The Australian Nursing Federation,
Northern Territory Branch Secretary

Productivity Commission Submission – Caring for Older Australians

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Issues presented in the Australian Nursing Federation, Federal Office submission to the Productivity Commission – *Caring for Older Australian* also affect the Northern Territory. It is not the intention then of this submission by the Australian Nursing Federation, Northern Territory Branch, (ANF NT), to repeat all points covered by our national office. as they are well articulated and need not be expanded. Rather our intention is to highlight and refer to some of the key major issues affecting, and perhaps specific to, the Northern Territory, (NT).

Skill Mix

A 2007 Australian study found skills mix was a significant predictor of patient outcomes. Reinforcing the findings of other international studies, a skills mix with a higher proportion of registered nurses produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers; gastrointestinal bleeding; sepsis; shock; physiologic/metabolic derangement; pulmonary failure; and failure to rescue. The study found one extra registered nurse per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients, of pneumonia by 16 per 1000 patients, and of sepsis by 8 per 1000 patients. Patients are also less likely to fall and suffer injury as registered nursing hours increase, (Duffield et al 2007). Such reductions in risks to the residents results in less hospitalistion and a corresponding reduction in the overall cost to healthcare. Qualified nurses providing care are able to prevent injuries, complications and save money (Armstrong, 2009).

Assistants in Nursing, (AINs) and Patient Care Attendants (PCAs) (however titled), should have a minimum of a Certificate 111 for aged care workers. This would give the AIN/PCA improved skills for working at that level of responsibility and an opportunity of a career path into enrolled nursing or registered nursing, if they so choose. Issues arise with the quality and standard of the training provided for a carer to achieve a Certificate 111. Some courses have been shown to be questionable. In the NT, RTO delivery of Certificate 111 training is problematic. Challenges involve dealing with DEET, archaic funding methods, dealing with the apprenticeship centre, and workplaces not being supportive of trainees.

Some discussion has been presented in other PC Hearings that refer to residents needing to be considered as if they were in their own homes. While the environment can be structured to give a home-like atmosphere, the fact remains that a different level of 'duty of care' applies for workers in the residential aged care setting, than for family/friends caring for a person in their own home. Sound risk management for any aged care facility includes not only physical structures to prevent harm but also the equipping of direct care workers with knowledge and skills to deliver safe, competent care. Furthermore, statements have been made that residents of aged care facilities are institutionalised and over-medicated. The sad fact is that many residents in aged care facilities are there because they have such complex needs, and are so frail that they require high care, and their families are no longer able to care for them in the home environment. Complex needs are generally due to the fact that the resident has numerous co-morbidities (which comes with age and especially with living longer). This generally is demonstrated in the need for a complex range of medications to treat the co-morbidities and `older age'. Such comments, that *`residents are over institutionalised or over-medicated'* does not ring true for the vast majority of residents. What is true is that there is a need for funding to assist aged care residential facilities to provide occupational and social programs to lessen any perceived `institutionalised' effect.

Richardson and Martin (2004) highlight that the increasing numbers of residents with higher and more complex care needs have added to the workloads of nursing care staff in residential care settings. The available nursing and aged care staff numbers per resident have in many instances decreased despite this increase in the proportion of residents classified as requiring 'high care'. As a result, a 2003 survey reported that over two-thirds of direct care employees in residential

facilities felt they were not able to spend enough time with each resident and were too rushed to do a good job.

The majority of residents in aged care facilities are classed as 'high care', having a vast range of complex co-morbidities which require complex medications, as mentioned previously.

Closing the wages gap.

There are huge wage gaps between the wages paid to public sector nurses and to a lesser extent, AINs/PCAs (however titled) and those working in the aged care sector. Equity and fairness are major issues, especially within a workforce cohort that is mainly women, part time and migrants. The ability for aged care residential facilities to retain their nursing and care staff is extremely difficult, especially in the Northern Territory. In many instances nurses and AINs/PCSs (however titled) work in aged care residential facilities that are in close proximity to public acute hospitals. Most aged care residential facilities in the NT see a steady migration of their staff seeking employment into the far better paid public hospital sector. This is not good for the aged care residential facilities. There is no continuity of care with constant changing of staff, and understaffing is a common occurrence due to the difficulties in attracting and retaining qualified nurses and AINs/PCAs (however titled).

In order to deliver good quality care to the aged care residents, and in the interests of fair remuneration for care delivered, it is imperative that the wages gap be closed and competitive wages introduced in a manner that is both transparent and enforceable.

As discussed earlier, aged care residents are more commonly classified as 'high care' and therefore require a highly skilled workforce of nurses and AINS/PCAs (however titled). This can only be achieved if the wages gap is closed. Currently in the NT, nurses (Registered Nurses and Enrolled Nurses) employed by one of the two major providers of aged care residential services - Frontier Services or Masonic homes - see a significant wage differential **per week** ($184 or 13.6% for Masonic homes and $342 or 34% below the public sector wage comparison for Frontier Services). It is not a wonder that these facilities are unable to retain or attract staff. Please refer to Attachment 1.

National Licensing of AINs/PCAs (however titled)

The ANF NT believes that national licensing of AINs/PCAs (however titled) would ensure quality of care and better protection for the public. This protection is especially important when one considers the vulnerability and frailty of the clients and residents in their care. AINs/PCAs (however titled) are the main care providers within aged care and are the largest work group.

It is difficult to understand why the largest group of workers providing direct care in aged care are not required to be regulated to ensure that they are mentally and physically fit to provide quality care to residents/ patients/clients. The purpose of regulation is protection of the public. It makes no sense that registered and enrolled nurses are governed by a professional practice framework under regulation but AINs/PCAs, who likewise provide direct care, are not similarly covered by regulation. It is essential that these health care workers are safe and competent to practice and have a mechanism to assure protection of the public. The numbers of AINs/PCAs (however titled) in the health workforce is expected to grow quite significantly over the coming decades, whilst the numbers of nurses appear to be declining due to retirement and seeking better supported positions elsewhere. There is a need to ensure that AINS/PCAs (however titled) meet requirements of being appropriately qualified.

Currently, anyone may work in an aged care facility as an AINS/PCAs (however titled) without appropriate certificates, and provide care to those who often are unable to have articulate their care needs. It is highly possible for AINs/PCAs (however titled) to have unsafe practices which put the residents/patients/clients at risk. The AINs/PCAs (however titled) may be terminated or just resign and then seek employment providing care to other residents/patients/clients, without declaring where they last worked or if their provision of care should be monitored. If the AINs/PCAs (however titled) were licensed, their work practices would be known to the employer, as there would be a requirement to report unsafe practices to the Board. There is no accountability attached to AINs/PCAs (however titled), and this is not acceptable – either to the people receiving care/their families or to co-workers. There needs to be an assurance of safe, competent care attached to the AINs/PCAs (however titled) role.

The Productivity Commission draft report (p. 357) states'*..to ensure the best use of scarce workforce resources, wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care (2009)*'. Such outcomes are only achievable with the introduction of a professional practice framework under national licensing, which assures mechanisms to protect the public.

References

Armstrong. F. (2009). *Ensuring Quality, Safety and Positive Patient Outcomes. Why Investing in Nursing Makes $ense.* Australian Nursing Federation.

Duffield, C., Roche, M., O'Brien-Pallas, L., Diers, D., Aisbett, C., King, M., Aisbett, K. and Hall, J. (2007). *Glueing it together: Nurses, their work environment and patient safety.* Final Report. Centre for Health Services Management, University of Technology Sydney.

Productivity Commission (2011) *Caring for Older Australians Draft Report.*

Richardson, S. and Martin, B. (2004). *The Care of Older Australians: A Picture of the Residential Aged Care Workforce.* National Institute of Labour Studies for the Department of Health and Ageing. Flinders University, Adelaide.

Attachment 1

Northern Territory

Disparity in Rates

Public Sector/Private Aged Care Sector

NT Public Sector Nurse 2 (RN L1) Year 7 9 August 2010	Masonic Homes RN L1 Year 9 1 July 2010	Difference between Public Sector and Masonic Homes	Frontier Services RN L1 Year 8 29 Nov 2010	Difference between Public Sector and Frontier
$1,343.00	$1,160.00	14%	$1001.00	34%
NT Public Sector Nurse 1 (EN) Year 5 9 August 2010	**Masonic Homes Enrolled Nurse Year 7 1 July 2010**	**Difference between Public Sector and Masonic Homes**	**Frontier Services Enrolled Nurse Year 5 29 Nov 2010**	**Difference between Public Sector and Frontier**
$1015.00	$859.00	18%	$809.00	25%
NT Public Sector PCA PH4	**Masonic Homes PCA cert 3 L4A**	**Difference between Public Sector and Masonic Homes**	**Frontier Services Aged Care Worker GR 3 Yr 4**	**Difference between Public Sector and Frontier**
$841.00	$824.00	2%	$771.00	9%