Written Submission to the Productivity Commission Draft Report '*Caring for Older Australians',* January 2011

I would like to thank you for the opportunity to comment on the Draft Report. I acknowledge the need for an aged care reform and agree with the proposal of a simplified access and assessment avenue, if it helps older people and their carers / advocates to access care more easily. My overall impression of the Draft Report is that it is heavily biased towards the aged care providers. It contains a strong emphasis on funding options, but very little about how quality care will be delivered and improved with the reform.

My comments cover the following **Key areas of concern**:

1. **The lack of a balanced view**

   I am concerned about the lack of a balanced view in this Draft Report as it focuses heavily from an aged care provider's perspective and has a strong financial overtone. I appreciate it is the Productivity Commission's privilege to select an Associate Commissioner, who has knowledge of the sector to assist with this enquiry. However, I am deeply troubled that the Productivity Commission did not select a second Associate Commissioner, who can provide insight from the worker's or consumer's perspective. Such a person could give valuable information about the role of nurses in aged care, how care is delivered (rather than defining care as a series of tasks), and the critical connection between staffing levels and the quality care of residents.

   The selected Associate Commissioner has over 15 years work experience as a former CEO of an organisation that looks after the interests of private aged care providers. After leaving the CEO position, this person worked as a private consultant for the sector. In my view, if this enquiry is genuinely meant to guide future policy change, the Productivity Commission should have included a second Associate Commissioner who could have been either an experienced 'hands-on' aged care nurse or residents advocate. A second Associate Commissioner from a worker / carer perspective would have first-hand knowledge of the current crisis in residential aged care facilities including poor staffing, inappropriate skill mix, and its impact on the quality of care. Hence, this oversight from the Productivity Commission may help to explain why there is a lack of fundamental connection between staffing and skill mix, and its impact on the quality of care in the Draft Report.

2. **Workforce issues barely get a mention**

The Productivity Commission admits there is a workforce shortage that is exacerbated by uncompetitive wages but fails to link this to the impact on quality of care. Wage disparity, excessive workload and unrealistic responsibility for the registered nurses have led to a staffing crisis and recruitment difficulties. Ignoring this issue means the problem of attracting registered nurses to aged care will continue long into the future.

Nurses and assistants in nursing are not just the backbone of the sector. They are keeping the system going day in and day out. The Productivity Commission has ignored nurses' call for urgent workforce reform. They have also let down the residents and their families because the key issue of care barely features in the lengthy document.

The draft recommendations 11.3 and 11.4 do not address the current staffing crisis and recruitment difficulties particularly in relation to registered nurses. I wonder if there may be an 'implicit push' in the Draft Report to suggest that unlicensed care workers should replace registered nurses in aged care.

3. **Minimum care hours are vital for the delivery of quality care**

Staffing levels and skill mix are integral to improving care for older Australians, many of whom are experiencing more complex health needs including dementia. Minimum care hours are vital for the delivery of quality care. The Productivity Commission has failed to recognise this in the Draft Report.

One may argue that the Aged Care Standards and Expected Outcomes have sufficiently addressed the staffing and care hours issues. However, in my view, the current standards and expected outcomes are non-prescriptive, non-measureable and subject to individual assessor's interpretation. For example, Expected Outcome 1.6 – Human resource management '*There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives'.* It is well known among staff and residents that during accreditation or other visits by the Aged Care Standards and Accreditation Agency, extra staff are rostered on duty for the occasions. In reality, neither the residents nor the staff would dare to inform the assessor of the poor staffing levels for fear of reprisals.

Furthermore, I find it incomprehensible that ratios of nurses and care workers to residents do not exist in residential aged care facilities. In childcare and education, we have mandatory ratios of childcare workers to children, and limits on class sizes in primary and secondary schools. Yet for sick elderly Australians in residential aged care - a very vulnerable group in our society, this Draft Report has ignored the critical issue of mandatory staffing ratios and skill mix for the delivery of quality care. There are claims in the aged care sector that it is not possible to implement mandatory staffing ratios and skill mix in residential aged care facilities because every resident's health condition and care needs is different. However, these claims are not justified because the current government funding is calculated based on individual resident's care needs (Aged Care Funding Instrument – ACFI). In my view, similar formulas that are based on the Aged Care Funding Instrument (ACFI), could easily be developed for mandatory ratios of nurses and care workers to residents.

4. Licensing all care workers in aged care

Licensing of all care workers in the sector is critical for the protection of older Australians. Medications are now administered by assistants in nursing (unlicensed care workers with a Certificate IV qualification) in aged care. These care workers are trained to give the right medications and the right dose to the right resident, at the right time by the right route, which serves the purpose of completing the task only without knowing what kind of medications.

As unlicensed care workers do not have the same knowledge as a registered nurse (RN), they may not realise that they should inform the RN that the resident's vital signs have changed, which may be due to certain medications. For example, if the resident's blood pressure is lower than the usual reading, a registered nurse would consider whether he/she should contact the doctor and adjust the dosage of the antihypertensive drugs if necessary. On the other hand, unlicensed care workers would continue to give the medications because they don't know that the resident is taking antihypertensive drugs, and they should inform the RN or the doctor.

Registered nurses have the knowledge of anatomy and physiology of the human body, pharmacology and the side effects of medications. In aged care especially, the majority of residents take multiple medications. To identify medication side effects or recognise subtle changes of vital signs requires the complex clinical judgement of a RN. Registered nurses have the knowledge and skills to assess the residents, withhold the particular medication and contact the doctor immediately if necessary.

Residents with dementia in particular, are not in the position to express themselves if they experience any side effects of a particular medication. Nowadays, only one RN is rostered on duty in the majority of residential aged care facilities. This one RN is responsible for between 46 to over 100 residents[1]. Hence, many medication errors or side effects may not be picked up at all.

Furthermore, the RN would be totally occupied if a critical incident occurred to any residents, e.g. a fall (which is quite common among elderly residents). The same RN would have to assess the resident, call the ambulance, provide medical history, medication records and relevant documentations to the ambulance officer as assistants in nursing are unable to do so. Hence, it is unrealistic to expect the only RN to supervise all care workers properly and be held accountable for medications that <u>are not administered by himself/herself</u>.

Nurses have constantly expressed their grave concerns that with such excessive workloads, they don't have time to 'eye-ball' all residents despite working non-stop and giving up their meal breaks. Nurses are deeply troubled that they have to rely on unlicensed care workers to inform them of any changes in the residents' health condition, because they don't have the time to check on every resident during their shift. The inability to give quality care to residents due to excessive workload is one of the main factors that contributes to job dissatisfaction among nurses[1].

Therefore, licensing all care workers in aged care is critical for the protection of all residents. If all care workers are licensed, the licensing body would have a record of those care workers who have made serious medication errors and/or committed professional misconduct. With the establishment of a licensing body, it is easy for aged care employers to find out whether the prospective new staff member has such records in their previous employment. Whereas with the current system (which the care workers are not licensed), employers could only find out whether the prospective new staff member has a criminal record via a 'police check'.

Furthermore, the licensing body would be the 'gatekeeper' to make sure the training organisations (for Certificate III and IV) meet educational standards. At the moment, the educational standards and quality among training organisations vary a great deal. Neither the State Government nor the Federal Government conducts regular checks on these organisations to make sure the courses provided meet educational standards.

5. **Paying for aged care and the need for absolute transparency in the use of government funding to aged care providers**

There are 11 draft recommendations on '*Paying for aged care*' in the Draft Report. These draft recommendations suggest in detail that older Australians should fund their own aged care needs (a new care co-contributions regime) through a wider use of bonds or daily fees for their accommodation including the sale of their home.

While I agree that everyday living expenses should be the responsibility of individuals, I find it discriminatory that sick elderly residents have to pay a new care co-contribution. For Australians who go into a low care hostel or retirement village might do so by choice, but for those who are admitted to high care residential facilities (nursing homes), it is a health need and should be treated as such. Sick elderly Australians with complex health needs are no different to any other sick patients who require acute care in public hospitals. One may argue that aged care residents' care needs are long-term, and hospital patients' health problems are short-term. However, Australia has a universal health care system, and there is no valid reason to discriminate against nursing home residents and make them pay for their care.

The current aged care funding system does not require transparency from aged care providers in terms of how that money is used. The proposal that the homes of elderly Australians may be sold in order to pay for their own aged care (new care co-contributions), demands absolute transparency from aged care providers on how that money is distributed, particularly on staffing and care hours. There is no recommendation in the Draft Report to suggest that aged care providers will be held accountable with this 'new care co-contribution regime', and there is no guarantee older Australians will receive quality and better care when compared with the current aged care environment.

Therefore, any call for increasing responsibility by older Australians to pay for their aged care must come with a right for older Australians to the benefits of mandatory aged care staffing levels with mandatory quality control in staffing such as ratio levels on registered nurses and assistants in nursing (care workers) per resident.

More importantly, government funding on aged care are also taxpayers' money. Therefore the Australian general public have every right to know how much of this money is being spent on staffing and care hours and improvement towards

quality care. Otherwise, this ‘new care co-contribution regime’ will certainly be judged by the public as a means to boost profits for aged care providers.

Conclusion

If the aim of a fundamental reform is to address the current issues and respond to future challenges in aged care, the above key areas of concern need to be addressed adequately and urgently.

Elderly Australians have contributed significantly to this country in their younger days. When it comes to the time that sick elderly Australians with complex care needs require aged care, they deserve to be treated with dignity and respect. Most importantly, they deserve to receive quality nursing care instead of just being washed, dressed and fed like a ‘production line’.

Reference:

1. The University of Sydney (2007) *Survey of Registered and Enrolled Nurses in Aged Care.* Faculty of Nursing and Midwifery, The University of Sydney.

Submitted by Janet Ma
A very concerned retiree.

21 March 2011