Caring for the Older Australians (Melbourne)

The current ACSAA processes do not provide any kind of reliable way to adequately provide an appropriate staff mix or a ratio to provide for all the assessed care needs of a resident in accordance with ACFI. The assessors who conduct an audit or support visit rely heavily on 3 verifications – staff comments, resident/relative comments and a cursory glance at a roster, which may or may not be truly reflective. They have no way of knowing what the ACFI ratings are for the whole facility, individual areas or individuals. Therefore there is no correlation drawn between the care needs and the funding. The staff and resident/relative input is equally subjective and relies on the information from the proprietors.

In the current situation there are 3 distinct components.

1. The ACSAA standards, which are quite nebulous and open to interpretation.
2. The staff mix and staffing levels as determined by each facility and
3. The ACFI, which provides the funding for, but is totally detached from the previous two factors.

Although the ACFI process was developed to fund each resident according to assessed needs, in reality it has only been partly successful. There are many cases where it is underfunding residents and in others it may be overfunding. The funding instrument does not adequately fund in the behaviour domain, as the weightings are extremely low in that domain. This results in poor management for residents, who have cognitive impairment of any kind, or behavioural issues which are the most time consuming area of care. For the past 3 years the level of funding for residents in the highest category has been capped (despite the fact that the uncapped cost was the calculated cost of caring for a resident in that category 3 years ago). Therefore the facilities have had to carry that cost, which in reality means less access to care for all residents. This is immoral in a situation where all the allocated money for ACFI has not been spent each year. Also you have ACFI reviewers who regular audit to 'claw back' money by finding some small loophole or excepting some evidentiary material for the claim. For a system that is so prescriptive it seems to rely on subjective reviewing of the claims. If it is not possible to gain correct funding for the level of needs of the residents which is based on accurate data of what it really costs to provide for those needs, there will be a continuation of the current situation whereby staffing levels and staff mix is inadequate.

Within the industry there is a continual emphasis and drive for 'best practice' so why does this same principle not apply to the costing of care that should be given according to assessed needs. There is no basic data set available to demonstrate time required to care/skill mix for residents in certain categories. If there were some basic guidelines, each facility could use that as a baseline, and those who wished to demonstrate better staffing levels/skill mix could do so, and this could be used as a marketing and benchmarking tool. Currently the public and the consumer have no way of judging for themselves, and rely heavily on the provider's figures, which cannot be consistently compared with others.

The skill mix of any facility is dependent on 3 factors –

- The availability of skilled staff
- The affordability to have skilled staff
- The ability to attract, recruit & retain skilled and qualified staff members

At the present we have a situation where a PCW is paid an extremely low wage, which is only attractive to those who are unskilled in any other areas. Therefore these positions are being filled by new immigrants, unemployed, NESB workers and single mothers who are being forced to find work or those made redundant from other areas. The result is a workforce who have not necessarily chosen this area of work because of any altruistic feeling, or because they have a calling to care for others but it is from an economic basis. This results in the most vulnerable being cared for by those who care least. Those who care most are often not able to continue as they find it financially unviable, or they have to work 2-3 workplaces to make it viable, which in turn creates a burn out effect.

The fact that in 'Aged Care' the EN/RN wage has no parity with the public hospital system results in a workplace that is not attractive to younger, career minded registered nurses. There is no obvious reason why a registered nurse would choose to be responsible for up to 60 (or more) elderly residents who have multiple co-morbidities (with very little support from G.P.s or allied health professionals) when they

could be employed to look after only 4 patients with a multidisciplinary team supporting them for 20% more money. The average age of RNs in Aged Care is increasingly getting older. Who is going to do this work in 10 years time? Many RACFs are trying to introduce other factors to make Aged Care more attractive to a younger generation e.g. family friendly workplaces, self rostering, child minding, improved reputation of the facility in the community, career pathways, motivational philosophies, etc., but remuneration should be commensurate with the qualification and work, not with the place of work.

Since the Aged care industry is relying heavily on PCWs to perform the bulk of the work, which is without doubt one of the most intimate, personal and service centred work which can be performed – often requiring medical knowledge, patience, high level interpersonal relational skills, it would be obvious that those workers should be regulated as are other health professionals. The clientele of a RACF nowadays require highly skilled and trained staff to meet their challenging physical and mental needs. With the rise in residents experiencing dementia and cognitive problems, this can only be an increasing need in the years ahead. The training should be through an accredited training organisation such as a TAFE, which has a recognised and regulated outcome with a defined scope of practice, allowing for more accountability for practice and education, which would improve quality of care. The current situation of a PCW being qualified as a Cert. 3 Aged Care Worker after 3 weeks of classroom and 2 weeks of workplace placement (without a qualified mentor/tutor) is totally indefensible and unfair to the PCW and the recipient of their attempts to care. Many of the PCWs have been taken advantage of by the RTO, have had to pay heavily for the opportunity to learn and receive a Certificate but are unable to then find positions because they have no experience, skills, understanding of their roles & responsibilities and often do not have even basic English. When they do get positions the RACF and their staff has to train them properly, assist in English learning, and basically nurture them for 6-12 months. This creates a ‘burnout effect’ for other staff that become jaded and frustrated. The need for a minimum educational and industry standard is paramount if we are ever to get an overall, acceptable level of care for the frail elderly in Australia. This standard should be similar to the old EN course of 12-18 months but with no medication component.

The role of the RN in RACF should continue to be an important and vital part of the skill mix. There is a direct correlation between standard of care and the number of RNs available for direct support and supervision. Anecdotally, many RACFs are experiencing high numbers of decubitus ulcers since there has been a decline in the use of RNs in the last 5 years. This is one of the key performance indicators, which should alert all RACFs to a decline in standards of care. These are not the indicators that Aged Care Assessors look at – it is more about the process of documentation and auditing than about the result.

In Conclusion:

I would like to state at the conclusion of this submission that as a veteran of Aged Care, I remain totally amazed at the exceptional care delivered by many undervalued, under-remunerated and overworked staff at all levels of the Aged Care spectrum. The love, care, dedication, loyalty and perseverance of so many carers is what continues to make caring for the aged in our RACF’s such a joy despite all the frustrations. The interminable bureaucracy, over-regulation, negative community image, lack of acknowledgement of a job well done and the lack of resources, which includes but is not exclusive to money, cause these frustrations.

I take my hat off to all those who start their shift early to ensure the work is done, finish their shift late to ensure the work is all documented, keep on smiling when they are hot, bothered and their feet hurt from walking 10-15kms during their shift, respond with respect to every request and offer friendship and care to both residents, relatives and each other. This is all while trying to balance the needs of everyone of these, time manage, use resources wisely, and keep their wits about them to ensure no one escapes, assaults another, displays inappropriate behaviour or assaults them the caregiver.

Meanwhile they are also caring for the dying, grieving relatives and managing their own emotions, for they are humans too and they hurt and grieve for their clients as well as carrying the burdens of so many. They cry, they laugh and they care in what is often a very hostile environment.