



ROYAL COLLEGE OF NURSING, AUSTRALIA

Submission to the Senate Inquiry into Aged Care

1. Introduction

Royal College of Nursing, Australia welcomes the opportunity to provide comment to the Community Affairs References Committee regarding the Inquiry into Aged Care which was announced on 23 June 2004.

2. RCNA – Background

RCNA is the peak national professional organisation for Australian nurses. The College was established in 1949 and until the early 1990s was a provider of formal ongoing education for nurses who wished to gain higher qualifications in nursing. Following the completion of the transfer of nursing to the higher education sector in 1993, RCNA refocused its functions to encompass continuing professional development and policy analysis and development.

In 1997, RCNA became the Australian representative to the International Council of Nurses (ICN). The ICN is a federation of 125 national nurses' associations representing the millions of nurses worldwide. Operated by nurses for nurses since 1899, ICN is the international voice of nursing and works to ensure quality care for all and sound health policies globally.

RCNA represents nursing across all areas of practice throughout Australia. RCNA has members in all States and Territories of Australia, and internationally. RCNA is a not-for-profit organisation, providing a voice for nursing by speaking out on health issues that affect nurses and the community. With representation on government committees and health advisory bodies, RCNA is recognised as a key centre of influence in the health policy arena in Australia. When health policy decisions are made, RCNA presents a professional nursing perspective, independent of political allegiance.

In addition to the ICN, RCNA is affiliated with several other international organisations and numerous national organisations/associations. The College has a memorandum of collaboration with the Australian Nursing Federation. RCNA has well established

National Nursing Networks for members, which provide access to a range of expert practitioners. RCNA members and others from within the profession produce regular evidence based papers for *Collegian* – the refereed journal published by the College.

3. RCNA Response

In June 2004 it was announced that there would be an Inquiry into Aged Care to be conducted by the Senate's Community Affairs References Committee.

3.1 General Comments

As the leading national professional nursing organisation in Australia, our primary concern is that the Committee gives due recognition to the fact that nurses are the largest group of health and aged care workers and provide up to 90% of primary health services for older people. Nurses are, and will continue to be, the most important care givers as the population ages and care needs become more complex. As such, nursing workforce issues need to be addressed as a priority in order to ensure the future care of older people in our community.

In addition, the ageing of the population means that there will be increased need for health promotion and management of chronic illness, particularly for those living in the community. Nurses are the ideal group to provide this type of care – which is another reason for the need to address nursing workforce issues as a matter of priority.

The current situation in aged care for both residents and health workers is completely unacceptable for a wealthy nation such as Australia, and is a sad reflection on the value we place on our older people. While the recent Budget proposals were welcome and will go some way to rectifying current problems in aged care, as a nation we urgently need to look at how much we value our elderly and ensure that the funds are in place to give them a better deal in residential care, and to reduce the very heavy workloads and stresses placed on those dedicated staff who look after them.

3.2 Specific comments

The following comments relate specifically to the terms of reference of the inquiry.

- a) Adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training.*

Royal College of Nursing, Australia applauds the Government for the announcement in the 2004 Budget of the much needed and overdue funding for a range of aged care initiatives. The new aged care places, the increased funding for aged care workforce education including the increased undergraduate tertiary places in aged care nursing and for enrolled nurse education are particularly welcome. These measures will have a significant impact on the severe nursing shortages in aged care which are being experienced throughout the country and are likely to worsen as both the workforce and

the general population ages. The funding for unlicensed workers to upgrade their qualifications to enrolled nurse will also be helpful for improving the education base of health professionals caring for the frailest members of our community.

It is also pleasing that the issue of wage disparity between aged care nursing and other nursing specialties has been addressed at least in part by the \$877.8 million allocated to aged care providers to pay more competitive wages. The direct burden of resident care falls upon registered nurses and yet current salaries do not reflect the responsibility they carry.

This money from the Budget could be put to even better use however, if it had been allocated specifically to address the gap between wages for nurses in aged care, and wages in other specialties. There is much fear among our members that this money will not be used as intended but instead end up in the consolidated revenue of aged care facilities. This could be addressed by making it a condition of funding that the money be spent on improving wages. There is simply no incentive for nurses to want to work in aged care while the wages continue to be much lower than in other areas of nursing.

There is still also considerable room for improvement in other areas of aged care and many funding gaps which still urgently need attention.

The Budget's focus on lower level nursing education means that there was very little provision for specialist gerontological nursing education. The care needs of older people are becoming more and more complex, requiring increasingly highly skilled nurses capable of complex assessment and analysis.

It is vital that like other areas of specialist practice, there are a range of qualified workers including at least a proportion of registered nurses who have completed not only undergraduate education but who have formal specialist qualifications. Without the presence of these specialist skills, older people remain vulnerable to a significant lack of knowledge in their care providers. Specialist gerontological nurses are highly skilled professionals who also are the role models and mentors of lesser skilled care staff, and are necessary to provide them and newly graduated RNs with direction and guidance in their care of the aged.

The College trusts that the Committee will see the advantages in at least striving towards a future RN and EN workforce that is equipped with the specialist knowledge and skills of gerontological nurses. To this end measures should be put in place which increase the numbers of RNs working in aged care who have postgraduate gerontological nursing qualifications. These measures could include:

- Increasing government support and assistance for the expansion of the use of nurse practitioners across the country, including in aged care.
- Rewarding Schools of Nursing who can demonstrate they have "aged person specific" content in undergraduate and postgraduate curriculum.
- Supporting Schools of Nursing to employ aged care specialist educators.

- Supporting joint appointments between academic institutions and health service providers.

The medication management training funding in the Budget will enable ENs to better fulfill their role in the aged care team and ensure medication management is not relegated to a category of worker with no pharmacology education. This measure will enhance the EN role and lead to more ENs remaining in aged care. An related issue is that of minimum level education requirements for aged care workers. RCNA has been lobbying for some time for the legislating of minimum level qualifications for aged care workers being equivalent to the Australian Qualifications Framework Certificate Level III. This was a recommendation from the 2002 Senate Inquiry into Nursing which still has not been implemented.

This qualification needs to be consistent across the country and there must be a consistent curriculum. Many unlicensed workers have very little understanding of specific health needs of those in aged care or of their responsibilities and role, and work well beyond their qualifications and scope of practice.

In addition to the Budget proposals, funds are still urgently needed in other areas within residential aged care such as providing diversional therapy for dementia patients and for providing residents with better meals. There should be for example, guidelines established for ensuring residents are given fresh vegetables and interesting, varied diets and not just the cheaper frozen foods that are prepared in most facilities.

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

- (i) assessing and monitoring care, health and safety*
- (ii) identifying best practice and providing information, education and training for aged care facilities*
- (iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.*

Generally speaking the accreditation process has improved the standards of many nursing homes. Once again however there is much room for improvement. Not surprisingly, many RCNA members have expressed their frustration at the huge amount of documentation required by the accreditation process and the increasing amount of time they have to spend on paperwork to meet accreditation requirements instead of providing hands-on nursing care. There is also the tendency for assessors to spend more time focused on the documentation process instead of concentrating on the quality of direct care received by residents, as well as the tendency for aged care facilities to employ system managers and administrators at the expense of staff giving direct care to residents.

These complaints are not new and have been brought up again and again by nurses in a number of reviews of the accreditation process.

Just some ways to address the burdensome nature of the paperwork could be to:

- Further refine the kit to reduce unnecessary repetition between visits.
- Not require already accredited facilities to complete the full version of the kit which should be required only of new services or those requiring improvements. Making accredited facilities complete the full version is very burdensome and is akin to assuming that the facility was never in existence beforehand. In such cases the paperwork could focus on the previous kit as a template, with greater detail needed to be documented for changes and improvements.
- Seek input on the development of the kit from those who actually complete it.

Another idea which would address, at least in part, the amount of paperwork involved in accreditation would be to abandon the system of dual accreditation, which really serves no purpose for facilities who are part of a larger organisation and undergo ACHS accreditation. This is one factor that continues to frustrate providers. It is also expensive.

One simplified accreditation system with clear standards in terms of meeting requirements (such as the elemental table developed by ACHS) has the potential to be very helpful for providers and assessors alike. Language in such a system needs to be clear with mandatory criteria having very clear measurement indicators.

It would also help to improve the assessor training system by using a rigorous elemental table system as described above to ensure that there is no ambiguity in assessment. This would in turn reduce inconsistencies frequently reported between assessors, the Accreditation Agency and government.

Regarding the specific roles of the agency, it is appropriate that core business be limited to assessment and monitoring and does not flow into identifying best practice, education and training. There already exists a plethora of independent expertise involved in best practice research and development, and aged care education and training. If the agency persists in being involved in those activities outlined in (ii) above, (apart from education that assists the facility with accreditation per se and accreditation processes) they run the risk of alienating themselves from the sector and of being criticised of conflict of interest.

Regarding the specific roles of registered nurses, the RCS in its present form does not recognise and value these usually highly skilled workers for their levels of expertise. Instead it is based on a lack of trust in registered nurses and their ability to do resident assessments. A resident assessment completed by a registered nurse should be accepted in the same way as an assessment by any other health practitioner. This should be sufficient to establish RCS funding subsidies and would also reduce paperwork.

Currently RNs are faced with far too many demands to “prove” by excessive note-taking and paperwork that assessments are accurate. One member writes:

“Behaviour charts” should not be necessary to prove to the Health Department validators that a resident with dementia has “challenging behaviours”. Writing down every behaviour aberration for a whole week or more is degrading to the resident and undermines their dignity, something that we are striving to uphold for our residents (and something that accreditation demands). Staff are not comfortable doing this. A short summary of this problem, written by a registered nurse should be acceptable.

- 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 conditions are met under current funding arrangements.*

RCNA believes it is highly inappropriate for young people to be placed in residential aged care facilities. Young people have completely different physical and psychosocial needs to the aged. Being with older people does not encourage the mental stimulation and the range of activities required by young people, and the aged care staff are often not qualified to meet their care needs. Similarly there is little potential for innovative models of care for young people placed within aged care systems.

Likewise it is the College’s view that mentally ill patients – specifically, those who have had a diagnosis of mental illness in addition to or instead of those conditions commonly brought about by old age – should not be accommodated in mainstream residential aged care facilities.

On the other hand, dementia patients make up approximately 90% people in residential aged care facilities and therefore are no longer considered “special needs”. Residents with dementia should be included in mainstream facilities either alongside other residents or within the facility but in a separate area.

Care of dementia patients represents one of the biggest challenges facing aged care in the next decade and this needs to be given due recognition by the Committee.

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

Existing Home and Community Care programs do as much as they can given their funding and structure. Most problems relate to inter-sector issues such as documentation, transfer of information, and duplication of administration. Programs definitely need more flexibility with services aligned to meet needs, including the increasing demand for day and respite services, instead of being simply aimed at promoting independence.

The payment for family carers is also far too low and family caring should be recognised as a full-time job and payments awarded accordingly.

- e) *the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings and back to the community.*

The Australian Government-State/Territory divide over funding remains the single biggest hurdle to intersectoral collaboration, and is the cause of most problems, including many of the excessive documentation issues, as well as clinical issues such as the need for people in aged care facilities to be moved to hospital and back again. Given appropriately skilled staff (see above) many residents can be given necessary care in the facility, or at least be visited by acute care staff. Where movement across sectors is unavoidable/necessary, improved systems are needed for transfer of information relevant to the older person involved in order to ensure transition of appropriate care.

4. Conclusion

The 2004/05 Budget initiatives for aged care were substantial and very welcome. They were also much overdue and, at least in regards to addressing nursing issues within aged care, lacked definition in some areas. The recommendations outlined in this submission, including increasing access to specialist gerontological nursing education and expanding nurse practitioner programs, ensuring increased nursing wages are a condition of funding for aged care providers, and streamlining the accreditation process are the most important steps to ensuring that the services provided in current and future models of residential and community aged care can be skilfully provided for generations to come.

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