QUEENSLAND NURSING COUNCIL SUBMISSION TO THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE INQUIRY INTO AGED CARE

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The Queensland Nursing Council (Council) is a statutory body that is responsible for the regulation of nursing in Queensland. Advising the Queensland Minister for Health on nursing practice and nurse education is included among its functions. As part of this function, Council is represented on the Peak Nursing Body and other workforce-related bodies at the State level. It is also a member of the Australian Nursing and Midwifery Council which is represented on national health workforce bodies.

There are over 48,000 nurses currently licensed to practise in Queensland. As at 23 July 2004, there were 40,675 registered nurses and 7,457 enrolled nurses. Council sets the standards of practice for the profession in collaboration with key stakeholders. Among the standards of significance for this Inquiry is the *Scope of Nursing Practice Decision Making Framework*[1]. This document provides guidance to nurses and others in situations where nurses delegate activities from a care plan to non-nurses.

Summary of Recommendations

Council recommends that:

1. **funding models for aged care (residential and community based) take account of the need for qualified, licensed nursing staff**

2. **research be undertaken to establish the most appropriate ratio of direct nursing: indirect nursing service provision in aged care residential and community settings**

3. **urgent national attention be given to the development of incentives to attract and retain qualified, licensed nurses to work across institutional and community sectors for the improvement of the health status of older people**

4. **there be wage parity across nursing sectors**

5. **recruitment and retention strategies as recommended in numerous reports be implemented**

6. **work on developing a standardised format for Resident Classification Scale funding claims be commenced as soon as possible**

7. **consideration be given to establishing a mechanism for the exchange of information between the ACSAA and Nurse Regulatory Authorities**

8. **the current trend of employing fewer nurses in the aged care sector be reversed**

9. **action be taken to clarify the expectations of carers and health care workers in all sectors and to establish the relationship between and best mix of different levels of worker.**

[1] A copy of this Framework can be obtained from the Council's website www.qnc.qld.gov.au

The context for this submission

The following data is drawn from *Australia's Health 2004* published by the Australian Institute of Health and Welfare (AIHW) in 2004. This sets the context for discussion of aged care services.

June 2002	65 – 74 years	75 – 84 years	85 + years
	Per 1000 population		
Permanent residential care	10	55	247
Home and Community Care	87	245	425
Community Aged Care Packages	3	11	30
Total	**100**	**311**	**702**

There is general agreement that there will need to be an increasing focus on obtaining and maintaining the Australian health workforce. Access Economics (2001) has predicted that during the decade of 2020, the Australian workforce will grow by only 125,000 for the entire decade, compared with 170,000 per year in 2001. Public Hospital Activity Statistics in Queensland have been used to predict future service demand for Queensland and there is an expected increase of 42% in hospital admissions by 2016.

The National Health Workforce Strategic Framework (Australian Health Ministers Conference, 2004) highlighted the following:

- Australia has a slowly growing but ageing population
- the nursing workforce is ageing and working shorter hours
- the growth of the workforce overall is predicted to fall from the current figure of 170,000 per year to just 12,500 per year in 2020.
- there will be global competition for health practitioners
- the ageing population will affect the health workforce by increasing demand for services

The strategies identified by the Health Ministers Conference include exploring innovative approaches to address distribution issues, including:

- Incentives and disincentives to practise in areas / sectors of greatest need and workforce shortage;
- Flexible working environments;
- Models that enable articulated, multiple career pathways;
- Aligning education and training programs with health service needs; and
- Developing and supporting innovative educational strategies to facilitate accelerated entry and flexible delivery of clinical training.

Given the issues noted below in relation to the aged care nursing workforce, each of these strategies should be considered.

The need for nursing in an ageing population

The need for an educated competent and licensed aged care nursing workforce now and in the future has not been the subject of debate. However, what needs to be addressed urgently is the model of provision of service by those nurses.

According to the *Aged Care Core Component in Undergraduate Nursing Curricula Principles Paper* (Queensland University of Technology, 2004) the shortage of qualified, licensed nurses working in aged care has occurred at a time when demands for aged care health services are increasing. The *National Review of Nursing Discussion Paper* noted that the aged care nursing workforce was affected to a greater degree than the general nursing workforce, with an 8.2% rate of decline in employment of nurses in aged care compared to a 5.5% decline in the general nursing workforce (Department of Education Science and Training, 2001) Anecdotal evidence suggests that the number of nurses in the aged care sector has continued to decline since then.

This decline has variously been attributed to:

1. the use of a social model of care for the elderly (proponents of this model contend erroneously that nurses are more aligned to a "medical" model of care, and therefore are not appropriate employees for the sector. Nursing education has had a health rather than a medical focus for more than 30 years);
2. low attractiveness of aged care for nurses due to pay and conditions being lower than in other sectors; and
3. the desire by employers to contain costs who therefore employ alternative, less costly workers rather than qualified, licensed nurses.

There is, however, a growing need for nursing services for the elderly, whether provided in hospital, residential care settings or the community. This is supported by the Australian Institute of Health and Welfare (AIHW) publication *Australia's Health 2004*. In that document, it is noted that, while the overall health of older Australians is improving, the onset of long term, chronic medical conditions in older age (including for example dementia, stroke, and arthritis) may result in various levels of disability. In particular, AIHW reports that there is a sharp rise for most health conditions in the prevalence of associated disability in the 85 years and over age group. In addition, the rate of severe or profound restrictions resulting from disability increased with age. Such restrictions entail the need for personal assistance with activities in the areas of self care, mobility and communication.

Although many personal care services can safely be provided by non-nurses, it is essential that a nurse be involved in assessing the person to ensure that the care being provided continues to be beneficial and that changes in the older person's condition are identified rapidly and acted on appropriately. The reduction in qualified, licensed nursing staff in aged care is a risk factor for increasing morbidity and mortality arising from late identification of treatable conditions. Early intervention by registered nurses has the potential to reduce the need for residents to be transferred to the hospital sector, and to minimise cost shifting to the hospital sector.

The best ratio of direct nursing service : indirect nursing service needs to be established, with direct care by registered and/or enrolled nurses necessary in some settings while an advisory / educational service by registered nurses may be sufficient in others. Whether the licensed nurse should be a permanent staff member or a consultant contracted by the aged care service for specific services is a question that has not yet been satisfactorily answered in most settings. The answer is highly dependent on the acuity of the client population.

Council is currently in the process of developing some principles to guide decisions about when direct assessment / care provision by a registered nurse is required. Those principles will focus on benefit for the client and will relate to:

1. the client's capacity for self care / decision making;
2. the certainty of the client's condition / diagnosis;
3. the complexity / inter-relatedness of the client's needs;
4. the predictability of the client's condition – fluctuations / gradual change;
5. the range / severity / predictability / immediacy of negative outcomes if risk of harm is not identified early;
6. the subtlety of signs of changes in the client's condition;
7. the availability of other services (eg medical, pharmacy, physiotherapy);
8. the complexity / technical difficulty of procedures in the client's treatment plan; and
9. the level of education / competence of other health care workers providing care for the client.

Council therefore <u>recommends</u> that:

<u>Recommendation 1</u>: funding models for aged care (residential and community based) take account of the need for qualified, licensed nursing staff; and

<u>Recommendation 2</u>: research be undertaken to establish the most appropriate ratio of direct nursing : indirect nursing service provision in aged care residential and community settings.

<u>Previous Inquiries</u>

The Report of the Senate Community Affairs References Committee Inquiry into Nursing, *The Patient Profession* (June 2002) included eight recommendations associated specifically with aged care (recommendations 68 – 75 inclusive). These recommendations referred to:

- reducing the burden of paperwork required under Residential Classification Scale funding;
- the need for pay parity;
- the increasing use of unqualified workers in aged care;
- introducing measures to reduce occupational injuries of nurses working in aged care; and
- improving educational opportunity in aged care at undergraduate and postgraduate levels.

Specific mention of the importance of including clinical placements for undergraduate students in aged care settings was also made.

The Final Report of the Department of Education Science and Training Review of Nursing Education: *Our Duty of Care* (2002) also identified documentation, continuing professional development for aged care nurses to ensure that residents of aged care facilities have access to quality nursing care, and minimum qualifications (Certificate III)

for all workers in direct care in aged and community care sectors by 2008 as priorities for action.

None of these recommendations have been implemented to date.

Council submission according to Inquiry's Terms of Reference

Term of Reference (a) - adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training.

In its July 2001 submission to the Senate Community References Committee Inquiry into Nursing, Council made the following remarks regarding nursing in aged care:

> 5.3.3 Shortages in aged care In view of the changing demographic of older persons, there is also concern about the future supply of nurses in this clinical specialty. Happell (1999) notes that only 2% of Australian nursing students are attracted to aged care although it currently accounts for 28.5% of nurse employment. Strategies need to be developed to make this area more attractive. Higher profile recognition as an area of specialty and the development of career pathways would assist, along with ensuring wage parity between sectors.

The recommendation Council made at that time, and which remains relevant, is: **that urgent national attention be given to the development of incentives to attract and retain qualified, licensed nurses to work across institutional and community sectors for the improvement of the health status of older people. (Recommendation 3).**

The *Report on Recruitment and Retention of Nurses in Residential Aged Care* (Pearson et al, 2002) identified that 53.9% of aged care nurses responding to their survey would be interested in returning to aged care. Improved shifts, increased pay, greater provision of education and training and increased staffing were factors reported to encourage these nurses to return. It should be noted that the survey of nurses who had not re-registered in the previous renewal period found that 11.2% had left nursing for family commitments such as pregnancy and caring for children and another 10.4% did not maintain their registration because they moved house / retired / swapped jobs and 6.3% for ill health / injury / age related reasons (page 28). However, Pearson et al (2002, p 28) reported that over 60% of respondents left nursing for work related reasons such as hours of work (10.1%), rates of pay (7.6%), staff shortages (7.5%), stress (4.7%), low job satisfaction (4.1%), feeling devalued / no recognition for qualifications (4.4%) and poor work environment (4.1%).

Other factors identified by stakeholders in the Pearson et al (2002) study as needing improvement to increase recruitment and retention of nurses in aged care were:

- staffing levels generally, and qualified [licensed] staffing levels particularly;
- wage disparity across nursing sectors;
- specialised aged care training;
- documentation procedures;
- support for nurses, including career development;

- the negative image of aged care nursing;
- recognition of aged care qualifications.

Barbara Preston (2002, page 43) in her study of *Australian Nurse Supply and Demand to 2006* prepared for the Australian Council of Deans of Nursing noted that by 2006, on current projections, supply of nurses in Queensland would be only 61.9% of demand. She concluded that, "within the timeframe to respond to projected shortages … reducing staffing levels of registered nurses, even with cost equivalent substitution, cannot be a solution to shortages without compromising patient care" (page 31).

Among the solutions suggested by Preston (2002) was reducing the length of time patients or residents are in hospitals, nursing homes or other institutions without jeopardising care. Given the purpose of residential care facilities, reducing the length of time residents are in care is only possible by delaying their entry. This, however, means that a higher level of support services needs to be available in the community.

Preston (2002) also identified increasing the hours that nurses work, and delaying retirement, as potential solutions to projected shortages of nurses in all sectors. However, with the existing wage differential between acute and aged care (see Table 1 below), it is likely that nurses who chose to work longer hours, or more years beyond retirement, would do so in areas that were more financially rewarding than aged care.

Table 1: Pay rate differential – aged care and public sector nurses in Queensland

	Aged care	Public	% Difference
RN level 1/ Nursing Officer 1 – first paypoint	$32,841	$36,815	12%
Highest paypoint level 1	$40,642	$49,584	21%
Director of nursing / Level 5 – first paypoint	$54,469	$72,930	33%
Highest paypoint DON (level 7)	$66,546	$89,919	35%

Council therefore <u>recommends</u> that:

<u>Recommendation 4</u>: there be wage parity across nursing sectors; and

<u>Recommendation 5</u>: recruitment and retention strategies as recommended in numerous national reports be implemented.

Specific activities

Commonwealth funding for aged care re-entry in Queensland is provided through the Competence Assessment Service which is subsidised by Council. According to data supplied by the Competence Assessment Service[2], there were a total of 47 RN applicants and 23 EN applicants from June 2003 – 30 June 2004. Thirty-three (33) RNs and 8 ENs have successfully completed the program, with another 3 RNs and 8 ENs expected to complete the requirements by 31 December 2004. This represents a 76% and 70% successful completion rate for RNs and ENs respectively. On completion of the program 20 RN applicants had secured employment in the aged care industry as RNs, 3 had applied and not yet been employed and 10 were waiting for their registration to be finalised. Two ENs had secured employment in the aged care industry as ENs at the time of the report, one was negotiating a reclassification from Assistant in Nursing to EN and another 5 were awaiting their enrolment.

Documentation remains a particular issue for nurses. Pearson et al (2002) recommended to the Commonwealth Department of Health and Aged Care that a standardised format for Resident Classification Scale funding claims be designed to minimise confusion for those completing it (often registered nurses) and to assist the Commonwealth in validating resident classifications. This recommendation does not appear to have been implemented.

Recommendation 6: Council recommends that work on developing a standardised format for Resident Classification Scale funding claims be commenced as soon as possible.

Term of Reference (b) - the performance and effectiveness of the Aged Care Standards and Accreditation Agency (ACSAA) 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.

Council does not wish to formally submit on this term of reference, however, a suggestion for improving information flow and the appropriate management of concerns about residential aged care providers and individual nurses is provided for consideration.

It would be desirable for the ACSAA and regulatory authorities in all States and Territories to exchange information of interest to the other party through the implementation of a memorandum of understanding. For example, if Council, in investigating a complaint about the conduct of a nurse, identifies issues or concerns about the provider of the aged care service that may be of relevance to the ACSAA, it would be appropriate for that information to be forwarded to the ACSAA. Similarly, if the ACSAA becomes aware of concerns about the conduct of an individual or group of

[2] Final Report to the Australian Government Department of Health and Ageing, Aged Care Nursing Re-entry Program Pilot offered by Central Queensland University and Central Queensland Institute of TAFE, 7 July 2004

nurses, such information should be provided to the nurse regulatory authority in that jurisdiction, so that it can be determined whether the nurse(s) is (are) performing below the expected standards. Council has had such a memorandum of understanding with the Secretary of the Commonwealth Department of Health and Aged Care relating to investigations by the Aged Care Complaints unit. This could become the model for other such agreements. In some jurisdictions, legislative changes may need to be made to enable the proposed exchange of information.

Council therefore recommends that:

Recommendation 7: consideration be given to establishing a mechanism for the exchange of information between the ACSAA and Nurse Regulatory Authorities.

Term of Reference (c) - 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.

Certainly, it is inappropriate to have young people receiving the same kind of care and services / programs as an aged person. However, the issue is more one of skill and focus (exacerbated by the labeling of the service as "residential aged care"). As indicated before, the need for nursing in aged care / disability care is highlighted by such issues. Nurses have the knowledge and skill to plan and provide person-centred quality care for people, whether they are an aged resident with special needs or a young person experiencing a disability.

This capacity for registered nurses to provide for special needs is equally relevant for residents with dementia and mental illness. Licensed nurses receive comprehensive educational preparation for practice with all types of clients, and can ensure that the specialised care required by these groups is provided. Qualified, licensed nurses can help to ensure that individual needs are met regardless of the setting, provided that funding levels are appropriate for the services needed by those individuals.

Term of Reference (d) - the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly.

Council does not wish to make any submissions in relation to this term of reference.

Term of Reference (e) - the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

The context of Council's response

AIHW (2004) reported that the rate of hospitalisation per 1000 population for older Australians (over 65) was higher than for the general population. For the general population, the rate was 307 per 1000 for males and 348 for females. For those aged 65

and over, the rates were 978 (males) and 778 per 1000 (females). A higher number of Medicare services per person were also reported for older Australians (AIHW 2004).

Additionally, the average length of stay in hospitals increased with age (3.7 days for males and 3.8 days for females in the age range of 65 – 74 years; increasing to 5 days for males and 6.1 days for females between 75 – 84 years of age and increasing again to 8.1 days for males and 9.7 days for females aged 85 years and over).

Council's response

In 1998, participants in a group discussion conducted by Queensland Health identified a number of factors impeding continuity of care for older people who move in and out of the acute care system in Queensland (Queensland Health 1998). These factors included:

- Funding for programs being mixed with local, state and federal sources of funding often having different goals
- Lack of a State policy on aged care
- Ageism, with people in the acute sector sometimes perceiving older patients as liabilities
- A lack of attention to quality of life issues in the acute care sector, particularly in terms of short consultation times
- Inadequate attention to treating co-morbidities
- Resistance to change such as new models of care to prevent overlapping services
- The recognition that the government may no longer be able to provide for people in their old age
- Lack of knowledge of those in the acute care sector of appropriate referral paths to geriatric services
- Lack of comprehensive information systems that enable sharing of information between sectors.

Proposed solutions (Queensland Health 1998) to these factors were a coordinated approach and improved communication between services.

In their joint submission to the Federal government review of pricing arrangements in residential aged care (2003), Carers Australia, Alzheimer's Australia and COTA National Seniors made the following statement:

> Reports from all stakeholders indicate chronic problems in recruitment and retention of all care staff, appropriateness of staff : resident ratios for highly dependent residents, the availability of appropriately trained and skilled staff, inadequate skills upgrading and training for complex care; and long lead time toward the goal of minimum nationally accredited training for personal care workers. From the published RCS statistics, it is clear that the dependency level of residents is increasing, therefore staff skills need to be continually developing to be relevant to care needs.

Carers Australia also note in their submission to the House of Representatives Standing Committee on Ageing that, although there is data clearly identifying increasing need for care in an ageing population, there is little or no data to indicate that people of workforce

age will be able of willing to accept a caring role. In light of the knowledge that the bulk of care for people with disabilities / frail older people is provided by unpaid family members and other informal carers, greater recognition of this role is necessary. Without adequate provision to support / attract carers now and into the future, there may be an even greater workforce crisis looming.

Registered nurses have the knowledge and skill to plan for appropriate transition between sectors. However, the community and residential care facilities need to be adequately resourced to cope with the needs of clients moving between sectors.

Council therefore recommends that:

Recommendation 8: the current trend of employing fewer nurses in the aged care sector be reversed; and

Recommendation 9: action be taken to clarify the expectation of carers and health care workers in all sectors and to establish the relationship between and best mix of different levels of worker.

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