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Submission to the Productivity Commission on Aged Care
By Clare Dewan

I am an industrial relations consultant who has worked as such in the aged care sector for almost thirty years. I have a large number of clients in the sector, and over the years have been able to observe the many changes in the industry. Generally, of particular concern is the increasing part time nature of the work force and the effect on managing the roster, the standard of training for Division 2 nurses and personal care workers, the ability of organizations to provide continuity of care and the difficulty of maintaining a high standard of care.

In the 1980's I think is reasonable to say that rosters were static, staff worked predominantly for one employer ay one facility and stayed with that employer for many years. This is certainly not the case at present in many of the facilities I have been involved in. Gradually the idea that an employer had to be flexible in roster situations took hold but has now reached the point where many, if not most, facilities have little control over the roster. By that I mean the employees are working to suit their needs and chop and change shifts, drop shifts, do not come to work with little if any notice, work across a number of facilities, work shifts for different employers without a break etc. Managers are afraid to refuse employee requests to drop or change shifts as they think the employee will simply leave and go elsewhere or to an agency. Many employees do not want to have fixed rosters as they do not wish to be tied to a roster.

The result of this situation is a difficulty in providing optimum care or continuity of care. How can an employee working two shifts a fortnight for one employer provide continuity of care? How can employees who do not see the residents from one week to the next understand their needs or the changes in their condition? How can a care team be established? How can relatives feel they can communicate with staff they rarely see?

This situation also has a detrimental effect on the ability of an organization to provide training to staff, conduct meaningful appraisals or to hold staff accountable. Further, if an RN1 is in charge of a facility or part of a facility but only works say 2 shifts a week, how can that RN adequately oversee the care of aged people or a team of people? Conversely, if staff under the RN1 work on a roster which is not fixed and this has resulted in disjointed staffing and staffing mix, how can that RN properly undertake their role and responsibilities?
Making medication errors is another issue which can be used to gauge the problem. I can recall the time when an employer who found an employee say not signing a medication chart would be

horrified. The staff member would be dealt with very seriously and perhaps have their employment terminated. Now, many aged care facilities have to accept that medication errors occur on a regular basis. I have been told by managers that if they dismissed all the staff who for example failed to sign for medication given, they would have no staff left. Accountability is just too hard to enforce.

Another issue affecting the willingness of employees to work say a minimum of four shifts a week for one employer, is that they claim to work in excess of a certain number of hours will result in them earning so much that their pension or related benefits will be adversely affected. This would seem to be an issue which needs addressing as the work is there so why are they able to refuse it in order to keep receiving Government benefits? Many staff work for more than one facility to ensure they are able to maximize salary sacrificing at more than one organization. Having so many staff work part time also means that aged care facilities have to find so many more individuals to fill the EFT positions. So for example, if there were 60 EFT positions, an employer may have to find 120 people to staff the facility. As this applies across the industry, the problem is obvious. How to get so many staff and ensure they are quality staff?

Consideration needs to be given as to how to encourage staff to work for the one employer and to work a minimum of shifts so as to provide continuity of care and to form a more stable work force.

In relation to training I have observed the results of having little or no quality control processes in place for the Registered Training Organizations. While some produce excellent results, and some work closely with employers to obtain the results the employers want, there are too many who do not produce the results which are in either the interests of the employees or the industry. I have met with staff in trouble due to say, making medications errors. Upon looking into their personnel files, it is clear they have had no previous experience in aged care prior to completing a Certificate 3. In this case the employee was asked how they came to be in aged care. The answer was that the RTO came to their church and encouraged the young boys to undertake the training for their Certificate 3 in aged care. They managed to complete the training and obtain the Certificate 3 in 6 months of part time study, during which time no training in medication administration was provided.

Another example is where an employer had obtained a certificate 3 in 6 weeks having had no background or experience in aged care.

It is well known that “no one fails their Certificate 3”, that staff who have virtually no skills in reading or writing have obtained a Certificate 3, that people with very poor English skills have obtained a Certificate 3, that there is no continuity across RTOs as to the modules or make up of a Certificate 3, that the actual training provided is of little or no practical use once the person tries to work as an aged care worker, that most employers simply have to employ these people in desperation. I know of no RTO who actually takes the time to find out if a person has an aptitude for a caring job or to work with ageing people. It seems to me, after speaking to many staff who have undertaken the training and found themselves in trouble, that the driver behind much of the training being provided is simply money.

In some cases, it has been clear that the training for division 2 nurses has not resulted in those undertaking the training being competent, and yet they are said by the RTO to be competent. Once in the workplace, it becomes obvious from the reports of concern from the Division 1 nurses and the competency assessment, that they are not. Of course this does not apply to all RTO's but as it is happening in some cases, the situation is not satisfactory
.
In my view, the whole process of training people for roles in aged care needs to be reviewed. This includes, in the case of personal care workers, the training being provided, the lack of quality bench marks and quality service, the lack of accountability in relation to recognition of prior learning, the lack of accountability in outcomes for those being trained, including division 2 nurses, the lack of accountability in ensuring people undertaking the training are suitable, the lack of accountability in ensuring the staff who complete the training are actually competent, and the way aged care has been used in attempts to reduce the unemployment figures and been the repository for so many unsuitable people.

I have been told by new entrants into aged care things like "Well, I do not appreciate being spoken to like that by anyone including (name of resident)" which clearly shows that the person had no idea of what ageing is about or working with the aged entails. Where a medication error or omission was once grounds for disciplinary action, now, unless it is serious, no action is taken on the basis that if there was we would be disciplining almost all staff members.

With nurses being harder to recruit to aged care, especially Division 1 nurses, the role and function of division 2 nurses and personal care workers becomes pivotal to facilities. The industry must value the role of the division 1 nurse while recognizing they are becoming a rare breed, and this may include incentives to work in more managerial roles for at least four shifts per week. However, if employees being supervised by the Division 1 are not competent, then the industry will not be able to keep the Division 1 nurses who would be otherwise willing to stay in the industry.

The industry must look to what role the registered nurses will have in future, but there appears to be no doubt the reliance on personal care workers will grow and this means that all elements of the recruitment into training and the training itself has to be reviewed.

The current system ensures poor practice is continued because once the newly trained Division2 or PCA has worked say for 12 month with an employer, that person simply moves on stating they have the 12 months experience. No one seems to check how much actual training they did initially or since and no one seems to dig into what the modules completed consisted of. The employee simply blends into the system.

In general, it is my strong view that there must be a system introduced which stops aged care being the repository for the unemployed and that makes RTO providers accountable for the type of people they offer training to, the quality of the training and the outcome of the training. There needs to be a review into what the training has degenerated to and what is required to ensure people undertaking training are actually required to train in practical aspects of aged care so when they get into the sector they have the skills required for medication administration, hands on care and empathy for the residents/clients. The modules and competencies listed as being

offered are not reflective of a good outcome in relation to the courses being offered which are based on these competencies. I believe they have been watered down so as to be almost useless. This is not what is now happening.

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