Eldercare

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Committee Secretary
Senate Standing Committees on Community Affairs
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Parliament House
Canberra ACT 2600
Email: seniorclerk.committees.sen@aph.gov.au

Dear Committee Secretary

Re: Submission to Future of Australia's Aged Care Sector Workforce Committee from Eldercare Inc

Eldercare Inc is a not-for-profit, Uniting Church affiliated aged care organisation in South Australia. We provide residential care in 13 facilities across the State, as a well as a small home care program on the Yorke Peninsula in South Australia. We currently offer 1,000 residential aged care places and more than 200 retirement living units. We have a dedicated team of over 1,200 qualified staff, 300 contractors (providing hospitality services) and more than 350 passionate and energetic volunteers.

Staff Profile

As at 28 February 2017, Eldercare employed 1,289 people (885 FTE). The vast majority of our staff (87% n = 1120 / 770.1 FTE) of the staff work in direct care services. 73% are permanent part-time, 10% are full-time and 17% are casual employees. 81% of our staff are female. We have implemented a model of residential care that is led by Registered Nurses (Case Management Model) and we have made the decision to have a Registered Nurse on duty at every site 24/7. Eldercare believes a greater investment in qualified Nurses and Allied Health personnel leads to better outcomes for residents and clients. We are currently evaluating the Eldercare care model to determine if this is correct for our own services. Eldercare's own experience supports the conclusion drawn by Courtney et al (2008) that high quality clinical management lead by nurses is not only important for resident health, but also for enhancing quality of life.

Our mix of care staff is:
14.4% - Registered Nurses
17.8% - Enrolled Nurses
59% - Care Assistants
4.9% - Lifestyle Staff
3.5% - Allied Health.

Workforce Supply and Turnover

Eldercare is not alone in experiencing a high turnover of staff. For the 12 month period leading up to 28 February 2017, 267 staff members have left Eldercare (21%). 38% of these (n = 101) have left involuntarily for performance-related issues. Eldercare considers this to be a very high rate of turnover and an indication that we must significantly improve our recruitment processes to ensure that staff are well matched to the organisation's values and expectations. Whilst Eldercare experiences high volumes of applications for care staff roles in the metropolitan areas, it has become increasingly difficult to recruit high quality care staff with experience in aged care. A large proportion of applications come from overseas people on student visas. Managing their visa requirements and tertiary education commitments leads to a reduction in availability and flexibility and leads to a very part-time and costly workforce. Feedback from residents and their families is clear that consistency and familiarity with staff leading to positive interpersonal relationships and the feeling of safety and security is very important to them. Whilst achieving this is Eldercare's aim, it has been increasingly more difficult to attract staff prepared to, or able to, regularly work more than six shifts a fortnight.

Many staff inform us that they have multiple jobs across several providers so that they can increase their weekly earnings and escape industrial requirements around required breaks between shifts and days off. This clearly creates risk in terms of WHS and potential injury as well as potential breaches of visa requirements.

Eldercare experiences amplified problems with recruitment of staff for our regional sites on the Yorke Peninsula. Eldercare has recently commenced employing trainee care workers in collaboration with Minda's RTO (a large disability services provider in SA) to improve access to staff who live in the region or are prepared to travel to the region.

Results from an Eldercare staff engagement survey undertaken in late 2016 show that highest potential turnover triggers are general dissatisfaction with the aged care industry (22% of staff surveyed) followed by inadequate staffing levels (21%) and high workloads (18%). Interestingly, pay featured much lower on the list with only 16% of staff indicating this was a potential trigger.

In South Australia, there has been much concern expressed by the SA Government and local business advocates about the loss of manufacturing jobs in this State. Assumptions have been made that aged care is the ideal sector for many of these displaced workers.

Eldercare would be pleased to see active engagement between the State Government, the manufacturing industry (either individual organisations or sector bodies) and aged care providers to facilitate a transition of these workers into aged care.

Case management model in Residential Aged Care

Eldercare has invested in a Case Management Model of residential care that emphasises the importance of high quality clinical care for an increasingly dependent and high level cohort of residents. The average length of stay for our residents is now less than 15 months and over 80% of the residents have a diagnosis of dementia. Therefore, a strong clinical model is more important than ever.

Case Management is not a new concept to healthcare, either within Australia or internationally. Studies show that the model can increase both client and staff satisfaction.

Case Management models have key components which can be adapted to residential aged care. These are:

- Screening and eligibility
- Assessment of needs
- Planning of care
- Coordinating delivery of service (either internally or externally to the organisation)
- Liaising with the resident, other members of the health care team, and families to ensure care needs are met
- Regular and ongoing re-assessment of care needs
- Regular and ongoing re-assessment, monitoring and evaluation of the service to ensure the resident's needs continue to be met.

Within the Eldercare site structure, the role of the nurse as Case Manager is pivotal and essential to the successful provision of care.

This role has been defined in the job and person specifications for a Clinical Leader. The Case Manager will be responsible for planning and allocating services to a pre-determined number of residents to ensure that services are tailored utilising a person-centred approach to meet specific individual needs.

The Case Management Model delivers significant advantages for residents when compared with a task-oriented, "whole-of-facility" model. Case management provides residents with a coordinated clinical care service which is managed by the Clinical Leader. The Clinical Leader is able to develop a relationship with the resident and their families to ensure individualised plans, offering continuity of care both on and off site.

The Eldercare Case Management Model of Care has dedicated teams, led by a Clinical Leader. The Clinical Leader is allocated to coordinate the care for a prescribed cohort of residents and reports to the Clinical Care Manager.

The case management team has two sub-levels; the direct care team and the extended care team.

The direct care team works under the direction of the Clinical Leader, and is responsible and accountable for meeting all their designated residents' assessed care needs on an ongoing basis. This care is person-centred and considers the residents' mind, body and spirit.

The extended care team works under the Clinical Care Manager and is responsible for ensuring the spiritual, emotional and special care needs of the resident are met. Family members may be engaged to assist with care of their family member. All aspects of resident care are coordinated and managed by the Clinical Leader assigned to the resident and oversight is managed by the Clinical Care Manager.

The model has now been in place for over 12 months and Eldercare is in the process of evaluating the model to determine if the investment in this model has delivered benefit to the residents, their families and the staff.

Eldercare is confident that the benefits of this care model will be revealed through the evaluation – the concern is that it will be an unaffordable model of care under the current funding system for residential aged care. Another trend being observed is that providers are scaling down the input of professional health care professionals purely because these staff are unaffordable – this is of concern to Eldercare.

Nurse practitioners in Aged Care

Eldercare has recently employed our first Registered Nurse Practitioner in Palliative Care. The Nurse Practitioner has already delivered very positive outcomes to residents needing palliative care, as well as their families and the staff involved. Nurse Practitioners provide the residents with important support during their most vulnerable stage of life. The Nurse Practitioner supports the Eldercare Nurses, Allied Health and the visiting General Practitioners to deliver expert palliative care with the provision of clinical advice and medication management, as well as general support to deliver the resident's Advance Care Directives. This raises the ability of the Registered Nurses to confidently manage end of life as well as preventing transfer to the acute sector (hospital). Eldercare believes that a further investment in Nurse Practitioners will deliver better resident outcomes, but the current funding model makes further investment very difficult.

Roles of Allied Health Professionals in Aged Care and their engagement

Eldercare employs Physiotherapists, Occupational Therapists and a Speech Pathologist and contracts Speech Pathologists, Dieticians and Podiatrists (n = 16 head count / 9 FTE). Eldercare also contracts Physiotherapy services (equivalent of 8 FTE) from an agency to support the ACFI "12.4(b)" Program (pain management therapy for residential care residents).

A recent review of the Allied Health Program within Eldercare recommended bringing the majority of allied health services in-house to ensure continuity and better value for money. It was also determined that the contracted staff generally lack the professional insight required to manage quality outcomes and do not contribute to effective, efficient and accessible services for Eldercare's residents.

Feedback from Allied Health professionals has generally indicated that aged care is not the first choice, but the recent engagement survey indicated that once Allied Health professionals join Eldercare, only 11% think about leaving and only 6% have formed a specific intention to leave. 63% are "engaged". 83% of the Allied Health staff reflected that they received a fair day's pay for a fair day's work. 89% stated that they received appropriate remuneration for the responsibilities they have. This may indicate that once Allied Health professionals do make the move to aged care they are engaged, wanting to stay in the sector and are satisfied with the pay and their responsibilities. Eldercare is of the view that more needs to be done to attract this specific professional group to work in aged care.

Role flexibility and innovation in job design

The roles and design of jobs in residential aged care in Australia has been heavily influenced by the industrial environment. Residential aged care providers frequently espouse that they deliver "person-centred care", but the current industrial environment makes this difficult, as often the work is designed around meeting the needs of the staff, rather than the residents (shift times, role differentiation, breaks and rostering for efficiencies). The current funding model also drives providers to be efficient and cost conscious as a priority rather than focusing on the delivery of person-centred care. A role that combines the role of the traditional personal care worker and the lifestyle or activities worker with a domestic services role would be a good place to start. This would give a worker flexibility to meet the needs of the resident in a timely manner delivering continuity and familiarity.

Funding (cost of care study)

Funding remains one of the biggest barriers for providers to invest heavily in workforce development. The regulated environment also makes it more difficult for providers to increase income to support workforce development.

It is clear that there is a misalignment between the actual cost of care and the funding received for both home care and residential aged care. Eldercare supports a cost of care study to be undertaken to provide accurate information about the real costs which would include the current and future costs of a flexible, qualified and supported workforce for the future.

Jane Pickering
Chief Executive