australian nursing federation

Inquiry into Aged Care

1. Introduction

1.1 The ANF is the national union for nurses in Australia with branches in each state and territory. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing in Australia.

1.2 The ANF's 140,000 members are employed in a wide range of enterprises in urban, rural and remote locations in the public, private and aged care sectors, including hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industries.

1.3 The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veterans affairs, education, training, occupational health and safety, industrial relations, immigration and law reform. The ANF has also taken a positive role and active leadership in many of the Federal, State/Territory and local activities relating to aged care. ANF representatives are on a number of national committees including the Aged Care Workforce Committee, the Aged Care Advisory Committee, the National Accreditation Liaison Group, the Australian Pharmaceutical Advisory Council's working group that developed the guidelines for medication administration in residential aged care. The ANF has also taken a lead role in the National Aged Care Alliance which brings together many of the key stakeholders to develop consensus positions on matters of mutual interest and concern in relation to aged care and provides secretariat support for the group.[1]

[1] See www.naca.asn.au

1.4 Our members have consistently raised with the ANF concerns about the current delivery of aged care services. Inadequate staffing levels, inappropriate skills mix, excessive workloads, declining standards of care, and excessive documentation, have been frequently reported, and have contributed to difficulties recruiting and retaining qualified nursing staff to work in the sector.

1.5 The introduction of the policy of ageing in place has had significant implications for those providing care in residential facilities. Professor Warren Hogan, in his report [2] found that the age, dependency and acuity of people in nursing homes have increased and that as a direct result of the policy, there are an increasing number of high care residents in hostels.

1.6 A national shortage of nurses and the wages gap between nurses working in the aged care sector and nurses working in the public hospital sector, which currently stands at 21.6% or $170.50 per week national average, is exacerbating recruitment and retention difficulties in the aged care sector.

2. Recommendations

2.1 That a benchmark of care which links resident outcomes, staffing levels and skills mix to funding, including funding for nursing and other care staff be developed for inclusion in regulation and industrial instruments.

2.2 That guidelines be developed providing for minimum staffing levels and skills mix in aged care settings.

2.3 That there be a clear requirement for 24 hour registered nurse cover for all high care residents in aged care facilities.

[2] Hogan W Pricing Review of Residential Aged Care 2004

2.4 That the government consult with unions and providers on the amount of additional funding required to close the wages gap between staff working in aged care and their public hospital counterparts, that dedicated funding be made available to close the wages gap, and that provision of the funding be conditional on the achievement and maintenance of wage parity.

2.5 That the Australian Government legislates for the introduction of annual reporting on the way aged care providers spend their funding, particularly on care activities and staff.

2.6 That the funding arrangements for accommodation and care components of aged care services be accounted for separately.

2.7 That workload management tools be developed for use in residential aged care.

2.8 That the Workplace Relations Act 1996 be amended to provide for the extension of the current award making powers to allow the AIRC to make an award(s) including one by consent in a timely manner where the parties are unable to conclude an agreement.

2.9 That the current rural scholarships for nurses working in aged care be extended to urban areas.

2.10 That 1100 new undergraduate nursing places be allocated to universities per year for the next four years

2.11 That a chief nursing officer (however titled) be appointed at a federal government level.

2.12 That the staffing and skills mix standards in residential aged care facilities is given high priority during the accreditation process.

2.13 That the aged care standards agency is required to use professional guidelines as benchmarks during accreditation, eg. the Australian Pharmaceutical Advisory Committee (APAC) Guidelines for Medication Management in Aged Care.

2.14 That the government actions the recommendations of the priority action plan put forward by the Young People in Nursing Homes Alliance following the national summit in 2002 which outlines a process focusing on: the needs of individuals, seamless service delivery, whole of government approaches and cross sector partnerships.

2.15 That the National Aged Care Alliance's call for: *Greater incentives to mainstream residential care providers to provide quality dementia care; and an improved mix of capital/current funding to promote dementia specific care for people with challenging behaviours,* be adopted.

2.16 That a review of community care packages be undertaken that focuses on the integration of services and links between community service providers and health care providers.

2.17 That in order to facilitate the desire of most Australians to remain in their home, funding that is commensurate with that provided to residential aged care is considered for the community sector.

2.18 That a multifactorial approach be adopted to transitional care with an emphasis on multidisciplinary care and nurse oriented coordination of care across all health sectors.

3. Sector overview

Prior to addressing the terms of reference of this inquiry the ANF would like to take the opportunity to give an overview of the aged care sector with particular reference to the nursing workforce and the stressors currently being applied, and provide a report on the aged-care phone in undertaken by the ANF on July 3 2004.

3.1 Employers in the residential aged care sector

In the year 2003 there were 1,593 approved providers operating 2, 958 aged care facilities (nursing homes and hostels).[3] In broad terms, two thirds of care is provided by the not-for-profit sector, with the balance provided by the private for profit and government sectors.

3.2 Resident places in 2003

NSW	51,766
VIC	37,445
QLD	26,843
WA	14,234
SA	12,377
TAS	3,987
ACT	1,515
NT	380
TOTAL	**148,547**

Source: 2003. Report on the operation of the Aged Care Act 1997
1 July 2002-30 June 2003, Table 4, p. 8.

3.3 Nursing Numbers

The Australian Institute of Health and Welfare Nursing Labour Force Report 2002 reported that in 2001 there were 20,179 registered nurses in the residential aged care sector and 12,462 enrolled nurses, accounting for approximately 14.6% of the entire registered and enrolled nurse labour force.[4] More recently the aged care workforce numbers were assessed in a study commissioned by the Department of Health and Ageing (NILS study).[5]

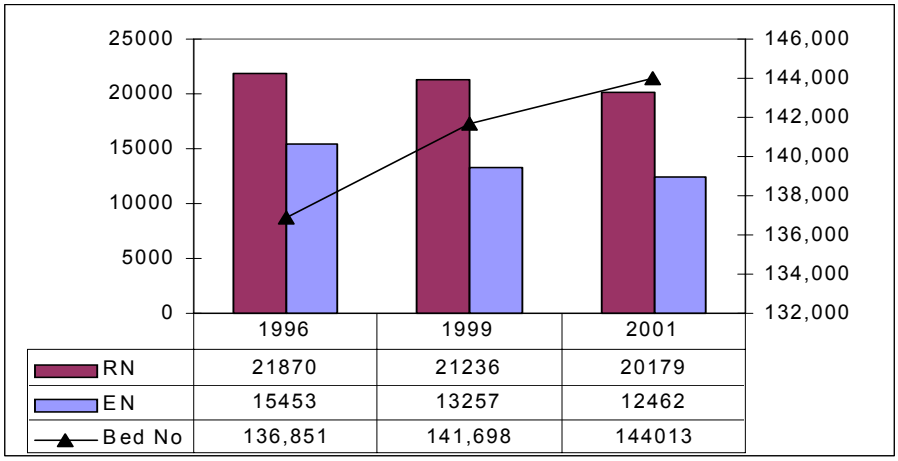
[3] Commonwealth of Australia 2004 *Review of pricing arrangements in residential aged care: final report*.
[4] 2003. AIHW. Nursing Labour Force 2002, p. 14 and additional tables Table 5 –xdo1, xdo2
[5] Richardson S 2004 *The Care of Older Australians: A picture of the residential aged care workforce* National institute of Labour Studies Flinders University Adelaide Australia

The results are as follows:

Direct nursing care employees	Public and Private Sector	Private Sector Only
RN (registered nurses)	16265	14720
EN (enrolled nurses)	10945	9905
PC (personal carers)	42943	38864

3.4 Decline in number of nurses employed in the aged care sector from 1996-2001

The Australian Institute of Health and Welfare[6] reported an 11.1% decline in the number of registered and enrolled nurses working in the aged care sector between 1996 and 2001. Using the above data for 2004 it can be estimated that a further decline of almost 18% has occurred since 2001. At the same time dependency levels in residential aged care facilities have risen, with the number of residents receiving high level care increasing from 58% in 1993 to 63.6% in 2002[7].



Source: 2002. AIHW. Residential aged care facilities in Australia – a statistical overview, Table 1, p2.

[6] Australian Institute of Health and Welfare 2003 *Nursing Labour Force 2002*

[7] Steering Committee for the Review of Government Service Provision 2004 Report on Government Services 2004, Productivity Commission, Canberra.

3.5 Wages

Prior to 1996 there was generally parity between nursing wages in the public acute hospital sector and residential aged care establishments. Since 1996 the wages differ considerably with the disparity progressively widening as nurses in the private and public acute sectors have secured superior outcomes through enterprise bargaining. As at April 2004 the wage disparity stands at 21.6% or $170.50 per week.

Based on RN Level 1 Year 8. Victorian rates are based on RN Grade 2 Year 8 (comparable to RN Level 1 Year 8 in other States and Territories)

3.6 Hours of work

Nationally, in 2001 the average hours worked by RNs was approximately 30.8 per week and ENs 29.4 hours per week. Fifty four percent of registered nurses work part time.[8] Research shows that many nurses work part time predominantly to cope with the stress and intensity of the work.[9] But the ageing of the nursing workforce is also a significant factor. The average age of nurses working in aged care is 47.[10]

[8] AIHW 2003 *Nursing Labour Force* 2002 additional tables table xdo5

[9] Buchanan J Bretherton T Bearfield S Jackson S 2004 *Stable but Critical: The working conditions of Victorian Public Sector nurses* in 2003 acirrt University of Sydney

[10] AIHW 2003 *Nursing Labour Force* 2002

3.7 Enterprise Bargaining

From 1996 to 2001 most employers avoided reaching EBA's and relied on movements in the award safety net to adjust nurses' wage rates. Consequently aged care wages lagged behind and this had a significant impact on the ability of the sector to recruit or retain nursing and other care staff. This in turn led to a decline in overall nursing numbers and nursing hours available per resident.

Employers have argued that enterprise bargaining does not suit the aged care sector given that the federal government will not fund wage increases above safety net adjustments and that aged care employers have little if any capacity to increase profits to grant wage increases.

Employers also argue that the lack of human relations or industrial relations support for small business employers means they are reluctant to engage in bargaining and the examination of productivity efficiency. The ANF has proposed that these matters be addressed on an industry or sector basis through the establishment of a consultative committee pursuant to s131 of the WRA 1996, however this proposal lacks employer support.

In response to the paucity of enterprise agreements, the Victorian and Northern Territory Branches sought to adjust wages using s.170MX of the Workplace Relations Act 1996 on the basis that agreements could not be secured and the employees were historically covered by paid rates awards (s.170MW [7]).

While this vehicle was available it proved to be cumbersome and time consuming with the Commission proceedings taking up to two years and the final wages adjustments doing little to close the wages gap.

One of the key problems with existing arbitral processes is that it is incumbent on the union to satisfy the AIRC that attempts at bargaining have been exhausted for each and every employer sought to be covered by the MX award. Nationally there are in excess of 1500 employers in the residential aged care sector

Over the past two to three years the numbers of agreements has risen – although they often only provide for salary packaging and where the agreements do provide for wage adjustments they lag well behind the market for nurses.

4. Aged Care Phone-in

On Saturday 3 July 2004, the Australian Nursing Federation (ANF) Federal Office and State Branches conducted a national aged care phone-in. The purpose of the phone-in was to raise awareness about aged care issues in the lead up to the forthcoming federal election, and to provide an opportunity for people working in aged care, residents, and families and friends of residents, to share their views about the current delivery of aged care services in Australia.

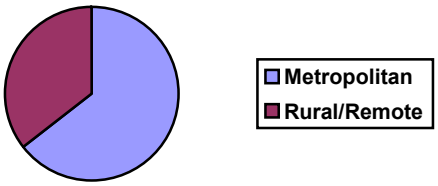
The results of the phone-in give a picture of what nurses, personal carers, residents and residents' families experience in the aged care sector. From this report, the needs of the sector can be clearly understood. The results are presented in the following report[11].

4.1 Aged Care Phone-in results

Over 1,000 people called the State Branches of the ANF to speak to Branch officials. The issues raised were carefully documented, collated and analysed.

Sixty four per cent of callers were from metropolitan areas, with 35.6% from rural or remote areas.

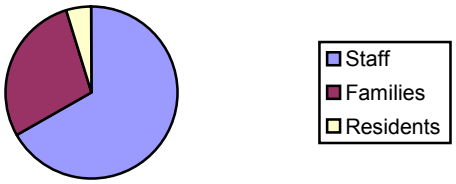
Figure 1
Place of Residence of Callers



[11] Australian Nursing Federation 2004 Aged Care Phone-in Report www.anf.org.au

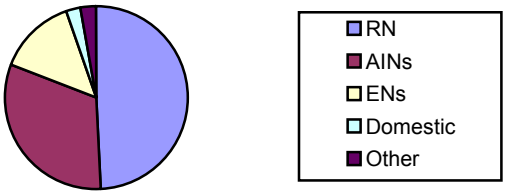
Staff comprised 61.9% of callers; 26.5% were relatives, friends, or concerned members of the community, and 4.5% were residents in aged care facilities.

Figure 2
Type of Caller



Staff callers comprised 49.2% registered nurses; 31.7% assistants in nursing (or personal care assistants); 13.7% enrolled nurses; 2.6% domestic services staff; and 2.8% other staff. The majority of staff (93.3%) worked in the residential aged care sector, with 3.4% working in public hospitals and 3.3% in the community.

Figure 3
Staff Categories



The four top issues of concern by staff, residents and families were: inadequate staffing levels (86.1%); inadequate standards of care (62.0%); complaints about food (27.1%); and inadequate domestic services (18.4%).

- *Staffing levels are appalling. Staff go through hell with unreasonable workloads, unreasonable stress levels and unreasonable expectations. Surely this is not what the Government want (resident Tasmania).*

- *Staffing levels have deteriorated over the past four years. It is very distressing (relative of resident Tasmania).*

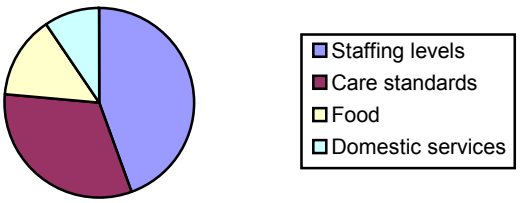
- *Staffing levels are too low. We only have time to perform essential tasks. We have no time to spend with the residents (PCA SA).*

- *Staff are doing a marvellous job but there aren't enough of them and they just can't keep it up (relative of resident NSW.)*

- *I worked in a dementia unit. We were forever losing nursing hours. We just couldn't provide adequate care. The last time hours were cut I told management 'this is unjust to both residents and staff. I'm out of here' (RN Queensland).*

- *Food and domestic services, particularly cleaning, have deteriorated. My mother's food is routinely delivered cold (relative of resident Queensland).*

Figure 4
Issues of Concern



Callers were also asked if they considered staffing levels to be adequate – 85.9% of callers said no, with 70.9% considering that there were inadequate numbers of registered nurses.

Callers were also asked if they considered government funding for aged care to be adequate – 86.7% of callers said no, however most callers qualified their response by saying they knew the Government had increased funding for aged care, however they did not know how the money was being spent and it had not resulted in any improvements in staffing levels or care.

- *Staff have no time to interact with or support residents, but they show extraordinary care and compassion (relative of resident Tasmania).*

- *Money is not spent on residents or staff. The owners need to be made answerable for how they spend the money (community member Queensland).*

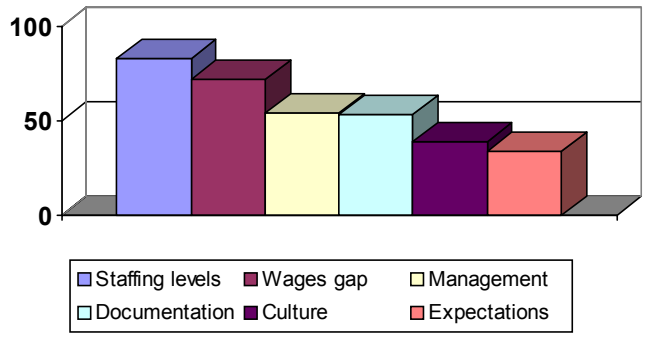
- *I think the funding is OK but it must be directed to 'frontline care'. That's just not happening now (relative of resident NSW).*

- *I worked out that I can only spend 27 minutes with each resident during an 8 hour shift. This is appalling. How can I treat people with dignity and maintain nursing standards? (RN SA).*

- *We survive because we have short breaks, go flat strap and work beyond our finishing times. We work under pressure all the time (RN Queensland).*

When asked why they thought nurses did not want to work or ceased working in aged care, 83.1% of callers nominated inadequate staffing levels; 72.1% the wages gap between nurses working in aged care and nurses working in other sectors; 54.6% inappropriate management practices, including lack of support for staff; 53.8% nominated excessive documentation; 38.9% the workplace culture; and 19.4% unrealistic expectations from residents and relatives and friends of residents.

Figure 5
Why Nurses Leave Aged Care



- *I no longer work in aged care. We were so short staffed that I couldn't provide safe care and my own safety was being compromised as well (RN Tasmania).*

- *We have horrendous workloads and heavy workloads particularly for the AINs. It is all task focused. We do not get any time to provide quality of care let alone quality of life (RN Queensland).*

- *I just can't cope with the workloads any more (EN Tasmania).*

- *Management need to spend time on the floor to see what is happening. It's all about money. They won't acknowledge that there is not enough time to get the work done (relative of resident Tasmania).*

- *I could work in a supermarket for more money and less stress (PCA Victoria).*

- *The poor wages in aged care are a disgrace. Management does not value older people. They are just there to make money (resident NSW).*

- *There is a huge amount of documentation, most of it repetitive. I do at least an hour of unpaid paperwork after every shift (RN Queensland).*

When asked what could be done to address the issues raised, 83.0% said more staff were required, while 77.6% of callers said more funding was required.

- *Money must be spent on staff and residents, not buildings or profits (Domestic services worker Victoria).*

- *Let's get real. The people we are caring for are someone's parents or grandparents. They deserve to be looked after properly (EN SA).*

- *It is very disheartening when I visit my mother. The facility needs more staff and more qualified staff not just extra staff (relative of resident Tasmania).*

- *The accreditation process is a farce. Everything is set up for the day and then disappears (Cook in aged care Victoria).*

- *Management don't value staff. When I think about it, they don't value residents either, otherwise they would employ more staff (relative of resident NSW).*

- *We need more staff. The burden of caring is falling on increasingly fewer people (RN Queensland).*

Other issues frequently raised by callers included: the increasing and inappropriate use of unqualified workers as substitutes for qualified nurses; the lack of accountability and transparency in the way funding to the aged care sector was being used; the lack of time staff had to spend with people to add the quality to their care; the lack of continuity of care due to increasing staff turnover; and the increasing reliance on family members and friends to provide basic care such as toileting and feeding.

- *When my mother goes to visit my father she goes to feed him. If she didn't he just wouldn't be fed. It's not the fault of the staff. There is just not enough staff to cope with all that needs to be done (relative of resident SA).*

- *My mother has dementia. I was told I had to help look after her because there wasn't enough staff. I am in my 70's and I'm finding it difficult. It's not the staff's fault. There just isn't enough of them to do the work. I feel the Government is neglecting my mother (relative of resident Tasmania).*

- *There needs to be more transparency and accountability in the management of funding. Where is it all going to? (relative of resident Tasmania).*

- *I am constantly doing duties beyond my skill level (AIN Queensland).*

- *I frequently worked double shifts and got called in to work on my days off. Sick leave was not replaced. I worked long hours and was always rushed. I became an expert in cutting corners which got too scary so I left (EN Victoria).*

The results of the phone-in confirmed the views held by the ANF. The messages for the current Federal Government, which has responsibility for the aged care sector, are very clear.

- *What is the point of the Government pouring money into aged care if it doesn't make things any better for residents or staff (EN SA).*

- *Governments need to value older people. How can they let older people suffer. It's inhuman (relative of resident Victoria).*

- *Politicians are getting older every day. They should think about what it will be like to be a resident in an aged care facility– then things might change (relative of resident Queensland).*

- *I just can't do it anymore. I love working in aged care but it is too demoralising, not being able to provide quality care to people who have every right to be cared for with dignity and respect (RN Tasmania).*

- *I'm not getting any younger myself, but if I need care, you would have to drag me kicking and screaming into an aged care facility (RN Victoria).*

It is within this climate and with this evidence in mind that we make our submission to the inquiry.

5. Terms of reference

5.1 The adequacy of current funding proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training

The current funding or legislative requirements incumbent upon providers in the aged care sector do not provide any impetus to improve the workforce shortage and retention issues in the sector. The above report from the recent ANF aged care phone-in indicates the two major reasons nurses leave the sector are staffing levels and wage disparity. This is accepted as fact by the majority of the aged care industry, and has been noted by the National Aged Care Alliance (NACA):

> *Nurses and care workers cite excessive workloads, lack of wage parity with their public hospital counterparts, and their inability to achieve desired care outcomes as deterrents to remaining in the industry. This impacts on the delivery of quality aged care services, contributes to the critical shortage of skilled staff, and has led to the current staffing crisis in aged care.*[12]

5.1.1 Staffing levels

Staffing levels and the skills mix of staff impact directly on the workloads of nurses and ultimately on the quality of health outcomes for residents.

The increasing dependency of residents in aged care facilities and the labour intensive nature of the service means that there are few opportunities for improving the productivity of aged care. Ultimately, with the current funding arrangements, any savings or 'efficiencies' deemed necessary are gained by decreasing nursing hours, or by eliminating nursing positions. The ANF is concerned that there are increasingly fewer registered and enrolled nurses available in aged care facilities and some high care residents in low care facilities have very limited or no access to a health care professional such as a registered nurse.

[12] NACA 2000 Quality staffing www.naca.asn.au

5.1.2 Skills mix

The ANF is concerned by the practice of replacing registered and enrolled nurses with unlicensed carers in order to provide a 'cheaper' alternative workforce. The NILS survey on the aged care workforce found that there had been a substantial substitution of personal carers for nurses in recent years.[13]

The ANF does not oppose the use of unlicensed nursing and personal carers (however titled) in residential aged care facilities. In fact, the ANF provides industrial coverage for these workers and includes them in all areas of ANF activities. We are however opposed to the replacement of registered and enrolled nurses with unlicensed workers where the work requires the skills and knowledge of either an enrolled or registered nurse.

Unlicensed nursing and personal carers generally are educated and competent to provide a basic range of personal services and some are competent to be delegated other aspects of nursing care by registered nurses. However, unlicensed nursing and personal carers are not able to always recognise serious problems including changes in the health status of residents and they require supervision and support from registered nurses.

Registered nurses, decreasing in number, are feeling the burden of being unable to adequately support more staff with lower qualifications, of assessing and caring for more patients who have complex needs, and of maintaining the lengthy and difficult documentation currently required by the RCS. Pearson et al (2001) found that *the increasing stress and responsibilities experienced in association with working with and supervising an increasing number of unqualified nursing staff is an important issue in the retention of qualified nurses in the aged care setting.*[14] The same study also identified that low work satisfaction was a key issue in the retention of nursing staff, and was associated with such issues as lack of time to build relationships with staff, residents and residents' families; lack of time to adequately use expertise in the assessment and care of their residents; adequate nurse to patient ratios; support for administration activities; and adequate supplies and equipment.

[13] Richardson S 2004 *The Care of Older Australians: A picture of the residential aged care workforce* National institute of Labour Studies Flinders University Adelaide Australia
[14] Pearson A Nay R Koch S Ward C 2001 *Australian Aged Care Nursing: A critical review of education, training, recruitment and retention in residential and community settings* LaTrobe University Melbourne

The ANF is therefore calling for minimum staffing levels in all aged care facilities, 24 hour registered nurse cover wherever there is one or more high care resident and for each facility employing nurses to employ a full time director of nursing (or classification equivalent). We also call for benchmarks of care that are directly linked to appropriate skill mix of staff required to deliver appropriate care.

5.1.3 Wage disparity

The current wage disparity between nurses working in aged care and their colleagues working in the acute care sector sends a very loud message that nurses in the aged care sector are deemed to be worth less than their other nursing colleagues. This message is being sent as we encourage new graduates and their experienced colleagues to seek opportunities in gerontic nursing.

Nursing in residential aged care requires special knowledge and skills to provide the type of care needed. Nurses in residential aged care often have primary responsibility for the health and well being of older residents and they work with less support from other professionals such as general practitioners and allied health care providers.

Gerontic nursing is not the same as the acute sector or the community, or primary health care, but it requires a distinct body of knowledge, and should not in any circumstance be considered less worthy than other specialties.

A major study funded by the Australian Government included the following recommendation: that *(aged) care employer groups and relevant industrial organisations together develop a strategy to move towards wage parity between aged care and acute sector nurses in each State and Territory.*[15] The ANF is disappointed that despite this recommendation attempts to address the situation have been thwarted.

Aged care providers argue that they are not adequately funded to provide wage parity for nurses, however there has been two large injections of Australian Government funds into aged care that have been specifically earmarked to address the wages gap issue.

[15] Commonwealth Department of Health and Ageing 2002 Recruitment and retention of nurses in residential aged care: Final report CDHA Canberra

In the 2002/2003 federal budget, $211.1m was provided over 4 years to 'close the wages gap'. $110m has already been dispersed over the last two years, yet despite that the wages gap has doubled (from $84 per week when the initiative was introduced to $170 currently). In the most recent federal budget, $877m was again allocated to assist aged care providers to 'pay competitive wages'. Although receiving the funds is provisional on a number of conditions, not one of those conditions is closing the wages gap. The ANF is very cynical about the true intention of the provision of those funds.

The ANF is calling for the development of a mechanism to ensure the aged care sector achieves and maintains wage parity with the acute care sector; a mechanism that responds to changes in wage rates and is accommodated by an effective indexation system that provides employers with adequate funds when wage rises are negotiated.

Recent findings in the current NSW aged care wages case in the NSW IRC has shown that the use of 'creative accounting' methods by some aged care providers has raised serious questions about claims of their inability to pay competitive wages.

The ANF is calling for a system to monitor that the funds provided for residential aged care are used to provide care to the residents of aged care facilities. Funding arrangements in residential aged care should include a transparent and accountable allocation for the health and aged care component. Accommodation and other 'extra' services as well as other funds should attract a separate allocation of funds that are accounted for independently.

Nurses, both enrolled and registered, are a significant investment that must be adequately funded. Nurses are the key to the quality of aged care and health services provided to Australians both now and in the future.

5.1.4 Workforce planning

Gerontology is a specialist area. Ageing is a complex process and care of ageing people requires advanced nursing skills, specialist qualifications and constant review of practice. To ensure quality of care is maintained and to provide an incentive to work and remain in aged care, adequate undergraduate nursing course places need to be made available in universities, scholarships for postgraduate study need to be extended to the urban areas and adequate workplace training and education needs to be accessible and of high quality.

The Australian Government has increased undergraduate nursing course places in universities but the number allocated falls well short of what the industry needs. Both the National Review of Nursing Education and the Hogan report called for far greater numbers of undergraduate places. The ANF has estimated that 1100 extra places per year for four years is necessary to adequately address the nursing shortage.

The ANF welcomes the funding provided in the most recent federal budget to assist aged care workers with a Certificate III qualification to access enrolled nursing qualifications. The ANF is advocating for the funding to be provided to registered training providers to enable them to offer additional enrolled nursing courses. It should be noted however that obtaining the quality clinical placements essential to the enrolled nursing qualification may present a significant difficulty.

The ANF is also concerned with the growing number of personal carers accessing a Certificate IV qualification that does not lead to licensing as an enrolled nurse. The licensing of people providing nursing care is an important process that provides protection and recourse for the public whose lives depend on those who are caring for them. Licensing ensures a consistent, safe and effective standard of nursing practice.

Aged care is one large sector among many where the Federal Government has direct responsibility for the nursing workforce. As we have outlined, the workforce needs of that sector are complex and require urgent attention. The appointment of a Chief Nursing Officer at a federal level will, among other things, assist the government to properly assess, address and maintain the nursing workforce requirements of the aged care sector. The ANF considers the appointment of a Chief Nursing Officer as a critical factor in managing the many challenges facing the aged care workforce.

5.2 The performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

i. assessing and monitoring care, health and safety;

ii. identifying best practice and providing information, education and training to aged care facilities, and

iii. implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.

The ANF is very concerned by a propensity by the aged care industry to apply what is in effect 'industry practice' as 'industry standard' in relation to staffing levels and skills mix. Industry practice can be seriously flawed, failing both the residents and staff of facilities, and arguably falls well short of industry standards as legislated in the Aged Care Act and its schedules. But the ANF is presented with 'industry practice' dressed up as industry standards time and again to support practices that result in poorer staffing levels, inadequate skills mix and ultimately an inability to maintain quality in the provision of care. It is a dangerous path to allow industry practice to become, by default, the industry standard. The care and safety of residents and the care and safety of those caring for them is severely compromised by this situation.

As such there is a missing link in the accreditation process that hinders the Agency's ability to formulate recommendations on quality outcomes related to skill mix and staffing numbers. It is the opinion of the ANF that this should be rectified immediately. There is increasing evidence in the acute health sector that health outcomes including morbidity and mortality are a direct correlation of the number of registered nurses and the hours of nursing care that they provide.[16] There are also some studies from the United States of America suggesting that higher ratios of registered nurses and licensed practical nurses (equivalent to enrolled nurses in Australia) lead to positive outcomes in residential aged care.[17]

The preparation for accreditation is an intense process requiring hours of nursing resources that would be better spent delivering care to residents. Many nurses resent the burden of paperwork that is involved in aged care, paper work that is necessary to complete the RCS and to undertake the intensity of the accreditation process. Although it is intended that the accreditation process merely assess the continuous routine management practice of the facilities, gearing for the actual accreditation visit can be gruelling. Anecdotally we know that all too often there is intense activity around accreditation and a number of callers to our aged care phone-in stated that they spent time documenting care that was never delivered. The accreditation process is overly focused on documentation with little assessment of the resident's condition and the care of the resident that is actually provided.

Staffing and skills mix are key performance indicators in residential aged care and information should be collected about the staffing profile in all facilities. The ANF recommends that the staffing and skills mix model used in residential aged care facilities is given higher priority during the accreditation process.

[16] For example Needleman et al 2002 Nurse staffing levels and the quality of care in hospitals New England Journal of Medicine 346(22) pp1715-1722 and Aiken L Smith H and Lake E 1994 Lower Medicare mortality among a set of hospitals known for good nursing care Medical care 32(8) pp 771-787

[17] cited in Harrington C et al 2000 Experts recommend minimum nurse staffing standards for nursing facilities in the United States The Gerontologist 40(1) pp 5-16

The ANF also recommends that workload management tools be developed for use in residential aged care. There is a need to have a validated method for assessing workloads taking into consideration the many variables present, eg. the competency of staff; the resident profile including their dependency and health care status; the design of the facility; and access to allied health personnel etc. These tools could be developed for use as a package together with a nursing care plan and other documentation and their application be assessed as part of the accreditation process.

5.3 The appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements

5.3.1 Young people in residential aged care facilities

Currently 4.5% of residents in aged care facilities are under 65. One third of these have an acquired brain injury, another third have a physical disability whilst the remaining third have neurological disease such as multiple sclerosis (MS) or an intellectual or physical disability.[18] Younger people in nursing homes are among the most disadvantaged and vulnerable people in the community. They face systemic bias in disability service access due to the nature of their disabilities, poor system interfaces and absurd funding anomalies that render them ineligible for certain government subsidies. They have little opportunity for choice.

Nurses working in aged care are skilled in just that, care of older people and the science of ageing. They do not necessarily have the skills required to meet the specialised needs of those with other disabilities not inherent with ageing. Although individual personal care needs are met to the best of the facilities' ability, little else can be done either therapeutically or socially. There is little or no peer support as the environment does lend itself to visits by friends of younger people adding to isolation caused by age difference.

[18] The National Summit on Young People in Nursing Homes 2002 Priority Action Plan: The way forward sourced from www.mssociety.com.au/itswrong/national_alliance.html

This isolation added to the fact that there are few opportunities to participate in community life, and little or no access to required therapy services, leads to deterioration in physical and psychological conditions. It is estimated that one third of younger residents with MS suffer depression. Only 11% of these get treatment.[19]

We know the stress the aged care sector is under currently, stress that makes it very difficult to provide quality care to the elderly. One can only imagine the limits to which the nurses and carers are stretched trying to meet the needs of younger people with specialised requirements. Or worse still, imagine to what degree those needs cannot be met.

The ANF supports the initiatives in WA where younger people have been relocated to more appropriate facilities. There are also isolated examples of intelligent practice where separate 'wings' have been added to facilities to accommodate younger people. The ANF recommends the government heeds the priority action plan put forward by the Young People in Nursing Homes Alliance following the national summit in 2002 which outlines a process focusing on: the needs of individuals, seamless service delivery, whole of government approaches and cross sector partnerships.

5.3.2 Residents with special needs

People with high levels of care needs such as those with dementia or a mental illness often have their care compromised in an environment where staffing and skills mix is chronically inappropriate. Dementia in particular is an issue of central concern to aged care as it impacts on every part of the care and community care systems. Currently there is little incentive to provide 'extra' care for such residents in the form of specialised accommodation and specially skilled nurses.

[19] Physical Disability Council of NSW 2004 It is wrong to have young people in nursing homes factsheet www.pdcnsw.org.au

The National Aged Care Alliance has called for the need for:

> *Greater incentives to mainstream residential care providers to provide quality dementia care; and an improved mix of capital/current funding to promote dementia specific care for people with challenging behaviours*.[20]

The ANF contends that the issue of funding for special needs is a vitally important one and recommends a funding formula that rewards those providing a high standard of care such as more staff supervision and opportunities to develop therapeutic relationships, the use of consultants such as expert nurses in mental health and dementia care, and better layout of facilities etc.

5.4 The adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly

Community care is a complex matrix of services and funding streams that is difficult for the most experienced person to negotiate. At a time when we are encouraging our older people and people with disabilities to plan their own care, or remain in their own homes and communities it is becoming more difficult to do so. The system is confusing for people to access and is administratively inefficient for Governments and service providers.

Most community care programs do not have agreed national targeting criteria or benchmarked standards of care. Availability varies widely and there is little coordination between the formal sections of the system and informal support networks.

Research has found that there is fragmentation, rigid boundaries around the kinds of care available, lack of flexibility and limits on choice of care for individuals.[21]

[20] National Aged Care Alliance 2003 Background paper: Dementia and aged care www.naca.asn.au
[21] The Myer Foundation 2004 2020 A vision for aged care in Australia Melbourne

There is also evidence of considerable unmet need for basic home support services and often it is wrongly perceived that low levels of service use imply low levels of need.[22] In fact this is often far from correct. The request from someone for help with gardening services may well be an indicator that their health is deteriorating and should be followed with an assessment by a suitably qualified health care provider such as a nurse. Links to and integration with health care providers on a regular and seamless basis is essential for the success of any home base care.

The ANF recommends a review of community care packages that focuses on the integration of services and links between community service providers and health care providers. Also, in order to facilitate the desire of most Australians to remain in their home or community as they age, funding that is commensurate with that provided to residential aged care should be considered for the community setting.

5.5 The effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

Meeting the post-acute needs of the older person has long challenged the health care system. Older patients take longer, on average, than younger patients to regain stability after acute illness and cannot always be transferred quickly from hospital to home or to a residential aged care facility. The therapeutic needs of 'difficult to discharge' older patients combined with increased numbers needing hospitalisations has significant implications for acute general and surgical beds in hospital settings. The most common reaction to the so called "bed blocking" phenomenon caused by this situation is to create 'transition beds' – indeed the recent federal budget allocated funding for an increase in such beds across Australia. Important as transition beds are, the issue requires a more multifactorial approach that has as its core, a change in focus from a hospital or bed centric model to include a patient/community focused model to meet the needs of this population group.

[22] ibid

Professor Hogan in his review of pricing arrangements in residential aged care supports this view and states that *there are alternatives which can complement residential aged care and delay or prevent admission to residential aged care*[23]. His report also supports the need for seamless and flexible services that are not administratively onerous. Trials of successful programs have been undertaken across the country that indicate progress can be made and the Hogan review cites some of these. But the programs to date have been sporadic and funding tenuous.

Rehabilitation is an essential part of the transition process. Rehabilitation of older people following an acute health episode requires expert knowledge and care, and any program needs to factor in the resources needed to employ experts in the field. Rehabilitation incorporates the skills of a multidisciplinary team such as nurses, medical specialists and allied health professionals. Adequate funding and supply of professionals will be a major concern when dealing with the issue of transition.

The Australian Health Care Agreements (AHCA) Reference Group in its report *The Interface Between Aged and Acute Care*[24] recommended a common assessment process using "Australian Care Pathways" to guide the care of older people across the acute/aged interface. It failed however to go one step further and recommend an implementation process.

Nurses play a vital role in the overall management of care coordination for the nation's elderly. Adequate funding for Primary Care Nurses with a coordination role across all health sectors for old people and those with disabilities would be a first step towards helping clients through the process.

[23] Commonwealth of Australia 2004 *Review of pricing arrangements in residential aged care: final report* section 13.3
[24] AHCA Reference Group 2002 *The Interface Between Aged and Acute Care*

6 Conclusion

Reform of Australia's aged care system is the key to meeting the care needs of a growing population of older Australians. Containing costs will be essential and enabling more older Australians to remain in their own home and communities supported by dramatically improved community care services that are focused on principles such as;

- ageing in place,
- single point of access,
- single assessment,
- individual need,
- continuity of care,
- flexible responses to changes in need,
- minimal disruption to clients' lives and living arrangements and
- care of significant others in clients' lives

Residential care will remain a reality for many Australians, and the care they receive must be delivered by a skilled and sufficient workforce and by an industry that is well resourced and accountable.