

SUBMISSION TO SENATE INQUIRY

The future of Australia's aged care sector workforce

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FOREWORD

The aged care sector in Australia is one that deeply interests the whole of the community. Most people you speak to have had some experience of the sector, sadly for many it hasn't been positive. But no matter the experience the ground swell of opinion is that there are significant issues that must be addressed as a matter of urgency.

For our part the members of the Australian Nursing and Midwifery Federation have been campaigning for years in an attempt to ensure quality care for residents and decent conditions for workers through the Because We Care Campaign.

That campaign had 4 objectives:

- Better wages
- Mandated staffing levels and skills mix
- Financial transparency and accountability
- Regulation of Assistants in Nursing (however titled)

Emblazoned on my mind is the day the Honourable Mark Butler announced the Living Longer Living Better reforms, it was April 20 2012. At the time I recall being delighted that at least the wages component of our campaign had to some extent been achieved with the announcement of the Workforce Supplement which was tied to workers' pockets delivered through enterprise bargaining.

I equally recall the day the Honourable Tony Abbott announced that money, previously quarantined for the Workforce Supplement would be given to providers/employers and put back into general revenue. The devastation from our members in the sector was palpable.

Despite the fact that this sector is the most reviewed of almost any other, our members are actively participating in this inquiry because they know it's their stories about the realities of the sector that will persuade you to act in the best interests of consumers and workers.



Lee Thomas
Federal Secretary

EXECUTIVE SUMMARY

The size and composition of the direct care workforce in aged care is the key ingredient in the ability to provide a decent and dignified standard of care to our growing, and increasingly frail, elderly population.

As a society Australians are living longer and generally remaining healthier. Technological and scientific advances are such that Australians now and into the future will be able to experience a good quality of life well beyond retirement age. The 2015 Intergenerational Report projects that within the next 40 years there will be approximately 40,000 people aged 100 and the number of people aged 65 and over will have doubled in Australia.

However, as Australia's aged population continues to grow, demand for aged care and related services will also continue to grow. The consequent increased health and personal care needs of individuals will require the preparation and provision of a sufficient and suitably qualified and skilled workforce.

Put simply, the elderly cannot receive proper care unless there is an appropriate number and mix of skilled and experienced staff, which includes registered nurses, enrolled nurses and assistants in nursing/personal care workers.

This means that staffing levels must be urgently addressed. Without legislated requirements in all Australian jurisdictions to mandate a minimum number and type nursing and care staff in the aged care sector, safe and quality care for the elderly cannot be assured.

In addition the barriers which inhibit people from working in the sector must be urgently addressed. Work performed by employees in the health and community services sector in general, including aged care, continues to be undervalued and underpaid. In aged care in particular, nurses and carers experience the double disadvantage of working in an undervalued and underpaid occupation in a sector that is not adequately resourced or recognised.

The pay for the majority of aged workers, both skilled and semi-skilled, simply does not reflect the nature of the work and the level of responsibility required nor does it value the importance of providing the best care possible to Australia's frail elderly. ANMF members are increasingly frustrated and distressed by what they regard as a lack of respect for the elderly by aged care employers who, in their view, could and should be doing a much better job

Their frustration is exacerbated by the fact that attraction and retention problems in the aged care sector are not new. The challenges are, in fact, well understood across the industry:

- low wages and poor conditions;
- inadequate staffing levels and workload issues;
- unreasonable professional and legal responsibilities;
- lack of career opportunities;
- stressful work environments;
- poor management practices; and,
- a poor perception of aged care in general.

Despite this understanding, the failure to address these factors persists. There is simply a lack of will by governments and industry to address these matters seriously.

To ANMF members it's straightforward:

More staff, safer environment, better care – so simple.

SUMMARY OF RECOMMENDATIONS

Recommendation 1

The Australian Government must fund and implement mandated minimum staffing levels and skill mix requirements for registered nurses, enrolled nurses and assistants in nursing/personal care workers in the aged care sector.

Recommendation 2

That the Australian Government close the wages gap between working in aged care and their public hospital for nurses and assistants in nursing/personal care workers.

Recommendation 3

That dedicated funding is made available by the Australian Government to close the wages gap, and that provision of the funding is conditional on the achievement and maintenance of wage parity.

Recommendation 4

All assistants in nursing/personal care workers (however titled) must be licensed and subject to regulation.

Recommendation 5

All assistants in nursing/personal care workers (however titled) must be required to meet a minimum standard of qualification.

Recommendation 6

That there is a mandated/legislated requirement for 24 hour registered nurse cover for all high care residents in aged care facilities, inclusive of those low care facilities with residents assessed with high care needs.

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INTRODUCTION

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing/personal care workers, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership which now stands at over 249,000 nurses, midwives and assistants in nursing/personal care workers, our members are employed across all urban, rural and remote locations, in both the public and private health and aged care sectors.

The ANMF takes a leadership role for the nursing and midwifery professions by participating 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, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

Nurses and midwives together comprise more than half the total health workforce. They are the most geographically dispersed health professionals in this country, providing health care to people across their lifespan and in all socio-economic spheres.

Approximately 30,000 ANMF members are currently employed in the aged care sector.

We therefore welcome the opportunity to provide feedback to the Inquiry into *The future of Australia's aged care sector workforce*.

Australians' lives are getting longer and they are enjoying good health for an increasing number of those extra years. The Australian Institute of Health and Welfare (AIHW) estimated that between 1998 and 2012, life expectancy at birth for males increased by 4 years, while the number of years without disability increased by 4.4 years — that is, all of the additional life expectancy was in years without disability. For women, this was an increase of 2.8 years of life expectancy, with 2.4 in years without disability. For Australians at age 65, a greater proportion of the increase in life expectancy has been for years without any severe disability².

It is estimated though that as we live longer, an increasing number of Australians will require formal aged care services³, as has been occurring over the last two decades. Consistent with the ageing of the population, there has been a steady increase in the number of Residential Aged Care places, from 134,810 in 1995 to 263,788 in 2014⁴.

The increasing aged population is currently and will continue to present Australia with a number of challenges. Meeting the increased care and support needs of this growing population is one of the most critical challenges as these increased needs will require significant expansion in the preparation and provision of a sufficient and suitably skilled workforce.

The current aged care workforce consists of people that come from varied pathways into aged care work and includes a mix of registered nurses and enrolled nurses (both regulated health professionals) and assistants in nursing/personal care workers (unregulated workers).

Currently, in the sector, nursing and personal care are legislated to be assessed, planned and co-ordinated in accordance with the *Aged Care Act 1997*. This requires registered nurses to plan nursing care. Approved providers are required under the *Aged Care Act 1997* and its principles to provide adequate numbers of care staff to carry out the assessed care needs. However, the Act is silent as to the number of nursing or unregulated care staff required to be sufficient to deliver assessed care needs.

This is the critical problem. The Act's silence has led to the current parlous state of the aged care workforce. Despite the very best efforts of those who work in the sector, there simply are not enough workers nor enough workers with higher level skills to provide quality care to all elderly Australians.

This situation must be urgently addressed because our elderly deserve better. The remainder of this submission examines how this can be achieved.

² Ibid.

³ Centre of excellence in population ageing and research, 2014, Aged care in Australia: Part 1 – Policy, demand and funding. Available online: http://www.cepar.edu.au/media/127442/aged_care_in_australia_-_part_i_-_web_version_fin.pdf

⁴ Australian Institute of Health and Welfare. 2016. Aged Care. Available at: <http://www.aihw.gov.au/aged-care/> Accessed 26.2.16

A. THE CURRENT COMPOSITION OF THE AGED CARE WORKFORCE

The size and composition of the direct care workforce in aged care is the key ingredient in the ability to provide a decent and dignified standard of care to our increasingly frail elderly population. Put simply, the elderly cannot receive proper care unless there is an appropriate number and mix of skilled and experienced staff, which includes registered nurses (RNs), enrolled nurses (ENs) and assistants in nursing/personal care workers (AINs/PCWs).

The most recent reliable national data available, from 2012, shows a significant change in the skill mix of direct care staff over the last decade in both residential and community aged care. This trend has continued and needs to be addressed urgently both now and as we plan for future needs. Up to date reliable data is therefore critical to evaluate the workforce changes since 2012, assess future needs and to develop an aged care workforce which is equipped to meet those needs.

Composition of the Residential Aged Care Workforce

The periodic census and surveys of the aged care workforce conducted for the Department of Health in 2003, 2008 and 2012 outline the numbers and proportions of direct care staff in residential aged care, particularly in relation to the relative numbers of registered nurses (RNs), enrolled nurses (ENs), assistants in nursing (AINs)/personal care workers (PCWs) however titled. The surveys also highlight the changing skill mix of the workforce over those years.

Census data from the 2012 Aged Care Workforce report includes both a headcount and a full time equivalent figure (FTE) for the different occupational groups providing direct care. FTE data should be used for measuring the size of the existing workforce.

Table 1 shows the number of full time equivalent (FTE) direct care employees in the residential aged care workforce by occupation in 2003, 2007 and 2012.⁵

Table 1 Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007 and 2012 (estimated FTE and per cent)

Occupation	2003	2007	2012
Nurse Practitioner	n/a	n/a	190 [0.2%]
Registered Nurse	16,265 [21.4%]	13,247 [16.8%]	13,939 [14.7%]
Enrolled Nurse	10,945 [14.4%]	9,856 [12.5%]	10,999 [11.6%]
Personal Care Attendant #	42,943 [56.5%]	50,542 [64.1%]	64,669 [68.2%]
Allied Health Professional	5,776* [7.6%]	5,204* [6.6%]	1,612 [1.7%]
Allied Health Assistant			3,414 [3.6%]
Total number of employees (FTE) (%)	76,006 [100%]	78,849 [100%]	94,823 [100%]

*In 2003 and 2007 these categories were combined under 'Allied Health'

#The term PCs includes personal carers, assistants in nursing and other unlicensed workers (however titled) working in aged care

The Aged Care Workforce report indicated that in 2012 the total number of direct care employees including RNs, ENs, AINs/PCWs and Allied Health was 147,086. Below is a brief outline of the characteristics of those workers.

Employment characteristics of the direct care workforce in residential care: RNs ENs and AINS/PCWs⁶

In 2012, 90% of the total direct care workforce in residential aged care were women. The characteristics outlined below describe the total population, that is, workforce head count as opposed to full-time equivalent.

RNs:

- Nationally, there were 21,916 employed in 2012 comprising 14.9% of the direct care workforce
- 61.3% are employed part time; 19.3% full time and 19.4% casual
- One third of RNs work from 16 to 34 hours per week; (36%) work between 35-40 hours per week and 28.6% more than 40 hours
- Median age is 51
- Median age of recent hires is 47.

⁵ King D, Macromaras K, Wei Z, et al. The Aged Care Workforce 2012, Canberra: Australian Government Department of Health and Ageing 2012 Table 3.3 page 10

⁶ Martin B and King D et al 2012 op.cit

ENs:

- Nationally, there were 16,915 employed in 2012 comprising 11.5% of the direct care workforce
- 74.7% are employed part time; 10.5% full time and 14.8% casual
- 42.7% of ENs work from 16 to 34 hours per week; (36%) work between 35-40 hours per week and 17.4% more than 40 hours
- About two thirds have a certificate III in aged care
- Median age is 59
- Median age of recent hires is 44.

AINs/PCWs

- Nationally, there were 100,312 AINs/PCAs employed in residential aged care in 2012 comprising 68.2% of the direct care workforce
- 73.6% are employed part time; 6.9% full time and 19.5% casual
- Over half (56.4%) of AINs/PCAs work from 16 to 34 hours per week; one third (32.1%) work between 35-40 hours per week;
- About two thirds have a certificate III in aged care and 20% have a certificate IV in aged care
- Median age is 47
- Median age of recent hires is 38.

Composition of the Community Aged Care Workforce

The 2012 Aged Care Workforce report⁷ also provided data on the size and composition of the direct care workforce in the community aged care sector.

Of the 149,801 employees estimated in 2012, 93,359 (63%) of the community aged care workforce were in a direct care role. Registered and enrolled nurses combined comprise up to 12.1% of the direct care workforce while 81.4% are categorised as community care workers. As with residential aged care, full time equivalent (FTE) figures provide a more accurate picture of workforce composition. There were 54,537 full time equivalent direct care employees with the vast majority (76%) employed as care workers, 12% are Registered Nurses (RNs), 4.3% Enrolled Nurses (ENs) and 7.7% allied health.

RNs comprise a smaller proportion of direct care staff in the community aged care sector than in residential aged care. There is also a similar trend in terms of a declining proportion of RNs between the 2007 and 2012 census reports as illustrated in Table 2 with RNs making up 12% of the direct care workforce in 2012, down from 13.2% in 2007.

Full-time equivalent direct care employees in the community aged care workforce, by occupation: 2007 and 2012 (estimated FTE and per cent)

Occupation	2007	2012
Nurse Practitioner	n/a	55 [0.1%]
Registered Nurse	6,079 [13.2%]	6,544 [12.0%]
Enrolled Nurse	1,197 [2.6%]	2,345 [4.3%]
Community Care Worker	35,832 [77.8%]	41,394 [75.9%]
Allied Health Professional*	2,948 [6.4%]	2,618 [4.8%]
Allied Health Assistant*		1,581 [2.9%]
Total number (FTE)%	46,056 [100%]	54,537 [100%]

Source: Census of community aged care outlets.

*Note: in 2007, these categories were combined under Allied Health

Overall, there are more direct care employees employed as casuels in community aged care (27.3%) compared to residential care (18.7%) and correspondingly less employed as part time compared to residential aged care.

An overview of the characteristics of the community aged care workforce is outlined below.

Employment characteristics of the direct care workforce in community aged care (head count)

RNs:

- Nationally, there were 7,631 employed comprising 8.2% of the direct care workforce
- 53.3% are employed part time; 32.6% full time and 14.2% casual

- 41.1% work between 16 to 34 hours; 38% work between 35 and 40 hours and 19% over 40 hours per week
- Median age is 50
- Median age of recent hires is 47.

ENs:

- Nationally, there were 3,641 employed comprising 3.9% of the direct care workforce
- 67.2% are employed part time; 17% full time and 15.8% casual
- 39.1% work between 16 to 34 hours; 39.1% work between 35 and 40 hours and 17.2% over 40 hours per week
- Median age is 49
- Median age of recent hires is 45.

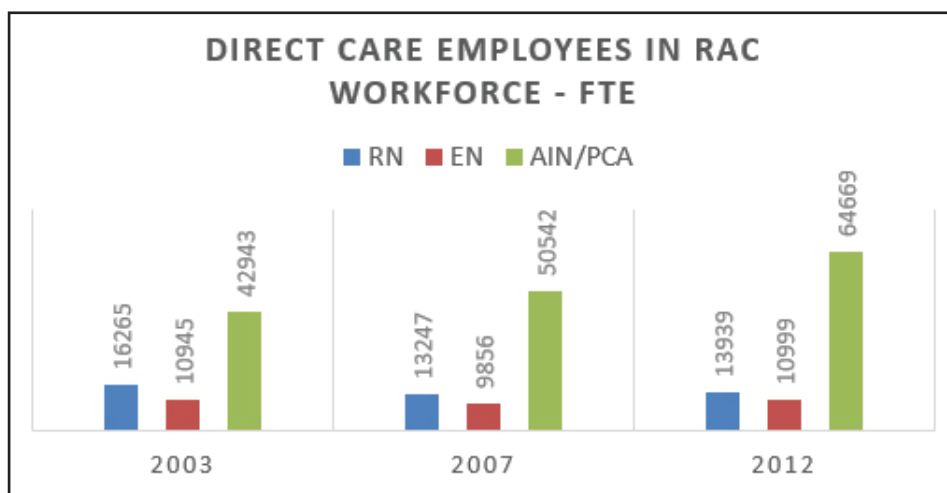
⁷ Kind D, et.al. 2012 p70

CCWs:

- Nationally, there were 76,046 employed comprising 81.4% of the direct care workforce
- 62.9% are employed part time; 6.7% full time and 30.4% casual
- Over half, 56.4% work between 16 to 34 hours; 20.2% work between 35 and 40 hours; 18.5% between 1 and 15 hours and 4.9% over 40 hours per week
- 60% hold a certificate III in aged care or home and community care; just fewer than 70% hold relevant Cert III or IV qualifications
- Median age is 50
- Median age of recent hires is 45.

Changes in the composition of the aged care workforce

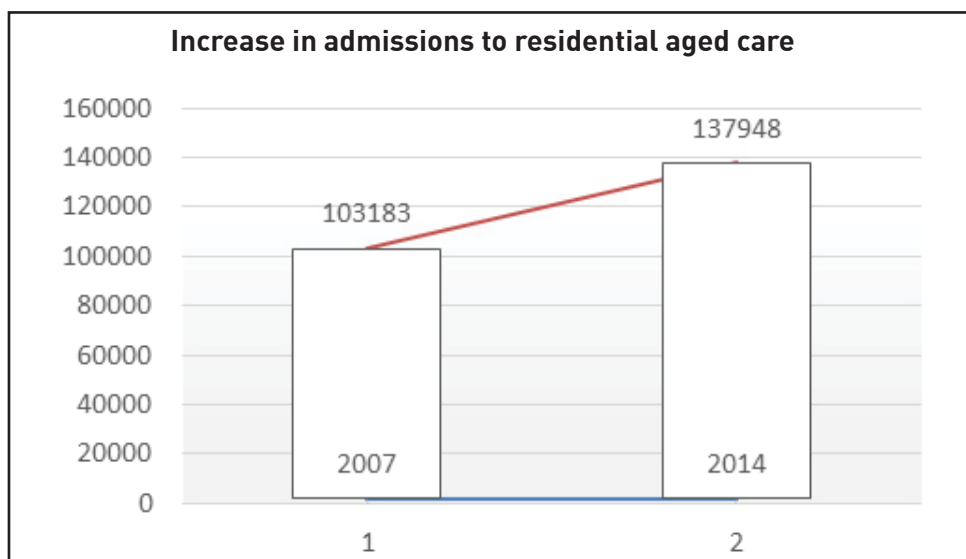
Between 2003 and 2012 in residential aged care the number of FTE RNs decreased by almost 14.3 percent; the number of FTE ENs increased slightly by 0.5 percent and the number of FTE AINs/PCWs increased by 50.1 percent. This represents a significant change in the occupational distribution of the FTE direct care workforce with RNs making up just 14.7 percent of the workforce, down from 21.4 percent in 2003. Enrolled nurses make up 11.6 percent, down from 14.4 percent in 2003 and AINs/PCWs make up 68.2 percent compared with 56.5 percent in 2003.⁸



As the skill mix of the workforce has been changing so have the needs of the elderly. However, the relationship between those two factors has moved in a negative rather than a positive direction.

This shift away from the employment of RNs coincides with a 25.2 percent increase in the number of operational residential aged care places between 2003 and 2014 from

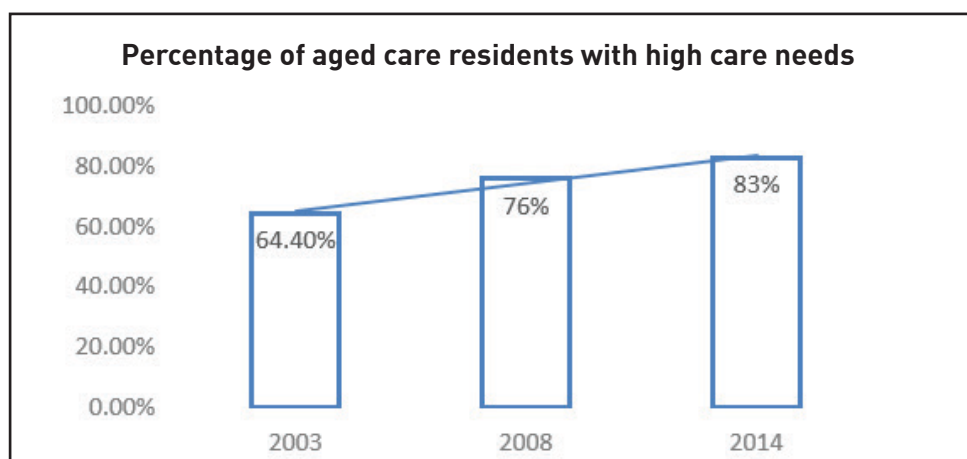
151,181 in 2003 to 189,283 in 2014⁹ and an increasing number of residents with high care needs. In 2003, 64.4 percent of residents were assessed as high care, while in 2014, 83 percent of residents were assessed as high care. Further, as at June 2014, more than half (52%) of residents had a diagnosis of dementia¹⁰.



⁸ Ibid

⁹ AIHW 2004 Residential aged care in Australia 2002-03: A Statistical Overview, page 2 AIHW 2015 Residential aged care and Home Care 2013-14: Web report

¹⁰ AIHW 2004 Residential aged care in Australia 2002-03: A Statistical Overview op. cit. page 5 AIHW 2015 Residential aged care and Home Care 2013-14: Web report op. cit. <http://www.aihw.gov.au/aged-care/residential-and-home-care-2013-14/>



The ANMF strongly supports the role of the Assistant in Nursing/Personal Care Worker (AIN/PCW) in residential aged care and regards those workers as integral to the nursing team in their work with registered and enrolled nurses to provide quality nursing and personal care at a professional standard. However, the workforce data clearly indicates a substantial shift towards the employment of AINs/PCWs at the expense of registered and enrolled nurses in a care environment where the work in many instances requires the skills and knowledge of either a registered or enrolled nurse.

The consequence of this shift is that the quality of care provided to the elderly has been directly affected, and negatively so. ANMF members observe this effect daily:

I work in aged care, there's only 1 RN on evening shift to 140+ residents. No RN at night. It is very stressful.

I have worked in many nursing homes as a RN and consider the ratio of staff to residents and workload to be unsafe practice created by the owners and management. When working in the emergency department of a public hospital many aged care persons are admitted due to falls often due to inadequate supervision.

I always strive to do my best as a carer but there is only so much we can do. Too often I think I could always get a job at Safeway and earn the same but then I feel a bit guilty for the oldies, it's not their fault.

Care hours provided by the direct care workforce in aged care

An analysis of staff hours worked per resident per day in the latest *Aged Care Financial Performance Survey* published by Stewart Brown, (an accountancy firm), shows a breakdown of average hours worked by care staff per resident per day¹¹. Total care hours are broken down into five categories: care management; registered nurses; enrolled and certified nurses; other care staff and therapists.

The results group facilities into 5 Bands according to the level of "care" income streams with Band 1, receiving the highest care subsidy and other care income, and Band 5 the lowest. Band 1 has the highest care hours worked per resident per day at 3.18 hours. This represents the total amount of care provided per resident per day across all three shifts. The distribution of care hours per resident/per day/per worker is set out in table 3:

Band 1 - Facilities - 2015	Minutes per resident per day (24 hours)
Care management	7.2
Registered nurses	22.2
Enrolled & certified nurses	27
Other care staff	126
Therapists	9
Total care hours	3 hours & 10 mins

At best, a resident receives a total of 22 minutes of RN care per 24 hours over three shifts, that is, 7 minutes and 19 seconds per shift.

The survey recorded that average care hours per resident per day in Band 5 facilities, (less care revenue, assumes a greater number of lower care residents), amounted to just 1 hour, 46 minutes of care over three shifts. Residents in this type of facility receive 6 minutes of registered nurse care over three shifts. Table 4 provides a further breakdown across the care classifications.

Band 5 - Facilities - 2015	Minutes per resident per day (24 hours)
Care management	6
Registered nurses	6
Enrolled & certified nurses	9.6
Other care staff	78.6
Therapists	4.8
Total care hours	1 hour & 46 mins

¹¹ Stewart Brown 2015, *Aged Care financial Performance Survey, Residential Care June 2015 Annual Report p.31*

Similarly, the Bentleys National Aged Care Survey 2015¹² provides national average care hours per resident/per fortnight for all facilities. The survey does not break down care hours by staffing classification, therefore care hours reflect average hours of care provided by all direct care staff. Total care staff hours per resident/per day were calculated at 2 hours and 52 minutes; this equates to a total of 57 minutes of care per resident/per shift. This is for residents who have high care needs, multiple co-morbidities and complex medication regimes.

As the population continues to age, and if appropriate adjustments to the workforce are not made, the ratio of care per resident is expected to worsen. This will result in a lower level of care being provided to those requiring the highest quality care, such as those with chronic and multiple health conditions, which may include dementia, itself a life-limiting illness, or other end of life care.

Included in the Stewart Brown report is an examination of the profitability of Band 1 facilities, which indicates that there has been a reduction in care costs, not as a result of less care hours but through utilising a less costly staff mix. Total direct care hours in 2014 averaged 3.19 hours per resident per day in 2014 and 3.18 in 2015¹³. However, how those care hours are being provided and by whom has changed significantly, shifting from registered and enrolled nurses to assistants in nursing/personal care workers.

Nurses understand, as stated above, that this directly impacts the quality of care provided to the elderly. Unfortunately this impact is rarely considered, if at all.

ANMF members clearly describe this effect:

It's just not fair to the elderly or the workers. Everyone is struggling in this situation. Workers fear telling the boss that the job is way beyond their scope and the patients and residents feel like no one knows about their plight in life... come on Australia we can do much better than this.

Currently, aged care reporting focuses on numbers and financial performance. The so called "better performers" are generally the facilities that have the lowest care costs as a percentage of care income. No-where is the actual "care" identified as the priority.

The *Aged Care Act 1997(Cth)* (the Act) requires approved aged care providers to ensure the availability of "sufficient skilled nursing staff" to provide for the nursing care needs of residents. And, in theory, the Australian Aged Care Quality Agency (AACQA) has the remit to ensure this part of the Act is implemented effectively within residential care, with the Quality of Care Principles underpinning this component of the Accreditation Standards. However, the terminology for these standards is not clear and is open to interpretation.

Furthermore, the current monitoring of the outcomes of the Quality of Care Principles included within the accreditation standards provide only a snap shot assessment at the time of a visit by AACQA. ANMF members explain that during accreditation assessment periods the staffing skill mix is often strengthened, both in number and levels of staff. However, once the assessment period is finished staffing then reverts to previous levels without any ongoing quality of care improvements in place.

Most aged care facilities are run on a tight budget the elderly are getting left too long on toilets, in wet beds and pads all because of the almighty dollar and staff cuts. When these places are accredited they bring on more staff, more towels and linen. It made me sick to see what goes on.

Improvements need to be made; regular monitoring of care outcomes within the accreditation process would enable a better understanding of current care provided and better inform workforce requirements moving forward.

Staffing levels must be urgently addressed. Without legislated requirements in all Australian jurisdictions to mandate a minimum number and type of nursing and care staff in the aged care sector, this situation will only continue to have an impact on the quality of life, or end of life care for the elderly.

To ANMF members it's straightforward:

More staff, safer environment, better care – so simple.

Recommendation 1

The Australian Government must fund and implement mandated minimum staffing levels and skill mix requirements for registered nurses, enrolled nurses and assistants in nursing/personal care workers in the aged care sector.

The ANMF is currently undertaking a comprehensive research project which will inform required minimum safe staffing levels and skill mix for aged care. Reports from the project's focus groups and missed care surveys will allow verbal submissions to be made to the Committee on outcomes by early May. A summary of the project's progress to date is outlined below.

¹² Bentleys, *National Aged Care Survey 2015*

¹³ Stewart Brown 2015, op.cit. p20

National Aged Care Staffing and Skills Mix Research: Addressing the Gaps

Over the last two decades, there have been several attempts to establish a method of determining safe staffing levels and skills mix in the aged care sector.

During 2011-2012, more than 200 aged care services participated in a national research project – funded by the Australian Government and undertaken by the Australian Nursing and Midwifery Federation – with the goal of finding a solution to this ongoing issue.

However, a funding shortfall meant that we were unable to finish this important work. While a final report provided a broad picture of staffing and skills mix in the aged care sector, it did not address the adequacy of current staffing arrangements.

Recognising the importance this project, ANMF Federal Executive has provided the funding to complete this project to its original scope. This twelve-month project commenced in July 2015 and is due to be completed by 30 June 2016. In partnership with Flinders University, the University of South Australia and the ANMF have developed a collaborative research plan with four key phases as follows:

- Establishment of resident complexity profiles with indicative interventions, timings and frequency of interventions over a 24 hour period.
- Establishment of expert aged care nursing focus groups to explore and validate the resident profiles and interventions
- A national missed care survey to gather information on problems related to incomplete or missed nursing and personal care
- A Delphi study for testing and verification of results from the residential care profiles and staffing and skill mix and will validate the outcomes from the national focus groups.

The anticipated overall outcomes of the research will provide for the establishment of evidence-based tools that will inform staffing and skills mix requirement in the Aged Care Industry.

Phase 1:

Establishment of resident complexity profiles with indicative interventions, timings and frequency of interventions over a 24 hour period with the expected outcomes of establishing 6-8 resident profile complexity groupings covering the vast majority of aged care residents have been developed by the research collaborative and verified by subject matter experts.

Status completed September 2015

Phase 2:

Establishment of expert aged care nursing focus groups to explore and validate the resident profiles and interventions. Six national focus groups facilitated by University of South Australia were held from November to December 2015 and reviewed in total 8 resident complexity profiles.

Status completed December 2015 with detailed analysis being undertaken by University of SA team scheduled to be completed by end March 2016

Phase 3:

A national missed care survey to gather information on problems related to incomplete or missed care was developed by Flinders University in partnership with University of South Australia and the ANMF. This survey was distributed nationally with more than 3000 respondents. The survey outputs and data is currently being analysed by the University partners and will further inform aged care resident requirements, adequacy of staffing and skill mix requirements.

Status survey closed January 2016 with detailed analysis being undertaken by Flinders University schedule to be completed by end March 2016.

Phase 4:

A Delphi study for testing and verification of results from the residential care profiles and staffing and skill mix and will validate the outcomes from the national focus groups. The Delphi process typically has three stages of repeated surveying of the expert group (eg aged care DONs) in order to arrive at an agreed/moderated outcome.

Status: Delphi study design (via survey) completed and ethics approval received February 2016. Survey distribution to commence April 2016.

Final report is due 30 June 2016.

B. FUTURE AGED CARE WORKFORCE REQUIREMENTS, INCLUDING THE IMPACTS OF SECTOR GROWTH, CHANGES IN HOW CARE IS DELIVERED, AND INCREASING COMPETITION FOR WORKERS

As a society Australians are living longer and generally remaining healthier. Technological and scientific advances are such that Australians now and into the future will be able to experience a good quality of life well beyond retirement age. The 2015 Intergenerational Report projects that within the next 40 years there will be approximately 40,000 people aged 100 and the number of people aged 65 and over will have doubled in Australia¹⁴. In accordance with the projected growth of Australia's aged population, demand for aged care and related services will continue to grow. The consequent increased health and personal care needs of individuals will require the preparation and provision of a sufficient and suitably qualified and skilled workforce.

The 2015 Aged Care Financing Authority (ACFA) report is the latest of many aged care reports to highlight that *the sustainability and quality of the sector relies on sufficient numbers of appropriately skilled staff, including nurses, personal care or community care workers*.¹⁵ While this refers to future workforce requirements, given the current inadequacy of the existing workforce in terms of sufficient numbers and skills, and the lack of any minimum requirement for staffing levels and skill mix, a great deal of work in preparing the workforce needs to be achieved.

Aged care, community and disability services will increasingly be required to meet more high-end complex needs particularly pertaining to the management of chronic illnesses and mental health issues. Support workers in these sectors will need to be educationally prepared and adequately supported by relevant health professionals and industry to meet growing complex care requirements.

In addition, the community care sector in Australia is undergoing a paradigm shift with the embedding of a demand driven model of service delivery in the disability and aged care service sector under the National Disability Insurance Scheme and Consumer Directed Care (CDC).

Where once these services were delivered in a block funding model spread across consumers, providers will now operate within individualised budgets. From 2017 these individualised budgets will be attached to the consumer rather than the provider. Substantially increased expenditure on aged care and disability support should see an increase from 72,000 to 100,000 Home Care Packages by 2017/18, with more than 40,000 additional packages expected to be available between 2017/18 to 2021/22.^{16, 17}

The significant impetus toward consumer-directed models of funding and care aims to drive improvements in efficiency and quality for consumers of services. These improvements are driven by giving consumers the power to choose their education provider and by promoting competition between education providers, existing and new.¹⁸ This direction is expected to grow.

The implementation of consumer-directed funding models and the emphasis on person-centred care and wellbeing is requiring service providers to develop new business models to continue to compete in the market and to remain viable, and indeed profitable (now a core goal for an increasing number of aged care providers). Additionally, as the ageing population presents increasingly complex care needs providers will need to restructure their services to be more responsive to consumers' needs.

The move to a more competitive environment is currently and will continue to drive organisations to find new ways of working in order to continue to be viable businesses. This trend will particularly affect smaller, less commercially experienced service providers who will need to gain skills in marketing, business analysis, financial modelling and use of new technologies in order to remain competitive.

14 Commonwealth of Australia Treasury, 2015, *Intergenerational Report: Australia in 2055*, Available online at: <http://www.treasury.gov.au/PublicationsAndMedia/Publications/2015/2015-Intergenerational-Report>

15 Aged Care Financing Authority (ACFA) 2015, *Third Report on the Funding and financing of the Aged Care Sector*, p. 15

16 Department of Social Services, <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform/home-care-packages>

17 Deloitte. How consumer driven care is reshaping the community care sector, <http://www2.deloitte.com/content/dam/Deloitte/au/Documents/life-sciences-health-care/deloitte-au-lshc-consumer-driven-care-reshaping-community-care-sector-180614.pdf>

18 Community Services & Health Industry Skills Council. 2015. *Environmental Scan: Building a healthy future: Skills, Planning and Enterprise*.

However, without the continued presence of a diverse range of providers, there is a risk that consumer choice may be reduced. If service provision were to be restricted to a few large providers, competition would decline, ultimately reducing the benefits offered by choice through a contestable market.

There may also be increasing tensions between profitability and ensuring the provision of quality care. There is conclusive evidence that providing the right skill mix of staff i.e. qualified nurses and nursing support staff, leads to better and more positive health outcomes for consumers and directly correlates to the quality of care they receive. However, as many providers are not currently willing to make the necessary investment in the workforce to ensure this level of quality, it is unclear how this will be managed in the future.^{19, 20}

The forecast changes in service demand and delivery and the impact on the size and skill mix of the workforce will inevitably result in competition for qualified and competent workers to meet the demand on providers. However, it remains imperative that these workers have the skills and knowledge to meet client needs and provide best practice quality care. Ensuring these workers are competent requires them to have attained nationally recognised training through the Vocational Education and Training (VET) system and to be guided and supervised by health professionals such as registered nurses.

To meet the future demand for quality care and service provision, consideration of potential barriers to workforce development must be addressed. Strategies to attract, recruit and retain skilled workers, including registered and enrolled nurses and AINs/PCWs, must include improvement in pay and work conditions and minimum mandated staffing levels.

C. THE INTERACTION OF AGED CARE WORKFORCE NEEDS WITH EMPLOYMENT BY THE BROADER COMMUNITY SERVICES SECTOR, INCLUDING WORKFORCE NEEDS IN DISABILITY, HEALTH AND OTHER AREAS, AND INCREASED EMPLOYMENT AS THE NATIONAL DISABILITY INSURANCE SCHEME ROLLS OUT

As stated above, the provision of safe and quality aged, disability and health care in Australia demands a sufficient and suitably skilled workforce. The size and skill mix of the workforce in these sectors requires dedicated workforce planning to ensure consumers receive quality care in a timely and efficient manner.²¹

However, the current crisis in the caring workforce, principally, ongoing workforce shortages in the sectors, is inhibiting Australia's ability to meet increasing demands for high quality child care and aged care workers. Similarly, the same workforce shortage is potentially limiting to the implementation of the National Disability Insurance Scheme.²²

It has been projected that 229,400 new jobs will be created in the Community services and Health industry between 2013 and 2018. These projections suggest particularly strong growth in VET-qualified occupations such as aged care and disability support workers or assistants in nursing (however titled). In the context of increased service and workforce demand, mechanisms for ensuring high quality service provision and a competent workforce will be paramount.

19 Sargent, L., Harley, B., & Allen, B. 2009. *Working in Aged Care 2009: Phase 2 of the ANF-University of Melbourne Study*. Faculty of Economics & Commerce. University of Melbourne.

20 Sargent, L., Harley, B., Allen, B. & Casler, C. 2010. *Working in Aged Care 2009: Phase 3 of the ANF-University of Melbourne Study*. Faculty of Economics & Commerce. University of Melbourne.

21 Australian Government Department of Employment, 2014a, *Australian Jobs 2014*, Available at: <https://www.employment.gov.au/australian-jobs-publication>

22 Harrington, M. & Jolly, R. 2016 The Crisis in the Caring Workforce. Parliament of Australia. Available at: http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook44p/CaringWorkforce Accessed 26.2.16

The introduction of the National Disability Insurance Scheme (NDIS), which is built on the principles of consumer directed care giving clients greater autonomy over services they access, will involve a substantial expansion of the disability services sector, leading to increased demand and competition for disability support workers²³. The direct interface between workers and consumers in the community service and health sectors is critical to the provision of quality care, prevention of illness and injury and to initiate early interventions.

However, there is an increasingly sizeable proportion of the health workforce being forced to work outside these comprehensive regulatory safeguards. Their roles, therefore, have the potential to place the health care and treatment of people in these systems at risk.

Care workers are being increasingly employed across a wide range of health and aged care settings in Australia under a plethora of titles. Limited numbers are employed in acute clinical care settings – in hospitals, day procedure centres and in primary care centres in some Australian jurisdictions. They also work in the slow stream rehabilitation sector of the acute and sub-acute health care system. However, care workers predominantly

work in the residential aged care sector and residential disability sectors but are increasingly working in the community and in home care, where they are often privately contracted by individuals.

While accountable for their own actions, in the majority of settings it is the registered nurse who is always accountable for all delegated functions to these workers under a National Law. It is the long held position of the ANMF that the educational preparation of assistants in nursing/personal care workers should be competency based, recognise prior learning experience, be conducted in the Vocational Education and Training (VET) sector at a level appropriate to facilitate articulation and credit transfer to other nursing programs.²⁴

As competition for suitable workers is set to increase across these sectors, barriers to the recruitment and retention of the assistant workforce, including relatively low levels of pay, the prevalence of short shifts and casual employment for some roles, lack of professional supervision and support, poor staffing and skills mix and lack of incentives for career development, must be addressed.

D. CHALLENGES IN ATTRACTING AND RETAINING AGED CARE WORKERS

Attraction and retention problems in the aged care sector are not new. The challenges are well understood across the industry:

- low wages and poor conditions;
- inadequate staffing levels and workload issues;
- unreasonable professional and legal responsibilities;
- lack of career opportunities;
- stressful work environments;
- poor management practices; and,
- a poor perception of aged care in general.²⁵

Despite this understanding, the failure to address these factors persists. There is simply a lack of will by governments and industry to address these matters seriously.

For more than a decade, a number of health and aged care workforce reports have examined the nursing workforce and various components of the workforce in aged care. While there are variations in the projected supply and demand,²⁶ they all point to a shortage of nurses and direct care workers and show that this shortage is becoming more marked.

The reports, for example successive Productivity Commission reports, have indicated that this shortage is across all states and territories and is most acute in the aged care sector.²⁷

The 2012 Aged Care Workforce report indicates 76% of facilities reported a skill shortage of workers in at least one direct care occupation with 62% of all facilities reporting an RN shortage, 49% reporting an AIN/PCW shortage and 33.2% reporting an EN shortage.²⁸

23 Harrington, M. & Jolly, R. 2016 The Crisis in the Caring Workforce. Parliament of Australia. Available at: http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BriefingBook44p/CaringWorkforce Accessed 26.2.16

24 ANMF Position Statement: *Assistants in nursing providing aspects of nursing care*; Reviewed and re-endorsed Nov 2004, Dec 2007, June 2011, May 2015.

25 CEPAR, *Aged care in Australia Part II – Industry and practice*, CEPAR research brief 2014/02.

26 SCRGSP (Steering Committee for the review of Government Service Provision) 2016, *Report on Government Services*, Productivity Commission, Canberra.

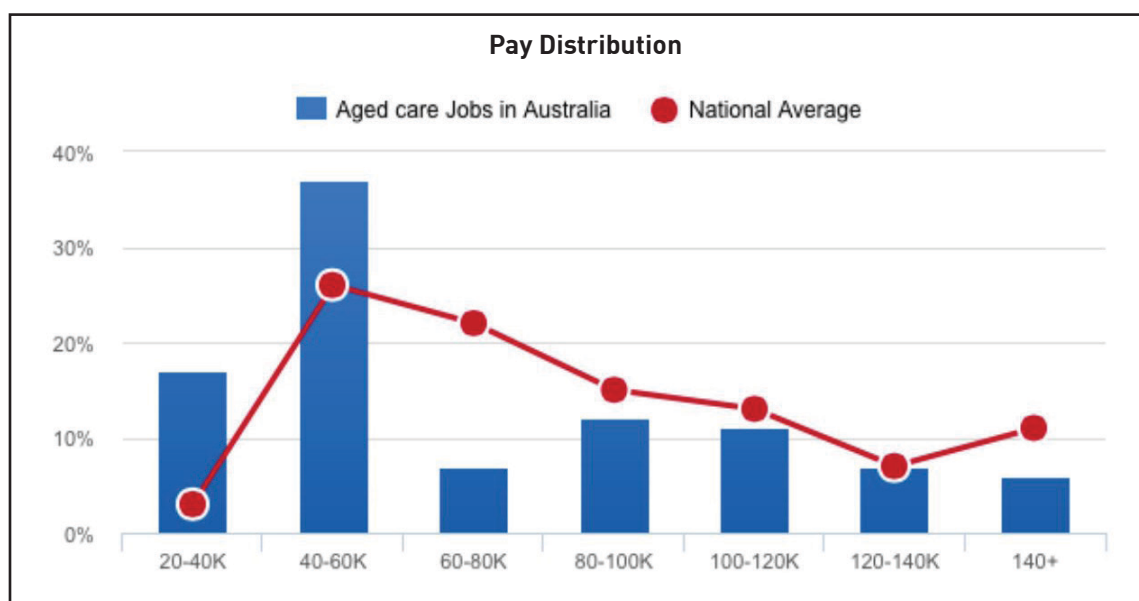
27 Productivity Commission 2008, *Trends in aged care services: some implications*, Commission Research Paper, Canberra; Productivity Commission 2011, *Caring for Older Australians*, Report No. 53, Final Inquiry Report, Canberra

28 Martin B and King D et al, op.cit. p.57

In February 2016, Business Insider, Australia reported on the significant, and anticipated ongoing, jobs growth in the health and care assistance sector in the last year. The report suggested some of that growth is because low wages are facilitating more employment opportunities and job openings. But the jobs are not being filled. Despite creation of these opportunities *there is still four times the number of aged care jobs than there are aged care job seekers.*²⁹

The report highlighted *an important point of tension between the growth in available jobs and the desires of the potential workforce.*³⁰ The majority of jobs being created are demanding and physical jobs but are very poorly paid. The report also highlighted an increase in the average salary across aged care workers. However, because this average includes all jobs in the industry from trainees to regional and operations managers the trend is *heavily skewed by the number of managerial roles offering a salary between \$80,000 and \$220,000.*³¹

The graph below, from the Business Insider report, illustrates the pay disparities both within the aged care sector and compared to national averages.



On seeing the disproportionate number of poorly paid jobs in aged care, it is little wonder that employers experience such difficulty in recruiting suitable workers.

ANMF members who work or have worked in the sector put it more succinctly than most:

I looked at branching into aged care several years ago. I couldn't live on the pay. At the time it was about \$8 an hour less than mainstream, twice as stressful and bloody hard work. And they wonder why they can't get staff. 300 residents and 3 RNs on dayshift, 2 on evening shift and 1 on night shift.

Actually the money is lousy and the job people working in aged care do is poorly acknowledged. Once the industry was privatised it all became about money and the profit margin. Such a crime for the people who went to war, survived the depression and worked so hard for our country.

These and other matters are examined in further detail in the section to follow.

The pay for the majority of aged workers, both skilled and semi-skilled, simply does not reflect the nature of the work and the level of responsibility required nor does it value the importance of providing the best care possible to Australia's frail elderly. ANMF members are increasingly distressed by what they regard as a lack of respect for the elderly by aged care employers who, in their view, could and should be doing a much better job:

²⁹ Business Insider, Australia, February 2016, *There's a boom under way in aged care jobs but all the wages are being sucked up by managers*, Available online at: <http://www.businessinsider.com.au/this-data-suggests-all-the-wage-rises-in-australias-crucial-health-sector-are-being-sucked-up-by-managers-2016-2>

³⁰ Ibid

³¹ Ibid

E. FACTORS IMPACTING AGED CARE WORKERS, INCLUDING REMUNERATION, WORKING ENVIRONMENT, STAFFING RATIOS, EDUCATION AND TRAINING, SKILLS DEVELOPMENT AND CAREER PATHS;

Undervaluing aged care and aged care workers

Work performed by employees in the health and community services sector in general, including aged care, continues to be undervalued and underpaid. In aged care in particular, nurses and carers experience the double disadvantage of working in an undervalued and underpaid occupation in a sector that is not adequately resourced or recognised.

The issue was singled out in a Parliamentary report, *Making it Fair*, which notes the amount of evidence presented on the situation of women employed in the aged care sector. The Committee's chair highlights this point and states:

Whilst the recommendations of this report do not specifically address this industry it is clear that action needs to be taken to improve wages and conditions. ...I am aware of the dependence on the Australian government for the funding of this sector. I urge the responsible Ministers (including the Minister for Finance) to look at how we can responsibly increase the funding for wages in this sector.³²

Despite several government initiatives to improve wages in the aged care sector (detailed later in this submission), it is widely acknowledged that this remains unaddressed. An analysis of the sector by the Centre of Excellence in Population Ageing Research suggests that future subsidy reviews should include wage costs with appropriate remuneration in mind, and commenting further on the situation states:

How long can the sector continue to rely on non-monetary motivations to recruit and retain workers when younger, increasingly educated women have more remunerative options elsewhere? Indeed, pay is low in aged care largely because it relies heavily on female employees, who face an unremitting gender pay gap – in itself the subject of policy attention.³³

Industrial Factors

Enterprise bargaining in residential aged care

Effective bargaining has been difficult in this fragmented and segmented sector with such a large number of facilities spread across the nation.³⁴

While enterprise agreement coverage for RNs, ENs and AINs/PCWs employed in residential care has now reached a high level, (753 enterprise agreements covering 90% of facilities), bargaining outcomes can best be described as patchy and wages and conditions continue to remain well below that of nurses and carers in other significant areas of employment such as public and private acute care.

The average hourly rates of pay nationally for selected classifications are shown in Table below. The average wage rates are based on a comprehensive mapping of enterprise agreements to residential aged care facilities covered by non-public sector agreements.

National averages - hourly rates of pay – Feb 2016

AIN/PCW top	AIN/PCW Cert 3 qual top	EN top	RN Level 1 top increment
\$21.35	\$22.14	\$26.35	\$35.11

Nationally, the difference between the average base rate of pay for a full time Registered Nurse level 1 at the top of the level 1 structure in the public sector and in residential aged care is 15% or \$200.00 per week calculated on the base rate. Similarly, for an AIN/PCW with a certificate 3 qualification, the difference is currently 14%.

The inferior enterprise bargaining outcomes for nurses and carers employed in the aged care sector not only result in significant wage disparity but also paucity in other conditions of employment including allowances, leave and other entitlements, such as professional development leave.

³² Xiii House of Representatives Standing Committee on Employment and Workplace Relations, "Making it Fair" Pay Equity and associated issues related to increasing female participation in the workforce, November 2009 Canberra

³³ CEPAR, *Aged care in Australia Part II – Industry and practice*, CEPAR research brief 2014/02, p.13

³⁴ Refers to non-public sector facilities.

As in the acute health sector, aged care is a 24 hour/7 days a week operation where shift allowances and penalty rates make up a substantial part of an employee's income. However, the growing disparity in entitlements in this area compounds the inequity in remuneration overall and the consequent attraction and retention problems in the aged care sector.

The lack of appropriate provision for other entitlements such as clauses covering staffing and workload management, professional development leave, occupation health and safety and opportunities for career advancement increases the disparity and inequities between the aged care and other sectors of employment for nurses.

Community and home care

The challenges facing the community aged care workforce are similar in many respects to those identified in residential aged care including low wages and poor conditions of employment; inadequate staffing levels and skill mix; high workloads; unreasonable professional and legal responsibilities; stressful work environments; poor management practices and a poor perception of the work in general.

Further to this list, we can add issues specific to the delivery of care in a home environment.

The industrial landscape in this sector is far more fragmented with a lower level of enterprise agreements overall than in residential aged care covering direct care workers. Where home care programs are run from residential aged care facilities, enterprise agreements generally cover both the residential and home care services.

While there is a growing number of enterprise agreements in this sector, many employees are reliant on awards, primarily federal awards such as the Nurses Award 2010 and the Social, Community, Home Care and Disability Services Industry Award 2010. Some employees may also be covered by a state award in situations where the service is run by an organisation outside the federal system, for example, local government in NSW.

In the community, nurses and care workers generally work alone and are required to provide care for a short period of time in the client's home, travelling between a specific number of clients over the course of the working day. There are additional occupational health and safety issues and little control over managing or reducing the risks in their workplace.

Employees in the home and community care sector also face particular challenges relating to hours of work and the way work is organised. For example, employees may be engaged for very short time periods, i.e. 1 or 2 hours at a time; in rural areas, travel between clients entails long periods of driving; there may be long gaps between clients and last minute cancellations.

Ensuring employees are treated fairly in these circumstances continues to be a challenge with some employers refusing to pay basic entitlements such as travel time between clients and not paying the correct travel allowance.

The role of Federal awards

While enterprise agreements are the predominant form of industrial regulation covering nurses and care workers in residential aged care, the relevant federal awards, (the Nurses Award 2010 and the Aged Care Award 2010), together with the National Employment Standards, provide a minimum safety net of wages and conditions of employment for nurses and AINs/ PCWs.

In the home and community care sector, wages and conditions are more likely to be determined by the relevant award.

Modern awards also play an important role in agreement making, providing the basis of the "better off overall test" under the *Fair Work Act 2009*. This requires employees covered by an agreement to be better off overall than they would under the relevant modern award. Awards are therefore important in providing a safety net for negotiating enterprise agreements.

Despite the notional obligation on industrial tribunals to establish and maintain a safety net of fair minimum wages and conditions of employment, for nurses, AINs and personal care workers, award entitlements have been in decline over the past two decades.

The most recent process of award modernisation involved the reviewing and rationalising of more than 1500 awards into 122 industry or occupational awards.

For nurses and nursing employers it meant approximately 50 federal awards and 80 state awards were merged into a single occupational award covering all national system employers of registered nurses, enrolled nurses and assistants in nursing, however titled, except primary and secondary schools.

This process meant a reduction in wages and conditions for many employees in the aged care sector, particularly those previously covered by state awards where wages had been subject to work value increases and conditions periodically adjusted to reflect changes in community standards.

The second modern award review, (the four-yearly review) commenced in 2014 and continues into 2016. Some parts of the aged care sector are seeking further reductions in entitlements and have made applications to the Fair Work Commission to vary awards to provide greater flexibility for employers in setting and changing part time employees hours and days of work as well as altering total daily and weekly hours of work.

In both residential and community care, an extremely high percentage of the direct care workforce is part time or casual, (90.5% in residential and 89.4% in home care).

For many part time and casual workers, uncertainty about the number of hours of work and actual days of work is already a reality, resulting in insecure employment, under-employment and a lack of financial security.

Working hours together with low rates of pay, are key factors impacting on recruitment and retention in the aged care sector. The issue is not only the hours of work but related matters such as minimum engagement, broken shifts and rostering arrangements that apply to those hours.

A major concern is that the changes being proposed to the relevant awards by some employers in the aged care sector will further reduce protections in this area. This will ultimately make employment no longer viable exacerbating recruitment and retention problems.

Government initiatives to close the wages gap

Aged care providers argue that they are not adequately funded to provide wage parity for nurses. This is despite several large injections of Government funds into aged care specifically earmarked to address the wages gap issue, leaving the issue unresolved.

In the 2002/2003 federal budget, \$211.1m was provided over 4 years to 'close the wages gap'. Despite \$110m being dispersed over the next two years the wages gap doubled. In the 2004/2005 Federal Budget, \$877.8m (over 4 years) was again allocated to assist aged care providers to 'pay competitive wages'. Receipt of the funds was provisional on a number of conditions, however none of these required aged care providers to direct the extra funding towards paying higher wages, therefore not one of those conditions closed the wages gap. In 2010 the Australian Government allocated a \$132 million aged care sector workforce package, but again none of the money provided was used to address and close the wages gap.

In 2013, The *Living Longer Living Better* (LLLb) aged care reforms initiated by the Labor government provided up to 1.1 billion dollars to the residential and home care sector to address workforce pressures through two programs: an Aged Care Workforce Supplement and an Aged Care Workforce Development Plan and was targeted at assisting providers build the capacity of the workforce by increasing wages, improving conditions, and providing better training and career opportunities. The workforce supplement, specifically, was a measure designed to assist the sector to attract and retain skilled staff and was funded to enable employers to offer more competitive wages.

This initiative had barely begun before the newly elected Coalition government scrapped the entire program in 2013, and instead provided additional one off funding to aged care providers in the 2014 -2015 budget equivalent to 2.4% of ACFI with 'no strings attached'. This money has not resulted in closing the wages gap.

Wages and conditions must improve to attract nurses into the sector. More fundamentally, since there is an evidence base to show that more nurses in the skills mix lead to better health outcomes, the intensity of nursing care requirement should be linked to the ACFI scale. This may assist in achieving adequate provisioning for wages.

A mechanism, which ensures the aged care sector achieves and maintains wage parity with the acute care sector must be developed. Such a mechanism must respond to changes in wage rates and accommodate an effective indexation system that provides employers with adequate funds when wage rises are negotiated. It must also incorporate a transparent and accountable process/framework.

Recommendation 2

That the Australian Government close the wages gap between working in aged care and their public hospital for nurses and assistants in nursing/personal care workers.

Recommendation 3

That dedicated funding is made available by the Australian Government to close the wages gap, and that provision of the funding is conditional on the achievement and maintenance of wage parity.

Despite being a complex and specialised area, aged care continues to be regarded as something of a 'poor cousin' within the broader context of the health system in which the majority of nurses traditionally work. This is not just because of the poor wages and working conditions as outlined extensively above, but also, and just as critically, because of the significant professional difficulties encountered by nurses and, increasingly, AINs/PCWs working in the sector.

In all areas of practice registered nurses and enrolled nurses work within a national regulatory framework governed by the Nursing and Midwifery Board of Australia (NMBA) under a National Law. The NMBA registers nurses and student nurses and develops standards of practice, codes and guidelines which form the regulatory framework that the nursing profession must adhere to and work within. The NMBA also manages complaints processes, conducts investigations as required and disciplinary hearings when necessary. In order to gain registration with the NMBA nurses must meet mandated minimum education standards, which have been formally accredited.

The key purpose of the NMBA's regulatory framework is to protect the safety of the public by ensuring nurses meet their professional requirements and maintain their competence to practise.

The framework clearly identifies that registered nurses are responsible and accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care. The registered nurse is required to complete a comprehensive assessment of the person receiving the care and identify if the nurse or non-nurse being delegated the care is competent and safe to do so. Registered nurses are also then required to provide adequate supervision.

The current environment in aged care is such that nurses, particularly registered nurses, frequently feel compromised in their efforts to meet their professional and legal obligations as set out by the NMBA. The environment is frequently incongruent with nurses' regulatory requirements and registered nurses are understandably deeply frustrated. (For full detail on this issue refer to Appendix B)

Inadequate staffing levels and workloads compounded by unreasonable (and even potentially unlawful) requests from employers to direct care staff to undertake tasks for which they may not possess the skills, leave many nurses feeling vulnerable and at risk of personal regulatory consequences.

I am still unable to leave my section in the morning between 6-7am as there is no staff member to supervise the section, if I ask for help from another staff member then that staff member will be leaving their section unattended and they also will not be able to complete their round compromising resident care.

I am unable to safely complete my clinical responsibilities to residents. One section upstairs is not safe for only one staff member to work there, the residents are highly confused/delirious and are at high risk for falls. Wanderers, aggressive and physically abusive towards staff and other residents, they are mostly needing two staff to assist with care, and there is only one staff member to look after them all.

It is physically not possible to provide safe care and it is not safe for staff to be working alone and dealing with aggressive and physically abusive residents on their own, [one] PCW had her arm fractured by a confused aggressive resident. We need another PCW overnight and that will also leave another PCW downstairs to monitor the section while the registered nurse attends to clinical duties.

I am not comfortable with compromising resident care or being placed in a position where I have to prioritise importance of care. If I went through the falls records and the residents' aggressive and physically abusive incidents towards staff and other residents you will be able to determine that the residents are very high care, and therefore requiring extra staff overnight. You will also notice that the number of incidents both falls and aggression and physical aggression are incredibly high. I am concerned about resident safety, should we have to evacuate the home in the advent of a fire, or other emergency.
(ANMF members)

The ANMF strongly supports the concepts of person centred and consumer directed care. These concepts have been central to the nursing profession since its inception. People should be able to choose the care they want in place and should control how their care is delivered. This leads to quality care. The ANMF also considers that quality care leads to quality positions and employment and job satisfaction.

However, to ensure that people receive quality care, whichever model of care they choose and prefer, minimum standards must be in place. As outlined above, nurses are regulated health professionals and have clear minimum standards in place. However, care workers currently do not have effective regulatory requirements. They are not required to work in accordance with any professional standards and they do not have an effective process for managing complaints. Care workers do not have a minimum education requirement to work in the sector, do not have to maintain regular professional development or need to have professional indemnity insurance.

As there is no national registering or licensing system in place for care workers, consumers, families or employers cannot check to ensure the care worker is appropriate to be looking after them or loved one. This is compounded by the fact that many care workers are working independently, such as in the home environment. Currently, if a care worker is found to be unsafe in the care they provide and is dismissed from their employment, they can move onto another employer with a minimal checking process occurring or, on many occasions, without any process at all.

This currently presents a significant and very real risk of harm to the public. Several incidents, detrimental to the aged care resident, have already occurred due to poor and inadequate staffing levels and skills.

We need mandatory staffing to resident ratios. In aged care the powers that be can only make recommendations that facilities do not have to implement, I know of 1 aged care provider that if the care staff only had to do personal care, meals etc. then they would have brilliant ratios. However, the care staff also cook the meals, do the cleaning & the medications as well as notes, care plans & all the other things that come up throughout the shift that may need different reports done. They also implement resident lifestyle activities. When all is said & done they are yet again understaffed & until mandatory ratios are brought in staff will remain over worked & under paid & residents will be at risk.

(ANMF member)

The vulnerability of the people who are cared for in the aged care system and the inherent potential for harm in delivering their care demand appropriate regulation. A comprehensive regulatory framework to manage this risk for most groups of health workers, especially those responsible for direct care and treatment, must be developed and implemented.

In order to implement regulation of care workers, minimum standards of education and qualification must be agreed. The ANMF considers that minimum standards of qualification of AINs/PCWs should be linked to the Australian Qualifications Framework and include a requirement for a recognised level of training to at least Certificate III level.

Recommendation 4

All assistants in nursing/personal care workers (however titled) must be licensed and subject to regulation.

Recommendation 5

All assistants in nursing/personal care workers (however titled) must be required to meet a minimum standard of qualification.

The need for registered nurses

A growing body of national and international research and evidence clearly demonstrates that inadequate levels of qualified nursing staff leads to an increase in negative outcomes for those in their care, which results in increased costs. In the acute setting, the implementation of safe mandated minimum staffing has been shown to prevent adverse incidents and outcomes, reduce mortality and prevent readmissions thereby cutting health care costs.³⁵ It is widely agreed that the same improvements could be achieved in the aged care sector.

However, rather than look to the benefits of better utilisation of qualified nurses, there is increasing discussion in the aged care sector about educational requirements for care workers, particularly around expansion of their roles and potential increases to the scope of activities they currently perform. Many of these proposed activities sit well within the existing practice of enrolled nurses and registered nurses. Not only would it be wasteful and unnecessary to attempt to expand the activities of care workers when suitable other workers already exist, it would be profoundly unsafe.

Unfortunately, despite care needs of the elderly increasing across a range of settings and environments, the Aged Care Act 1997 does not provide any distinction between high and low care. And, therefore as was discussed earlier, there is no meaningful requirement for appropriately skilled and qualified workers.

The ANMF is opposed to the replacement of registered nurses and enrolled nurses with AINs/PCWs where the work requires the skills and knowledge of either a registered nurse or an enrolled nurse.

AINs/PCWs generally are educated and able to provide a basic range of personal services and some are competent to be delegated other aspects of nursing care by registered nurses. However, AINs/PCWs are not able to always recognise serious problems including changes in the health status of an increasingly frail and vulnerable cohort of residents. These elderly people often live with multiple chronic conditions and who are at high risk of injury and side effects of complex medication and health treatment regimes on top of old age and in some instances acute on chronic health issues. In addition the ANMF estimates that approximately 30% of AINs/PCWs do not have formal aged care qualifications.

The reduction in the number of nurses and the subsequent changes to skill mix is leading to a lower level of safety and quality of care and putting these vulnerable residents at risk. The aged care accreditation data on failed standards reveals this reduction in the numbers of nurses has led to a decline in quality of care with residents exposed to serious risk from neglect, poor infection control, malnutrition and dehydration, and assault.

Care workers do a fantastic job in aged care but their workload is huge, they don't have enough time now to be able to care for our elderly population in the standard that is expected! They are already struggling for time to be able to meet the demands on them. By making them responsible for medication administration, the ability for them to care for the activities of daily living and especially personal hygiene will be overlooked. The constant cut of resources in aged care is appalling, these people helped build this country and they deserve to be treated with respect. Not to be subjected to substandard care by management trying to cut costs!! Nurses are educated in the ability to assess the changes in health status and to be able to implement strategies to ensure the best outcome for the patient, taking them away and placing the burden on untrained care staff is disrespectful to the industry and the people we have chosen to care for!

(ANMF member)

It is therefore critical there are minimum staffing levels in all aged care facilities, with 24 hour registered nurse coverage wherever there is one or more high care residents. It is also critical that national benchmarks of care are developed that are directly linked to relevant skill mix of staff required to deliver appropriate care.

³⁵ Detailed analysis of the cost benefits of nurse to patient ratios can be found at: <http://www.nswnma.asn.au/wp-content/uploads/2013/07/Benefit-of-more-nurses-booklet.pdf>

As a civilised society it is our absolute responsibility to care for the aged. Sadly most staffing models in residential care facilities do not allow for the staff to provide the level of care these vulnerable people require. Shame on all who think that one staff member can provide appropriate care to 12 residents. Care of the aged requires expert nursing knowledge and skills. The staff who work in residential care need to be commended for their commitment. More RNs are needed to support other staff with education, maintaining standards and delivery of care. It's time we started treating our aged and aged care workers with more respect. Say Yes to more RNs and staff. (ANMF member)

Recommendation 6

That there is a mandated/legislated requirement for 24 hour registered nurse cover for all high care residents in aged care facilities, inclusive of those low care facilities with residents assessed with high care needs.

Nurse Practitioners

The ANMF strongly supports the role of the nurse practitioner in aged care. The role is an important development that should continue to be expanded as a key element in the provision of aged care across metropolitan, rural and remote settings. Aged Care Nurse Practitioners work autonomously, provide professional leadership, use their expert clinical knowledge, extensive experience and advanced clinical skills, to ensure that comprehensive assessment is made of care needs, that this care is evidence-based, and is responsive to the individual older person requiring the care, their family/friends, and the community.

In aged care settings, nurse practitioners have an important role in providing support and direction to registered nurses and enrolled nurses in the complex care needs and chronic disease management of residents such as diabetes, respiratory conditions, urinary conditions, and cardiac disease. More importantly they provide timely intervention to prevent unnecessary admission to tertiary health care facilities.

Investing in increasing the nurse practitioner workforce and enabling innovation in models of care, is key to meeting the projected demand arising from the substantially increased proportion of complex care for older people in both residential aged care and home care. In addition, the nurse practitioner workforce has the potential to deliver significant cost savings. See case study below:

An example of savings achieved by an aged care NP working in a major Australian city:

The NP is employed full time Monday to Friday, with an aged care provider across 4 sites with 750 beds. The NP contributes to a specific program called RUTH (Reducing unplanned transfers to hospital).

In a 12 month period, 2014 -15, the NP has provided direct care that has prevented 55 hospital transfers. This does not include all of the situations where hospital transfer was indirectly prevented due to prophylaxis or advanced care planning, just the situations where at the point of crisis hospital transfer was called for and avoided.

In order to understand the cost benefit of the NP role in hospital avoidance several calculations must be made, including the costs of ambulance transfer, ED visit, investigations, pathology tests and the cost of a hospital bed.

Using conservative estimates of these costs averaged across the population of 55 aged care residents, and assuming that a transfer to hospital without admission would cost approximately \$2,000 and a transfer with admission (assuming the average length of stay for this population of 11 days) would cost approximately an extra \$6,000, savings can be calculated.

Based on the assumption that half the residents prevented from being transferred to hospital would have been admitted, that is 27 occasions of transfer and admission at \$8,000, the cost savings equate to \$216,000. Assuming the remaining 28 occasions of transfer required non-admitted care in ED at \$2,000 per occasion, the cost savings equate to \$56,000 leading to a total of \$272,000 in savings. The NP's wage is approximately \$110,000 per annum with an additional earnings of \$30,000 in the same 12 month period from billable items under Medicare. Using these gross calculations the net savings equate to \$132,000.

These are the savings created by one NP related to the 55 residents discussed. This does not take account of all the other activities performed by this NP in the normal course of her work.³⁶

Directors of Nursing

In addition to 24 hour registered nurse coverage and much greater utilisation of nurse practitioners, it is critical that all aged care facilities employing nurses employ a full time director of nursing, or classification equivalent, in the role of the person responsible for the overall care of the residents of the residential aged care facility. The person appointed to this role, however titled, must be a registered nurse.

³⁶ Detailed analysis of the economic value of nurse practitioners in Australia can be found at: https://acnp.org.au/sites/default/files/docs/final_report_value_of_community_nps_1.pdf

F. THE ROLE AND REGULATION OF REGISTERED TRAINING ORGANISATIONS, INCLUDING WORK PLACEMENTS, AND THE QUALITY AND CONSISTENCY OF QUALIFICATIONS AWARDED;

The role of registered training organisations (RTOs) including TAFE institutes is to educate and train aged care, disability and community workers, as well as enrolled nurses, to the minimum agreed standard and to equip workers with knowledge and skills required to work effectively in the sectors. Regulation by governments must provide the mechanism to ensure that this occurs. However, the ANMF is aware that this is not currently occurring amongst all training providers nationally.

The ANMF receives consistent reports from stakeholders concerned with the quality and variability of the skills and knowledge of RTO graduates, particularly in regard to the educational preparation of aged care and community care workers. National qualifications in aged and community care have been reported to vary in delivery time from six weeks to twelve months, with some education providers omitting provision of workplace training and assessment for their student cohorts. Those reports indicate that graduates do not hold the required skills and knowledge to meet the care needs of clients.

Over the past three years the ANMF has worked closely with the Community Services and Health Industry Skills Council (CS&HISC) and industry stakeholders to align the Community Services and Health Training Packages to the 2012 Standards for Training Packages and industry requirements. The ANMF participated as members of the CS&HISC Training Package Advisory Committee (TPAC) and on relevant Industry Reference Groups (IRG's) and Special Matter Expert Groups (SMEG's) in the review of qualifications and Units of Competency (UoC) related to areas of nursing work. Specifically, work has been undertaken in the areas of Direct Client Care being inclusive of Aged Care, Community Care and the Disability sector; Enrolled Nursing; Health Services Assistant; Mental Health; Dental Health; and Technicians and Support Services.

The aim of this extensive review was to update existing content to ensure both training packages supported the delivery of industry relevant, high-quality training. Extensive consultation took place with industry including direct feedback, analysis of industry relevant data and research, and identification of priority areas for development.

In addition, to ensure compliance with the new standards and Australian Qualifications Framework (AQF) requirements, including processes and structure, the review process focused on addressing the following industry identified areas of concern:

- Clear definition of job roles the qualifications must reflect
- Updating of content to address identified skills gaps
- The promotion of workforce mobility within and between the relevant sectors
- Ensuring and supporting best practice in assessment
- The minimisation of duplication and inconsistencies between relevant qualifications
- The creation of new roles and changes to existing roles in the face of emerging new models of service delivery
- Inclusion of training and assessment content and strategies to ensure graduates are competent to deliver person-centred care and support
- Updating of content to address the shift from 'illness' to 'wellness' models of care

The review yielded several significant outcomes, including the removal of duplication, consolidation and rationalisation of training package content resulting in approximately 26% reduction in the number of qualifications and a 32% reduction in the number of UoCs across both training packages, making these training packages easier to use. Selected qualifications, including those where direct client care is provided, now specify a minimum number of work placement hours for demonstration and assessment of required competencies. This new requirement is supported by the national regulator for the VET sector, the Australian Skills Quality Authority (ASQA).

Supported work placement based learning and assessment is crucial to the acquisition of the required skills and knowledge to prepare workers for their employment. Unfortunately VET placements have continued to be unfunded and difficult to source. Quality work placements and assessments by qualified assessors can only be achieved if supported by financial incentives which allow for provision of an appropriately trained and skilled workforce to respond to clients' needs and the increased demand for services.

ASQA's role is to ensure that RTOs which deliver nationally recognised qualifications meet the requirements of industry developed training packages so that VET graduates have the required skills and competencies for employment. It is envisaged that the revised Community Services and Health training packages, including new assessment requirements, will assist ASQA in recognising providers who are poor performers and distinguishing them from those who consistently demonstrate the delivery of high-quality training outcomes.

The ANMF considers the best option for improving quality at this time is the greater role for the Skills Service Organisations and Industry Reference Committees

(replacing ISCs) in the development of companion manuals relating to assessment of training packages. If these manuals are sufficiently robust they provide quality auditors/surveyors with the tools needed to identify deficiencies in RTO assessment strategies and assist in ensuring good outcomes from training.

Increasing the quality of outcomes of VET qualifications, increasing access to these qualifications, and improving the capacity of the VET workforce must be enabled through focused government financial support. This will ensure the VET sector is better placed to deliver on responding to the changing needs of the health and community care sectors.

G. GOVERNMENT POLICIES AT THE STATE, TERRITORY AND COMMONWEALTH LEVEL WHICH HAVE A SIGNIFICANT IMPACT ON THE AGED CARE WORKFORCE;

Policy and Legislative Components Impacting Aged Care Workforce:

- Terminology - Use of terminology within the 'Act' which is open to multiple interpretations (adequate staff; appropriately skilled)
- Resident Classification - Removal of High/Low distinction has resulted in the promulgation of cheaper Low Care models of care into facilities that predominantly have high complex residents. ('med competent' carers administering medications to all residents and not just those residents assessed as self-administering)
- Legislation/Regulations relating to medication management – despite recommendations of the Health Workforce Australia National Aged Care Medications Report 2011, there have been no development or implementation of national medication legislation specifically for Aged Care. The pathway to enforce compliance with regulations and standards is extremely convoluted and may involve the individual health professional being held to account, but not the provider organisation.
- Professional and Industry Guidelines – providers are not abiding by guidelines professional or otherwise and the outcomes of their failure to do so are also not measured and publicly reported.

Federal / Commonwealth legislation and policies

Commonwealth subsidised aged care is governed by the Aged Care Act, the Aged Care (Transitional Provisions) Act 1997, the Aged Care (Accommodation Payment Security) Act 2006, and the Aged Care (Accommodation Payment Security) Levy Act 2006. This legislation is administered by Department of Health. These 'Acts' are supported by a number of legislative instruments made under the Aged Care Act and the Transitional Provisions Act. In addition the Australian Aged Care Quality Agency Act 2013 sets out the functions of the Australian Aged Care Quality Agency.

The legislation allows the Commonwealth Government to:

- give financial support to aged care providers through the payment of subsidies and grants for the provision of aged care,
- stipulate the approvals and decisions that must be made before the Commonwealth can pay subsidies to providers,
- regulate the fees and payments Commonwealth subsidised providers of aged care can charge, and
- specify the responsibilities providers of Commonwealth subsidised aged care have to care recipients.

Clauses within the Act Care Act 1997 that influence and could impact the composition of the workforce are:

Act or related document	Impacts/Issues/Risks
Aged Care Act 1997 https://www.comlaw.gov.au/Series/C2004A05206 Part 2.4—Classification of care recipients	Classification of residents is an issue in Aged Care. This part of the Act that was adjusted to remove the high / low distinction in the 2014 Aged Care Reforms. The removal of this distinction has had a significant impact upon the delineation of medication competent carers assisting with medications for low care self-administering residents to medication competent carers administering medication to all residents. (In contravention of professional guidelines) Classification of residents is an area that needs to be addressed to reflect the changed resident acuity profile and reduced length of stay. For example a funding model needs to be developed for residents who are short stay palliative/ terminal. Examples of residents who are admitted and die before the lodgement of ACFI assessment. Ensuring providers are funded may assist in the providers employing sufficient skilled staff to manage palliative residents.
Part 4.1—Quality of care - Division 54—Quality of care 54-1 Responsibilities of approved providers The responsibilities of an approved provider in relation to the quality of the *aged care that the approved provider provides are as follows: (a) to provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question; (b) to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met; (c) to provide care and services of a quality that is consistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles for the purposes of paragraph 56-1(m), 56-2(k) or 56-3(l); (d) if the care is provided through a residential care service—to comply with the Accreditation Standards made under section 54-2; Note: The Quality of Care Principles are made by the Minister under section 96-1.	This section of the 'act' pertains to the skill mix requirements. The wording is obtuse. Terminology such as adequate and appropriately skilled is open to misuse or variable interpretation of meaning.

The Quality of Care Principles 2014 https://www.comlaw.gov.au/Details/F2014L00830 • specify the care and services that an approved provider of residential care is to provide; • set out the Accreditation Standards that must be met by a residential care service to achieve accreditation; • Are prescriptive about nursing services in particular the areas that relate to complex care.	Following the review of specified care and services, and the removal of the high/low care distinction, changes were made to the quality principles under the guise of modernising and consolidating content. One of the aims was to reflect modern quality of care and nursing practices. In particular, Part 3 of Schedule 1 updates nursing services to include evaluation of care for residents, carried out by a registered or enrolled nurse acting within their scope of practice. Initial assessment and care planning are carried out by a NP or RN and ongoing management and evaluation by NP, RN or EN acting within their scope of practice. There is no mention of the NMBA decision making framework or professional standards and guidelines. This sets up an argument about scope of practice and who determines it. Providers are implementing models of care which are inconsistent with the NMBA delegation framework. In many instances they are not delegating willingly.
54-2 Accreditation Standards – whilst referred to separately in the 'act' are a derivative of the Quality of Care Principles - The Quality of Care Principles Accreditation Standards are standards for quality of care and quality of life for the provision of residential care. There are four Standards: Standard one: Management systems, staffing and organisational development Standard two: Health and personal care Standard three: Care recipient lifestyle Standard four: Physical environment and safe systems Each Standard consists of a principle and a number of expected outcomes. Standard one also has an 'intention' which indicates it acts as the umbrella for the other three Standards. There are 44 expected outcomes across the four Standards. Aged care facilities must comply with all 44 expected outcomes at all times.	Monitoring of the outcomes of care provides an opportunity to influence staffing and skill mix. Outcomes that need to be monitored by the accreditation agency or the complaints authority are outcomes related to nurse sensitive indicators (NSI). Whilst the government is exploring this with voluntary KPI reporting, this monitoring needs to be mandatory and public. Falls and Falls with Injury, Pressure Ulcers, Hospitalisation, Sepsis, Wounds; pain management, continence; challenging behaviours management etc. There is a failure on the part of the accreditation process whereby its officers are not required to assess compliance and they do not interrogate care outcomes. Example Expected outcomes 2.7 medication management states – <i>There are various laws and guidelines which govern medication management practices. While assessors do not assess compliance with such requirements, the home should be able to demonstrate how its processes are in accordance with relevant protocols and are hence 'correct'.</i> There is a question as to who assesses and monitors compliance and a suggestion that this is why there has been such a decline in the quality of care as the staffing and skill mix has been eroded.

Health Practitioner Regulation National Law Health Practitioner Regulation National Law (South Australia) Act 2010 Schedule 2—Health Practitioner Regulation National Law Subdivision 6—General 136—Directing or inciting unprofessional conduct or professional misconduct	A person must not direct or incite a registered health practitioner to do anything, in the course of the practitioner's practice of the health profes- sion, that amounts to unprofessional conduct or professional misconduct. Maximum penalty: (a) in the case of an individual—\$30 000; or (b) in the case of a body corporate—\$60 000. (2) Subsection (1) does not apply to a person who is the owner or operator of a public health facility.
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Government policies at the state and territory levels which currently have a significant impact on the aged care workforce are outlined at Appendix A.

H. RELEVANT PARALLELS OR STRATEGIES IN AN INTERNATIONAL CONTEXT

The CEPAR analysis of the aged care sector includes information on an OECD survey of policy makers in 2009-10 documenting the public measures taken by OECD countries in response to aged care workforce challenges. As the table below indicates, Australia, at that point in time, had adopted a limited range of measures focusing particularly on recruitment, funded training and career creation, rather than addressing wages and conditions, raising job status and management. ³⁷

It could be argued that the recent cuts made to the aged care workforce development fund and workforce program puts Australia's response even further beyond most other OECD countries.

Table 3 Public measures to support aged care workforce in Australia and OECD, 2009-10

	AUS	AUT	BEL	CAN	CZR	FIN	FRA	DEU	IRL	JPN	KOR	MEX	NLD	NZL	NOR	SVK	SVN	CHE	UK	USA
Recruitment	✓		✓	✓			✓	✓	✓	✓	✓		✓	✓	✓				✓	✓
Funded training	✓		✓		✓	✓	✓	✓						✓	✓			✓	✓	
Wages / benefits			✓		✓		✓	✓		✓	✓			✓		✓	✓			✓
Work conditions						✓	✓	✓		✓	✓				✓			✓		✓
Raising job status		✓					✓	✓	✓	✓	✓				✓				✓	
Management							✓	✓					✓		✓				✓	✓
Career creation	✓	✓					✓								✓				✓	✓
Certification										✓	✓				✓				✓	✓
Workforce planning			✓	✓				✓					✓	✓	✓			✓	✓	✓
Other retention	✓												✓		✓				✓	✓

Source: Adapted from Colombo (2011)

³⁷ CEPAR, *Aged care in Australia Part II – Industry and practice*, CEPAR research brief 2014/02, p.13

I. THE ROLE OF GOVERNMENT IN PROVIDING A COORDINATED STRATEGIC APPROACH FOR THE SECTOR

The ANMF supports the discussion and proposal from the NSW Nurses and Midwives' Association (the NSW Branch of the ANMF) as follows.

There needs to be better consistency in relation to aged care between federal and state government. Much of the legislation governing RACFs³⁸ is centered around a federal model which means there is little scope to develop localised approaches to improving the workforce. There is opportunity to remodel the entire legislation that governs aged care workers and to develop national benchmarking in this area. Funding should be allocated to this as a matter of urgency.

There are two main issues impacting on the aged care workforce. Firstly there is much variation in relation to legislation governing staffing and skill mix in aged care, the way medications are handled and local safeguarding protocols. This creates a divide and rule system for aged care providers and is not conducive to consistency in quality across Australia. Secondly, there are many excellent local initiatives aimed at retaining staff in aged care, furthering the role of nurse practitioners and rural and remote projects that facilitate coordination of local services. However, there is lack of federal oversight in relation to the sharing of best practice and benchmarking standards. The Association calls for the federal government to develop consistency in legislation across all states and further national benchmarking in aged care including investment in research aimed at improving quality.³⁹

J. CHALLENGES OF CREATING A CULTURALLY COMPETENT AND INCLUSIVE AGED CARE WORKFORCE TO CATER FOR THE DIFFERENT CARE NEEDS OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES, CULTURALLY AND LINGUISTICALLY DIVERSE GROUPS AND LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX PEOPLE

The ANMF recognises the unique needs of Aboriginal and Torres Strait Islander peoples and as such supports the joint submission to the Australian Senate Standing Committee on Community Affairs inquiry into the future of Australia's aged care sector workforce from the

Australian Indigenous Doctors Association (AIDA), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSiNaM), Indigenous Allied Health Australia (IAHA) and the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA).

³⁸ Residential aged care facilities

³⁹ Submission by the New South Wales Nurses and Midwives' Association, Senate Inquiry into the future of Australia's aged care sector workforce, March 2016, unpublished.

Equally, due regard must also be given to the unique needs of culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people in order to provide appropriate, safe and individualised care. As diversity within Australian society increases there will be no standardised approach that fits all, therefore the needs of the aged care workforce will always be determined by the communities in which they serve. This will require greater emphasis on local experts and building community capacity.

Within aged care, specialist nurse practitioners and educators would be ideally placed to work with local communities to support the aged care workforce within those communities to meet their specific needs. There are already examples of good practice in this regard. Further federal and state funding would enable this good practice to be widened, strengthen local communities and provide meaningful career opportunities for aged care workers.

K. THE PARTICULAR AGED CARE WORKFORCE CHALLENGES IN REGIONAL TOWNS AND REMOTE COMMUNITIES

Australians living in regional and remote areas generally have worse health outcomes than those living in metropolitan areas. In 2014, the COAG Reform Council reported that they have lower life expectancy, higher death rates and longer waits both to see a GP and to enter a high residential aged care service.⁴⁰

The rate of aged care places declines with remoteness, that is, the more remote an area is the less available a place in residential aged care becomes. This is moderately offset by a greater availability of community aged places than in major cities. However, the difficulty arises once a person can no longer remain in community care but is in need of residential care.

This is on top of the existing challenges in the aged care sector and the provision of a suitable aged care workforce, which have been described in detail throughout this submission. To address the particular aged care workforce challenges in regional towns and remote communities, Governments must ensure that:

- workforce development is planned and provides for a health workforce with appropriate skills and professional group mix.
- the health workforce has the appropriate qualifications and experience to provide safe, high quality aged care services .
- workforce development activities are in place that improve quality and safety in ways that are coordinated and efficient.
- expectations and standards of performance are clearly communicated
- the workforce is supported through training, development and mentoring.
- the health workforce is fulfilling its roles and responsibilities competently.
- workforce competence is sustained, innovation is fostered and corporate knowledge is passed on
- multidisciplinary teamwork is promoted and fostered

⁴⁰ COAG Reform Council, 2014, Healthcare in Australia 2012-13: *Comparing Outcomes by remoteness. Supplement to the report to the Council of Australian Governments.*

L. IMPACT OF THE GOVERNMENT'S CUTS TO THE AGED CARE WORKFORCE FUND

Announced at the end of last year in the Mid Year Economic and Fiscal Outlook [MYEFO], were further cuts healthcare and aged care. In particular, \$472m in cuts to aged care initiatives (the Aged Care Education and Training Initiative; and the Aged Care Vocational Education and Training professional development programmes).

The aged care workforce development fund was implemented originally as strategy to assist attraction, retention and education of workers within the sector. The MYEFO merged the Aged Care Workforce Development Fund with the Rural Health Outreach fund to become the Health Workforce Fund.

Despite the several name changes the fact remains the original purpose of this fund was to assist with education, innovation and retention in a sector desperate for attractive solutions to an ever increasing resource issue. It is unfortunate that over the years this fund has been watered down, now, almost to the point of extinction. At a time when the country is facing increasing growth in the elderly population and increasing difficulty in attracting and retaining aged care staff reduction in funding for training that it is critical to the sector is incomprehensible.

CONCLUSION

The ANMF wishes to conclude this submission with a comment received from an aged care resident on their view of the state of the sector:

As a resident of a care facility I know only too well the traumas that occur due to the shortage of staff. The staff are expected to cover for people that do not turn up for their shifts or are genuinely sick, medications and dressings are dispensed late and everyone gets stressed which reflects on to the residents. Most of our carers are exactly that, great carers, but not so the people at the top running the various facilities.

APPENDIX A

South Australian legislation and policies which impact upon aged care workforce

South Australian legislation does not include any regulation of staffing for residential aged care facilities providing high level of care to residents who receive Commonwealth subsidies. Acts and regulations that have an influence or minor bearing on staffing mainly relate to the management of drugs of dependence and the act that defines residential aged care facilities as a health service. Being defined as a health services determines the way in which providers are required to manage medications.

Act or related document	Impacts/Issues/Risks
SA Health Care Act 2008 https://www.legislation.sa.gov.au/LZ/C/A/Health%20Care%20Act%202008.aspx	Health Care Act 2008 contains a definition of health service which at this point includes residential aged care facilities. This has relevance for the application of the Controlled Substances Act 1984 and Controlled Substances (Poisons) regulations 2011 particularly in relation to the requirement for management of drugs of dependence. There have been a number of attempts to change the legislation and definition of RACF's being health services to remove the requirement to comply with the regulations as they apply within the acute sector. This includes changing the frequency of counting restricted medicines eg narcotics.
SA Act's and regulations relating to the management, transport and storage of medication SA Controlled Substances Act 1984 https://www.legislation.sa.gov.au/lz/c/a/controlled%20substances%20act%201984.aspx - SA Controlled Substances (Poisons) Regulations 2011 - SA Code of Practice for the Storage and Transport of drugs of dependence	The Controlled Substances Act 1984 and Controlled Substances (Poisons) regulations 2011 and the SA Code of Practice for the Storage and Transport of drugs of dependence, relate to the requirements for management of drugs of dependence. Under this legislation the supply and administration of medication in health facilities, the definition of which includes nursing homes, is restricted to registered health practitioners who must follow the legislative procedures and maintain certain records. The term "registered health professionals" can include enrolled nurses but some of the other requirements of the legislation may have the effect of limiting the administration of some medications to registered nurses. Controlled Substances (Poisons) Regulations 2011 Definitions - health service facility means a hospital, nursing home or other facility at which a health service is provided for the public or any section of the public for the purpose of curing, alleviating, diagnosing or preventing the spread of any mental or physical illness, disease, injury, abnormality or disability; Section 44 of the regulations —Additional requirements for administration of drugs of dependence in health service facility outlines the requirements for a registered health practitioner in respect to administration of drugs of dependence. (Registered health practitioner includes Registered Nurses and Enrolled Nurses).

Supported Residential Facilities Act 1992 https://www.legislation.sa.gov.au/LZ/C/A/SUPPORTED%20RESIDENTIAL%20FACILITIES%20ACT%201992.aspx Supported Residential Facilities Regulations 2009 https://www.legislation.sa.gov.au/LZ/C/R/Supported%20Residential%20Facilities%20Regulations%202009.aspx	There is a provision for staffing in the Supported Residential Facilities Act 1992 (SRFA) and Supported Residential Facilities Regulations 2009 (SRFR). These relate to privately operated low level supported accommodation to older people and disabled people in facilities known as Supported Residential Facilities. SRFs are not classified as offering aged care and they do not receive Commonwealth funding under the Aged Care Act. Despite this “nursing homes” are defined in clause 3 of the SRFR as being “a supported residential facility where nursing care is provided or offered on a continuing basis”. Under SRFR Part 5, “Staffing Arrangements”, clauses 18-20 the manager is required to ensure that the provision of nursing care is overseen by an approved registered nurse (the Director of Nursing) and that the staff includes a registered nurse. In addition the manager has to ensure that a registered nurse is on duty at all times although the registered nurse does not have to be on duty at the premises during a night shift if there is another nursing staff member (not necessarily a registered nurse) on duty at the time and the registered nurse is either on the premises or within close proximity and can be summoned to attend immediately. Division 2—Staffing requirements 19—Staffing levels—nursing homes are prescriptive and need to be enforced.
SA Aged Care EBA’s Safe Staffing and Skills Mix Clauses are limited.	Limited staffing clauses to protect staffing levels – example clause • Staffing levels and skills mix should be driven primarily by the need to achieve optimal health and quality of life outcomes for, and meet the needs of, people requiring or in receipt of aged care services. • 8.2.2 In determining staffing levels and skills mix, the following variables need to be taken into consideration: - the resident or client profile and their nursing/health care needs; - palliative care; - the complexity of care required, including factors such as: frailty or dementia; - the location of the facility or service, whether metropolitan rural or remote; and - the nature of the care provided, whether short or long term, rehabilitative or the type and design of the facility or the focus of the service. • The level of staffing and the skills mix of staff must enable [Employer’s Name] and staff to meet their duty of care responsibilities in providing quality care to people requiring or in receipt of aged care services, especially special needs groups such as those requiring dementia care, palliative care or complex nursing care.

	• The level of staffing and the skills mix of staff must also enable [Employer's Name] to meet their responsibilities under occupational health and safety legislation and must aim for the promotion of a safe and healthy workplace. • To meet optimal health and quality of life outcomes at an individual and service level, [Employer's Name] will establish a process for determining staffing levels and skills mix, which provides flexibility at the local level to respond in a timely manner to changes in the care needs of residents in the facilities and clients in the community; and which also takes into consideration work and life balance for staff and gives priority to permanent employment. • The level of staffing and the skills mix of staff should be regularly reviewed and adjusted at the local level with staff allocated/rostered according to the resident or client profile and any other changing service variable. Consultation with staff and the Unions must occur when changes to the level of staffing and the skills mix of staff have an impact on staff working conditions or to their work and family balance. • [Employer's Name] will ensure that all staff have the necessary skills for them to be able to perform the role required of them or facilitate access to suitable training for the acquisition of such skills. All staff should have, or undertake, a basic qualification or equivalent experience for entry to work in the sector and be provided with opportunities for further education and professional development. This is an essential component of continuous quality improvement and the provision of quality care. [1]
SA Public Sector Hospitals with Aged Care Units	Commonwealth funded beds in 3.2 SPECIAL ADDITIONAL PROVISIONS FOR COUNTRY HOSPITALS AND HEALTH UNIT SITES 3.2.1 The N/MHPPD for health unit sites managed by Country Health SA LHN are stipulated in Appendix 2. 3.2.2 Staffing for Commonwealth licensed aged care beds will be 3.2 NPCHPPD averaged across CHSALHN high care beds by the nominal expiry of this Agreement. The increase to 3.2 is subject to a commensurate increase in ACFI funding being provided to reflect increased care needs. 3.2.3 Health unit sites other than those listed at Appendix 1 are agreed as being minimum staffed health units; that is sites for which staffing levels and mix are unchanging from day to day or by time of the day. In these sites a minimum of 1 registered nurse and 1 other nurse/midwife must be on duty at all times. These staff are in addition to the DON/M and the Clinical Nurse Coordinator roles.

Victorian Policies which Impact the Aged Care Workforce

The Victorian Government's ageing and aged care agenda supports policy, programs and services to meet the needs of an increasing number of older Victorians by responding to the changing demographic profile of Victoria, understanding its impacts and maximising the opportunities of an ageing population. Within the Victorian public sector aged care context the state government has policy in place to guide aged providers to ensure they have the most effective workforce with the appropriate skills and knowledge required to fulfil their role and responsibilities within the employing organisation. Support is required to ensure clinicians and managers have the skills, knowledge and training to perform the work roles and tasks that are required of them and that they understand the concept of governance. In the case of health practitioner, a sound understanding of clinical, operational and professional governance is a high priority.

The Victorian Public Sector Residential Aged Care Providers (PSRAC) are encouraged to have processes in place that support the appropriate selection and recruitment of staff, maintenance of professional standards; and control of the safe introduction of new therapies or procedures. Central to this approach is improving care through a safety and quality approach for supporting public sector residential aged care services. For that reason, aged care provision that is based on evidence, that is person-centred in its approach and is promoted to support high-quality care and quality of life outcomes that focus on important areas of care, evidence translation, better use of data and learning from deaths and preventable harm is the driver for this policy.⁴¹

Within Victoria there are some challenges for rural towns where their aged care service and nursing homes are attached to their public hospitals and are usually a major employer within such communities. The Victorian government provides additional funding to these types of health services to ensure they can provide nursing staffing levels consistent with mandated nurse patient/resident ratios, outlined in Victorian legislation⁴². There are over 180 PSRACS throughout the State, making the Victorian Government the largest public provider of residential aged care in Australia. Most services are operated by public health services, in rural and regional Victoria. This helps older people to access residential aged care within their local community.

Within Victoria PSRACS play a key function in providing care to older people with more complex and specialist aged care needs. Victoria is the only provider of aged persons' mental health services that specialise in caring for older people with a mental illness and/or persistent cognitive, emotional or behavioural issues.

The Department of Health & Human Services contributes funding for PSRACS to support:

- the viability of small rural services
- residents with specialised care needs
- a skilled and qualified nursing workforce.

The Victorian health policy and funding guidelines explains the departments' process and unit-priced funding approach for PSRACS.

⁴¹ Department of Health and Human Services, Victoria. 2016 Webpage. Available at: <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-car>. *Improving resident care in PSRACS - health.vic 2016 e/safety-and-quality/improving-resident-care*. Accessed 29.2.16

⁴² Victorian Government. 2015. *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*. Anstat. Victoria.

APPENDIX B

Regulation impacts

There are a number of professional nursing issues that significantly impact nursing care in the aged care sector relating to delegation and accountability. The Nursing and Midwifery Board of Australia's (NMBA's) national regulatory framework for registered nurses, including the national framework for the development of decision-making tools for nursing and midwifery practice [i] (the decision making framework) clearly articulates the criteria under which a registered nurse is able to delegate a nursing activity to another nurse or a non-nurse. The NMBA's definition of a non-nurse is *any person who is not registered to practise as a registered or enrolled nurse*[ii]. The decision making framework states that *registered nurses are accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care*[iii]. The explanatory statements in the decision making framework go on to say the following:

Decisions about nursing practice are made, in partnership with the client whenever possible, to ensure that the right person (nurse or non-nurse) is in the right place to provide the right service for the client at the right time.

Decisions are based on, justified and supported by considerations of whether:

- *there is a legislative or professional requirement for the activity to be performed by a particular category of health professional or health care worker*
- *the registered nurse has completed a comprehensive health assessment of the client's needs*
- *there is an organisational requirement for an authority/certification/credential to perform the activity*
- *the level of education, knowledge, experience, skill and assessed competence of the person who will perform an activity that has been delegated to them by a registered nurse from a nursing plan of care has been ascertained by a registered nurse*
- *the person is competent, confident of their ability to perform the activity safely, or is ready to accept the delegation, and understands their level of accountability for performing the activity*
- *the appropriate level of clinically-focussed supervision can be provided by a registered nurse for a person performing an activity delegated to them by a registered nurse*
- *the organisation in which the nurse works has an appropriate policy, quality and risk management framework, sufficient staffing levels, appropriate skill mix and adequate access to other health professionals to support the person performing the activity, and to support the decision-maker in providing support and clinically-focussed supervision.* [iv]

The decision making framework then outlines the following:

If all of these factors are positive, then the registered nurse can delegate the activity and ensure that the appropriate level of supervision is provided. If any of these factors is negative, the activity should not be delegated. In the absence of another competent non-nurse, or if necessary additional support (education, competence assessment, supervision etc) cannot be provided, the activity should either be performed by a nurse or referred to another service provider. In the latter case, the registered nurse would continue to collaborate to ensure the provision of any ongoing nursing care required by the client.

Further consultation and planning may be necessary to achieve changes at the organisational or professional level to permit delegation in future, if this is considered appropriate.[v]

The Nursing and Midwifery Board of Australia's remit is to protect the public and to that end has developed the regulatory framework, including the decision making framework, to ensure the public is protected. Registered Nurses are required to work within this regulatory framework to maintain their registration and for the protection of the public.

A registered nurse working in the current aged care environment, including residential care, is faced with this complex professional issue every minute of every shift they work within this environment.

As the ANMF has highlighted earlier in this submission, the latest Aged Care Financial Performance Survey published by Stewart Brown (2015) states that, on average, at best, registered nurses are spending 7 minutes and 19 seconds per shift with a resident in a residential facility. A comprehensive health assessment on its own takes more than 7 minutes and 19 seconds to complete. Therefore, the current working environment does not allow registered nurses to fulfil the current regulatory requirements.

Medication administration is a good example to demonstrate the issue of delegation in aged care. The aged care workforce, as highlighted earlier, consists of registered nurses, enrolled nurses and care staff. Medication administration, even when using a blister pack or similar administration aid, is considered a high risk activity. For a registered nurse to delegate this activity, she or he needs to have completed a comprehensive health assessment of the person receiving the care, to have ensured the nurse or non-nurse has the appropriate level of education, knowledge, experience, skill and is assessed as competent and confident to complete the care, and, then be in a position to be able to provide the appropriate level of supervision to the nurse or non-nurse completing the care. While the drugs and poisons legislation in each state and territory is different across jurisdictions, all clearly state that a registered nurse,

or an enrolled nurse who does not have a notation on their registration preventing them from administering medicines, can administer medication. The legislation regarding non-nurses administering medicines is less clear and could be argued at length.

Enrolled nurses who complete a Diploma of Nursing are educated to the level required by the NMBA to administer medicines, and have been assessed as competent on completion of their course. It should be noted that there are some enrolled nurses who have a notation on their registration which will prevent them administering medicines, as they may have completed their initial program leading to registration before medicines administration was a compulsory requirement and have not later completed an upgrade. An individual assessment of an enrolled nurse's registration, experience and skill would need to be completed. If these were appropriate, then an enrolled nurse could be delegated medication administration, with the appropriate level of supervision by a registered nurse. As the decision making framework outlines, if any requirements were negative then the enrolled nurse could not be delegated the care.

Delegation to administer medicines to a non-nurse or an AIN/PCW within aged care, is complex. The drugs and poisons legislation is unclear in each state and territory and in many jurisdictions the legislation is, in fact, silent. Assessment of an AIN/PCW's level of education, knowledge, experience skill and competence is difficult. A registered nurse needs to understand the education completed by each AIN/PCW. As there is no nationally consistent minimum education requirement, this is complicated. Further to this, AIN/PCWs are not nationally regulated and do not work to professional standards, which makes the assessment of delegation and determination of the level of supervision required very difficult. The ANMF has developed nursing guidelines titled *Management of Medicines in Aged Care*^[iv] to help support nurses and AIN/PCWs in medicines administration in aged care. This document provides best practice guidelines for quality use of medicines.

Although the process of delegation and supervision is complex for registered nurses in the aged care setting, registered nurses are required by their employer in many settings across the country to delegate medicines administration to AIN/PCWs due to the staffing ratio not allowing the registered nurse or enrolled nurse to undertake this function themselves.

This also places the AIN/PCW in a difficult position. The ANMF receives extensive enquiries from AIN/PCWs who are required to administer medicines. AIN/PCWs express concern about their personal liability in the event of making an error. As AIN/PCWs are not nationally regulated, they do not have a professional practice framework within which they work and are not required to hold any professional indemnity insurance. AIN/PCWs are unclear of the boundaries of care they can provide and are required by some employers to take on high risk care, such as medicines administration, with little, if any, foundation knowledge and poor remuneration for such responsibility.

It is important to note that the NMBA, with its remit of public protection, will not allow an enrolled nurse who has completed a minimum of 12 months preparatory education (minimum of Certificate IV) in nursing, to administer medicines, if they have not completed the approved regulated medication educational units. This is irrespective of the years of experience of the enrolled nurse and the provider facilitating training or competence assessment. The only way an enrolled nurse can administer medicines is if they have completed the preparatory education program, currently an 18 months Diploma of Nursing, which includes medicines administration requirements. Considering this, AIN/PCWs across the country are currently administering medicines in the aged care setting, without the safeguards of a minimum education level or professional standards.

Registered nurses are held to account for their actions within the nursing role with the NMBA stating that nurses are accountable to the people in their care, the NMBA, their employers and the public. The NMBA further state that *the registered nurse who delegates an activity to another person is accountable, not only for their delegation decision, but also for monitoring the standard of performance of the activity by the other person, and for evaluating the outcomes of the delegation.* ^[vii]

Considering the national regulatory framework which holds registered nurses accountable and responsible for their practice in delegating and supervision, the foregoing commentary makes it evident why it is so difficult to retain or readily recruit nurses into, the aged care sector. Their regulatory requirements are incongruent with the practices imposed on them within many aged care settings.

[iv] *ibid*

[v] *ibid*

[vi] Australian Nursing and Midwifery Federation. 2013 *Management of medicines in Aged Care, Nursing Guidelines*. Available at: <http://anmf.org.au/pages/nursing-guidelines-for-the-management-of-medicines-in-aged-care>

[vii] Nursing and Midwifery Board of Australia. 2007. *A national framework for the development of decision-making tools for nursing and midwifery practice*. Available at: <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx>



