ANF (VIC. BRANCH) SUBMISSION

SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE

INQUIRY INTO AGED CARE

July 2004

ANF (Vic. Branch) Submission will format our comments under Terms of Reference to which they apply:

(a) *the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training:*

Current Federal government policies and proposals in regard to education places for Registered Nurses will, demonstrably, NOT meet the increasing needs of the Acute Health Sector – let alone address the needs of the Aged Care sector.

The Registered Nurse workforce in Victoria – as in all States – is ageing and it was estimated by the Victorian Department of Human Services in 2001 that Victoria would need an additional 2,000 Registered Nurse places in universities to meet our needs alone. We have been given an additional 240 places Nationally. I believe that Victorian universities received an additional 50 odd places last year with about as many to come over the next 2 years.

Victoria is the only State that offers Traineeships for Division 2 Registered Nurses (EN's). Currently State funding to our VET sector is in a "no growth" mode, so increases in funded positions for Division 2 RN training is not possible, but Federal funded traineeships for Division 2 RN's are in great demand. However, due to the wages gap between Public/Private Acute and Aged Care, most of these nurses once registered move out of Aged Care.

Certificate III in Aged Care work and, to a much lesser extent, Certificate IV in Aged Care, are delivered widely in the State. Directors of Nursing in Aged Care still maintain that this training does not meet the needs/skills required in High Care facilities and that more Division 2 RN's and Division 1 RN's are needed.

Victorian skills mix of RN's to residents has fallen from an average of 1 RN : 30 residents across all shifts in 1997 to 1 RN : 60 residents during the day, out to 1 RN : 90 or 120 at evening and night shift. Some high care facilities only employ an RN for two two hour shifts per day – to administer medications. These facilities still meet accreditation standards.

Given current Federal government proposals, ANF (Vic. Branch) envisages these staffing levels for RN's will further deteriorate, but while the Federal government does nothing about regulating or mandating staffing levels or minimum qualifications in the sector and the Standards Agency continues to accredit facilities, the Aged Care providers will certainly not spend any more money on staff or skills mix.

Previous Budget initiatives by the Federal government in the form of additional funding to attempt to address the "wages gap" have effectively done nothing to stem the deteriorating staffing levels and skills mix – the monies have **NOT** been tied to wages movements – nor have the proprietors been required to maintain staffing levels. Proprietors simply reduce staff hours and deplete RN numbers to maintain the previous "wages budgets" and extra money goes to profits or perceived imperatives e.g. refurbishments or buildings.

ANF (Vic. Branch) would be happy to provide concrete examples of this if the Committee believes it is required.

(b) *the performance and effectiveness of the Aged Care Standards & Accreditation Agency in:*

(i) *Assessing and monitoring care, health and safety.*

ANF (Vic. Branch) have numbers of examples where on reporting to the Department Complaints Resolution Process/Agency episodes of poor care and health outcomes, the response back to ANF (Vic. Branch) has been NOT to address the issues as they are "industrial". For example, lack of access to RN assessment and ongoing management by residents in high care, very poor staffing levels leading to poor care. We have made written inquiries of the Federal Department and been told "the Government reserves the right to determine appropriate staffing levels" – but they have NOT made that determination. Therefore, any judgment that the Agency makes in relation to the issue of adequate care, health and safety is on an ad hoc case by case basis – in isolation to staffing levels and skills mix (which is considered "industrial").

The Health Sector now abounds with research which demonstrates that the level of nurse education and levels of nurse staffing are directly related to health outcomes of patients/residents. Still the Accreditation Agency ignores this, as does Federal Departments.

We attach for your reference an extract from "Keeping Patients Safe" (Attachment A) the latest (January 2004) research and recommendations from the Institute of Medicine U.S.A.

(ii) *Identifying best practice and providing information, education and training to Aged Care Facilities.*

As this requirement of the Agency is relatively recent, it is hard to judge whether it will be effective. But a similar process was tried in the early 1990's by the Federal Department and it failed – to expect one organisation to perform two such diverse roles as Accreditation and education, we believe will lead to a conflict of interest. It can also lead to idiosyncratic training. That is, training to meet a goal that is other than focused on the best outcomes of the resident/client but to meet the outcomes of accreditation.

(iii) *Implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demand on staff.*

Given that current Accreditation processes require similar burdens as other accreditation systems in Health and other industries, e.g. EQUIP in the acute sector, it is hard to envisage a continual improvement process that will reduce those burdens. The greatest "paperwork" burden on Aged Care staff is the documentation required to meet accountability requirements for the funding of RCI payments to residents. Unless the government decided to move away from accreditation of facilities, it is hard to see how the current accreditation "paperwork" burden could be reduced. ANF (Vic. Branch) would not believe it is overly burdensome compared to other such systems.

(c) *the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific needs are met under current funding arrangements:*

In the early 1990's in Victoria's public sector Nursing Homes, there was an attempt to provide specific purpose nursing homes for young, severely disabled, persons. This attempt lost impetus (largely due to cost cutting by the then State Government and the subsequent Privatisation Policy put in place by the same Government). The ANF (Vic. Branch) would support specific Nursing Homes for this group. We have reservations about the feasibility of such a policy unless specific funding was designated as current funding arrangements would not meet or address the needs of these clients.

The High Care needs of dementia residents were intended to be addressed in the 1997 changes to the Aged Care Act i.e. Ageing in Place. From the perspective of giving high care dementia residents access to appropriate nursing and health care, Ageing in Place has not been successful. As facilities such as Low Care or Hostels are not required to employ Registered Nurses, the only access generally that such High Care Dementia residents have to Registered Nurses is on a "casual" or "call in basis". ANF (Vic. Branch) believes that such care is not always appropriate or adequate. In particular, there are issues around Medication Management and Medication Administration. Still the highest "Non Compliant" Standard through accreditation is medication management – and by far the largest group of homes non-compliant under this standard are low care facilities providing "mixed care" i.e. low care beds providing services to High Care residents.

The current data shows that nationally on average over 30% of low care beds are occupied by high care residents (DoHA March 2004). In some states this figure is over 40%. Such lack of access to skilled nursing care by high care residents is untenable. The Federal Government must amend the Act to ensure these residents (largely suffering dementia) have access to nursing care.

In Victoria, historically our ageing population of mentally ill are well serviced by access to Public Nursing Homes (some 5,000 – 6,000 beds across the State). These homes would NOT be able to continue to provide Psychiatric nursing care if they were reliant on Federal funding. Our State Department of Human Services provides additional top up funding (around $50.00 per resident per day) to ensure maintenance of appropriate skilled care and services to this vulnerable group. ANF (Vic. Branch) believes this should be a Federal responsibility.

Of concern to ANF (Vic. Branch) on behalf of our nursing members who work in the sector, are the needs of a small group of severe behavioural disturbed residents who are not mentally ill but are violent and aggressive. This violence can be to other residents or staff. The ability of staff who are under-resourced and not skilled in managing such residents, causes great physical and mental distress to staff. There is currently no ability for homes finding themselves with such a resident, being able to access special funding to address the resources needed to manage such clients – either on a short or long term basis. This has in the past led to Homes attempting to evict such people in order to protect their other residents and staff, or trying to get such people back into a public hospital.
This issue must be addressed by special assessment and specific funding substantial enough to address the need for skilled nursing care.

(d) *the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly:*

The Home and Community Care Programs are one of the great success stories in Aged Care and over the past two decades have provided our communities with much

needed and appreciated services. There has had to be, and continues to be, a great deal of co-operation between all levels of government in delivering HACC services.

The greatest impact on HACC services – apart from an ageing population – has been the pressures placed on them through the Federal Government's policy of not approving Residential Aged Care places according to their own ratios. The fact that increasing numbers of increasingly dependent older people are "forced" to stay in the community because there is no Residential "place" for them, has exponentially increased pressure on HACC services, despite the use of CACP's by the Commonwealth.

District Nursing Services – which receive on average in Victoria 80% of their funding from HACC, are increasingly finding that the needs of their clients in the home are more complex and using greater resources.

ANF (Vic. Branch) recommends: that the Commonwealth should review the dependency level of HACC clients with the intent of re-evaluating funding needs of these services.

(e) *the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community:*

ANF (Vic. Branch) believes that the Victorian Government have been particularly pro-active in developing and funding initiatives in this area. Unfortunately, it does not appear to be attracting the appropriate levels of funding from the Commonwealth government.

We are aware that currently the Federal Government is providing a pool of funding for "Initiatives" in this area. One such initiative in Victoria is being funded in Ascot Vale and will be run by Doutta Galla.

Information on such initiatives is not forthcoming from the Commonwealth.

It has long been recognised that one of the flaws of Federal funding for residents in RAC's (i.e. RCS and then RCI funding) actually penalises facilities that rehabilitate residents (i.e. they lose funding if the resident improves in activities of daily living).

Yet, with the introduction of DRG Casemix funding in the Acute Public sector, there are positive incentives for the hospital to discharge the elderly as soon as possible. There are also positive reasons why these elderly post acute phase patients should be discharged from the acute hospital into their permanent residence as soon as possible. But there is no provision in Federal funding to ensure that these elderly citizens can benefit from appropriate rehabilitation to ensure their quality of life is maximised. We have constant examples of this – a very recent one was the discharge back to the Nursing Home post total hip replacement within 24 hours of surgery. Another was discharge home following brain surgery within 36 hours – in neither case did there appear to be appropriate resources and services from the Federal Government to follow up the patient.

ANF (Vic. Branch) recommend that there be research carried out into the needs of the elderly post acute phase with the intent of ensuring that elderly who would benefit from additional skilled nursing and allied health are funded and able to receive such care in their Residential Aged Care facility.