Queensland Nurses' Union

Submission to the Productivity Commission

Inquiry into

Caring for Older Australians

July, 2010

Nurses. For you. For life.

because we care
Quality care for older Australians

Contents

Summary of Recommendations

The QNU recommends that the federal government:

- Conducts a survey of older Australians to determine what it means to age, the perceptions and expectations about ageing, everyday life, and family relationships so that aged care policy development recognises the real life experiences of older Australians;
- Engages the community in consultations about the values underpinning aged care and the quality and quantity of care aged Australians will require now and into the future;
- In the first instance, establishes a tripartite group consisting of unions, government and employers to consider the recommendations relating to the sustainability of the aged care workforce put forward by the Productivity Commission in its final report on this inquiry;
- Establishes an authority specifically to regulate the aged care sector, including compliance with statutory obligations, accreditation, performance standards, benchmarking, risk profiling and management, and annual financial reporting;
- Continues to develop and improve efficiency and outcome indicators for aged care in accordance with the priorities identified by the Productivity Commission (2008);
- Undertakes economic modeling to establish a robust financial reporting mechanism so that there is greater transparency and accountability of expenditure of government funding;
- Introduces national licensing of all direct care staff under the NMBA to ensure that aged carers meet standards of practice that deliver quality of care for older Australians;
- Provides mechanisms to ensure minimum staffing levels in all aged care facilities and an appropriate skill mix of staff to deliver proper levels of care and address workloads;
- Provides further research grants to investigate the needs of the future aged Australian, their families, palliative care, acuity and skill mix;
- Provides funding directly to care and wages rather than activity under ACFI;
- As a priority, closes the wages gap for nurses employed in aged care (compared to their counterparts in other sectors);
- Addresses the barriers to attraction, recruitment and retention in aged care – including workloads and the wages gap – as a perquisite to training/education reform;
- Develops a high level evidence base to inform the practices and organisational arrangements that underpin clinical education in aged care;
- Develops a robust and transferable model to facilitate quality clinical placements in aged care (Robinson et al, 2008);

- Raises the training capability of the aged care sector by instituting or renewing, enlarging and enhancing partnerships between the industry and the education bodies (Robinson et al, 2008);

- Moves the clinical placement experience into the realm of structured, planned, resourced, education delivered through a collaborative arrangement underpinned by an evidence-based model backed by careful planning and preparation, accountability mechanisms, appropriate staff selection and recurrent training regimes (Robinson et al, 2008);

- Broadens the trial for expanding the role of Nurse Practitioners in aged care to include the role of Enrolled Nurse Advanced Practice (ENAPs).

- In conjunction with Workforce Australia and the states, develop and implement a national nursing workforce plan based on best practice in any setting that will inform the national health policy. The nursing workforce plan should recognise the specific needs of indigenous Australians and a culturally diverse population.

Attachments

Attachment A - Comments from Members (*Add Your Voice* statements)

Attachment B – *Social Charter for Nursing and Midwifery in Queensland*

Attachment C – *Your Work. Your Time. Your Life*. Summary

Attachment D – Average Pay as at 2010

Attachment E – Nursing Practice Decision Summary Guide

Attachment F – Summary of Minimum Hours Care

Attachment G – Comparison of Skill Mix in Selected Private and Qld State Government Nursing Homes

Attachment H – *Nursing and Midwifery Skill Mix Policy, Nursing and Midwifery Workloads Policy, Nursing and Midwifery Workforce Planning Policy*

"It is my firm belief that the ultimate test of our worth as a democratic nation is how we treat our most disadvantaged and vulnerable."

Sir William Deane

Opening of the Mission Australia National Conference

Newcastle 2 February 1998

1.0 Introduction

The QNU thanks the Productivity Commission (the Commission) for providing this opportunity to comment on the current aged care services and to make recommendations on how the federal government can improve these services. Our submission responds to the questions the Commission specifically posed in its issues paper *Caring for Older Australians* (the paper), and includes some comments from individual members (see Attachment A). A number of our members have also made individual submissions directly to the Commission.

Aged care relies on its dedicated workforce. As a trade union we represent the industrial and professional interests of our members who provide the care our older Australians expect and deserve. We therefore begin our submission with an overview of the QNU and the nursing profession in order to bring to light the nature of the work our members undertake when caring for the community and in particular our older Australians.

We ask the Commission to read this submission in conjunction with that of our federal counterpart the Australian Nursing Federation (ANF).

2.0 About the QNU

Nurses and midwives are the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNU - the union for nurses and midwives - is the principal health union in Queensland. The QNU covers all categories of workers that make up the nursing and midwifery workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 40,000 financial members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNU.

The QNU promotes and defends the industrial, professional, social, political and democratic values and interests of members. In practice, this means the QNU works to:

- Establish and promote standards for nursing practice, nursing education and nursing service by taking any action deemed necessary to do so including legal, industrial, political, professional and social activities;
- Stimulate and promote research designed to widen the knowledge on which the practice of nursing is based;
- Obtain and maintain desirable conditions of work and just remuneration for all nurses and midwives and for this purpose to obtain awards or determinations from industrial tribunals and to enter into agreements or treaties with employers;
- Represent nurses and midwives and serve as their spokesperson before any tribunal, court, board, committee, or other authority and to present their cause;
- Obtain representation on boards, institutions and organisations as may be considered necessary to further the interests of nurses and midwives;
- Establish special funds to endow scholarships, promote research or conduct any activity which may be of general benefit to the members; and
- Communicate effectively with members on all matters relating to nursing.

The QNU vision statement:

- Unites members to work together to achieve security and fairness in the workplace and fairness, equality and opportunity in the community;
- Promotes the recognition and acceptance of the legitimacy of the core nursing values of caring, professionalism, advocacy and holism as central to the identity and social contribution of nursing and midwifery;
- Advances our collective values in a health system that supports the efforts of nurses and midwives in providing high quality care, in work that is meaningful, and where their roles are advanced and rewarded as a recognised professional partner within a social model of health;
- Promotes the general health and wellbeing of nurses and midwives; and
- Seeks an environmentally sustainable future for our members, families and communities.

With the collective strength of our members the QNU works with nurses and midwives to bridge the gap between the real and the ideal of nursing at all levels.

3.0 About Nursing

Nurses represent the single largest group of health care providers and are in close proximity to the delivery of care. Nurses are the most geographically dispersed health professionals in Australia, working independently or collaboratively to provide professional and holistic care in a range of circumstances.

Nurses work to promote good health, prevent illness, and provide care for the ill, disabled and dying. Most nurses and midwives work in an area of clinical practice such as medical and surgical, aged care, critical care, perioperative, midwifery, emergency, general practice, community health, mental health, family and child health, rehabilitation and disability, rural and remote health and occupational health and safety. Nurses provide continuity of care for patients 24 hours a day, seven days a week.

Nurses advocate for the patient as a whole person within a complex health system. At every site and level of the nurse-patient relationship nurses facilitate and mediate the competing demands of patients, families, carers, the environment at points of immediate care, the system and society to achieve the best possible outcomes. They conduct research into nursing and health related issues and participate in the development of health policy and systems of health care management.

Nurses' values

The values identified as central to nursing are reflected universally in codes of ethics and practice for nurses and represent the beliefs about nursing held by nurses (Fawcett 1983, 2003; Mohr, Deatrick, Richmond and Mahon 2001; International Council of Nurses 1953-2006 cited in Volpe, 2006). Despite the profession being extremely diverse, nurses generally agree on the values that guide their practice. These values are standards for action that are accepted by the practitioner and the profession. They provide a framework for evaluating the beliefs and attitudes that influence what nurses do and how they do it.

Nursing's unique capacity to claim these values (as unique to nursing) is supported by the fact that the nursing discipline takes direction from these values. These values direct the development and application of nursing theory, nursing knowledge and nursing practices. This differentiates nursing from other groups who might claim the same values, but where their disciplinary focus is not nursing. This is important in clarifying the realm of nursing responsibility and accountability (Volpe, 2006).

The core values of nursing adopted in the QNU Model for Nursing and Policy Framework are:-

- Caring
- Professionalism
- Advocacy
- Holism

The core values stem from the experience of nurses and what they value most in their practice. These core values and the disciplinary focus on the relationship of nursing to health and healing is what differentiates nursing's unique concerns from other disciplines. The expression of these values by nurses in their work distinguishes nursing from the work of other health professionals. While no one value is proposed as the exclusive domain of nursing, the distinction of nursing is the enactment of all four in relationship with the other – integrated, holistic and dynamic (Volpe, 2006).

These values form the basis of a social charter to which the QNU and the QNC (now the NMBA Qld Branch) is a signatory. A social charter is a joint statement by those who share common views. The *Social Charter for Nursing and Midwifery in Queensland* is a brief statement recognising the broad expectations and mutual obligations of nurses, midwives and the community regarding their roles (See Attachment B).

The community and the nursing and midwifery professions are committed to the continuing improvement of the health care system within a framework of social justice and equity. The *Social Charter for Nursing and Midwifery in Queensland* reflects the commitment of the community and the nursing and midwifery professions to this framework. With the advent of a national registration and accreditation scheme, the QNU is now seeking to extend this charter nationally.

Nursing in Aged care

Aged care is a critical issue facing our nation. Currently, there are some 2.8 million Australians – about 13 per cent of the population – aged 65 and over. Estimates indicate that this number will triple in 40 years (Commonwealth of Australia, Department of Ageing, 2008). The rising dependency on aged care that this forecast suggests coincides with a national shortage of nurses, particularly in the aged care sector where there has been a significant decrease in the number of qualified nurses in the last ten years.

In its recent (2008) research into aged care services, the Productivity Commission highlighted that older people's care needs can be thought of as a spectrum, depending on the degree to which the ageing process has impaired their ability to care for themselves. Older people will often experience increasing support needs either gradually or following acute care episodes. Various bundles of services are available to cater for these needs, ranging from in home support with some everyday and personal activities, through to full-time personal and nursing care provided in a residential care facility (Productivity Commission, 2008).

Nurses provide the linchpin for these services. They are the care and service co-ordinators across all sectors of aged care and the continuum of care. This gives nurses a unique perspective that is invaluable to policy-makers. Health care policy makers are demanding improved quality, reduced costs, and expanded access to care. We believe that the Commission's inquiry provides an opportunity to contextualise the 'reform' debate by establishing the dimensions of 'aged care' and the critical role of nursing within it.

4.0 The Nursing Workforce – Some recent data.

According to Australian Institute of Health and Welfare (AIHW) data (2010) in 2007/8 in Queensland there were statewide shortages across all nursing classifications including Nurse Managers, Nurse Educator, Registered Nurse (RN), Registered Midwife, Registered Mental Health Nurse and Enrolled Nurse (EN). This concurs with shortages across most specialty nursing areas including accident and emergency, critical/intensive care, midwifery, mental health, community care, aged care and indigenous health (Commonwealth Department of Education, Employment and Workplace Relations, 2008). The significant migration to this state and its consequent demand on health services, especially in the south east corner, has exacerbated these shortages.

ABS Census (2006) figures on the rate of nurses per 100,000 population by state or territory reveal Queensland is well below the Australian average of 1107 nurses per 100,000 population with just 1025.3 nurses per 100,000 population. As the population continues to rise in Queensland, the QNU's data modeling indicates we can expect a shortfall of 14,000 nurses by 2014 across the public, private and aged-care sectors. This is borne out by further data of demand and supply projections until 2020 for graduates of pre-registration nursing courses which indicate that supply as a percentage of demand will reach its lowest point in 2015 (78.2%) (Preston, 2010).

In the aged care sector, where the average age of the workforce was around 50 years in 2007 (Martin & King, 2008) recent projections suggest that shortages are even more acute due to the poor wages and conditions on offer and the lack of incentives (Access Economics, 2010). In 2003, personal carers comprised about 59% of employee numbers and 57% of full time equivalent (FTE) staff. By 2007, both these figures had risen to about 64%, indicating that nearly two thirds of RAC direct care workers are now personal carers. In absolute numbers, employment of personal carers rose by 17,500 over the four years, to approximately 85,000.

Projected total nursing workforce levels are determined by the staffing level (FTE nurses per 100,000 population) and the population. Between 2010 and 2020 the medium (Australian Bureau of Statistics, Series B) is for an increase of 15% in the total Australian population. The projected increases for the older age ranges are greater:

- 47.2% for the 65-74 age range;
- 33.2% for the 75-84 age range; and
- 36.4% for the 85 and over age range.

These older age ranges require higher levels of staffing by nurses (other things being equal). Preston (2010) developed an estimate of the magnitude of these higher levels of staffing for RNs using AIHW data. Compared with the staffing levels required by the 0-64 age range, the 65-74 age range requires around three times, the 75-84 age range requires around six times, and the 85 and over age range requires around eleven times. The application of these differential requirements (a 'population age profile factor', or PAPF) to the ABS population projections

results in an increase in requirements for RNs of 23.3% (maintaining 2007 staffing levels for each age range). The increase in requirements for ENs is likely to be even greater because a much higher proportion of ENs work in aged care.

In 2001, 2004 and 2007[1], the QNU commissioned extensive exploratory studies by the University of Qld and the University of Southern Queensland into the major factors impacting upon nursing work in Queensland and nurses' work satisfaction (Hegney, Tuckett, Parker & Eley 2007) (See Attachment C). The study surveyed members of the QNU who were employed in the public, private and aged care sectors. Some of the major findings relevant to the aged care sector were:

- Ongoing differences among the sectors, particularly between the aged care and the public and private sectors. For example, nurses employed in the aged care sector were
    - less likely to be able to complete their work in the time available,
    - more likely to say there were insufficient staff,
    - more likely to report their workload as 'heavy',
    - more likely to see work stress as high,
    - more likely to believe morale was poor and deteriorating, and
    - less satisfied about their level of remuneration than nurses in the other sectors;
- Nurses in the aged care sector were the least likely to state that they could complete their job satisfactorily and were most likely to believe that there were sufficient staff employed in their work unit;

Of significance to this inquiry, were the researchers' comments on the aged care sector which emerged as

> … bleak; where nurses are time-starved, poorly staffed, poorly paid, overworked and more stressed than other sector nurses. Whilst targeted attention needs to be given to aged care nurses, high work stress and load, rising work hours, a remuneration-skill mismatch and a nursing workforce morale that is less than robust also require attention in equal measure across the nursing workforce generally (Hegney et al, 2007).

In a tighter labour market, workers' experience of their jobs is likely to be of increasing concern to employers seeking to recruit and retain a competent, committed workforce. In aged care, there remain high levels of turnover of direct care staff. Martin and King (2008) found that some of this turnover involves movement between aged care employers, rather than departure from aged care altogether. Employers will therefore need to provide greater incentives, particularly remuneration, in order to attract and retain skilled aged care nurses.

[1] We will conduct the survey again later in 2010.

The QNU believes that the future of aged care and its nursing workforce relies on overcoming the obstacles produced by poor remuneration and heavy workloads. These important issues require immediate attention to enable nurses to provide the high level of quality care that they, as professionals aspire to and that older Australians deserve.

5.0 The Current System

There has been no shortage of reviews of the aged care sector and its workforce[2]. Yet challenges in coping with the future increase in demand for services, the range and flexibility of service delivery and the cost of these services clearly remain high on the public agenda. We ask that this inquiry address the 31 recommendations made by the Senate Standing Committee on Finance and Public Administration in its 2009 Inquiry into Residential and Community Aged Care.

In its 2008 study, the Commission also highlighted several areas requiring further analysis to aid the development of an improved framework for aged care including:

- Assessing the potential for unbundling residential care;
- Examining the current dual gate-keeping system and the scope to improve it;
- Considering the feasibility of introducing 'consumer-centred' care arrangements;
- Looking at ways of improving responsiveness in the educating and training the aged care workforce and extending scopes of practice (Productivity Commission (2008).

The QNU seeks further clarification of these areas, particularly the notion of 'unbundling residential care' and 'examining the current dual gate-keeping system'.

Nurses play a vital role in ensuring continuity and co-ordination of care across settings. This starts with community engagement to establish the best means of protecting and caring for older Australians. It will require a wider concept of aged care as one element in the continuum of health care in general, and a better understanding of 'being old'. A national U.S. study (Taylor, Morin, Parker, Cohn, & Wang, 2009) on aspects of everyday life ranging from mental acuity to physical dexterity to sexual activity to financial security found a sizable gap between the expectations that young and middle-aged adults have about old age and the actual experiences reported by older Americans themselves.

The survey of a nationally representative sample of approximately 3000 adults found that these disparities came into sharpest focus when the survey asked about a series of negative benchmarks often associated with ageing, such as illness, memory loss, an inability to drive, an end to sexual activity, a struggle with loneliness and depression, and difficulty paying bills. In

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[2] These include:

- *Australia's future tax system: Report to the Treasurer (2010)*(Henry Review);
- National Health and Hospitals Reform Commission (2009) *A Healthier Future for All Australians;*
- Productivity Commission (2008) *Trends in Aged Care Services* and 2009 *Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services;*
- Senate Standing Committee on Finance and Public Administration Report on *Residential and Community Aged Care in Australia* (2009);
- Hogan (2004) *Review of Pricing Arrangements in Residential Aged Care.*

every instance, older adults report experiencing them at lower levels (often far lower) than younger adults report expecting to encounter them when they grow old.

At the same time, however, older adults reported experiencing fewer of the benefits of ageing that younger adults expect to enjoy when they grow old, such as spending more time with their family, traveling more for pleasure, having more time for hobbies, doing volunteer work or starting a second career (Taylor et al, 2009)[3]. This type of research in an Australian context could provide an important reference point for the actual experiences and expectations of the coming generation of ageing adults.

Looking overseas again more broadly at the Canadian experience, the Romanow inquiry (2002) into the future of health care in Canada found that while Canada will be 'greyer' in the future than it is now, that reality is neither a catastrophe waiting to happen nor an issue that can be ignored. The Canadian baby boomers of today will be healthier in old age than their parents were, with fewer chronic health conditions, and fewer health problems caused by smoking and other lifestyle factors. Even with this, however, the demand for particular kinds of services will increase. For example, with an ageing population there will likely be an increase in the number of people who require joint replacement or suffer from Alzheimer's disease and other types of dementia. Recent Australian research (Access Economics, 2009) into the dimensions of care provided to Australians with dementia indicates that:

- Family carers may be the only source of care for people with dementia (around 37% of people with dementia received no formal care in 2008);
- The cost of replacing the family carers with paid carers is estimated at $5.5 billion per annum;
- The opportunity cost or lost productivity borne by individuals, business and Government is estimated at $881 million.

The process of adjusting health programs and financing should begin to address the impact of ageing, and in particular, the increase in demand for services linked to a decrease in independence as people age (Hogan & Hogan, 2002). However, because it may be impossible to accurately forecast the health needs of the population too far in advance, flexible approaches need to be taken to avoid investing in facilities and programs that an ageing population may not need. With foresight and appropriate planning, Australia, can also adapt in a timely manner to the new reality of an older population.

Like Canada, Australia's health system has been characterised by fractious debate between federal and state governments over levels of and types of responsibility. However, where Romanow (2002) sought community consultation to establish common values – universality and equity - on which to base a renewed Canadian system, there has not been the same type of engagement here. The National Health and Hospitals Reform Commission developed 15 principles to guide their processes but there was not the same level of consultation as the Canadian experience. The QNU welcomes the National Health and Hospitals Network (NHHN)

[3] The 5% of older Americans who reside in nursing homes were not interviewed for this study.

reforms which will develop a nationally consistent and integrated aged care system that provides improved access to appropriate care to meet the needs of older Australians and their families.

Under the network the Commonwealth will take full policy and funding responsibility for aged care services, including a transfer to the Commonwealth of current resourcing for aged care services from the Home and Community Care (HACC) program, currently except in Victoria. This will enable the development of a consistent aged care system covering basic care at home through to high level care in aged care homes. It will enable the Commonwealth — as the majority funder of Australia's health and hospital system — to drive increased integration between acute care, public hospitals, GPs, primary health care and aged care (Commonwealth of Australia, 2010).

The QNU is concerned at the very short timeframe for these initiatives and the real potential for unintended consequences. This change is occurring in advance of the Commission completing its inquiry into aged care, so we believe that the Commission should be monitoring developments carefully.

This should also mean that older people and their carers are better able to access information and services close to where they live through one-stop shops. We believe that these venues should provide a holistic approach to aged care that includes advice on housing, government benefits and other related areas of retirement.

Recommendations

The QNU recommends that the federal government:

- Conducts a survey of older Australians to determine what it means to age, and the perceptions and expectations about ageing, everyday life, and family relationships so that aged care policy development recognises the real life experiences of older Australians;
- Engages the community in consultations about the values underpinning aged care and the quality and quantity of care aged Australians will require now and into the future.

6.0 What Role for regulation?

The *Aged Care Act 1997 (Commonwealth)* (the Act) regulates the aged care sector. In its Objects, the Act aims to:

> ... encourage diverse, flexible and responsive aged care services that:
>
> (i) Are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and
>
> (ii) Facilitate the independence of, and choice available to, those recipients and carers.

The Act introduced a new system of funding, the main features of which were:

- A single classification instrument for determining funding for nursing home and hostel residents;
- The introduction of *Ageing in Place*, a system where resident as they become more frail did not have to move to a dedicated high care or nursing home facility. It meant a high level of service where the resident lived;
- The introduction of accreditation;
- The removal of the requirement of aged care proprietors to acquit funding from the commonwealth.

A net effect of the 1997 changes has been to deregulate the staffing aspect of aged care funding by reducing the level of government in regulating and monitoring the way providers deliver care.

Since 1997, there has been no distinction between staffing and infrastructure costs, which means that some providers can use the opportunity either to reduce staffing hours or to replace qualified nurses with less expensive personal carers. It has undermined the capacity to match appropriately residents to the skill mix of care staff they require as they age and become more frail and dependent.

We have therefore seen a reduction in the number of registered nurses and an increase in Assistants in Nursing (AINs)[4]. A comparison of the residential aged care workforce in 2007 with 2003 shows a total workforce growth from 76,006 to 78,849 FTE:

- Personal carers (AINs) increased most, from 57% to 64% of FTE;
- RNs fell from 21% to 17%;
- ENs fell from 14% to 12½%; and
- The remainder (allied health workers) fell from 7.6% to 6.6%.

Analysis of newly hired staff suggests these trends will continue, yet the exit of nurses from residential aged care is in stark contrast to the growth in the acute care nursing workforce (Martin & King, 2008).[5]

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[4] Also referred to in other states as Personal Carers (PCs).

Transparency of Funding

The QNU believes that residential aged care is in need of major reform of financing. This should cover the excessive array of ways in which the government disburses funding as well as the non-transparent manner in which it is acquitted. One option to achieve this could be the removal of government legislated fee caps. Residential aged care facilities would then also have greater capacity to fund accommodation costs from accommodation charges, thereby reducing the need to cross subsidise with funds nominally allocated to operational costs (Access Economics, 2010).

Prior to 1997, the Care Aggregated Model/Standard Aggregated Model (CAM/SAM) was the funding mechanism introduced in 1987 for nursing homes in the non-government sector as part of a broad strategy of reform of aged care services. The state-based CAM/SAM funding system incorporated wage costs under relevant award increases in the funding formula. A significant implication of removing the CAM/SAM funding system was the loss of protection of the nursing staff wages component of the nursing home budget. The CAM system allocated funds to nursing homes for the provision of nursing and personal care. The system allocated funds on the basis of a formula which assumed a certain number of nursing hours for identified categories of resident. There was a requirement to roster a certain number of 'nurse hours'. This model guaranteed residents with the greatest need for nursing and personal care received the most resources.

The purpose of CAM acquittal was to ensure that nursing homes spent the funds that they received from the Commonwealth for the purpose for which it was allocated. This meant that the nursing home proprietors were to provide an annual report for the Commonwealth on how they spent CAM money. Providers calculated this by showing how many nursing and personal care hours a resident was funded for and then giving a detailed statement on the number and cost of nursing care hours provided. Providers were to spend funds on direct resident nursing care and not used on SAM work such as dedicated domestic tasks, gardening, laundry or administration work not related to resident care.

Funding in residential aged care should include a transparent and accountable allocation of the health and aged care component with a separate allocation of funds for accommodation and other services accounted for independently. At present, lack of information makes it difficult to determine how both providers and government account for spending in these areas. Many companies are not publicly listed. In particular, the 'for profit' sector displays extreme reluctance to QNU requests for review of their profit and loss statements. The federal government would greatly improve the regulatory environment by implementing a more detailed and transparent acquittal process where residential aged care providers clearly account for how they spend capital and recurrent funding. The QNU believes that 'transparency' should take into account the following:

- Accreditation of auditors for the aged care industry;
- The authority regulating the aged sector (see recommendations below) must ensure the highest standard of independence of its auditors.

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[5] We discuss this more fully under section 4.

While provisions of the *Fair Work Act, 2010* have assisted workers to re-engage with employers through union representation, there remain major obstacles in achieving real consistency in pay and conditions across the health sector where a culture of non-disclosure remains. Funding in the aged care sector should be contingent on openness in all areas, including the financial management of the organisation. Clearly regulating and monitoring care standards are vital for the industry. Equally important, however, is the prudential management and proper use of scare public resources by providers.

We believe that there is merit in a single, integrated assessment approach for care needs. There also needs to be more choice within the residential aged care sector and better information on how individuals use aged care services. This would involve lifting the current restrictions on the number of aged care places within an aged care facility. Information on the performance of residential aged care providers should help ensure residents are able to choose the better providers (Access Economics, 2010). This would necessitate more rigorous performance standards that are publicly available to consumers.

Regulation can have significant implications for the aged care workforce. However, it is worth noting here that regulation can affect the ability of the aged care industry to attract and retain staff and adapt work practices in response to changing labour market conditions. For example, some argue that excessive government regulation is resulting in registered nurses having to spend more time on administration and less time on providing care, which is undermining job satisfaction in the industry[6].

The QNU believes that quality and safety underpin all aspects of aged care. In its 2010 report on government services the PC commented that for several aspects of aged care services, indicators are not fully developed and there is little performance reporting available. We concur with the Commission's priorities for the future which include:

- Continued improvement of efficiency indicators, including for HACC services and assessment services;
- Improved reporting of waiting times for residential aged care;
- Improved reporting of long term aged care in public hospitals;
- Further development of outcome indicators (Steering Committee for the Review of Government Service Provision, 2010).

[6] See, for example, Venturato, Kellett & Windsor (2007) cited in Productivity Commission, (2008).

Recommendations

The QNU recommends that the federal government:

- In the first instance, establishes a tripartite group consisting of unions, government and employers to consider the recommendations relating to the sustainability of the aged care workforce put forward by the Productivity Commission in its final report on this inquiry;
- Establishes an authority specifically to regulate the aged care sector, including compliance with statutory obligations, accreditation, performance standards, benchmarking, risk profiling and management, and annual financial reporting and auditing;
- Continues to develop and improve equity, effectiveness and efficiency indicators for aged care in accordance with the priorities identified by the Productivity Commission (2010);
- Undertakes economic modeling to establish a robust, industry specific financial reporting mechanism in addition to statutory financial reporting standards so that there is greater transparency and accountability of expenditure of government funding.

7.0 A workforce to care for the elderly

In March, 2009, the ANF launched the *Because We Care* campaign for quality aged care. The key objectives of this campaign seek to improve the industry for aged care nurses and the residents in their care. Here we reiterate the key aspects of our campaign:

- Wage parity;
- National licensing of all direct care staff;
- Minimum staffing levels and appropriate skill mix; and
- Transparency of funding[7] .

The 2010 federal budget delivered a total package of $132 million of new spending on aged care. However, we believe the federal government needs to commit much more funding and attention towards this sector to meet the needs of the ageing population.

Closing the wages gap and maintaining wage parity for nurses working in aged care with their colleagues in other sectors;

Pay is an important symbolic indicator of the value placed on work by employers and the community. It is understandable that nurses feel underpaid and undervalued when their colleagues in acute settings earn significantly more. Personal carers who legitimately view their work as of great social value feel slighted when they see their children earning similar wages to themselves in check-outs at the local supermarket (Martin & King, 2008). Indeed, the symbolic value of increased pay is likely to be substantial, and to have direct effects on job satisfaction and commitment.

Prior to 1996 when there was centralised wage fixation, there was generally parity between nursing wages in the public acute hospital sector and residential care establishments. Since that time, the gap has widened considerably as nurses in the private and public acute sectors have obtained more favourable outcomes through enterprise bargaining. Currently the wages gap stands at $393.77 per week national average under an Award or $168.52 per week national average under an Enterprise Bargaining Agreement (ANF, 2010)[8] Such a significant disparity makes it virtually impossible to attract adequate numbers of nursing staff to aged care.

In late 2009, the Australian Industrial Relations Commission made the *Nurses Award 2010* which in part set pay rates at levels significantly below those contained in the *Nurses Aged care Award State – 2005* (the Notional Agreement Preserving State Awards) which applied at the time. The new award provided challenges for the QNU in our quest to maintain and improve the

[7] We address this topic under section 6.0

[8] Based on rates for RN level 1 at the top of the scale.

terms and conditions of employment our aged care members who are award-reliant for the following reasons:

- It required award-reliant employers not to reduce wages for nursing employees but gave no certainty as to how this would occur or whether there would be future increases in their actual rates of pay through safety net adjustments;
- Award-reliant Queensland aged care employers have a history of minimal and sporadic engagement with the QNU. It is unclear how many are members of Aged Care Queensland (ACQ), but we understand the number is small;
- There is minimal engagement between ACQ and the QNU on industrial matters. ACQ appears to rely on advice from external advisers;
- There appears to be no industrial organisation for aged care providers in Queensland who do not have the benefit of in-house expertise. Many are small providers in terms of industry representation and have limited expert Human Resources advice;
- In our view, many of these award-reliant employers are likely to lack adequate information in order to make decisions related to their obligations under the *Nurses Award 2010;*
- In recent years, aged care providers have employed significant numbers of employees from Non-English Speaking Backgrounds (NESB). These workers are not always aware of their award entitlements or remedies and are vulnerable to award breaches.

In Queensland, approximately 60% of aged care employers have, over time, negotiated enterprise agreements with the QNU. There are disparate outcomes among these agreements where some provide wages that are only marginally greater than those set out in the *Aged care Award 2010* (the award) and others have significantly reduced (but not closed) the gap with the public sector rates (See Attachment D - Union Negotiated Agreements Compared with the *Nurses Award 2010*).

In our experience, it is common for aged care employers to argue that any significant increase in wages will require a reduction in care hours. This approach has a number of effects on recruitment and retention of the workforce. In Queensland, staff turnover rates of between 20-30% are not uncommon, particularly among new recruits to aged care nursing. As the workforce in predominantly part-time (Martin & King, 2008), there are significant levels of 'under-employment' where many nurses have more than one part-time nursing job.

There are limited career opportunities in aged care nursing compared with other sectors and a sense of professional isolation[9]. As well as lower wages, aged care agreements also provide lesser entitlements in long service leave, annual leave and parental leave. The overall package leaves aged care nurses severely disadvantaged in comparison to their counterparts in the public and private sectors.

[9] Discussed further under 'Education'

The federal government's commitment to provide additional funding for aged care initiatives is of course very welcome, however, lack of wage parity with other areas of nursing remains for the QNU the most significant issue in addressing the future of aged care. While employers continue to pay aged care staff on relatively poor wages, the inability to recruit and retain appropriate numbers of aged care nurses will continue. Wages and conditions must improve to attract nurses into the sector. Productivity improvements can help to fill the wages gap realised through better technology and restructuring activities e.g. more sophisticated monitoring and scheduling systems which can also allow staff to spend more time with residents and increase the quality of care provided. More fundamentally, since there is an evidence base to show that more nurses in the skill mix lead to better health outcomes, the intensity of nursing care requirement could be linked to the Aged Care Funding Instrument (ACFI) scale and this may assist in achieving adequate provisioning for wages (Access Economics, 2008). We refer the Commission to the ANF submission for further information on our shared position regarding funding arrangements.

For some time, the QNU has been concerned that two of the most significant reform agendas of the federal government (the reform of the industrial relations system and health reform) could be working at cross purposes. The support and promotion of enterprise based bargaining and rejection of the concept of industry wide bargaining through the industrial relations framework contributes to the development of significant pay and condition differentials across the health and aged care systems (within states and between states). This is occurring at a time when it is critical for our health and aged care systems to act as one system without significant labour market distortions. The QNU has consistently argued for some time now that this discrepancy needs further closer examination.

Recommendation

The QNU recommends that the federal government:

- As a priority, closes the wages gap for nurses employed in aged care (compared to their counterparts in other sectors);
- Provides funding directly to care and wages rather than activity under ACFI.

National licensing of all direct care staff;

We appreciate the federal budget commitment of $3.5 million to explore a national regulation system for personal care workers[10]. The QNU is concerned that the rapid increase in the number of unlicensed workers giving direct nursing care to residents will impact on the aged care workforce and the quality of care it is able to deliver. While we accept that unlicensed nursing and personal carers may be competent at providing a basic range of services and are valued

[10] In Queensland, personal carers are referred to as Assistants in Nursing (AINs). The Nursing and Midwifery Board Australia does not currently licence AINs. Many AINs hold a Certificate III or IV qualification but this is not a mandatory requirement. The AIN assists with nursing care and works under the direction and supervision of a registered nurse.

members of the team providing care to residents, these staff may not be able to recognise more serious issues that require supervision and support from RNs.

The QNU has consistently argued that anyone undertaking nursing should be designated as such and operate within a regulated framework. Where care and support includes nursing, then a nurse should undertake this work whether it is in the home or a facility. This will require consistent, transparent criteria on the nature of nursing in order to make a judgment.

The QNU contends that the Nursing and Midwifery Board Australia (NMBA) as the regulating body for registered nurses, enrolled nurses and midwives should also regulate AINs. Through a licensing regime, AINs will require a minimum level of formal education and accountability in their practice. Competency standards should be based on those currently governing the regulated nursing workforce. Attachment E sets out the NMBA *Nursing Practice Decisions Summary Guide* that could form a useful guide to developing a similar framework including AINs.

We refer to recommendation 2 of the ANF submission that recommends there is recognition of the professional skills of AINs through a national licensing system. The QNU believes that the development of competency standards for AINs requires further discussion between government, employers, unions, the regulator and other key stakeholders. We are keen to take part in any future discussions in this regard.

Recommendation

The QNU recommends that the federal government:

- Introduces national licensing of all direct care staff under the NMBA to ensure that aged carers meet standards of practice that deliver quality of care for older Australians.

Minimum nursing staff levels and an appropriate skill mix of carers (however titled) and enrolled and registered nurses throughout the aged and community care workforce.

The *Aged Care Act 1997* explicitly aims to encourage and facilitate 'ageing in place'. The Act does not define 'ageing in place', but one useful definition is 'the provision of a responsive and flexible care service in line with the person's changing needs in a familiar environment'. In effect, 'ageing in place' refers to a resident remaining in the same residential aged care service as his or her care needs increase from low level to high level. This is changing the profile of people in services (Steering Committee for the Review of Service Provision, 2010).

The *Aged Care Act 1997* does not establish any 'program' or require any residential aged care service to offer 'Ageing in Place'. Rather, it creates the opportunity for providers to choose to provide the full continuum of care, by removing the legislative and administrative barriers that prevented this outcome in the past. The concept of 'ageing in place' is linked to the outcomes of increasing choice and flexibility in residential aged care service provision. These are difficult outcomes to measure. Data on 'Ageing in Place' is reported for the indicator 'intensity of care' (Steering Committee for the Review of Government Service Provision, 2010).

The 'Ageing in Place' policy has had implications for those providing care in residential facilities. Age, dependency and acuity of people in nursing homes have increased and as a direct

result of the policy, there are an increasing number of high care residents in low care facilities (Hogan, 2004). The result of 'Ageing in place' has been to deregulate the nursing labour market with the substitution of registered nurses with Assistants in Nursing and other types of home carers.[11]

Between 1995 and 2007, the number of registered and enrolled nurses employed in residential aged cared declined by almost 8000 (Martin & King, 2008). During the same time the number of residents and their acuity increased. Increased patient acuity and shortened lengths of stay in facilities as well as a renewed focus on primary and preventative health care, have changed the way in which individual nurses practice and the nursing profession. It is therefore likely that more acutely ill patients requiring more complex interventions and treatment regimens in shorter periods of time will have a significant impact on expected nursing workloads, and create the need for more rather than less skilled staff (Aiken et al. 2002, Duffield and O'Brien-Pallas, 2002).

There are significant risks to patients from understaffing and inadequate skill mix, including compromised safety and diminished quality of care; increasing morbidity (incidence of disease) and mortality (death rate); and an increased occurrence of adverse or sentinel events (injury or death resulting from a health care intervention, not the underlying condition of the patient) (Armstrong, 2009). Efforts to cut costs and achieve financial savings in aged care through constraints on nurse staffing are actually driving up economic costs, affecting service delivery and health care practice, and compromising patient safety (Heggen & Wellard, 2004).

Skill mix is a significant predictor of patient outcomes. Skill mix refers to the balance between trained and untrained, qualified and unqualified, and supervisory and operative staff within a service area, as well as between staff groups. The optimum skill mix is consistent with the efficient deployment of trained, qualified and supervisory personnel and the maximisation of contributions of all staff (Nessling, 1990).

The increase of unlicensed aged care workers has also placed extra demands on ENs and RNs to support and supervise less qualified staff while assessing and caring for more patients with complex needs, and carrying out lengthy administrative tasks. Work intensity for residential aged care nurses has increased with 6.7 residents per nurse in 2007 up from 5.2 in just four years and projected almost to double to 12.1 in the next decade on current trends (Access economics, 2009). This means that each nurse is required to supervise more residents as well as more staff sometimes across multiple locations. As the population of residents becomes older with more chronic needs, there will be growing complexity of care and this will impact on nursing workloads unless there is a suitable model developed to address this. We attach a summary of the Minimum Care Hours model applied in public sector residential aged care facilities in Queensland to project care hours and guide resource allocations. While we recognise that the circumstances in the public sector are unique in that the certified agreement establishes clinical judgment as a valid criterion for determining safe workloads, the QNU believes that this is a

[11] We discuss the regulation of AINs under section 7.0.

useful basis for developing workload management tools in aged care across all facilities (See Attachment F).

Skill mix issues in the aged care sector include the inability to ensure adequate staffing and preparation of staff for their roles. A particular problem is the limited availability of specialised nursing care and thus clinical care limitations, which can have serious adverse consequences for the frail aged (Access Economics, 2010). In the acute sector there is evidence that more nursing hours for patients bring quality of care and economic benefits (Duffield, 2007; Aiken et al, 2003) through decreased complications, higher care standards and improved outcomes, measured using various indicators (e.g. behavioral and pain management, sleep, infection control, emotional support and so on). Studies similarly show that care delivered by RNs in residential aged care settings is strongly related to better resident outcomes (Horn et al, 2005). An implication is that future residents should be made aware of a facility's skill mix when considering a place.

There is currently little evidence available nationally or internationally to make any recommendations concerning implementation of a specific nursing model into residential aged care facilities and the Department of Health and Ageing has limited standards for skill mix with no consistency across states. While the $500,000 the federal government allocated in the budget for a research study on staffing levels, skills mix and resident care needs is a worthwhile start, this area needs further research to take into account the characteristics of a future aged Australian and their family, palliative care, acuity and skill mix.

The acute and aged care systems are interdependent. If the federal government is genuine about its stated commitment to promoting seamless care that is in the most appropriate location then this will mean improving the skill mix in aged care. We have attached a comparison of service profiles between two employers in high care facilities in Queensland – Queensland Health in State Government Nursing Homes and a private provider. This table shows the number and type of nursing staff and the number of beds at each location (See Attachment G).

Where the number of beds may differ slightly, the Queensland Health facilities utilise advanced nursing positions and more registered nurses than the private facilities. The QNU believes, and indeed evidence supports (Horn et al, 2005) that a richer skill mix results in better outcomes for residents and an enhanced career path for AINs and ENs.

We attach a suite of three QNU policies that set out our position on Models of Care, Workloads and Skill Mix (See Attachment H).

Recommendations

The QNU recommends that the federal government must provide:

- Minimum staffing levels in all aged care facilities and an appropriate skill mix of staff to deliver proper levels of care and reduce workloads;
- Further research grants to investigate the needs of the future aged Australian, their families, palliative care, acuity and skill mix.

8.0 Other workforce issues

Education

While it is clear that inequitable wage rates are at the forefront of recruitment and retention of aged care staff, there are several other causes for this declining trajectory. Equally certain is a widespread rejection of the actual or anticipated aged care clinical experience by student nurses (Robinson et al, 2008).

Training and education have been found in acute and residential aged care contexts to enhance quality of care and health outcomes (measured through indicators such as resident satisfaction, functionality, ulcers, infections, bleeding, weight loss and death) (Duffield, 2008). Better quality of care and health outcomes reflect the level of education, training and ongoing professional development invested in skilling and equipping nurses to meet the challenging and changing needs of aged care, particularly for the high proportion of residents with dementia (Access Economics, 2009).

It is important to view nursing education as an investment, with failure to invest in adequate training and education resulting in patient, economic and social costs. Cost effectiveness of residential aged care training programs can be measured in terms of workload (efficiency before and after the training), work quality and number of people trained. It will be vital to continue to monitor and evaluate the cost effectiveness of skills training and key performance indicators of quality through the sector.

We note that the federal government will offer support to establish teaching nursing homes and will provide up to 400 nursing graduate placements. For the first time, the federal government will offer support for:

- The establishment of Teaching Nursing Homes to strengthen the links between the aged care sector, research and training institutions and Local Hospital Networks;
- Up to 400 nursing graduate placements to provide graduates with support from experienced staff, mentoring, access to clinical support and additional training to support graduates as they become fully functioning nursing staff;
- Existing aged care nurses and personal care workers to upgrade their qualifications through further training;
- 900 new nursing scholarships - 600 for ENs and 300 for RNs (Commonwealth of Australia, 2010).

These measures recognise the importance of upskilling ENs and AINs in order to respond to the greater needs of those entering aged care. However, these initiatives are not likely to work if the wages gap is not addressed – that is a prerequisite for successful reform in these areas.

Ongoing education and training will need to complement a well developed career structure and appropriate remuneration scheme to ensure nurses remain within the aged care sector and do not leave to work in higher paying sectors having gained their qualification.

The perception of a gap between academic preparation and clinical preparedness is now being recognised as a matter of concern to members of the public, government, the professions and students themselves. In the sphere of nursing, and most especially residential aged care nursing, the raising of the intellectual/educational capabilities of student nurses has outstripped the quality of the clinical education and training available to them, not due to any failure of will or lack of commitment on the part of those involved. The root of the problem appears to lie at the strategic level. The scope of coordination between the education institutions and the sector has not risen sufficiently to match the magnitude of what is inescapably a joint task; and the training capability of the residential aged care sector has not been able to expand to meet the new responsibilities placed upon it (Robinson et al, 2008).

Professional isolation poses a risk of reduced awareness of current practice and a performance gap can develop between individuals without regular contact with and the influence of practice peers. Aged care nurses need to have regular contact with other professionals and peers in day to day practice for professional development and supervision (Coleman and Lynch, 2006).

The federal government and employers can grow and develop the aged care workforce by focusing on student clinical placements and supporting excellence in training and learning for students. Teaching nursing homes will provide a more stimulating and fulfilling clinical experience in a fully attuned, educative and supportive high quality aged care setting (Robinson, et al, 2008). We believe that curriculum design must take into account community needs, not just those of service providers.

Recommendations

The QNU recommends that the federal government provides funding to:

- Address the barriers to attraction, recruitment and retention in aged care – including the wages gap – as a perquisite to training/education reform;
- Develop a high level evidence base to inform the practices and organisational arrangements that underpin clinical education in aged care;
- Develop a robust and transferable model to facilitate quality clinical placements in aged care (Robinson et al, 2008);
- Raise the training capability of the aged care sector by instituting or renewing, enlarging and enhancing partnerships between the industry and the education bodies (Robinson et al, 2008);
- Move the clinical placement experience into the realm of structured, planned, resourced, education delivered through a collaborative arrangement underpinned by an evidence-based model backed by careful planning and preparation, accountability mechanisms, appropriate staff selection and recurrent training regimes (Robinson et al, 2008).

Extended Roles

One way of facilitating workplace change and innovation in job design is by extending the training and scope of practice of certain groups of workers (such as registered and enrolled nurses). This primarily involves making the most of the skills and experience of workers in relation to the broad range of functions associated with the delivery of aged care services, while still ensuring the safety and quality of care provided to clients (Productivity Commission 2008 p. xxiii).

The aged care workforce structure is predominantly non-RN, overwhelmingly part-time/casual, and suffers from professional isolation (Robinson et al, 2008). This is likely to impose some limitations on the staff's training capacity, a limitation, which may be magnified by a lack of training in the skills of preceptorship and, often, a failure to define teaching and supervision as falling within the scope of duties (Robinson et al, 2008).

The QNU supports the role of Nurse Practitioners (NPs) and Enrolled Nurse (Advanced Practice) (ENAPs) in aged care. The federal government has committed $19 million to trial new models that expand the role of nurse practitioners in aged care, improving career pathways and nursing care. We believe that the federal government should expand this trial to include the ENAP role.

NPs provide a high level of care and the ability to interface with General Practitioners (GPs). U.S. research indicates that nursing homes that employ NPs make a significant investment in quality of care for their residents. NPs have been increasingly included in care teams in nursing homes particularly those with higher managed care (Intrator et al, 2005). Further, NPs working in Australian aged care treating the elderly in their homes and in residential aged care facilities have saved $1.5 million in hospital admissions for the over 65 years aged group (ANF, 2009).

In similar fashion, the QNU believes that the ENAP role could work effectively in aged care facilities. Since 2004, Queensland Health has introduced these positions into almost all Health Service Districts in the State, and in many clinical areas including: outpatient clinics, inpatient wards, operating theatres, mental health units and community health facilities. Their role includes leadership, clinical competencies related to the clinical specialty of the unit, and an ability to practice more autonomously - with supervision by the RN being more often indirect rather than direct. Some areas require the ENAP to have medication endorsement and other areas may not (Queensland Health, 2010).

On the following page we highlight the *Hospital in the Nursing Home* (HINH) service offered by the Royal Brisbane and Women's Hospital (RBWH). This is an example of a successful, alternative for the acute management of residents in aged care facilities that utilises advanced nursing roles (Clinical nurses and Clinical Nurse Consultant) in conjunction with GPs and aged care nursing staff.

Hospital in the Nursing Home

The HINH service is a team of nurses working in partnership with general practitioners (GPs) and aged care facility staff to provide an alternative option for the acute management of residents in aged care facilities. The service provides education, support and advice to prevent unnecessary presentations to the RBWH so that residents are cared for in the most appropriate environment.

- Residents present to the HINH service or the Emergency Department at the request/agreement of the resident's GP.
- The resident remains under the medical management of their GP. The facility nursing staff and HINH provide nursing support.
- HINH nurses provide assistance and support to residential aged care staff to care for the resident at home.
- HINH offers GPs access to management protocols for residents with conditions such as urinary sepsis, cellulitis and pneumonia;
- HINH conducts an annual conference and workshops in response to the needs for residential aged care staff and other stakeholders to maintain and refresh their knowledge and skills in a range of relevant nursing management interventions, including nursing management of palliative symptoms, management and prevention of complications In-Dwelling Catheters (IDCs) and Percutaneous Endoscopic gastrostomies (PEGs), care of tracheostomies and stomas, infectious diseases protocols and wound management.

The service operates 7 days per week and is staffed by 1 full time Clinical Nurse Consultant, 1 full time Clinical Nurse and 1 part-time Clinical Nurse (0.8 FTE).

Commonwealth Longer Stay Older Patients (LSOP) funding has enabled enhancement of the HINH. The most significant enhancement was the extension of HINH into the inpatient units of RBWH. This enabled comprehensive assessment and management of inpatients from residential aged care facilities and established collegiate working relationships with inpatient nursing and medical teams with the following results:

- Reviewed over 40 admitted residents per month
- Case managed complex cases throughout admitted stay (22 patients per month)
- Prevented unnecessary use of sub-acute care options by facilitating transfer back to the RACF with follow-up support
- Facilitated early discharge from acute care (2009/10) saved 365 days with potential cost saving of $255,500)

This funding also allowed the HINH service to strengthen its existing profile in the community and the Emergency Department such that it was able to:

1. Maintain a consistent ambulatory service to outreach to facilities for clinical care and education of facility staff to undertake more acute care on-site
2. Establish work processes, orientation manuals and service profiling for the longer term
3. Participate on local, state-wide and national aged care forums to advocate for improvements for residents presenting to acute care facilities
4. Establish a comprehensive database to capture HINH clinical activity and enable benchmarking internally, and possibly externally
5. Organise annual Aged care Conferences with nationally recognised experts with the aim of closing the gap between aged and acute care
6. Participate in a research project with the local GP Division to improve clinical handover between the two care environments for residents of aged care facilities.

Over the period of LSOP funding there has been a consistent reduction over 3 years in the annual hospital separation rate of residents and a corresponding reduction in total Occupied Bed Days (OBD) , (34% reduction between 2007-8 and 2009-10)

Year	Separations	OBDs
2007-2008	1430	12 157
2008-2009	1185	10 294
2009-2010	945	8 431

Although there has been no notable reduction in corresponding length of stay (LOS) over this same period it would be reasonable to suggest that the enhancement of the HINH has been able to prevent avoidable admissions of those residents with conditions able to be managed within the aged care facility (such as urinary tract infections, wound management, chest infections and chronic anemia) through intensive education of clinicians and an effective phone liaison service.

A survey of internal and external stakeholders showed that the enhanced role of HINH has made a significant contribution in raising the awareness of the needs of the long stay older patient and improving the patient journey by achieving an earlier and potentially more complex discharge for this cohort from aged care facilities.

Recommendation

The QNU recommends that the federal government:

- Broadens the trial for expanding the role of Nurse Practitioners in aged care to include the role of ENAPs.

Workforce Planning

The QNU has consistently argued for a national nursing workforce plan to provide a systematic assessment of state and facility staffing needs and the actions necessary to address these needs through a consultative process involving key stakeholders. Although there is already some interface between stakeholders such as health and aged care service providers and those involved in the educational preparation of the nursing and midwifery workforce, this needs to be strengthened considerably to ensure that Universities and TAFEs prepare candidates who are 'work ready' and providers ensure there are enough clinical placements to accommodate students.

Investing in nursing and midwifery care through systematic planning of the workforce will provide returns of better care outcomes and less use of expensive health care resources. Supply must meet demand by recognising that nurses and midwives have sound professional judgment to identify the resources required to build and deliver models of nursing tailored to specific community needs in a safe and valuable way. Models of care are dependent on the availability and sustainability of the appropriate and relevant skill mix and the recruitment of appropriately qualified nurses.

Governments and employers must not regard recruitment of overseas trained nurses and midwives as the solution to Australia's aged care nursing shortage. Although we acknowledge the international mobility of the nursing workforce, this must occur within the context of an ethical migration framework. The fundamental premise for health workforce planning must continue to be one of national self sufficiency. Migration from those countries that are already experiencing crisis in their health workforce will further weaken their already fragile health systems. Comprehensive workforce planning that includes the education sector will provide the most effective and sustainable solution to Australia's health care needs.

Planning the aged care workforces requires estimates of:

- The total size of that workforce through the period (FTE and persons). From this can be calculated the number of additional workers required for growth;
- The net numbers leaving the workforce requiring replacement;
- Net arrivals into the jurisdiction which contribute to the supply of new recruits to meet growth and replacement needs;
- The number of recent graduates who are available and suitable for positions;
- Any accumulating shortages or surpluses (Preston, 2010).

In April, 2010, the QNU co-sponsored the Nursing and Midwifery Workforce Summit, a meeting of key stakeholders to discuss the future of the nursing workforce in Queensland. The summit identified the following priority issues:

- Increasing the supply of nurses and midwives;
- Increasing new graduate employment;
- Improving educational articulation;
- Promoting advanced and independent practice;
- Improving retention of targeted cohorts of nurses and midwives.

As a result of the summit, the Office of the Chief Nurse (OCNO) has prepared a draft *Nursing and Midwifery Workforce Strategy 2010-2020* which sets out the priorities and strategies for addressing the key workforce challenges faced in Queensland. The QNU will be working with OCNO to refine this document and implement its strategies.

In 2008, the Council of Australian Governments (COAG) announced the establishment of Health Workforce Australia (HWA), a statutory body that seeks to produce more effective, streamlined and integrated clinical training arrangements and to support workforce reform initiatives. HWA will develop policy and deliver programs across four main areas - workforce planning, policy and research; clinical education; innovation and reform of the health workforce; and the recruitment and retention of international health professionals. HWA will also consider the adequacy and availability of workforce data (Health Workforce Australia 2010). We believe that HWA can benefit from a similar approach to workforce planning that we have adopted in Queensland. This will involve putting in place mechanisms for gathering reliable workforce data across all health sectors.

Recommendations

The QNU recommends that the federal government in conjunction with Workforce Australia and the states:

- Develops and implements a national nursing workforce plan based on best practice in any setting that will inform the national health policy. The nursing workforce plan should recognise the specific needs of indigenous Australians and a culturally diverse population.

9.0 Conclusion

If the federal government is serious about reforming Australia's aged care system it calls for a new paradigm, one that recognises and rewards the dedicated nursing workforce upon which the system relies so heavily. The future of aged care depends on community input and appropriate funding and staffing strategies that will deliver quality outcomes for residents and their families. The QNU is keen to assist the Commission with its important deliberations in the coming months.

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