workers not be permitted to administer medications.

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[2] Aged Care Act 1997
[3] Hon Kevin Andrews Speech The future of aged care 26/02/02 also 29/10/02
[4] The NHS Plan. A plan for investment. A plan for reform July 2000 Department of Health

Recommendation 39: That the standard minimum level of training required for unregulated workers before they can be employed in healthcare facilities be equivalent to Level III of the Australian Qualifications Framework (Certificate Level III).

Recommendation 68: That the Commonwealth review the level of documentation required under the RCS tool to relieve the paperwork burden on aged care nurses.

Recommendation 69: That the outcomes of reviews and research be used to establish appropriate benchmarks for resources and skills mix in aged care nursing so as to support improved care for residents, workforce management, organisational outcomes and best practice and that Commonwealth funding guidelines be reviewed in light of this research.

In addition, the ANF (SA Branch) argues the inquiry should commission specific research to facilitate the review along similar lines as the National Review of Nursing Education thus providing an evidence base from which to add to the developing understandings and provide currency of evidence. Ongoing education and professional development of the nursing workforce within a supportive work environment are key pillars to future infrastructural support for older people.

Care provision for older people

Older people receive care services across acute, aged, primary and community care sectors. Wherever older people interact with these systems and associated interfaces there is the risk of harm to that older person, a risk of functional decline and altered quality of life[5]. It is no longer possible to consider one sector without the impact of the other.

The committee therefore needs to consider structures of care provision in the future given the trend towards having high care aged care homes and community based service provision with little or no hostel or low care facilities. This evaluation must include the role, quality and availability of CACPs, and EACH. Specifically who is providing the care, at what level and whether this sufficient. Alternative models of funding should be explored for example, abolishing the RCS and replacing with a per capita payment model or a modified casemix model (based on the increasing actual care needs of residents). There is also a need to address the inbuilt delay (suggested at 3 years retrospective) between demand identification and supply of beds. There is also a clear need to ensure that funding provided on the basis of residents care needs, whether under the present or a new model, is in fact spent on the delivery of care to residents.

Lack of integration between hospitals and residential aged care facilities and aged care funding requires attention through case management of older people through the systems. Models internationally such as Canadian 'Hotels in hospital' to facilitate transition back into the community require investigation. Similarly, the role of acute hospitals also requires review and models such as the Acute Transition Alliance in Adelaide could be explored as means to facilitate timely and appropriate assessment

[5] DHS SA Moving Ahead 1999

of ongoing care and support needs. New roles such as nurse practitioners who work across interfaces to focus on complex assessment, quality and behaviour needs including medication prescribing need to be explored to complement the current lack of GP emphasis on residents of aged facilities as a primary foci (the role of EPC items to facilitate this could be explored). The ANF (SA Branch)does not support the location of nurse practitioners at GP surgeries rather for the NPs to operate as a health professional and boundary worker across a number of residential aged care facilities on a sessional or shared basis.

Needs of the client group in the residential aged care sector

The assessed needs of the client population in aged care have continually escalated over the period in which acuity data has been available. The increased complexity of care has been recognised (if not adequately resourced) by the Commonwealth Department of Health and Aged Care (as it was then known)[6].

This has led to a position where, we submit, the clients now resident in a high care RACF have comparable care needs to those patients in a medical ward of many acute hospitals.

Treatments and nursing interventions that were unknown in the sector a few years ago are becoming commonplace and, importantly, have relevance for the roles of all classes of worker involved in the deliver of nursing care. Examples of such interventions and treatments include ventilators, PEG feeds, IV therapies including the use of continuous infusion pumps, management of complex medication regimes

The information that best demonstrates the increasing care requirements is that from the RCI/PCAI and more recently the RCS which replaced them. **See Charts 1 & 2**. These support our contention in relation to the increasing care requirements of clients in the sector.

You can see that in a period of less than 3 years, acuity as measured by the RCS rose by over 6% in low care facilities and by approximately 10% in high care facilities.

Chart 1 Resident acuity in low care facilities in SA

[6] Hefford J. Address to National Nursing Workforce Forum. Rethinking Nursing. P57 September 1999.

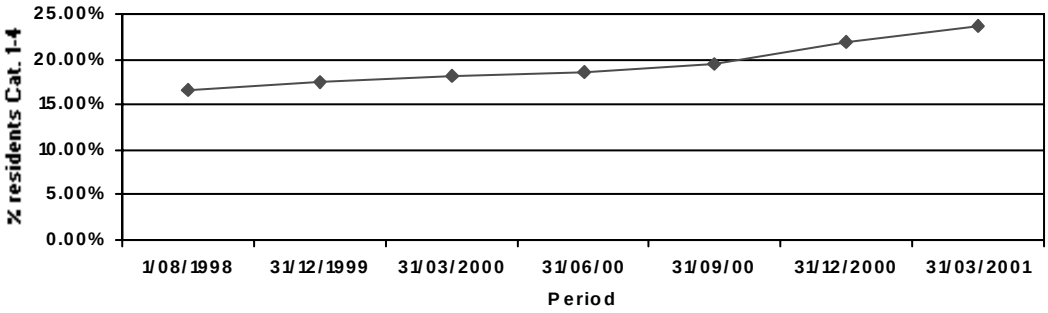
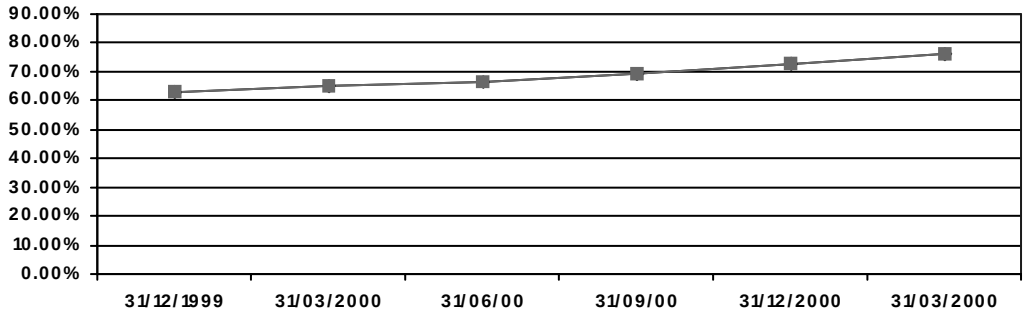

25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
% residents Cat. 1-4
1/08/1998
31/12/1999
31/03/2000
31/06/00
31/09/00
31/12/2000
31/03/2001
Period

Chart 2 Classification of high care facility residents in SA



These changes have occurred due to a variety of factors including:

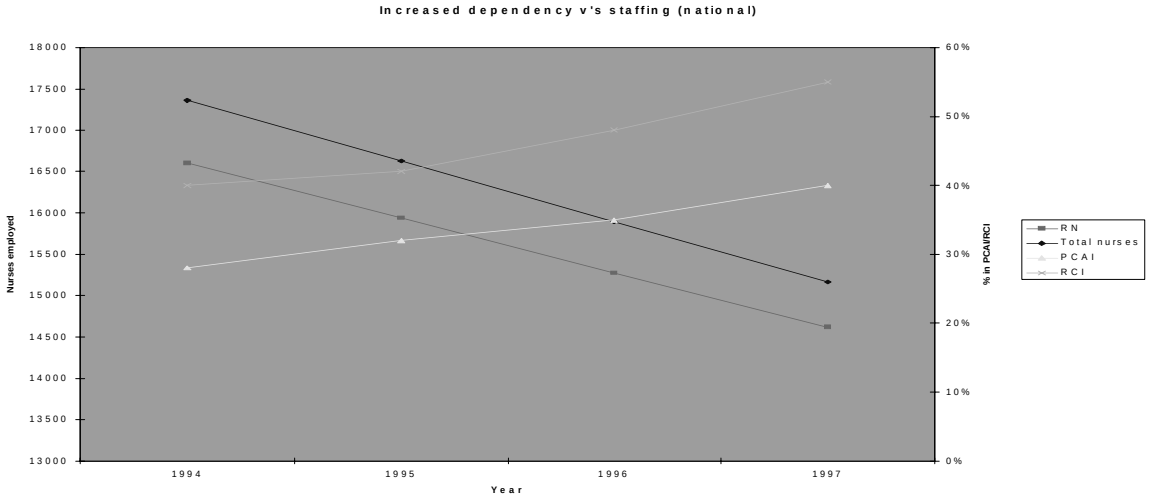
- The ageing of the population and increasing lifespan which affects frailty and health care needs;
- Earlier discharge from hospital care to the residents home or to a RACF; and
- Increase in the availability of treatments and technology to preserve life albeit with ongoing care needs.

They follow a period of continuing acuity increase under the previous care assessment tools ie the Resident Classification Instrument (for the [then] nursing homes, and the Personal Care Assessment Instrument (for the [then] hostels. **See Chart 3**. This is national data drawn from the Commonwealth Department of Health & Family Services [subsequently the Department of Health & Aged Care] reports and contrasted with Workforce information reported by the AIHW.

This Chart shows the continuing decline (nationally) of the Registered nurse and total (professional) nursing workforce within the aged care system at the same time as the assessed care needs of the resident population were increasing consistently.

The same outcomes are clear from examination of recent SA workforce data as will be discussed later in this submission.

Chart 3 Increased acuity – national data before Aged Care Act.



The RCS whilst not an accurate measure of each residents individual care needs on a day to day basis is used as a measure of relative care needs across the sector. The RCS contains elements that measure each residents care needs across a number of areas many of that could be regarded as being central to their nursing and or health care needs. These include but are not limited to:

- Mobility
- Personal hygiene
- Toileting
- Bladder management
- Bowel management
- Medication
- Technical and complex nursing procedures
- Behavioral issues.

Examination of data provided by the Department of Health and Ageing shows that there are high proportions of residents requiring each of these elements of care both in high and low care establishments.

For example in December 1999 some 37.9% of high care residents scored a D (the maximum score) for technical and complex nursing procedures (Question 18). By March 2002 this figure had grown to be 50.9% of residents. Less than 7% of all high care residents failed to register any need for technical and complex nursing care.

In low care the proportion of residents not requiring technical and complex nursing procedures has fallen from 53.4% to 49.4% over the same period meaning that more than 50% of residents now required such assistance.

Attachment 1 is a Table that sets out the change in resident appraisals over the relevant period and provides the basis for other comparisons that demonstrate significant requirement for:

- Continence management programs (only <4% of high care residents do not require bowel management and 89% do require bladder management.) In low care facilities just over 50% of residents required bowel management and around 30% bladder management.
- Hygiene care - no high care residents do not require assistance with personal hygiene. In low care more than 80% of residents needed this care.
- Assistance and care related to mobility – 97% of high care residents and 60% of low care residents need such care.
- Medication management – 99% of high care and 86.5% of low care residents have medication management issues. In high care over 90% of residents medication management scored either a C or D. In low care the number whilst smaller was still a significant 40%.

All residents admitted to either high or low care are required to be provided with a range of care and services (see Quality of Care Principles 1997 issues made under subsection 96-1 of the Aged Care Act 1997).

Role of the RN and EN in delivering health care and interface with Care workers

In high care facilities the requirement for supervision by a registered nurse is commonplace and is generally provided by a RN being rostered on duty at all times.

In low care facilities supervision is less structured. Most low care facilities (the vast majority) employ a Registered nurse at least on day duty Monday to Friday. Supervision, in relation to the delivery of care, is provided through the care plan, through communication books and through handover activities.

Credentialling of Care workers to undertake specific tasks or activities is relatively commonplace. Indeed 'credentialling' of Care workers has extended beyond the proper use of such programs and has been used as an alternative to appropriate training/education for the role and has taken workers beyond their scope of practice, particularly in areas such as administration of medications.

It is also of concern that some workers have been credentialled by an external RN to undertake specific tasks and are then left with no structured supervision or support in relation to the delegated activity. Some employers have required an employee credentialled in one circumstance to apply that delegation to other contexts or cases.

Until very recently Enrolled nurses were not commonly found within the aged care sector. Job descriptions reveal that there has been little to distinguish their role from that of Care workers in many facilities. Some use Enrolled nurses as team leaders in conjunction with care staff however others have Care workers acting as team leaders in teams including ENs.

The role of Care workers in the aged care sector as an integral component of the nursing team is increasingly recognised and accepted. In addition to the earlier references to the NRNE it is also of note that the recently published SA Nursing &

Midwifery Recruitment & Retention Plan[7] acknowledges the role played by Care workers [p15, 23]. The report also notes that Care workers are a potential source of future registered nurses and calls for 'their advancement within the professions' structures.' [p15].

Workforce issues in the aged care sector

As shown in Chart 3 the available data demonstrates that the number of Registered and Enrolled nurses working in the aged care sector nationally has declined through the last decade.

An examination of workforce data produced by the Department of Human Services (and previously the SA Health Commission) reveals that the size of the Care Worker workforce in SA is substantial and growing.

The data for 2002 (to what date) reveals that in the private aged care sector some 9981 (headcount) employees and 5973.3 (FTE) were engaged.

This was comprised as follows:

RN		EN		CW	
Headcount	FTE	Headcount	FTE	Headcount	FTE
2041	1264.6	1176	749.9	6763	3958.8

This means that approximately two thirds of the aged `care workforce is comprised of Care workers with the balance made up of registered and enrolled nurses.

This can be contrasted to the position as recently as June 2000 where the same source showed that the make up of the workforce was just over 60% Care worker and nearly 40% combined RN and Enrolled nurse. The RN proportion of staff had fallen from just over 25% in 2000 to just over 21% in 2002. This reduction to the RN proportion of workforce has taken place despite the increases to resident acuity over that same period.

Earlier data is not directly comparable since it was limited to nursing homes (both public and private sector) and excluded hostels.

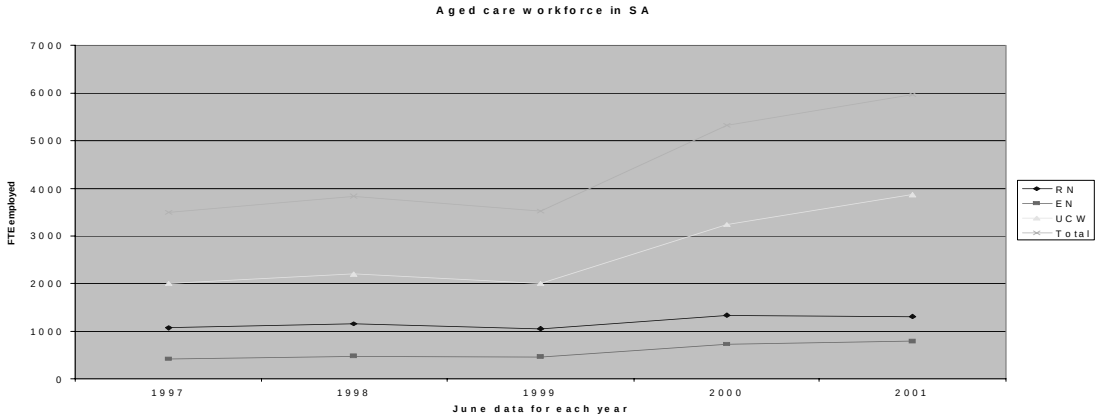
However examination of that data between 1993 and 1999 showed once again that there had been a reduction in the proportion of the RN/EN workforce. Care workers as a percentage of the workforce grew by about 2% over that period.

Chart 4 sets out the relevant workforce information from 1997 to 2001. However it must be noted that the data from 2000 onwards deals with all private aged care, that is both high and low care, whilst the earlier data refers to nursing homes only.

[7] The South Australian Nursing & Midwifery Recruitment and Retention Strategic Directions Plan 2002-2005. Department of Human Services (SA) August 2002.

Even so it clearly shows that the growth in employment is attributable to the growth in employment of Care workers rather than to any significant change in the proportion of Registered or Enrolled nurses employed.

Chart 4 Aged care workforce in SA



Minister for Ageing, Hon Kevin Andrews[8] himself recognized the complexities of the aged care environment in which nurses provide support for older people. He said "It is an unfair burden on nurses to shoulder the responsibility for the income of their aged care facility. That is a business matter. "I am convinced we have to uncouple the relationship between funding and care plans so that nurses can concentrate on what they are trained for - providing the best possible care". Future initiatives to support older people must be cognizant of this requirement. A new documentation model is currently undergoing a process of consultation[9] and the benefit if any in terms of increasing available care hours to resident by nurses is yet to be seen.

However, a significant issue for the recruitment and retention of registered nurses into the aged care sector is the disparity in salary between the acute and aged care sectors[10]. The current gap in South Australia is approximately 10%. With the next round of benefits for acute sector nurses this difference will increase between 13-18% by April 2004, making delivery of parity of salary for aged care nurses a key issue. These factors influence the availability of registered nurses willing to work in the aged care sector. Thus care workers may be employed in increasing numbers in an attempt to fill some of the gap between care needed by older people and available appropriate human resources to provide it.

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[8] Minister for Ageing, Hon Kevin Andrews Press release May 9, 2002
NEW FUNDING SCHEME TO RELIEVE NURSES' PAPERWORK

[9] Pearson et al 2002 Draft national model care documentation system for residential aged care www.health.gov.au/acc/

[10] Cheek, Jones, Ballantyne, Roder-Allen 2002 Ensuring Excellence: Issues impacting on registered nurses providing residential care to older Australians, Final report, CRNHC, Adelaide. See also the 'Recruitment and retention of nurses in residential aged care 2002, Commonwealth Department of Health and Ageing

The recruitment and retention of nursing and care worker workforce has been clearly identified as a significant concern in a number of national and State reports including Ensuring Excellence (Cheek et al 2002); 'La Trobe report 'Recruitment and retention of nurses in residential aged care (CDHA 2002); South Australian Nursing & Midwifery Recruitment and Retention Strategic directions plan 2002-2005 (SADHS 2002);Senate Inquiry into Nursing (2002) and National Review of Nursing Education (2002). Each of these reports identify documentation, supervision of unregulated care workers and increasing acuity of their client population with complex care needs as factors influencing attrition and or stress within the aged care workplace.

Nursing skill mix and succession planning

There is to date little objective evidence of what constitutes an ideal skill mix for nursing services in the aged care sector. Therefore how individual facilities meet their requirements under the Act is currently ad hoc. More research is required as indicated by the following from the Senate Inquiry:

Recommendation 7: That research be undertaken to examine the relationship between health care needs, nursing workforce skill mix and patient outcomes in various general and specialist areas of care, with a view to providing "best practice" guidelines for allocating staff and for reviewing quality of care and awarding accreditation to institutions.

However the evidence is that we are already seeing replacement of Registered and Enrolled nurses by care workers. Research in settings other than aged care have demonstrated a link between the quality of care outcomes and the skill mix of the nursing staff provided. If this experience is replicated in the residential aged care sector we will, over time, see diminishing standards of care.[11]

The ageing care worker workforce and its role in provision of care support is important. The GHR reports the average age of South Australian nursing workforce at 41years, greater than the Australian average of 39.3 years (p102) and suggests that this ageing workforce will opt for greater part-time work and or retirement in the future. It has been suggested that South Australia is between 500-700 registered nurses short of nursing requirements[12].

The environment of complex care requires complex assessment of older people, complex drug management, complex physical care needs and complex behavioural and mental health needs. There is a current lack of infrastructure such as a lack of community mental health care provision and access to support of skilled individuals (systems). Adequate resourcing of the community mental health services should ensure regular ongoing visits to residential aged care facilities. The GHR (p6) reports national data which is consistent with South Australian that states mental health represents 20% of the disease burden but receives only 8% of resources. Only 38% of people with mental health problems access ANY service in relation to their condition in any one year.

[11] New England Journal of Medicine Vol 346:1715-1722 May 30 2002 No 23)
[12] GHR p102 citing Committee Hansaard 27.3.02, p709 (ANF)

Once considered a rare disorder, dementia (often used inter-changeably with Alzheimer's disease) is now a major public health problem which, due to the aging of the population, is predicted to double over the next 20 years[13]. In addition the many forms of Dementia and other challenging behaviours are resource intensive and require capacity, knowledge and skills to continue to manage them. A review of the literature reveals that due to factors such as confusion and compromised communication dementia clients are rendered more vulnerable in acute care environments[14]. Indeed there are risks associated with hospital admission for long-term dementia patients[15]. Although older people constitute only 12% of the population in Australia, as a cohort they occupy 56% of acute bed days[16]. It is possible that some older people with dementias may end up in hospital as a consequence of limited availability of skilled nursing staff in aged care facilities. The review must consider the consequences again of one sector's issues (eg recruitment and retention of registered nurses in aged care) and how they impact and flow on to the other (number of people with co-morbidity and dementia in acute hospitals).

Conclusion

The ANF (SA Branch) believes that decisive action must be taken now if Australians are to be assured of access to good quality care which may be provided by acute hospitals, in the community and in residential aged care. A positive focus on active ageing must also recognise the potential for rehabilitation and transitions of health status not necessarily a continuing decline as pathways for the future ageing population.

Issues of available, appropriate staffing, the ageing and poorly rewarded staff of aged care services are issues that have been in the public domain for some time and must be resolved.

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[13] Hamdy, R. 2001, 'Alzheimer's disease: An overview', *Southern Medical Journal*, vol. 94, no. 7, pp. 661-662.

[14] Cherry, J. & Reid, J. 2001, 'Fast-tracking older people through A&E', *Nursing Standard*, vol. 15, no. 16, pp. 42-44.

[15] Nay, R., Closs, B., Pitcher, A. & Koch, S. 2000, *Dementia Project: Improving the Admission and Discharge Practices of Acute and Sub-Acute Care Facilities in Relation to People Who Are Dementing*, Gerontic Nursing Professional Unit, La Trobe University, Vic., October.

[16] Nay, R., Garratt, S. & Koch, S. 1999, 'Challenges for Australian nursing in the International Year of Older Persons', *Geriatric Nursing*, vol. 20, no. 1, pp. 14-17