A response to the

Nursing Home Subsidies Position Paper

issued by the Productivity Commission
in October 1998

prepared by the
Australian Nursing Federation (SA Branch)

November 1998

Contents

Introduction

The Australian Nursing Federation (SA Branch) represents the interests of some 9,500 nurses in South Australia across the health and aged care sector.

Nurses working in the aged care sector have reported cuts in the staffing levels in their nursing homes and hostels, reductions in the quality of services to residents in some facilities and many of them are considering whether they will continue in the provision of care to the aged.

Most of these cuts have been portrayed as a consequence of the current funding regime and in particular the effect of the disadvantageous position South Australia holds within the current system. If that disadvantage is not addressed as a matter of urgency the frail aged residents of nursing homes will become increasingly at risk.

We, therefore, urge the Productivity Commission to work towards the earliest possible ending of the current unfair funding or subsidy system and its replacement by one based on meeting the real care needs of the frail aged across Australia.

Response to conclusion relating to nursing home costs and their determinants (3.6 at p32)

The evidence presented to the Commission has been inconsistent in relation to relative costs. In the absence of specific research conducted or initiated by the Commission itself it is difficult to see how the varying claims and counterclaims can be tested and answered.

Given the Commission's own comments that 'an unfunded cost penalty of even a few percentage points can be significant for home viability' it is difficult to see how:

- variances of up to 12% in labour costs; and
- what are seen as significantly varying land and building costs,

can be ignored or at least not subjected to greater analysis than is contained in the position paper.

If the industry is to accept any new regime as fair it must be satisfied that due consideration has been given to all of the facts and that some real level of independent research has been undertaken to ensure the veracity of claims made.

However, we welcome the finding that 'even if a differentiated subsidy regime is to be retained, the current scales would need to be restructured.'

This finding is consistent with our earlier submission regarding the shift in relative wage and related costs as between the states and territories. It is fundamental to any fair and equitable subsidy or funding mechanism that this issue and the current inequities be addressed.

We further welcome **Preliminary proposal 1**, which suggests the termination of the program for coalescence. That scheme was flawed by 2 key factors being:

- the length of the implementation period (7 years) which placed great pressure on under funded states such as Queensland and SA; and
- the reliance on a redistribution of funds from some states to others rather than the injection of funds to meet the actual costs of good quality care.

Productivity improvement and enterprise bargaining

Enterprise bargaining is a strategy aimed at improving the productivity/efficiency and effectiveness of businesses or industries. It assumes a capacity to define then easily measure and quantify such improvements. There is then a process of allocating salary and conditions improvements, which should accrue, to employees as a consequence of their contribution to the process of improvement.

A number of issues arise in the application of these principles to the residential aged care sector including:

- the fact that outcomes from the process are difficult to measure in any consistent way;
- that, as is the case in the health sector, performance measurement is likely to involve a range of factors related to quality, appropriateness, accessibility and cost, without any capacity to produce a *'bottom-line'* outcome;
- improvements to quality, access & appropriateness do not necessarily deliver cost savings or reductions in unit costs but are nevertheless tangible to the consumer, the provider and to employees;
- the capacity to 'share' the gains through such improvements is therefore difficult and relies on additional funds to be made available rather than through a distribution of the saved costs.

The changes to resident profile are a case in point.

There have been profound changes to the role of nursing homes and hostels particularly over the last 5-6 years. Acute public (and now some private) hospitals have sought to discharge patients at much earlier points in their post-acute recovery. This has led to a significant growth in the demand for community or domiciliary care services and also to more complex care needs of people discharged into a residential aged care facility.

The complex and technical care needs of residents has grown significantly along with a growth in the use of technology, complex drug regimes and other therapies.

At the same time the number of nursing home beds has remain tightly under control thereby denying admission to less needy elderly people who now receive services at the hostel level or in the community.

There are significant cost savings to government as a consequence:

- of the early discharge from hospitals which have very high cost structures into nursing homes with lower costs; and
- of capping the number of nursing home level beds and instead using hostel level or community based services to meet the needs of people with lower care needs.

Evidence of this change in location of care can be found in the Report on Government Services, Steering Committee for the Review of Commonwealth/State Service Provision, 1998 which sets out the trends in admissions to residential aged care and to the growth in other services. At p 607 the decline in the proportion of persons over 70 years resident in nursing homes is shown. Between 1995 and 1997 it had fallen from 49.6 persons to 46.7 - nearly a 6% fall in only 2 years.

Hostel residency increased slightly over the same period (by 1.5%). Community Aged Care Packages more than doubled increasing from a low base of 1.5 persons to 3.9.

The costs associated with care are examined at p 631 of the report which shows only a very small increase in expenditure per person over 70 of 0.4% to nursing homes whilst hostel expenditure rose by 118% and Home and Community Care by 10%. These figures represent increases since 1985/86 to 1996/97.

The increasing acuity of residents in both nursing homes and hostels is widely recognised and is well described in the Department of Health & Family Services Annual Report of 1996-97. At page 169 the change in new resident profile of nursing homes and hostels is examined. Over the period 1993-1997 both nursing homes and hostels showed an increase in residents requiring higher levels of care. At p168 the Report comments 'Figures 20 and 21 show that the average dependency level of new residents in nursing homes and hostels has been rising steadily.' They attribute this to better pre-admission assessment and to the increase in community care options.

These cost savings flowing from these shifts in care are not shared by the individual nursing home or hostel since they form usually only one or two links in the continuum of health care provided to the community and in particular to the aged. However they are a significant contribution to the overall efficiency or productivity of the health and residential care sector and must be recognised. Its is therefore most unreasonable for government to adopt a stance which says that further facility specific cost savings must be generated in order to fund quality improvement and salary and other wage costs to staff.

The only example of 'improved productivity' referred to in the position paper is that arising from the TriCare Agreement. The ANF (SA Branch) notes that:

- Wage increases appear to be totally or substantially funded through cutting of other conditions of employment. This is at odds with the objective of sustainable improvement to real efficiency or productivity and is instead a short-term negative cost cutting approach, which has, been disavowed repeatedly by industrial tribunals as a proper approach to the issue.
- The level of wage increases achieved (3.6% over 2 years) are of questionable value to the employees involved. Safety net increases in recent years have delivered minimum increases of at least $8 per week, which translate into percentage increases of approximately 1.7% per annum (or 3.4% over a 2 year period) without any loss of conditions of employment.
- Other so-called productivity improvements have yet to be achieved.

We therefore reject proposition that such a model is appropriate for the residential aged care sector.

The value of nurses' work in the sector

The ANF (SA Branch), other nursing organisations along with most employer organisations in the aged care sector sought to have the Commission deal with the issue of indexation of funding to meet the costs of maintaining reasonable wage levels for employees.

In considering the issue the Commission said that 'there are differences between the two sectors (acute care and aged care sectors) in the nature of the work and the work environment. Thus to try and encourage uniformity in wage and condition outcomes through the subsidy regime would, *'in the Commissions view, be inappropriate.'* (italics added.)

The ANF (SA Branch) strongly objects to and disputes this comment or finding.

- No evidence has been referred to substantiate the claim; and

- The finding is at odds with reviews of nurse's wages and conditions by various industrial authorities and in particular by a 5 member Full Bench of the Australian Industrial Relations Commission that reviewed nurse's wages and salary related conditions from 1989 to 19991. That review contemplated evidence in relation to nurse's work in public hospitals, community settings, private hospitals, aged care and other environments across the nation. It concluded that there was commonality in nurses work value and awarded consistent rates of pay and conditions. The Commonwealth, various state governments and private employer organisations were party to those considerations. There was no serious argument advanced by anyone that would have led to the conclusions adopted in the discussion paper.

The changes referred to elsewhere in this submission in the nature of admission and discharge of the aged to hospitals, homes, hostels and to community based services illustrate the interconnectedness of services and commonality of work. What may have been regarded as work previously only the province of nurses in acute care settings is now .relatively commonplace in residential aged care and even in the community.

Indeed in many co-located facilities (aged care facilities co-located with acute hospitals) which are relatively common in the non-metropolitan area of SA, nurses may well work across a range of client groups including aged care, emergency and medical cases.

It should also be remembered that the elderly are disproportionately represented in the admissions and occupancy of acute hospitals so that most 'acute care' nurses are in fact ministering to the needs of the aged in the same way as their colleagues formally working in the aged care sector.

A recently released report by the Australian Institute of Health & Welfare 'Nursing labour force 1995' 1998 gives further evidence of this. The report shows that only approximately 76% of nurses working in the area of geriatrics or gerontology actually work in nursing homes. 11.3% work in public acute hospitals with others employed in hostels (2.2%), Community services (1.9%) and other services.

These changes or outcomes have not led to productivity or efficiency based wage outcomes for nurses.

Convergence or disparity - trends in nurses rates

Nurses rates of pay were diverse until the Professional/National Rates Case in 1989/90. As a consequence of those hearings and decisions the AIRC established consistent rates of pay for Registered nurses under federal awards (at that time excluding Victoria and NSW). However even with the decision excluding the 2 largest states the Commission adopted rates for the RN Level 1 Year 1 consistent with the NSW/Vic rates. In effect at that time we had national rates for Registered nurses. This step was followed in 1993 by the establishment of a common structure and consistent rates of pay for Enrolled nurses in all states but NSW.

Since the 1991 National Wage Increase (of 2.5%) the only increases paid to nurses in aged care (apart from implementation of National rates for EN's) have been those flowing from Consent Award Variations (in SA, Tas, NSW and Qld) or implementation of safety net increases in the other states and territories.

This has created a position where the RN Level 1 Year 1 rate now varies by up to 8.47% from state to state. The RN Level 1 maximum rate of pay, which is where all Registered nurses move to by annual increments, varies by up to 18.16%. Th current weekly rates are:

State	NSW	Vic	Q1d	Tas	SA	WA	NT	ACT
RN1.1	561.60	517.70	546.15	538.77	529.21	519.60	519.54	521.15
RN1.8	788.60	667.40	718.90	721.15	711.15	682.60	682.60	684.75

The level of variation in rates between the states in the public sectors is significantly smaller given that all states and territories have achieved similar order increases as a consequence of enterprise bargaining agreements.

Funding of wage increases for staff

The proposition that the call for indexation be dealt with by the annual review of the overall input costs is problematic due to:

- the fact that operating margins are sufficiently narrow as to prevent a commitment to ongoing costs without any assurance as to the availability of funding. There would certainly be a difficulty in 'advancing' wage growth ahead of the availability of increased subsidies;
- the proposal to make such a review subject to a 'productivity discount' means that there will need to be real cost savings generated. In the vast majority of cases this will mean either a reduction in the number of staff employed, the skills mix of staff employed or in the level of conditions which accompany the wages component;
- if any evidence is needed for this view the experience of the industry in SA over the last 12 months as measured by a survey conducted by the ANF (SA Branch) shows a reduction in all levels of Nursing & Personal Care staff. See Attachment A for the findings of this survey;
- the productivity discount in any case is, in our view, flawed (see comments regarding Preliminary proposal 4)

Industry composition and nursing labour force changes

There was a small increase in the number of nursing home beds across Australia between 1992 and 1996 from some 74039 to 75004. A shift in ownership occurred with a reduction of public sector beds by 2,287 whilst private sector beds increased by 3,252.

At the same time nurse employment fell. Between 1993 and 1995 public sector nursing home employment of nurses fell from 22,209 to 15,758 - a reduction of some 6,451. Nurse employment in private nursing homes remained stable over the same period at just over 20,000 despite the growth in beds.

This represents a 29.04% decrease in the number of nurses employed in public nursing homes whilst the number of beds fell by only 17.35%. Private nursing home beds grew by 5.34% whilst nurse employment remained static. Overall there was a small increase in the total number of beds and a significant (15%) reduction in nursing staff employed.

Given the steady growth of resident acuity over this same period these figures support earlier claims made by the Australian Nursing Federation (SA Branch) concerning the growth in nurses workloads, reported stress levels and pressures on the capacity to meet resident care needs.

There must be a serious commitment nationally to labour force planning and development to make sure that health and residential care services have the ability to attract and retain professional nurses with the appropriate educational base and skills. Attraction and retention of nurses in the aged care sector is becoming a serious concern nationally and must be addressed.

In addition there must be recognition that the basis on which funding is calculated will impact on the number and type of staff employed within individual aged care facilities. This link has been strenuously denied in the past in an attempt to avoid responsibility for ensuring appropriate outcomes. However it is clear that CAM was based on a notional skill mix and that the Commission's proposals will deal with a nominated input mix.

Both of these models have limiting influences on the choices that individual providers and consumers can make.

Relating subsidies to care needs (Preliminary proposal 2)

The principle of matching subsidies to the care needs of residents is one supported by ANF (SA Branch). However we do have concerns regarding the proposal advanced in the position paper.

They are:

The assumption that the RCS equates to the measurement of care needs.

This is not the case. The RCS and its predecessors, the RCI and PCAI are not used to allocate inputs for care but rather as funding tool to allocate a relatively fixed amount of money based on relative need. Such a tool is not comparable with for example the casemix funding system in the acute care sector which is based on meeting the actual costs of inputs for a particular diagnosis related group.

That the standard of care to be provided as a minimum is clearly ascertainable.

The quality of care principles which underpin the new accreditation and certification systems do not clearly enunciate a baseline standard of care to be achieved.

In addition the whole accreditation process was developed as alternative to standards monitoring on the basis that it would be based on continuous quality improvement principles which would, over time, raise what was seen as acceptable quality outcomes.

The notion therefore of funding at a minimum level or standard puts at risk the quality improvement strategy.

The proposal to deal with an 'efficient sized facility.

Apart from the definitional issue the ANF (SA Branch) is concerned about the cost implications of such a decision. It is accepted by the Commission that this would lead to the rationalisation of the industry over time. However given the existing capital program expectations of the industry in its current form, and the limited funding available to meet these costs we do not believe that it is appropriate to add to these capital pressures unless there is a substantial additional resources available from government to assist in the restructuring. The alternative, additional recurrent resources to the 'less efficient' sized facilities may be more cost effective, at least in the short term.

Determining inputs should be based on either an industry average or 'best practice' input structures. (Preliminary proposal 3)

In our view there are very real dangers associated with the adoption of either of these options without further research and consideration. The government has in the past resisted all approached to measure inputs preferring instead to concentrate on outputs achieved by the industry. As a consequence there is some significant variation across the industry.

Basing future funding based on current averages or 'best practice' assumes that:

- the lowest common denominator in inputs can in fact meet standards, which have yet to be broadly applied to the industry. Accreditation does not have to be achieved until 2000.

- best practice in input costs delivers outputs of an acceptable quality. In fact we know that volume and skill level of staff is related to quality outcomes.

Funding based on the achievement of outcomes should follow the establishment of clear and accepted care outcomes as a consequence of further research and development.

However there has been little work done to link research undertaken in relation to quality outcomes achieved with input variances such as staffing levels or mix. That research, which has been undertaken, does suggest that staffing levels and mix does directly affect the outcomes achieved.

Surveying the industry or benchmarking have the same limitations, which led to the CAM systems obsolescence soon after implementation. Because the process was not transparent, able to be dis-aggregated and related to particular inputs and was not subject to change or review, the relative positions of states was fixed. Changes in relative costs could therefore not be reflected in the funding base.

Any new system of costing inputs must therefore be subject to identification and separate costing of the constituent elements.

One of the major elements will be the cost of nursing and personal care staff costs. We suggest that these costs be studied in relation to the varying care needs of residents either by category or in relation to each element of the RCS and outcome standards. Such a process should be able to be completed within a 12 month period and would be served well if brought under the continuing oversight of the Commission.

In the interim use of an industry average would lead to a better funding outcome for the lower paid states.

It should also be recognised that staff in many nursing homes are presently working hours in excess of their paid time. Directors of Nursing and staff themselves have reported this as a common means of coping with chronic understaffing, particularly in the professional nursing workforce. An averaging or best practice approach would simply look at recorded or paid labour inputs rather than confront the real level of staff care provided which is substantially higher as a consequence of this level of staff volunteerism and commitment to resident care.

If funding is to be based in inputs required to produce predetermined care outcomes we believe therefore that further detailed costing work needs to be undertaken to determine appropriate volume and skill labour force weighting's. Under casemix arrangements this was recognised as a fundamental component of a funding system based on meeting the input costs.

- **Costs of workers compensation premiums should be included in the average cost base.**

The effect of workers compensation varies considerably across the states and territories. At Table 3.4 of the position paper the effect of workers compensation premiums was to vary the all state and territory average labour costs by only 0.05%. However for SA the effect was an increase of 1.73%.

Once again this effect whilst apparently small would potentially be quite disadvantageous to some facilities with very small operating margins.

- **Nursing labour costs.**

We refer to our comments elsewhere regarding the comments made in the discussion paper regarding this issue.

We therefore recommend that:

The principle of matching the funding mechanism with care requirements be adopted.

Further work be undertaken by Government, providers, unions and professional organisations with a view to determining measures for inputs necessary for the achievement of quality outcomes in care. We suggest that this work continue to be overseen by the Commission as a continuation of this reference or as a new reference by Government.

The Commission revise its findings in relation to indexation to the extent necessary to provide for a system which would provide for funding of wages growth for nurses in the aged care sector to match the rates of pay in place or ratified for implementation in the relevant State/Territory public sector. It is important to note that these public sector rates also apply to many nurses involved in aged care services provided through State owned services. Alternatively the Commission should recommend a system of labour force input cost indexation based on AWOTE earnings growth in the health sector.

Increases in subsidies should be based on annual increases in input cost bundle less a productivity discount. (Preliminary proposal 4)

The imposition of a 'productivity discount' in fact imposes a continuing process of double dipping. Firstly the government is providing subsidies at lower levels than they require to meet the cost of care outcomes set by government. Secondly government continues to increase the standard of outcomes to be achieved. Thirdly the recommended position is that government not prospectively meet the costs of expected wages growth.

The productivity approach recommended in the position paper also ignores the role that nursing homes play in providing substantial savings to overall government outlays, which we discuss at page 2 of this submission.

Implementation of a productivity discount would lead inexorably to pressure for increased costs to be past on to consumers in the event that government was unwilling to increase its contribution.

We recommend that:

The process of annual review of cost inputs be seen as the means to ensure that the industry is operating efficiently and to make any possible savings. No further or automatic productivity discount should be made to funding of the input costs.

Supplements and deductions (Preliminary proposal 5)

We support the thrust of this recommendation. It is consistent with our preferred approach which is to examine the actual input costs for resident care as opposed to reliance on the RCS which as we stated earlier has been devised to measure relative as opposed to actual need for care.

We support the maintenance of a discrete subsidy for workers compensation for the reasons advanced elsewhere in this submission.

In relation to the other matters canvassed in this section of the position paper we make the following comments:

- **Concessional resident subsidies**

The proportion of residents who require support through this subsidy is one important factor in the financial viability of nursing homes. If there is to be change to the current 2 tier arrangement we would suggest that a sliding scale of payments dropping from a proportion of 40% of Concessional residents should be explored in preference to movement towards to a single rate.

- **Input tax supplementation**

The Commission has suggested the possibility of subsidies being paid to overcome the current disadvantage of the 'for profit' providers as against the charitable and government sectors who enjoy tax exempt status.

On one hand this proposition appears to create a more even playing field and removes a disadvantage endured by the private (for profit) sector. However it would also place this group in a very privileged position in terms of their tax status and would add to their ultimate profitability.

It should be noted that the reason behind tax exempt status for charitable organisations is that they would not be withdrawing a level of profit from their 'businesses' but would rather reinvest such funds in the provision of services to their communities. We believe that the community should not be asked to support or subsidise tax liabilities for private for profit facilities.

We therefore recommend that:

Input taxes, other than payroll taxes, should not be the subject of subsidies or exemptions for private for profit providers.

- Payroll tax (Preliminary proposal 6)

The Australian Nursing Federation (SA Branch) supports a move to cost reimbursement for payroll tax payments rather than the maintenance of current subsidy arrangements. Reimbursement avoids the potential for either under funding of real costs or in windfall gains.

This position would overcome the additional issue dealt with by Preliminary proposal 6 which deals with charitable facilities since only actual expenses accrued through payment of payroll tax would be reimbursed.

We therefore recommend that:

The proposal to move to a reimbursement system for payroll tax payments should be implemented and current subsidies abolished.

- **Workers compensation (Preliminary proposal 7)**

The evidence set out in Chapter 3 of the discussion paper shows that far from minor deviations in costs, workers compensation payments constituted 4% of payroll in some states and up to 7% in others. A 3% variation in costs can hardly be described as insignificant.

We believe that as is the case with payroll tax, the Commission should recommend a system of cost reimbursement rather than maintain a subsidy scheme, which cannot meet the real costs in some states/territories. However there is an argument that the government should not subsidise poor performance in claims management or in a poor approach to injury prevention.

We therefore recommend that:

Workers compensation premiums or levies be subject to a cost reimbursement system rather than a subsidy scheme.
Increases in costs attributable to poor performance in claims management or injury prevention should not be recoverable.

- **Deductions for government homes (Preliminary proposal 8)**

The Australian Nursing Federation (SA Branch) supports the proposed payment of basic subsidies presently paid to the charitable and private sectors to government facilities. Increasingly these facilities are reliant on the funding from the Commonwealth and fees as their only funding source. They should therefore not be disadvantaged in the funding regime. Moreover discrimination based on public sector ownership leading to lower subsidies could force governments to outsource or privatise services as a means to overcome the funding inequities.

- **Special needs funding pool (Preliminary proposal 9)**

The needs of some rural and remotely located facilities are recognised and supported. However they are not the only facilities which can make out such a case.

Some facilities targeted towards particular ethnic communities or dealing with substantially disadvantaged groups may well have a similar claim to greater levels of subsidy.

The needs of such homes should be subject to greater consideration as has been proposed in the discussion paper. However we are concerned that the current $6m paid through the viability supplement may be seen as a cap or limit to any new supplement. This should not be the case. Need should drive funding not the reverse.

We recommend that:

There be further consideration of the special funding needs of facilities disadvantaged as a consequence of location or service orientation. The current level of viability supplement payments should not be seen as a limit to any future disadvantage payments.

Acquittal (Preliminary proposal 10)

The Australian Nursing Federation (SA Branch) disagrees strongly with the conclusions of the Commission regarding this issue.

An industry, which receives substantial levels of public funding both directly and as a consequence of the use of pensions, must require greater levels of public scrutiny than those, which do not.

The accreditation process does not require consideration of the use of funds provided. This issue is about accountability for the use of public money. The public and indeed the residents and their families have a right to know how each facility is spending the money provided for their care.

In addition we submit that there ought to be a requirement for disclosure and display of information relating to:

- staffing levels and skills mix;
- nurse:resident ratio;
- and qualifications held by nursing staff.

We recommend that:

A system of acquittal or public disclosure of financial statements be required of all providers in receipt of subsidies or other funds for aged care.

Subsidy payments to providers or residents (Preliminary proposal 11)

We do not disagree with the conclusion reached by the Commission that subsidies should continue to be provided to providers. We agree that real competition and choice is extremely limited and that attaching subsidies to residents would not change the bargaining power of consumers in any tangible way.

Income and asset tested resident charges and extra service arrangements. (Preliminary proposal 12)

The Australian Nursing Federation (SA Branch) continues to believe that nursing home accommodation is an essential component of health care services to the community. Access and range of services ought to be available as required by residents assessed needs not on their capacity to make further payments.

We therefore continue to oppose the principle of resident fees for either capital works or additional services. Such systems have the capacity to either discriminate against the well off or alternatively to create a 2 tier system of care one for those who can afford to make payments with another 'welfare' based system for those who cannot.

Implementation issues (Preliminary proposal 13)

The Australian Nursing Federation (SA Branch) seeks the speedy ending of the current under funding situation to SA nursing homes. However we do not believe that this should be achieved by reducing funds available to meet legitimate cost increases to other states.

This was one of the major concerns with the previous coalescence proposals ie that there was to be a redistribution from the higher paid states to the lower paid with both groups merging to an average subsidy level.

We argue that the real cost of inputs required to meet appropriate standards of care and resident outcomes ought to be determined through further research and then become the basis for funding. This rather than a simple redistribution forms a firm basis for ongoing funding or subsidy of the sector in a way that can be assured of meeting the needs of residents, providers and their employees. It also provides government with an opportunity to demonstrate its commitment to achieving the outcome standards it has set down, including the quality improvement principle.

ATTACHMENT A.

ANF

Australian Nursing Federation
(SA Branch)

AGED CARE
SURVEY RESULTS

November 1998
Attachment contains 11 pages

Overview

This survey was undertaken to obtain information from nurses working in residential aged care about the effects of changes in regulation and in funding to their facilities.

It is apparent from the results gathered that:

- nurses are working under great pressure to deliver care to the frail aged;
- nurses and other care staff have had hours of care cut over the
- last 12 months in a large number of facilities;
- nurses are being asked to undertake housekeeping and other
- tasks to reduce costs;
- standards of care provided have fallen in a quarter of aged
- care facilities;
- work related injury to nurses and the threat of increased injury
- has increased by more than 25%.

These results have contributed to the decision of many nurses to leave aged care facilities. Over 13% of respondents to the survey have made that decision. A further 34% are not sure whether they will stay or leave.

It is important that these issues be addressed in order that the frail aged receive the level of care they deserve.

Introduction:

195 questionnaires were distributed. 76 responses were received by 31/11/98 (i.e. 39% response rate). The results have been broken down into the following types of facility: Low Care, High Care and Mixed Care. Combined results are also provided for each question.

1. Size of Aged Care Facility

NUMBER OF BEDS	LOW CARE	HIGH CARE	MIXED CARE	COMBINED RESULTS
Less than 35	2	13	4	19
36-50	3	10	8	21
51-65	2	3	2	7
66-80	-	2	4	6
81-95	-	1	6	7
More than 95	-	1	15	16

2. Area of service

SERVICE LOCATION	LOW CARE	HIGH CARE	MIXED CARE	COMBINED RESULTS
Metropolitan	7	28	36	71
Country	0	2	3	5

3. Level of services provided

LEVEL OF SERVICE PROVIDED	NUMBER OF RESPONDENTS
Low Care	7 (9.21%)
High Care	30 (39.26%)
Mixed Care	39 (51.32%)
TOTAL	76

3. Described observations of any changes over the last 12 months in nursing working conditions and workloads:

Most respondents focussed on higher workloads, greater resident demands, funding and staffing cuts and greater demands on the remaining staff. A sample of the comments received is set out below.

Comments made included the following:

Increase in nursing care workload, huge increase in documentation. No extra care hours to cope with the increased level of care residents require. This causes extra stress on all staff.

Heavier residents, less staff, more Workcover, more agency staff, staff left in high care all time. Funding cuts in workplace affected food, there is just sometimes enough food to go around. Cheap and nasty plastic mac's for beds. Cheaper dressings etc. Residents only receive cordial in bedside jug if they request it. Because they use cheaper plastic on beds, it makes full bed changes instead of kylie change. Staff are exhausted after 4 shifts straight whereas before they did 6 straight.

Aged care reform has changed documentation process for DON/CNC. Other staff not affected. Workload of residents has remained the same - no reduction in nursing hours.

With the expectations of new RCS and preparation for accreditation more and more staff are taking work home to complete, i.e. rosters, appraisals, inservice documentation for manual etc.

Workloads increased due to High Care residents among hostel residents. Limited access to RNs on late shifts. Lack of equipment. Night duty & weekends 1 EN or PCW to a ratio of 36 residents in one section. The second section 1 EN or PCW to 37 residents (including a 15 bed Dementia Unit) in the second section.

Work loads have increased as clients are more frail, behavioural problems have increased, expectations of DH&FS and clients have increased, causing added pressures and stress for staff.

Increased patient turnover has meant increased workload which has not been adequately compensated for by increased funding.

The range and degree of operational and programme management and accountability has increased quite significantly over the past twelve months. This places an inordinate responsibility on staff and management who are still reeling under the weight of additional paper

work and regulation requirements and the expectation of achieving more and more with less and less. Whilst staff strive to cope there is a personal price being paid and a limit to human endurance. This rampant political and bureaucratic insanity is perpetrated under the guise of doing what is best for aged people, or what is perceived as necessary to achieve such a desirable outcome. The whole process is questionable as to its extent and complexity to meet the more realistic expectations of our aged residents.

All workers more stressed - workloads increased - personal carers care lower standard now. Residents must wait for attention for longer periods. Most RNs work over their clock off time. Nursing home not so tidy or clear eg. Lockers, commode chairs very irregularly cleaned. More incidents of bruising as carers hurry their care, less stock of all kinds.

Extra workload on management/DONs. Increase in documentation for QA → accreditation. Inconsistencies with validators with RCS therefore increase in documentation for RCS. Staff input on a voluntary basis to ensure work completed before going off duty. Due to decrease in funding hours have decreased causing extra pressure and stress on staff to maintain quality care and service.

Less RGNs employed - shifts reallocated to EGN. High care residents' medication administered from dosettes as well as low care ones. PCAs struggle to maintain high standards of care. Difficult to get experienced good staff in response to job adverts.

Heavier workload - more paper work, less time for residents.

The type of residents being admitted to home more difficult due to behavioural problems and more technical procedures, i.e. gastrostomy tubes, diabetes etc. On ward of 34 residents there are 5 gastrostomy feeds, 9 insulin dependent diabetics, 5 on nebulisers at least four times per day.

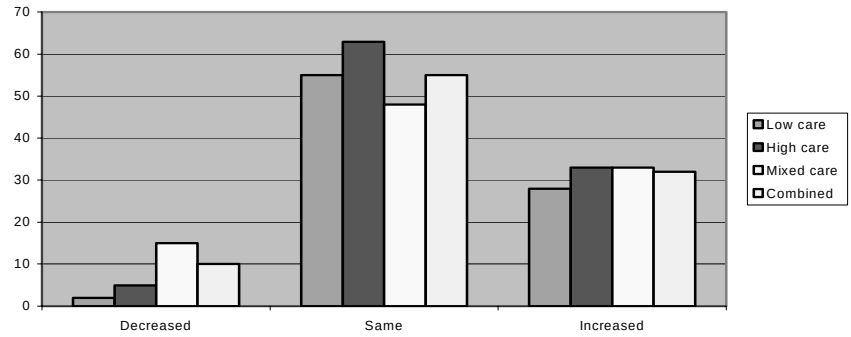
Resident frailty increases workloads. Decrease in amount of money per resident - given new funding arrangements. Staff are under incredible pressure to deliver holistic care to residents with present staffing levels. Staff work voluntarily to give holistic care as funding level is inadequate.

Staff expected to spend more of their own time formulating committees and policies. Most training in own time. Some trained staff (usually RNs) stay overtime, completing tasks. Increases and priority with paperwork.

Question 5. Patient meals

Over 9% of all respondents reported a decrease in the standard of patient meals provided. There was a marked concentration of these reports in mixed care facilities whilst there were no reports of reduced standards from low care facilities.

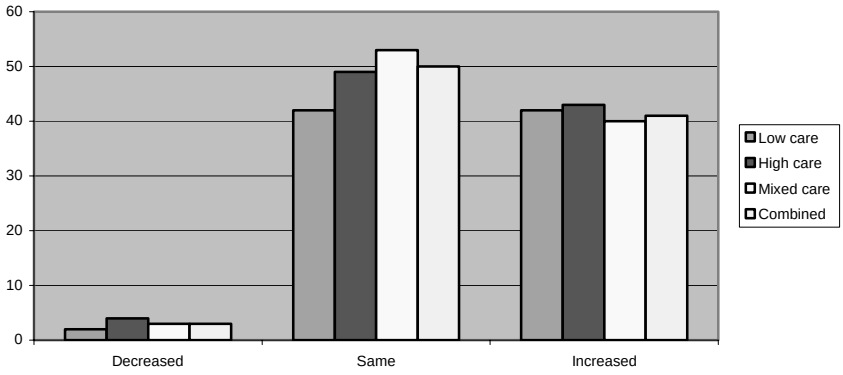
Nearly a third of all respondents reported improved standards of meals. This figure was fairly constant across all 3 classes of facility.



Question 6. Non nursing duties

Some 42% of respondents reported an increase in the number of requests for nurses to perform previously SAM funded functions. These are largely cleaning, catering and laundry tasks.

The comments from nurses show the frustration that this additional work is creating since it adds to already growing clinical workloads. It also needs to be seen in the context of reducing staffing levels across many aged care services.

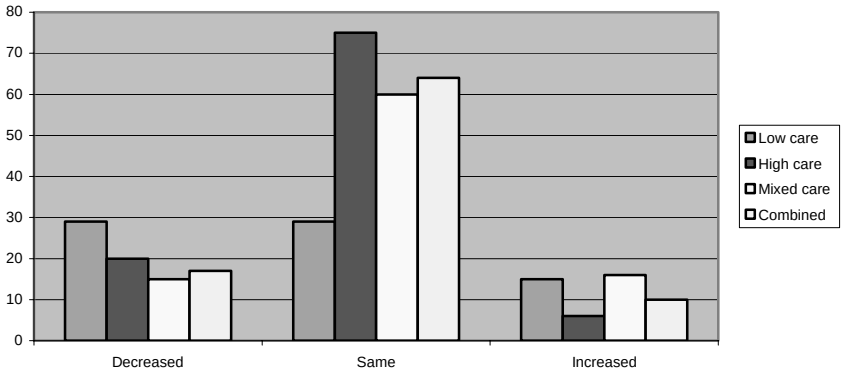


Question 7. Change in hours of staff

Registered nurses

18% of respondents reported cuts in the hours worked by Registered nurses in their facilities. In the low care area this reached an alarming 28.57% and whilst lower in high care facilities still affected one in five homes.

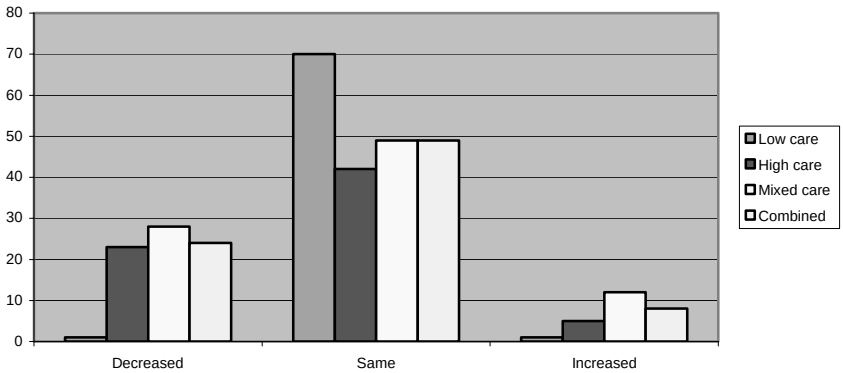
Only 10% reported an increase in RN staffing so there is a very clear downward trend in nursing skills available to the frail aged. The reductions were lowest in mixed care facilities.



Enrolled nurses

The cuts to Enrolled nurse hours were even greater with nearly one in four (23.68%) reporting cuts. Considering the relatively high number (19%) who did not respond as a consequence of their facility already not employing Enrolled nurses the real impact is even higher.

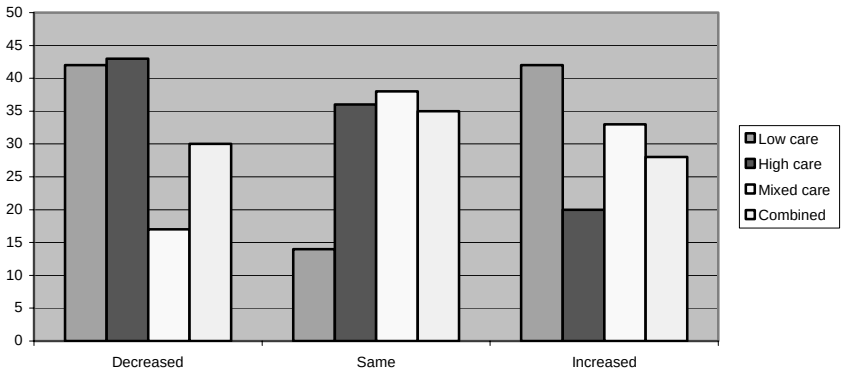
The cuts were greatest in mixed care facilities and did not impact on the low care area at all.



Personal carers (Nurse assistants)

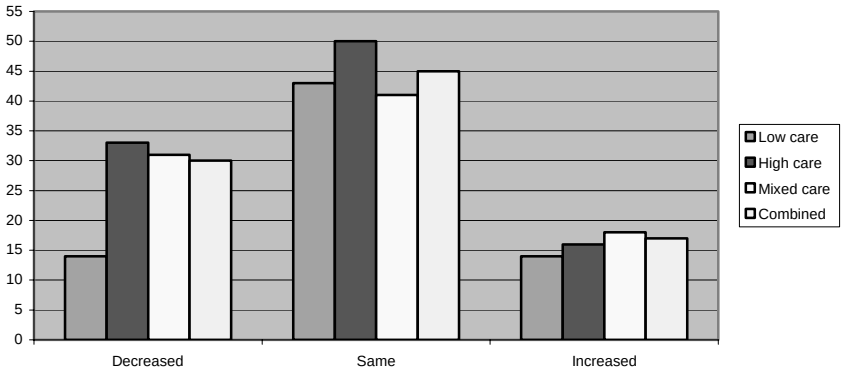
Nearly one in three respondents reported cuts to the hours of personal care workers. In stand alone facilities, both high and low care, the reports of cuts exceeded 40% and was a lower 18% in mixed facilities.

However, unlike the RN and EN group a high number reported increases in the level of PCA employment (nearly 29%) largely in the low and mixed care groups. For high care facilities, however, the number reporting cuts more than doubled those with increases.



Other staff (eg therapists)

Once again nearly one in three respondents reported cuts in hours, this time with high and mixed care facilities facing the brunt of the cuts.



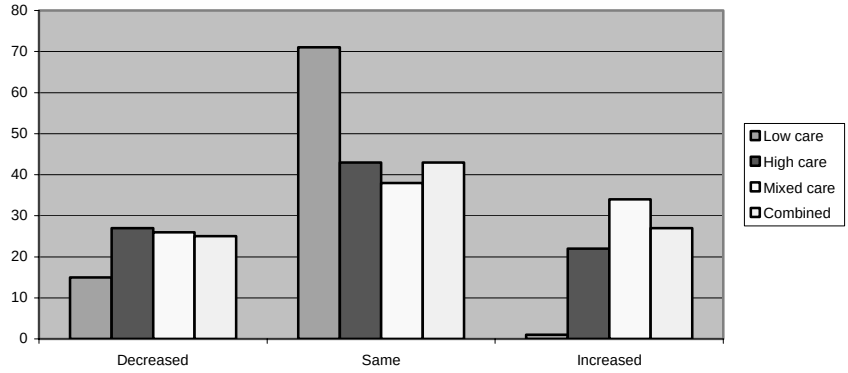
Overall comment in relation to Question 7

It is clear that most aged care facilities have been reducing care staff hours in the last 12 months. Cuts to qualified staff hours have been reported in a significant number of facilities and are at odds with a resident population with increasingly complex demands for care.

Question 8. Standards of care

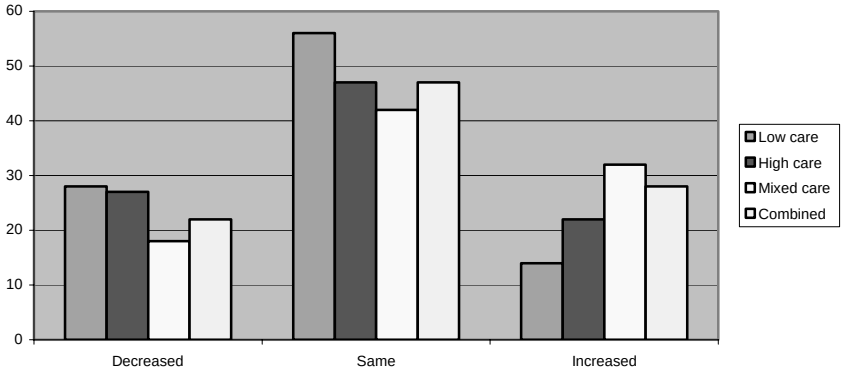
25% of respondents reported a reduction in the standard of care provided over the last 12 months. This decrease in quality is most evident in high care (26.6%) and mixed care (25.64%) facilities but is still at a concerning 14.29% in low care facilities.

An almost equal number reported increased standards of care. However there was great variability with no low care facilities and some 33% of mixed facilities reporting this outcome.



Question 9. Number of work injuries

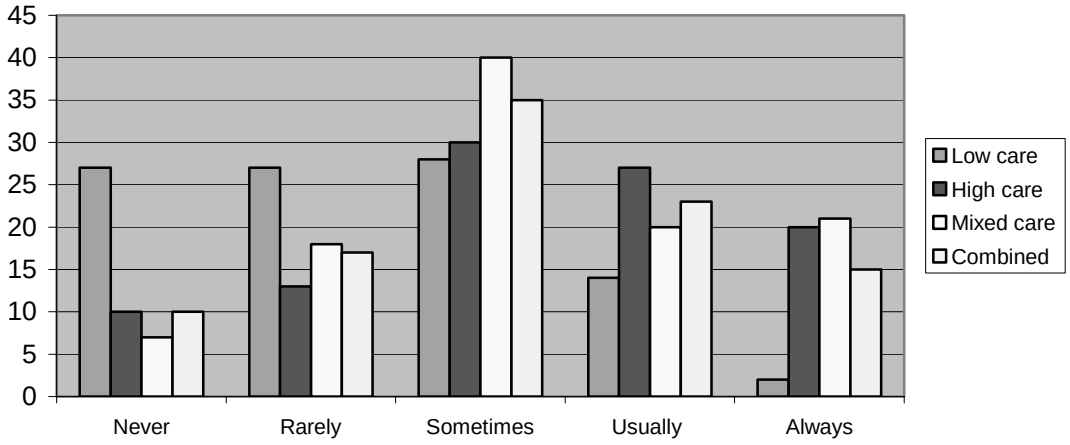
Some 27.63% reported increased levels of work injuries over the last year. This ranged from 14.3% in low care, 23.3% in high care to a massive 33.3% in mixed care facilities. The reverse trend is evident when looking at respondents reporting lower incidence of injuries ie low care show the highest rate with mixed care the lowest.



Question 10. Occupational health & safety risk from staffing levels

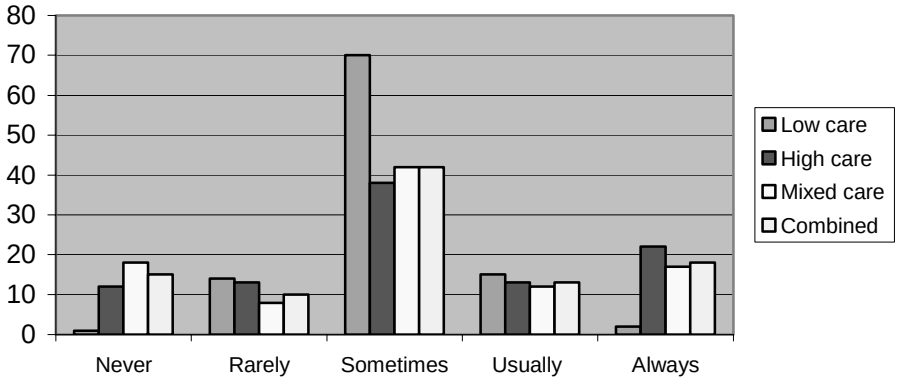
Nearly 90% of respondents believed that the staffing arrangements in their facility created risk to the health and safety of nursing staff. Nearly 37% felt that this risk was usually or always present.

The risk was seen to be lowest in low care facilities and highest in high care facilities. The more intense demands of residents, particularly for assistance with their mobility or lifting, may well contribute to this heightened sense of risk felt by staff.



Question 11 Support to maintain contemporary nursing practice

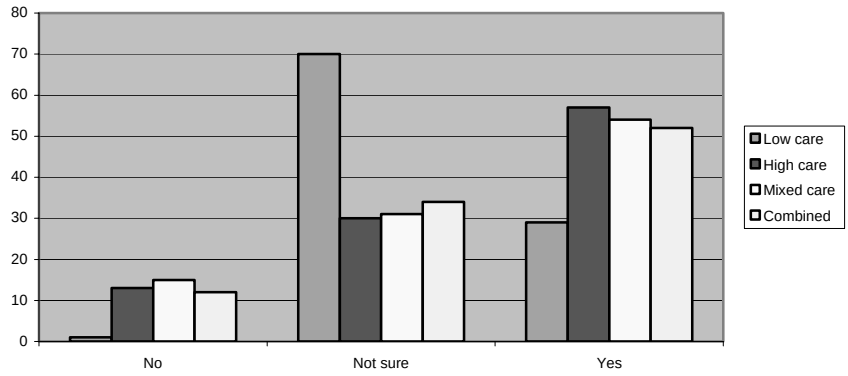
There was significant variation in the level of employer support from employers for contemporary nursing practice. However only one in five employers was reported as always supporting this level of professional practice at all times. One in six were reported as never supporting it.



Question 12. Intention to continue working in aged care

Only a little more than half (52.6%) of the respondents are committed to remaining employed in aged care. An alarming 13.16% said they intended to leave the aged care sector with a further 34.2% considering their future.

In the comments of nurses issues such as workloads, standards and pay rates featured highly along with the relative status of their work as compared to the acute sector. Given the overall under supply of nurses and the problems already experienced by some aged care facilities in attracting and retaining nursing staff this indication of intention is of concern.



APPENDIX

Australian Nursing Federation (SA Branch)

PERCENTAGE RESULTS FROM AGED CARE SURVEY

Question 5 re: Patient Meals

STANDARD	Low	High	Mixed	Combined
Decreased	0	3	15	9
Same	57	64	49	55
Increased	29	33	33	33
No Response	14	0	3	3

Question 6 re: Non-Nursing Duties

REQUESTS	Low	High	Mixed	Combined
Decreased	0	3	2	3
Same	43	50	54	51
Increased	43	44	42	42
No Response	14	3	2	4

Question 7 re: Changes to Hours

RN

NO. OF HOURS	Low	High	Mixed	Combined
Decreased	29	20	15	18
Same	29	77	62	65
Increased	14	3	15	10
No Response	28	--	8	7

EN

NO. OF HOURS	Low	High	Mixed	Combined
Decreased	--	23	28	23
Same	71	44	49	49
Increased	-	3	13	8
No Response*	29	30	10	20

No. had policy of not employing Enrolled Nurses so question was not applicable.

PC

NO. OF HOURS	Low	High	Mixed	Combined
Decreased	43	43	18	30
Same	14	37	39	36
Increased	43	20	33	29
No Response	--	--	10	5

Other (e.g. Therapy)

NO. OF HOURS	Low	High	Mixed	Combined
Decreased	14	33	31	30
Same	43	50	41	45
Increased	14	17	18	17
No Response	29	-	10	8

Question 8 re: Change in Standards of Care

STANDARD	Low	High	Mixed	Combined
Decreased	14	27	26	25
Same	72	43	38	44
Increased	-	23	33	26
No Response	14	7	2	5

Question 9 re: Work Related Injuries

INJURIES	Low	High	Mixed	Combined
Decreased	29	27	18	22-
Same	57	47	44	46
Increased	14	23	33	28*
No Response	-	3	5	4

Question 10 re: OH&S of Nursing Staff

SAFETY RISK	Low	High	Mixed	Combined
Never	28.3	10	8	1T
Rarely	28.3	13	18	17
Sometimes	28.3	30	41	36
Usually	14.0	27	20	22
Always	--	20	13	14
No Response	--	--	--	--