

Delivering Care to the aged – A focus on workforce

*A PwC response to
the Interim Aged Care
Productivity Commission
Draft Report and
recommendations.*

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Introduction



In 1998 57.1% of females and 59.6% of males, in Residential Aged Care were classified as High Care.

With the ageing of our society and the anticipated increase in demand for aged care services, workforce will be one of the most important factors to be addressed. If we don't have the right staff with the right skills to meet requirements, a substantial group of the most vulnerable people in our society will be poorly serviced for their most basic human needs.

In 1998 57.1% of females and 59.6% of males, in Residential Aged Care were classified as High Care. In 2009 74.7% of females and 75.2% of males were classified as High Care. (Australian Government. Australian Institute of Health and Welfare 2010. Residential Aged Care in Australia 2008-09 p 184) This obviously has massive implications for the skills and type of staff required to address the needs of this expanding population.

PwC strongly supports the Aged Care Productivity Commission Draft Report recommendations relating to workforce:

- **11.2 The proposed Australian Aged Care regulation Commission (draft recommendation 12.1), when assessing and recommending scheduled care prices, should take into account the need to pay competitive wages to nursing and other care staff delivering aged care services.**
- **11.3 The Australian Government should promote skill development through an expansion of courses to provide aged care workers at all levels the skills they need including:**
 - Advance clinical courses for nurses to become nurse practitioners
 - Management courses for health and care workers entering management roles

- **11.4-The Australian Government, in conjunction with universities and providers, should fund the expansion of 'teaching aged care services' to promote the sector among medical, nursing and allied health students.**

Our experience working with the residential aged care sector has highlighted the staff and skillmix issue as one that warrants further investigation in regards to workforce:

A. Are workforce skills aligned to the changing care needs of residents?

Taking a broader view of the Commission's draft recommendations relating to workforce, the following sections outline our understanding of the implications of the above question and contain a number of recommendations to address the issues raised.

Recommendations

1. Align the skills of the workforce to the needs of aged care residents

People are entering residential aged care facilities when they are older and have more complicated health needs. The industry required staff that can provide for the needs of this challenging population.

Over the past ten years we have witnessed significant increases in life expectancy. In 1991 life expectancy was 74.4 years and 80.3 years for males and females respectively. The 2009 data shows an increase to 79.33 years and 84.25 years for males and females¹.

While Australians are living longer than ever before, an increasing number are affected by chronic disease, much of which can be prevented or minimised by better health management.

Chronic non-communicable diseases are now responsible for around 80% of the total burden of disease in Australia².

The prevalence of cardiovascular disease increases with age. In 2004-05, of those aged 35 to 44 years, 13% reported a long term cardiovascular condition. This increases to 23% for those aged 45 to 54 years and 63% for those aged 75 years and over³.

World-wide, diabetes is in epidemic proportions. The most recent global predictions by the International Diabetes

Federation suggest that worldwide there are currently 285 million people with diabetes currently. This is set to escalate to 438 million by 2030, resulting in a 54% increase⁴.

Many of these health issues exhibit differently in the elderly population and require specific skills for correct recognition and assessment. This has implications for the extent to which:

- training programs enable care staff to identify and deliver appropriate care
- the assessment tools required to meet the specific needs of geriatric assessment and diagnoses?

With increases in Commonwealth funded community services allowing people to stay in their homes for longer (CACP, EACH, EACH-D), referrals for residential aged care placement occur at times when care needs are much higher than when people were previously referred.

According to an Australian Government 2008 report 'the average age on entry to permanent residential aged care is 82 for both men and women'⁵.

To compound the issue, the diverse range of health needs within the geriatric population provides a challenge to aged care providers in employing the right mix of skills and specialist knowledge, particularly in low care facilities.

The impact of a misalignment between the needs of a resident aged care population and the skills mix required to appropriately assess and deliver

relevant care, is felt by the public health sector, carers within the sector and residents. It also inhibits the provider's ability to accurately assess and claim for appropriate funding.

By 2050, ageing will increase the demand for bed-days by between 70% and 130% depending on the underlying assumptions, and the proportion of bed-days devoted to older people will increase from under 50% in 2005 to over 70%⁶.

There are four key implications of the misalignment of skills to the changing needs of our elderly population:

- Inappropriate hospital admission and discharge
- Inadequate delivery of care
- Misalignment of skills to role in the workplace
- Inability to attract and retain appropriately skilled staff.

a. Inappropriate hospital admission and discharge

The challenge

A common view is that there is inadequate undergraduate and postgraduate training for all key disciplines across medicine, nursing and allied health for the specific needs of the geriatric population. The result is a failure to diagnose and recognise treatable illness in the elderly population early enough⁷.

¹ Australian Bureau of Statistics

² Australian Government Department of Health and Ageing. 2008. Ageing and Aged Care in Australia. p3

³ Australian Bureau of Statistics (2006) Cardiovascular Disease in Australia: A snapshot, 2004-05, accessed 16/03/2011 at www.abs.gov.au/ausstats/abs@.nsf/mf/4821.0.55.001

⁴ HealthInsite: <http://www.healthinsite.gov.au>

⁵ Australian Government Department of Health and Ageing (2008), Ageing and Aged Care in Australia, p3.

⁶ Schofield & Earnest (2006), Demographic change and the future demand for public hospital care in Australia, 2005-2050 in Australian Health review Vol 30 No 4

⁷ Miller S (2003) Unnecessary and avoidable hospital admissions in the elderly- A report to the Department of Health and Ageing, p46.

Care staff that can recognise and treat the common ailments of the elderly are in a position to improve both the timeliness and comfort in which treatment is provided in the residential aged care setting. This equates to a reduction in preventable ambulance transfers and avoided bed-day costs to the local hospital.

PwC Recommendation

PwC strongly supports draft recommendation 11.3:

The Australian Government should promote skill development through an expansion of courses to provide aged care workers at all levels the skills they need including:

- **Advanced clinical courses for nurses to become nurse practitioners**
- **Management courses for health and care workers entering management roles.**

Further to this recommendation, an alternative or complimentary approach is the employment of a Nurse Practitioner in residential aged care facilities. This would represent a win-win to residential and community care providers and the wider aged care community.

Nurse Practitioners with expert knowledge and extended practice skills of the elderly can provide substantial benefits to the care of residents. Nurse Practitioner roles are well established in many overseas jurisdictions and there is evidence from these jurisdictions to suggest that the introduction of such roles:

- Increases service-users satisfaction
- Improves outcomes – timely access, assessment and client interventions
- Reduces the prescription of pharmaceuticals
- Decreases readmission to acute care and reduces costs⁸.

The way to maximise the advantages of employing a Nurse Practitioner is to make use of their ability to provide Medicare funded services and with a provider number prescribe necessary medications. The Nurse Practitioner could provide care to residents and the broader aged care community and so enhance access to medical services and potentially avoid the disruptive situation of transferring the resident to the hospital.

The Nurse Practitioner could offset their wage by drawing funding to their organisation from Medicare and increase the level of service provided to the local aged community. This funding in turn would be offset by reduced medical expenses and hospital utilisation.

This option represents a reduction in cost to the public health system and as such, the government should consider ways to enable the funding to follow this activity in a way that incentivises aged care providers to establish a financially viable service that benefits the resident, the aged care provider and the wider community.

b. Inadequate delivery of care

The challenge

While advances continue in other sectors of the health continuum around effective treatment for depression and pain management, the quality in assessments and subsequent programs for the aged care community have stagnated.

Research shows that unrecognised and untreated pain, especially non-cancer pain, is widespread among aged care residents. Because many residents have impaired cognition, more than 40 per cent of the Australian nursing home (high-level residential care) population is unable to even report pain⁹. Older adults living in aged care facilities represent a particularly high risk group for depression, with recent prevalence estimations of major depressive disorder in the range of 14 to 26 per cent, well above those of the general population¹⁰.

Staff with inadequate or basic skills and training (about two thirds of the workforce) are also less likely to recognise health problems in the early stages thereby delaying the start of appropriate care. Delayed treatment can lead to skin tears becoming chronic wounds and chest infections progressing to pneumonia which are more complicated, time consuming and expensive to treat. This is also likely to result in further health complications for the resident involved.

PwC Recommendation

PwC strongly supports the use of a case management model in residential aged care.

This recommendation is outside the Productivity Commission draft recommendations but is aligned to the draft recommendations 11.3 and 11.4 in that it leads to a staffing and skill mix tailored to the individual residents care needs.

An effective mechanism for the overall management of the health of individual residents and community care recipients may be in the tailored design and application of a case management model. The model must be specific to aged care and supported by the necessary investment to address the skills gap in assessing the health needs of geriatrics.

Subsequently, a holistic case management model will lead to more effective and timely identification and treatment of health issues including chronic pain and depression which tend to be under-recognised.

A case management model allows for the care provided to an individual to be accurately determined and tailored to meet the assessed needs, to optimise their quality of life and maintain health.

The key principles of good case management is that the case manager coordinates the process, consulting informal carers and key service providers to ensure that the plan is developed appropriately, clearly contracted and monitored for effective and financially accountable service provision based on specified and desired outcomes¹¹.

The skills need to be relevant to the specific setting practitioners are working in. For example:

Carers in Dementia specific units require skills to address the needs of people who have decreased cognition and may have aberrant behaviours.

Carers in nursing homes require skills to address the needs of immobile residents who may have chronic wounds and require indwelling catheters and feeding tubes.

Carers in the hostel require the skills to help people maintain their independence through tailored assistance with the activities of daily living.

It is critical carers have regular contact and an ongoing relationship with the residents for whom they are responsible. There also needs to be a certain level or number of staff with strong geriatric knowledge and assessment skills.

In the residential aged care setting the case managers need to have core skill sets including assessment skills, clinical knowledge, organisation, teaching and communication and succinct documentation to enable the responsive provision of services to be coordinated for the best care of the resident involved.

Of considerable importance is the case manager's role in providing mentorship and education to care staff and liaise with the residents families.

c. Misalignment of skills to role in the workplace

The challenge

Registered Nurses (RNs) in most residential aged care settings are the senior members of staff within a facility and subsequently the majority of their time is allocated to managerial tasks such as rostering, administration, budget management, documentation and family relationship management¹².

Furthermore, not all RNs in aged care settings have an extensive understanding of geriatric diagnoses and assessment. Often RNs' experience is in an emergency or acute care environment which requires a different set of skills, expertise and care management approaches.

Carers with little to no formal training in geriatric clinical diagnoses and assessments, are primarily responsible for both identifying changes in clinical care requirements and delivering clinical care.

In many low care facilities a multitude of medications are dispensed without any registered nursing staff on-site in case of complications. In low care facilities, it is not uncommon that staff are not allowed to administer oxygen to residents who become breathless or have cardiac chest pain, resulting in delayed medical assistance while waiting for an ambulance to arrive.

Low care facilities providing 'ageing in place' often have a high population of high care needs residents, yet may still be staffed to support a low care resident population.

PwC Recommendation

PwC strongly supports the Commission's Draft recommendation 11.4:

The Australian Government, in conjunction with universities and providers, should fund the expansion of 'teaching aged care services' to

promote the sector among medical, nursing and allied health students

In line with this recommendation, an expanded approach to teaching warrants further exploration, that is the application of the concept of a teaching hospital to the residential aged care sector with the objective of providing ongoing in-depth and specialised geriatric training for all aged care workers to improve the overall skill mix.

Aged care facilities with a dedicated teaching role, similar to a 'teaching hospital' could raise the education and skill levels across the sector. Ideally, Doctors, Registered Nurses, Allied Health professionals and carers could attend the 'teaching facility' for both formal education and practical hours to develop their skill and competence.

Aged Care teaching facilities may also be an incentive to attract carers, nurses and specialists to the aged care sector, by offering ongoing skills development to extend their practice.

The role of the teaching facility may include:

- Induction: An induction tool for new staff entering the aged care sector. Practically this would translate to a short-term placement whereby practitioners work as supernumerary in a busy multi-disciplinary aged care environment. They could be provided

⁸ Australian Government Department of Health and Ageing (2007) HA - Nurse Practitioner- Like Services in Residential Aged Care Services- Evaluation Report

⁹ The Australian Pain Society (2005), Pain in Residential aged Care Facilities. Management Strategies p iv.

¹⁰ Davison et al., (2007) The prevalence and recognition of depression among aged care residents with and without cognitive impairment. Aging and Mental Health, 11, 82-88

¹¹ Case Management Society of Australia. www.cmsa.org.au/definition.html

¹² Aged and Community Services Association of NSW & ACT (2005) Guidelines on Management of Medications in Allocated High Care Places in NSW p1

with didactic as well as practical learning opportunities in a controlled and well supervised environment. Practical skills assessments could also be carried out so that when finished their induction, they have a sound platform of knowledge and skills to take with them to their aged care workplaces.

- Graduate nurses programs: Due to the often autonomous role of an RN in an aged care facility, aged care providers have struggled with the challenge of developing an appropriate graduate nurse program that offers on the job training and mentoring in the first years. The teaching facility approach may be a way to address this.

This solution would require some external sustained funding to provide the supernumerary staffing and the high levels of teaching and supervision provided. It may also require effective communication and change management to address any concerns families or residents have with the concept of working with trainees.

d. Inability to attract and retain appropriately skilled staff

The challenge

Despite recent investments by the Australian Government to strengthen the Residential Aged Care (RAC) nursing workforce, over the past decade, RAC nurses have been declining both in numbers and as a share of the total workforce in 2001, some

15% of nurses worked in RAC, but by 2007, just 11.6% of all nurses were working in this sector. Personal care attendants (PCAs) make up almost two-thirds of the workforce providing direct care in RAC facilities. Over the last 4 years, the number of PCA's working in residential aged care has grown by 17.5%¹³.

The profoundly low job satisfaction felt by nurses is a major factor in retaining and recruiting nurses to the aged care sector. The lack of a supportive work environment is cited in many studies as a major causative factor in the area of morale.

Staff shortages are reported to have compounded the low morale. Experienced and overworked nurses express their inability to provide quality resident care, thereby reducing their own estimation of personal professional effectiveness, and self-esteem. These factors result in endemic low morale and poor image which appears most profound in the aged care sector. Recruitment therefore becomes problematic as women in general, and nurses in particular, seek employment opportunities that are more rewarding emotionally and financially¹⁴.

PwC Recommendation

PwC strongly supports draft recommendation 11.2:

The proposed Australian Aged Care regulation Commission (draft recommendation 12.1), when assessing and recommending

scheduled care prices, should take into account the need to pay competitive wages to nursing and other care staff delivering aged care services.

To attract new staff into the aged care industry, the wages must be competitive. As the Australian workforce ages and retires, more opportunities for work become available. For nurses with opportunities to work in the acute sector or move into working for pharmaceutical or medical device companies, there has to be some effort made to attract them into aged care to satisfy the staffing requirements. Currently there is a significant wage gap between hospital and aged care staff and a significant gap between Care Workers wages and the National average wage.

The majority of aged care workers providing direct care for residents – assistants in nursing (AINs), enrolled nurses (ENs) and registered nurses (RNs) – are between \$65.00 and \$150.00 per week behind their colleagues working in public hospitals¹⁵.

In addition to competitive pay, the ways to move forward suggested above around the appropriate use of the skilled workforce, training facilities and case management approaches will provide RNs with more support, infrastructure and job satisfaction as they apply themselves optimally to delivering care in the aged care setting.

Staff shortages are reported to have compounded the low morale. Experienced and overworked nurses express their inability to provide quality resident care, thereby reducing their own estimation of personal professional effectiveness, and self-esteem.

¹³ Report by the National Health Workforce planning and Research Collaboration- Residential Aged Care Nursing Supply and Demand Projections (2000)

¹⁴ Commonwealth Department of Education, Science and Training (2001) Australian Aged Care Nursing: a critical review of education, training, recruitment and retention in residential and community settings accessed 16/03/2011 at www.dest.gov.au/archive/highered/nursing/pubs/aust_aged_care/1.htm#contents

¹⁵ NSW Nurses Association (2004) NSW Aged Care Nurses – Wages and Conditions Case Update accessed 15/03/2011 at www.nswnurses.asn.au/news/2627.html



Funding the recommendations

Consideration needs to be given to the role of ACFI as a robust model of Activity Based Funding (ABF) in the industry – more rigor and dialogue is required to understand and therefore fund the costs associated with an appropriately skilled workforce in line with the policy objectives of aged care providers.

Funding Models must support the staff and skills required to care for the residents needs.

ACFI needs to provide a consistent way for providers to profile their resident base. By better understanding their resident profile and their assessed care needs, there is an evidence base for establishing the skills required to deliver the care and the associated costs that the government needs to acknowledge in order to appropriately fund providers.

With clarity around the purpose of aged care in the health care continuum, the ABF instruments used for aged care should be continually reviewed against a basis of costing evidence to enable both government and providers to establish the true cost of delivering care in the aged care setting and subsequently address the skills mix required to deliver the care appropriately.

Broader implications for the Industry

The fragmented nature of the residential aged care sector, which is characterised by a small number of large providers averaging close to 2,500 beds each and a large number of small providers (close to 1,000) with an average of 80 beds, raises the question as to how well placed many small and independent providers are to achieve the recommendations put forward by both the Productivity Commission's draft report and our response recommendations.

To what extent will scale be necessary to develop, attract and sustain an appropriately skilled workforce? How feasible is the employment of a Nurse Practitioner and access to teaching facilities be for many smaller providers in the industry?

Furthermore, with PCAs making up almost two thirds of the direct care workforce it is critical to acknowledge and highlight the level of investment that will be required to elevate the skills to the level required.

This in itself will represent a significant cost to many providers in up-skilling or acquiring skilled workers to appropriately implement recommendations such as case management.

These two issues together highlight the need for the appropriate funding model to support and incentivise the industry to achieve the skills and workforce profile required to deliver the expected level of care across the industry.

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