Advancing nurse leadership

Australian College of Nursing

Ms Jeanette Radcliffe
The Secretariat
Senate Select Committee on Aged Care Sector Workforce
PO Box 6100
Parliament House
CANBERRA ACT 2600
community.affairs.sen@aph.gov.au

Dear Ms. Radcliffe,

Re: Senate Committee Inquiry- Future of Australia's aged care workforce

Australian College of Nursing (ACN) is pleased to provide a submission to the Senate Standing Committee on Community Affairs regarding the future of Australia's aged care workforce.

ACN consulted with its members, held two focus groups, consulted its Expert Advisory Group on Ageing and conducted an extensive literature review concerning the future of the aged care workforce, to inform this submission.

Thank you for the opportunity to contribute to this submission.

Yours sincerely,

Helen Goodall
Acting Chief Executive Officer

24 March 2016

Canberra
PO Box 219, Deakin West ACT 2600
freecall 1800 061 660 (charges apply to mobile phones)
t 02 6283 3400 | f 02 6282 3565

Sydney
PO Box 650, Parramatta NSW 2124
freecall 1800 265 534 (charges apply to mobile phones)
t 02 9745 7500 | f 02 9745 7501

www.acn.edu.au
Australian College of Nursing Ltd
ABN 49 154 924 642

Introduction

Australian College of Nursing (ACN) is the national professional organisation for all nurse leaders and its aim is to ensure that the Australian community receives quality nursing care now and in the future. ACN is a membership organisation with members in all states and territories, health care settings and nursing specialties. ACN is also the Australian member of the International Council of Nurses headquartered in Geneva.

The Terms of Reference:

a. the current composition of the aged care workforce;

b. future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers;

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;

d. challenges in attracting and retaining aged care workers;

e. factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths;

f. the role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded;

g. government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;

h. relevant parallels or strategies in an international context;

i. the role of government in providing a coordinated strategic approach for the sector;

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;

k. the particular aged care workforce challenges in regional towns and remote communities

l. impact of the Government's cuts to the Aged Care Workforce Fund; and

m. any other related matters

Australian College of Nursing

Senate Standing Committee on Community Affairs Inquiry - Future of Australia's aged care sector workforce

Senate Standing Committee on Community Affairs Inquiry - Future of Australia's aged care sector workforce

Executive Summary

Australians are living longer and in general remain healthier for an increased amount of time. The advance in science and technology has seen that Australians can experience a good quality of life now and well into retirement. The 2015 Intergenerational Report projects that there will be a doubling of people over 65 years of age and more than 40,000 people over 100 years in the next half century. However, the phrasing of ageing as a tsunami or burden only de-humanised those entering the healthcare system, and ageing needs to be reframed as an opportunity.

This continued positive growth of Australia's aged population, will require well planned aged care and related services including a suitably qualified and skilled workforce to provide quality and safe care. Meeting these projected long-term needs of an ageing population has particular challenges including quality, equity and acceptability for uses of care and disability services (Duckett and Wilcox 2011).

The aged care workforce as it evolves, needs to be responsive to the broader community in delivering services and have a broad range of competencies to deliver care, both in the community and the residential aged care facility (RACF). The workforce should have the inter-personal and communication skills, including English and health literacy, to deliver responsive care, especially in a consumer directed care context.

Greater alignment between the educational goals of education providers and the workforce expectations of service providers is required to ensure aged care workforce development needs are appropriately targeted and supported.

Summary of Recommendations

Recommendation 1

The Australian Government to stipulate minimum requirements for staffing levels in residential aged care.

Recommendation 2

At a national level, the regulation of Assistants in Nursing (AIN), (however titled), practice through the establishment of a practice framework, which, articulates a minimum level of education, a defined scope of practice, and national codes, standards and guidelines is supported.

Recommendation 3

Australian Government to set a minimum requirement for a registered nurse (RN) to be on site and available in residential aged care facilities at all times.

Abbreviations

Australian Bureau of Statistics: ABS

Australian Institute of Health and Welfare: AIHW

Aged Care Expert Advisory Group: EAG

Aged Care Funding Instrument: ACFI

Aged Care Workforce Fund: ACWF

Australian Industry and Skills Committee: (AISC),

Australian Skills Quality Authority: ASQA

Australian College of Nursing: ACN

Bachelor of Nursing: BN

Behavioural and psychological symptoms of dementia: BPSD

Community Care Workers: CCW

Care support employee: CSE

Chef Executive Officer: CEO

Centre for Applied Economic Research: CEPAR

Consumer Directed Care: CDC

Culturally and Linguistically Diverse: CALD

Continuing Professional Development: CPD

Council of Australian Governments: COAG

Enrolled Nurse: EN

Gay and Lesbian Health Victoria: GLHV

Lesbian, Gay, Bisexual, Transgender and Intersex: LGBTI

Living Long Living better: LLLB

National Aged Care Alliance: NACA

National Aged Care Workforce Census and Survey: NACWS

National Code of Conduct for Healthcare Workers: The Code

Nurse Practitioner: NP

National Disability Insurance Scheme: NDIS

Non English speaking background: NESB

Occupational Safety and Health: OSH

Professional Development: PD

Personal Care Assistant/Worker: PCA/W

Quality Innovation Performance: QIP

Quality of Life: QOL

QUM: Quality use of medicines

Registered Age Care Facilities: RACF

Registered Nurse: RN

Registered Training Organisations: RTO

TOR- Terms of Reference

World Health Organisation: WHO

United Kingdom: UK

Contents

TOR a: The current composition of the aged care workforce;

ACN understands that the Department of Health is preparing to conduct the fourth National Aged Care Workforce Census and Survey (NACWCS), an initiative ACN believes is invaluable in gaining a more comprehensive understanding of Australia's aged care sector. According to data from the *Aged Care Workforce 2012 Final Report*, more than 240,000 workers are employed in direct care roles in the aged care sector. This figure includes 29,547 Registered Nurses (RNs) and 20,556 Enrolled Nurses (ENs) (King et al. 2013) who are registered with the Nursing and Midwifery Board of Australia (NMBA) under national regulation law.

Workers employed in residential aged care facilities

There were 147,000 aged care workers employed in residential aged care facilities in 2012 (RACFs) (King et al. 2013). Unlicensed care workers/personal care assistants (however titled) comprised the largest occupational group (68%) and were the only occupational group in this sector to be increasing both numerically and proportionally. This is in contrast to the number of RNs working in RACFs which decreased from 17 per cent to 15 per cent from 2007 to 2012 (King et al. 2013). The number of ENs increased but as a proportion of the direct care workforce they decreased marginally to make up 11.5 per cent of the total (King et al. 2013). See Appendix A for Table 1: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007 and 2012 (estimated headcount and per cent).

Workers employed in community aged care settings

There are 93,350 workers in community aged care settings (King et al. 2013). In 2012, community care workers (CCW) accounted for 81 per cent of employees in community aged care settings compared to RNs comprising eight per cent and ENs almost four per cent. There has been a decrease in RNs as a percentage of the community aged care workforce from 2007 to 2012 of two per cent (King et al. 2013).There were 6,544 full-time RNs in community age care compared to 41,394 CCWs (King et al. 2013). See Appendix B for Table 2: Direct care employees in the community aged care workforce, by occupation: 2007 and 2012 (estimated headcount and per cent). Due to the increasing acuity of the population groups receiving aged care services, the diminishing role of RNs is a significant concern for the sector as RNs cannot and should not be substituted by unlicensed care workers/personal care assistants/community care workers (however titled).

Roles of RNs, ENs and unlicensed care workers in aged care

While unlicensed care workers (however titled) make up the majority of the aged care workforce, it is RNs who provide direction and supervision to ENs and unlicensed care workers (however titled) in the delivery of nursing services. The direct care role of RNs in aged care settings, both in RACFs and in community aged care settings, ensures patients have timely, safe, quality and efficient access to the nursing expertise they require. It is anticipated that the demand for nursing expertise will continue to grow within the sector.

The Role of the RN

The RN is an authorised health practitioner under the Health Practitioner Regulation National Law and is required to demonstrate competence in the provision of nursing care specified by regulatory arrangements that govern their practice. RNs practise "...independently and interdependently, assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers" (Nursing and Midwifery Board of Australia 2006). Enrolled nurses (ENs) and unlicensed care workers/personal care assistants (however titled) work under RN direction and supervision and they do not possess the education, knowledge and skill to substitute for an RN.

RNs provide education and guidance to other aged care workers they supervise and are the key personnel available to assess, plan, implement and evaluate nursing services. RNs also collaborate with general practitioners and other health professionals and service providers in the coordination and delivery of aged care services. The availability of RNs at all times in residential aged care and overseeing the delivery of nursing services within many community based programs is essential to facilitate and manage the health and well-being needs of care recipients.

The presence of RNs within RACFs and community aged care facilities enables the provision of a more complex level of care for residents and other care recipients. RNs are comprehensively educated to care for those with broad ranging health care needs, and to monitor and manage those needs through applying a higher level of knowledge and expertise than that possessed by ENs or unlicensed care workers/personal care assistants (however titled).

Aged Care Leadership and Management

RNs play a primary role in both executive and clinical leadership in the aged care sector. It is not uncommon for nurses to hold CEO positions and it is generally the case that RNs hold key management roles (Cziraki et al. 2014). RNs also oversee and provide frontline clinical leadership. They assess, plan, implement and evaluate essential nursing services in the aged care context. RNs working as clinical leaders in community and residential aged care provide education and guidance to their nurse colleagues and to other health workers and engage in consumer advocacy and support.

Quality Use of Medicines in Aged Care

ENs are able to administer medication within their scope of practice under the delegation and supervision of an RN and within the scope of jurisdictional legislation. ACN is of the view that the role of the unlicensed care worker/personal care assistant (however titled) should not extend beyond *assisting* older people with *self-administration* of their medicines from dose administration aids. Unlicensed care workers/personal care assistants (however titled) do not have the clinical education to administer medication to people too unwell to attend to this need themselves. Where dose administration aids are not used in RACFs and community aged care facilities, unlicensed care workers/personal care assistants (however titled) should not be involved in any aspect of the use of medication.

Unlicensed care workers/personal care assistants (however titled) do not possess skills in the quality use of medicines (QUM) and their unqualified participation in medication administration could have catastrophic outcomes for care recipients. RNs have a primary role in QUM across aged care settings.

Preventing Unnecessary Hospital Transfers

The direct care role of RNs is also key to responding to critical incidents and to preventing unnecessary hospital transfers in the aged care context. RNs are qualified to monitor the health care needs of care recipients and take responsibility for the early detection of health issues and the management of the deteriorating resident. Additionally, RNs are often responsible for being the point of contact for medical, emergency and hospital staff. RNs' ability to evaluate and decide when a care recipient needs emergency care and then accurately explain their medical history and symptoms to health professionals external to the RACFs and community aged care setting supports the provision of the most appropriate care.

RACFs and community aged care services can only provide appropriate care and potentially prevent unnecessary hospital transfers if led by RNs who take responsibility for appropriate clinical assessment, management, nursing care planning, implementation, coordination and evaluation. A decreased presence of RNs in RACFs and community aged care facilities and a greater dependence on other category workers could have adverse effects on the safety and quality of care for care recipients.

While there is a current gap in research demonstrating the direct impact of RN care on consumer outcomes in the Australian aged care context, a growing body of international evidence links RNs skill-base and leadership to better quality outcomes in residential aged care facilities and community aged care settings (Kontezka et al. 2008).

Specialist Nursing Roles and Nurse Practitioners

Increasingly, there is a need for specialised nursing care in RACFs and community aged care facilities as dementia rates increase (Alzheimer's Society (AS) 2014), as well as increasing rates of chronic diseases and co-morbidities amongst Australia's aged care populations (KordaMentha 2014, KPMG 2013).

Specialist nurses and nurse practitioners are able to provide a comprehensive approach to the care and support of people with challenges to their health or safety. Specialist and consultant nurses with post graduate specialty qualifications can greatly increase the range of services available in aged care contexts such as services in palliation, diabetes management and care and management of people with dementia and behavioural and psychiatric symptoms of dementia (BPSD). These services are not offered on a consistent basis within aged care. Incentives and innovative models of care that would allow the sector to improve access to specialist nursing services, would assist in meeting the growing demand for services resulting from the ageing population.

TOR b: Future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition from workers;

The 2015 Intergenerational Report projects that in the next 40 years the number of people over 65 will and have doubled and there will be over 40,000 people living beyond 100 years.

This will result in the need for a further expansion of the workforce required to care for the increasing number of older Australians.

In 2020s when the baby boomers reach their 80s, additional strain will be placed on the aged care sector to provide the skilled aged care workforce that will be required.

This strain will be compounded by a decline in the working age proportion of the population, the expansion of disability services under the National Disability Insurance Scheme (NDIS), and the increasing demand for health care services as the population ages.

The Department of Health in its submission to the Productivity Commission report: *Caring for Older Australians* estimated that a workforce of some 830,000 will be required by 2050, compared with 260,000 in 2012. The Productivity Commission, taking into account its recommendations for a more deregulated system, estimated a total workforce by 2050 of up to 980,000.

Forecasts alert us to the broad dimensions of projected requirements in the aged care sector and inform part of the planning process, but it is not the whole picture. The difficulty is that predicting demand over an extended period includes inherent uncertainties. Considerations for future aged care workforce planning: short and long term:

- changes in comorbidities patterns which will in turn influence the care needs of the older health care consumer, greater consumer choice over service delivery in relation to as how and where services may be delivered;
- the availability of carers both formal and informal;
- innovation in enabled technology in the sector;

- innovation in models of care including scopes of practice;
- university and training organisations adapting to deliver courses to deliver innovative best practice care; and
- changes in government policy which supports the aged care sector.

The impact of some of the above issues will inform the short, medium and long term workforce strategies of governments, university and training organisations, and employers. The aged care workforce as it evolves, needs to be responsive to the broader community in delivering services and have a broad range of competencies to deliver care, both in the community and the residential aged care facility (RACF). The workforce should have the inter-personal and communication skills, including English and health literacy, to deliver responsive care, especially in a consumer directed care context.

To support the workforce strategies there needs to be greater alignment between the educational goals of education providers and the workforce expectations of service providers to ensure aged care workforce development needs are appropriately targeted and supported.

For example some of the educational provider's goals and workforce expectations of service providers should include:

- provide a workforce competent to deliver care for older people living with co-morbidities and complex health care needs;
- provide a workforce competent to deliver best practice care for the increasing number of older people who will be living with dementia, including people presenting with behavioural and psychological symptoms of dementia;
- provide a skilled workforce to deliver best practice end of life care;
- provide a workforce that has an understanding of caring for people from culturally and linguistically diverse backgrounds (CALD) including the Aboriginal and Torres Strait Islander populations; and
- a workforce that is more digitally and health literate.

Having a national education system, which is responsive to sector needs, is fundamental to ensuring the availability of a skilled workforce that reflects sector the requirement. This is discussed further in TOR f.

Consideration

Greater alignment between the educational goals of education providers and the workforce expectations of service providers to ensure aged care workforce development needs are appropriately targeted and supported.

TOR 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;

Both the aged care and the disability workforce sector have workforce requirements that have seen a significant growth trajectory with the changes in demography and the implementation of consumer directed care (CDC) in the Australian setting.

Both sectors, to variable degrees, require access to staff with common skill sets. It needs to be considered that this will increase competition between these sectors for skilled staff, both in terms of attracting enrolments in entry level education and training and subsequently in attracting graduates to the individual sectors and retaining their services.

As a consequence, the workforce requirements of aged care cannot be considered in isolation by either governments or education and training organisations. They must take into account the combined workforce demands generated by all of these sectors, especially with regard to those occupations and skills, such as nurses and care workers, whose skill sets are more readily transferable across the sectors.

The transferability of skills across the aged care and disability sectors has recently been addressed by the creation of a new Individual Support Certificate III qualification to replace the former separate Certificates in Aged Care, Home and Community Care and Disability Care. The new Certificate requires all students to complete core subjects and then choose to specialise in up to two of aged care, home care and community care or disability care streams.

TOR d: challenges in attracting and retaining aged care workers;

ACN's members have identified the following key challenges that they believe the sector already faces in attracting and retaining aged care workers:

These points were identified to be challenges to varying degrees across the sector nationally:

- increasing demand for direct care workers across health, aged care and disability care;
- inconsistency in the quality of knowledge, skills and competence of Regional Training Organisation (RTO) graduates, who often complete courses and are not always 'workforce ready';
- variability in supervision in new graduates in residential aged care, with a need for transition programs for new graduates and those RN's that which to transition to the aged care sector;
- variability across jurisdictions in relation to medication management regulations;
- the need for English language training for non-English speaking backgrounds (NESB) workers and diversity training for all carers;
- disparity in wages across the aged care, health and disability sectors;
- availability of skilled staff in rural and remote locations, especially nursing staff and allied health;
- cost of accessing post entry-level workforce development programs for staff, especially in rural and remote locations;
- the need for English language training for NESB workers and diversity training for all carers;
- negative image of the aged care sector held in some sections of the community, including by younger people contemplating a career in the industry;
- the absence of structures for career progression within the aged care sector in relation to nurse practitioners;
- access to allied health professionals, General Practitioners (GPS)s and medical specialists in RACFs; and
- flexibility to increase hours worked on a part time basis.

TOR e: factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths;

Aged care providers are obligated to ensure that residents' care, treatment, protection and support needs are met by appropriately qualified personnel sufficient in numbers to meet residents' demand for care (Department of Social Services 2015). ACN recognises that unlicensed care workers/personal care assistants, (however titled); make a valuable

contribution to the provision of care that registered nurses and enrolled nurses provide. However, ACN has concerns that there are no nationally agreed minimum education requirements or competency standards supporting the regulation of their roles.

ACN believes that unlicensed care workers/personal care assistants, (however titled), contribution to nursing care should be underpinned by a nationally endorsed practice framework. This framework should identify the minimum formal education requirements, scope of practice, practice standards, and codes of ethics and conduct for unlicensed care workers/personal care assistant (however titled). A nationally endorsed practice framework would facilitate a consistent understanding, utilisation and development of the unlicensed care worker/personal care assistant role across care settings nationally.

Unlicensed care workers/personal care assistants (however titled) are increasingly obtaining qualifications through the vocational education system (King et al. 2013). However, in 2012 just over 15 per cent of unlicensed care workers/personal care assistants (however titled) employed in RACFs had no post-school qualifications of which 7.8 per cent had a year 10 qualification or below (King et al. 2013). Among community aged care workers, 10.2 per cent did not continue their education beyond Year 10 (King et al. 2013).

The Need for Increased Nurse Leadership

ACN believes it is timely to focus on nurse leaders in any examination of the future of the aged care sector workforce. The increasing fragility of aged care populations points to the need for strong nurse leadership across the aged care sector to ensure care recipients have timely access to the levels of nursing expertise they require. Strong nurse leadership is key to effective aged care service planning and delivery.

Aged Care Leadership and Management

RNs play a primary role in both executive and clinical leadership in the aged care sector. It is not uncommon for nurses to hold CEO positions and it is generally the case that RNs hold key management roles (Cziraki et al. 2014). RNs also oversee and provide frontline clinical leadership. They assess, plan, implement and evaluate essential nursing services in the aged care context. RNs working as clinical leaders in community and residential aged care provide education and guidance to their nurse colleagues and to other health workers and engage in consumer advocacy and support.

While there is a current gap in research demonstrating the direct impact of RN care on consumer outcomes in the Australian aged care context, a growing body of international evidence links RNs skill-base and leadership to better quality outcomes in residential aged care facilities and community aged care settings (Konetzka et al. 2008).

As the Australian population ages the proportion of the population aged 65 years and over is projected to reach 19.4 per cent by 2031 (ABS 2013). It is critically important that nurses' skills and leadership capabilities are fully embraced to support meeting ongoing challenges in aged care. With demands on the community and residential aged care sector increasing, emphasis needs to be placed on broadening nurse leaders' potential contribution to quality aged care services delivery.

ACN's 2015 white paper *Nurse Leadership* explains that the term nurse leader applies to nurses who work effectively to improve health care delivery whether working at the care delivery or board level (ACN 2015). Nurse leaders are individuals who have a broad knowledge of the forces shaping health care and aged care including political, societal and economic factors. Typically, they are equipped with a deep understanding of nurses' working conditions and play key roles in fostering supportive work environments and in the recruitment and retention of an appropriately skilled nurse workforce. Nurse leaders in executive roles use their nursing knowledge to influence the strategic direction of an organisation and to inform operational planning. Clinical nurse leaders are involved in the coordination; delivery and

monitoring of evidence-based practice care and continuous quality improvement activities. Nurse leaders' decisions have a direct bearing on the development of nursing systems and these systems are inextricably linked to meeting the challenges of delivering quality aged care (ACN 2015).

It is ACN's view that in order to promote safety and quality, regulation of RACFs and community aged care facilities should stipulate appropriate staffing requirements in the delivery of direct care.

Appropriate Staffing

The current lack of clarity around the meaning of appropriate staffing in the Commonwealth Age Care Act 1997 is highly concerning as appropriate nursing skill-mix is fundamentally linked to the delivery of appropriate care. Measures of indicators of care could identify whether care staff and number meet residents' demand for care/assistance and attention. ACN would support the introduction of such measurements. Until such time nurse to patient ratios may ensure appropriate staffing and should be considered in the context of residential care.

Consideration

That the Australian Government defines the meaning of appropriate staffing in the Commonwealth Aged Care Act 1997 to support appropriate staff skill-mix in aged care facilities.

TOR f: the role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded; government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;

Most recently industry concerns have been reported in the former Community Services & Health Industry Skills Council's 2015 Environmental Scan. The concerns are about the quality and consistency of qualifications awarded by Registered Training Organisations (RTOs), which are jointly funded and administered by the Australian Government, states and territories. ACN members continue to advise that quality of training is still an issue, including having to run their own re-skilling programs for new employees.

ACN considers that the quality and consistency of qualifications awarded is fundamental to securing a skilled workforce and notes that new entry level qualifications for aged care have been recently introduced in order to help address current inconsistencies. The new arrangements to operate from 2016 include:

- creating new Industry Reference Committees, supported by new Skills Service Organisations, to guide and provide input on industry demand for qualifications;
- creating a new Individual Support Certificate III qualification to replace the separate Aged Care, Home and Community Care and Disability qualifications as mentioned previously; and
- a requirement that all Individual Support certificate students must undertake a minimum 120 hour workplace placement, with many competencies assessed in the workplace.

These arrangements put a responsibility on employers to keep the Industry Reference Committees and RTOs fully appraised so that the training packages are current with the evolution of skill needs in the sector and to support changes in scopes of practice.

These new arrangements also place responsibility on the RTOs and aged care providers to provide appropriate work placements that support appropriate training and assessment. These arrangements are an opportunity for both the training organisations and aged care providers to work together on addressing issues in regard to workforce planning and skill requirement.

There is also a responsibility placed on the Australian Industry and Skills Committee (AISC) working through the relevant Industry Reference Committee, to monitor and report on the effectiveness of the new arrangements.

Given the well documented concerns about the quality and consistency of the aged care qualifications under the national training system, a review of the current registration and quality assurance arrangements for RTOs under the Australian Skills Quality Authority (ASQA) may be appropriate. Noting the increased emphasis on assessing certain competencies as part of the mandatory workplace placement, there would also be value in reviewing the appropriateness of the current arrangements in the context of the decision to place greater emphasis on trainee competency assessment.

With the current overlap in Australian Government/state responsibilities for the national training system it may be timely for the Committee to consider whether the present arrangements are conducive to the delivery of an effective national training system.

Consideration

That the Australian Industry and Skills Committee (AISC), which is the national body responsible for overseeing the national training system, be required to monitor and publicly report on the effectiveness of the new training arrangements in aged care to enhance transparency.

TOR g: government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;

NSW legislation has required nursing homes (this is a term used specifically in NSW referring to RACFs) to be staffed by a RN at all times. ACN supports this requirement and believes legislation in other states and territories should adopt a similar policy requiring RACFs to have at a minimum an RN on site and available at all times.

ACN is in favour of a Commonwealth policy that requires the development of a comprehensive workforce strategy. ACN supports the National Aged Care Alliance (NACA) reform recommendation to take an integrated approach to workforce planning requiring:

> *"the Australian Government to work with stakeholders to co-design a definitive workforce development strategy to ensure a sufficient future workforce to meet the service needs of the health, aged care, disability and community service sectors (including in regional, rural and remote areas). This strategy should work towards greater coordination across the social services sectors and should focus on recruitment, retention, education, development and remuneration to ensure that the workforce needs of each of the sectors are met."*

As an attraction and retention strategy in the sector, ACN urges the Australian Government to take action on wage disparity between nurses in age care facilities and those in the public health care system. The recent NSW Legislative

Council General Purpose Standing Committee No. 3 report 'Registered nurses in New South Wales nursing homes' outlined clearly in Recommendation 15:

> *"That the NSW Government, through the Council of Australian Governments, urges the Commonwealth Government to take active measures to address the wage disparity between registered nurses in aged care and registered nurses in the public health care system."* (New South Wales Legislative Council 2015).

TOR h: relevant parallels or strategies in an international context;

Australia's aged care and broader health care systems are often claimed to be as good as any in the world. To the extent that this is true it is not a reason for complacency. There are issues in the current systems which need to be addressed such as underfunding, over regulation, workforce shortages and, not least, the capacity of services to work together in a coordinated way to meet the often complex and changing care needs of older people, people with a disability and their carers.

Australia's fragmented healthcare funding which sees the Australian Government responsible for aged and primary care, and the states responsible for acute care and hospitals is hindering the potential for the adoption of more integrated and collaborative models of care, such those as working successfully in countries like Singapore.

In Singapore all facets of healthcare are linked by technology and where, using large databases and analytics, the different segments of the aged population most at risk are being stratified. This long term planning and proactive approach has proved successful there. The delivered care is supported by telehealth and other technological innovations such as wearable technology.

Furthermore, the Japanese Government's national social insurance model, funded by a tax on all citizens over 40 years of age is reported to work well. Japan has also invested in mobilising community resources to allow members of the community to act as vicarious carers.

In Hong Kong carers pay less tax and the housing system support multi-generational households.

More broadly, the reported best models had the default locus of care as the home, and no longer thought of hospitals as bricks and mortar but a part of a health system that allowed patients to flow in and out. To achieve this model, there must be government and social incentive to boost informal carers, as well as care within the community.

Quality indicators are used to measure outcomes of care and services. Several countries including the Netherlands, United Kingdom, Korea, Canada and the United States have introduced measures of outcomes of care and services. Quality indicators are currently used in the health care system in Australia, and in some Victorian aged care homes to collect data for internal quality improvement purposes.

TOR i: the role of government in providing a coordinated strategic approach for the sector;

The Australian Government has an important role to play in providing a coordinated strategic approach for the aged care sector. This involves working with all levels of government and a range of organisations that are involved in aged care. On a broad systems level, the Australian Government needs to address the disparate funding models between tertiary, aged and primary care which create confusion and silos in the health system. In an important step in addressing the current aged Care workforce, the Australian Government should ensure that Australia's workforce capacity and capability address current variation (territory and state) to legislation governing aged care staffing and medication management within the aged care sector.

As a member of the National Aged Care Alliance (NACA), ACN offers strong support and urges government commitment to the following NACA positions stated in its 2015 paper *Enhancing the quality of life of older people through better support and care* (NACA 2015).

Management of Dementia and Behavioural and Psychological Symptoms of Dementia (BPSD)

ACN supports the view that effective high quality care and management of older people living with dementia and behavioural and psychological symptoms of dementia (BPSD) can significantly improve health and lifestyle outcomes for people with dementia causing illnesses. ACN therefore stresses the importance of the following NACA recommendation:

- "Providing more appropriate care and support services for people with dementia

  This will require stakeholders and governments working together to co-design and implement a dementia strategy which builds on the draft 2013-2017 National Framework for Action on Dementia, and is reviewed and updated regularly.

  The strategy should focus on:

  - *the development of dementia-friendly communities;*
  - *risk reduction and prevention measures;*
  - *a holistic approach to providing appropriate, best-practice care for people with dementia and their carers through assessment, diagnosis, social engagement, care and support;*
  - *the development of dementia-friendly environmental design; and*
  - *staff education, support and training.*

  Holistic support for people with dementia includes targeted and comprehensive funding for services that support the care of individuals experiencing behavioural and psychological symptoms of dementia (BPSD), including non-pharmacological and psychosocial approaches to care."

ACN stresses the need for education of health care staff and health care professionals in the management of people presenting with dementing illnesses and BPSD in aged care settings. Appropriate staffing is consistently an issue in aged care as the skill mix of staff is often not appropriate to meet the needs of people with dementing illnesses and BPSD. Further to this point, ACN supports the following NACA recommendations:

- *"Delivering more appropriate palliative, end of life care and advance care planning for older people in the community and in residential care*

This will require:

- *Development and implementation of practices that ensure consumers can exercise choice over where they die, matched by support for informal carers, a skilled workforce that can deliver palliative care, and access to specialist palliative care services where and when required.*
- *That the Australian, State and Territory governments work together to develop and implement harmonised laws administering advance care planning across Australia, including law related to power of attorney, enduring guardianship and end of life wishes.*

- *Supporting informal carers*

This will require complementary approaches across the aged care and disability sectors, including in relation to the evaluation of informal carer support needs alongside the needs of those requiring care, and an extension of carer supports by providing additional education and training, counselling, advice, peer group support, flexible respite and wellness."

TOR 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;

ACN recognises that nurses work in a culturally diverse environment and play a significant role in fostering culturally appropriate care for residents and promoting team cohesion and productivity. Aged care in Australia is staffed by a multicultural workforce that provides care to residents from a diverse range of cultures (AIHW 2012; King et al. 2013).

The Current Workforce

ACN recognises that migration plays a significant role in shaping Australia's Aged Care Workforce. Australia's Health Workforce Series –Nurses in focus, Health Workforce Australia (Health Workforce Australia, 2013) highlights the results of the AIHW Nursing and Midwifery Labour Force Survey which showed the number of employed RNs who received their first qualification overseas increased from 14% in 2004 to 16% in 2009. Other results between 2004 and 2009 were similar:

- 2% of employed RNs received their first qualification in New Zealand (NZ) in both years;
- 7% of employed RNs received their first qualification in the United Kingdom (UK)/Ireland in both years; and
- those who received their first qualification in Asia increased slightly from 3% to 4% from 2004 to 2009.

Furthermore, for employed ENs in 2009, 4% reported receiving their first qualification overseas. Reasons for lower numbers of overseas trained nurses may include:

- ENs are not on the skilled occupation list, so the skilled independent pathway is not an option for ENs to apply as a primary visa applicant; and
- many countries do not educate to EN level. For example, in the UK training was phased out in 1989 and many countries such as Austria, France and Spain appear to only have one category of qualified nurse.

The *Aged Care Workforce, 2012: Final Report* identifies that the top languages spoken by residential staff are African languages, Hindi and Filipino.

The Aged and Community Services Australia (2014) report "No data is publically available on the distribution of workers with an Aboriginal and Torres Strait Islander background across the States and Territories to determine if the locations with a high proportion of Aboriginal and Torres Strait Islander residents also have a high proportion of Indigenous [workers]".

Furthermore, "the proportion of employees with an Aboriginal and Torres Strait Islander background who work in residential aged care in 2012 is lower than this population group in the wider Australian population but higher than the proportion of permanent residents in residential aged care facilities across Australia in 2012" (Aged and Community Services Australia, 2014).

Culturally and Linguistically Diverse (CALD) populations in aged care

Older people with limited English proficiency may not have the same needs of interests in relation to aged care services. Factors influencing this may include "variations in language and culture, experiences at settlement, reason for migration, length of time in Australia, socioeconomic status and geographical location, gender and age" (Benevolent Society, 2013). In most circumstances populations of CALD backgrounds fall into two categories; those who migrated as young people and those who migrated at an older age. The former group experiences more challenges as a new environment with a different culture and language may be harder to adapt to (Benevolent Society, 2013).

The Profile of the Australian CALD Population

- Australia-wide the largest birthplace groups are Italy, Greece, the Netherlands, China, Croatia and Poland. By 2026, it is estimated that one in four people over 80 will be of CALD background (Benevolent Society, 2013).
- Approximately 10% of residents in aged care facilities prefer communicating in a language other than English (AIHW 2012), while approximately 35% of the aged care workforce are born outside Australia and 24.4% of the workforce being from non-English speaking countries (King et al. 2013).

Barriers to use of care services by CALD older people

The Benevolent Society (2013) highlights that the key barriers are identified as:

- lack of familiarity or awareness of the care and service system;
- communication difficulties related to limited English proficiency;
- concerns about privacy and confidentiality, for example, related to use of interpreters or workers from within the older person's community;
- attitudes about family roles and responsibilities, such that in some communities caring for an older person may be seen as a family responsibility only, resulting in criticism for those who relinquish it culturally inappropriate services and lack of cultural competence among workers;
- misperceptions that CALD older people all have support from extended families;
- service providers' unfamiliarity with or reluctance to use interpreting services;
- Lack of information resources in community languages, particularly pertaining to small and emerging communities or lack of knowledge about the existence of such resources;
- lack of services for small or emerging communities in urban or geographically remote areas; and
- services to CALD clients perceived as posing additional costs to service providers intolerance, prejudice and discrimination.

Aboriginal and Torres Strait Islander People

It has been well documented that Aboriginal and Torres Strait Islander people are more likely to access and experience greater health outcomes from services that are culturally safe. This coupled with the complexities of location, cost and responsiveness are likely to influence service utilisation by Aboriginal people (Australian Government, 2013).

The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 highlights current challenges Aboriginal and Torres Strait Islander people experience in utilising aged care including:

- older Aboriginal and Torres Strait Islander people have strong cultural ties in their community. This includes passing traditional knowledge (languages and customs);
- older Aboriginal and Torres Strait Islanders may have caring roles within the community and often care for multiple generations;
- the underpinnings of historical policies such as the forcible removal of children cannot be ignored. This still has immense social and psychological impact on Aboriginal elders and their families;
- support must be given to families who undertake caring roles of older Aboriginal and Torres Strait Islander people;
- options must be given to Aboriginal people who wish to age "on country"; and
- palliative services must be responsive to respecting and delivering appropriate end of life services to Aboriginal and Torres Strait Islanders.

Literature indicates that there are two primary challenges in training culturally competent aged care workers:

- universities are unable to use uniform models of evidence based culturally competent health practice, particularly in mental health (Westerman, 2010); and
- organisations do not have clear benchmarks that can identify cultural competence or incompetence amongst practitioners (Westerman, 2010).

To develop a culturally competent aged care workforce there must be:

- cultural and linguistic diversity must be addressed at all levels of training including vocational, tertiary and continuing professional development (Westerman, 2010);
- ongoing access to cultural supervision for clinicians working with CALD. Cultural supervision is "formal relationship between members of the same culture or different cultures for the purpose of ensuring that the supervisee is practising according to the values, beliefs, protocols and practices of that particular culture" (Westerman, 2010); and
- training the aged care workforce in cultural competency as well as employing interpreters will improve the delivery of culturally appropriate care. For example, training should be delivered from workers who come from Aboriginal and Torres Strait Islander CALD. An example of this is nutrition programs that understand food security and cultural foods (Australian Government, 2013).

Furthermore, the Mental Health Coordinating Council (2008) recommends that at an individual staff level cultural competence may be improved through professional and personal development strategies including:

- regular education and training (professional development) - where possible, integrating cultural competence training into mainstream courses for Community Mental Health Support Workers, Consumer Workers and Carer Workers, rather than it being provided in the form of 'stand-alone' or 'one-off' modules/workshops;
- supervision and mentoring;
- reflective practice;
- consumers, carers and people from CALD & Aboriginal and Torres Strait Islander backgrounds participate in the orientation of new staff members - this is an opportunity for the staff to learn about the organisation through the eyes of someone who uses the service;
- frequent in-service education with participation by consumers, carers and people from CALD & Aboriginal and Torres Strait Islander backgrounds;
- forums which bring together consumers, carers, Mental Health Support Workers, Consumer Workers, Carer Workers, community workers, and people from CALD and Aboriginal and Torres Strait Islander backgrounds, etc.;

- working with cultural brokers/mediators/consultants; and
- training in working with interpreters/having access to face-to-face and phone-based interpreting services.

LGBTI (Lesbian, Gay, Bisexual, Transgender and Intersex) People in Aged Care

ACN recognises that there are growing numbers of LGBTI people accessing aged care services. It is estimated that up to 11% of the population may identify as LGBT and that this group experiences poor health outcomes (Department of Health and Ageing, 2012).

The current situation suggests there is little attention paid to the growing needs of LGBTI people. The National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, 2012 highlights these challenges. This is compounded by:

- Historical discrimination of people who identify as LGBTI. Individuals may have suffered "stigma, family rejection and social isolation" (Department of Health and Ageing, 2012). Many people still hide that they are LBGTI.
- Poor relationship between the medical profession and the LBGTI population. Historically, homosexuality was considered a criminal offence and as such those who identified may have been forced to undergo "medical cures" or face imprisonment. 65% of LGBT Queenslanders are concerned that their sexuality or gender identity may affect the quality of services provided to them (Department of Health and Ageing, 2012).
- LGBTI are not a homogenous group. They may be "veterans, care leavers, people from CALD, Aboriginal and Torres Strait Islander people, people living with HIV, people living with dementia, those in palliative care, those suffering financial disadvantage and those living in rural and regional areas" (Department of Health and Ageing, 2012).

Workforce Challenges of caring for LGBTI people

It is of important that LGBTI individuals are supported "as consumers and self-advocates when they engage with the aged care sector and relevant agencies, including government" (National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, 2012).

- There has been a shift in the aged care sector to consumer-directed care model which has been a key component in the Commonwealth Living Long Living better (LLLB) aged care reform initiatives. According to the National LGBTI Alliance, The Consumer Directed Care (CDC) model understands that cultural views cannot be ignored with ageing and aged care. The CDC allows elderly people to have a say in their health and life management, rather than being posed a set of services. (National LGBTI Health Alliance 2014b) "This approach can increase LGBTI inclusion by including LGBTI-specific care needs that may not have been addressed or included in the previous list of care options" (National LGBTI Health Alliance 2014b).

Challenges with inclusion of LGBTI people in mainstream aged care services include:

- talking with multicultural and CALD communities about LGBTI- particularly older people. (Department of Health and Ageing, 2012);
- LGBTI still remains a taboo subject amongst multicultural communities (Department of Health and Ageing, 2012);
- cultural barriers still exist with volunteers and staff. There is uncertainty on where to start and how to include LGBTI (Department of Health and Ageing, 2012); and
- further workforce development and training of staff. In 2010 a study found "86 per cent of workers in aged care facilities were unaware of the existence of LBGTI in the workforce" (O'Keeffe, 2015)

Historically, LGBTI issues have been neglected from Australian gerontology, including the areas of clinical services and practice, training and education, research, policy development and legal reform.

Implications for Workforce Development:

- The Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013 includes provisions that ensure "that no discrimination against older LGBTI people is lawful across the aged care sector. This includes the provision of services by faith based aged care providers-however it is not extended to their role as employers so carers may still be discriminated against" (National LGBTI Health Alliance, 2014a). This means that a faith-based organisation could terminate a staff member's employment on the basis of gender identity/sexuality and the individual would be unable to seek legal resolution (National LGBTI Health Alliance, 2014a).
- The development of the accreditation standard *Rainbow Tick* has been a positive step towards a culturally safe and diverse business. The Rainbow Tick was developed in 2013 by Gay and Lesbian Health Victoria (GLHV) and Quality Innovation Performance (QIP). These organisations worked together to develop the Rainbow Tick Standards and related resources. "QIP has been recognised by GLHV as the accreditation provider for these standards in the health and community services sector. QIP works with organisations to support and recognise them for being committed to safe and inclusive service delivery for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people in our community" (QIP, 2015).
- The National LGBTI Alliance is currently implementing a national workforce training program to "build the skills of the aged care workforce to provide inclusive, accessible and appropriate care to older LGBTI people" (Shaw, 2016). The program will run for 3 years until June 2016 with support from the Department of Social Services. At time of writing the program has been held in 208 workshops with a total of 3,057 participants (average of 15 participants per workshop). The program has been successful with 95% feeling they know how to make their workplace LGBTI inclusive up from 44% who reported this at the time of commencement of the training (Shaw, 2016).

ACN supports the National LGBTI Health Alliance (2011) which highlights the following requirements for future workforce developments:

- develop a LGBTI national training package for the vocational education sector;
- include LGBTI specific training for all health professionals, including nurses, doctors and allied health professionals;
- require existing aged care workers and allied health professionals to receive ongoing in-service training.
- Require that staff competency be monitored on a regular basis; and
- demonstrated staff competency must be a prerequisite for on-going funding for the service.

ACN believes aged care services need to develop policy structures that are inclusive, welcoming and culturally appropriate for LGBTI individuals.

Nurse leaders in the communities in which they serve, will continue to address the specific needs of their communities supported by their professional organisations, as the diversity within Australian society increases.

TOR k: the particular aged care workforce challenges in regional towns and remote communities;

The changing demographic of the rural and remote Australia in recent years has influenced how healthcare is delivered. The current picture of rural health in Australia sees reliance on telehealth and technology, services are delivered in the community and primary care setting and increasingly elderly are choosing to be cared for at home.

Current issues with the Aged Care Workforce in Rural and Remote Areas:

- Workforce shortages are acute in rural and remote areas of Australia. The nursing workforce is aging with an average age in 2003 was 43.1 years. (Baldwin et al. 2013, Health Workforce Australia 2013) There are not enough nurses to carry the current model of nursing care;
- There is a general shortage of health professionals and specialists. For example, the recent Department of Employment Personal Care Workers Labour Market Research found that half of providers had vacancies for personal care workers (PCW) (Australian Government Department of Employment 2015). Similar issues exist for Registered Nurses with low levels of applications for vacancies and poor suitability for vacancies (education and work experience) (Aged and Community Services Australia, 2013);
- There is increased difficulty in recruiting aged care workers outside of major metropolitan areas. It is in these areas where many people retire to and will later be a recipient of aged care services. Government incentives to attract workers to these regions may be necessary;
- Providing support for travel costs might help retain workers and accommodation in regional, rural and remote areas can be expensive so attracting new employees without housing solutions in place is very difficult. ACN is pleased to administer scholarships on behalf of the Australian Government for students who undertake clinical placement in a remote area. This scholarship is called the NAHSSS Remote Clinical Placement Scholarship and is available during a student's course of study (Australian College of Nursing, 2016). The scholarship offers financial assistance for travel and accommodation costs.
- On-job training and CPD opportunities are difficult to obtain in rural and remote aged care environments and limited career pathways contribute to health care workers leaving the area (Humphreys et al. 2009).

Whilst it has been highlighted earlier in this submission that the aged care workforce sector has a high proportion of workers born overseas, this drops in rural areas to 14% and 10 % in remote areas (Australian Institute of Family Studies, 2011). Cultural obligations are high in regional, rural and remote Aboriginal communities. This has been addressed in TOR J.

ACN believes targeted support to rural and remote areas for staff is required to deliver high standards of aged care services to the community. With an increased number of older people in rural and remote communities, ACN believes there will be increased workforce requirements.

Consideration

That the Australian Government investigate additional programs to support nurses to train, work and undertake clinical placements in rural and remote aged care facilities.

ACN believes targeted support to rural and remote areas for staff is required to deliver high standards of aged care services to the community.

TOR l: impact of the Government's cuts to the Aged Care Workforce Fund;

The Government's cuts of $40.2 million over four years (Australian Government 2015c) to the Aged Care Workforce Fund poses further challenges for a sector already grappling with workforce attraction and retention issues. The Government has a moral obligation to ensure the care needs of frail older Australians, one of our most vulnerable groups in society, are adequately funded and effectively provided. The cuts to the Aged Care Workforce Fund diminish available funds for much needed training and skills development opportunities for the aged care workforce. This will effectively risk the quality of care within the sector and undermine a key workforce recruitment and retention priority.

In addition, previously scholarships were available under the Aged Care Nursing Scholarships Scheme funded by the Australian Government to support up-skilling the aged care workforce which ceased in June 2014 (Australian College Nursing, 2013)

ACN understands that the Government is redesigning the Aged Care Workforce Fund (ACWF) to "support more targeted training and skilling opportunities for the aged care workforce to better meet the increasing complexity of older people's care needs" (Australian Government 2015c). Advancing nurse leadership and retaining the number of nurses should be a key priority in any training and skilling initiatives for the aged care sector. However, reducing opportunities for nurses and other aged care workers to upskill and attain formal aged care qualifications will not support greater utilisation of the existing workforce nor support recruitment and retention strategies in the sector. These risks are highly concerning at a time of increasing service demand.

TOR m: Any other related matters;

Deregulation of the aged care sector

The de-regulation of the aged care sector, and increasing consumer control will pose opportunities and challenges for the future aged care workforce. While ACN is supportive of innovative business models and platforms, it is important that the care recipients are not disadvantaged in anyway. The implementation of deregulation must be appropriately considered, based on comprehensive industry research, well managed, and staff well supported.

Dementia and cognitive impairment

In 2015, the World Health Organisation (WHO) held a summit to address global action for dementia. At the summit it was estimated that there would be a significant increase in dementia cases with a projected global cost of US $1-2 trillion by 2050 (Lancet editorial, 2015).

In Australia, Alzheimer's Australia (2016) recently released national statistics that supported these global estimates by reporting that there will be almost 900,000 Australians with dementia by 2050; and within a couple of decades, dementia will become the third greatest source of health and residential aged care spending, representing approximately 1% of GDP (Access Economics, 2009a). At the same time it is estimated that Australia faces a shortage of more than 150,000 paid and unpaid carers for people with dementia by 2029 (Access Economics, 2009b).

When considering the additional care needs of people who cognitive impairment, in which cognitive impairment is greater than expected for normal ageing, and is now recognised as carrying increased risk of later development of dementia, occurring at a rate of 5-15% per year in older people (Peterson et al., 2014). It has been estimated that up to 21% of older people (or 1 in 5 aged between 70 and 90 years) will display features of cognitive impairment (Brodaty et al., 2013).

In our ageing societies, maintaining independent living is important for sustaining physical and mental health, thereby minimising pressure on limited social services. Therefore, being proactive in delivering early cognitive interventions and support programs, which moderate cognitive difficulties and assist in maintaining functional independence as long as possible would be useful to advantageous for this group of people.

Reliance on volunteer workforce

- The aged care sector is reliant upon a large volunteer workforce who are heavily involved in the provision of care. Volunteers provide valuable support. Research has shown that volunteering fosters long term benefits for volunteers including "boosting social inclusion, improving health outcomes for consumers, promoting general well-being and independence" (Aged and Community Services Australia 2015).

The Aged Care Workforce 2012- Final Report highlights the following:

- In a designated fortnight there were 57,000 volunteers who contributed more than 250,000 hours of service. This equates to 4.6 hours per volunteer and an average of 27 volunteers per location.
- Not-for-profit facilities were more likely to utilise volunteers (92%).
- 84% of facilities have more than one volunteer member of staff.

Young people in Aged Care

In 2012, the ABS Survey of Disability, Ageing and Carers (SDAC) found there were 730,000 people less than 65 years of age with "profound or severe core activity limitation". According to the AIHW in 2013, the total number of permanent residential aged care clients under the age of 65 was 6,209 (AIHW, 2014). The Young People in Nursing Homes National Alliance (2016) reports that young people in aged care frequently have "**disabilities acquired largely as a result of catastrophic injury or through progressive neurological diseases, these young people require service responses from not one arm of the service system, but multiple, including health, disability and sometimes aged care, amongst others**".

RACFs may be reluctant to offer long term support to younger people due to their unique and sometimes complex and high care needs. To compound this, it is acknowledged that younger people are less able to fund alternative solutions such as engaging private carers in the home (Peisah & Sklazein, 2014). When a young person is placed into aged care, their disability funding is ceased with the facility responsible for the care and support of the person. Unfortunately, aged care funding is catered towards the end stages of life rather than the complex needs of a young person with a disability (Young People in Nursing Homes National Alliance, 2016).

The Aged Care Act (1997) ('The Act") sets out principles, which approved aged care providers must meet. These include Accreditation Standards, which highlight the provision of care and services provided to residents and ensure residents maintain their civil rights. The issue is that whilst The Act is well equipped to address the requirements of frail, elderly people, younger people needs are significantly different (Department of Social Services, 2015).

A Senate inquiry *titled Adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia* (Commonwealth of Australia, 2015) in 2015 identified 12 recommendations one of which highlights the urgency in preventing admissions of young people into nursing homes. The report recognises that some facilities will have staff caring for both groups of people and often aged care staff are inadequately trained or experienced to care for younger residents.

ACN recognises that alternative models of care should be explored to address the needs of young people.

Unpaid Carers

ACN recognises the important role unpaid carers have in supporting the ageing community. Carers Australia (2013) estimates there are 2.6 million carers which provide 1.32 billion of hours of care a year equating to a replacement value of $40.9 billion annually. Over 59% of carers who provide more than 40 hours of care per week have been in the role for 50-25 years.

Carers are often socially and economically disadvantaged with 62% in the two lowest income quintiles. They are more likely to experience poorer health outcomes. For example, carers are more likely to experience chronic pain or injury associated with caring (Carers Australia, 2013). Unpaid care responsibility often has a negative impact on workforce participation further influencing potential earnings and negatively impacting superannuation and retirement savings (Working Carers Gateway, 2015).

The Deloitte Access Economics Report, *The Economic Value of Informal Care in Australia* 2015, released by Carers Australia reports that there is an ever increasing need for carers with estimates showing that by 2025 that only "42% of people with a severe mental disability who are aged over 65 years and not living in residential care will have access to an unpaid family and friend carer" (Bastian, 2015) The report warns of a widening gap between supply and demand which have significant policy implications.

The report highlights a number of policy alternatives to help reduce the burden on unpaid carers and improve support services in Australia. These include:

- *Greater flexibility in working arrangements to accommodate workers' care responsibilities and employment preferences;*
- *Improvement in access to carer support services, such as respite care, to alleviate the impact of caring;*
- *Further investigation of carer perceptions of the costs and quality of formal care in order to encourage an optimal mix of formal and informal care provision; and*
- *Adapting the formal care sector to better meet the needs of older Australians from culturally and linguistically diverse backgrounds* (McKail, 2015).

Furthermore, the Scoping the Australian Care Economy Report, published in 2010 recognises that the overall value of unpaid care "is likely to be underestimated since it does not account for the opportunity costs of providing unpaid care, the value placed on emotional wellbeing and the financial costs of caring" (Murray & Adams, 2012).

ACN supports the Australian Human Rights Commission report Supporting Carers in the Workplace: A Toolkit (2013) recommendations for the current issues including (Working Carers Gateway, 2015):

- *Legislative mechanisms: legislation must be strengthened to recognise unpaid caring responsibilities.*
- *Flexible work arrangements: Enhancing the ability of parents and carers to remain in the workforce.*
- *Carer support payments: Income support should not penalise unpaid carers for engaging in education and training or participating in the workforce.*
- *Leave arrangements: Provisions to support carers to engage in training and education.*
- *Services: Resources such as access to early childhood education to combine paid work and care work.*
- *Workplace Initiatives: Changing workplace culture and organisation to support carers.*

Appendices

Appendix A

Table 1:

Direct care employees in the residential aged care workforce, by occupation: 2003, 2007 and 2012 (estimated headcount and per cent)

Occupation	2003	2007	2012
Nurse Practitioner (NP)	n/a	n/a	294 (0.2)
Registered Nurse (RN)	24,019 (21.0)	22,399 (16.8)	21,916 (14.9)
Enrolled Nurse (EN)	15,604 (13.1)	16,293 (12.2)	16,915 (11.5)
Personal Care Attendant (PCA)	67,143 (58.5)	84,746 (63.6)	100,312 (68.2)
Allied Health Professional (AHP)	8,895* (7.4)	9,875* (7.4)	2,648 (1.8)
Allied Health Assistant (AHA)	Combined with AHP*	Combined with AHP*	5,001 (3.4)
Total number of employees (headcount) (%)	115,660 (100)	133,314 (100)	147,086 (100)

Source: Census of residential aged care facilities.

King, D., Mavromaras, K., Zhang, W., He, B., Healy, J., Macaitis, K., Moskos, M., & Smith, L. 2013, The Aged Care Workforce 2012, Department of Health and Ageing.

Appendix B

Table 2:

Direct care employees in the community aged care workforce, by occupation: 2007 and 2012 (estimated headcount and per cent)

Occupation	2007	2012
Nurse Practitioner	n/a	201 (0.2)
Registered Nurse	7,555 (10.2)	7,631 (8.2)
Enrolled Nurse	2,000 (2.7)	3,641 (3.9)
Community Care Worker	60,587 (81.8)	76,046 (81.4)
Allied Health Professional*		3,921 (4.2)
Allied Health Assistant*	3,925 (5.3)	1,919 (2.1)
Total number of employees (headcount) (%)	74,067 (100)	93,359 (100)

Source: Census of community aged care outlets.

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

King, D., Mavromaras, K., Zhang, W., He, B., Healy, J., Macaitis, K., Moskos, M., & Smith, L. 2013, The Aged Care Workforce 2012, Department of Health and Ageing.

References

Access Economics. (2009a). Keeping dementia front of mind: Incidence and prevalence 2009-2050. Report for Alzheimer's Australia. viewed 3 March 2016 <http://apo.org.au/resource/keeping-dementia-front-mind-incidence-and-prevalence-2009-2050>

Access Economics. (2009b). Making choices, future dementia care: Projections, problems and preferences. Report for Alzheimer's Australia, viewed 3 March 2016, <https://www.deloitteaccesseconomics.com.au/uploads/File/Making%20choices%20-%20Future%20dementia%20care%20;%20projections,%20problems%20&%20preferences.pdf>

Aged and Community Services Australia (ACSA) 2015, The Aged Care Workforce in Australia, viewed 3 March 2016 < http://www.agedcare.org.au/news/copy_of_2014-news/acsa-position-paper-the-aged-care-workforce-in-australia>

Aged and Community Services Australia (ACSA) 2014, The Aged Workforce in Australia- White Paper, viewed 20 February 2016 < https://www.acs.asn.au/wcm/documents/ACS%20Website/Resources/Publications%20Submissions/ACSA%20Submissions%20Documents/ACSA%20Workforce%20White%20Paper%20-%20July%202014.pdf>

Alzheimer's Australia. (2016). Key facts and statistics 2016. viewed 15 February 2016, <https://fightdementia.org.au/about-dementia/statistics>

Alzheimer's Society (2014) 'Dementia 2014: Opportunity for change', viewed 20 February 2016, https://www.alzheimers.org.uk/dementia2014

Australian Bureau of Statistics (ABS), 2013, *Projection Results – Australia*, cat. no. 3222.0, viewed 20 January 2016, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/3222.0main+features52012%20(base)%20to%202101>

Australian College of Nursing (ACN) 2015, *Nurse Leadership*, ACN, Canberra, viewed 20 January 2016, <http://acn.edu.au/sites/default/files/leadership/ACN_Nurse_Leadership_White_Paper_FINAL.pdf.>

Australian College of Nursing 2016, Nursing and Allied Health Scholarship Support Scheme, viewed 15 February 2016 < https://www.acn.edu.au/nahsss_rural_and_remote>

Australian College of Nursing 2013, Aged Care Nursing Scholarships: Undergraduate, Accessed 1 March 2016 < https://www.acn.edu.au/sites/default/files/scholarships/acns_ug_website_text-closed.pdf>

Australian Government Department of Employment 2015. Personal Care Workers, Australia, viewed 15 February 2016 : <https://docs.employment.gov.au/system/files/doc/other/pcwreport2014.pd>

Australian Government 2013, National Aboriginal and Torres Strait Islander Health Plan 2013-2023, Accessed 15 February 2016 < http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf>

Australian Human Rights Commission (2013) Supporting Carers in the Workplace: A Toolkit 2013, viewed 1 March 2016 < https://www.humanrights.gov.au/sites/default/files/UnpaidCaringToolkit_2013.pdf>

Australian Institute of Health and Welfare (2014), Residential aged care and aged care packages in the community 2012–13. Canberra: AIHW

Australian Institute of Health and Welfare (2015), A Profile of people with disability, viewed 18 February 2016 <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129552310>

Australian Institute of Family Studies 2011, Families in regional, rural and remote Australia. Viewed 15 February 2016 <https://aifs.gov.au/publications/families-regional-rural-and-remote-australia>

Baldwin, R, Stephens, M, Sharp, D & Kelly, J 2013, Issues facing aged care services in rural and remote Australia, Aged and Community Services Australia, viewed 15 February 2016 < http://www.agedcare.org.au/publications/issues-facing-aged-care-in-rural-and-remote-australia>

Bastian, D 2015, Unpaid Carers worth $60.3 billion per year, *aged care insite*, viewed 1 March 2016 < http://www.agedcareinsite.com.au/2015/08/unpaid-carers-worth-60-3-billion-a-year/>

Benevolent Society 2013, Supporting older people from culturally and linguistically diverse backgrounds, viewed 1 March 2016 < file:///C:/Users/apak/Downloads/Supportingcaldbackgrounds.pdf>

Brodaty, H., Heffernan, M., Kochan, N. A., Draper, B., Trollor, J. N., Reppermund, S., Slavin, M. J., & Sachdev, P. S. (2013). Mild cognitive impairment in a community sample: The Sydney Memory and Ageing Study. Alzheimer's and Dementia: *The Journal of the Alzheimer's Association*, 9, pp. 310-317.

Cairns J & Vreugdenhil A 2013, 'Working at the frontline in cases of elder abuse: It keeps me awake at night', *Australasian Journal on Ageing*, vol. 33, no. 2, pp. 59-62.

Carers Australia 2013, Unpaid Carers: The Necessary Investment, viewed 1 March 2016 < http://www.carersaustralia.com.au/storage/1-Election%20Document%20web%20version.pdf>

Cheah J, Wong LM,et al: Integrate Now Create Health, Perspectives from Singapore, Editorial, IJIC Vol 10, 3 June 2010

Clare, M, Black Blundell, B, Clare, J 2011, Examination into extent of elder abuse in Western Australia. A qualitative and quantitative investigation of existing data. University of Western Australia.

Commonwealth of Australia 2015, Adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia, viewed 18 February 2016 <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Young_people_in_aged_care/Report>

Community Services & Health Industry Skills Council 2015 Environmental Scan, Building a Healthy Future: Skills, Planning and Enterprise Future of Australia's aged care sector workforce

Council of Australian Governments Health Council 2015, *A National Code of Conduct for health care workers*, viewed 19 February 2016, <http://www.coaghealthcouncil.gov.au/Publications/Consultation/ArtMID/515/ArticleID/40/A-National-Code-of-Conduct-for-health-care-workers. >

Cziraki, K., McKey, C, Peachey, G., Baxter, P & Flaherty, B 2014, 'Factors that facilitate Registered Nurses in their first-line nurse manager role', *Journal of Nursing Management*, vol. 22, no. 8, pp. 1005-1014.

Department of Health and Ageing 2012, National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy, viewed 18 February 2016 <https://www.dss.gov.au/ageing-and-aged-care/older-people-their-

families-and-carers/people-from-diverse-backgrounds/national-lesbian-gay-bisexual-transgender-and-intersex-lgbti-ageing-and-aged-care-strategy>

Health Workforce Australia 2013, Australia's Health Workforce Series –Nurses in focus, Health Workforce Australia: Adelaide, viewed 20 February 2016 < http://www.cshisc.com.au/media/164812/HWA_Nurses_in_Focus.pdf>

Department of Health and Ageing 2012, The Aged Care Work Force 2012: Final Report, viewed 13 February 2016 < http://apo.org.au/files/Resource/DepHealthAgeing_AgedCareWorkforce1012_2103.pdf>

Department of Health 2015, *Nursing Workforce Sustainability – Improving Nurse Retention and Productivity report*, viewed 2 March 2016, <http://www.health.gov.au/internet/main/publishing.nsf/Content/nursing-workforce-sustainability-improving-nurse-retention-and-productivity.>

Department of Social Services 2015, My Aged Care, viewed 19 February 2016, http://www.myagedcare.gov.au/financial-and-legal/protecting-consumer-rights.

Hirth et al (2009) "Program of All-Inclusive Care (PACE): Past, Present and Future" J Am Med Dir Assoc 2009; 10:155-160.

Humphreys J, Wakerman J, Pashen D, Buykx P 2009, Retention strategies and incentives for health workers in rural and remote areas: what works? Canberra: Australian Primary Health Care Research Institute, viewed 3 March 2016 < http://files.aphcri.anu.edu.au/research/international_retention_strategies_research_pdf_10642.pdf>

King D, Mavromaras K, Wei Z, He B, Healy J , Macaitis K, Moskos M &Smith L 2012, The Aged Care Workforce 2012-Final Report, Department of Health, viewed 15 February 2016 < http://apo.org.au/resource/aged-care-workforce-2012-final-report>

Konetzka T, Stearns S and Park J. 2008, 'The Staffing–Outcomes Relationship in Nursing Homes', *Health Research and Educational Trust*. Vol. 43, No. 3. pp. 1025-1042.

KordaMentha. (2014) *Residential aged care industry Consolidation and convergence.* December 2014, Publication No. 14-07., viewed 20 February 2016, <http://www.kordamentha.com/docs/default-source/publications/14-07-aged-careindustry.pdf>

KPMG. (2013) *Report on the residential aged care sector: Current state and potential impacts from LLLB financial arrangements*. Prepared by KPMG for Aged Care Financing Authority (ACFA), July 2013, viewed 20 February 2016, https://www.dss.gov.au/sites/default/files/documents/05_2014/attachment_3_kpmgs_report_to_acfa1_0.pdf

Kurrle, S & Naughtin, G 2008, 'An overview of elder abuse and neglect in Australia', *Journal of Elder Abuse and Neglect*, vol. 20, no. 2, pp. 108-125.

Lacey, W 2014, 'Neglectful to the Point of Cruelty? Elder Abuse and the Rights of Older Persons in Australia' *Sydney Law Review*, vol. 36, no. 1, pp. 99-130.

Lancet editorial. (2015). WHO takes up the baton for dementia? The Lancet Neurology, 14, 455.

McKail, B 2015, The Economic Value of Informal Care in Australia, Victorian Council of Social Service (VCOSS), viewed 1 March 2016 < http://vcoss.org.au/blog/the-economic-value-of-informal-care-in-australia/>

Mental Health Coordinating Council 2008, Mental Health Recovery Philosophy Into Practice- A Workforce Development Guide 2008, viewed 1 March 2016 < http://mhcc.org.au/media/10405/wfdg-intro.pdf>

Moyer, B.A. & Wittmann-Price, R.A. (eds) 2008, Nursing education: foundations for practice excellence, F.A. Davis Company, Pennsylvania, United States of America.

Murray, J & Adams, V 2012, Counting the cost of Australia's care economy, *The Conversation*, viewed 1 March 2016 https://theconversation.com/counting-the-cost-of-australias-care-economy-9946

National Aged Care Alliance (NACA) 2015, *Enhancing the quality of life of older people through better support and care*, NACA Blueprint Series, viewed 2 March, <http://www.naca.asn.au/Publications/NACA_Blueprint_2015.pdf.>

National Institute of Labour Studies The Aged Care Workforce, 2012 October 2012 Future of Australia's aged care sector workforce

National LGBTI Health Alliance 2011, National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing Roundtable, viewed 04 March 2016 < http://lgbtihealth.org.au/wp-content/uploads/2014/12/National-LGBTI-Ageing-Roundtable-Summary-Report-21-Nov-11.pdf>

National LGBTI Health Alliance 2014a, LGBTI Ageing & Aged Care in perspective, viewed 17 February 2016 < https://lgbtihealth.wordpress.com/2014/04/03/lgbti-ageing-aged-care-in-perspective/>

National LGBTI Health Alliance 2014b, What is Consumer-Directed Care (CDC) and what does it mean for older LGBTI Australians?, viewed 17 February 2016 < https://lgbtihealth.wordpress.com/2014/04/03/what-is-consumer-directed-care-cdc-and-what-does-it-mean-for-older-lgbti-australians/>

New South Wales Health 2014, NSW Rural Health Plan: Towards 2021, viewed 15 February 2016 < http://www.health.nsw.gov.au/rural/Publications/rural-health-plan.pdf>

Nursing and Midwifery Board of Australia (NMBA). 2006 *National competency standards for the registered nurse*. NMBA, January 2006, viewed 20 February 2016, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards

Nursing and Midwifery Board of Australia (NMBA) 2010, *National competency standards for the registered nurse*, viewed 3 March 2016, http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx.

Nursing workforce sustainability: Improving nurse retention and productivity (August 2014) *Nurses*. Viewed 15 February 2016 <Nursing Workforce Sustainability - Improving Nurse Retention and Productivity report >

O'Keeffe, D 2015, Multicultural workforce may be an issue for gay-friendly aged care: Kirby, Australian Ageing Agenda, viewed 1 March 2016 <http://www.australianageingagenda.com.au/2015/09/02/multicultural-workforce-may-be-an-issue-for-gay-friendly-aged-care-kirby/>

Peisah C, Skladzein E 2014, The Use of Restraints and Psychotropic Medications in People with Dementia. A report for Alzheimer's Australia. Canberra. AA

Petersen, R. C., Caracciolo, B., Brayne, C., Gauthier, S., Jellic, V., & Fratiglioni, L. (2014). Mild cognitive impairment: A concept in evolution. Journal of Internal Medicine, 275, 214-227.

Productivity Commission 2011, *Caring for Older Australians*, viewed 1 March 2016, <http://www.pc.gov.au/inquiries/completed/aged-care/report.>

Quality, Innovation, Performance (QIP) 2015, AGPAL Group of Companies employees participate in Living LGBTI training, viewed 1 March 2016 <https://www.qip.com.au/2015/12/>

Shaw, A 2016, Aged care program Trains carers to be more queer friendly, *Gay News Network*, viewed 1 March 2016 < http://gaynewsnetwork.com.au/checkup/aged-care-program-trains-carers-to-be-more-queer-friendly-20148.html>

Weirs, D & Chittick, M 2006, 'Case Study, Elder Abuse – a hidden form of familial violence', *ACCNS Journal for Community Nurses*, vol. 11, no. 1, pp. 9-10.

Westerman, T.G 2010, Engaging Australian Aboriginal Youth in Mental Health Services, *Australian Psychologist*, vol. 45, no. 3, pp. 212-222.

Working Carers Gateway 2015, Supporting Carers in the Workplace, viewed 1 March 2016 <http://www.workingcarers.org.au/index.php/work-n-care/work/1732-supporting-carers-in-the-workforce>

Young People in Nursing Homes National Alliance (2016), FAQ, viewed 1 March 2016 <http://www.ypinh.org.au/resources/faqs>