



Australian Nursing Federation (Victorian Branch)

**Initial Submission to the Australian Government
Caring for Older Australians
Productivity Commission Review of Aged Care**

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1. Executive Summary

In 2002, the Senate Committee into Aged Care (SCAC, 2002) warned that the delivery of quality aged care was under threat as a consequence of inappropriate staff mix and the retreat from the sector of registered and enrolled nurses, who are best qualified to care for sicker patients and to supervise unqualified direct care staff.

In 2010, evidence increasingly indicates that the threat to quality has deepened, and, without concerted action and sustained reform, will engulf and overwhelm the functioning and performance of the overall health care system.

Aged care, including residential aged care, is an integral part of the health system. Its functioning can either enhance or obstruct the performance and capacity of other health care modalities to meet the needs of people requiring their services.

In spite of this, there is justified concern that the aged care system is failing to meet demands created by an ageing population, by increased prevalence of disease and the increasingly complex medical and nursing care needs of the aged care demographic.

This failure is placing undue pressure on other health care modalities, diminishing their respective performance and capacity, and directly militating against key National Health and Hospital Reform (NHHR) objectives to reduce elective surgery waiting lists and improve emergency care.

At the same time there is increasing evidence that the aged care system is failing its most fundamental of objectives – to guarantee an acceptable standard of care. Data from the Aged Care Standards and Accreditation Agency reveals a decline in quality of care. Incidents of non compliance with accreditation standards increased fourfold in the areas of clinical care and medication management between 2007 and 2009. Additionally, non compliance in the areas of nutrition and hydration, behaviour management and human resource management doubled during the same period.

This submission outlines, in accordance with the Inquiry's Terms of Reference, where and how the aged care system is failing to meet core objectives set out for it in the *Aged Care Act 1997*, and examines the factors contributing to current systemic problems in aged care service provision. The most significant of these factors concerns a multi-faceted failure to sustain a nursing and direct aged care workforce that is sufficient in number and appropriately qualified and skilled to competently meet the complex care needs of the burgeoning aged care demographic; and the failure to recruit, retain, support and remunerate the staff on whom a functioning aged care system depends – registered and enrolled nurses and personal care workers (however titled, [PCWs]).

The University of Melbourne's ongoing longitudinal study of registered and enrolled nurses and PCWs has identified issues preventing these staff from providing standards of care that based on their clinical and professional judgment, they believe to be necessary. These include:

- inadequate staffing levels;
- inappropriate skill mix;
- insufficient numbers of registered nurses;
- a culture of cost cutting; and
- excessive workloads.

(University of Melbourne, 2008; University of Melbourne, 2009; University of Melbourne, 2010)

As detailed in section 6 of our submission, funding inadequacy is a probable factor contributing to this over-stretching of the aged care workforce. The Aged Care Funding Instrument (ACFI) is not designed to reflect the cost of care, and aged care funding indexation does not provide for actual wage increases. This adds a perverse incentive, which discourages approved aged care providers from employing optimal staffing levels and skill mix. Our submission details how these perverse incentives have been intensified by inadequate transparency and accountability in the provision of aged care services.

Section 7 of our submission considers the reforms required to ensure the nursing and direct aged care workforce is equipped to competently meet the burgeoning medical and nursing care needs of the aged care demographic. Our submission identifies that in addition to the overall ageing of the population, there has been an increase in the proportion of persons aged 85 years and over, and in the prevalence of chronic disease (including in particular the escalating incidence of dementia, which is forecast to rise threefold between 2007 and 2050 – or from 220,000 to 730,000 respectively), and in persons requiring palliative care. Critically, these factors combine to make an aged care demographic that is frailer and that has more complex medical and nursing care needs.

At a time of systemic stress due to the ageing of the population and increased prevalence of chronic disease, our submission identifies there has been a steady and dramatic reduction in the number of registered and enrolled nurses working in aged care, and conversely, an exponential increase in the number of unlicensed personal care workers. Occurring at the precise time that the aged care demographics' nursing care needs are becoming more complex and demanding more from the knowledge, skill and expertise of nursing and direct care staff, this shift in the makeup of the aged care workforce – and overall loss of human capital – has diminished the capability and performance of the aged care system, and contributed to a decline in quality of care.

Section 7.2.3 précis's the contemporary research and literature showing that adequate staffing levels, skill mix and particularly the presence of registered nurses are the crucial linchpin to providing quality care. This is the "inconvenient truth" of the aged care system which can no longer be ignored. Registered nurses make a difference to resident outcomes, providing the surveillance system for early detection and prevention of health complications.

Despite this, aged care staffing levels and staff skill mix are increasingly inadequate. Section 7 of our submission considers how these inadequacies should be addressed identifying that workforce planning must take into account the varying levels of educational preparation and professional scope of practice that registered nurses, enrolled nurses and PCWs bring to aged care; and ensure these nursing and direct aged care staff are deployed at the bedside in sufficient number and proportion to match the assessed care needs of residents.

The ANF (Vic Branch) contends that legally mandated and fully funded nurse to resident/patient ratios provide an effective and transparent mechanism to realise adequate and stable staffing levels, which in turn deliver aged care nurses and PCWs manageable workloads, address recruitment and retention and improve capacity to provide quality care to residents.

Section 7 of our submission also details expansions and adaptations in aged care education and training that will be necessary to meet the forecast growth in aged care service capacity and the changing pattern of disease prevalence. The number of places in the tertiary and VET sector need to be significantly increased to ensure we have sufficient nurses and PCWs to match future demand. Curriculum in these sectors also needs to adapt to incorporate contemporary aged care nursing issues, including dementia and palliative care; and nurses and PCWs must be given improved opportunity for professional development and to up-skill or upgrade their existing qualifications.

Section 8 identifies that remuneration of aged care nurses and PCWs is spectacularly inadequate and is a cause of widespread discontent amongst these staff. Inexplicably, nurses and PCWs

working in the private aged care sector continue to be paid between 8% and 31% less than their public sector colleagues performing the same work. Removing this gap, and providing public sector wage parity to the dedicated and hard working nurses and PCWs in the private aged care sector must be a mandate of government.

Sections 9 and 10 examine the various factors that militate against the recruitment and retention of a sustainable nursing and direct aged care workforce. These constraints include excessive workloads and intensification of work; inadequate remuneration; poor recognition; insufficient ongoing education and training; a culture of cost cutting; the presence of workplace hazards relating to manual handling and occupational violence and aggression; and poor levels of job satisfaction. If not addressed, these factors will severely undermine the supply of staff, and in turn the ability of the aged care system to competently meet burgeoning demand.

There is scope to improve the productive efficiency of the aged care system, and this is outlined in Section 11. The Australian Government must be mindful that the substitution of qualified aged care staff with cheaper labour has not been cost effective when measured in terms of the diminished capability of the aged care sector to meet the burgeoning complex care needs of the aged care demographic; the resultant increased incidence of avoidable hospital admissions; and the unacceptably high levels of staff turnover caused by inadequate staffing levels and poor skill mix. Government must recognise that improving productive efficiency does not mean producing the lowest quality service at the least cost, and instead focus on providing high quality services, with minimal waste.

There are 340,000 people unnecessarily admitted or readmitted to the acute hospital system due to a lack of palliative or sub-acute services such as rehabilitation, geriatric and psychogeriatric care (Australian Government, 2010). ANF (Vic Branch) estimates that these unnecessary admissions cost upwards of \$1.7 billion dollars per year, adding significantly to overall health and aged care expenditure. At the same time, 31% of transfers from residential aged care facilities to acute hospitals are potentially avoidable (Australian Government, 2010). ANF (Vic Branch) estimates the cost of these admissions at more than \$138 million dollars per year. This is more than four times the cost of caring for these people in the residential aged care sector, and adds \$107 million dollars to overall health and aged care expenditure.

At the same time ANF (Vic Branch) estimates that current staff turnover rates drain up to \$1.6 billion dollars from the aged care sector per year.

Plainly, these estimates reveal considerable waste of resources, which could otherwise be put towards improving staffing levels and skill mix to better equip the aged care system to provide quality care, and towards ensuring the aged care workforce is adequately remunerated.

ANF (Vic Branch) contends that Government can also improve productive efficiency through fully realising the expanded scope of practice of Nurse Practitioners and enrolled nurses. As outlined in Section 12 of our submission, Government has an opportunity to maximise the exciting potential of Nurse Practitioners, whose advanced qualifications and clinical skills can improve the capacity and efficiency of aged care service provision. To further support these initiatives, Government must improve systems of quality assurance and professional oversight, which are currently lacking in the aged care system.

Section 13 outlines the action that must be taken to ensure there are robust mechanisms safeguarding the rights of vulnerable elderly people. This action must be underpinned by a strengthening of the current Aged Care Standards and Accreditation process, and through requiring all staff who provide intimate resident care to be licensed with the Australian Health Professionals Regulation Agency (AHPRA) and Nurses and Midwifery Board of Australia (NMBA) requirements.

The aged care system is at the crossroads. The Australian Government has commissioned ample

reports and inquiries to consider how the overall quality of aged care services can be improved. There is no shortage of knowledge on the factors contributing to its decline or about the measures required to steer it onto a path of sustainability.

What appears to have been lacking to date is a willingness to take firm action, and a commitment to implement the concerted, brave and bold reform that is required if the system is to be equipped to competently meet rising demand flowing from population ageing; from the increased prevalence of disease, and the more complex medical and nursing care needs of the aged care demographic.

Government has a choice. One option is to recognise serious failings within the aged care system that obstruct it from meeting the objectives set out in the *Aged Care Act 1997*, and to implement concrete and sustained action to address these failings. In doing so, the Australian Government has the opportunity to ensure the aged care system is well equipped to capably and competently meet significant future demand.

Alternatively, the Government can continue to ignore the gathering storm on the horizon – the manifest reality that the aged care system is floundering, failing to meet its most fundamental of objectives to guarantee an acceptable standard of care, and is spectacularly ill equipped to meet future demand.

If Government chooses the latter course, or simply continues to tinker at the edges, there will be catastrophic effects on the quality of aged care provision and the functioning of the overall health system. If the aged care system cannot safely and competently meet the complex medical and nursing care needs of the expanding aged care demographic, these frail and elderly Australians will have no choice but to default to the acute hospital system to receive care. In turn, the acute hospital system, together with other health care modalities, will unavoidably become engulfed and overwhelmed by the effective failure of the aged care sector to conduct its core business – meeting the medical and nursing care needs of elderly Australians.

Faced with these consequences, ANF (Vic Branch) contends that there is no room for continuing inaction, and every imperative for the Australian Government to make the bold, brave and enduring reform of the aged care system that is required for the sustainability of aged and health care services into the future.

The ANF (Vic Branch) is therefore pleased to submit the following recommendations to ensure the sustainability of aged services and, in turn, the efficient performance of all other health care modalities.

2. Recommendations

Recommendation 1

To enable health and aged care services to maximise their performance and capacity, ANF (Vic Branch) recommends the Australian Government:

- a) Acknowledge and implement the ANF (Vic Branch) recommendations contained in this paper.
- b) Recognise the integral role the aged care system plays in the overall health care system.
- c) Improve and equip the aged care system to meet both the current and forecast expansion in nursing and medical care demands for elderly Australians.
- d) That on the basis of (a) to (c) above, ensure that optimal nursing care is provided in residential and community aged care thereby eliminating the unnecessary admission of aged care residents to the acute hospital system.

Recommendation 2

To enable effective integration and coordination of health and aged care services across the aged care sector, ANF (Vic Branch) recommends:

- a) The same statutory body charged with overseeing the national health and hospitals reforms resulting from the National Health and Hospitals Networks review also have responsibility for planning and oversight of any changes to the aged care sector.

Recommendation 3

To improve the quality of aged care service provision, and ensure the aged care system consistently meets its objective to guarantee an acceptable standard of care, the ANF (Vic Branch) recommends the Australian Government:

- a) Acknowledge that the aged care system does not currently consistently guarantee an acceptable standard of care for all aged care residents; recognise the factors identified within this paper as contributing to the failure of the system and leading to the decline in the quality of aged care provision.
- b) Give due regard to the reform measures identified by ANF (Vic Branch) to remedy this failure, and reverse the decline in the quality of aged care provision.
- c) Implement a system of sustained and determined reform to eliminate the factors contributing to unacceptable standards of care.

Recommendation 4

To ensure that aged care funding more accurately reflects the real cost of care and provides revenue that is sufficient for the delivery of high quality services appropriate to individual needs, ANF (Vic Branch) recommends:

- a) A review of ACFI to ensure the tool more accurately captures the complex care needs of aged care residents.

- b) That, as an outcome of this review, ACFI is refined to provide clear guidance on the skill mix and staffing levels required to provide for all assessed resident care needs.
- c) That, on the basis of (a) and (b) above, a nursing score is developed for each resident that clearly articulates the minimum nursing hours per resident per day required by each classification of worker – including registered nurse, enrolled nurse and personal care worker – to deliver all assessed resident care needs.
- d) That approved providers be required to reflect (at least) these minimum nursing hours and skill mix in a roster that reflects actual ratio of nurses and carers to residents, on a per shift basis, that is readily available and easily understood by both staff and families.
- e) The Australian Government must, from consolidated revenue, bridge any shortfall in funding and thereby ensure revenue is sufficient to meet the true cost of providing quality resident care.
- f) Implementation of ANF (Vic Branch) Recommendation 5.

Recommendation 5

To ensure that aged care funding is sustainable and adequate to meet demand arising from the forecast expansion in aged care service capacity and the increasingly complex medical and nursing care needs of people requiring residential and community aged care, ANF (Vic Branch) recommends the Australian Government:

- a) Provide funding that accurately reflects the real cost of care, as per ANF recommendation 4.
- b) Ensure aged care funding indexation mechanisms incorporate and reflect different expenditure structures across the industry, wage variations, regional variations and the expanding care needs of people requiring residential or community aged care.
- c) Ensure review of existing aged care funding indexation mechanisms is undertaken by an independent body, preferably with expertise in health cost analysis.
- d) Develop an independent authority to incorporate activity funding pricing as part of the Australian Government's health and hospitals reform process.
- e) Immediately commence a national policy dialogue to discuss and develop options to provide increased aged care funding.
- f) Reject industry calls to implement accommodation bonds for high care residents.

Recommendation 6

To enable improved and adequate transparency and accountability in funding for the provision of aged care services, ANF (Vic Branch) recommends the Australian Government:

- a) Audit the finances of approved aged care providers in respect to profit, loss and accommodation bonds, no less than six monthly, and mandate a requirement that approved providers submit audited annual accounts to the Australian Government.
- b) More closely monitor compliance with statutory obligations (e.g., compulsory superannuation and industrial instruments), which may indicate 'at risk' providers. To facilitate this, the Australian Government must require accredited providers to sign an authority allowing DOHA to seek information from superannuation funds and the Australian Tax Office.

- c) Develop a risk profile for approved providers and undertake annual unannounced financial audits of approved providers who have been identified as being 'at risk'. Such an audit would measure financial health, expenditure against benchmark measures and compliance with bond management requirements.
- d) Require a proportion of aged care subsidies (we propose 75%) to be spent exclusively on employment costs of direct care staff – and, furthermore, mandate higher expenditure if necessary, to be compliant with minimum staffing level and skill mix requirements. Direct care costs must be limited to care staff that are licensed/registered.
- e) Establish clear benchmarks for all categories of expenditure, to ensure consistency between providers (of like type and size) and regions, together with a monitoring and review process.

Recommendation 7

To enable the future nursing and aged care workforce to safely and competently provide for increasingly complex nursing care needs of RAC residents, ANF (Vic Branch) recommends that the Australian Government:

- a) Accept the plethora of research indicating that:
 - I. adequate staffing levels and appropriate skill mix, and particularly the presence of sufficient registered nurses, are crucial to providing high quality care; and,
 - II. registered nurses are a strong determinant in resident health outcomes, are essential to oversee the practice of enrolled nurses and PCWs, and are therefore the critical linchpin in providing high quality complex care.
- b) Urgently implement enduring and far reaching measures to reverse the reduction in the number and proportion of registered and enrolled nurses currently participating in the aged care workforce, through measures outlined in this submission.
- c) Implement sustained aged care reform to ensure registered and enrolled nurses, together with PCWs, are consistently employed at the residents' bedside in adequate numbers and in appropriate proportions to capably meet the assessed care needs of residents.

Recommendation 8

To ensure that nursing and direct care staffing levels and skill mix are adequate, and that such staff are deployed at the bedside in a proportion and number that matches the assessed needs of residential aged care residents, ANF (Vic Branch) recommends:

- a) The minimum nurse to resident ratios that currently apply in the Victorian public aged care sector be improved and adapted for utilisation throughout the private RAC sector.
- b) In all Victorian public RAC facilities minimum nursing/resident ratios of 1:6, 1:7 and 1:10 apply for each AM shift, PM shift and night shift respectively.
- c) In all Victorian non public RAC facilities comprising either high, low or mixed care, minimum nursing and direct care staff/resident ratios of 1:6, 1:7 and 1:10 apply for each AM shift, PM shift and night shift respectively.
- d) Within the above stated ratios, at least one registered nurse must be rostered for the entire AM, PM and night shift in each facility, regardless of acuity or the outcome of the skill mix tool, with additional Registered Nurses for each 30 beds or significant part thereof.

- e) In Victorian non public RAC facilities, the ACFI funding tool can provide assistance to determine appropriate skill mix within the nursing and direct care staff/resident ratio, provided it is refined and adapted in accordance with ANF (Vic Branch) Recommendation 4 (and as detailed in Appendix A), and applied in accordance with the following guiding principles:
 - I. ACFI is transparent and can be easily understood by managers, nursing and direct care staff, the Aged Care Standards and Accreditation Agency and residents/families.
 - II. ACFI is used as the primary indicator of whether a provider has met its obligations under the Aged Care Principles in providing an adequate number of appropriately qualified staff.
 - III. The calculation of minutes/hours of care per resident per day for different resident needs within the skill mix tool is evidence based to ensure sufficient staff to provide quality care.
 - IV. The staffing requirements are expressed as number of staff per shift for RNs, ENs and licensed PCWs, and allocated as actual staff positions on a roster which can be observed and verified.
 - V. Direct nursing care staff within the skill mix tool consist only of RNs, ENs and licensed PCWs.
 - VI. The tool takes into account the ACFI score of each resident, together with weighting for other factors relevant to workload and care quality (e.g., special needs or facility design).
 - VII. To ensure stability, the direct care staffing requirement for each facility should not be re-evaluated more than 4 times a year, except in exceptional circumstances.
 - VIII. The direct care staffing re-evaluation is provided to ACSAA and DOHA as part of normal reporting requirements, together with written confirmation that resultant staffing changes have been implemented.
 - IX. Compliance with the direct care staffing evaluation is measured and forms part of the auditing and accreditation process.
- f) An approved aged care provider's compliance with minimum mandated ratios must be monitored and form part of the accreditation process.

Recommendation 9

To ensure that the nursing and aged care workforce is suitably skilled and in sufficient supply to competently meet the forecast growth in residential and community aged care capacity and the predicted increase in the more complex medical and nursing care needs of the aged care demographic, the ANF (Vic Branch) recommends the Australian and State Governments:

- a) Undertake a thorough needs analysis to determine the number of tertiary and VET places required to meet future aged care demand.
- b) Increase the number of undergraduate training opportunities and clinical placements for undergraduate and postgraduate registered and enrolled nurses, to meet the growth in demand for registered and enrolled nurses to enter the sector.
- c) Increase the number of training places within the VET sector for personal care workers (however titled), to meet the anticipated growth in future demand for personal care workers.

- d) Ensure curriculum in the tertiary and VET sector be adapted to better incorporate the changing patterns of disease and complex care needs in the aged care sector demographic.
- e) Ensure nursing and direct care staff have ongoing access to professional development that focuses on contemporary aged care issues and related complex nursing care issues.
- f) Ensure that qualifications for direct care workers in residential aged care settings are aligned so as to provide greater recognition of prior learning towards the Enrolled Nurse qualification.
- g) Ensure professional development aims to augment knowledge acquired through formal education and does not attempt to substitute or remove the need for direct aged care staff to obtain tertiary and VET sector qualifications.
- h) Continue to provide improved opportunities and incentives for enrolled nurses who currently work in aged care services to expand their accredited qualifications and scope of practice.
- i) Continue to provide improved opportunities and incentives for enrolled nurses who currently work in aged care services to access Bachelor of Nursing programs.
- j) Provide improved opportunities for personal care workers without formal education qualifications to obtain an Australian Qualification Framework (AQF) level III – Certificate III in aged care, and make this the minimum educational requirement pending consideration by the Nursing and Midwifery Board of Australia (NMBA).
- k) Provide opportunities and incentive for people holding a Certificate III qualification to up-skill/upgrade their qualification to enable registration with the NMBA as an Enrolled Nurse.
- l) Make nationally accredited training programs and training places available, accessible and affordable, and thereby entice potential students to the aged care sector.
- m) Implement a Government program to ensure adequate undergraduate and postgraduate nursing clinical placements are provided, in a national scheme that is inclusive of undergraduate enrolled nurse students.
- n) Ensure that personal care workers (however titled) have access to, and be required to hold, registration with the NMBA.

Recommendation 10

To ensure that registered nurses, enrolled nurses and PCWs (however titled) working in aged care are appropriately remunerated, the ANF (Vic Branch) recommends:

- a) The remuneration of nurses and PCWs working in the non public aged care sector is improved to ensure they are provided pay parity with their public sector colleagues.
- b) The funding mechanism be targeted specifically at closing the wages gap (and not delivered to employers as part of a general funding stream with multiple purposes as per the Conditional Adjustment Payment which was originally introduced in 2004 to address the wages gap).

- c) Employers be required to ensure that the wage supplement is passed on to employees and that they be obliged to account for the expenditure as part of the financial reporting requirements each six months.
- d) In each state, a current benchmark wage rate for each classification be established, and that each employer is funded the difference between that benchmark rate and the relevant public sector comparator. Those employers paying below the benchmark rate at the commencement should not receive additional funding, but only the amount between the benchmark rate and the comparator rate. It is important to note that those currently paying above the benchmark rate may be doing so at the expense of nursing hours or skill mix.
- e) The benchmark and comparator rates for each state/territory and the accountability requirements for employers should be set out in specific legislation (or regulations pursuant to the *Aged Care Act*) for a period of at least three years. After that time, if Enterprise Agreements had been negotiated to reflect the new wage rates, these regulations could be *sunsetting* provided there is on-going commitment by the Commonwealth to reflect the increased wage rates in funding and indexation formulas.

Recommendation 11

To ensure that the nursing and direct aged care workforce is sustainable and the aged care sector able to attract and retain sufficient supply of registered and enrolled nurses and PCWs to competently meet the demands of the expanding aged care demographic, ANF (Vic Branch) recommends the Australian Government:

- a) Give due regard to the factors identified by ANF (Vic Branch) that militate against the retention and recruitment of staff to the aged care system.
- b) Urgently implement enduring measures to address these factors, and to improve the attractiveness of the industry to existing and prospective nursing and direct care staff. Specifically, the Australian Government should:
 - I. Address the intolerable and unsustainable intensification of work and workload pressures faced by nursing and direct care staff in the aged care system, through implementation of ANF (Vic Branch) recommendations 4,5,6,7, and 8.
 - II. Address the significant wage gap that exists between nurses and PCWs working in private RAC and their colleagues in the public health and aged care system, through implementation of ANF (Vic Branch) recommendation 10.
 - III. Improve the educational opportunities for registered and enrolled nurses through implementation of ANF recommendation 9.
 - IV. Support residential aged care facilities to develop graduate nurse programs in aged care.
 - V. Oversee implementation of an acquittal system to ensure funds made available for aged care graduate nurse programs are directed to wages and educational support for nurses undertaking graduate nurse programs.
- c) Eliminate, as far as practicable, the significant occupational health and safety risks facing nurses and direct care staff in residential and community aged care. To enable this, ANF (Vic Branch) recommends that:

- I. Management of occupational health and safety be significantly improved in residential and community aged care.
- II. Effective and comprehensive occupational health and safety management systems in aged care be developed, in conjunction with the ANF and approved provider representatives, and be mandated.
- III. Funding be provided to educate and train line managers in respect of their legislative OHS and injury management responsibilities, to decrease the risks of injury and illness to nurses and PCWs.
- IV. OHS training form a mandatory part of all education programs required to be completed by aged care workers (both nurses and PCWs).
- V. The level of knowledge and engagement amongst approved aged care providers and managers of aged care facilities be increased to ensure they fully understand and therefore meet their OHS legislative obligations.
- VI. Adequate funding be supplied to approved aged care providers to implement and extend No Lifting programs.
- VII. The provision of dedicated funding to employ nurse No Lifting Coordinators to champion and oversee the implementation and maintenance of No Lifting programs across the aged care sector.
- VIII. The provision of dedicated funding for the purchase, maintenance and replacement of equipment required to implement No Lifting programs in all aged care facilities.
- IX. Improvement of knowledge and understanding of occupational health and safety issues (and the specific OHS audit criteria stipulated in the accreditation standards) amongst accreditors involved in the aged care accreditation process.
- X. The accreditation process incorporate adequate OHS criteria.
- XI. The provision of specific and detailed design requirements for new/refurbished aged care facilities, incorporating requirements based on safe patient handling to reduce manual handling injuries, and CPTED (Crime Prevention Through Environmental Design) guidelines to reduce violent incidents and injuries.
- XII. Staffing levels and skill mix are ensured as adequate and sufficient to
 - prevent intensification of work;
 - implement the No Lifting philosophy; and,
 - competently meet the complex care needs of people with challenging behaviours, or who may be predisposed to acts of violence and aggression.
- XIII. Residents in RAC facilities are regularly assessed by registered nurses and appropriate medically qualified staff for challenging behaviours that may otherwise give rise to incidents of occupational violence and aggression.
- XIV. Appropriate risk control strategies are implemented to eliminate or minimise incidents of occupational violence and aggression that may arise from residents with challenging behaviours or relatives of residents in RAC facilities.

- XV. The promotion of a pro-active focus on the elimination and prevention of hazards and injuries, and a workplace culture encouraging reporting of all incidents and injuries.

Recommendation 12

To maximise the productive efficiency of the aged care system and reduce waste, ANF (Vic Branch) recommends the Australian Government:

- a) Ensure staffing levels and skill mix are improved to adequately meet the expanding and more complex care needs of people requiring residential and community aged care, in accordance with ANF recommendations 4, 5, 6, 7, 8 and 9.
- b) As a consequence of recommendation (a) above, reduce the incidence of avoidable resident health complications and the number of elderly people unnecessarily admitted to the acute hospital sector when nursing and medical care could be more appropriately provided for in residential or community aged care.
- c) Ensure the remarkably high level of nurse and PCW staff turnover is minimised through implementation of the reform measures outlined in Recommendation 11 of this submission.
- d) Ensure the reliance on casual staff is reduced through implementation of the reform measures outlined in Recommendation 11 of this submission.

Recommendation 13

To facilitate an improvement in the productive efficiency of the aged care system, ANF (Vic Branch) recommends the Australian Government:

- a) Review ACFI to add nurse practitioners into the staffing and skills mix of all nursing homes.
- b) Create incentive and opportunity to realise an increase in the number of aged care nurse practitioner candidates.
- c) Fund the creation of aged care nurse practitioner networks across geographical clusters to enhance aged care services in metropolitan, regional and rural areas.
- d) Ensure there are annual grants available for enrolled nurses to access nationally accredited educational program to advance their practice in medication administration and complex care needs of older Australians.

Recommendation 14

To improve aged care quality assurance and ensure the rights of consumers are appropriately safeguarded, ANF (Vic Branch) recommends the Australian Government:

- a) Mandate that Aged Care Standards and Accreditation Agency staff conducting audits of nursing homes and approved providers' compliance with accreditation standards be registered nurses, and any other people involved in accreditation audits be appropriately qualified and experienced in nursing and aged care. Further, mandate that the Aged Care Standards and Accreditation Agency be required to use professional guidelines as a benchmark for accreditation.

- b) Ensure that consequences of non compliance are more consistently imposed, such as sanctions and the more frequent use of nurse advisers to oversee management of the facilities.
- c) Ensure that the Aged Care Standards and Accreditation Agency continues to conduct frequent unannounced 'spot' checks of RAC facilities.
- d) Ensure that the Aged Care Standards and Accreditation Agency does not give approved providers forward notice of unannounced 'spot' visits.
- e) Ensure that a national education program is developed by the Aged Care Standards and Accreditation Agency, to provide consistent application of national benchmarks of accreditation standards and quality care principles and ensure that processes are aligned to monitor best practice and quality care to nursing home residents.
- f) Ensure that intimate resident care is only provided by appropriately educated and licensed health practitioners.
- g) Mandate that all personal care workers (however titled) are required to be licensed in accordance with the Australian Health Professionals Regulation Agency and the Nurses and Midwifery Board of Australia requirements.
- h) Mandate that PCWs employed in the health and community services industries are required to have obtained a nationally accredited and industry approved qualification; and are required to abide by a professional code of conduct and/or ethics, and in accordance with established practice standards.
- i) In respect of recommendation f), g) and h) above, ensure that a reasonable period of transition applies to enable compliance.

3. Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each state and territory of Australia.

The ANF (Victorian Branch) represents in excess of 52,000 nurses, midwives and personal carers (the latter predominantly in the private residential aged care sector). Our members are employed in a wide range of enterprises in urban, rural and community care locations in both the public and private health and aged care sectors.

The core business for the ANF is the representation of the professional and industrial interests of our members and the professions of nursing and midwifery.

The ANF participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANF (Victorian Branch) is pleased to provide comment to the national consultation being undertaken by the Productivity Commission in relation to *Caring for Older Australians Productivity Commission Review of Aged Care*.

Our submission should be read in conjunction with the submission of the ANF Federal Office.

4. Aged Care – An Integral Part of the Health System

Aged care, including residential aged care, is an integral component of the overall Australian health care system. Whilst every effort is and should be made to deliver care in a homelike environment, support mechanisms in the community already mean that when an elderly person enters residential aged care, they do as they are in need of nursing care that cannot be met at home. Crucially, the capacity of the Australian aged care system to provide timely, affordable health and personal care to elderly people directly affects the ability of other health care modalities to meet the needs of people requiring their services.

The successful implementation of the Australian Government's National Health and Hospital Reform (NHHR) is dependent on an aged care system that provides elderly people with affordable and timely access to appropriate and high quality care (Australian Government, 2010). Justified concerns are emerging that our aged care system is unable to keep pace with demand for its services. Increasingly, there is recognition that this failure places undue pressure on our acute, primary, sub-acute, community and palliative health care systems. In particular, the Australian Government (2010) has identified that:

The supply of high level residential care is not keeping up with increased demand from the population ageing. The aged care sector, and in particular the high level care sector (nursing homes), needs to expand capacity to meet the increasing demand driven by population ageing (page 18).

Furthermore:

Many Australians are unnecessarily admitted to hospital due to a lack of palliative and sub-acute care services (such as rehabilitation, geriatric and psycho geriatric care)

And:

Up to 340,000 older people per year leaving public hospitals could have been more appropriately cared for elsewhere (page 75).

There are many examples of older Australians defaulting to acute public hospitals to receive both medical and nursing care, when their care needs would have been more appropriately met in their residential aged care home, or in their own home, assisted by a community aged care package (Victorian Government 2009). The Australian Government (2010) estimated:

31% of transfers from aged care homes to hospitals (about 27,000 admissions each year) were potentially avoidable. (Page 116)

Reform aimed to prevent the unnecessary or avoidable admission of elderly people to the acute hospital system is vitally important. Such admissions dislocate residents from their home and social setting, and militate against the achievement of key NHHR objectives by reducing the capacity of acute health services to maximise elective surgery and provide timely emergency care to those with more urgent need.

This reduced aged care capacity increases the overall cost to government of providing health and aged care services. According to the Aged Care Funding Instrument Subsidy Rates (Department of Health and Ageing, 2010), the cost of providing nursing care in residential aged care is estimated at between \$112.58 and \$155.23 per day, compared to between \$340.00 and \$706.00 per day in the acute hospital setting (Victorian Government Health Information, 2010). Given this cost disparity, the incidence of avoidable admissions to the acute hospital system represents significant avoidable expense, and a waste of finite health and aged care resources.

Importantly, acute and aged care services are predicted to come under even greater pressure with the forecast ageing of the population, and associated increased prevalence of disease. Australian Government spending on aged care is projected to rise as a proportion of GDP from:

- 0.8 % in 2009 – 2010; to
- 1.8 % by 2049 – 2050.

Per capita real spending (2009 – 2010 dollars) in aged care is projected to increase from:

- \$450 in 2009 – 2010; to
- \$1,900 in 2046 – 2047.

(Australian Government, 2010; Martin & King, 2008).

Given the significant spending on aged care services, and that their functioning can either enhance or obstruct the efficient performance of other health care modalities, it is imperative that the aged care system is equipped to function as efficiently as possible and moreover equipped to meet the expanding demand for its services.

Recommendation 1

To enable health and aged care services to maximise their performance and capacity, ANF (Vic Branch) recommends the Australian Government:

- a) Acknowledge and implement the ANF (Vic Branch) recommendations contained in this paper.
- b) Recognise the integral role the aged care system plays in the overall health care system.
- c) Improve and equip the aged care system to meet both the current and forecast expansion in nursing and medical care demands for elderly Australians.
- d) That on the basis of (a) to (c) above, ensure that optimal nursing care is provided in residential and community aged care thereby eliminating the unnecessary admission of aged care residents to the acute hospital system.

Recommendation 2

To enable effective integration and coordination of health and aged care services across the aged care sector, ANF (Vic Branch) recommends:

- a) The same statutory body charged with overseeing the national health and hospitals reforms resulting from the National Health and Hospitals Networks review also have responsibility for planning and oversight of any changes to the aged care sector.

5. Types of Aged Care Providers

The main providers of residential aged care services across Australia are made up of religious organisations (29%), private aged care providers (28%), community based providers (17%), and charitable organisations (16%) (AIHW, 2009).

In Victoria, of the 776 accredited aged care facilities, 194 are in the public sector and the remaining 582 are private aged care facilities.

In the public sector, the nursing and direct care workforce predominately comprises registered nurses, enrolled nurses and, traditionally in low care facilities personal care workers (however titled). For public sector 'nursing home' facilities accommodating high care residents, the Nurses (Victorian Public Sector) Multiple Employer Agreement obliges public sector employers (Schedule C Part 11) to apply nurse/patient ratios of:

1:7 plus In Charge on AM shift

1:8 plus In Charge on PM shift

1:15 on night shift

In contrast, no such minimum ratios are mandated for private sector facilities.

The 194 public aged care facilities had 6385 beds as at September 2009 (an average of almost 33 beds per facility). Of these, 66.2% were high care beds and 33.8% were low care. A high proportion of these facilities are in regional Victoria.

No other Australian state has retained such a significant public sector presence in the delivery of aged care.

Of the private providers, 52.9% are for profit providers. Of all jurisdictions Victoria has the highest proportion of for profit aged care providers (compared to the not for profit NFP sector).

Almost 75% of all beds in the private aged care sector are in networks (i.e., the provider operates more than one facility). This is more pronounced in the for profit sector, although there is a high proportion of small NFP providers in regional communities.

The Aged Care Standards and Accreditation Agency have reported in briefings on their National Data Set (to March 2010) that there is also a higher proportion of smaller (less than 30 beds) facilities in Victoria and a higher proportion of family owned and operated facilities (which they believe contributes to poorer compliance with certain standards). They report that, of the 777 accredited facilities in Victoria, only 19.7% – or 153 – are large (i.e., 80 or more beds), compared to 32.4% or 297 in NSW (of 916 facilities). It is apparent to the ANF that the public sector (especially small regional aged care facilities attached to small acute facilities) comprise a significant proportion of the 85 small facilities (Victorian Government, 2009).

6. How Effectively Is the Aged Care System Meeting its Objectives?

6.1 What are the objectives of the aged care system? An overview of the regulatory framework

The principle regulatory instruments for aged care services are set out in the *Aged Care Act 1997*, the accompanying *Aged Care Principles 1997* and the *Home and Community Care Act 1985*.

The key objectives of the regulatory framework include:

- guaranteeing an acceptable standard of aged care;
- providing funding for aged care services that enables the provision of high quality aged care services appropriate to individual needs;
- ensuring funding for aged care services to those with the greatest need;
- providing transparency and accountability in funding and provision of aged care services; and,
- encouraging aged care services that are flexible, diverse and responsive to individual needs and choice. (Access Economics, 2009; Australian Government, 2010)

The Australian Government established the Aged Care Standards and Accreditation Agency (the Agency) as the accreditation body under the *Aged Care Act 1997*. The Agency functions as an independent company limited by guarantee, established under the Australian Securities and Investment Commission and subject to the *Commonwealth Authorities and Companies Act 1997*. The functions of the Agency are to:

- manage the accreditation process using the Accreditation Standards;
- promote high quality care and assist the aged care industry to improve service quality, by identifying best practice and providing information, education and training to the aged care industry;
- liaise with the Department of Health and Ageing about services that do not comply with Accreditation Standards.

The 4 major Accreditation Standards are:

- Standard 1 – Management, Systems, Staffing and Organisational Development
- Standard 2 – Health and Personal Care
- Standard 3 – Resident Lifestyle
- Standard 4 – Physical Environment and Safe Systems

6.2 Does the aged care system meet its objective to guarantee an acceptable standard of care?

The Aged Care Standards and Accreditation Agency (the Agency) has the responsibility for carrying out independent auditing of Australia's residential aged care homes. The aim of such audits is to assess an approved provider's compliance with the Australian Government's *Quality of Care Principles* and the *Aged Care Act 1997*, together with the relevant accreditation standards.

Despite the rigorous auditing process undertaken by the Agency to monitor approved aged care providers, the ANF (Vic Branch) asserts that this process shows only a 'snapshot' of a home's compliance with the set standards on the particular day of a visit by the Agency. The ANF (Vic Branch) further asserts that this 'snapshot' may not always provide a truly representative picture of the home's compliance with accreditation standards, nor of the enduring standard of resident care or safety within the RAC facility.

On this point, ANF (Vic Branch) is regularly advised by our members of reports that an RAC facility can be deemed to be compliant with accreditation standards at the time of a scheduled visit from the Agency, yet the same home may become non compliant very shortly thereafter, or when the Agency undertakes an unannounced visit to the same home. For example, on 4/3/09 sanctions were imposed on Grandview Gardens Aged Care Facility. This was in response to the Agency identifying serious risk in relation to accreditation standards 1.6 Human Resource Management; 2.4 Clinical Care; 2.8 Pain Management; and 2.11 Skin Care. These areas of non compliance encompass the core business of aged care service provision, and raise obvious doubt regarding the integrity of the accreditation process, and specifically how a RAC facility can be deemed compliant at one point in time, yet shortly after be deemed non compliant in areas that are fundamental to quality aged care provision.

Mindful of these compliance issues, and considering the significant allocation of Government funds to aged care services, the ANF (Vic Branch) holds that the Australian Government should facilitate continuous, robust independent research into how the aged care system is meeting its obligations outlined under regulatory frameworks. This research must be urgently considered as a major part of the Australian Government's future directive to ensure all aged care standards are not only being met at the time of an accreditation visit by the Agency, but are sustained between Agency visits and required audits. The results of this research must be reported to the Australian Government and appropriate action taken where there are recurring system failures.

Despite inconsistencies and shortfalls of the current auditing process, data collected by the Aged Care Standards and Accreditation Agency nonetheless provides useful guidance on the status of compliance within the industry and importantly, reveals a decline in quality of care, with residents being exposed to serious risk from neglect, poor infection control, malnutrition, dehydration and assault (Department of Health and Ageing, 2007).

Moreover, an Access Economics (2009) report corroborates the finding that instances of non-compliance with accreditation standards increased in RAC facilities from 2007 to 2009.

Specifically, their data analysis shows the non-compliance changes as follows:

- clinical care from 25 in 2007 to 90 by 2009;
- medication management from 21 in 2007 to 80 by 2009;
- nutrition and hydration from 23 in 2007 to 42 by 2009;
- behavioural management from 14 in 2007 to 42 by 2009;
- human resource management from 22 in 2007 to 59 by 2009;
- information systems from 53 in 2007 to 103 by 2009.

Further, on analysis of this data, Access Economics (2009) concluded that:

Non-compliance across all of these expected minimum standards has significantly worsened, indicating declining performance across RAC facilities.

Outcomes with particularly high non-compliance figures were clinical care, medication management, nutrition and behavioural management. Such indicators suggest a declining quality of care across crucial RAC outcomes.
(Page 34)

What is interesting about this is that, during the same period, the number of complaints received by the Office of Aged Care Quality and Compliance also increased significantly. During just six months in 2007, the Federal Government's Office of Aged Care Quality and Compliance received nearly 4,000 complaints (more than triple the number of complaints lodged in the previous twelve month period) about treatment of people that potentially breached the *Aged Care Act 1997*. This included 418 reportable assaults (Department of Health and Ageing, 2007). Whilst this increase may be partially explained by factors such as greater community preparedness to make a complaint, or more 'aspirational' consumer expectations, the increase cannot be ignored, and in the absence of any other explanation points to a decline in standards in aged care.

6.2.1 A qualitative assessment – guaranteeing an acceptable standard of care: University of Melbourne longitudinal study

Since 2007, the University of Melbourne has been undertaking a longitudinal study of registered and enrolled nurses and personal care workers in the Victorian public, private for profit and private not for profit residential aged care sectors. The research has examined participants' experiences of working in aged care, and measured a range of factors including their perceptions regarding the quality of resident care and safety.

The methodology of the research used a questionnaire sent to 3102 individuals who had been selected randomly from ANF (Vic Branch) membership. Of this number, 1038 usable and completed surveys were returned, representing a 35% response rate.

The results of the first survey findings are published by the University of Melbourne (2008) in a report prepared for ANF (Vic Branch) titled *Working in Aged Care: Medication Practices, Workplace Aggression, and Employee and Resident Outcomes*. University of Melbourne (2008) found workers were under significant stress from factors including:

- excessive workloads and intensification of work;
- a culture of cost cutting;
- competing role demands; and,
- workplace violence and aggression.

Participants reported that these factors prevented them from providing the standard of care they believed suitable (based on their professional judgment and clinical assessment of a resident), resulting in participants feeling frustrated and disillusioned.

The University of Melbourne researchers repeated the original survey again in 2009, capturing data from the cohort of participants first surveyed in 2007. The results of this survey are contained in the University of Melbourne (2009) report prepared for ANF (Vic Branch), titled *Working in Aged Care 2009: Phase two of the ANF-University of Melbourne Study*. University of Melbourne (2009) found participants' ability to provide high quality care was being increasingly hampered by excessive workloads, cost cutting, a hostile work environment and competing role demands.

The University of Melbourne is currently processing and collating the results from its third longitudinal survey of nurses and PCWs originally surveyed in 2007. Although the final report is not due for publication until November 2010, the preliminary findings of the study have been reported to ANF

(Vic Branch) and reveal a worsening assessment of the quality of care being provided in Victorian RAC facilities, particularly those in the private for profit, and private not for profit residential aged care sector.

Nurses and PCWs participating in the third survey state that they are increasingly being obstructed from providing an appropriate standard of care due to:

- inadequate staffing levels;
- inappropriate skill mix; and, in particular,
- insufficient numbers of registered nurses.

In turn, participants report suffering intolerable workplace stress and exhaustion, feeling unable to provide adequately for the vulnerable residents under their care and feeling disillusioned with their professional practice.

The University of Melbourne (2010) research respondents detailed that:

I left aged care because I was frustrated and disillusioned about the care given to residents. I felt that the staff resident ratio was unrealistic to provide adequate care and also created OH&S issues for staff. (Page 1)

I left aged care because the facility in which I worked was not up to scratch. The standard of care, was not up to what I would like my mother or father to have. Aged care needs a big revamp. (Page 3)

I have ceased working in aged care after twenty years. I would have liked to have continued but was unable to due to bad health brought on by stress. As an ex Div 1 I found during my time working that the standard of nursing deteriorated. I found myself working with untrained staff, PCAs who in some cases could hardly speak English. (Page 1)

As the only Div 1 on duty I found it very stressful ensuring residents were properly cared for. My stress levels would have been reduced if, like in the past, I had Div 2s to work with. Unless this situation is rectified more Div 1 nurses will leave aged care. (Page 1)

I could not continue to work in a system that is so flawed and where patient care is being compromised. I was a manager whose budget for food was just over \$2.80 a day per resident. I was on 24 hour call. The lack of staff-patient ratios definitely compromised care. Private providers are largely "rorting" the system – accepting high care patients and do not provide the resources to manage the care. I am now working in a public hospital. I chose not to go back into the private aged care system as I cannot reconcile the lack of good, planned care for residents. In the hospital we have staff patient ratios which ensure a much better standard of care. The elderly deserve better. (Page 1)

I left aged care because I was fed up with the lack of staff. There was too much pressure on staff to attend to residents with inadequate time to give optimum care... (Page 2)

I left aged care because after 24 years I became very despondent and disheartened with the staffing levels and timeframes expected of us to provide the appropriate care. It posed an ethical and moral dilemma for nurses with the elderly being viewed as \$\$\$ and a business, not people. (Page 3)

For full details of these preliminary findings please refer to Appendix G

6.2.2 A qualitative assessment – guaranteeing an acceptable standard of care: ANF national telephone survey

Regrettably, assessments of working in aged care such as those contained in the University of Melbourne longitudinal study are not new to the ANF.

Back in 2004, both the ANF Federal Office and the ANF (Vic Branch) conducted a national aged care telephone survey of its members, with the view to:

- ascertain the views of nurses employed in the aged care sectors about contemporary aged care issues; and
- provide an opportunity for people working in aged care, aged care residents and their family and friends to share their views on the adequacy of aged care service delivery.

Over 1,000 people participated by telephoning branches of the Australian Nursing Federation.

The results of the survey have been published in *The Australian Nursing Federation – Inquiry into Aged Care August 2004*. In summary, the findings showed that the four areas of most significant concern to direct care staff, aged residents in care and their families were:

- staffing levels (86.1%);
- inadequate standards of care (62.0%);
- complaints about food (27.1%); and
- inadequate domestic services (18.4%).

Participants in the telephone survey commented that:

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. (Page 14, relative of aged care resident)

Staffing levels are appalling. Staff go through hell with unreasonable workloads, unreasonable stress levels and unreasonable expectations. (Page 10, aged care resident)

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? (Page 12, registered nurse)

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.' (Page 11, Registered nurse)

My mother has dementia. I was told I had to help look after her because there weren't enough staff. I am in my 70s 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. (Page 15, relative of resident)

The qualitative assessment of results from the University of Melbourne longitudinal study and the ANF national aged care telephone survey conclusively highlights evidence that the aged care system is not consistently meeting its objective to guarantee an acceptable standard of care for all RAC residents in all settings. As such, the aged care system is failing in its core function.

Recommendation 3

To improve the quality of aged care service provision, and ensure the aged care system consistently meets its objective to guarantee an acceptable standard of care, the ANF (Vic Branch) recommends the Australian Government:

- a) Acknowledge that the aged care system does not currently consistently guarantee an acceptable standard of care for all aged care residents; recognise the factors identified within this paper as contributing to the failure of the system and leading to the decline in the quality of aged care provision.
- b) Give due regard to the reform measures identified by ANF (Vic Branch) to remedy this failure, and reverse the decline in the quality of aged care provision.
- c) Implement a system of sustained and determined reform to eliminate the factors contributing to unacceptable standards of care.

6.3 Does the aged care system meet its objective to provide sufficient funding for the provision of high quality care?

6.3.1 Aged Care Funding Instrument (ACFI) – an overview

The Aged Care Funding Instrument (ACFI) replaced the Resident Classification Scale (RCS) to determine the level of care payments for residents living in nursing homes and hostels. The ACFI tool was a deliberate change to the old RCS classification system, intended to provide a simpler payment method and to better match funding to the assessed care needs of residents in RAC facilities, particularly those with complex health care requirements.

The ACFI is designed to measure residents' care needs through the use of standard assessment tools and the completion of ACFI checklists. Specifically, an ACFI assessment requires a resident of an aged care service to be appraised in relation to three separate domains considered to contribute to the cost of the individual's care. These domains include:

- Activities of Daily Living – evaluates client needs in relation to nutrition, mobility, personal hygiene, toileting and continence;
- Behavioural Supplement – evaluates mental and behavioural diagnosis in respect of cognitive skills, wandering, verbal behaviour, physical behaviour and depression;
- Complex Health Care Supplement – evaluates and measures the needs of a client for medication, and complex health needs.

Each of these domains has three funded levels – Low, Medium and High. Additionally, there is a 'lowest application classification level' in each domain which results in **nil** funding.

There are also two additional classification categories of health condition diagnosis – Mental and Behavioural, and Medical. Diagnosis data within these classifications can be used to support other ratings and to determine whether a resident is eligible for supplementary funding.

ACFI classifications are defined as either high or low care. For a resident to be considered for high care, the resident has to be assessed and classified as requiring one or more of the following levels of care:

- Medium or High in the Complex Health Care supplement;
- Medium or High in the Activities of Daily Living domain; and

- High in the Behavioural supplement.

If a resident does not meet the above criterion on their ACFI score, they will be classified as requiring low care.

ACFI classifications generally do not expire, except under certain circumstances.

6.3.2 Does funding reflect the cost of care?

Despite the intention with ACFI to simplify funding and better match funding to resident needs, inadequacies still exist with this instrument.

ANF (Vic Branch) argues that, in its current form, the ACFI tool provides no concrete data to enable the prediction of a suitable staffing skill mix and classification. More specifically, the system does not provide reliable predictors of how many registered nurses, enrolled nurses and personal care workers will be required, on a day-by-day or shift-to-shift basis, to meet the care needs of residents as determined by their ACFI assessments. Nor is there any predictor of how much time it will take direct care staff members to provide the assessed care. Such a lack of specificity results in a failure to capture specific costs of care and, moreover, contributes to a shortfall and/or mismatch of funding to approved providers of residential aged care services (Access Economics, 2009).

This shortfall in funding can introduce perverse incentives that discourage residential aged care providers from employing optimal staffing levels and skill mix (Access Economics, 2009). At the bedside this can result in residents being cared for by nursing and direct care staff who have been chosen, not because they are best suited to provide for the complex care needs of residents, but because they represent the least financial cost to the approved provider.

Interestingly, the Bentleys Report (2009) highlights that, despite the growing number of people living in residential aged care homes with increasingly complex needs, the number of nursing and care staff hours reduced from 36 hours per resident per fortnight (PRPF) in 2007 to 34.41 hours PRPF in 2008. This is also despite government subsidies increasing from \$93.21 per resident per day (PRPD) in 2007 to \$99.04 in 2008, and resident fees increasing from \$37.69 PRPD in 2007 to \$39.55 in 2008.

In the context of the more frail and dependant RAC resident profile, ANF (Vic Branch) contends that this reduction in staff hours is driven by an effort to reduce cost, rather than an effort to ensure that the number and mix of nursing and care staff are appropriate to meet the care needs of residents. ANF (Vic Branch) further contends that, when staffing level and skill mix decisions are based on budgetary considerations rather than the assessed needs of residents, quality of care and resident safety will suffer.

The ANF Federal Office undertook a national survey of its members employed in RAC services, to ascertain their views on the effectiveness of ACFI as a funding instrument. Respondents identified the following as inadequately captured by ACFI:

- Time and expertise required for specialised nursing care arising from the more dependant RAC demographic, associated co-morbidity and impairment.
- Rapid changes to health status, in particular for those residents transferring to the RAC from acute hospitals.
- Length of time required to deliver complex care, such as in the area of palliative care.
- Pain management.
- Managing residents with challenging behaviours such as dementia or mental illness.

- Feeding dysphagic residents safely.
- Some aspects of ADLs, such as identifying residents at risk of falling, and the level of time and expertise required to assist frail residents in all areas of ADLs.

Respondents also emphasised the extensive role of registered nurses in medication management, and the failure of ACFI to allow enough time for this:

Medication management by the RN is not recognised. Medication management is more than the time it takes to give a person a tablet. That is the end result. RNs spend many hours chasing up INR reports [international ratio for determining clotting tendency for patients on blood thinning therapy], following up lab results for infections, none of which is reflected in the tools. Even following up phone orders and monthly reviews of DDA [dangerous drugs of addiction] take huge amounts of time but cannot be claimed for under ACFI. (Kearney, 2010, page 15)

These concerns resonated with attendees at the ANF (Vic Branch) Private Aged Care -Productivity Commission Forum on 16 July 2010 where participants' commented that:

- ACFI provides no guidance on staffing levels and skill mix.
- ACFI weightings are incorrect and don't adequately capture the amount of time required to administer care.
- The time required for nurses and PCWs to liaise, comfort, educate and communicate with the relatives of residents is not captured at all by ACFI.
- Completion of ACFI is too labour and time intensive.

For detailed analysis of participant feedback from the ANF (Vic Branch) Private Aged Care - Productivity Commission Forum, please refer to Appendix D.

In spite of these significant inadequacies, the ANF (Vic Branch) believes that the current Aged Care Funding Instrument could function effectively to assess how the needs of residents translate into requirement for, and funding of, an appropriate minimum skill mix of registered and enrolled nurses and personal care workers within the care team. With minimal adjustments, ACFI could be used to assess every resident in an RAC facility not only in terms of their low, medium or high care needs, but also on which level of nurse or aged care worker would be required to meet these needs.

A detailed description of how ACFI could be refined and improved in this way is provided in Appendix A of this submission.

This transition would equip ACFI to more accurately reflect the costs of providing care to RAC residents, and in doing so would help to ensure that revenue was sufficient to meet the assessed care needs of residents and meet quality standards. Additional costs associated with adjusting the system through more radical and untested means would thereby be minimised.

Participants at the ANF (Vic Branch) Private Aged Care - Productivity Commission Forum were addressed by Applied Aged Care Solutions managing director, Mr Richard Rosewarne, the original creator of ACFI. Forum participants recognised and acknowledged the benefit of adapting ACFI to ensure that staffing levels are safe, adequate and responsive to the assessed care needs of RAC residents.

Recommendation 4

To ensure that aged care funding more accurately reflects the real cost of care and provides revenue that is sufficient for the delivery of high quality services appropriate to individual needs, ANF (Vic Branch) recommends:

- a) A review of ACFI to ensure the tool more accurately captures the complex care needs of aged care residents.
- b) That, as an outcome of this review, ACFI is refined to provide clear guidance on the skill mix and staffing levels required to provide for all assessed resident care needs.
- c) That, on the basis of (a) and (b) above, a nursing score is developed for each resident that clearly articulates the minimum nursing hours per resident per day required by each classification of worker – including registered nurse, enrolled nurse and personal care worker – to deliver all assessed resident care needs.
- d) That approved providers be required to reflect (at least) these minimum nursing hours and skill mix in a roster that reflects actual ratio of nurses and carers to residents, on a per shift basis, that is readily available and easily understood by both staff and families.
- e) The Australian Government must, from consolidated revenue, bridge any shortfall in funding and thereby ensure revenue is sufficient to meet the true cost of providing quality resident care.
- f) Implementation of ANF (Vic Branch) Recommendation 5.

6.3.3 Is funding adequate for the future sustainability of the aged care system?

6.3.3 (i) Commonwealth Own Purpose Outlay (COPO) indexation payments

The ANF (Vic Branch) has noteworthy concerns about both the level of funding of aged care and the extent to which current funding indexation mechanisms provide sufficient increases to afford sustainable funding for quality aged care services. Specifically, ANF (Vic Branch) contends that the indexation formula – the Commonwealth Own Purposes Outlays (COPO) index – does not allow for:

- increases in wages (see 6.3.3 (ii) for details); or
- increases in the cost of care arising as a result of population ageing and consequent increased prevalence of disease.

According to the Australian Institute of Health and Welfare (2008) survey, over 70% of those entering residential aged care are now classified as high care, compared to 56% a decade ago. More than 54% are over 85 years of age – whereas a decade ago the resident population was significantly younger and more mobile. The indexation arrangements applied to aged care do not provide for these changes in the demographic of aged care recipients.

The COPO index for aged care is weighted at 75% for wage costs and 25% for other costs and is calculated using the following algorithm:

$$COPO\% = (annual\ CPI\ \% \times 0.25) + (annual\ *SNA\ \% \times 0.75) \text{ where } *SNA\ \text{Safety Net Adjustment: } SNA\% = \text{Safety Net Increase per week/average weekly.}$$

(Senate Standing Committee on Finance and Public Administration – Residential and Community Aged Care in Australia [Senate Standing Committee], 2009)

Significantly, in 2008/9 there was no Safety Net Adjustment granted by the Australian Fair Pay Commission, which in relative terms, has reduced COPO indexation payments.

The aged care industry through Aged and Community Care Australia submitted table 6.3.3.1 below to the Senate inquiry to illustrate the significant shortfall.

Table 6.3.1 **Shortfall in COPO Indexation Payments 1997 – 2008**

Year	COPO % Increase	CAP % Increase	COPO/CAP % Increase	SNA –Min Wage % Increase	AWOTE % Increase
1997	1.80	0.00	1.80	2.86	4.55
1998	1.70	0.00	1.70	3.90	3.62
1999	1.70	0.00	1.70	3.21	3.12
2000	2.10	0.00	2.10	3.89	4.17
2001	2.30	0.00	2.30	3.25	4.62
2002	2.40	0.00	2.40	4.35	6.16
2003	2.20	0.00	2.20	3.94	4.64
2004	2.00	1.75	3.75	4.24	5.26
2005	1.90	1.75	3.65	3.64	4.76
2006	2.00	1.75	3.75	5.65	4.49
2007	2.00	1.75	3.75	2.02	3.50
2008	2.30	1.75	4.05	4.15	4.61

Dr David Cullen of the Department of Health and Ageing told the Senate Standing Committee (2009), that:

The fundamental difference between the department's analysis and the industry's analysis is that the industry looks at what would be called the unit costs of inputs and says, 'How much does a unit of input go up?' We look at the unit cost of outputs. We say, 'How much does it cost to produce a day of care?' When you are producing a day of care, or in any industry, each year you make productivity improvements. It becomes cheaper to produce care one year on the next because of productivity improvements. We take that into account; they do not.

The problem with this analysis is that the cost of providing a day of care is never static. The increasing age, frailty and complexity of care needs of residents means that over the last decade the actual cost of care should have increased as the skill mix required to ensure quality care changes. Furthermore the ANF questions, apart from reducing labour costs, how you make these productivity improvements. We understand that some approved providers turn the heating down or make other cost saving measures, but these are minimal savings in the larger context.

The Senate Standing Committee (2009) concluded that:

It is clear that the current COPO indexation is inappropriate for the Aged Care industry. The Veterans' Home Care program does not use the COPO index and private health insurance premiums have had much higher increases authorised by successive Ministers for Health, which have actually fuelled wage growth.

The ANF (Vic Branch) agrees. The gross inadequacy of the current funding mechanism has become even more apparent given the 2010 COPO increase from 1 July was just 1.7%, at a time when the Conditional Adjustment Payment (CAP) has been frozen at 8.75% post 2008. The supplementation provided by the CAP indexation previously assisted the industry to meet the pressures of increasing costs. That indexation has now been capped.

6.3.3 (ii) The Victorian perspective

In Victoria, in 2006 – 2008, the wages growth alone across the industry was 12%, with wage increases usually being provided in three instalments of 4%, or in some circumstances four instalments of 3% (with two x 3% in 2008). Similarly the 2003 – 2005 Enterprise Agreements for the vast majority included 12% wage increase over a three year period, with some Enterprise Agreements incorporating wage increases of up to 16%.

The ANF (Vic Branch) has recently concluded a new round of aged care Enterprise Bargaining, which has seen wage increases average at approximately 3.5% per annum over either a three or four year period. The real effect of wages growth is actually slightly less due to the timing of increases. Nevertheless, it is easy to see that the cumulative impact of the wage increases – which have been applied uniformly across all nursing and direct care worker classifications – far outstrips the COPO indexation. Moreover, the enterprise bargaining wage increases do not take into account increases in other costs that have been imposed by changes to regulation, such as improvements in training, accreditation and building standards. These wage increases are extremely modest, reflect below average wage increases for private sector bargaining, and do nothing to alleviate wage disparity.

The Productivity Commission (2008) found that:

A longstanding concern of the aged care industry has been that the indexation of basic subsidy rates is not based on movements in industry-specific costs. Rather, subsidies are indexed using the Commonwealth Own Purpose Outlays (COPO) index, which is weighted 75 per cent for wage costs and 25 per cent for non-wage costs. The COPO is premised on the view that virtually all wage increases are productivity based. Hence, it only makes provision for safety net increases in wages and for economy-wide movements in non-wage costs. Thus, if productivity gains within the aged care sector do not keep pace with other sectors, the subsidy, as indexed, will be increasingly inadequate.

The inadequacy of the indexation mechanism, despite the introduction of the CAP, has had serious consequences for the aged care workforce. The 'productivity improvement' that Dr Cullen refers to in the quote above has largely been the reduction of jobs and hours, usually borne by the skilled staff that are relied upon to provide quality care for increasingly frail and ill residents.

This effect, and specifically the evident attempt of approved aged care providers to reduce cost through labour substitution and through reducing total nursing and direct aged care staff hours is explored in detail in section 7 of this submission – together with the devastating effects this had on quality of care and sustainability of the aged care system.

At the same time however, it is surprising that the changing demographic of aged care residents has not led to an urgent review of funding mechanisms.

The 2009 Senate report concluded that:

5.49 The committee recommends that the taskforce undertake a review of the indexation formula used for the aged care sector in order to identify its adequacy in relation to costs faced by the sector and to identify modifications to the formula if required.

5.50 *The committee further recommends that consideration be given to an independent mechanism to continually assess the indexation formula.*

ANF (Vic Branch) agrees with these recommendations. Furthermore, we submit that the input costs should be industry specific and take into account actual wage increases in the industry and changing resident needs and demographics. Additionally, we support the setting of the indexation formula by an independent body, and propose that such a body could logically be the same one responsible for the establishment and review of the activity based pricing under the national hospitals reform process.

6.3.3 (iii) How can future funding be provided?

The ANF (Vic Branch) understands that significant additional expenditure will result from the expansion in aged care service capacity and the increasingly complex care needs of the aged demographic, together with aged care reform – particularly funding for an improved skill mix and to close the wages gap between aged care and the public sector. The question, of course, is where should this additional funding come from?

The ANF (Vic Branch) believes that the provision of quality aged care services is not an individual responsibility, but a challenge that must be shared by the whole society and economy. Every Australian citizen should have access to an acceptable standard of care. The Australian Government should therefore have primary responsibility for the funding of aged care, as it does for the public acute and preventative health system. The vast bulk of aged care funding should be sourced from consolidated revenue.

With the ageing of the population, and the declining number of workers/tax payers as a proportion of the population, there is understandable concern that future tax income will be insufficient to meet the growth in expenditure on health and ageing (let alone provide for improvements in quality or access). It is clear that expenditure on aged care will be one of the biggest challenges arising out of the ageing of the population over the next 30 years.

ANF (Vic Branch) supports a national debate regarding:

- how the tax base might be broadened so that aged care services can receive appropriate funding from the Australian Government to meet the future burden of cost; and,
- debate about the development of dedicated and universal measures which would raise additional funds for future aged care needs.

These measures would constitute a hypothecated tax, with the income dedicated to aged care. Arrangements might include:

- An additional levy/contribution collected through Medicare specifically for aged care.
- A tax surcharge through the income tax system.
- An additional superannuation contribution.
- Adjustment to the current aged care funding instrument.

A national policy discussion must be seen as high priority for the Australian Government. Furthermore, the process must include eliciting the views of key industry stakeholders. In the interim, the cost of improvements advocated by the ANF (Vic Branch) and other stakeholders must be addressed. The ANF (Vic Branch) could simply adopt the attitude that spending priorities need to be reviewed; for example, by shifting \$2b per year from the defence budget to the aged care budget.

However, the Terms of Reference for this inquiry encompass the issue of how much personal financial responsibility individual recipients of care should be expected to bear. The ANF (Vic Branch) recognises that, especially since 1997, the aged care system has been premised on the idea that individuals (depending on their assets) have some responsibility to meet the cost of their accommodation and/or care.

In the case of people who have been assessed as requiring low care in a residential aged care facility, approved aged care providers currently have the capacity to request an accommodation bond, subject to an assets minimum threshold. Some aged care providers have called for the application of accommodation bonds to high care, as a panacea for the funding pressures on the aged care industry. The ANF (Vic Branch) does not support the extension of bonds to people admitted as high care residents. We believe the imposing of accommodation bonds is a crude instrument, and that developments since its inception have made it even less attractive as an option. A bond may have been justified when it was at least possible that an individual was making a lifestyle choice – i.e., entering a very low care hostel where they might have resided for many years. This is no longer the case. Relevant changes in recent years include:

- The increasingly advanced age of residents on entry to residential aged care. These residents are usually frail and vulnerable and not necessarily capable of dealing with a request for an accommodation bond.
- The significant decline in the length of stay in care for those admitted as high care residents, making it unreasonable to require them to sell or mortgage a property for such a short time span (increasingly, less than a year).
- The likelihood that a spouse/partner is still living in the family home.
- The decline in the value of property in some regional areas, meaning that the imposition of bonds on high care residents is problematic to say the least.

Recommendation 5

To ensure that aged care funding is sustainable and adequate to meet demand arising from the forecast expansion in aged care service capacity and the increasingly complex medical and nursing care needs of people requiring residential and community aged care, ANF (Vic Branch) recommends the Australian Government:

- a) Provide funding that accurately reflects the real cost of care, as per ANF recommendation 4.
- b) Ensure aged care funding indexation mechanisms incorporate and reflect different expenditure structures across the industry, wage variations, regional variations and the expanding care needs of people requiring residential or community aged care.
- c) Ensure review of existing aged care funding indexation mechanisms is undertaken by an independent body, preferably with expertise in health cost analysis.
- d) Develop an independent authority to incorporate activity funding pricing as part of the Australian Government's health and hospitals reform process.
- e) Immediately commence a national policy dialogue to discuss and develop options to provide increased aged care funding.
- f) Reject industry calls to implement accommodation bonds for high care residents.

6.4 Does the aged care system meet its objective to provide transparency and accountability in funding and provision of aged care services?

ANF (Vic Branch) asserts that there is a need to ensure that management and expenditure of aged care subsidies and accommodation bonds is more transparent and accountable, without imposing unnecessary cost or paperwork on the system. One of the largest single Commonwealth budget allocations each year is to residential aged care. However, the sector appears to be largely self regulating, with only minimal oversight or standard-setting by the Commonwealth. This is largely as a result of the de-regulation that occurred in the mid-late 1990s under the Howard Government. In our view, the light regulation approach has had serious consequences with respect to quality of care and workforce recruitment and planning issues.

6.4.1 Financial reporting by providers

The ANF (Vic Branch) understands that financial reporting by providers is not mandated and that providers must supply the Commonwealth with a copy of their audited accounts only as a condition for access to the Conditional Adjustment Payment (CAP).

ANF (Vic Branch) contends that this level of financial reporting is inadequate, and that, instead, approved providers should be required to provide clear and transparent financial information to the Australian Government as a matter of course, at least annually and more frequently if requested.

The benefit of applying this methodology is illustrated by the experience of both Bridgewater Aged Care Facility (2008) and the Kendalle Group (2009) in Victoria, where approximately \$10m and \$8m respectively were 'lost' in resident bonds.

In both these cases, defalcations occurred over a lengthy period of time (at least 18 months). The Australian Government and the Department of Health and Ageing (DoHA) has a duty to monitor the businesses of approved aged care providers and provide protection of public and/or resident funds.

It is our experience that shortfalls in an approved aged care provider's bond accounts, non-payment of superannuation or failure of the provider to meet tax obligations can be an early indicator of risk and vulnerability to corporate collapse (or at the very least the risks and traumas associated with cost cutting and the eventual sale of the business/beds).

This was the case in the collapse of JKL Nominees/TCL Nominees (2008), where employees lost an estimated \$200,000 in superannuation payments (which could not be recovered through the Commonwealth GEERS scheme) and the Australian Government lost an estimated \$1m in unpaid tax obligations.

The ANF (Vic Branch) is of the view that a private aged care provider is simply a contractor working exclusively for the Australian Government, as the overwhelming percentage of revenue is derived from Australian Government aged care subsidies. It is not unreasonable that one of the obligations under the contract or licence of an approved provider should be a requirement to give DoHA the authority to seek information relating to payments and debts, both to the relevant superannuation funds and the Australian Taxation Office.

Further, we believe that, given the significant level of Commonwealth funding, a more interventionist financial risk management strategy should be implemented by DOHA – one which identifies the 10% of providers at highest risk of financial failure, and which works proactively to:

- monitor key indicators of financial stress;
- undertake spot financial health audits of some of those in the 'at risk' category; and

- offers support (e.g., IT and financial systems) to those most at risk.

6.4.2 Separation of care costs from accommodation costs

The ANF (Vic Branch) was a strong supporter of the old division of aged care funding into care costs (75% CAM) and accommodation costs (25% SAM) provided under the Care Aggregate Module (CAM) and Standard Aggregate Module (SAM) from 1987 and through most of the 1990s.

The CAM funding, which was provided to employ nurses and personal care staff as need was determined using the then resident needs tool (RCI, Resident Classification Instrument) and confirmed through audits of resident care records. 95% of CAM funding had to be spent on care staff wages.

The SAM component was a daily allowance for infrastructure purposes. Ultimately, the CAM/SAM system came under pressure, not least from the National Commission of Audit (Report to the Commonwealth Government, 1996). The then Treasurer opined:

Both nursing home and hostel per-unit costs are escalating rapidly, beyond what might be reasonably expected in terms of the increasing frailty of residents. There is little incentive to introduce labour saving technology. The funding system for nursing homes actively encourages the use of labour instead of technology. Care Aggregated Module (CAM) funding (55 per cent of nursing home funding) requires that care expenditures are on nurses' wages.

The abolition of the CAM/SAM system has allowed approved providers absolute discretion as to how funding received from the Australian Government is expended. The ANF (Vic Branch) contends that this has facilitated workforce restructuring and the de-skilling of nursing and direct care staff labour in the private aged care sector. For example, in 1988, the Victorian 'nursing home' sector comprised around 40% registered nurses, 33% enrolled nurses and 27% PCWs. In contrast, today the proportions would be more like 20%, 15% and 65% respectively. This significant workforce shift and the accompanying deleterious consequences on the quality of aged care service provision will be explored in section 7 of this submission.

The ANF (Vic Branch) recommends that there be a much clearer obligation on approved providers to expend a particular proportion of Australian Government funds on care costs, especially direct care costs. The percentage of funding would need to be properly assessed in accordance with average direct care and non care costs (for a range of facility types) and used as an initial guide, previous CAM funding models. It would appear that a provider should spend at least 75% of Government aged care funding on costs associated with the employment of direct care staff. Experience through information provided as part of good faith bargaining would show that, over 10 years, the percentage of funding spent on care costs has dropped to as low as 52%.

Further, ANF (Vic Branch) recommends that these care costs be carefully defined to ensure that items not associated with care are excluded.

6.4.3 Benchmarking expenditure

On examination of the 2009 Bentley Report, there appears considerable variance between states and territories in relation to the level of residential aged care expenditure in particular areas. For example:

- NSW and Queensland spend approximately \$21.31 and \$17.63 respectively, per resident per fortnight on administration, compared to \$14.27 in Victoria;
- Victoria spends \$66.08 per resident per fortnight on nursing care costs, as opposed to between \$62 and \$63 in both NSW and Queensland; and,

- Queensland spends \$6.93 per resident on cleaning per fortnight compared to \$5.63 in Victoria and \$5.20 in NSW – a more than 30% gap between NSW and Queensland

There are other examples of significant variances in expenditure. Whilst there may be valid reasons for these differences (e.g., trends in facility or network size or better and fairer pay for cleaners in some states), it would seem obvious that, in a system under such pressure, the Australian Government should endeavour to ensure that every dollar is used to its maximum efficiency and expended in areas that affect the quality of care. A first step towards achieving maximum financial efficiency would be for the Australian Government to actively benchmark expenditure categories, and establish what best practice is for different types of nursing homes, rather than allowing current expenditure in the market to become the de facto benchmark.

Recommendation 6

To enable improved and adequate transparency and accountability in funding for the provision of aged care services, ANF (Vic Branch) recommends the Australian Government:

- a) Audit the finances of approved aged care providers in respect to profit, loss and accommodation bonds, no less than six monthly, and mandate a requirement that approved providers submit audited annual accounts to the Australian Government.
- b) More closely monitor compliance with statutory obligations (e.g., compulsory superannuation and industrial instruments), which may indicate 'at risk' providers. To facilitate this, the Australian Government must require accredited providers to sign an authority allowing DOHA to seek information from superannuation funds and the Australian Tax Office.
- c) Develop a risk profile for approved providers and undertake annual unannounced financial audits of approved providers who have been identified as being 'at risk'. Such an audit would measure financial health, expenditure against benchmark measures and compliance with bond management requirements.
- d) Require a proportion of aged care subsidies (we propose 75%) to be spent exclusively on employment costs of direct care staff – and, furthermore, mandate higher expenditure if necessary, to be compliant with minimum staffing level and skill mix requirements. Direct care costs must be limited to care staff that are licensed/registered.
- e) Establish clear benchmarks for all categories of expenditure, to ensure consistency between providers (of like type and size) and regions, together with a monitoring and review process.

7. Providing an Appropriately Skilled Workforce: Future Staffing Requirements and Education and Training

7.1 An Overview – the ageing and more dependant residential and community aged care demographic

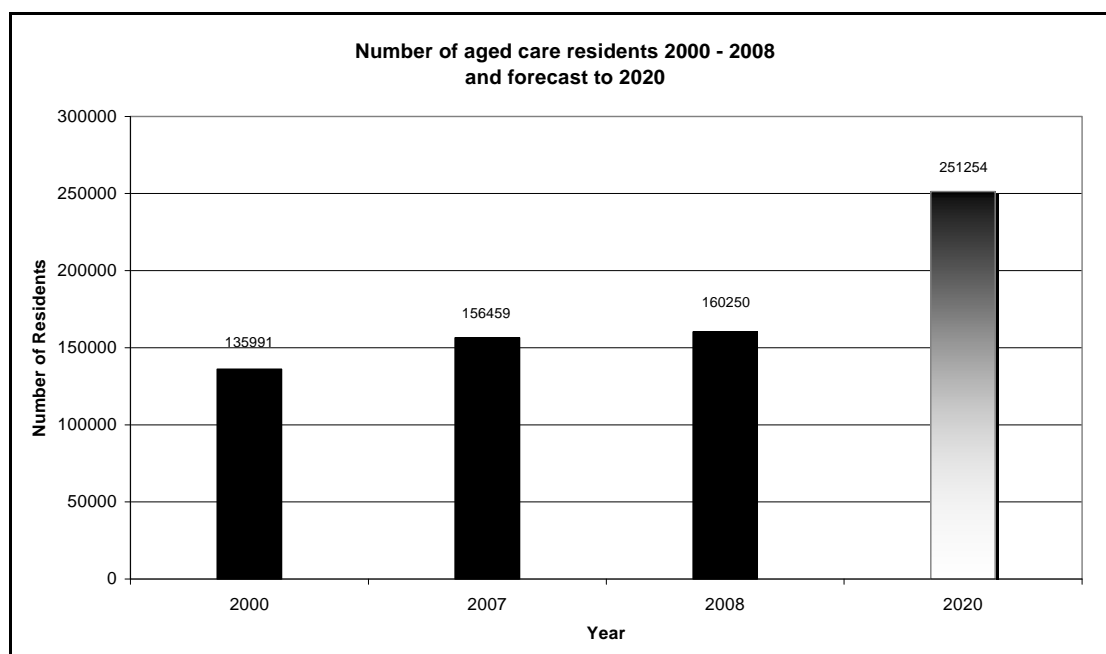
Health and aged care services will come under increasing pressure as a result of the ageing of the population and the increasing prevalence of chronic disease in the community (Australian Government, 2010).

There are some thought-provoking statistics presented in the Intergenerational Report (2010), predicting the Commonwealth of Australia will be faced with an increase in the proportion of Australia's population aged 65 or over, from 14% in 2010, to 23% by 2050. Additionally, the number of people aged 85 or over is expected to rise fourfold, to 1.8 million by 2050. Meanwhile, Australia's crude mortality rate has decreased from 9.1 deaths per 1,000 people in 1968 to 6.7 deaths per 1,000 people in 2008. Further, life expectancy at birth is projected to rise from 80.1 years for men born in 2010 and 84.4 for women, to 87.7 years for men born in 2050 and 90.5 years for women.

Consistent with the ageing of the population, there has been a steady increase in the number of RAC places, from 134,810 in 1995 to 175,472 in 2008. At June 30 2008, these places were occupied by 160,250 residents in RAC facilities, an increase from 156,549 at 30 June 2007 and 135,991 at 30 June 2000 (AIHW, 2009).

This increase is presented in Figure 7.1.1, together with the predicted 56.8% increase in the total number of people in RAC facilities, taking the number to 251,254 by 2020 (Access Economics, 2009).

Figure 7.1.1 Number of Aged Care Residents 2000 – 2008 and Forecast to 2020



Significantly, as shown in Figures 7.1.2 and 7.1.3, there has been an increase in the proportion of residents aged 85 years or over and in the proportion of aged care residents assessed as having high care needs (AIHW, 2009; Access Economics, 2009; Australian Government, 2010; Productivity Commission, 2008).

At 30 June 2000, 50% of residents in aged care facilities were aged 85 years or over, and 23% were aged 90 years or over. By 2008, this had increased to 55% of residents aged 85 years or over, and 27% aged 90 years or over (AIHW, 2009).

In Victoria it is projected that the number of people aged 70 years and over will increase by 9.6% to 2011 and 26% to 2016. Those over 80 – the primary users of aged care services – will increase by 14% to 2011, and 26.5% to 2016 (Victorian Government 2009).

Furthermore, modelling done by Access Economics (2009) predicts a ‘drift’ toward even older demographics, with those aged 95 years or over increasing by 9.5% per annum.

This is evidenced by the proportion of residents classified as high care [resident classification scale “RCS” 1-4], which rose from 58% at 30 June 1998 to 70% at June 2008. Conversely, the proportion of residents classified as low care fell from 42% to 30% (Martin and King, 2008; AIHW, 2009).

Figure 7.1.2 Residents aged over 85 and 90 years 2000 - 2008

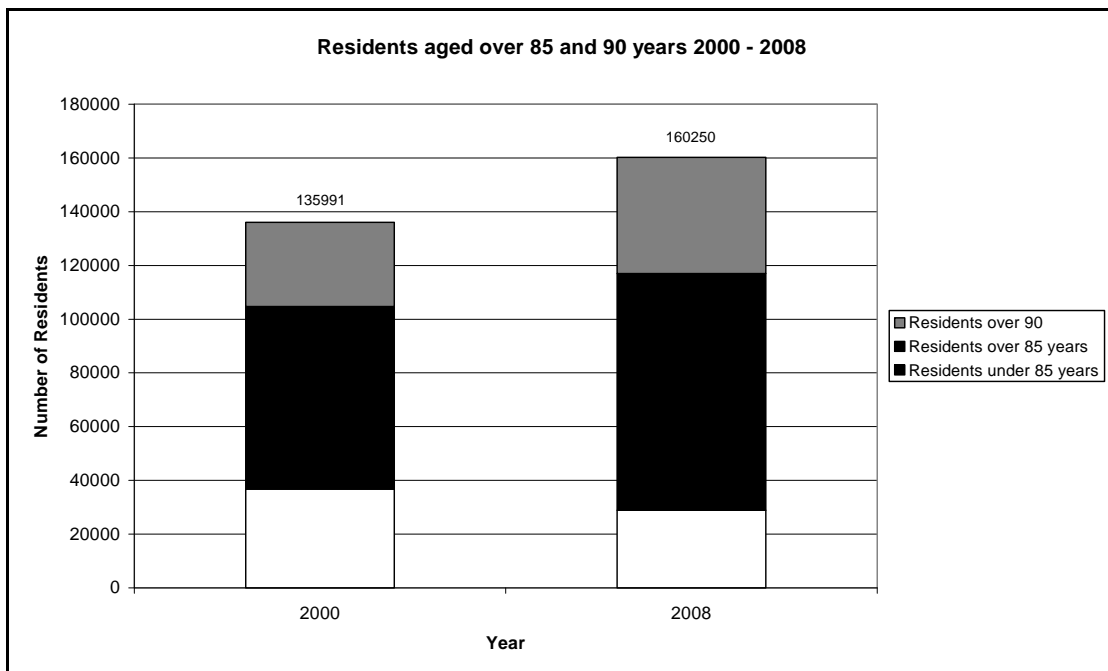
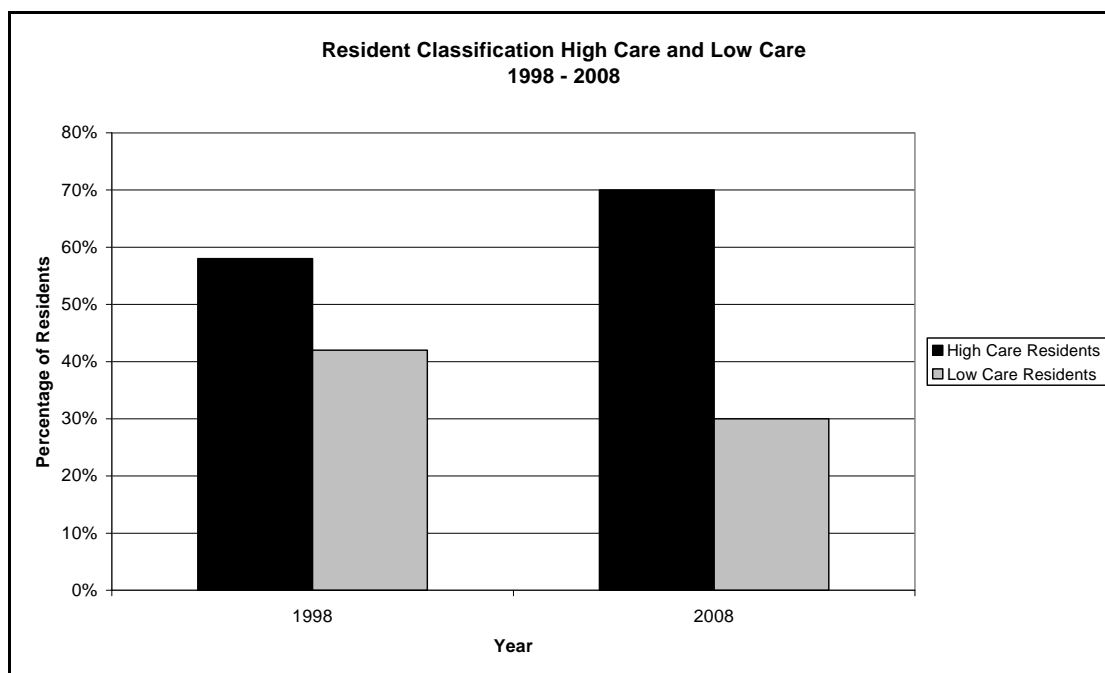


Figure 7.1.3 Resident Classifications High care and Low care 1998- 2008



Additionally, the incidence of chronic disease in Australia increased from 2001 to 2008 as follows:

- Diabetes mellitus from 2.9% of the population or 554,200 people in 2001, to 4% of the population or 818,200 persons in 2007 – 2008.
- Heart failure, heart, stroke and vascular disease from 4.1% of the population or 782,200 people in 2001, to 5.2% of the population or 1,079,100 in 2007 – 2008.
- Malignant neoplasm from 1.4% of the population or 261,300 people in 2001, to 1.6% of the population or 326,600 people in 2007 – 2008.
- Mental and behavioural problems from 9.6% of the population or 1,812,600 people in 2001, to 11.2% of the population or 2,309,800 people in 2007 – 2008.
- Obesity from 50.1% of the population or 6,551,700 people in 2001, to 56% of the population or 7,628,900 in 2007 – 2008, with the highest rates of obesity – 75% – occurring in the 65-75 year old age group (Australian Bureau of Statistics, 2009).

Of particular relevance to aged care services, the number of people suffering dementia is also forecast to rise exponentially, from around 220,000 in 2007 to over 730,000 in 2050. Additionally, the number of people in residential aged care with palliative care needs is also predicted to grow (Jones, Matias, Powell, Jones, Fishburn, Looi 2007; Chiarella and Duffield, 2007).

The ageing of the population and the forecast increased prevalence of chronic disease combine to create a residential aged care demographic that is more dependant and has more complex nursing and medical care needs. The ANF asserts that, in order to meet these needs, the nursing and direct care workforce must not only expand in size and number, but just as importantly, must become more skilled and educated.

Adapting to the more complex care needs of the RAC demographic will therefore require a change to the composition of the aged care workforce, and specifically an increase in the number and proportion of registered and enrolled nurses – the staff who are educationally prepared and have the professional scope of practice to safely and competently provide for these expanding needs.

7.2 Future staffing requirements

7.2.1 An overview – the nursing and aged care workforce profile

Victoria has two levels of nurse, the registered nurse and the enrolled nurse. With the move to national registration on 1 July 2010 the licensing and registration of nurses in these classifications has been assumed by the Nursing and Midwifery Board of Australia (NMBA) through the Australian Health Professionals Regulation Agency (AHPRA).

For licensure in Australia, the registered nurse must successfully complete a minimum three year undergraduate degree at a recognised higher education institution or, historically, the equivalent from a recognised hospital based program. For a nurse to maintain their licensure or registration, the registered nurse must satisfy requirements in respect of continuous professional development, recency of practice, professional indemnity insurance, criminal history and English language.

The registered nurse is a crucial part of the aged care workforce, managing teams of staff, making nursing assessment, and applying advanced and specialist knowledge to the increasingly complex care needs of the RAC demographic.

The enrolled nurse, for licensure or registration, must have satisfactorily completed a qualification at the minimum Certificate IV for entry to practice; or a Diploma of Nursing from a Vocational Education and Training (VET) provider such as TAFE, or, historically, the equivalent from a recognised hospital based program. More recently however, the educational preparation for enrolled nursing in the majority of Australia is the diploma of nursing, which involves around 1500 student contact hours and is delivered full time over 18 months. The enrolled nurse may undertake more complex tasks than a personal care worker (PCW) including, where educationally prepared, medication management and client monitoring. The enrolled nurse works closely with the registered nurse, generally undertaking delegated care under the direct or indirect supervision of the registered nurse.

Personal care workers or assistants in nursing (however titled) are not currently licensed. Their educational preparation while generally at a certificate III level, is not regulated and there is no requirement to hold accredited education to undertake the role. The most common qualification, the Certificate III in Aged Care Work, is not currently overseen by any regulatory authority. Whilst there are nominal hours allocated to the Certificate III (around 550 hours), the number of hours and standard of delivery vary between Registered Training Organisations (RTO). Personal care workers or assistants in nursing (however titled) undertake routine care tasks that have been delegated by registered or enrolled nurses, under direct or indirect supervision.

7.2.2 Background – changes to the composition of the nursing and aged care workforce

Historically, the majority of nursing care in RAC facilities has been provided by registered and enrolled nurses. Whilst this remains the case in the Victorian public aged care sector, regulatory changes, efforts to minimise cost and a difficulty in recruiting and retaining registered and enrolled nurses, have dramatically affected the composition of the private aged care workforce and the way nursing care is administered in RAC facilities.

Significantly, as detailed in table 7.2.1, there has been a steady and dramatic reduction in the number and equivalent full time quota (EFT) of registered nurses and enrolled nurses working in the

residential aged care sector. Conversely, over the same period, there has been an exponential increase in the number of unlicensed personal care workers in RAC facilities.

Table 7.2.1 Residential aged care workforce by occupation

(Employment and distribution), Facilities Census, 2003 and 2007 (percent)

Occupation	2003		2007	
	Number of persons	Equivalent Full-time	Number of Persons	Equivalent Full-time
Registered Nurse	24,019 (21.0)	16,265 (21.4)	22,399 (16.8)	13,247 (16.8)
Enrolled Nurse	15,604 (13.1)	10,945 (14.4)	16,293 (12.2)	9,856 (12.5)
Personal Carer	67,143 (58.5)	42,943 (56.5)	84,746 (63.6)	50,542 (64.1)
Allied Health	8,895 (7.4)	5,776 (7.6)	9,875 (7.4)	5,204 (6.6)
Total Number	115,660	76,006	133,314	78,849

Source: Census of residential aged care facilities. (Martin and King, 2008)

Note: Estimated total numbers are the estimated total number of workers in each category employed in all Australian aged care facilities. Thus, we estimate that altogether, aged care facilities employed 24,019 registered nurses in 2003 and 22,399 in 2007. The numbers in brackets are percentages of total number in each occupational group. Thus, 21.0% of direct care workers were registered nurses in 2003, and 16.8% were registered nurses in 2007.

The reduction in the number of registered and enrolled nurses, as outlined in table 7.2.1, has caused a significant 'reorganisation of care' in residential and community aged care, with more nursing care now being provided by unlicensed workers and less being provided by registered and enrolled nurses (Martin and King, 2008). The ANF (Vic Branch) asserts that this reduction of registered and enrolled nurses, i.e. those direct care staff most educationally prepared to provide for the increasingly complex care needs of residents, is counter-intuitive in the context of the ageing and increasingly dependent RAC demographic. ANF (Vic Branch) further asserts that the effective reduction in nursing skill mix is contributing to a lower level of resident safety and quality of care, and placing vulnerable residents at risk (Department of Health and Ageing, 2007).

Additionally, nursing and care hours in the RAC sector have neither kept pace with, nor matched the expansion in the number of RAC places, nor adapted to meet the demand arising from the more complex care needs of the RAC demographic. Whilst there was a 15.3% increase in the number of care staff employed in RAC facilities from 2003 to 2007; this translated to only a 3.4% increase in EFT.

The 3.4% EFT increase is significantly less than the corresponding increase in RAC places of 12.5%, indicating that nursing and care staff hours have not increased to meet demand.

Similarly, Bentleys (Qld) Pty Ltd (2009) identified that care/nursing staff hours per resident per fortnight reduced from 36.00 in 2007, to 34.42 in 2008. This is despite the backdrop of increasing care subsidies, resident fees and the increasingly dependent RAC profile.

The failure to increase nursing hours relative to the increase in number of RAC places and to RAC residents' more complex health and care needs is resulting in inadequate staffing levels, particularly in the private residential aged care setting. In turn, inadequate staffing levels are causing intensification of work for nurses and PCWs, which is impeding both the retention and recruitment of

a sustainable aged care workforce, and contributing to a decline in resident safety and quality of care (University of Melbourne, 2008; University of Melbourne, 2009; University of Melbourne, 2010).

7.2.3 Future workforce requirements – staffing levels and skill mix

The provision of staffing levels and skill mix adequate and appropriate to the assessed care needs of residents is crucial to providing high quality care (Productivity Commission, 2008; Clarke, 2003; Needleman, Buerhaus, Mattke, Stewart, Zelevinsky, 2002; Shannon and French, 2005; Haberfield and Bedecarre, 2005; Aitken, Clarke, Sloane, Sochalski & Silber, 2002; Beurhaus, Donelen, Des Roches, Lamkin & Mallory, 2001; Waters, 2005; Horn, Buerhaus, Bergstrom & Smout, 2005; Jones et al., 2007; Aitken, Clarke, Cheung, Sloane and Silber, 2003).

With this in mind, aged care workforce planning must ensure that staffing levels and skill mix are adequate and appropriate. Consideration of what comprises an appropriate staffing level and skill mix in residential and community aged care must take into account the different educational preparation and scope of practice of registered nurses, enrolled nurses, and unlicensed care workers. These staff must be deployed at the bedside in proportions and numbers that match and can competently meet the assessed care needs of residents.

The Certificate III educational preparation of PCWs equips them to provide routine care tasks delegated by a registered nurse and performed under the supervision of a registered nurse. The scope of practice of a PCW is therefore limited and does not extend to planning or evaluating resident care. Additionally, PCWs cannot reasonably be expected to detect sometimes subtle but serious changes in a resident's health status – changes that may signal a need to deviate from the plan of care, or to implement medical or nursing interventions.

In contrast, registered nurses are educationally prepared and enjoy a broad scope of practice that equips them to clinically assess a resident's complex care needs and, additionally, to plan, implement, monitor and evaluate this care. Registered nurses make a difference to resident and patient outcomes and provide the surveillance system for the early detection of complications. As a result, they are a strong determinant in the incidence of resident or patient complications including decubitus ulcers, pneumonia, sepsis, dehydration and malnutrition, and falls leading to injury. With this in mind, and considering that registered nurses are required to delegate and oversee the delivery of care by enrolled nurses and PCWs, registered nurses must be recognised as the crucial factor in provision of quality care to the increasingly frail and dependant aged care demographic (Aitken et al, 2003; Clarke, 2003; Needleman et al, 2002; Shannon and French, 2005; Horn et al, 2005; Haberfield and Bedecarre, 2005; Aitken et al, 2002; Aitken et al, 2003; Beurhaus et al, 2001; Waters, 2005; Benveniste, Hibbert and Runciman, 2005).

The ANF (Vic Branch) believes that an appropriate staff skill mix, adequate staffing levels and sufficient registered nurses are absolutely necessary in the provision of high quality care and, conversely, that a failure to provide these staffing standards contributes to a reduced quality of care. This correlation is corroborated in the assessment of the Aged Care Standards and Accreditation Agency (2008), which counsels that:

Among those homes found to be non compliant in 1.6 Human resource management, it was found that a significant proportion did not maintain appropriate numbers and types of staff, with many of them not being able to ensure that staff skills and qualifications were the right fit for the work required and to reflect their residents' needs... (Page 2)

And that

a strong causal link was found between homes that were non compliant with Human resource management 1.6 and deficiencies in other service systems, in particular Clinical care 2.4, Specialised nursing care needs 2.5, Medication management 2.7, Behavioural

management 3.7 and Information systems 1.8... (And) ... that in homes where workloads are unrealistic, or where staff are unqualified, poorly trained or poorly deployed, then process malfunctions occur across a range of expected outcomes. Employment of staff without appropriate skills may exacerbate any staff shortages as this may lead to inefficiencies in time and effort and place greater work related stresses on staff. (Page 3)

From the perspective of those working in the system: nurses from the Night and Day Nursing Agency advised in correspondence to ANF (Vic Branch), 19 May 2010 (Appendix F) that:

The nurses and care staff are under pressure because there are no mandatory staffing levels, shift lengths and skill mix implemented in a high percentage of facilities they are working. The nurses consider this to be dangerous to residents, and a thereby to their ability to practice under the guidelines set by the Nurses and Midwifery Council of Australia and the Nurses Board of Victoria.

There is also an increasing body of international and Australian research and literature that supports the proposition that the number of nursing and care staff, and moreover the proportion of registered nursing staff and skill mix, significantly determines outcomes in respect of quality of care, and the incidence of complications or sentinel events.

Horn et al. (2005) conducted a study of long stay nursing home residents to examine the relationship between registered nurse staffing time and the care and health outcomes of long stay nursing home residents. In a retrospective study of data collected as part of the National Long term Study, Horn et al analysed data on 1376 residents of 82 long term care facilities whose lengths of stay were 14 days or longer, and who were at risk of developing pressure ulcers but at the commencement of that study had none. The study found that more registered nurse direct care time per resident (examined in 10 minute increments up to 30 to 40 minutes per resident per day) was associated with fewer pressure ulcers, hospitalizations and urinary tract infections, lower rates of catheterisation, less deterioration in residents' ability to perform activities of daily living, and greater use of nutritional supplements. Whilst an increase in staffing levels had some positive effect on patient outcomes, the study found:

strong and consistent associations between the average time RNs (registered nurses) provided direct care and pressure ulcer development, weight loss, deterioration in the ability to perform ADLs and hospitalisation...(Page 62 and 63).

There is an obvious need for Government to commission further independent research into the impact of staffing levels and skill mix on resident care outcomes in the Australian residential aged care setting. Nonetheless, a significant number of studies have been undertaken in the acute care setting to determine the effect of staffing levels, skill mix and particularly the presence of registered nurses on a range of health outcomes. The results of these acute care studies are relevant to residential aged care, as the health outcomes measured in them are directly applicable to the residential aged care setting.

Haberfield and Bedecarre (2005) examined the ramifications of reorganising care delivery (as a result of increasing the number of unlicensed care workers) on a number of health outcomes. They found that the proportion of hours of registered nurse care was inversely related to the incidence of medication errors, pressure ulcers and patient complaints, and found that a 10% increase in the proportion of registered nurses was associated with a 9.5% decrease in the likelihood of pneumonia and associated mortality. They also found that increased registered nurse hours had a positive effect on fall rates and pain management, and that an increased proportion of registered nurses was associated with lower rates of urinary tract infection and 'failure to rescue'. Haberfield and Bedecarre concluded that more hours of care by registered nurses, and a higher proportion of registered nurses in the skill mix, are associated with better outcomes for in both medical and surgical patients.

Shannon and French (2005) examined the effect of what they describe as the re-engineering of nursing and care skill mix on patient outcomes. They found that nurses reported the quality of care and services being seriously compromised as a result of cutbacks. In investigating what difference the quantity of nursing makes to patient outcomes, they concluded that:

There is clear proof that there is a direct correlation between the ratio of nurses and the patient's health outcomes... and that skill mix and staffing ratios are significant predictors of mortality (Page 234).

Further, they observed that:

We know higher ratios of registered nurses to patients are linked to increased patient satisfaction...fewer inpatient complications, decreased costs, safer and shorter hospital stays (Page 234).

Needleman et al. (2002) examined whether staffing by nurses was associated with increased risk of patient complications or death. They consistently found that:

[A] higher proportion of nursing care provided by registered nurses and a greater number of hours of care by registered nurses per day are associated with better care... (Page 1715)

Clarke (2003) interpreted the results of numerous studies into the effect of skill mix and staffing levels on care outcomes, and concluded that consistent and statistically significant links exist between registered nurse staffing and patient outcomes, with better staffed hospitals experiencing lower rates of sentinel events. In addition, Clarke identified outcomes that were particularly sensitive to nurse staffing and concluded that insufficient numbers of registered nurses compromised surveillance of a patient's health status and prevented early detection of health complications.

Beurhaus et al (2001) completed a study to determine the effect of staffing levels and skill mix on patient care and found substantial evidence that patient outcomes are related to nurse staffing. Moreover, their study found that increasing either the level of registered nurses or skill mix would decrease adverse patient outcomes by between 3% and 25%.

In looking at the provision of care to persons with mental illness, Beneviste et al. (2005) analysed data on incidents involving violence from the Australian Incident Monitoring System (AIMS). Their study examined 3621 incidents involving patients becoming violent in Australian health services between 1 July 2000 and 30 June 2002. They found that *insufficient numbers or inadequate staff* and *inadequate knowledge or experience* were second only to the patient's own *mental health condition* as the most common factors contributing to a violent incident. Again, in the accident and emergency setting, *insufficient staffing* was found to be second only to the patient's own *mental health condition* as contributing to a violent incident. These findings are particularly relevant in the context of the projected increase amongst the aged care demographic of dementia, associated behavioural problems and mental illness (Australian Government, 2010; Productivity Commission, 2008; Australian Bureau of Statistics, 2009).

The New South Wales Department of Health commissioned the University of Technology, Sydney to complete a study into health and workforce issues, examining the impact of models of care on patient outcomes, and the impact of skill mix (proportion of registered nurses) on patient outcomes and adverse events. This study commenced in 2003 and encompassed 27 hospitals and 286 nursing wards. It found that:

A skill mix with a higher proportion of RNs produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers, gastrointestinal bleeding, sepsis, shock, physiologic/metabolic derangement, pulmonary failure as well as 'failure to rescue'.

Estimates for improvements in a number of patient outcomes related to skill mix were found:

- *Decreased rates of decubitus an extra RN per shift per patient per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients;*
- *Decreased rates of pneumonia; an extra RN shift per patient per day would reduce the incidence of pneumonia by 16 per 1000 patients;*
- *Decreased rates of sepsis; an extra RN per shift per patient per day would reduce the incidence of sepsis by 8 per 1000 patients...*
- *Patients were less likely to fall and suffer injury as RN hours increased [about half the falls produced patient injury] (Page 16).*

There exists a plethora of research and literature corroborating the correlation between registered nurses, adequate staffing levels and resident/patient health outcomes and quality of care. Consequently, ANF (Vic Branch) contends that this correlation should be given significant weighting when determining future nursing and care staff workforce requirements.

7.2.4 The University of Melbourne – a qualitative comparison of registered nurse to resident ratios and their effect on resident outcomes

The effect of staffing levels, skill mix and particularly registered nurse to resident ratios on resident and staff outcomes are further corroborated in the findings of The University of Melbourne longitudinal study.

As part of its study, The University of Melbourne (2009) measured a number of scales or outcomes under the broad headings of job changes, medication practices, job stressors, management practices, work, psychological and physical health outcomes and resident outcomes. These scales were broken down further into subheadings and explored in detail (Appendix C), enabling analysis and 'group comparisons' to be made of outcome measure or 'scales' in the public, private not for profit and private for profit residential aged care facilities.

This analysis commences with a comparison of the vastly different registered nurse to resident ratios in mixed or high care facilities within public, private not for profit and private for profit facilities that existed at October 2007 ('Time 1') and March 2009 ('Time 2').

The next series of tables and graphs depict the mean (an average calculated by summing the responses of all participants and then dividing this total by the number of participants) registered nurse to resident ratio for both Time 1 and Time 2 based on the type of care provided by the facility (mixed or high), the type of organisation the facility is (public, private not for profit, private for profit) and the timing of shifts (AM, PM or ND).

Table 7.2.2 Time 1 Mixed Care Facilities

Shift	Organisation Type		
	Public	Private Not for Profit	Private for Profit
AM	1:17	1:21	1:23
PM	1:18	1:31	1:33
ND	1:21	1:36	1:39

Table 7.2.3 Time 2 Mixed Care Facilities

Shift	Organisation Type		
	Public	Private Not for Profit	Private for Profit
AM	1:13	1:18	1:22
PM	1:17	1:29	1:33
ND	1:15	1:40	1:47

Figure 7.2.1 Time 1 Mean RN to Resident Ratios at Mixed Care Facilities

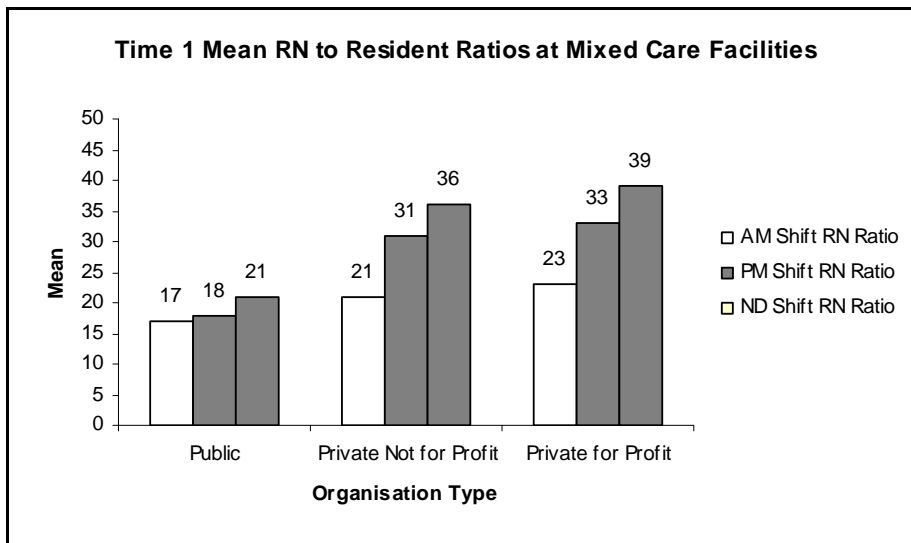


Figure 7.2.2 Time 2 Mean RN to Resident Ratios at Mixed Care Facilities

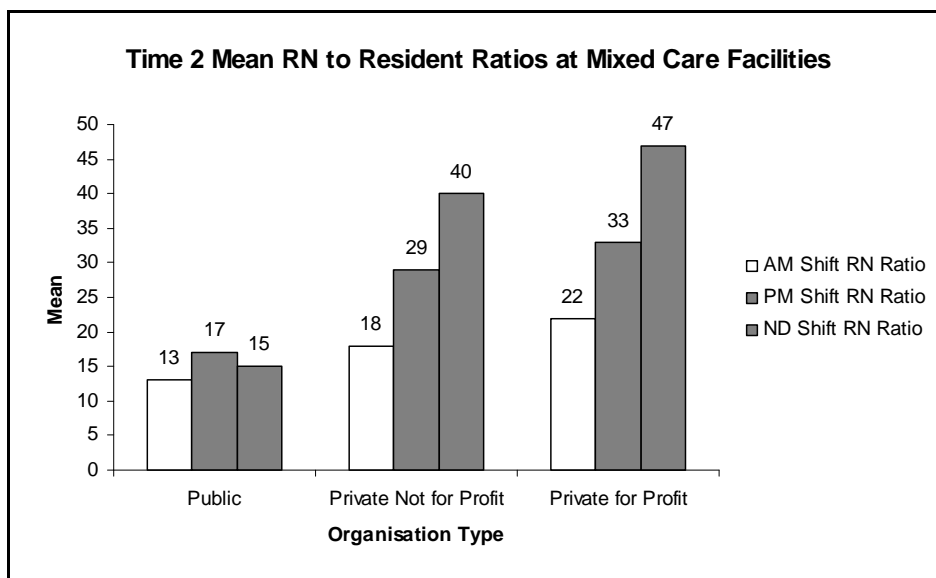


Table 7.2.4 Time 1 RN to Resident Ratios in High Care Facilities

Shift	Organisation Type		
	Public	Private Not For Profit	Private for Profit
AM	1:6	1:17	1:16
PM	1:8	1:23	1:22
ND	1:14	1:29	1:29

Table 7.2.5 Time 2 RN to Resident Ratios in High Care Facilities

Shift	Organisation Type		
	Public	Private Not For Profit	Private for Profit
AM	1:9	1:15	1:17
PM	1:10	1:23	1:24
ND	1:14	1:28	1:37

Figure 7.2.3 Time 1 Mean RN to Resident Ratios at High Care Facilities

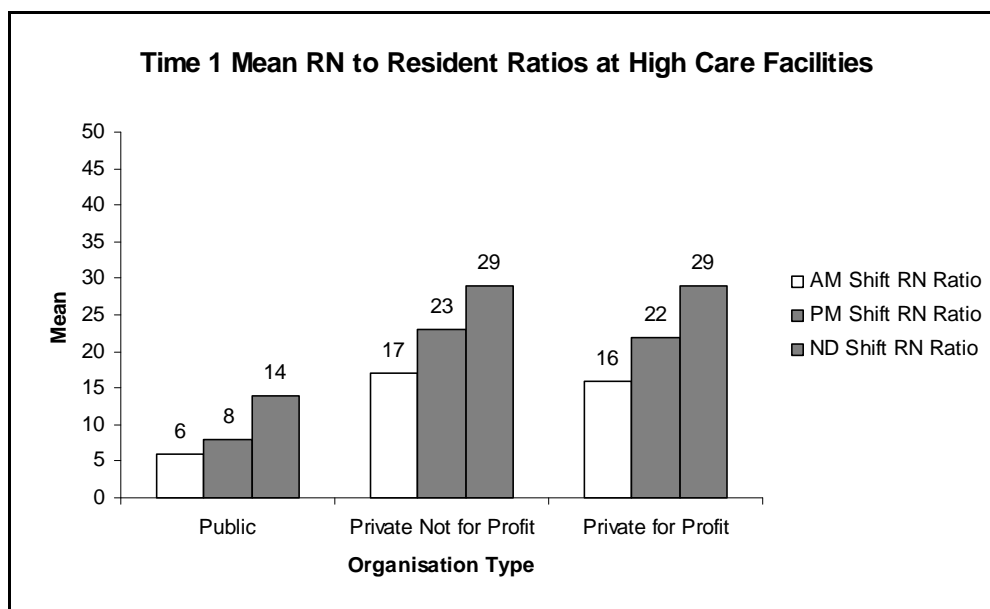
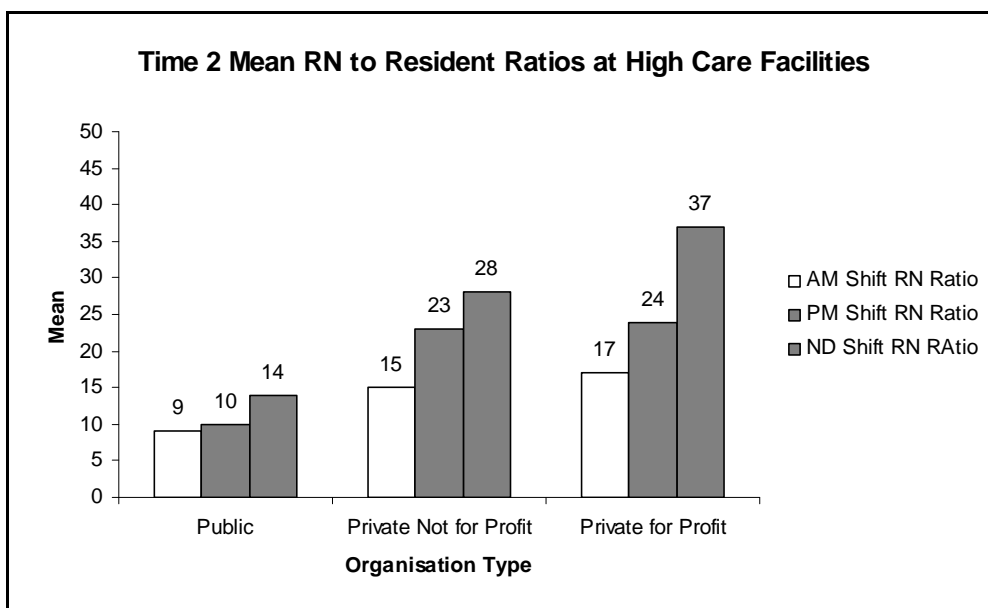


Figure 7.2.4 Time 2 Mean RN to Resident Ratios at High Care Facilities



These tables and figures reveal a dramatic difference between the registered nurse to resident ratios in Victorian public sector facilities and those in the private not for profit or profit sector. Figure 7.2.4, for example, reveals that during the night duty shift registered nurses working in private for profit facilities were, at Time 2, having to care for almost triple the number of residents (with a registered nurse to resident ratio of 1:37) than their colleagues in public sector facilities, who had a registered nurse to resident ratio of 1:14. Similarly, during the afternoon or PM shift, registered nurses working in the private for profit sector were, at Time 2, having to care for more than double the number of residents (with a registered nurse to resident ratio of 1:24) than their aged care public sector colleagues, who had a registered nurse to resident ratio of 1:10.

The study found that registered nurse to resident ratio on all shifts was a significant predictor of resident safety and that, in respect of night duty:

The registered nurse to resident ratio significantly predicted resident care... [and that] analysis revealed that where there were more residents for registered nurses to care for on the night shift, individuals felt that the resident care at their facility was poorer (Pages 21 and 22); and,

In all cases the more residents each registered nurse had to care for the more negative or poorer the outcomes were. (Page 26)

In an illustration of the correlation between better staffing levels and better resident and direct care staff outcomes, the University of Melbourne (2009) made the following important *group comparisons* of *scales* of outcome measures between the different types of aged care facilities:

1. Participants from private for profit facilities reported significantly lower level of resident care, as compared to participants from public facilities.
2. Participants from private for profit facilities reported significantly lower level of resident safety, as compared to participants who worked at public facilities. (Page 73)

3. Participants from public sector facilities reported that staff were significantly more responsive to the needs of residents, as compared to participants from private for profit facilities. (Page 71)
4. Participants who worked at public facilities were significantly more likely to feel that their facility was currently meeting accreditation standards, as compared to participants from private for profit facilities. (Page 26)
5. In general, participants from public sector facilities tended to report that medication errors were made less frequently compared to participants from private not for profit or private for profit facilities. (Page 36)
6. Participants from public sector facilities less frequently reported feeling emotionally exhausted as a result of their work, compared to participants from private not for profit or private for profit facilities. (Page 60)
7. Participants from public sector facilities reported significantly lower levels of nursing grade dilution, as compared to participants from private not for profit and private for profit facilities. Nursing grade dilution is defined within the study as tasks that they were previously responsible for now being the responsibility of other employees with fewer qualifications. (Page 23)
8. The frequency with which overtime had to be worked was significantly lower at public facilities for both registered nurse and PCWs. (Page 25)
9. Participants from private for profit facilities reported significantly lower levels of job satisfaction than participants who worked in private not for profit facilities. (Page 47)
10. Participants from private for profit facilities reported significantly higher intentions to leave their current job than participants who worked in public facilities.

Adequate staffing levels and appropriate skill mix are crucial to providing quality care. Critically, registered nurses are the surveillance system of patient and resident care. They provide the advanced skill, expertise and educational preparation to detect changes in a resident's health condition, and to implement appropriate, complex care (Productivity Commission, 2008; Clarke, 2003; Needleman et al, 2002; Shannon and French, 2005; Horn et al, 2005; Haberfield and Bedecarre, 2005; Aitken et al, 2002; Beurhaus et al, 2001, Waters, 2005). As articulated by Aitken et al (2003):

nurses are in the best position to initiate actions that minimise negative outcomes for patients... the exercise of clinical judgement by nurses, as well as staffing adequacy, is key to effective surveillance and explain the link between higher nursing skill mix (i.e., a higher proportion of RNs among the nursing personnel of a hospital) and better patient outcomes.
(Page 1617)

The reduction in registered nurses and re-engineering of the aged care workforce has translated into an overall reduction in the level of skill and expertise of the aged care workforce. The associated loss of human capital has occurred at precisely the time that the demands of the aged demographic are becoming greater and more complex, and is a significant contributor to the decline in quality of resident care and in resident safety (SCAC 2002).

That adequate staffing levels and an appropriate skill mix, inclusive of sufficient numbers of registered nurses, are essential to providing quality aged care services is the "inconvenient truth" of aged care that can no longer be ignored. This reality should be given significant weight in determining what measures will improve the quality and sustainability of aged care services.

Recommendation 7

To enable the future nursing and aged care workforce to safely and competently provide for increasingly complex nursing care needs of RAC residents, ANF (Vic Branch) recommends that the Australian Government:

- a) Accept the plethora of research indicating that:
 - I. adequate staffing levels and appropriate skill mix, and particularly the presence of sufficient registered nurses, are crucial to providing high quality care; and,
 - II. registered nurses are a strong determinant in resident health outcomes, are essential to oversee the practice of enrolled nurses and PCWs, and are therefore the critical linchpin in providing high quality complex care.
- b) Urgently implement enduring and far reaching measures to reverse the reduction in the number and proportion of registered and enrolled nurses currently participating in the aged care workforce, through measures outlined in this submission.
- c) Implement sustained aged care reform to ensure registered and enrolled nurses, together with PCWs, are consistently employed at the residents' bedside in adequate numbers and in appropriate proportions to capably meet the assessed care needs of residents.

7.3 A discussion on staffing models

How can we have a sufficient and skilled workforce into the future, so we can match the right number of staff with the right mix of skills to provide the care people should receive?

(Prime Minister Gillard, 2010)

7.3.1 Nurse to patient/resident ratios – a shortage of nurses OR a shortage of nurses willing to work in the current aged care environment?

Legally mandated and fully funded minimum nurse to patient/resident ratios provide a stable and predictable staffing base (Gordon, Buchanan and Bretherton, 2008). In determining their potential application and benefit to improve quality of care and workforce sustainability within the residential aged care sector, it is worth examining the landmark decision of Commissioner Blair in the Australian Industrial Relations Commission (AIRC), 31 August 2000 [S9958]. Commissioner Blair's decision was the outcome of a private arbitration between ANF (Vic Branch) and the Victorian Hospitals Industry Association (VHIA) regarding a replacement enterprise bargaining agreement. Fundamental to the claim of ANF (Vic Branch) at the time was the need to effectively address untenable workload pressures, intensification of work, a decline in quality of care and an inability to attract and retain sufficient registered nurses. Commissioner Blair wrote that:

There is a crisis in nurse recruitment and retention and workload to the extent that if it is not addressed now, with measures to deal with the short term issues as well as providing some measures to deal with the long term issues, then the nursing crisis will get worse.
(Gordon et al, 2008, Page 133)

During the arbitration process, witnesses for VHIA submitted that there was no quick fix to resolving the workload issues; however, they claimed that purchasing equipment such as wheelchairs, beds, commode chairs and blood pressure machines, as well as providing more IT training, would help

(Gordon et al 2008). Conversely, ANF (Vic Branch) argued that such minor measures were simply tinkering at the edges of a public health and aged care system in crisis, and, rather than implementing measures comparable to shifting the deckchairs on the Titanic, that nurses and patients desperately required a mechanism to provide adequate, safe and stable staffing levels.

ANF (Vic Branch) argued in the AIRC that there was not so much a shortage of nurses as a shortage of nurses prepared to subject themselves to work in an environment where they had little control over their workloads, were consistently overburdened with inadequate staffing levels and were, as a result, obstructed from providing safe, meaningful, high quality care. ANF (Vic Branch) submitted that minimum mandated, enforceable and fully funded nurse to patient/resident ratios would provide certainty and manageability of nursing workloads, and as part of a range of measures would improve quality of care and nurse recruitment and retention.

In a watershed moment for the Victorian public health and aged care system, Commissioner Blair determined the first minimum mandated nurse to patient/resident ratios, and a range of other measures to reduce intensification of work for registered and enrolled nurses and assist their recruitment and retention. In making his decision, Commissioner Blair stated that:

The Commission cannot ignore the issue of nurse patient ratio mix. It is obvious to the Commission that whatever measures (if any) have been put in place by the hospital networks to address the recruitment and retention issues have failed. During the s. 111AA process and the conciliation conferences, there was ample opportunity for the hospital networks to provide alternatives to the nurse to patient ratio mix proposed by the ANF and this did not eventuate. (Gordon et al, 2008, Page 131)

Whilst there is scope to improve the ratios provided under this decision, the effect of the minimum mandated nurse to patient/resident ratios was spectacular, with 2,300 nurses returning to the Victorian public health and aged care sector within 12 months of implementation, compared to 400 or less nurses who had been entering the sector prior to the introduction of ratios. Further, by 2007 approximately 7000 nurses had returned to the sector (Gordon et al, 2008).

As additional measures to improve quality of care and boost the recruitment and retention of nurses, Commissioner Blair recommended improving professional development opportunities for nurses, limiting agency usage, mandating the creation and appointment of senior nursing positions to provide clinical nursing leadership at the bedside, making real improvements in nurses' salaries, and setting minimum shift length requirements to reduce intensification of work.

Significant parallels exist between the pressures currently facing the aged care system and those that faced the Victorian public health system prior to Commissioner Blair's decision in 2000. These pressures include inadequate staffing levels, excessive workloads and intensification of work, leading to a crippling inability to attract and retain adequate numbers of appropriately skilled staff, and a decline in levels of patient/resident safety and quality of care. Even prior to the significant reduction of registered and enrolled nursing staff that has occurred over recent years; the Senate Committee into Aged Care (SCAC, 2002) concluded that:

Evidence indicates that the delivery of quality aged care is under threat. The Committee considers that the threat comes from the retreat of qualified nurses, both RNs and ENs, from aged care and the increased employment of unqualified staff. This results in staff with skills mix which is at best variable and in some cases not up to standard. The qualified nurses remaining in the aged care workforce are left to care for sicker clients and to supervise increased numbers of unqualified staff... At the same time workloads have increased due to the massive amount of repetitive documentation required by government. The Committee considers that the shortage of qualified staff has now reached crisis point... There will be no resolution without involvement of all stakeholders including

employers and without implementation of solutions already identified. There needs to be a concerted and sustained effort to act and ensure that all those in the aged care sector receive the quality of care that the Australian community expect to be available and that aged care nurses receive working conditions, remuneration and recognition commensurate with their training. (Page 158)

Combined with establishing minimum shift lengths, mandated minimum nurse to patient/resident ratios provided Victorian nurses a 'safety net' of minimum staffing levels. The ratios provide nurses with certainty and confidence that there will be enough staff to provide safe care and respond to emergencies, and to the 'predictably unpredictable' events that are a hallmark of health and aged care nursing. The enduring benefits that ratios have brought to the Victorian public health sector can also be brought to resolving the intolerable intensification of work pressures currently facing aged care nurses and PCWs, and can help to resolve the current crisis in recruitment and retention of these staff. The aged care system would thereby be better equipped to guarantee an acceptable standard of care.

7.3.2 Patient dependency systems

Superficially, in the computer age, a patient dependency system seems attractive; however ANF (Vic Branch) experience is that patient dependency systems alone do not reliably provide for adequate staffing levels. Whilst these systems are designed to measure patient acuity and the required nursing hours, this data is of limited value without

- an underlying constant in staffing levels, and
- without reliability in obtaining and funding the required staff.

Further, they add to the already high levels of data entry required of direct care staff and provide only a retrospective assessment of staffing levels rather than a predictor.

7.3.3 Nursing Hours Per Patient Per Day (NHPPD)

In the states of Western Australia and Tasmania, industrial agreements have been achieved in the public health sector that require staffing levels to be determined by calculation of nursing hours needed to administer care per patient per day. The industrial agreements incorporate the NHPPD model, which, as well as calculating the number of nursing hours required to provide care in various settings, also mandates that staffing profiles and staff EFT be developed and implemented to realise these staffing levels. Additionally, government funding is provided to match the nursing hours determined under the NHPPD, enabling rosters to be developed and an adequate core of staff recruited.

ANF (Vic Branch) recognises the improved certainty in managing workloads and improving patient care that the NHPPD model has brought our interstate nursing colleagues. We also recognise, however, that these systems require considerable nursing time, and are unnecessarily complex compared to the simple and transparent means of ensuring minimum staffing levels that Victoria's nurse to patient/resident ratios provide.

The NHPPD model determined by the Industrial Commission in WA, provides for a minimum of 4.0 hours of nursing care per resident per day. This would provide enough nursing hours to meet the ratios applicable in Victorian public aged care.

Recommendation 8

To ensure that nursing and direct care staffing levels and skill mix are adequate, and that such staff are deployed at the bedside in a proportion and number that matches the assessed needs of residential aged care residents, ANF (Vic Branch) recommends:

- a) The minimum nurse to resident ratios that currently apply in the Victorian public aged care sector be improved and adapted for utilisation throughout the private RAC sector.
- b) In all Victorian public RAC facilities minimum nursing/resident ratios of 1:6, 1:7 and 1:10 apply for each AM shift, PM shift and night shift respectively.
- c) In all Victorian non public RAC facilities comprising either high, low or mixed care, minimum nursing and direct care staff/resident ratios of 1:6, 1:7 and 1:10 apply for each AM shift, PM shift and night shift respectively.
- d) Within the above stated ratios, at least one registered nurse must be rostered for the entire AM, PM and night shift in each facility, regardless of acuity or the outcome of the skill mix tool, with additional Registered Nurses for each 30 beds or significant part thereof.
- e) In Victorian non public RAC facilities, the ACFI funding tool can provide assistance to determine appropriate skill mix within the nursing and direct care staff/resident ratio, provided it is refined and adapted in accordance with ANF (Vic Branch) Recommendation 4 (and as detailed in Appendix A), and applied in accordance with the following guiding principles:
 - I. ACFI is transparent and can be easily understood by managers, nursing and direct care staff, the Aged Care Standards and Accreditation Agency and residents/families.
 - II. ACFI is used as the primary indicator of whether a provider has met its obligations under the Aged Care Principles in providing an adequate number of appropriately qualified staff.
 - III. The calculation of minutes/hours of care per resident per day for different resident needs within the skill mix tool is evidence based to ensure sufficient staff to provide quality care.
 - IV. The staffing requirements are expressed as number of staff per shift for RNs, ENs and licensed PCWs, and allocated as actual staff positions on a roster which can be observed and verified.
 - V. Direct nursing care staff within the skill mix tool consist only of RNs, ENs and licensed PCWs.
 - VI. The tool takes into account the ACFI score of each resident, together with weighting for other factors relevant to workload and care quality (e.g., special needs or facility design).
 - VII. To ensure stability, the direct care staffing requirement for each facility should not be re-evaluated more than 4 times a year, except in exceptional circumstances.
 - VIII. The direct care staffing re-evaluation is provided to ACSAA and DOHA as part of normal reporting requirements, together with written confirmation that resultant staffing changes have been implemented.
 - IX. Compliance with the direct care staffing evaluation is measured and forms part of the auditing and accreditation process.

- f) An approved aged care provider's compliance with minimum mandated ratios must be monitored and form part of the accreditation process.

7.4 Providing a Skilled workforce – adapting education and training to meet demand

The Productivity Commission (2008) explains that:

The objective of aged care workforce education and training is to underpin the efficient and effective delivery of aged care services. This can be achieved by ensuring that there is an appropriate number of workers who are equipped with the right skills and competencies. In addition, pathways for career progression through upgrading and retraining should be available to ensure that the skills of workers are responsive to the changing demands placed on them. (Page 151)

7.4.1 An appropriate number of workers – registered nurses, enrolled nurses and PCWs

The Victorian Government (2009) has highlighted in its report that:

Population ageing will thus continue to accelerate demand for residential aged care in Victoria. Some initial analysis based on 2007 Commonwealth population projections suggest that should current trends continue, by 2021, there may be over 24,000 additional places required. Even if all future facilities provided 100 beds this would equate to some 270 facilities in total, or 21 facilities to be opened in Victoria each year. (Page 4)

The starting point to providing an appropriate number of workers equipped with the right skills and competencies to provide high quality aged care services, is to ensure that the tertiary and VET sector provides sufficient places for registered and enrolled nurse and PCWs, to meet the demand arising from both the forecast expansion of aged care services and the increased complexity of care needs. Additionally, the number of educational places provided by the tertiary and VET sector needs to be sufficient to offset the loss of aged care staff that will occur through natural attrition, as a consequence of the ageing of the aged care workforce, and that may arise through an improvement in staffing levels and skill mix.

It is the view of ANF (Vic Branch) that government should undertake a thorough needs analysis, considering each of these factors in order to determine the number of tertiary and VET places required to meet future aged care demand.

It is of note that in the Victorian experience, the prevailing employer view on introduction of ratios was that there would not be sufficient nurses to meet them. This turned out to be a fallacy, with the predominantly part time existing workforce picking up additional hours, and the return of many 1000s of nurses to the sector.

However, in the interim, ANF (Vic Branch) has made conservative estimate of the number of nursing and care staff that would be required to meet the demand arising from the RAC service expansion predicted by the Victorian Government (2009). This estimate is premised on a staffing model that incorporates the nurse/direct care staff ratios outlined in recommendation 8 of this submission, and a senior nursing structure that includes a Director of Nursing (DON), Clinical Care Coordinator (CCC) and Nurse Unit Manager (NUM) to each aged care facility:

- 3,780 EFT of registered nurses by 2021 (this includes 810 EFT for the senior nursing positions of DON, CCC and NUM);

- 4,995 EFT of enrolled nurses by 2021;
- 8,613 EFT of personal care workers by 2021.

The ANF (Vic Branch) welcomes the 2010 Budget commitment of the Australian Government to provide an additional 300 undergraduate nursing scholarships and an additional 600 enrolled nursing training places nationally over the next four years. At the same time, we contend that these additional scholarships are spectacularly insufficient to meet the demand for registered and enrolled nurses and PCWs that will arise from the forecast growth in Victorian RAC places.

7.4.2 The appropriate skills and competencies – adapting curriculum

Shortfalls have been identified in undergraduate and VET nursing curriculum; there is a need to ensure that the educational preparation of registered and enrolled nurses focuses adequately on contemporary aged care issues. Specifically, there is a need to expand undergraduate nursing education in the following clinical areas:

- Providing complex care to persons suffering dementia, depression and mental illness, and competently managing challenging behaviours that may arise from these conditions.
- Providing complex care to persons requiring palliative care or a palliative approach, including effective pain management.
- Providing complex care in respect of wound management, medication management, nutrition and hydration

(Productivity Commission, 2008; Chiarella and Duffield, 2007; Jones et al., 2007).

To ensure the nursing and aged care workforce is appropriately skilled, undergraduate nursing and VET sector curriculum must adapt to incorporate the changing patterns of disease in the RAC profile, and the associated care needs of the RAC demographic.

7.4.3 The appropriate skills and competencies – adapting facility based education and training

ANF (Vic Branch) contends that the amount of facility based education and training provided to nursing and care staff in residential aged care is inadequate. Shortfalls are particularly apparent in the areas of palliative care, and in managing residents who exhibit challenging behaviours or suffer conditions such as dementia, depression, anxiety disorders and mental illness (Arendts, Reibel, Codde, Frankel, 2010). Indeed, Jones et al (2007) assert that, in these areas:

Front line care within facilities is typically done by staff who have no professional training at all. (Page 329)

To enable direct care staff to competently provide for the increasingly complex care needs of RAC residents, professional development opportunities must be provided in the form of ongoing facility based and external education. Professional development should focus on contemporary aged care issues and the increasingly complex care needs of residents, having regard to the different roles and scope of practice of registered and enrolled nurses and PCWs. Professional development should aim to augment knowledge acquired through formal education, and not attempt to substitute or remove the need for direct aged care staff to obtain tertiary and VET sector qualifications.

7.4.4 Pathways for upgrading qualifications and retraining

The proportion of direct care staff employed in aged care without post school qualifications has increased from 13% in 2003 to 20% in 2007. Over the same period the proportion of PCWs with no post school qualifications rose from 16.4% to 23.7% (Access Economics, 2009).

To meet the increasingly complex care needs of residents, the Australian Government must ensure that people without formal post school qualifications can access and are supported to undertake formalised, nationally accredited training. Supporting the existing aged care workforce to upgrade their level of qualification will not only better equip nursing and care staff to meet the complex care needs of people requiring residential and community aged care, but will also assist in meeting shortfalls in the supply of enrolled and registered nurses.

Recommendation 9

To ensure that the nursing and aged care workforce is suitably skilled and in sufficient supply to competently meet the forecast growth in residential and community aged care capacity and the predicted increase in the more complex medical and nursing care needs of the aged care demographic, the ANF (Vic Branch) recommends the Australian and State Governments:

- a) Undertake a thorough needs analysis to determine the number of tertiary and VET places required to meet future aged care demand.
- b) Increase the number of undergraduate training opportunities and clinical placements for undergraduate and postgraduate registered and enrolled nurses, to meet the growth in demand for registered and enrolled nurses to enter the sector.
- c) Increase the number of training places within the VET sector for personal care workers (however titled), to meet the anticipated growth in future demand for personal care workers.
- d) Ensure curriculum in the tertiary and VET sector be adapted to better incorporate the changing patterns of disease and complex care needs in the aged care sector demographic.
- e) Ensure nursing and direct care staff have ongoing access to professional development that focuses on contemporary aged care issues and related complex nursing care issues.
- f) Ensure that qualifications for direct care workers in residential aged care settings are aligned so as to provide greater recognition of prior learning towards the Enrolled Nurse qualification.
- g) Ensure professional development aims to augment knowledge acquired through formal education and does not attempt to substitute or remove the need for direct aged care staff to obtain tertiary and VET sector qualifications.
- h) Continue to provide improved opportunities and incentives for enrolled nurses who currently work in aged care services to expand their accredited qualifications and scope of practice.
- i) Continue to provide improved opportunities and incentives for enrolled nurses who currently work in aged care services to access Bachelor of Nursing programs.
- j) Provide improved opportunities for personal care workers without formal education qualifications to obtain an Australian Qualification Framework (AQF) level III – Certificate III in aged care, and make this the minimum educational requirement pending consideration by the Nursing and Midwifery Board of Australia (NMBA).
- k) Provide opportunities and incentive for people holding a Certificate III qualification to up-skill/upgrade their qualification to enable registration with the NMBA as an Enrolled Nurse.

- l) Make nationally accredited training programs and training places available, accessible and affordable, and thereby entice potential students to the aged care sector.
- m) Implement a Government program to ensure adequate undergraduate and postgraduate nursing clinical placements are provided, in a national scheme that is inclusive of undergraduate enrolled nurse students.
- n) Ensure that personal care workers (however titled) have access to, and be required to hold, registration with the NMBA.

8. Providing an Adequately Remunerated Aged Care Workforce – Closing the Wages Gap for Private Aged Care Nurses and Care Staff

Wages and conditions in the Victorian aged care industry are split into two parts: the public and private aged care sectors. As well as contending that aged care nursing staff are inadequately paid overall, considering the skills and responsibility required of them, the ANF (Vic Branch) is particularly concerned about the wages gap between the public and private sectors. This gap makes it more difficult for private aged care providers to attract and retain staff, especially younger workers who may not necessarily choose aged care as their career path in nursing.

This issue was first recognised by the Howard government in 2004 when they introduced the Conditional Adjustment Payment (almost \$900m over four years) which, according to Treasurer Peter Costello's statements at the time, was at least in part intended to address the wages issue (as well as increase staff training and facility efficiency and viability). Unfortunately, that money did not address the wages gap, and in Victoria at least, there is no evidence that any of this taxpayers' money went to improving nurses' wages or conditions.

Prior to the introduction of enterprise bargaining, nurses received the same wages and classifications for the same skill and responsibility, regardless of the setting in which they were engaged.

This section describes the origins, scope and implications of the wages gap, and the measures that ANF (Vic Branch) recommends to close the gap.

8.1 Wages in the public aged care sector

In the public sector (14% of residents), nurses (registered and enrolled) are paid in accordance with the Nurses (Victorian Public Sector) Multiple Employer Agreement 2004 – 2007, as extended and varied in 2009.

Public sector aged care rates of pay at 1 January 2010 were:

- Nurse Unit Manager (NUM) (in charge of a ward or unit of around 30 beds) was paid between \$1531 (year 1) and \$1605.70 (year 3);
- Associate Nurse Unit Manager was paid between \$1308 (year 1) and \$1336 (year 2);
- Enrolled Nurse was paid \$825.60 (year 3), \$858.60 (year 5) and \$902.60 (year 8);
- Personal care worker (however titled) 2 (Cert III qualified) was paid \$739.60, with four additional years of experience payments ranging from \$5.60 to \$18.80.

8.2 Wages in the private aged care sector

In Victoria there are approximately 559 out of 582 private aged care facilities covered by approved or in-principle Enterprise Agreements. These Enterprise Agreements are underpinned by the pre modern award: *Nurses (Victorian Health Services) Award 2000* or the *Health and Allied Services – Private Sector – Victoria Consolidated Award 1998* (the HASA Award) for PCWs.

Very few facilities (approximately 10-12) are covered by the modern awards – the *Aged Care Award 2010* and the *Nurses Award 2010*.

Another small group (again about 10-12) are covered by expired Enterprise Agreements and will now have the modern award rates of pay as the default wage base because the pay rates in their agreements have slipped below the modern award rates.

Table 8.2.1 Facilities, beds and number of high care residents by provider type

Facilities by Provider Type	No. of Facilities	No. of Beds	% of all Beds	No. beds in Networks	% of beds in Networks	No. beds Stand Alone	% of beds Stand-Alone	High Care residents	% of all high care residents
For Profit	308	22758	49.4%	18249	62.6%	4554	43.6%	13376	49.5%
Not For Profit	274	16822	36.6%	10888	37.4%	5889	56.4%	9441	34.9%
Public Sector	194	6443	14.0%	-	-	-	-	4225	15.6%
Total	776	46023	100.0%	29137	100.0%	10443	100.0%	27042	100.0%

8.2.1 Wage Bargaining in Victoria in the private aged care sector

The setting of wages in the Victorian private aged care sector is now relatively settled. In 2000 an ANF application for nurses in nursing homes was arbitrated under section 170MX of the then *Workplace Relations Act 1996*. This decision granted a 15% increase to nurses in named nursing homes that principally admitted high care residents (as compared to mixed care facilities and hostels). That decision still echoes in the industry and in Enterprise Agreements, with a division between wage rates in those facilities designated 'high care' and some of those designated as 'low care'. Analysis of agreements covering the 582 private aged care facilities reveals that 297 facilities are designated as 'high care' and 245 as 'low care'. A further 40 facilities are not designated as either high or low care; however, the inclusion of certain wage and staffing provisions in the agreements of these 40 facilities indicates that they are split evenly between high and low care.

However, a significant number of network providers do not distinguish between types of facilities and pay 'high care rates'; that is, the pay rates that have their genesis in the MX Award, even though such an award did not necessarily apply to them. For example, networks such as TLC Aged Care, Uniting Aged Care, Regis, Benetas and Mercy Aged Care all pay high care rates (or even in excess of high care rates) to all staff, irrespective of the type of facility. Others such as Blue Cross and Homestyle Aged Care still pay different wage rates in high and low care facilities. Most low and mixed care stand-alone facilities still pay standard low care rates.

This means that a Registered Nurse Grade 4A Year 2 (a senior clinical nurse, often the only RN on duty) in a low care facility at the end of the 2006 – 2008 Enterprise Agreements would typically receive \$1113 per week, versus \$1216 per week in high care.

For enrolled nurses the difference is smaller but still substantial, with an EN at Pay Point 4 (the middle of the 8 Pay Point structure in Victoria) in low care typically receiving \$716, compared to \$758 in high care.

As the 170MX Awards did not apply to personal care workers, their rates are largely standard across all types of facilities where employers have had agreements with a PCW2 (Certificate III), at around \$676 at Year 1 of Wage Skill Group 6, rising to \$695 after five years of experience, as at the end of 2008.

With the introduction of ageing in place and the rapidly increasing acuity and age of residents upon entry to residential aged care, this distinction between 'high', 'low' and 'mixed' care no longer reflects

reality, and is meaningless except as an artificial barrier to higher wages and implementation of the limited staffing provisions of the Enterprise Agreements.

Apart from wage rates, the other obligation imposed on 'high care' facilities by the agreements is staffing requirements; namely the requirement to have a full-time Director of Nursing and to ensure all practical efforts to maintain 24 hour RN coverage of the facility. To avoid these obligations, many of the 245 facilities currently designated as low care have resisted any change to that status, despite the obvious increases in resident acuity.

To illustrate this effect of ageing in place: the last ACSAA accreditation audit found that, of those facilities designated as low care in their Enterprise Agreement, a significant number had a significant proportion of residents classified as high care.

Table 8.2.2 High care residents in low care facilities

Designated Low Care facilities in Agreements	No. of low care facilities with no high care residents	More than 25% high care residents	More than 50% high care residents	More than 70% high care residents
245	13	179	83	20

The number of 'low care' facilities with significant proportions of high care residents would be greater today, as many of the accreditation reports date back to 2008. According to ACSAA audits, over one third of facilities designated as 'low care' have 50% or more high care residents.

Since 2002, the industry has engaged in enterprise bargaining. There have now been three rounds of bargaining, in 2002/3, 2005/6 and 2009/10. Over 90% of employers have an agreement or abide by agreement rates.

In the 2005/6 round of bargaining there were around 80 private aged care facilities which did not have an Agreement certified or approved by the then AIRC, although approximately half of these had reached in-principle Agreement but never balloted and/or lodged. Nevertheless, many of these continued to pay the agreed rates.

In the 2009/2010 round, which is currently concluding, of the 582 private aged care facilities, as at 31 July there are:

- 460 facilities covered by Agreements approved by Fair Work Australia (FWA) or lodged with FWA;
- 80 facilities covered by in-principle Agreements not yet balloted or lodged;
- 17 facilities covered by pre *Fair Work Act* Employee Collective Agreements;
- 23 facilities where there is no Agreement at all and in most cases the wages at these facilities are at approximately Modern Award rates (although, for RNs in particular, market pressures mean these employers have to pay a higher rate to attract nurses).

In the first two rounds, the standard outcome was 24%, or 4% per year on average across the six years (in most 2006 – 2008 Agreements employers paid a 3% increase in each of 2006 and 2007 and then two 3% increases in 2008). This enabled some modest catch-up with public sector rates, which rose by about 3.25% per year across this period.

In 2009, the ANF (Vic Branch) again sought an outcome across the industry of 4% per year over either a three or four year Agreement period. However, the onset of the global economic crisis and, in particular, the effect of lower interest rates forced the ANF to moderate the claim to an average of 3.5% per year across the agreement – either 10.5% across three years or 14% across four years.

Our claims focussed on the enrolled nurse group in particular, for two reasons:

1. It was our impression that, with RNs being more difficult to recruit and retain than enrolled nurses with authority to administer medicine (formally called medication endorsed ENs) are defaulting to being in-charge of high care facilities more regularly, especially on night shift and weekends.
2. The 2007 public sector Enterprise Agreement settlement in Victoria increased the proportion of ENs in the public sector nursing workforce, up to 15% of the workforce.

Additionally, in the public sector, apart from a higher pay rate there were certain other conditions which did not apply in private aged care, such as:

- payment of the 4% medication endorsement allowance on all hours,
- paid maternity leave,
- automatic pay point progression.

Therefore, if the private aged care sector is to recruit and retain ENs, these issues needed to be addressed. The issues of medication endorsement allowance and pay point progression have been largely resolved in the outcomes of this round.

ANF (Vic Branch) believes that, apart from workload issues, the wages gap between public acute/aged care and private aged care is the significant factor in preventing nurses entering and staying in the private aged care sector. While there is some advantage to a younger nurse in terms of quicker career advancement in private aged care, the wages gap is a deterrent, especially for those starting families and acquiring mortgages.

8.2.2 What are private aged care workers in Victoria paid?

The tables in Appendix B show how much workers across 542 of the 582 private aged care facilities in Victoria are paid. We have analysed every private aged care facility Agreement, noting in a spreadsheet the wage rates for key classifications at the commencement of the Agreement and at 1 January 2010. However, 40 facilities were not designated as either high or low care and have not been used in the separate analysis for high or low care facilities (although they are included in all facilities). The ANF can make this spreadsheet available to the Productivity Commission for examination.

There are five tables. These relate to:

- Table 1: High care facility RN/EN rates of pay
- Table 2: Low care facility RN/EN rates of pay
- Table 3: All facilities RN/EN rates of pay
- Table 4: All facilities PCW rates of pay
- Table 5: Weighted Rates (70% HC + 30% LC for RNs & 50% HC + 50% LC for ENs)

What these tables show is that, for RNs and ENs over all facilities:

- 58.4% were paying equal to or more than standard high care rates for RNs and ENs. Standard high care rates, as described above, were based on a range of \$1200-1235 for a Grade 4A Year 2 nurse at the commencement of the Agreement (plus a further 3% payment at 1 January 2010).
- 17% paid standard low care rates (based on \$1113 for the Grade 4A Year 2 at the commencement of the Agreement) with 12% paying somewhere between standard low care rates and standard high care rates.
- Around 10.7% pay below standard low care rates. These are primarily stand-alone providers who have always been award reliant or who had an agreement in 2002 – 2005 but did not enter an Agreement in 2006 – 2008 and where wages have now fallen behind.

8.3 The Wages Gap

The calculations for allocation of EFT and the wage rates for classification and sector are presented in Table 8.3.1.

Table 8.3.2 calculates the overall wages gap at 1 January 2010, taking into account the factors and EFT allocations outlined above. The gap is \$85.035m and with an allowance of 30% for the flow on effect to shift and weekend penalties and allowances and 20% for on costs, the estimated cost is \$127.554m.

This figure is at variance with the figure arrived at by the ANF Federal Office in their submission to this Inquiry of \$45.928m for the wages gap and \$71.64m with the 30% penalties/allowances flow on and 20% on costs. The bulk of this discrepancy relates to the large difference between our calculation of \$38.78m for PCWs and the \$15.334m allowed for by the ANF Federal Office. This difference may result from the almost \$38 per week difference in the public sector wage rate.

The Health Services Union Victorian public sector agreement is a Heads of Agreement and has not been balloted by employees or approved by Fair Work Australia. ANF Federal Office was using the last publicly available rate.

In respect of registered nurses there is also a significant discrepancy between our calculation and that of the ANF Federal Office.

This is largely due to ANF Federal Office using the top of the Grade 2 (clinical nurse rate) for both the private aged care RNs and public sector comparator. However, as explained above, in Victoria most RNs have significant management responsibility and are therefore employed at considerably higher levels/Grades than the base level. The gap between these higher Grades in aged care and the equivalent Grades in the public sector (primarily ANUMs, NUMs, Clinical Nurse Consultants and DONs) is larger than between the respective Grade 2 rate of pay.

How this translates to a national wages gap would require specific costing at each state. As an approximation though, if Victoria is almost 28% of all beds (and around 28.6% of EFT) and the Victorian figures are an accurate reflection of the gaps, then the national figure would be around \$455m. However, it is clear that in some states the gaps between the private aged care wage rates and the public sector are greater than others and this would cause the figure to be increased. On the other hand, NSW with its much lower reliance on enterprise bargaining to set minimum wages, may have less cost impact.

Please see Appendix B for a detailed explanation of the methodology underpinning all matters relating to the wages gap, and the amounts arrived at by ANF (Vic Branch) to close this gap.

Table 8.3.1 EFT Allocation and Wage Rate Weighting

PRIVATE AGED CARE						PUBLIC SECTOR					
PRIVATE AGED CARE CLASSIFICATION	No. nurses/ PCW (Current Distribution)	No. nurses/ PCW HIGH CARE	No. nurses/ PCW LOW CARE	Percent % (Current Distribution)	Weighted average weekly rate of pay	PUBLIC SECTOR CLASSIFICATION COMPARATOR	No. nurses/ AIN (Current Distribution)	PUBLIC SECTOR Rate as at 1 Jan 2010	Percent % (Current Distribution)	Weighted average weekly rate of pay	
as at 1 Jan 2010						as at 1 Jan 2010					
Registered Nurse	70%	30%				Registered Nurse					
Grade 2 (Clinical) top rate + Grade 3 (ANUM)	520	364	156	15.00%	\$ 1,064.60	Gr 2 Yr 9	260	\$ 1,174.00	7.50%	50.00% \$ 587.00	
						Gr 3A Yr 1	260	\$ 1,251.20	7.50%	50.00% \$ 625.60	
							520			\$ 1,212.60	
Grade 4 A yr 2	1385	970	415	40.00%	\$ 1,222.72	ANUM (yr 2)	1108	\$ 1,397.40	32.00%	80.00% \$ 1,117.92	
						NUM (NUM yr 3)	276	\$ 1,605.70	8.00%	20.00% \$ 321.14	
							1384			\$ 1,439.06	
Grade 4B (Top rate)	346	312	34	10.00%	\$ 1,289.28	ANUM (yr 2)	276	\$ 1,397.40	8.00%	80.00% \$ 1,117.92	
		90%	10%			NUM (NUM yr 3)	70	\$ 1,605.70	2.00%	20.00% \$ 321.14	
							346			\$ 1,439.06	
Grade 5 51-200 beds (bed adjusted) + Gr 6	779	702 (90%)	77 (10%)	22.50%	\$ 1,307.10	CNC B (4B yr 2)	554	\$ 1,459.00	16.00%	71.00% \$ 1,035.89	
						NUM (NUM yr 3)	139	\$ 1,605.70	4.00%	17.90% \$ 287.42	
						DDON (51-200 beds)	86	\$ 1,488.20	2.50%	11.10% \$ 165.19	
							779			\$ 1,488.50	
Grade 7 (DON) ¹	432	302	130	12.50%	\$ 1,422.50	DON (51-200 beds)	432	\$ 1,664.80	12.50%		
TOTAL EFT RN	3,462										
Enrolled Nurse	50%	50%				Enrolled Nurse					
Pay Point 1+ Pay Point 2 + Pay Point 3	643	321	322	25%	\$ 749.39	Year 3	643	\$ 825.60			
Pay Point 4+ Pay Point 5 + Pay Point 6	1547	774	773	65%	\$ 773.85	Year 5	1547	\$ 858.60			
Pay Point 7 + Pay Point 8	385	193	192	10%	\$ 817.45	Year 8	385	\$ 902.60			
TOTAL EFT EN	2,575										
PCW	50%	50%				AIN					
TOTAL PCW	13,212										
WSG 3 (Unqualified) ²	1,651	1,651		12.50%							
WSG 6 (Cert III)	9,910	9,910		75.00%	\$ 700.90	WSG6 yr 3	13,212	\$ 757.20			
WSG 8 (Cert IV Qualified – low/mixed care only)	1,651	1,651		12.50%							

1. bed adjusted (multiplied by 8.28%)

2. mid point between WSG6 yr1 and WSG6 yr 6

Table 8.3.2 Wage Gap Calculation

Classification	Difference between Public and Private Aged Care Sectors Weekly Rate		Weekly Wage Gap	Annual Wage Gap	PLUS oncosts and shift allowance (50%)		Total Annual Wage Gap
		Rate					
Grade 2/Grade 3	\$	148.00	\$ 76,959.64	\$ 4,012,675.66	\$ 2,006,337.83	\$	6,019,013.50
Grade 4A (ANUM/NUM)	\$	216.34	\$ 299,413.24	\$ 15,611,406.38	\$ 7,805,703.19	\$	23,417,109.56
Grade 4B (ANUM/NUM)	\$	149.78	\$ 51,823.40	\$ 2,702,072.02	\$ 1,351,036.01	\$	4,053,108.03
Grade 5 (CNC/NUM/DDON)	\$	181.40	\$ 141,314.11	\$ 7,368,117.92	\$ 3,684,058.96	\$	11,052,176.89
DON	\$	242.30	\$ 104,673.21	\$ 5,457,661.33	\$ 2,728,830.66	\$	8,186,491.99
EN PP3	\$	76.21	\$ 49,006.07	\$ 2,555,176.49	\$ 1,277,588.25	\$	3,832,764.74
EN PP5	\$	84.75	\$ 131,102.06	\$ 6,835,661.51	\$ 3,417,830.76	\$	10,253,492.27
EN PP8	\$	85.15	\$ 32,784.18	\$ 1,709,367.04	\$ 854,683.52	\$	2,564,050.55
PCW (Cert III) WSG 6	\$	56.30	\$ 743,835.60	\$ 38,783,588.18	\$ 19,391,794.09	\$	58,175,382.28
	\$	1,240.24	\$ 1,630,911.52	\$ 85,035,726.53	\$ 42,517,863.27	\$	127,553,589.80

Recommendation 10

To ensure that registered nurses, enrolled nurses and PCWs (however titled) working in aged care are appropriately remunerated, the ANF (Vic Branch) recommends:

- a) The remuneration of nurses and PCWs working in the non public aged care sector is improved to ensure they are provided pay parity with their public sector colleagues.
- b) The funding mechanism be targeted specifically at closing the wages gap (and not delivered to employers as part of a general funding stream with multiple purposes as per the Conditional Adjustment Payment which was originally introduced in 2004 to address the wages gap).
- c) Employers be required to ensure that the wage supplement is passed on to employees and that they be obliged to account for the expenditure as part of the financial reporting requirements each six months.
- d) In each state, a current benchmark wage rate for each classification be established, and that each employer is funded the difference between that benchmark rate and the relevant public sector comparator. Those employers paying below the benchmark rate at the commencement should not receive additional funding, but only the amount between the benchmark rate and the comparator rate. It is important to note that those currently paying above the benchmark rate may be doing so at the expense of nursing hours or skill mix.
- e) The benchmark and comparator rates for each state/territory and the accountability requirements for employers should be set out in specific legislation (or regulations pursuant to the *Aged Care Act*) for a period of at least three years. After that time, if Enterprise Agreements had been negotiated to reflect the new wage rates, these regulations could be *sunsetting* provided there is on-going commitment by the Commonwealth to reflect the increased wage rates in funding and indexation formulas.

9. Factors Affecting Supply of the Aged Care Workforce

9.1 The ageing of the aged care workforce

The aged care workforce is ageing. The average age of nurses in Australia in 2005 was approximately 45.1 years, and the proportion of nurses aged over 55 years was 35.8%. By 2010 the average age of nurses had increased to 48 years. Additionally, the average age of people working in residential aged care in 2007 was around 50 years (Martin and King, 2008). The ageing of the aged care workforce can reasonably be predicted to effect supply of labour as nursing and care staff retire from the workforce. This effect will be intensified by a significant proportion of aged care staff approaching retirement at the very time that the number of people requiring aged care will be increasing exponentially.

9.2 Competition for labour

As the population ages and the number of people of working age diminishes, the aged care system will face increased competition for labour. The shrinking pool of potential workers caused by the ageing of the population, and the resultant increased competition for labour, intensifies the imperative to make the aged care industry as attractive as possible to potential workers (Productivity Commission, 2008). To ensure that the aged care system is able to compete for skilled workers in a shrinking labour market, it is therefore imperative that the factors militating against the recruitment and retention of aged care staff be identified and countered.

10. The Recruitment and Retention of a Sustainable Aged Care Workforce. What are the Constraints?

In attracting and retaining registered and enrolled nurses and PCWs to work in the aged care system there are significant constraints which, if left unaddressed, will severely undermine the sustainability of the aged care workforce and therefore the ability of the system to competently meet the needs of people requiring its services. These factors, which will be explored in the following sections of the submission, are contributing to staff turnover rates in aged care that are significantly higher than in comparable industries. Specifically, these rates have been estimated as not less than 20% in 2010 (The University of Melbourne, 2010 – please see Appendix G), and not less than 25% in 2008 (Martin and King, 2008).

10.1 The effect of excessive workloads and intensification of work on job satisfaction and staff turnover

The workloads of aged care nurses and PCWs have increased due to the growing dependency and complexity of care needs amongst the RAC resident demographic. Moreover, workload pressure has been exacerbated by the failure of the sector to adapt staffing levels and skill mix to these more complex care needs. The excessive workloads and intensification of work for direct aged care staff is reducing job satisfaction amongst the aged care workforce, and contributing to high levels of staff turnover. This problem becomes self-perpetuating as high levels of staff turnover further intensify the work of those permanent direct care staff who remain (Productivity Commission, 2008; University of Melbourne, 2008; University of Melbourne, 2009; University of Melbourne, 2010). The situation is sufficiently critical that 83% of participants in the ANF (Vic Branch) Private Aged Care interviews, when asked to describe their workload, used the descriptors 'very heavy' or 'crushing' (Please refer to Appendix E for further analysis of the findings from the interviews conducted in July 2010).

The University of Melbourne's longitudinal study has consistently corroborated that registered and enrolled nurses and PCWs are under significant stress as a result of excessive workloads and that, where workloads are unreasonably heavy, staff are more likely to leave their jobs (University of Melbourne, 2008).

In 2009, The University of Melbourne found that staff with heavy workloads were more likely to feel emotionally exhausted and to suffer physical symptoms, including backache, headache, chest pain, and upset stomach or nausea. Further, the study found that:

[The] greater the number of residents there were for each registered nurse to care for... the more likely individuals were to be dissatisfied with their job, intend to leave their job, and frequently feel emotionally exhausted as a result of their job. (Page 20)

Conversely, in 2008, the study found significantly better outcomes in respect of employee turnover intentions where staff had fewer residents to care for.

The preliminary findings of the 2010 University of Melbourne longitudinal study reveal a worsening picture, with 44.5% of participants who had left aged care at the time of the study citing working conditions, inadequate staffing levels, poor staff resident ratios, too much paperwork or poor pay as their reason for leaving. Significantly, the study also found that poor working conditions had driven some staff to retire earlier than they otherwise would have done had working conditions been better.

The following comments are taken from the 2008, 2009 and 2010 University of Melbourne longitudinal surveys of nurses and PCWs, and confirm that excessive workloads have a corrosive effect on job satisfaction and turnover intentions:

I felt I had to stop working in aged care out of complete frustration at the nurse to resident ratios and so many other issues... (Page 46)

I no longer work in aged care. I stopped working in aged care because I could not nurse the residents the way I would have liked to because of limited time... (Page 46)

I stopped working in aged care due to the management cost cutting which put extra strain on workers resulting in not enough time to care properly for residents... (Page 4)

(University Of Melbourne, 2008)

I am doing the work of 5 people. My role has been extended because kitchen staff have left and not been replaced so now I have to give residents their food and drinks. The staff to resident ratio is extremely inadequate. It is impossible to do anything effectively under these conditions which are like something from the 3rd world. There is no one to replace sick/burnt out/exhausted staff so I am having to do double shifts. We are lucky to get any new staff because conditions are so bad. If staff complain they just get sacked. Nothing gets resolved and things just deteriorate. (Page 27)

I left aged care in early 2008 due to high workloads... (Page 52)

I had been in aged care for nearly 30 years and I have left for many reasons. I was sick of working short staffed and never having time to do what the elderly really need – care. Attention, talking time with them. Years ago it was much better. We used to have time to sit with them, cut their nails, do their hair, not rush them, not have to cut showers short. I did my job because I loved the elderly. I still miss them... (Page 52)

I retired 12 months ago. I was unable to perform appropriate quality care due to economic rationalisation – \$\$\$ signs instead of people. Hopefully something can be done to improve the plight of residents and the nurses. My health has improved dramatically since I have left... (Page 52)

I moved out of the aged care sector 14 months ago. I was no longer able to work in such an environment with so much...cost cutting that compromised patient care... (Page 53)

I've been working in the residential aged care sector for the last 20 years. I love aged care. However, in June 2008 I left my beloved job in a private sector facility due to continuous pressure from the provider to 'get rid of those more expensive RN, Div 1s'... (Page 53)

(University of Melbourne, 2009)

I left aged care because I no longer gained work satisfaction. The workload was too strenuous and the pressure from management was unrealistic. There was low morale because of low staffing levels. I am now working in a complex care unit where there are great staffing levels and morale. I am now enjoying nursing again. (Page 3)

I left aged care because I was frustrated and disillusioned about the care given to residents... (Page 1)

I left aged care because I found it physically exhausting – the patient load was too great... I no longer enjoyed my work. (Page 1)

I left because I needed to get my life back. I was working 60 hours (paid 38 hours) a week due to a lack of funding. You just got more and more exhausted. I miss aged care but it just takes over your life. Sadly many of my RN peers have also left. It won't be long before there is no one left! (Page 3)

I left aged care because the workload was unreasonable. Management was reducing the number (halving the number of RN Div 1s) of registered staff. We were always short staffed. (Page 3)

I left aged care because of concern and frustration over poor skills mix placing pressure and stresses on those few RNs employed. There were unrealistic clinical expectations of those well meaning but unqualified and inexperienced staff left to manage residents with complex care needs. (Page 3)

After 21 years in aged care the increased workload and responsibilities became untenable and professionally risky with the replacement of Div 1s... (Page 3)

I left aged care because... management wanted to get rid of long term, experienced, permanent staff as we were 'more expensive' than unqualified staff! I am very happy in my new job as I am free from stress and anxiety and it is great to be appreciated once more. (Page 3)

I left aged care because I was the only Div 1 in a 60 bed facility where 45% of the residents were high care. I was on call 24/7 and was expected to do everything! (Page 1)

I left aged care because I was fed up with the lack of staff. There was too much pressure on staff to attend to all residents with inadequate time to give optimal care. (Page 2)

(University of Melbourne, 2010)

These comments clearly confirm that direct care staff working in aged care can no longer tolerate excessive workloads and that these workloads are causing an alarming rate of workforce attrition.

The destructive effect that excessive workloads have on job satisfaction and staff turnover is also well documented in nursing literature (O'Brien-Pallas, Duffield and Hayes, 2006; Cheung, 2004; Hart and Associates, 2001; Aitken et al, 2002).

According to Hayes, O'Brien-Pallas, Duffield, Shamian, Buchan, Hughes, Laschinger, North and Stone (2006):

A consistently heavy workload increases job tension and decreases job satisfaction, which in turn increases the likelihood of turnover... Empirical evidence suggests that each additional patient per nurse is associated with a 23% increase in the odds of burnout and a 15% decrease in the odds of job satisfaction (page 240).

The unambiguous correlation between excessive workloads and staff turnover makes it patently clear that the factors contributing to work intensification in residential and community aged care must be resolved. The sustainability of the aged care workforce is dependent on adequate staffing levels and skill mix. Nurses and PCWs in these sectors need realistic, safe and manageable workloads.

10.2 Inadequate remuneration

Remuneration of direct aged care staff is inadequate and a significant cause of dissatisfaction amongst registered and enrolled nurses and PCWs in the aged care system. As canvassed in

Section 8 of this submission, direct care staff working in the private for profit and private not for profit aged care sectors are paid between 8% and 31% less than their public sector nurse colleagues. This differential varies between the classifications of aged care workers; and in the case of registered nurses is up to 31%; for enrolled nurses is up to 10%; and for PCWs is 8%.

Poor remuneration is in general, well recognised as a factor contributing to staff turnover (O'Brien-Pallas et al., 2006; Hegney, Plank, Buikstra, Parker and Eley, 2005; Cheung, 2004). The corrosive effect of poor salary on staff morale and turnover intentions is no less significant in aged care, where inadequate remuneration is obstructing the recruitment and retention of sufficient numbers and quality of direct aged care staff.

This effect is corroborated by the University of Melbourne (2010) study, where 44% of participants cited poor salary as a factor contributing to their decision to leave. This sentiment is best summarised by the qualitative comment of a participant in this study:

I left aged care because of the poor pay rates, lack of nurse/resident ratios and incompetent staff to care for high care residents. Whilst I am enjoying my new job as practice nurse I miss aged care!! Better conditions would keep good aged care nurses there. (Page1)

Conversely 83% participants in the ANF (Vic Branch) Private Aged Care interviews identified *improved wages* as a factor that would improve the private aged care sectors' ability to recruit and retain nursing and direct care staff (Appendix E).

Significantly, the most common reason cited by employers having difficulty recruiting and retaining aged care staff is:

Substantially lower level of remuneration of its employees compared with similar employment settings. (Productivity Commission, 2008, Page 144)

The sustainability of the aged care system depends on its ability to attract and retain sufficient numbers of staff who are appropriately qualified, skilled and experienced to meet the expanding needs of aged care residents. Given the correlation between remuneration and attracting and retaining staff, it is vital that the direct care workforce in aged care is remunerated adequately and at rates no less than their public sector colleagues.

10.3 Workplace culture, recognition and occupational health and safety

The Productivity Commission (2008) states that a healthy workplace culture is essential to securing an adequate workforce, and defines this culture as one which:

Takes account of professional and personal needs and aspirations. (Page 148)

The qualitative assessment of participants in the University of Melbourne Longitudinal study (2008, 2009 and 2010) indicates that direct care staff are burdened by increasingly unrealistic workload demands and are at risk of sustaining injury through manual handling hazards or occupational violence and aggression. Participants' comments indicate that the prevailing aged care workplace culture and environment is a world away from that healthy one defined above by the Productivity Commission.

According to WorkSafe Victoria, approximately 76% of nurses'/carers'/aides' claims in aged care during the four years up to 2008/09 were related to musculoskeletal disorders (MSDs). Of these MSD injuries, 78% were caused by body stressing whilst performing manual handling tasks associated with lifting/transferring residents (Saunders, 2009).

The well recognised factors and hazards that contribute to these MSDs include:

- Poor physical layout and design of aged care facility workplaces, especially around beds and access to toilets/bathrooms:
 - no overhead tracking hoist system installed;
 - difficulty being able to use mobile lifting equipment to lift/transfer residents due to lack of space or access;
 - inadequate space to store lifting hoists/equipment; and,
 - manoeuvring lifting equipment across floor surfaces in “home-like” facilities, which may provide unacceptable resistance (specifically carpet).
- Insufficient numbers of lifting equipment for the number of dependent residents.
- Lack of staff to safely assist in use of lifting equipment.
- Lifting equipment that is provided but not readily available when needed due to work and time pressures on staff, resulting in manual patient handling.
- Lifting equipment that has not been adequately maintained or serviced.
- Lack of adequate training in how to use the lifting hoists and equipment leading to incorrect and unsafe use.
- Lack of communication during handover of staff about equipment required for lifting/transferring residents according to their mobility/needs – i.e., care plans are not always accurate regarding mobility status.

In an effort to reduce the incidence of manual handling injuries amongst nurses and PCWs, the ANF (Vic Branch) implemented *No Lifting Programs* throughout the Victorian public health and aged care sectors. These programs were provided for under the Victorian Back Injury Prevention Project (1998 to 2003) and were remarkably successful in reducing the incidence of manual handling injuries to nurses and PCWs in public health and aged care (Department of Human Services, Victorian Nurse Back Injury Prevention Project Evaluation Report, December 2004). Despite the demonstrated success of *No Lifting Programs*, and the appallingly high incidence of manual handling related injuries amongst nurses and PCWs in private aged care, funding has not been provided to the private residential aged care sector to implement *No Lifting Programs* at the same level or scale as that previously provided to the public aged care sector. For example, in 2001 the WorkSafe Private Aged Care No Lifting project realised the implementation of *No Lifting Programs* in only 10% of private aged care facilities. ANF (Vic Branch) contends that the poor level of attention and funding provided to this sector is contributing to unacceptably high levels of manual handling related injuries amongst nurses and PCWs in the private residential aged care sector. Given the human and financial cost of such injuries, and that they reduce the supply of vital nursing and PCW labour in aged care, the reluctance to adequately fund preventative programs such as *No Lift* is, without doubt, a ‘false economy’.

Occupational violence and aggression is also an emergent risk to the occupational health and safety of nurses and PCWs working in residential and community aged care settings. This risk is intensified as a consequence of the increased prevalence of dementia amongst the aged care demographic, and particularly the associated likelihood that people with dementia will be predisposed to display ‘challenging’ or ‘aggressive’ behaviours. Caring for such people is a highly specialised task, and requires staff who are skilled and qualified in providing complex care. The reduction in registered nurses in the aged care sector and the paucity of education and training for those remaining have combined with inadequate staffing levels to place both vulnerable residents and also nursing and

PCW staff in aged care at unacceptable risk of occupational violence and aggression (Jones et al, 2007).

Additional hazards faced by nurses and PCWs working in aged care include:

- **Falls, slips and trips** – 10% of MSDs are caused by falls, slips and trips arising from wet, oily or slippery traffic surfaces;
- **Stress** – approximately 9% of all nursing/personal care workers/aides claims concern stress, largely due to bullying and occupational violence;
- **Bullying** -- mostly from managers and supervisors but also occurring between co-workers.

Despite WorkSafe Victoria Inspectors conducting strategic intervention compliance visits (with strong focus on manual handling risks) to more than 90% of aged care facilities over the last ten years, ANF (Vic Branch) contends that there are still shortfalls amongst approved aged care providers, and managers of aged care facilities, regarding their OHS legislative obligations.

Furthermore, line managers in the RAC sector frequently lack the capacity and skills to effectively manage OHS issues and the health and safety of their staff. Contributing to this problem, there is often no dedicated and skilled OHS manager to deal with health and safety issues at the workplace. As a result, crucial OHS responsibilities are instead often assigned to employees who are not appropriately qualified, and who, moreover, are expected to perform this OHS function in addition to their substantive roles. A failure to appoint a suitably qualified and dedicated OHS manager results in a lack of leadership on OHS matters, reactivity and reduced effectiveness in preventing injury and providing safe systems of work.

Additionally, whilst the residential aged care sector is monitored by the Aged Care Standards and Accreditation Agency, ANF (Vic Branch) is concerned that those involved in the accreditation process are often inadequately qualified or expert in OHS matters. ANF (Vic Branch) contends that this militates against proper assessment of an approved provider's compliance with OHS criteria contained in the accreditation standards. Consequently, there is an increased likelihood that OHS risks in residential aged care may go unnoticed and that nurses and PCWs in the sector will face unacceptable risk to their health and safety.

According to WorkSafe Victoria, the rate of injury claims for the aged care sector workforce has remained spectacularly high in comparison to the hospital sector. Specifically, the number of injury claims in aged care is almost three times higher than in the general health sector. Of these claims, WorkSafe Victoria data reveals that nurses and carers/aides represent approximately 65% of all claimants (Saunders, 2009).

The WorkSafe data cited above illustrates that there is unacceptably high incidence of work-related injury and illness amongst nurses and PCWs working in aged care. This, it pays to note, only reflects those injuries and illnesses that have actually been claimed for. Given that injured nurses are often unable to return to their accustomed roles, and that the likelihood of sustaining work related injury can deter nurses and PCWs from wishing to work in the sector, reducing the risks involved in manual handling is critical to the sustainability of the nursing and aged care workforce. Government must identify the hazards that give rise to such injuries, and implement risk control strategies to prevent their occurrence.

10.4 Education and training

The University of Melbourne (2009 and 2008) found that individuals who had undergone additional training to enable them to provide a better range of care skills were less likely to leave their current

job. There is, however, a paucity of professional development opportunities provided to registered nurses, enrolled nurses and PCWs in aged care. As discussed in Section 7, a culture of cost cutting, and the severe intensification of work in aged care, means that there is little opportunity for or attention given to facility based education of staff, or of staff being supported to attend external education.

To meet the professional needs and aspirations of aged care staff, and to ensure they feel confident to meet the care needs of their residents, it is imperative that they be provided with expanded opportunity for professional development.

Recommendation 11

To ensure that the nursing and direct aged care workforce is sustainable and the aged care sector able to attract and retain sufficient supply of registered and enrolled nurses and PCWs to competently meet the demands of the expanding aged care demographic, ANF (Vic Branch) recommends the Australian Government:

- a) Give due regard to the factors identified by ANF (Vic Branch) that militate against the retention and recruitment of staff to the aged care system.
- b) Urgently implement enduring measures to address these factors, and to improve the attractiveness of the industry to existing and prospective nursing and direct care staff. Specifically, the Australian Government should:
 - I. Address the intolerable and unsustainable intensification of work and workload pressures faced by nursing and direct care staff in the aged care system, through implementation of ANF (Vic Branch) recommendations 4,5,6,7, and 8.
 - II. Address the significant wage gap that exists between nurses and PCWs working in private RAC and their colleagues in the public health and aged care system, through implementation of ANF (Vic Branch) recommendation 10.
 - III. Improve the educational opportunities for registered and enrolled nurses through implementation of ANF recommendation 9.
 - IV. Support residential aged care facilities to develop graduate nurse programs in aged care.
 - V. Oversee implementation of an acquittal system to ensure funds made available for aged care graduate nurse programs are directed to wages and educational support for nurses undertaking graduate nurse programs.
- c) Eliminate, as far as practicable, the significant occupational health and safety risks facing nurses and direct care staff in residential and community aged care. To enable this, ANF (Vic Branch) recommends that:
 - I. Management of occupational health and safety be significantly improved in residential and community aged care.
 - II. Effective and comprehensive occupational health and safety management systems in aged care be developed, in conjunction with the ANF and approved provider representatives, and be mandated.
 - III. Funding be provided to educate and train line managers in respect of their legislative OHS and injury management responsibilities, to decrease the risks of injury and illness to nurses and PCWs.

- IV. OHS training form a mandatory part of all education programs required to be completed by aged care workers (both nurses and PCWs).
- V. The level of knowledge and engagement amongst approved aged care providers and managers of aged care facilities be increased to ensure they fully understand and therefore meet their OHS legislative obligations.
- VI. Adequate funding be supplied to approved aged care providers to implement and extend No Lifting programs.
- VII. The provision of dedicated funding to employ nurse No Lifting Coordinators to champion and oversee the implementation and maintenance of No Lifting programs across the aged care sector.
- VIII. The provision of dedicated funding for the purchase, maintenance and replacement of equipment required to implement No Lifting programs in all aged care facilities.
- IX. Improvement of knowledge and understanding of occupational health and safety issues (and the specific OHS audit criteria stipulated in the accreditation standards) amongst accreditors involved in the aged care accreditation process.
- X. The accreditation process incorporate adequate OHS criteria.
- XI. The provision of specific and detailed design requirements for new/refurbished aged care facilities, incorporating requirements based on safe patient handling to reduce manual handling injuries, and CPTED (Crime Prevention Through Environmental Design) guidelines to reduce violent incidents and injuries.
- XII. Staffing levels and skill mix are ensured as adequate and sufficient to
 - prevent intensification of work;
 - implement the No Lifting philosophy; and,
 - competently meet the complex care needs of people with challenging behaviours, or who may be predisposed to acts of violence and aggression.
- XIII. Residents in RAC facilities are regularly assessed by registered nurses and appropriate medically qualified staff for challenging behaviours that may otherwise give rise to incidents of occupational violence and aggression.
- XIV. Appropriate risk control strategies are implemented to eliminate or minimise incidents of occupational violence and aggression that may arise from residents with challenging behaviours or relatives of residents in RAC facilities.
- XV. The promotion of a pro-active focus on the elimination and prevention of hazards and injuries, and a workplace culture encouraging reporting of all incidents and injuries.

11. What 'Productive Efficiency' Gains Can be Made to the Aged Care System?

According to the Productivity Commission (2008):

*Productive efficiency involves the delivery of an appropriate level and quality of care services at the lowest possible cost, by using the least cost combination of inputs. Productivity efficiency incorporates technical efficiency, which refers to the extent to which it is technically feasible to reduce any input without decreasing the output, and without increasing any other input. It **should be emphasised that productive efficiency does not mean producing the lowest quality service or at the least cost to Government. Put simply, productive efficiency is primarily concerned with avoiding waste in providing aged services.** (Page 65)*

Whilst the scope for achieving efficiency gains in aged care is limited because its core business of providing care to residents predominantly involves inherently time and labour intensive 'hands on care' (Productivity Commission, 2008; Access Economics, 2009), ANF (Vic Branch) contends nonetheless that there is considerable scope to reduce waste in the sector, and some capacity to improve efficiency.

11.1 Reducing waste

11.1.1 Preventing avoidable health complications and adverse events

As we have already illustrated in this submission, inadequate aged care staffing levels and skill mix have caused severe intensification of work for aged care nursing and care staff, and in turn contributed to a decline in the quality of aged care provision. What we have not so far emphasised is that this decline in care has dire productivity ramifications for the aged care sector. Gordon et al., (2008) point out that:

Although workers all over the world complain about increased stress, nurses' concerns about work overload have some unique features. When a nurse doesn't have time to turn a patient in bed, that patient can develop an excruciating and costly bed sore. When a nurse can't give prescribed medication on time, a patient may develop a serious infection or suffer from unremitting pain. When a nurse is running among eight different rooms, that nurse will not have time to notice a subtle change in a patient's condition that indicates a catastrophe about to happen. Recent research on 'failure to rescue' confirms that without enough educated eyes on patients enough of the time, that is, nurses monitoring what are often very subtle changes in a patient's status, hospitals cannot catch serious problems that could be prevented. When this happens patient mortality rises, and expensive complications add to total hospital and health care coast. For patients, the consequences of nurse-work overload can be dire... (Page 11)

Put simply, nursing care cannot be stored or filed away. Its effectiveness depends on timely delivery, and when this is obstructed by intensification of work, quality of care suffers, resulting in increased incidence of health complications. The development of common resident health complications or adverse events have a strong relationship with nursing care, and specifically the presence or otherwise of sufficient registered nursing staff to plan, implement, monitor and evaluate care, and provide effective surveillance of residents. Therefore, the incidence of health complications and adverse events are partially avoidable through the provision of adequate staffing levels and skill mix.

Despite this demonstrable correlation, insufficient numbers of trained and skilled staff in the private residential and community aged care sector continues to be a major contributor to unnecessary hospital admissions (Arendts et al., 2010). These admissions in turn compromise the capacity of acute hospitals to reduce elective surgery waiting lists and provide timely emergency care, increase

the overall cost of providing health and aged care, and inflict considerable human suffering on elderly people and their loved ones. In this context, enduring measures to reduce and prevent avoidable hospital admissions must be a significant focus of health and aged care reform (Rothberg, Abraham, Lindenauer and Rose, 2005).

There are 340,000 persons unnecessarily admitted or readmitted to the acute hospital system due to a lack of palliative or sub acute services such as rehabilitation, geriatric and psychogeriatric care (Australian Government, 2010). ANF (Vic Branch) estimates that these admissions add \$1.7b (\$1,737,889,660) to overall health and aged care expenditure.

At the same time, 31% of transfers from residential aged care facilities to acute hospitals (or 27,000 admissions per year) are potentially avoidable (Australian Government, 2010). ANF (Vic Branch) estimates the cost of these admissions at \$138m (\$138,000,880) per year. This is more than four times the cost of caring for these people in the residential aged care sector (which for the same period is \$30,344,360 per year), and therefore adds a further \$107m (\$107,656,520) in health and aged care expenditure.

These costs are significant and avoidable. Preventing such waste and additional expense must be a government imperative, and can be achieved by implementing the enduring measures outlined in this submission, to equip the aged care system to meet the expanding and complex care needs of the aged care demographic.

In a thematic assessment of the ANF (Vic Branch) Private Aged Care interviews the following resident outcomes were identified as consequences of inadequate staffing levels and skill mix:

- resident falls – 84%
- residents with challenging behaviours becoming violent and aggressive – 84%
- pressure area sores – 33%
- medication errors – 17%

For a complete thematic analysis of these qualitative interviews please see Appendix E.

One interviewee – the Director of Nursing at an RAC facility of 50 high care residents – commented of her own facility:

There are a number of examples of consequences of insufficient skill mix, falls that shouldn't have occurred in the first place; skin tears; and pressure ulcers. When there are less RNs in the skill mix changes in resident conditions can go unnoticed and they are usually too far gone by the time PCA can recognise there is a problem. They do not realise the importance of pressure area care, to them it's just a task, so they might be busy and not realise the importance of moving residents around. They do not understand the importance of hydration, on many occasions I have noticed residents' drinks are sitting there on the tray and have not being given, I have had to pick them up on these types of issues all the time. Other things they do not understand are residents that have coeliac disease; residents not being able to swallow... To them it's a series of things they have to remember, for a nurse it's a basic part of training and part of resident care. I notice most medication errors are being made by the PCAs with Medication Endorsement. They are taught the "task" of giving out the medications, but do not understand complexities. Added to this is a lack of qualified staff around to look out for these mistakes; this can be really bad. Also PCAs have to weigh the residents. There have been occasions where a resident might have lost 4kg PCAs would record this information but they wouldn't think to report it, whereas for an RN this would be of great concern... An RN might notice a cold foot and realise it could be an

occlusion, whereas a PCA wouldn't notice, they would just think the resident has cold feet. What worries me is that we have people with the highest complex needs and people with the lowest skills looking after them.

Conversely, in ANF (Vic Branch) Private Aged Care interviews:

- 67% of respondents identified that falls could be prevented through adequate staffing levels; and,
- 50 % of respondents thought that the incidence of pneumonia requiring admission would be reduced with more registered nurses and improved skill mix.

One interviewee commented of her own RAC, where she is the sole registered nurse on duty for 50 high care residents, that:

Generally the residents are sent to ED when they've had a fall, hit their head or sustained a fracture. If there were more qualified staff on for supervision, they may not have fallen in the first place. If there was a higher skill mix, staff would be able to pick up early signs of pneumonia instead of letting them get sicker and having to send them to A&E.

Another interviewee, who works night duty in the 'low care' section of a mixed level care facility with a specific dementia wing, but is responsible for supervising all 75 low and high care residents, commented that:

I have sent residents to ED for a number of reasons, one lady was sent because she was having breathing difficulties, but most commonly they are sent because they have fallen. There was one example of a preventable fall recently in the dementia wing. A lady fell and fractured her wrist, there was only one PCA rostered on that night and he had been reported for sleeping several times. This situation could have been prevented if there were other staff members on that night supervising.

Similarly, at the ANF (Vic Branch) Private Aged Care - Productivity Commission Forum, inadequate staffing levels and skill mix were repeatedly identified by participants as contributing to the incidence of resident complications, and the need to transfer residents to acute hospitals for care. In fact, 100% of participants identified inadequate staffing levels and skill mix as obstructive to the provision of quality aged care, and 83% of participants believed that establishing minimum staffing levels and skill mix would reduce the need to transfer aged care residents to acute hospitals for nursing and medical care. Participants also identified that providing the following conditions would help to prevent the need to transfer RAC residents to acute hospitals:

- additional registered and enrolled nurses (more 'skilled direct care staff');
- aged care Nurse Practitioners;
- increased education for existing nursing and PCW staff (e.g., prevention of falls, dietary requirements, continence, wound management, pain management, palliative care, PEG feeding, etc);adequate and well functioning equipment to care for residents; and,
- 24 hour access to general practitioners and better education for them in aged care issues.

For detailed analysis of participants' feedback from the ANF (Vic Branch) Private Aged Care - Productivity Commission Forum, please refer to Appendix D.

Given that the community and residential aged care demographic is expected to be increasingly comprised of people with complex nursing care needs, meeting these needs will, in the near future, become the core business of residential aged care and is therefore not a function that can continue to be shunted onto the acute sector.

The increasing inability of the community and residential aged care sector to adequately provide for the changing care needs of its clientele is reflected in initiatives of the Victorian State Government, such as the 'Residential Aged Care In Reach Program'. This program is:

Aimed at providing access to clinical assessment and treatment from health services into residential aged care facilities, especially after hours. Health services are building on existing HARP, HITH and ED services to develop and trial models of clinical support that will ... avoid unnecessary ED presentations (Victorian Government, Page 9).

It is well recognised that aged care facilities are increasingly required to care for residents who have palliative care needs and that this trend is forecast to continue. Whereas in the past, palliative care was most commonly provided only in hospices or via skill nurses in the home, the incidence of chronic diseases, including Alzheimer's and Parkinson's disease, has meant palliative care increasingly needs to be provided in RAC facilities. Palliative care requires specialist skill, expertise and knowledge and is associated with advanced nursing assessment and complex care needs (Australian Government, 2010; Productivity Commission, 2008). Unfortunately however, the reduction in the number of registered nursing staff, and a paucity of ongoing work based education for nursing and care staff in respect of caring for residents with palliative needs, has resulted in the RAC sector being ill equipped to meet the increasing demand of its demographic for high quality palliative care.

ANF (Vic Branch) applauds the 'Residential Aged Care In Reach Program' initiative to the extent that it assists in the short term to provide palliative care to RAC residents, and recognises that our palliative care nurse colleagues view this initiative as an important strategy to assist the delivery of palliative care. At the same time, however, ANF notes that underlying this initiative is a fundamental failure by the RAC sector to provide sufficient numbers of registered nursing staff at the RAC bedside to provide for increasingly complex care needs. Furthermore, with the forecast exponential increase in people requiring a palliative approach, ANF contend that the failure to provide for the palliative care needs of people in residential or community aged care represents a failure in the core function of the aged care system.

ANF (Vic Branch) contends that consistent and enduring improvements in the quality of palliative care can be achieved, through ensuring that every RAC facility is resourced with sufficient registered nurses to provide for the complex care needs of residents requiring a palliative approach. Supplying these registered nurses at every RAC resident's bedside would ensure that RAC facilities are not only equipped with suitably qualified and expert staff to make the required nursing assessment, and moreover would ensure that RAC facilities are equipped to implement, monitor and evaluate this care and provide the important function of health 'surveillance' (Aitken et al, 2003).

ANF (Vic Branch) contends that the price of inadequate staffing levels and skill mix is great when measured in terms of the increased incidence of resident health complications that arise from these factors, and the inability of the sector to meet the complex care needs of RAC residents, such as those requiring palliative care. The resulting increase in hospital admissions, and the associated human misery that flow from the incidence of avoidable complications, combine to make the attempt to reduce cost by employing inadequate or unqualified nursing and care staff inarguably a false economy (Duffield, Forbes, Fallon, Roche, Wise and Merrick, 2005).

11.2 Reducing staff turnover

This submission has explored in detail the combination of excessive workloads, inadequate staffing levels, inappropriate skill mix, decreased job satisfaction, poor remuneration, burnout and exhaustion that are leading to alarmingly high turnover levels of registered and enrolled nurses and PCWs in aged care (University of Melbourne, 2008; University of Melbourne, 2009; University of Melbourne, 2010; Access Economics, 2009; SCAC, 2002). There are significant costs associated with staff turnover, relating both to staff replacement and to the associated reduction in workplace productivity (Hegney et al., 2005; Duffield, Roche, O'Brien-Pallas and Catling-Paull, 2009; Duffield and O'Brien-Pallas, 2002).

Staff replacement costs arising from recruiting, orientating and training new staff are estimated to range from \$10,000 to \$60,000 per staff member (Hayes et al, 2004). Additionally, there is an estimated workplace productivity reduction of 30% in the first month of a new staff member's employment, costing between \$5,245 to \$16,102 in reduced workplace productivity (Duffield and O'Brien-Pallas, 2002; Hayes et al, 2004).

If these staff replacement costs were applied across the aged care workforce, as depicted in Table 7.2.1, this would amount to additional cost in aged care spending of between \$266m (\$266,628,000); (based on \$10,000 per individual) and \$1.6b (\$1,599,768,000); (based on \$60,000 per individual), assuming a staff turnover rate of 20%.

These costs are significant and avoidable. Preventing this waste and additional expense must be a mandate of government, and can be achieved through implementing the enduring measures outlined in this submission to eliminate factors contributing to staff turnover.

11.3 Reducing casualisation of the workforce

A shortage of registered nurses and/or a shortage of registered nurses willing to work as permanent employees in the current aged care environment has led providers to rely on nursing agencies to supply skilled staff. The cost of staffing RAC in this way is far greater than doing so with permanent registered nurse employees, and is estimated to add a premium of more than 30% on a day by day basis (SCAC, 2002).

In addition, ANF contests that the high reliance of casual nurse agency staff can add to the intensification of work of permanent employees, and further obstructs their ability to provide quality care.

The increased financial cost and reduction in quality of care caused by a high reliance on casual staff is well summarised in the *Australian Ageing Agenda* (2010) journal, where the experience of BUPA services, and in particular BUPA Caulfield Aged Care facility is detailed. BUPA Caulfield Aged Care is an RAC to 116 residents and employs 156 staff. When facility Manager Kathleen Collings took over management of the facility in January 2009, it had the highest usage of agency of the BUPA group, amounting to 17% of staff costs. Ms Collings is quoted in *Australian Ageing Agenda*:

The staffing was also somewhat unstable with quite a large number of relative and resident complaints as well, relating to care issues... I think staffing is the absolute baseline of any facility. If you've got very large agency usage it's very difficult to have smooth running shifts, obviously, because you've got temporary staff... So it's not rocket science to say that of course there's a huge impact – apart from the financial impact – in stabilising the whole situation. (Page 43)

In an effort to reduce agency nurse usage and thereby reduce cost and improve resident care, BUPA services implemented a graduate nurse program in its 47 nationwide RAC facilities, whereby roster

vacancies previously filled with registered nurse agency staff were instead filled with registered graduate nurses. The initiative is credited with providing a more stable and committed workforce and reducing agency usage at BUPA Caulfield Aged Care from 17% of staff costs in 2009 to 1.4%, resulting in huge savings that are being reinvested into more and better aged care services (*Australian Ageing Agenda*, 2010).

Recommendation 12

To maximise the productive efficiency of the aged care system and reduce waste, ANF (Vic Branch) recommends the Australian Government:

- a) Ensure staffing levels and skill mix are improved to adequately meet the expanding and more complex care needs of people requiring residential and community aged care, in accordance with ANF recommendations 4, 5, 6, 7, 8 and 9.
- b) As a consequence of recommendation (a) above, reduce the incidence of avoidable resident health complications and the number of elderly people unnecessarily admitted to the acute hospital sector when nursing and medical care could be more appropriately provided for in residential or community aged care.
- c) Ensure the remarkably high level of nurse and PCW staff turnover is minimised through implementation of the reform measures outlined in Recommendation 11 of this submission.
- d) Ensure the reliance on casual staff is reduced through implementation of the reform measures outlined in Recommendation 11 of this submission.

12. Improving Efficiency – Scope of Practice

12.1 Nurse practitioner

The ANF (Vic Branch) is an avid supporter of nurse practitioners' expansion into both residential and community aged care services. The ANF (Vic Branch) views their introduction as an integral component of improving the productive efficiency of the aged care system and its ability to meet the increasingly complex care needs of its demographic.

Nurse practitioners (NPs) are registered nurses who have advanced academic educational preparation together with extensive clinical experience within a defined area of clinical practice, allowing them to meet the objectives of the regulatory authority and be endorsed to practice in an advanced clinical role.

The nurse practitioner's scope of practice extends beyond that of the registered nurse and encompasses assessment and management of clients using knowledge and advanced skills that may include providing complex care, referring residents to other health care professionals, prescribing medications and ordering diagnostic investigations.

NPs in Victoria are authorised to prescribe medications from within their designated category drugs and medicines list, and the scope of the individual nurse practitioner's prescribing practice is supported by an established clinical governance framework.

(<http://www.health.vic.gov.au/nursing/furthering/practitioner> Accessed 3.8.10).

Commonwealth legislation has now been passed which will allow some nurse practitioners to access the PBS from November 2010. This PBS access is distinct from the state based authority to prescribe and will only apply to some NPs and some drugs.

The nurse practitioner role is designed to augment existing general practitioners, registered and enrolled nurses and support other health professionals and health service providers. Nurse practitioners are first and foremost nurses with advanced educational preparation at Masters level and significant clinical work experience, who have authorisation to practice in an expanded nursing role. In the aged care setting, nurse practitioners have an important role to play in providing support and direction to registered and enrolled nurses. Their work may include undertaking advanced clinical assessment, prescribing drugs and overseeing resident care, diagnosis and management for a range of conditions, either within their own practise or in collaboration with other health professionals. In an aged care setting, a nurse practitioner may manage co-morbidities such as diabetes, respiratory disease and cardiac disease, and assist in meeting the complex care needs associated with residents requiring palliative care and dementia specific care.

ANF (Vic Branch) asserts that nurse practitioners are well placed to significantly reduce the incidence of costly health complications, and thus better equip the sector to meet the complex care needs of residents and reduce the incidence of avoidable acute hospital admissions.

Additionally, nurse practitioners provide an educative role in the quality use of medications, being involved in activities including the review and evaluation of medicine systems (ANF, 2009; Productivity Commission, 2009; Access Economics, 2009).

12.2 Enrolled nurses

The ANF considers there is potential to reduce the current work burden on registered nurses in the aged care sector through properly incorporating enrolled nurses to the full scope of their practice.

Recently educated Enrolled Nurses, are educationally prepared to administer medicine as part of the current qualification outcome. Enrolled nurses who completed their nursing education prior to 2010 may not have been educated to administer medicine, although many individual ENs have completed an approved post registration program giving them the authority by the NMBA to administer medicine.

The nationally accredited Health Training Package sets out qualifications and units of competence that enrolled nurses can undertake to up-skill an existing qualification to expand their scope of practice.

The ANF Federal Office has, on July 30 2010, provided a submission to the Productivity Commission on the review of the vocational education training system. In this submission we outlined a range of concerns about enrolled nurse education in Australia.

Enrolled nurses with an expanded scope of practice are valuable assets to the aged care workforce; however, they are not a substitute for registered nurses and cannot replace the role of the registered nurse in all practice settings. An enrolled nurse must always practice under the direct or indirect supervision of a registered nurse.

Recommendation 13

To facilitate an improvement in the productive efficiency of the aged care system, ANF (Vic Branch) recommends the Australian Government:

- a) Review ACFI to add nurse practitioners into the staffing and skills mix of all nursing homes.
- b) Create incentive and opportunity to realise an increase in the number of aged care nurse practitioner candidates.
- c) Fund the creation of aged care nurse practitioner networks across geographical clusters to enhance aged care services in metropolitan, regional and rural areas.
- d) Ensure there are annual grants available for enrolled nurses to access nationally accredited educational program to advance their practice in medication administration and complex care needs of older Australians.

13. Providing Appropriate Quality Assurance for Consumers

Significant government funding is allocated to aged care services. With this in mind, and considering the more 'aspirational' expectations of consumers regarding the quality of aged care services (Productivity Commission 2008), robust mechanisms must exist to assess and monitor the quality of aged care service delivery and to provide effective professional oversight of direct care staff working in the sector.

13.1 Aged care standards and accreditation agency

As stated in Section 6.2 of this submission, ANF (Vic Branch) is concerned that, despite the seemingly rigorous approach taken by the Aged Care Standards and Accreditation Agency to monitor approved aged care providers, inconsistencies and inadequacies exist with this process.

ANF (Vic Branch) contends that the current accreditation process:

- offers only a 'snapshot' of an RAC facility's compliance status on a particular day of a visit from the Agency, and that this picture may not be reflective of the enduring standard of resident care or safety in the facility; and
- is open to manipulation from approved providers, who may focus on ensuring that staffing levels or other measures of accreditation are sufficient for the period of assessment, but reduce these immediately after the facility has been accredited.

These inadequacies resonated strongly with participants attending the ANF (Vic Branch) Private Aged Care -Productivity Commission Forum, who further commented that:

- RAC providers commonly employ additional staff during the period of accreditation to give the appearance of having adequate staff, only to reduce these staff immediately after being accredited.
- The accreditation process is too heavily focused on documentation of care delivery rather than actual care delivery itself. Participants cautioned that what has been documented in terms of care delivery may not reflect actual care delivery, and that the accreditation process should therefore delve deeper into delivery of care rather than rely on documentation.
- Nursing and care staff are often coached by RAC providers on what they 'should' say to people from the Aged Care Standards and Accreditation Agency. Participants stated that coaching and pressuring staff in this way may lead to staff giving information to help the RAC facility pass accreditation, rather than providing accurate information.
- Too often Accreditors are neither qualified nor have expertise in nursing, aged care or health issues. Participants believed this detracted from an accreditor's ability to analyse relevant information and accurately assess the facility.

The potential for providers to manipulate the accreditation process, and related concern that the process does not accurately assess the quality of care being provided in RACs, is also reflected in the comments of the University of Melbourne (2009) research respondents, who stated that:

My facility manages to meet accreditation standards because it 'looks good on paper' (Page 27); and,

Although the facility I work at meets accreditation standards I don't actually believe these accreditation standards are an accurate measure of quality. (Page 27)

Correspondence sent to ANF (Vic Branch), 19 May 2010, from nurses employed at Night and Day Nursing Agency Pty Ltd (Appendix F) corroborates these concerns:

Facility spot checks by the accreditation agency should be exactly as the name suggests. Facilities are given notice and have the ability to use this time to improve their standards. Extra staff are often allocated to work on these occasions, providing a false representation of the normal staffing levels and working environment. (Page 3)

Somewhat alarmingly, the Productivity Commission (2008) has also identified inconsistencies and constraints in any outcomes arising from the auditing of RAC facilities:

Quality suffers because, except in extreme cases, providers not meeting minimum standards are unlikely to be forced out because the shortage of alternate facilities for residents makes moving affected residents difficult ... [and consumer choices] and provider responsiveness is constrained because bed licensing arrangements and associated high levels of capacity utilisation restrict competition in the aged care 'market'. (Page 111)

13.2 Regulation of unlicensed personal care workers

To be employed in aged care, all registered and enrolled nurses must be registered or licensed through the Nursing and Midwifery Board of Australia (NMBA). The NMBA provides professional guidance and oversight of registered and enrolled nurse practice by undertaking a number of roles. These include approving and developing standards, codes and guidelines, determining requirements for registration, maintaining registers, overseeing receipt and follow up of notifications on the health, performance and conduct of persons on their register. Through the Australian Nursing and Midwifery Council, nursing courses are approved and accredited.

Currently, however, despite 65% of the aged care workforce now comprising PCWs, personal care workers (however titled) are not required to be registered or licensed to work in aged care. ANF contends that intimate resident care should only be provided by appropriately educated and licensed health practitioners. At this time personal care workers need not hold any qualification, and of those that do, the quality of the education varies considerably.

The licensure of this level of nurse through the Nursing and Midwifery Board of Australia would ensure consistent educational underpinning and knowledge of practice boundaries, and must therefore be considered a crucial component of ensuring proper quality assurance and protection for the increasingly frail and vulnerable aged care consumers and the public.

To progress this option there would need to be a formal classification and a national naming of this craft group. Titles of craft groups can only be legally used by those who are licensed by the relevant registration board. A statutory registration board establishes qualifications and character requirements for entry to the profession, develops standards of practice, receives and investigates complaints of unprofessional conduct, poor health or performance, and applies sanctions if necessary, including deregistration.

For registration or licensing to be effective, only those registered can perform nursing work.

It is difficult for a deregistered worker to practise, because if they advertise their services to the public or use the reserved title they can be prosecuted through courts for committing an offence. Finally, this form of regulation assures consumers that workers are qualified to provide services and that their practice is subject to the scrutiny of a registration board (ANF, 2009).

Recommendation 14

To improve aged care quality assurance and ensure the rights of consumers are appropriately safeguarded, ANF (Vic Branch) recommends the Australian Government:

- a) Mandate that Aged Care Standards and Accreditation Agency staff conducting audits of nursing homes and approved providers' compliance with accreditation standards be registered nurses, and any other people involved in accreditation audits be appropriately qualified and experienced in nursing and aged care. Further, mandate that the Aged Care Standards and Accreditation Agency be required to use professional guidelines as a benchmark for accreditation.
- b) Ensure that consequences of non compliance are more consistently imposed, such as sanctions and the more frequent use of nurse advisers to oversee management of the facilities.
- c) Ensure that the Aged Care Standards and Accreditation Agency continues to conduct frequent unannounced 'spot' checks of RAC facilities.
- d) Ensure that the Aged Care Standards and Accreditation Agency does not give approved providers forward notice of unannounced 'spot' visits.
- e) Ensure that a national education program is developed by the Aged Care Standards and Accreditation Agency, to provide consistent application of national benchmarks of accreditation standards and quality care principles and ensure that processes are aligned to monitor best practice and quality care to nursing home residents.
- f) Ensure that intimate resident care is only provided by appropriately educated and licensed health practitioners.
- g) Mandate that all personal care workers (however titled) are required to be licensed in accordance with the Australian Health Professionals Regulation Agency and the Nurses and Midwifery Board of Australia requirements.
- h) Mandate that PCWs employed in the health and community services industries are required to have obtained a nationally accredited and industry approved qualification; and are required to abide by a professional code of conduct and/or ethics, and in accordance with established practice standards.
- i) In respect of recommendation f), g) and h) above, ensure that a reasonable period of transition applies to enable compliance.

14. Conclusion

The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of their life, the elderly; those who are in the shadows of life; the sick, the needy and the handicapped.

(Hubert H. Humphrey)

It is clear from the territory canvassed in this submission that there are significant challenges facing the aged care system; but these are all challenges that can and must be met.

Through concerted and sustained reform, and with real investment in the aged care system, it will be possible to respond effectively to the increasing and increasingly complex needs of the residential and community aged care demographic.

Conversely, an ongoing failure of government to make bold, brave and enduring aged care reform will not only place Australia's frail and elderly at risk, but also anyone seeking timely emergency, medical and nursing care in the acute hospital system.

There is every imperative to implement determined action now, so that the crisis in aged care does not engulf and overwhelm the entire health care system.

Underpinning this objective must also be the recognition that free public health care is an entitlement of all Australian citizens; it must not be abrogated simply because a person is now in residential aged care.

ANF (Vic Branch) is pleased to submit this paper, in the full expectation and hope that the Australian Government will pass the 'moral test' set by Hubert H. Humphrey and ensure all Australians can receive high quality, timely and affordable aged and health care services.

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Appendix A - ACFI Funding Model – Improving the current approach.

It is the understanding of the Australian Nursing Federation that the current ACFI classification and funding system was developed from a number of different options proposed to the Australian Government – Department of Health and Ageing (DoHA). Once all the options were tested the final model was selected that included three domains of care – and three levels of care need within a domain:

Aligning Care Needs to Funding Levels

It is the view of the ANF that it is now time to consider the use of *four* levels in the base Activities of Daily Living (ADL) domain. We believe the lowest level in this domain could be used to cover the lowest level care need for residents who may now find it difficult to access residential care. The new highest level can then be reserved for those with very significant ADL support needs [i.e., provide a higher funding allocation than the current top ADL level].

The ADL needs are a significant care need driver and a more accurate and stepped classification will assist providers to receive the appropriate funding to support the needed staffing requirements.

Funding Relativities Based on Care Needs

The current ACFI funding relativities between domains (ADL, Behaviour, Complex Health) and the funding levels within each domain (i.e., ADL low, medium, high) were calibrated from the previous RCS system developed many years earlier. The ACFI however allows for all relativities to be revised without any change to the overall model thus providing maximum flexibility if changes are required.

The ANF purport the time has come to re-assess the funding calibrations both between and within the ACFI domains, together with the total quantum of funding. Further the ANF believes the funding system should also have a clear idea of the types of baseline care programs and the supports expected to provide for any particular aged care facilities ACFI case mix profile.

A Funding Model Separating Care Costs from Non Care Costs

The ANF is also of the view, that the separation of care and non care costs is highly desirable and indeed a viable option using the current funding model as the calculation basis, without any significant modification of the current system.

A system that separately identifies yet at the same time links care and accommodation/hotel costs could be achieved by adapting the current ACFI tool - after analysis of residential care ACFI data and the residential care sector income and expenditure data.

It should be noted that as a recent government publication implies that the basic subsidy payment as determined by ACFI - covers care only, and is not inclusive of accommodation or hotel services, it is therefore not relevant to estimate a care and non-care component from within the current ACFI funding subsidy. (Report on the Operation of the Aged Care Act 1997 July 2008 - 30 June 2009, page 36)

Assessing the Relationship between Accommodation/Hotel Costs and Resident Profiles

As outlined earlier, the ACFI allows for:

- a separation of the types of care (personal care, complex health, behavioural);
- the relative care costs of these domains and the cost relativities within (A vs. B vs. C vs. D); and

- for examination of the relationship between these care profiles; as well as
- the impact on accommodation and hotel services costs.

A practical way of achieving cost separation would be to undertake a statistical analysis of the relationship between total costs, care costs, accommodation/hotel services costs and facility case mix types (e.g., mostly complex health vs. personal care need focus ACFI profiles).

If accommodation and hotel costs varied with facility case mix types the non care payment could be allowed to vary with the resident profile (e.g., low or high care) to allow for a more accurate non-care infrastructure aspect related to the overall case mix.

If the ACFI were to be used as a high level (package care not HACC) community aged care funding tool in the future, it could be adapted to have the funding determination from the residential care program model reduced by a discount factor, because homecare services will not be operating on 24 hour coverage basis in a private home, like residential aged care services. Furthermore, the funding could be varied against a specific ACFI domain to provide more flexibility (eg ADL discount factor 50%; Complex Health 10% discount). The discount factor could then be calibrated on the current community care high care package program models.

Once all these adjustment were made it would be possible for the ACFI model to function as a care need and associated cost need predictor and funder. Depending on the accommodation or person type the “fixed” level non care amount (ACFI-AH) is then added to the ACFI care need funding figure (ACFI-C) to comprise the total client funding.

For the Australian Government to implement this type of approach, is no fundamental change required to the current ACFI system.

Care and Accommodation costs are separated in a national system that already exists.

- The approach can then be applied universally to all aged care and community care programs.
- The model will facilitate choice for older Australians in terms of their care and support options.
- The system can be calibrated on the existing support approaches and modelled extensively with existing data before introduction.
- The cost of the approach will be predictable and the levers are in place to allow government control over outlays as the population ages.

The following model is proposed for using the ACFI System to allow for the separate treatment of the care and accommodation/hotel domains.

The ACFI allows for separation of the types of care (personal care, complex health, behavioural), the relative care costs of these domains and the relativities within these domains (A vs. B vs. C vs. D) but it will also allow for examination of the relationship between these care profiles and the impact on accommodation and hotel services costs.

A. Accommodation & Hotel Services Domain (ACFI-AH) covering accommodation and hotel-type services, which cover the cost of for example food, utilities, laundry, heating/cooling and providing accommodation.

Step 1 – create an ACFI Accommodation Domain (ACFI-AH)

- analyse existing data from care providers on total costs together with ACFI/RCS profiles considering the accommodation/hotel allocations present in the Basic Daily Care Fee
- determine if the accommodation domain average costing varies with the type of person supported (e.g., low or high care or by ACFI domains – ADL, behaviour or nursing)
- determine an accommodation domain costing and if it should vary for person/facility/accommodation type

Table 1: ACFI-AH Classifications (example only)

ACFI-AH Classification(theoretical only)	Accommodation/Hotel Domain
High care palliative care (ACFI determined)	\$XXXX per day
High care person (ACFI determined)	\$XXX per day
Low Care person (ACFI determined)	\$XX per day
Supported accommodation person	\$X per day
Community Care person (higher level – package type)	Not eligible

B. Care Domain (ACFI-C) Calculations

Step 2 – create an ACFI Care only funding allocation (ACFI-C).

Table 2: ACFI-C Classifications

ACFI-C Domain	Category (e.g.)	Funding Calculation	
		Residential Care	Domestic Setting
ADL	C	\$ amount	\$ amount x discount factor ¹
Behaviour	A	\$ amount	\$ amount x discount factor ¹
Complex Health	C	\$ amount	\$ amount x discount factor ¹
Total ACFI-C funding		\$ ACFI-C total funding	\$ ACFI-C total funding

¹ To be determined from calibration with current high level community care programs

C. Total Funding (ACFI-F) Calculations

Step 3 – The total funding for an individual will then equal the = ACFI-AH + ACFI-C. The ACFI-C funding would be discounted for people living in community care and it could be based on the profile of the persons care and service needs.

Appendix B - Closing the wages gap – The underlying assumptions (methodology)

We know the agreements which cover the facilities, the designation as either high or low care and the bed numbers. However, we do not know the exact number of employees and in what classifications they work in each facility.

In this respect we have had to make a number of assumptions. These include:

- what Grades, Pay points or Wage Skill Groups within the Registered Nurse, Enrolled Nurse and personal care worker (however titled) classifications employees work;
- how many nurses/PCWs and in what categories work in facilities that pay at least high care rates;
- the comparator classifications, numbers and rates in the public sector.

In 2007, the Victorian private aged care workforce was comprised of 3,462 RNs, 2,575 ENs and 13,212 PCWs. (Martin and King, 2008) Based on these figures ANF (Vic Branch) has made estimates of the spread of this EFT across the various classifications in current Agreements. We have then made assumptions about how those classifications would translate to public sector classifications.

Given the change to the composition of the nursing and aged care workforce, and specifically the reduction of registered and enrolled nurses depicted in Table 9.2.1, (3018 EFT of registered nurses and 1089 EFT of enrolled nurses) it is difficult to estimate what the precise breakdown of nursing and PCW classifications will be in 2010. We have therefore based our estimations on 2007 data provided in table 9.2.1.

We have made the following assumptions:

6.3.1 Registered Nurses

There are very few RNs in lower Grades in private aged care. We have estimated 15% of the RN EFT to be in Grade 2 and Grade 3 (which in the public sector are the clinical nurse/clinical nurse specialist and initial appointed classifications). We are supported in this belief by our observation and more recently by a questionnaire completed by approximately 20 providers. Apart from the odd graduate nurse or a handful of facilities that have ANUMs (paid at Grade 3) most other approved providers pay all RNs at the Grade 4 rate in order to attract and retain staff.

Historically it has also been the case that most night shift RNs were paid the Grade 5 rate (adjusted for facility bed numbers). Payment of Grade 5 has now been extended under Enterprise Agreements to RNs who are in charge in the out of hours of the Director of Nursing (only in workplaces of 61 beds or more) and often there will only be one RN in the facility on PM, night and weekend shifts.

Lastly, the Bentleys (Qld) Pty Ltd (2009) State Averages show that in Victoria the hours of care per resident delivered by a Level 2, 3 or 4 nurse are significantly higher than those delivered by a level 1 nurse (4.94 to 3.6). In NSW the reverse is true with the RN level 1 delivering about 29% more care hours than level 2, 3, or 4 (3.72. to 5.18) while in Queensland the level 1 nurse delivered 150% more hours per resident (3.92 to 1.76) than the higher levels. We have therefore estimated that 50% of RN EFT in Victoria is at Grade 4 (40% at Grade 4A and 10% Grade 4B).

In respect to comparisons in the public sector as to where the current Grade 2-Grade 4 workers would be translated we have allocated as follows:

- 260 at top of Grade 2 and 260 at bottom of Grade 3 (15% of workforce)
- 1384 ANUMs (40% of workforce)
- 485 NUMs (14% of workforce)

In respect to higher Grades/classifications we have estimated that many facilities, including larger ageing in place facilities, will have a Clinical Care Coordinator (CCC) responsible for quality and systems. We have allowed for a combined total of 550 EFT for these CCCs and for RN Grade 5 for those in charge in the out of hours of the NUM, We have also allowed for approximately 86 Deputy Directors of Nursing, restricted to larger high care facilities. This combined Grade 5/6 amounts to 22.5% of the RN EFT.

In respect to translation to public sector classifications we have we have allocated as follows:

- 554 Clinical Nurse Consultant B or Grade 5 (51-200 beds) (16% of workforce)
- 86 Deputy Director of Nursing (2.5% of workforce)

We have estimated that approximately 432 facilities (12.5% of the RN EFT) will be Directors of Nursing (DON). Nearly all designated high care facilities must have a full-time DON (however titled). However a significant number of the larger ageing in place facilities will also have Directors of Nursing or the equivalent, so we believe approximately 75% of facilities having DON is a fair estimate. It is worth noting that while all agreements include the DON classification and pay rate, a significant number would pay in excess of the Agreement rate. This may have a significant impact on reducing the real cost of improved wages for DONs is for the industry. We would estimate that at least 50% of employers already pay in excess of the current Agreement rates. We have compared the DON rates in the Agreements (adjusted by 8.28% which is the bed adjusted rate for 69 beds - the average number of beds in each facility across the sector) to the bed adjusted DON rate in the public sector.

To estimate the wages gap for RNs we used a weighted average of 30% of facilities paying *above standard low care rate in low care facilities* plus a weighted 70% of the *standard high care rate in high care facilities*. The reason is that there will be considerably more RNs employed in the designated high care facilities than low care facilities. Clearly this is a matter of some speculation on our part (it could be 65%-35% for example).

6.3.2 Enrolled Nurses

In Victoria there is an eight level or pay point structure for Enrolled Nurses with approximately \$13-14 between each level. Low care rates range from \$700 to \$790 at 1 January 2010 while high care rates range from \$739 to \$835 plus allowances such as a 4% Medication Endorsement Allowance and a 10% Leader Allowance (for those leading a small team or responsible for a portfolio or specialist role in addition to normal duties).

The entry level under the *Nurses (Victorian Health Services) Award 2000* was pay point 2 for an EN who completed a course of more than 500 hours. This has been confirmed in Enterprise Agreements which now provide for entry level at pay point 2 for Certificate 4 and pay point 3 for those completing a Diploma. No EN should now enter at pay point 1 in Victoria. Despite this recent surveys indicate that a small number of employees commence at pay point 1.

Pay point 6, 7 and 8 were added to agreements in 2002. However, there has been a dispute with employers about how ENs progress beyond pay point 5 (the highest pay point in the *Nurses (Victorian Health Services) Award 2000*. Employers took the view that an EN had to be appointed to

a pay point 6-8 by virtue of leading a team or some other position that carried additional responsibility. The ANF held the view (as did some employers) that the intention of the Agreement was that ENs were presumed to advance provided they had met the experience and education criteria and were capable of performing the skill indicators at that pay point.

This meant that many ENs have been limited to pay points 4 and 5 and have not progressed. This issue has been largely resolved in the recent round of bargaining with nearly every agreement now providing for a presumption of progression to pay points 6-8, provided experience and education criteria are met. The majority of agreements provide for the phasing in of access to these higher pay points over the life of the agreement. Consequently we would expect that by 2012-2013 the majority of ENs will be at pay point 6-8.

For the purposes of the wage gap calculation we have not attempted to reflect this shift in population within the EN structure but have allocated as per the above comments as follows:

- 25% at pay points 1-3
- 65% at pay point 4-6
- 10% at pay point 7-8

Unlike RNs where we weighted the employment between 'high and 'low' care facilities we have split the EN EFT evenly between the two on the basis that often ENs are more predominant in low and mixed care facilities, whereas in predominantly high care facilities there will often be an RN/PCW workforce.

For ENs we used a combination of 50% of average of facilities paying above standard low care rate in low care facilities and plus 50% standard high care rate in high care facilities

6.3.3 Personal care workers

Personal care workers (PCWs) in Victoria are paid at either Wage Skill Group 3 (PCW 1 unqualified) or Wage Skill Group 6 (PCW 2 - Certificate III qualified). These Wage Skill groups emanate from the *Health and Allied Services – Private Sector – Victoria Consolidated Award 1998* (the HASA Award). However, the HASA Award only provided for three experience payments, whereas from 2006 the vast majority of industry agreements have provided 5 years of experience payment above the base (usually a maximum of \$18.85 after 5 years).

Our survey of facilities has shown that there are now virtually no PCWs at WSG 3 (unqualified). A PCW will not usually find employment until they have the Certificate III in Aged Care. There are a relatively small number of PCWs with a certificate 4 in Aged care who are paid at Wage Skill group 8 (about 10% of the workforce as an estimate) who work predominantly in low/mixed care.

At 1 January 2010 the standard PCW rates at the base of Wage Skill Group 3 was \$666, Wage Skill Group 6 was \$695 and Wage Skill Group 8 was \$722, although the average for all facilities was slightly lower as those paying below standard rates and modern award rates dragged the average down.

In calculating the wages gap for personal care workers we have used the mid point (year 3) between the WSG 6 Year 1 and Year 6 for All Facilities at 1 January 2010. The public sector rates in the Heads of Agreement between the Health Services Union and the Victorian health services are:

- PCW Grade 1 Wage Skill Group 3 \$705.60
- PCW Grade 2 Wage Skill Group 6 \$739.60
- PCW Grade 3 Wage Skill Group 8 \$737.10
- PCW Supervisor Wage Skill Group 11 \$882.30

Experience payments are:

- After 1 year's experience \$5.60
- After 2 year's experience \$11.00
- After 3 year's experience \$17.60
- After 4 year's experience \$18.80

There has been a recent 3.25% wage increase effective from 1 July 2010. The comparator we chose was PCW Grade 2 which equates to the PCW 2 at WSG 6. We have added the after three years of experience payment to make a total of \$757.20 at 1 January compared to the \$700.90 for a PCW 2 at Year 3 of WSG 6 currently.

As there is no distinction for PCWs between high and low care it has not been necessary to consider weighting the rates.

Table 1: HIGH CARE FACILITIES - RN & EN Rates of Pay

Nurse Rates for High Care	No. of High Care facilities	% of High Care facilities	As at Commencement 4Ayr2 Wage High Care	As at 01 Jan 2010 Grade 2 Top Rate	As at 01 Jan 2010 Div 1 Gr 4A Yr 2 \$	As at 01 Jan 2010 NUM 4B Top Rate	As at 01 Jan 2010 RN Gr 5 51-200 beds \$	DON Rate at 1 Jan 2010	As at 01 Jan 2010 EN PP3	As at 01 Jan 2010 EN PP5	As at 01 Jan 2010 EN PP8	No beds	%beds	No. of High Care residents	% High Care residents
Paying Above Standard High Care Rates	56	18.9%	\$1,265.52	\$1,102.61	\$1,278.37	\$1,353.60	\$1,356.72	\$1,390.04	\$781.70	\$807.88	\$850.13	4170	19.2%	2773	18.5%
Paying Standard High Care Rates	163	54.9%	\$1,216.38	\$1,088.92	\$1,245.45	\$1,314.76	\$1,331.79	\$1,340.16	\$763.42	\$789.35	\$832.69	12136	56.0%	8583	57.1%
Paying Below Standard High Care Rates	39	13.1%	\$1,178.62	\$1,041.01	\$1,207.53	\$1,265.25	\$1,292.39	\$1,303.60	\$744.58	\$769.16	\$812.39	2666	12.3%	1966	13.1%
Paying Standard Low Care Rates	9	3.0%	\$1,118.82	\$1,000.84	\$1,138.71	\$1,198.39	\$1,210.44	\$1,210.44	\$712.18	\$735.08	\$779.58	577	2.7%	360	2.4%
Paying below Standard L/Care	30	10.1%	\$1,023.02	\$1,029.57	\$1,189.65	\$1,256.64	\$1,268.99	\$1,278.49	\$740.53	\$764.40	\$809.04	2118	9.8%	1201	8.0%
Standard H/Care Rate (70% RN, 50% EN)	297		\$851.47	\$762.24	\$871.82	\$920.33	\$932.25	\$938.11	\$381.71	\$394.68	\$416.34	21667			

Table 2: LOW CARE FACILITIES - RN & EN Rates of Pay

Nurse Rates for Low Care	No. of Low Care Facilities	% of Low Care Facilities	As at Commencement Nurse 4Ayr2 Wage Low Care	As at 01 Jan 2010 Grade 2 Top Rate	As at 01 Jan 2010 Div 1 Gr 4A Yr 2 \$	As at 01 Jan 2010 NUM 4B Top Rate	As at 01 Jan 2010 RN Gr 5 51-200 beds \$	DON Rate at 1 Jan 2010	As at 01 Jan 2010 EN PP3	As at 01 Jan 2010 EN PP5	As at 01 Jan 2010 EN PP8	No beds	%beds	No. of High Care residents	% High Care residents
Paying Above Standard High Care	67	27.9%	\$1,262.14	\$1,102.59	\$1,284.61	\$1,355.16	\$1,369.89	\$1,443.05	\$783.25	\$809.39	\$853.24	4745	30.8%	2273	34.8%
Paying Standard H/Care	36	15.0%	\$1,215.90	\$1,104.45	\$1,251.40	\$1,335.65	\$1,338.06	\$1,343.02	\$768.96	\$794.57	\$838.32	1934	12.6%	778	11.9%
Paying Above Standard Low Care	25	10.4%	\$1,151.80	\$1,007.87	\$1,169.68	\$1,229.82	\$1,249.49	\$1,252.05	\$735.35	\$758.36	\$802.21	1465	9.5%	623	9.5%
Paying Standard Low Care	90	37.5%	\$1,113.88	\$1,014.81	\$1,143.32	\$1,216.58	\$1,215.33	\$1,217.27	\$723.08	\$745.01	\$787.26	5798	37.6%	2253	34.5%
Paying Below Standard Low Care	27	11.3%	\$1,049.90	\$1,020.21	\$1,160.12	\$1,224.37	\$1,238.40	\$1,256.50	\$735.12	\$758.20	\$803.77	1465	9.5%	611	9.3%
"Above Standard Low Care" (30% RN, 50% EN)	245		\$345.54	\$302.36	\$350.91	\$368.95	\$374.85	\$375.62	\$367.68	\$379.18	\$401.10	15407			

Table 3: ALL FACILITIES - RN & EN Rates of Pay

Nurse Rates for all facilities	Total Number of Facilities	Percent (%) of ALL Private Aged Care Facilities	As at Commencement Nurse Wage High Care 4Ay 2	As at Commencement Nurse Wage Low Care	As at 01 Jan 2010 Grade 2 Top Rate	As at 01 Jan 2010 Div 1 Gr 4A Yr 2 \$	As at 01 Jan 2010 NUM 4B Top Rate	As at 01 Jan 2010 RN Gr 5 51-200 beds \$	DON Rate at 1 Jan 2010	As at 01 Jan 2010 EN PP3	As at 01 Jan 2010 EN PP5	As at 01 Jan 2010 EN PP8	No of Beds	% of total beds	No. of High Care residents	% High Care residents
Paying Above Standard High Care Rate	127	21.8%	\$1,264.74	\$1,264.53	\$1,103.55	\$1,282.61	\$1,355.92	\$1,364.91	\$1,419.49	\$782.99	\$809.20	\$852.37	9305	23.5%	5261	35%
Paying Standard High Care Rate	217	37.3%	\$1,216.37	\$1,215.89	\$1,091.26	\$1,244.99	\$1,316.07	\$1,330.98	\$1,341.35	\$763.55	\$789.35	\$832.39	14950	37.8%	9955	66%
Paying Below Standard High Care Rates	39	6.7%	\$1,178.62	\$1,180.29	\$1,041.01	\$1,207.53	\$1,265.25	\$1,292.39	\$1,303.60	\$744.58	\$769.16	\$812.39	2666	6.7%	1966	13%
Paying Above Standard Low Care Rate	31	5.3%	\$1,157.86	\$1,154.89	\$1,007.38	\$1,174.50	\$1,234.17	\$1,251.49	\$1,251.61	\$734.94	\$757.91	\$801.37	1783	4.5%	781	5%
Paying Standard Low Care Rate	101	17.4%	\$1,204.40	\$1,139.34	\$1,114.94	\$1,029.41	\$1,154.24	\$1,229.13	\$1,226.16	\$1,203.08	\$728.32	\$750.82	6620	16.7%	2770	18%
Paying Below Standard Low Care Rate	67	11.5%	\$1,204.40	\$1,138.31	\$1,109.99	\$1,029.61	\$1,149.70	\$1,225.04	\$1,220.04	\$1,180.86	\$725.14	\$748.45	4256	10.8%	2084	14%

Table 4: ALL FACILITIES – PCW Rates of Pay

PCW Rates for all facilities	Total Number of Facilities	Percent (%) of ALL Private Aged Care Facilities	As at Commencement PCW rates	As at 01 Jan 2010 PCW 2 WSG 6 Yr 1	As at 01 Jan PCW Top Rate WSG6 yr 6	No of Beds	% of total beds	No. of High Care residents	% High Care residents
Paying Above Standard HASA Rate	152	26.1%	\$694.69	\$700.93	\$718.77	10298	26.0%	5326	23%
Paying Standard HASA Rate	352	60.5%	\$675.60	\$691.45	\$710.32	24513	61.9%	14285	63%
Paying Below Standard HASA Rate	39	6.7%	\$656.33	\$677.19	\$695.16	2386	6.0%	1585	7%
Paying Award Rate for PCW	38	6.5%	\$630.08	\$664.53	\$681.42	2321	5.9%	1616	7%
Paying Below Award Rate	1	0.2%	\$614.45	\$702.20	\$720.85	62	0.2%	5	0%

Table 5: Weighted Rates

70% HC + 30% LC - RN

& 50% HC + 50% LC - EN

Nurse Rates for Low Care	As at Commencement Nurse 4Ayr2 Wage Low Care	As at 01 Jan 2010 Grade 2 Top Rate	As at 01 Jan 2010 Div 1 Gr 4A Yr 2 \$	As at 01 Jan 2010 NUM 4B Top Rate	As at 01 Jan 2010 RN Gr 5 51-200 beds \$	DON Rate at 1 Jan 2010	As at 01 Jan 2010 EN PP3	As at 01 Jan 2010 EN PP5	As at 01 Jan 2010 EN PP8
Standard High Care Rate (70% RN, 50% EN)	\$851.47	\$762.24	\$871.82	\$920.33	\$932.25	\$938.11	\$381.71	\$394.68	\$416.34
"Above Standard Low Care" Rate (30% RN, 50% EN)	\$345.54	\$302.36	\$350.91	\$368.95	\$374.85	\$375.62	\$367.68	\$379.18	\$401.10
Weighted Rates for RN and EN	\$1,197.01	\$1,064.60	\$1,222.72	\$1,289.28	\$1,307.10	\$1,313.72 DON: Bed Adjusted Rate* \$1,422.50	\$749.39	\$773.85	\$817.45

* 0.12% X average beds (69 beds) = 8.28%

Appendix C – University of Melbourne – Questionnaire Scale Items

(Sargeant, L., Harley, B., and Allen, B. (2009) Working in Aged Care 2009: Phase two of the ANF-University of Melbourne Study – Questionnaire scale items)

Job Changes

Please indicate the degree to which each of the following statements describes changes in your job role over the last 12 months.

Multi-Skilling

-
1. You have undergone additional training to enable you to provide a broader range of care skills.
-

Role Extending

-
2. You have been required to take on new tasks that may have previously been undertaken by others (e.g., medication administration).
-

Increased Managerial Functions

-
3. You have been required to take on managerial tasks that were previously undertaken by others (e.g., paperwork, supervision of other employees).
-

Nursing Grade Dilution

-
4. Tasks you had previously been responsible for are now performed by other employees with fewer qualifications (e.g., as a RN some of your tasks are now the responsibility of PCWs).
-

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Medication Practices

Medication Administration by Non-Endorsed Div 2s

-
1. I have seen non-endorsed Div 2s administering medication from a DAA (e.g., blister packs) in my facility without supervision.
-

Note: Response scale 1="Yes", 2="No".

DAAs Incorrectly Filled

-
1. In the past 6 months how often have DAAs (e.g., blister packs) been incorrectly filled?
-

Note: Response scale ranged from 1 "Never" through to 6 "Several times per day".

Computerised Medication Management System

-
1. Do you have a computerised medication management system at your facility?
-

Note: Response scale 1="Yes", 2="No".

Medication Errors

Please indicate over the past 6 months how frequently medication errors that resulted in resident harm have been made by different categories of staff in your facility. Harm refers to the need for increased observation, technical monitoring, visit by a doctor, laboratory tests, medication intervention or treatment or resident transfer to hospital.

Medication Errors

Please use the scale to indicate how often in the past 6 months **Division 1 Registered Nurses** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Please use the scale to indicate how often in the past 6 months **Division 2 Endorsed Nurses** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Please use the scale to indicate how often in the past 6 months **Division 2 Non-Endorsed Nurses** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Please use the scale to indicate how often in the past 6 months **PCWs** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Note: Response scale ranged from 1 "Never" through to 6 "Several times per day".

Workplace Aggression

Co-worker Aggression towards Residents

Sometimes when conflicts occur with residents, the staff may find it difficult to respond in ways they are supposed to. Please use the scale to indicate how frequently in the past 6 months you have seen others act in each of the following ways towards residents:

1. Pushed, grabbed, shoved, or pinched a resident.
 2. Yelled at a resident in anger.
 3. Insulted or swore at a resident.
 4. Threatened to hit or throw something at a resident.
-

Note: Response scale ranged from 0 "Never" through to 5 "Five or more times".

Resident Aggression

Please indicate how often you have experienced each of the following in the past 6 months:

1. Been threatened with an object e.g., walking frame or stick, wheelchair, furniture.
 2. A resident tried to hit you with something e.g., cup, saucer, plate, furniture, walking stick.
 3. A resident cried to make you feel guilty.
 4. Been yelled, shouted or sworn at by a resident.
 5. A resident was verbally aggressive to you.
-

Note: Response scale ranged from 0 "Never" through to 5 "Five or more times".

Job Stressors

These questions deal with different aspects of work. Please indicate how often these aspects appear in your job.

Staff Cost-Cutting

1. My facility focuses on cost saving by reducing staffing levels at the expense of resident care.
 2. My facility has fewer registered nurses on than they used to reduce labour costs.
 3. My facility emphasises getting the job done as quickly as possible.
 4. My facility cuts corners to get the job done.
 5. My facility focuses on saving costs by having fewer activities and diversional therapies for residents than they used to.
-

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Resident Quality of Living Cost-Cutting

1. My facility has reduced the nutritional quality of food for residents to save money.
 2. My facility has reduced the portion size of meals to save money.
 3. My facility has reduced the quality of dressings available for wound care.
 4. My facility has reduced the quantity and quality of incontinence aids.
 5. My facility is using DAAs (e.g., blister packs) to reduce costs.
 6. My facility has the air conditioning turned off/down during the day to save money.
 7. My facility has the heating turned off/down during the day to save money.
-

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Management Practices

Grievance Procedures

1. My organisation has clear and effective policies and procedures in place for resolving complaints by residents or their families.
 2. Complaints by residents or their families are resolved in a timely fashion in my organisation.
 3. My organisation has clear and effective policies and procedures in place for resolving complaints by staff.
 4. Complaints by staff are resolved in a timely fashion in my organisation.
 5. Staff here are aware of the policies and procedures for resolving complaints by staff.
 6. I have received adequate training from my employer in the policies and procedures for resolving complaints by residents or their families.
 7. I have received adequate training from my employer in the policies and procedures for resolving complaints by staff.
 8. Staff are allowed representation at meetings with management when a complaint is made against the staff member.
-

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Recruitment & Selection Practices

1. How rigorous is the employee selection processes for a job in this organisation? (e.g., Does the process involve tests, interviews etc?)

Response scale ranged from 1 "Not rigorous" through to 7 "Very rigorous".

2. How much money is generally spent selecting people for a job?

Note: Response scale ranged from 1 "Very little" through to 7 "A great deal".

Performance Practices

1. How much effort is given to measuring employee performance?

Response scale ranged from 1 "Very little" through to 7 "A great deal".

2. How often is performance discussed with employees?

Response scale ranged from 1 "Rarely" through to 7 "Daily".

3. How closely are raises, promotions, etc., tied to performance appraisal?

Response scale ranged from 1 "Not closely" through to 7 "Very closely".

4. The wages in this organisation are not very competitive for this industry.

Response scale ranged from 1 "Completely true" through to 7 "Completely false"

5. How closely is pay tied to individual performance?

Note: Response scale ranged from 1 "Not closely" through to "Very closely"

Training

1. During the past 12 months, how much training have you had, paid for by your employer? Include only training away from your normal place of work, but it could be on or off the premises.
2. To what extent do you agree or disagree that you get the training needed to do your job effectively?
3. To what extent do you agree or disagree that you've had sufficient training and education to do the work you're doing?

Note: Response categories for question 1 were 1- none, 2- less than one day, 3 – one to less than two days, 4 – two to less than five days, 5- five to less than ten days, 6 – ten or more days. The response scale for questions 2 & 3 ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Work, Psychological & Physical Health Outcomes

Job Satisfaction

1. All in all, I am satisfied with my job.
2. In general, I don't like my job. [R]
3. In general, I like working here.

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Turnover Intentions

1. How likely is it that you will look for a job outside of this organisation during the next year?

Response scale ranged from 1 "Very Unlikely" through to 7 "Very Likely".

2. If it were possible, how much would you like to get a new job?

Response scale ranged from 1 "Not at all" through to 7 "A great deal".

3. How often do you think about quitting your job at this organisation?

Note: Response scale ranged from 1 "Never" through to 7 "All the time".

Reasons for continuing to work in Aged Care

1. Better pay than other jobs you could get.

2. You want to work part-time.

3. You want flexible hours.

4. You like the close personal connection you have developed with residents.

5. You believe it is important the elderly are properly cared for.

6. You like this job better than other jobs you could get.

7. This is the kind of job you know how to do.

8. This is the only job you can get.

Note: Response scale ranged from 1 "Very Unimportant" through to 7 "Very Important".

Organisational Commitment

1. I would be very happy to spend the rest of my career in this organisation.

2. I really feel as if this organisation's problems are my own.

3. I do not feel like "part of the family" at my organisation. [R]

4. I do not feel "emotionally attached" to this organisation. [R]

5. This organisation has a great deal of personal meaning for me.

6. I do not feel a strong sense of belonging to my organisation. [R]

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Emotional Exhaustion

How often do you feel:

1. Emotionally drained from your work.

2. Used up at the end of the workday.

3. Fatigued when you wake up and have to face another day on the job.

4. Working with people all day is really a strain for you.

5. Burned out from your work.

6. Frustrated by your job.

7. You're working too hard on your job.

8. Working with people directly, puts too much stress on you.

9. Like you're at the end of your rope.

Note: Response scale ranged from 1 "Never" through to 7 "Every day".

Social Functioning

We would like to know how your health has been in general, over the past few weeks. Please answer the following questions by circling the answer which most nearly applies to you. Have you recently...

1. Felt capable of making decisions about things?
 2. Been able to enjoy your normal day-to-day activities?
 3. Been able to face up to your problems?
 4. Been feeling reasonably happy, all things considered?
-

Note: Response scale ranged from 0 "Never" through to 6 "All the time".

Depression

We would like to know how your health has been in general, over the past few weeks. Please answer the following questions by circling the answer which most nearly applies to you. Have you recently...

- d) Felt that you couldn't overcome your difficulties?
 - e) Been feeling unhappy or depressed?
 - f) Been losing self-confidence in yourself?
 - g) Been thinking of yourself as a worthless person?
-

Note: Response scale ranged from 0 "Never" through to 6 "All the time".

Physical Symptoms

During the past 30 days did you have any of the following symptoms? If you did have the symptom, did you see a doctor about it?

1. An upset stomach or nausea
 2. A backache
 3. Trouble sleeping
 4. A skin rash
 5. Shortness of breath
 6. Chest pain
 7. Headache
 8. Fever
 9. Acid indigestion or heartburn
 10. Eye strain
 11. Diarrhoea
 12. Stomach cramps (not menstrual)
 13. Constipation
 14. Heart pounding when not exercising
 15. An infection
 16. Loss of appetite
 17. Dizziness
 18. Tiredness or fatigue
-

Note: Response scale 1 = "No", 2 = "Yes, but I didn't see a doctor", 3 = "Yes, and I saw a doctor"

Resident Outcomes

Facility Satisfaction

1. The food is good and nutritious here.
 2. Residents are kept well hydrated.
 3. Rooms and surroundings are clean.
 4. Residents can keep many personal possessions in their room.
 5. It is easy to arrange for a doctor to see a resident.
 6. At night residents decide when they will go to bed.
 7. Residents have privacy.
 8. It is a cheerful place.
 9. When residents have a complaint, something is done about it.
 10. There are a range of activities for residents to be involved in.
 11. Family and friends are welcome to visit residents and be involved in their care.
 12. This facility utilises a community visiting scheme.
-

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Staff Responsiveness

How responsive are staff to:

1. A resident requesting assistance using their buzzer or call system.
 2. A resident calling out for assistance.
 3. A resident requesting assistance to go to the toilet.
 4. Resident incontinence.
 5. Resident pain.
 6. Resident nausea.
 7. Residents' inability to sleep.
 8. Resident discomfort.
 9. Resident difficulty getting around.
 10. Personal grooming of residents.
-

Note: Response scale ranged from 1 "Very Unresponsive" through to 7 "Very Responsive".

Resident Safety

1. Resident safety is never sacrificed to get more work done.
 2. Our procedures and systems are good at preventing errors from happening.
 3. Staff will speak up freely if they see something that may negatively affect resident care.
 4. Staff feel free to question the decisions or actions of those with more authority.
 5. Staff feel pressured to administer medications without appropriate supervision. [R]
 6. Management provides a working environment that promotes resident safety.
 7. The actions of management show that resident safety is a top priority.
 8. This facility has a falls prevention program.
 9. Staff at this facility receive education and training in resident safety on a regular and ongoing basis.
-

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Resident Care

1. The nurses and personal carers have the skills to provide appropriate care.
2. Residents decide what they will wear each day.
3. Residents are able to talk to staff as needed.
4. Nurses show real interest in residents.

Resident Care

5. Personal carers show real interest in residents.
 6. Life is better than residents expected when they first moved in.
-

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Appendix D – ANF (Vic Branch) Private Aged Care - Productivity Commission Forum (16 July 2010) Analysis of results

Table 1: Barriers to recruitment & retention in private aged care (Individual responses)

Theme	No. of respondents	Percentage
Inappropriate skill mix (not enough qualified nursing staff)/excessive workloads/Inadequate staffing levels(No minimum legislated ratios)	28	78%
Low wages	22	61%
Lack of recognition from management and public (negative image of aged care)	19	53%
Poor working conditions poor workplace culture and environment (job satisfaction and peer support/teamwork/bullying and harassment) Cost cutting culture	18	50%
Inadequate training and education: Lack of career opportunities/PCW training needs to be standardised and accredited	10	28%
Need better/fairer working hours	5	14%
Stress levels	5	14%

Table 2: Factors preventing the provision of high quality care in Private Aged Care (individual responses)

Theme	No. of respondents	Percentage
Inappropriate skill mix/Insufficient qualified nursing staff	36	100%
Insufficient staffing levels/No minimum legislated Ratios/ Excessive workloads	27	75%
Lack of funding to provide for identified needs on ACFI	10	28%
Lack of training opportunities	9	25%
Poor pay rates	8	22%
Language barriers with English as a second language	6	17%
Employers profit driven rather than care oriented	5	14%
Communication problems between staff at handover/teamwork	4	11%

Table 3: List 3 changes you would make to improve the quality of aged care and the sustainability of the workforce in the private aged care sector (Individual responses)

Theme	No. of respondents	Percentage
Improved staffing levels and skill mix e.g. mandated minimum nurse to resident ratios and more qualified nurses in skill mix	26	72%
Improved wages and entitlements/wage parity with other nursing sectors	11	31%
Employ nurse practitioners in aged care	9	25%
Better training and development opportunities for nurses and PCWs e.g. scholarships and standardisation of PCW training	8	22%
Ensure funding goes to care for residents	7	19%

Table 4: Identify 5 measures that you believe would better equip the aged care home you work in to prevent a resident being transferred to an acute health service, i.e. admission to an emergency department, for an event that might have been avoidable.

Theme	No. of groups	Percentage
Minimum and legislated skill mix level e.g. for assessment, to administer IV, monitor episodes of unstable Blood Sugar Levels, supervision of residents to prevent falls, and ensure hydration	10	83%
Incentives for GP/consultants to visit aged care facilities 24hr	7	58%
Access to more education, training and development e.g. syringe driver, IV, male catheter, PEG tube, Falls, continence, dietary requirements, diabetes	5	42%
Education for families on end of life/expectations	5	42%
Nurse Practitioners in Aged Care would decrease ED admissions	4	33%
Management to provide adequate resources and equipment all in good working condition	3	25%
More access and training to palliative care services	3	25%
Use Aged Care Liaison Service, availability 24/7 with better qualifications to assess problem	3	25%
More allied health staff	2	17%

Table 5: Does the aged care accreditation process provide an accurate picture of the quality of care in an aged care facility and of an approved provider's compliance with the accreditation standards? If not, why not? (Group work responses)

Theme	No. of groups	Percentage
No it doesn't provide an accurate picture	12	100%
Aged care provider "tidy up" before an audit e.g. employ additional staff for the audit, amend documentation	10	83%
More unannounced visits are needed (spot checks) to prevent owners giving manipulating documents and staffing levels	7	58%
Assessors need to be more objective and less threatening to staff	7	58%
There needs to be more of a focus on resident care rather than what care has been documented.	6	50%
Accreditors need to be qualified nurses and have experience in aged care	5	42%
Provide constructive feedback and advice to staff on how to improve compliance, in a non threatening way	2	17%
Should involve consultation with working staff/clients/residents and families	2	17%
Should involve interviews with the Div 1s without provider involvement	2	17%

6. Comments from ANF Private Aged Care Forum participants regarding ACFI.

Are there any shortfalls with ACFI? If so, what are they?

- *There is too much subjectivity in the ACFI*
- *The time required to liaise with relatives, is not accounted for at all in ACFI.*
- *ACFI funding should be linked to staffing levels and skill mix*
- *There is a conflict of interest between aged care accreditation standards which encourage independence and ACFI which allocates funding based on dependence*
- *There is no requirement for owners of aged care facilities to spend the money ACFI provides on employing staff and caring for residents.*
- *Must separate funding for staffing from accommodation funding to ensure care funding is guaranteed*
- *The time involved in ACFI scores is prohibitive, there are too many variables in the domains*
- *We need to streamline/reduce documentation*
- *The weightings for ACFI are inadequate, especially for complex care and challenging behaviours*
- *Lifestyle is not included in the ACFI and should be as psychological well-being is vital*
- *A resident's condition and acuity can change quickly. ACFI doesn't keep up with these changes.*

Do you believe ACFI would be useful to provide an improved staffing level and a more appropriate staffing skills mix in the facility?

- *Yes. However this would require good education.*
- *Yes, but this would require a change in culture around how the tool is used.*
- *Yes, but on each shift with same staffing level by adapting ACFI.*
- *Yes the ACFI can provide evidence to management that we require appropriate qualified staffing level.*
- *Yes, but the profile changes with every new admission or upon death of a resident*
- *Yes, it could be used to decide on the skills mix needed. However ACFI as a funding tool does not provide facilities with enough funding to employ sufficient skills mix of staff.*
- *Yes, however only to support better staffing and skill mix. ACFI funding is inadequate and would need to be increased.*
- *Yes, but more funding will need to be provided in order to employ additional nurses that ACFI says we need*
- *Yes if it changes to provided guidance on the right number of staff who have the scope of practice to provide direct care*
- *We need to also change the name to remove emphasis on funding alone*
- *No not in all cases. It has to be changed a lot.*

Appendix E – ANF (Vic Branch) Private Aged Care interviews (July 2010): Analysis of results

Classification of participant

Classification	Percent
Registered Nurse Div 1	50%
Enrolled Nurse *(Med End)	33%
Director of Nursing	17%
Total	100%

From your experience, what are some of the consequences of insufficient staffing levels for quality care?

Response	Percent
Resident falls whilst unsupervised	84%
Residents with dementia become aggressive/violent/verbally abusive	84%
Residents who are bed bound develop pressure ulcers	33%
Medication errors. Some staff giving out medications cannot make a clinical decision about whether to withhold or give a medication	17%
Emotional needs of residents not met, boredom, depression, anxiety and loneliness	17%

From your experience, what are some of the consequences of insufficient skill mix levels for quality care?

Response	Percent
Resident falls	50%
Transferring residents to hospital due to a fall or not having qualified staff to care for the resident	50%
Resident safety is compromised as a result of unqualified staff providing care that is outside of their scope of practice, who don't understand the complexities e.g. Feeding resident with swallowing difficulties with tablespoon, giving those on thickened fluids a drink in a normal glass, administering medication, not detecting or reporting changes to residents conditions	50%

How do you think staffing levels could be improved?

Response	Percent
Minimum mandated nurse to resident ratios e.g. 1 to 4 or 5 as a minimum especially for residents with advanced dementia	83%
Minimum one Registered Nurse Division 1 on all shifts in High Care and Hostels	33%
PCW training needs to be standardised and accredited	33%
We simply need more staff	33%
Greater accountability for providers on expenditure of aged care funding (minimum amount to be allocated to staffing levels)	17%
More Registered Nurse Division 1 in charge of units	17%

Can you think of any improvements to PCW education and practice?

Response	Percent
PCW training needs to be standardised/Currently big variation in education outcomes in	67%
PCW training needs to be accredited	50%
Registration/Licensing of PCWs	33%
PCWs should not be giving out medications	17%
More qualified staff on to oversee PCW practice	17%

How would you describe your workload?

Response	Percent
Very heavy/Crushing	83%
We are so short staffed, we are literally running, you have to get the residents up as quickly as possible whilst still ensuring they have their dignity	33%
Its very stressful and causes a lot of staff burnout	33%
I have to do unpaid overtime every day	33%
Impossible workload e.g. I am in charge of 140 residents	17%

If you could make any changes, what are 3 main things that would improve your workload?

Response	Percent
Additional Staff/Minimum Nurse to Resident ratios and minimum skill mix	67%
Accredited training and Licensing/Registration for PCWs	33%
Better Wages and Conditions e.g. better wages to allow us to attract people in the first place	33%
More holistic approach to care so not all the needs of residents are being put on Div 1 shoulders	33%
Sufficient equipment and resources and all in working order, to be able to carry out our job	33%
Up skilling of staff	33%
A clinical care coordinator who is an experienced Div 1 at least 5 days per week. The root of the problem is we need registered staff In Charge of each unit - everything else flows from there.	33%
Support from management	17%

Can you think of an occasion where you have sent a resident to ED?

Response	Percent
Yes	100%

If yes, could this situation have been avoided if there were higher staffing levels/more RNs?

Response	Percent
Yes, falls could be prevented if there are adequate staffing levels to supervise residents at all times	67%
Yes, if there were more registered nurses, staff would have better assessment skills and be able to recognise early signs of pneumonia and avoid sending resident to ED	50%
If we had better equipment and more RNs, to put in IVs, this would minimise admissions (e.g. we could give IV antibiotics)	17%

What are the 3 main things that could assist recruitment and retention in private aged care?

Response	Percent
Improved wages/wage parity with public sector	83%
Improve the image of aged care nursing e.g. needs to be promoted as a career and a specialty in its own right	83%
Improved workloads, better staffing levels/minimum ratios and skill mix	67%
Invest in education and up skilling of staff in order to retain them (students need a positive aged care placement and a positive experience)	50%
Industry need to provide an appealing environment where work is valued and there is respect for staff	33%

If you could change 3 things that would make a difference to the private aged care system, what would they be?

Response	Percent
Minimum nurse to resident ratios/mandated and improved staffing levels and skill mix	100%
Wage parity/Improved Pay	67%
Improved image of aged care	33%
More of a focus on activities program and diversional therapy for residents, rather than just physical needs of residents we need to nurture the social cultural and emotional needs so they feel they have a purpose.	33%
Make all private aged care not for profit and publicly run	17%
Improve English language skills of staff. Staff with ESL who cannot write in English put extra burden on other staff to fill in documentation	17%

Do you think the current system of accreditation adequately reflects the standard and quality of care being provided in your aged care facility?

Response	Percent
Needs to be more feedback about good things other facilities are doing so that industry can learn from good examples and we can meet our goals	33%
Not always, it depends on the assessor on any given day and their level of objectivity	33%
Not really, everything is made to look good e.g. They increase staffing levels in the lead up and on the day of accreditation and cut staffing afterwards	33%
Accreditation Standards & ACFI contradict each other e.g. Standards encourage to allow residents to be independent but we are not funded to allow for it. No funding to assist resident to walk, maximum funding if they are "non-ambulant"	33%
No because they just sit down and look at paper work but this doesn't always reflect the care we've provided for our residents	17%
I stay back every night to get the paperwork done, the pressure is enormous	17%
Everything is just glossed over	17%

Appendix F - Correspondence Night and Day Nursing Agency



- 3 JUN 2010
ANF (VB)

109 Bedford Road
Ringwood East 3135

Telephone: **1300 AGENCY**
1300 243 629
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ABN 52 075 763 022

Wednesday, 19 May 2010

Australian Nursing Federation Vic Branch
Box 12600 A'Beckett Street
PO Melbourne Vic, 8006

Over the past 15 years we have witnessed numerous changes in the Aged Care industry, some very positive and several very concerning to both the welfare of our current elderly population and the future of care for the aged.

A meeting was held at 10.30 am on Wednesday 31st of March so that we could listen and discuss some of these concerns. Concerns are not isolated to staff provided by an agency, however these staff work in a variety of facilities and settings where they are unprejudiced and witness the lack of quality care and experience.

Our staff would like to draw your attention to the following concerns raised. We have allocated accreditation standards to the points raised.

1. Quality of Staff and education. Standard 1

Concerns were raised about the amount/quality of training given to staff. Some Personal Care Worker courses run for only 2 weeks duration, whilst others are for 6 to 12 months. Clinical placement hours are being given to staff in domestic roles and not in supervised care roles. Then new trainees are employed in roles that require these practised care skills, this is a considerable concern when dealing with frail and vulnerable members of the community.

2. Staffing levels. Standards 1 & 2

The nurses and care staff are under pressure because there are no mandatory staffing levels, shift lengths and skill mix implemented in a high percentage of facilities they are working. The nurses consider this to be both

dangerous to the residents, and a threat to their ability to practice under the guidelines set by the Nurses and Midwifery Council Australia and The Nurses Board of Victoria.

3. Staff well being. Standard 1 and Employment legislations

The nurses discussed their concerns about vertical and horizontal violence; most are too scared to make formal complaints in case they lose their jobs or are bullied as a result. This is concerning because staff well being filters through to the well being of the residents.

4. Communication. Standards 1 & 3 and Documentation/record keeping obligations

Several staff indicated the anguish caused to residents and staff by nurses/carers with little or no understanding of the English language. This is also concerning where clear comprehension is required to complete a job safely.

5. Scope of Practice. Standard 1,2,3 & 4

Concerns were raised about grey areas in nurses and care causing confusion with scope of practice.

6. Pay Parity. Employment legislation and long overdue promises.

Nurses in aged care have been asking for pay parity in line with the public sector and have been ignored. The public sector received their pay rise in October 2009 while private sector wages were frozen. This has increased the difference even more! The nurses feel they play just as important role in caring for the aged in the private sector as nurses do in the public sector and this should be recognised by equal pay.

7. Nursing registration. Standards 1,2,3 & 4

Nursing and care staff all agreed that Personal Care Workers should be included in the public register. This was suggested to protect the care of the residents, to recognise their responsibilities towards those in their care and to protect them from discrimination about their ability to act in a caring and respectful manner.

8. Funding. Not accounted for in Aged Care Standards, something needs to be put in place.

Nurses suggested that any organisation receiving Commonwealth Funding should be held responsible for ensuring that all primary care needs of the residents are paid for and met. Organisations need to be held more

accountable for how that money is being spent and distributed in line with resident care.

9. Concerns were raised about the provision of essential items. This included toiletries, clothing medication and dietary needs. Standards 1,2,3 & 4

10. Extra care services. Needs to be clearly defined in Act.

Service providers are cutting costs by eliminating other Allied Health Services and expecting Nurses to undertake duties that are not included in their specific body of knowledge. Examples given were Physiotherapy, Podiatry and Occupational Therapy.

11. Many facilities have State of the Art equipment but seldom use this equipment. Standards 1,2,3, & 4

12. Spot checks at facilities.

Facility spot checks by the accreditation agency should be exactly as the name suggests. Facilities are given notice and have the ability to use this time to improve their organisations standards. Extra staff often allocated to work on these occasions, providing a false representation of the normal staffing levels and working environment.

13. Cleanliness was addressed: Provision of disposable gloves to prevent cross infection and facility cleanliness. Standards 1,2 & 4

- Increase in incidence of dementia
- Increase obesity/co-morbidities.
- Increase overall in Aged Care Facility Care.
- Increases in Training colleges offering Fast Track training in Aged Care.

We would appreciate if you would take seriously these concerns and that in 2010 some positive steps are taken to build both a more rewarding and happier environment for our ageing population and the future of the employees in this growing industry.

Name	Qualification	Date	Signature
[Redacted]	RNR	28/4/10	[Redacted]
[Redacted]	RN2	28/4/10	[Redacted]
[Redacted]	RN.DIV.1	28.4.2010	[Redacted]
[Redacted]	RN DIV 1	28/4/2010	[Redacted]
[Redacted]	RN Div 2	28/4-2010	[Redacted]
[Redacted]	PCA	28/4/10	[Redacted]
[Redacted]	RNDiv 2	28/4/10	[Redacted]
[Redacted]	RNDIV2	28/4/10	[Redacted]
[Redacted]	PCA	6-5-10	[Redacted]
[Redacted]	PCA	11.5.10	[Redacted]
[Redacted]		19.5.10	[Redacted]
[Redacted]	PA	21.5.10	[Redacted]
[Redacted]	RNDIV 1	26.5.10	[Redacted]
[Redacted]	PCA	20/4/10	[Redacted]
[Redacted]	PCA	21/5/10	[Redacted]
[Redacted]	RNDiv.2	26/5/10	[Redacted]
[Redacted]	RNDIV2	28/5/10	[Redacted]
[Redacted]	PCA	28/5/10	[Redacted]

ANF (Vic Branch) has shaded out names and signatures of the authors of this letter in order to preserve their anonymity.

Appendix G – Preliminary findings from phase three of the ANF – University of Melbourne Working life in aged care study, The University of Melbourne, 2010.

Summary of data from Participants who have left Aged Care

Of the 1007 participants who were in our original T1 August 2007 sample 200 have indicated to us that they have left aged care. As we had 301 individuals who did not respond at all to our T3 questionnaire it is conceivable that there may in fact be more participants from our original sample who have actually now also left aged care. On average participants had left the aged care sector 17 months ago.

Key reason for leaving aged care	Percentage
Working conditions (e.g., inadequate qualified staff, poor staff-resident ratios, too much paperwork, poor pay)	44.5%
Retirement	16.0%
Health reasons/Injury	10.5%
Another job offer	8.5%
Retrenchment/Made redundant	6.5%
Workplace politics (e.g., bullying, poor staff dynamics)	5.0%
Not specified	9.0%

What individual is doing now	Percentage
Retired	29.5%
Acute nursing in a hospital	26.5%
Working in the community sector (e.g., welfare position, home & community care program, case management)	14.5%
Not working	13.0%
General practice/clinic nurse	6.0%
Other (e.g., office admin, teacher, massage therapist)	3.5%
Not specified	7.0%

N.B. Quite a few individuals stated that poor working conditions in the aged care sector drove them to retire early. This explains why the percentage of participants who stated that they were now retired is higher than the percentage that cited retirement as the key reason for leaving aged care. In other words a number of participants would not have retired and would still be working in aged care had the working conditions been better.

Sample of Qualitative Comments from Participants who have left Aged Care

Comment

I have ceased working in aged care after twenty years. I would have liked to have continued working, but was unable to due to bad health brought on by stress. As an ex Div 1 I found during my time working that the standard of nursing deteriorated. I found myself working with untrained staff, PCAs who in some cases could hardly speak English. As the only Div 1 on duty I found it very stressful ensuring residents were properly cared for. My stress levels would have been reduced if like in the past I had Div 2 nurses to work with. When I had the luck to work with Div 2 nurses, they became very upset about working with PCAs as they found their workload increased. Unless this situation is rectified more Div 1 nurses will leave aged care.

Comment

I left aged care because of the poor pay rates, lack of nurse/resident ratios and incompetent staff to care for high care residents. Whilst I am enjoying my new job as a practice nurse I miss aged care!! Better conditions would keep good aged care nurses there.

I stopped working in aged care because I, along with many other Div 1 nurses, was made redundant by the facility.

I left aged care because I was the only Div 1 in a 60 bed facility where 45% of the residents were high care. I was on call 24/7 and was expected to do everything!

I left aged care because I was frustrated and disillusioned about the care given to residents. I felt that the staff/resident ratio was unrealistic to provide adequate resident care and also created OH&S issues for staff.

I left aged care because I found it physically exhausting – the patient load was too great, there was too much documentation that required repeating yourself over and over. There was also a lack of support from management. I no longer enjoyed my work!

I think once a patient enters permanent care they should all be funded on the one level to reduce paperwork and allow more time for direct patient care. These days patients are very debilitated when entering care and this should not need to be justified time and time again.

I could not continue to work in a system that is so flawed and where patient care is being compromised. I was a manager whose budget for food was just over \$2.80 a day per resident. I was on 24 hour call. The lack of staff-patient ratios definitely compromised care. Private providers are largely “rorting” the system – accepting high care patients and do not provide the resources to manage the care. I am now working in a major public hospital. I chose not to go back into the private aged care system as I cannot reconcile the lack of good, planned care for residents. In the hospital we have staff-patient ratios which ensure a much better standard of care. The elderly deserve better.

I left aged care because I was fed up with the lack of staff. There was too much pressure on staff to attend to all residents with inadequate time to give optimum care. There were no activities to help alleviate the residents’ boredom or help stimulate them. There was also too much documentation which negatively impacted on resident care. Management also had a very negative attitude towards staff.

I left aged care because of the lack of respect for my knowledge/skill level. There was continual role undermining by upgrading Div 2 nurses who became things like care managers.

I left aged care because I was tired and unable to keep up with the demands of the job and the effects the job was having on my health. My health has improved since I left. I feel the problems in aged care are enormous and will never be addressed unless there are significant changes. For staff who care going home shift after shift feeling they haven’t been able to do their job properly despite multi-tasking, rushing, frequently working through breaks, going home late etc is soul destroying. The current system of complex paper trails to justify funding and also to prevent sub standard care does not work because the time taken to perform this paperwork is never factored into the system. It means time taken to do this is time stolen from direct care. Routine appropriate nursing documentation should be all that is necessary. I have been told for years, “that if it hasn’t been written down it hasn’t been done.” My experience is that just because it is written down doesn’t mean it has been done. Frequently it hasn’t. The attitude persists that residents in aged care facilities are there because they are old and that caring for them is easily done by anyone with minimal or no training. Multiple medical conditions and disabilities determine the need for admission to an aged care facility. In addition to requiring a broad knowledge base to nurse such individuals, aged care nurses have to go beyond this and develop and implement plans that ensure residents obtain maximum quality of life as well. I am sure I had more to contribute to aged care but could no longer justify sacrificing my health for a system that was so punishing and unforgiving.

I left aged care because of increased stress due to being the only Div 1 nurse in a 60 bed low care facility. I worked full-time Monday – Friday and was expected to be a resource after hours and weekends for personal care workers who were running the facility after hours.

Comment

I left aged care because I was made redundant when the organisation replaced RN Div 1s with RN Div 2s as supervisors. I was also unhappy with the trends in aged care.

I left aged care because it was too stressful, too many responsibilities, not enough properly trained staff, too much paperwork. Being a Div 1 in charge I was discouraged to assist on the floor and was told I should concentrate on paperwork. I left feeling very disappointed and sad. I am now looking for a position where I can practice my nursing skills and it is not all about paperwork.

I left aged care because the roster was restructured at the facility I worked at and there was a push to get rid of Div 1 RNs.

I left aged care because after 24 years I became very despondent and disheartened with the staffing levels and timeframes expected of us to provide the appropriate quality care. It posed an ethical and moral dilemma for nurses with the elderly being viewed as \$\$\$ and a business, not people!!

I left aged care because the facility in which I worked was not up to scratch. The standard of care was not up to what I would like my mother or father to have. Aged care needs a big revamp.

After 21 years in aged care the increased workload and responsibilities became untenable and professionally risky with the replacement of Div 1s with Div 2s (all newly medication endorsed but lacking the in depth knowledge of a Div 1 to carry out their duties).

I left because I needed to get my life back. I was working over 60 hours (paid 38 hours) a week due to a lack of funding. You just got more and more exhausted. I miss aged care but it takes over your life. Sadly many of my RN peers have also left aged care. It won't be long before there is no one left!

I left aged care because of bullying, harassment, and a lack of care and support from management. They wanted to get rid of long term, experienced, permanent staff as we were "more expensive" than unqualified staff! I am very happy in my new job as I am free from stress and anxiety and it is great to also be appreciated once more.

I left aged care because the workload was unreasonable. Management was reducing the number (halving the number of RN Div 1s) of registered staff. We were always short staffed.

I left aged care because of all the unpaid overtime and refusal of management to pay. There were never enough hours in a shift to complete the ever increasing workload of a RN Div 1.

I left aged care because of concern and frustration over poor skills mix placing pressure and stress on those few RNs employed. There were unrealistic clinical expectations of those well meaning but unqualified and inexperienced staff left to manage residents with complex care needs.

I left aged care because there was too much paperwork and not enough hands on care.

I left aged care because I no longer gained work satisfaction. The workload was too strenuous and the pressure from management was unrealistic. There was low staff morale because of the low staffing levels. I am now working in a complex care unit where there are great staffing levels and morale. I am now enjoying nursing again!

I left aged care because of the lack of staff-patient ratios. There were 10 high care residents to 1 nurse at my facility and I couldn't work like that any longer. I am now working in a hospital where there are much better ratios and working conditions.

I left aged care because I was burnt out. I was unable to meet the needs of my residents to my liking. There were too many agency staff and PCAs. The residents were frail and ill and we needed more RNs.

I left aged care because there was less caring and MORE paperwork. There were not enough staff and the staff were less qualified. I was asked to do more work than I was able to fit in during a shift. I was always working unpaid overtime.