Quality Aged Care Action Group Incorporated (QACAG Inc.)

QACAG Inc. is an advocacy group that aims to improve the quality of life for residents in residential and community aged care

Quality Aged Care Action Group Inc. Submission to the 'Caring for Older Australians' Productivity Commission Inquiry 2010

INTRODUCTION

Quality Aged Care Action Group Incorporated (QACAG) is a community based group which aims to improve the quality of life for people in residential and community aged care settings. We do this through talking to community groups, running events and activities such as the 'Dignity and Respect' postcard campaign and several aged care community forums, lobbying government at local, state and federal levels, and participating on committees and networks.

On 21 July 2010 a delegation of eight QACAG members met with Commissioners Mr Mike Woods and Mr Anthony Housego from the Productivity Commission Inquiry 2010. This meeting provided an opportunity for the Commission to increase its understanding about the role and motivation of QACAG, hear about our personal and professional experiences and receive our suggestions towards redesigning Australia's aged care system. It also provided an opportunity to lobby for meaningful consumer involvement in aged care reform.

This particular submission is primarily focused on our experiences with residential aged care as this is the area that consumes most of our groups' work. We would love to offer up more ideas about new models or innovations, but at this stage we feel unable to adequately do so. This is because the 'details of daily life' for those in residential aged care dominates our concern, and we call for immediate solutions to make the care more comfortable and less hurried for those already receiving care. We have taken this opportunity to tell you some of our experiences, observations and concerns and to make constructive suggestions where we feel able to.

As discussed in the meeting, we have attached the two QACAG responses to previous reviews as these contain extensive comments from our members in relation to the accreditation processes[1] and the complaints system[2].

QACAG is ready and willing to participate in shaping the future of aged care through this Inquiry, and we regard this submission as one important step in that process.

ABOUT QACAG

Background

QACAG Inc. was established in 2005 and became incorporated in 2007. The group is steadily expanding with a current membership of 150 drawn from individuals and organisations across NSW who strive to promote positive change through collaboration and community action. Regular meetings occur in Sydney, the Central Coast and the Blue Mountains, and an Annual General Meeting is held each year. To assist the sustainability of

[1] QACAG Submission to the Review of the CIS, August 2009
[2] QACAG Submission for the Review of Accreditation Process for Residential Aged Care Homes, July 2009

our group the NSW Nurses' Association provides some secretariat support and access to meeting and teleconferencing facilities.

Membership
QACAG is made up of people from many interests and backgrounds brought together by common concerns about the quality of care for people in aged care. We offer a wealth of experience with members including people receiving aged care services in nursing homes or the community, family and friends who support loved ones, nurses and retired nurses, people who work in aged care or health, long term activists in welfare and health and other concerned community members. Membership includes representatives from the Older Women's Network, The Combined Pensioners & Superannuants Association of NSW Inc, the Retired Teachers' Association and the Newcastle Combined Pensioners' Area Council. Several members sit on boards or committees or belong to other associations bringing a wider context and knowledge to their membership to QACAG.

Many QACAG members are older people themselves, some well into their eighties. Some members travel on public transport or in car pooling for up to three hours each way to attend meetings, and this speaks to the commitment and passion in this group. We recognise that at times our older members face the discriminative and devaluing attitudes towards older people that are insidious in the wider community. In fact, some are reluctant to disclose their age due to experiences of dismissive or patronising responses in various settings. Within QACAG we highly value the influence of older people with such a depth of life experience and know that this adds particular richness to our submission and to the work of our group

QACAG INSIGHTS INTO THE AGED CARE SYSTEM
As a group with hugely diverse experiences and knowledge we have a range of reasons that motivate us to belong to QACAG. Members have witnessed considerable changes in the aged care sector over the many collective years we share. This section provides insights into the aged care system from different viewpoints within our group, and in some of our members' own words.

- <u>People requiring aged care services themselves</u>

QACAG has some members who are receiving aged care services themselves in the community or residential aged care. We are very mindful of individual privacy concerns when we receive input from residents of care, and also the fears expressed that speaking up may backfire on the person themselves or particular staff that they respect and rely upon. In previous QACAG submissions to the CIS review and the Review of the Accreditation Process these fears were echoed by residents, relatives and staff. We greatly appreciate the input received from members who are receiving care services.

> "I go home when QACAG meetings are on so that I can join in by teleconference and not be over-heard. I have to be very careful what I say at the nursing home as the staff have been instructed to not tell me things... like how many staff are on shift at one time (luckily I can count!). It is clear that the management don't want me to be talking about care matters and staffing, even though this is about MY care. I belong to QACAG not to air my own grievances, but to keep involved and to make a difference for others." (*Resident in a nursing home with mid-life onset disability, retired RN, QACAG Metro*)

- <u>Relatives, Volunteers, Community members.</u>

Several members are relatives who have provided care themselves to loved ones and have sought community or residential aged care as part of that. A feature of this is that several members have formed relationships with other people living in the same facility as their loved ones, or with their families. This increases the support networks and also the insights about care successes and shortfalls.

"I spent almost two and a half years making extended daily visits to my husband who was in a nursing home and during that time I became an observer of the day to day functioning of this particular nursing home. I continue to visit now, past the time of my husband's passing, due to forming a bond with another couple with one partner in the nursing home. Through reading and contact with other people I became aware that the problems which I observe in the day to day functioning are typical of many other facilities. Less than optimal conditions exist because of a shortfall of funds which affects the availability of nursing staff and material goods and services. Directors of Nursing do not hold the purse strings and the issues noted lie squarely in the hands of the owners and their management. The community needs a forum such as QACAG to raise issues and to lobby the appropriate people for improvements in aged care." *(Relative, QACAG Metro)*

"I want to see changes in the way people are cared for in Aged Care facilities and belonging to QACAG enables me to have a role in this. I joined about two years ago after talking to someone else with a relative at the same nursing home as my mum's. I am still working as a volunteer at Mum's nursing home after she passed away recently, and I want to stay involved as the problems remain and I want to see change, even though mum's not here now." *(Relative / Volunteer, QACAG Central Coast)*

"When my mother in law was in care, she was a very unhappy in herself, and she didn't really want to participate in activities, but she really just liked one to one contact. She got good physical care, but there just wasn't time for staff to sit with her, to talk or be company for her. So if we weren't there, I knew that her emotional needs just weren't being met. I have had two relatives in nursing home care and I belong so I can influence the care for others, most importantly, emotional care." *(Relative, QACAG Metro)*

- <u>Aged Care Nurses</u>

There is a strong presence of nurses in the membership, and when QACAG calls for input to submission, there is always an active response for these members. Through QACAG, nurses can voice their concerns and aspirations for the aged care system, often in a way that they feel unable to do within their particular workplace. Many say they are reticent to speak up at work, or that they do and feel it doesn't have an impact. Some fear conflict with management, including risk to their jobs. Amongst these nurses, several members have careers of over 35 years in aged care and have seen many changes at the bedside and in the systems of funding, reporting, accreditation and ownership. We believe that there are not enough avenues for nurses to influence change in aged care. The continued loss of registered and enrolled nurses from the sector also results in a loss of 'professional mass', and creates more isolation for those remaining, and some feel like a 'lone voice' when they do speak up.

Many members have raised that the accreditation process in particular does little to engage nurses to speak freely about their views and experience, with many frustrated by pressure to 'toe the facility line' or being completely excluded from the process, including examples of being rostered off duty when accreditation is underway. Often problems identified by nurses in speaking at QACAG are systemic and long-term such as the erosion of skill mix or staffing numbers, and stem from concern about the impact on residents as well as on the staff themselves. These contain a complex mix of components which then require nurses to ascertain the correct channel to raise these: for example not enough staff to complete the care needs raises issues that are related to resident rights, resident safety, staff occupational health and safety, industrial matters, professional accountability and accreditation standards. Amongst this, incidents or near misses, or indications for making a report or complaint may also arise. Members are frustrated that their attempts to raise these through various channels may result in small or temporary changes, or in no response or avoidance, and rarely seem to result in systemic change.

"I became involved in QACAG after a Nurses Forum, when I realized that aged care was well in the back ground and not spoken about enough. I was working for a provider that I saw only cared about shareholders and not the residents or staff. The people that work in aged care are often people with big hearts, and many are too intimidated to say anything about what was happening around them, as many of them were afraid of losing their jobs, and the frail aged being left without good staff to look after them. I myself was put off - they didn't say it, but I know it was because I spoke out about the lack of care, the absence of good nurse to residents ratios, the food (ghastly), the overall reluctance to offer any quality of life to the residents, and a caring for the return on investment only. So I started to make more noise and tell as many people that would listen what was happening. I needed to be part of a group of people that felt the same. That is why I became involved in QACAG and it has escalated from there until today, and no-one can't stop me speaking up now!" *(AiN/Trainer, QACAG Blue Mountains)*

"A main issue for me is the funding tool, it needs to be simplified, to reduce paperwork, to increase the quality of care and guarantee adequate staffing levels." *(RN, QACAG Metro)*

"I joined QACAG to help lobby for change in aged care and to work in the community giving information about aged care issues. The main issue for me is staffing and wages i.e. Staff mix, Staff Ratio's, increased wages and better conditions for staff. As an RN myself, I know that something must change to keep and attract RNs: there needs to be more RN'S and a better number of qualified staff with manageable workloads." *(RN, QACAG Blue Mountains)*

- Nurses post-retirement age

Amongst the nurses who belong to QACAG, several are continuing to work well past retirement age.

"I worry for who will do the work if I leave, and I know I carry so much sector knowledge, from over 40 years, and its not easy to hand this on. Working in aged care is so rewarding, I continue to hope that other nurses will see this, but as the number of nurses employed into aged care decreases, so does the appeal for nurses making this their career choice. The erosion of nursing positions de-professionalises and devalues the work, and ultimately this devalues the care of older people." *(DoN, QACAG President)*

"I am many years past retirement age and have dropped to part-time but I constantly get asked to do extra shifts, including night shifts due to the difficulty getting other RNs on the roster. I love my work, but I want to know that there are other RNs coming after me to do this work." *(Educator/RN, QACAG Blue Mountains)*

"I keep working because I need to keep bringing an income into my family with adult children with disabilities, and fortunately aged care is a job I enjoy, and where I can continue to work. Now, though, I only work night shifts as there is no way I could meet the demands of day shifts these days. There is so much less staff (especially other RNs) and so much more to do. I have seen so much change in over 30 years, and the biggest change by far is less staff per shift, and more residents with more complexity to look after. It's not just because of my age that I find the workload too high." *(RN, QACAG Metro)*

- Nurses retired from aged care

Of the nurses in the group, there is a significant number of retired nurses who wish to remain involved in aged care reform due to long term commitment to aged care.

"After witnessing the drastic reduction of nursing staff and inappropriate skill mix in residential aged care, I decided to form the Quality Aged Care Action Group in 2005 and, after my retirement, I have stayed involved as an active member. Elderly frail aged care residents are not in the position to advocate or lobby for better care services, and there was (and still is) little consumer voice in the Department of Health and Ageing as well as the Aged care Standards and Accreditation Agency. Aged care residents are the most vulnerable citizens in our society particularly those who suffer from dementia and have no family to visit them. Elderly aged care residents deserve to have the best care in their twilight period of their lives." *(Founder of QACAG, retired RN, QACAG Metro)*

"I joined QACAG to keep promoting 'best practice' in aged care as I feel really strongly about this. My long career in aged care included a focus on education and best practice, as well as specialist wound care. I believe that we must continue to maintaining high clinical standards through education and training, and to do this, we must keep a good proportion of clinically skilled nurses in aged care. I am pleased to see the focus on developing Nurse Practitioner roles in aged care and this must be prioritised. The increased presence of Nurse Practitioners would go a long way to enhancing the roles of nurses and other staff and making sure the best clinical care is available to the residents on site in nursing homes." *(Retired RN, QACAG Central Coast)*

- Nurses and health workers outside of aged care

Many people not directly involved in provision of aged care identify with the concerns of QACAG and some nurses in other sectors want to add their support to older people, and to nurse colleagues.

"I joined QACAG when I was working as a RN in aged care many years ago but I left that work because of intolerable workloads and feeling defeated in actually meeting my professional responsibilities. It was a terrible choice: to leave and let someone else have to pick up that role, or to stay and know that I wasn't actually practising safely. There seemed no interest in addressing this at a management level, RNs were leaving, care staff were being given clinical roles (wound care, medications) with little or no training, and the RNs remaining had to pick up the responsibility. I stayed involved in QACAG so that I could still contribute to changing this system while choosing not to stay and 'collude' with it myself." *(RN, QACAG Metro)*

"I work in a private acute hospital setting. I heard about QACAG from other nurses in a local network I was attending, and I decided that aged care is really important to me professionally and personally. I have aged parents now, and one lives in hostel care. I see the effects of people coming to the hospital from home or nursing homes, and I know that many of them could leave much quicker, or maybe not even have to come in, if they had registered nurses or nurse practitioners available to them where they live, or enough GP visits at the nursing home. Services such as mobile radiology could come to them – they used to but these were de-funded in our area, a great loss. I want to support older people and I want to support my colleagues in aged care work – that's why I belong and get out in the community to talk to people about this. This really has to change – it is not good for anyone to shift the pressure on aged care services to the hospital system, or to unnecessarily disrupt older people who could receive care in the community, their home or nursing home." *(RN, QACAG Central Coast)*

OBSTACLES TO FINDING AGED CARE SERVICES

Learning about the system

There has been mention at times by the DoHA of developing a 'one stop shop' access point for people seeking aged care services. Many of us in this group have experienced trying to

find aged care for a loved one. Often this was due to an illness or incident, either of the person needing care or of the main carer. Looking for care brings an instant overload of information and decisions, and few 'maps' to navigate this. Often the family or loved ones have the onus of sifting through the information and initiating the steps, while trying to juggle their other work and family commitments and responsibilities. GPs were often be the first point of contact, and from here, it was up to the partner or family member to organise ACAT assessment, decide what sort of care is needed and how to find it. There remains no straight forward way to gather this information, and people are trying to take in enormous amounts of information, arrange and attend appointments, make visits to potential residential services and make decisions.

> "When I get a phone call from a family seeking nursing home care they have so many questions, and I make a time to meet with them. Often they have just been given a list of homes and told to go and find one. This is overwhelming. Some places just give them a brochure, but this doesn't answer all the usual questions which are not just about the particular nursing home, but about assets, fees and charges, what to pay when and to whom, the steps to admission and how to make the transition smoother for the person. Amongst this, the family is often having to make joint decisions, quick decisions, or making decisions not readily accepted by the parent or partner needing care, and this can be very hard and upsetting. " *(DoN, President QACAG)*

> "I know of a person who has set up a private business helping families to find a nursing home – but what about families who can't afford this? I am a nurse (not in aged care), and I had some contacts in the health system to help me find my way when our family needed to find a nursing home for our parents. What about families who know nothing about the system or where to start? We looked at four, and one was horrendous, one was ok and two seemed really good – we were shocked by the differences and wondered how this could be so. We were determined to secure one of the 'good' ones. I think people working higher up in the system forget how stressful and bewildering this time is, and the system doesn't help manage it very well, it is left very much to the personal skill, knowledge or assertiveness of the family/support people." *(RN, parents both lived in a nursing home for 5 years)*

> "When I went to find a nursing home and then placed my husband, I was so overtired from sleepless nights caring for him, so upset that the time had come where I couldn't have him home anymore, and so worried about how he would be in the new surroundings without me. I'm sure the staff thought I was 'difficult' or 'interfering' – they only saw me at face value – but I know form talking to others like me, it was the hardest time and I was so at my wit's end, compounded by trying to take it all in, and being so sleep deprived." *(Carer, QACAG Metro)*

Recommendation:

- QACAG wants development of programs and systems to assist residents and families to better understand the sector, to more easily find the best facility for their needs and to make the transition easier from home to nursing home.

"I don't want to go to a Nursing Home."

While there is a significant shift towards care in the home, residential care remains a necessity for many people, and for the families who may face the decision on their loved one's behalf. It seems to us that the overwhelming public view of nursing homes is negative. Media reports are predominantly weighted towards 'horror stories and exposé's', and there seems no shortage of material to fuel these. People may also have fears based on their own personal experiences with family and friends with current or past care. Some of this fear and aversion may be justified, if care has fallen short, while some may be persistent myth. There is also the impact of people's own grief or regret, or judgement from others. Sometimes, sadly, these negative attitudes can be also perpetuated by people who work in the system and should know better: that for some people's needs and circumstances 24 hour care is the only option.

We believe this negativity can and must change. We accept that few people want to go into high care rather than be in their own home, and that often the move occurs in difficult circumstances. There must be a concerted effort to challenge the fear that people have of nursing homes. It might be common, but it is totally unrealistic for people to say they rather die or be 'euthanased' than go to a nursing home. It also creates a terrible dilemma for loved ones who may not be able to cope with care at home, but know that the alternative is so feared or despised by their loved one. The fear and negativity also overshadows the overwhelming 'good' that we believe exists in so many nursing homes: in the interactions and relationships amongst residents, family members, staff, volunteers and community groups.

Our vision for those who need 24 hr care is that they should receive this at home if it is feasible, and if it is not, that they should receive care in a nursing home that is predominantly centred around their needs. Most facilities will advertise this as a key feature; 'person centred care' yet we continue to hear of basic care needs not met: meals left cold due to lack of staff, (or family or volunteers) to assist with meals, people put to bed in the early afternoon or got up very early due to staffing flow not their own preference, people rushed through or missing showers as their isn't enough staff or equipment (chairs, lifters) to go around, people's modesty compromised due to being rushed from bed to bathroom partially unclothed, no knocking on doors and waiting to be answered as homes become 'workplaces' more than 'homes'. These are but some examples, and they point to a culture that needs to be redressed in the sector: of rushing, of task-focussed care, of equipment deficits, of staffing deficits, and consequently of a lack of valuing on *how* care is delivered.

We want care models which have time inbuilt to truly care in an 'unhurried' and personalised way, where staff have time to reflect on care strategies and have resources for skill development and continuous learning. There needs to be a culture of leadership in developing values-driven (not task driven) care. There needs to be authentic feedback mechanisms between residents, staff, family, management which result in quality management and improvement. There <u>are</u> nursing homes with models of care with these features and we hear of facilities where there are enough nurses and a strong skill mix, and a culture of learning, respect and accountability. By looking to those services of good practice and positive culture, there must be ways increase the prevalence, and make these the standard. In order to do this, there needs to be honesty in the system: to truly examine where the deficits and shortcomings are – otherwise it will continue to be a culture of denial which showcases the exceptional, rather than making 'exceptional' the standard.

<u>Recommendations:</u>

- Good models of care be properly examined and benchmarked.
- Identify how to connect 'success' with good care and ensure financial viability is intrinsically connected with good care ie: values or care driven, consumer-satisfaction driven, not solely profit driven.
- Consider a combination of regulation and incentive. We believe that regulation alone can create resistance or avoidance tactics, but that incentive on its own is not enough.
- Ensure accreditation processes are improved to measure what *actually* occurs, not what is documented to occur.
- Increase the input of older people and key consumer and carers' groups.

RESOURCES, STAFFING AND IMPACT OF 'AGEING IN PLACE'

We understand and support the principles of Ageing in Place to focus on the person and to have the care come to them, and minimise them having to 'move to the care'. However, we are greatly concerned about the impact on care with the current implementation of Ageing in Place.

Most people move into hostel or retirement style living expecting that they can remain there if their care needs increase. Many retirement clusters, or hostel settings may be equipped for this, in building and site designs, for example making rooms accessible to wheelchairs, bathing or lifting equipment, covered walkways etc. What is glaringly lacking in this is the staffing component to complement this. We are appalled by the lack of obligation that comes with increased funding of care needs. A person may come to be assessed as high care and the funding for that person's care increases accordingly, on the basis that their care delivery will cost more. However, this comes with no concurrent obligation about how the care is delivered and by whom. Terms such as 'reasonable staffing' and 'appropriate care' in the accreditation standards are nebulous and totally ineffective in shaping care delivery. We continuously hear from staff, from relatives, from residents about the real impact of ageing in place: that regardless of the levels of care needs, staffing operates at unacceptably low numbers, and low skill mix:

> "A colleague told me that the facility has 113 beds and with ageing in place, and 93 of these residents have now been assessed with high care needs. Recently the staffing mix has been changed to remove the RN position off the night duty roster, and to have a CSE (care service employee) as Team Leader (ie not a nurse) and just have an RN on call."
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> "I work in a hostel with 50 low care residents, and 85 high care residents, and the in-charge person is a CSE. There is an RN on call, but I know there are staff who are hesitant to call – they don't want to 'bother' that person. Besides, they have to know what warrants a call – ie they may have to make a clinical judgement, without clinical training. There's too much pressure on those staff."
>
> "Ten years ago, where I was one of 6 nurses caring for 39 patients, 13 of these were high care. Today 6 of us nurses care for 39 patients and 26 of these are high care."

Added to this, staff who are caring for increasingly high need residents in 'hostel' style living are making many more visits to the rooms or units and this often involves working alone in whole wings or walking across outdoor areas at night alone. Many staff talk about being uneasy or scared, and do raise this through occupational health and safety or union avenues. Some staff also say they can't physically provide the care at night without another person but that the staffing often just doesn't allow for this, or they are constantly 'running'. If there are only two staff on and they are required to both attend one person, it leaves all the rest of the residents without access to a staff member.

Other comments about staffing and equipment:

> "When I first came to live in this facility seven years ago we had six nurses to give morning care and now we have four or sometimes five. When there are four to give care to thirty seven of us with showering, washing, dressing, feeding, bathroom, psycho-social support it is a very heavy workload. I notice the core of nurses stay because they love their work, and the people they care for, but many new staff in Assistant positions often don't cope well with the workload and don't stay long. In my opinion, the training of new staff won't be successful unless there is legislated staff to resident ratios."
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> "Where I work we have two lifters for forty people. It's just not enough. And the lifters need two staff. When you need two staff for any procedure, you just can't run out and attend to something else like a bell or someone calling out – there needs to be recognition in the staffing for how many '2 person' procedures there are as well as how many residents overall."
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> "It's very frustrating, knee jerk reactions to problems, nurses scratching around trying to find pads for residents (all pads are locked away on weekends and the RN has the key), if you asked the management they deny there is pad rationing but I see it all the

time as a regular visitor, and the staff talk about it. How can you limit pads to incontinent residents? Talking to other staff and families it isn't uncommon! And one RN for 180 residents, I could go on and on!"

"I am concerned about call bells and enough staff to answer these. At my mother's nursing home they have a policy of answering a bell within ten minutes, but sometimes in reality it is 20-30 minutes. What happens if a resident is desperate for the bathroom, or tries to get out themselves? This happened to my mother when I wasn't there and she broke a bone."

In the previous system of Cam/Sam, there was a clear relationship between funding, care needs and care provision. A proportion of funds were tied to provision of direct care, and funds not spent on this were returnable to the Dept. QACAG wants this principle restored.

The Grand Plan[3] proposes to remove the distinction between low care and high care. Reading this proposal is of great concern to us, unless it comes with a new set of obligations to re-instate and protect the relationship between care needs, funding and staffing.

Clearly it has not worked to ask providers to self regulate their staffing to meet care needs (or to correlate to increased funding of care needs), nor for the accreditation process to monitor and remedy deficits in staffing numbers and skill mix, unless 'incidents' are involved.

Recommendations:

- We want a formula for mandatory staffing numbers and skill mix, and a system tying a set proportion of funding to staffing.
- We want a formula to ensure that wherever there are high care residents in residential care, there must be an RN on duty at all times as a minimum.

NSW REQUIREMENTS IN NURSING HOMES

One protection we greatly value in NSW is Section 52 of the Public Health Act NSW 1991 No 10 where anyone who operates a nursing home (as per the definition) must *"ensure that a registered nurse is on duty in the nursing home at all times"*[4]. QACAG has continued to oppose any changes to this Act and supports the NSWNA in also seeking to maintain this as staffing necessity and quality of care issue. We are concerned however that rather than seek to change the Act, there is a move to sidestep this by some providers by removing the boundaries between high and low care areas and requiring RNs to have responsibility across a huge geographic area, with upwards of 100 residents. Our obvious concerns are that this places residents at risk, undermines quality of care and places staff in compromising situations professionally. There is confusing in some facilities about where the 'nursing home' starts and ends, and this clearly undermines the intention of this Act. Nurses also say they are asked to help in other areas (eg hostels to look at a wound or give a certain medication) and the onus is then upon them to say no due to their adherence to the Act, but they tell us they face pressure or feel torn when there may be no-one else to carry out the duty. The responsibility must rest with the facility to properly staff all areas so residents get the correct care and ensure staff can meet legislative requirements and not be in compromising positions. The intention of the Act: to have an RN on duty at all times in a nursing home; must be protected, and, we believe this should be extended to ensure that there is an RN on duty *wherever* there are high care residents in residential care.

Recommendations:

- QACAG wants protection of the current requirements in NSW for an RN on duty at all times in a nursing home.

[3] The Grand Plan, The Campaign for Care Of Older Australians
[4] http://www.legislation.nsw.gov.au/viewtop/inforce/act+10+1991+FIRST+0+N/

- That it becomes a minimum requirement that an RN be on duty in any residential facility where there are high care residents, as a minimum part of a staffing formula.

ATTRACTING STAFF

We recognise that there is a shortage of nurses across the health system and that aged care is suffering as part of this. We also know that there are added barriers to attracting nurses to aged care: lower wages, high workloads and difficulty meeting professional responsibility, less nurses in the skill mix means less opportunity for professional collaboration and support, and the limited career paths and barriers to accessing to professional development. The ageing of the workforce in aged care is alarming, and we agree that there must be strategies to bring younger staff, including nurses, into aged care as a career. Offering 'family friendly' shifts, paid parental leave and mentoring from older nurses to younger nurses are some strategies. It is really important that older staff don't feel devalued by any push to attract younger staff. There needs to be valuing of those older staff, and perhaps a recognition that aged care work appeals to an older workforce and perhaps to celebrate and capitalise on this, as well as seeking younger staff into the mix.

Recommendation:

- That workforce strategies combine the aim of attracting newly graduating staff and younger staff into aged care, while valuing older, experienced staff to balance a mix of age and experience.

LICENSING OF CARE STAFF

QACAG supports the 'Because We Care Campaign in its proposal to register all staff who provide direct care in aged care. We think this gives recognition and pride to the staff, and provides a safer care system for people receiving care. Many of us were shocked to learn that many staff caring for relatives had little or no training, and while we see lots of good will and dedication, this needs to be backed up with minimum training and a licensing system. QACAG has lodged its concerns for a long time about programs that advertise ''be a nurse in... x days" or a few weeks. These have been reigned in somewhat by the protection of the nursing title and nursing work in National Registration and the Nurses Award, but there remains too much variation in the minimum requirements for achieving a cert 111 or 1V in aged care. There is significant skill and ethic involved in providing direct care to the elderly, especially with many having dementia, and complex needs, and being highly vulnerable. Licensing is imperative, and it must come with a requirement that only licensed staff provide direct care in aged care.

Recommendation:

- That the proposal submitted by the ANF on licensing of AiNs and care staff is adopted.

BONDS

QACAG does not support the introduction of bonds for people entering high care. We believe that other solutions must be explored. Most people who residential care at the high care level are doing so in a crisis. Life expectancy is months rather than years for people who first enter residential care at high care level. To add the necessity to restructure assets, including possibly selling the family home, is a cruel burden to add at this time of crisis. We regard high care in a nursing home as health care, not a lifestyle choice.

Recommendation:

- People entering care at high care level are not required to pay a bond.

COMPLAINTS

QACAG has written of concerns about complaints processes in its submission to the Review of CIS, and in particular about a lack of faith in the autonomy and agency of the current system. We were pleased to read the Report of this review as we found it to comment on many areas in need of change and in particular we support "the establishing of an independent Aged Care Complaints Commission and an Aged Care Complaints Commissioner who will report directly to the Minister for Ageing." We want a complaints system that is strong, compassionate, decisive and in good touch with the stakeholders in the sector, but autonomous.

Recommendation:

- QACAG wants the implementation of the recommendation of the CIS review re the establishment of an Aged Care Complaints Commission and Aged Care Commissioner.

CONSUMER INVOLVEMENT IN CONSULTATION AND REFORM PROCESSES

In closing our submission we wish to affirm the importance of having consumer input at all stages of age care reform. Structures must be put in place to ensure consumer involvement is properly sought and supported, and this should include consulting on details such as timing and location of meetings, transport, out of pocket costs, and ensuring proper briefing of consumers in process and content (eg acronyms, meeting procedures, and access to reference and background materials). QACAG is well placed to provide consumer input and in particular, we look forward to being involved in the future phases of this Inquiry.

Recommendation:

- That ongoing input and representation from older people, consumer groups and carers be built in to all phases of the aged care reform process.

Appendix:

QACAG OBJECTIVES

QACAG

- strives to raise community awareness about aged care services and to take action to promote and achieve positive change
- aims to ensure the views of consumers are represented in networks and forums where aged care services are being developed, evaluated or commented upon, in government and non-government sectors
- maintains communication with providers of aged care services in relation to the views of consumers, but is not a forum for proprietors or owners.

QACAG provides a forum for members to discuss issues that affect the quality of life for people receiving aged care services in residential or community settings, including:

- what to look for when choosing aged care services
- what services are provided and payment structures
- staffing levels and staff skill mix: nursing staff and other staff
- who runs aged care services: for-profit, not-for-profit, government
- funding and accreditation systems
- state and federal legislation governing aged care
- how to raise concerns or make a complaint
- how to lobby for change