CPSA COMBINED PENSIONERS & SUPERANNUANTS ASSOCIATION OF NSW INC

Submission to Senate Community Affairs References Committee for Inquiry and Report: *The future of Australia's aged care sector workforce*

March 2016

Combined Pensioners & Superannuants Association of NSW Inc (CPSA)
Address: Level 9, 28 Foveaux Street, Surry Hills NSW 2010 **ABN**: 11 244 559 772
Phone: (02) 9281 3588 **Country Callers**: 1800 451 488 **Facsimile**: (02) 9281 9716
Email: cpsa@cpsa.org.au **Website**: www.cpsa.org.au **Donations:** 1800 451 488

CPSA is a non-profit, non-party-political membership association founded in 1931 which serves pensioners of all ages, superannuants and low-income retirees. CPSA has 119 branches and affiliated organisations with a combined membership of over 31,000 people living throughout NSW.

CPSA welcomes the opportunity to comment on the Senate's Inquiry into the Future of Australia's Aged Care Workforce. This submission focuses on the workforce provisions necessary to ensure that older Australians receive high quality aged care. As such, CPSA's priorities are to ensure that all residential aged care facilities are required to have a Registered Nurse (RN) on duty at all times and to see the introduction of mandatory staff to resident ratios.

Summary of recommendations:

- **Recommendation 1:** That the Australian Government take responsibility for developing an Aged Care Workforce Strategy, that recognises the Government's central role in the operation of the aged care sector.
- **Recommendation 2:** That the Aged Care Workforce Strategy takes into consideration the shifting balance of residential vs home care and the growing need for appropriately trained workers to provide care in the home.
- **Recommendation 3:** That the Australian Government develop and implement an active housing policy to enable the focus in aged care to shift from institutional care to home care.
- **Recommendation 4:** That the accreditation standards be redesigned to include the outcomes experienced by care recipients.
- **Recommendation 5:** That accreditation standard '1.6 Human resource management' is rewritten to include minimum annual wage increases for staff and to specify the basic working conditions required to support the delivery of high quality care
- **Recommendation 6:** That accreditation standards 1.3, 2.3, 3.3 and 4.3, which deal with education and staff development, specify the particular qualification, skills and training each staff member is expected to hold in order to perform their role effectively.
- **Recommendation 7:** That a National Board, similar to the Nursing and Midwifery Board of Australia, be established to oversee the training, registration and background checks of PCAs and AINs.
- **Recommendation 8:** That **all** residential aged care facilities be required to have a Registered Nurse on duty at all times.
- **Recommendation 9:** That there should be mandatory staff to resident ratios, which specify the number of care recipients an RN, EN and PCA/AIN can reasonably be expected to care for at one time and the level of supervision required to do so.
- **Recommendation 10:** That aged care providers be required to publish the staff to resident ratios they operate under so that it is accessible by the public.

Senate Community Affairs References Committee

Future of Australia's aged care sector workforce

March 2016

CPSA's aim is to improve the standard of living and well-being of its members and constituents. Accordingly, CPSA is concerned with the universal availability of high quality, person-centred aged care, which maximises the autonomy and dignity of recipients. As such, this submission focuses on how staff working conditions influence the quality of care they are able to deliver and subsequently, the workforce provisions needed to safeguard quality of care.

The status of older Australians

CPSA notes that the low status of aged care work stems at least in part from negative attitudes towards ageing and older people. The work carried out in the aged care sector is often disregarded by a society that does not fully acknowledge its significance. As noted by the Australian Human Rights Commission (AHRC), negative attitudes towards ageing, discrimination and harmful stereotypes of older people are issues of national concern[1]. We tend to associate getting older with deterioration, loss of autonomy and bodily decline, which means that entry into aged care is viewed as the beginning of the end. This can act as a barrier to positive discussions about quality of life in older age and indeed about quality of death. Further, public aversion to nursing homes makes it difficult to talk about what's actually going on and this means that the experiences of both those who provide and receive aged care often go unheard. This, in turn means that policy issues related to ageing, aged care and older people struggle to generate the kind of political traction necessary for change to occur. The lack of political momentum is particularly pronounced in the area of aged care, where advocates' calls for action to address the horrific experiences of older Australians in nursing homes have gone largely unanswered for decades.

[1] AHRC (2013) 'Fact or Fiction? Stereotypes of older Australian's' [Accessed 15 February 2016] available:https://www.humanrights.gov.au/sites/default/files/document/publication/Fact%20or%20Fiction_2013_WebVersion_FINAL_0.pdf

The role of government

CPSA views the Australian Government as playing a central role in the aged care sector. The Minister for Health, the Honourable Sussan Ley, has been clear in asserting that responsibility for the aged care workforce rests primarily in the hands of providers and that they must take the lead in developing a workforce strategy. CPSA rejects this position and argues that the Australian Government is the only appropriate authority to take charge. Outsourcing leadership and strategic direction at such a turning point would have a disastrous effect on the quality of care available to older Australians. Without a coordinated strategy driven by a government committed to ensuring older people receive the care they deserve, Australia's aged care system will not be able to make the adjustments necessary to meet growing demand. The leadership and change required to shore up the aged care sector is huge and cannot be underestimated.

As the body overseeing funding, accreditation and regulation, the Australian Government retains control over the aged care sector. Accordingly, it is the only player with the authority and oversight necessary to drive the changes needed for the aged care sector to manage growing demand for high quality care. These changes cannot be left to the market, as the Minister's comments imply, because the market for aged care is largely controlled by Government. The Government provides funding to aged care providers who meet accreditation criteria, with the amount of funding dependent on the number of people being cared for and the level of care required by each. The accreditation criteria are input based, meaning they look at the processes and resources that should allow recipients to be cared for. This means that the Australian Government, through control of the accreditation and funding processes, retains significant control over the operations of aged care providers. Accordingly, CPSA is of the view that the strategic direction of the Australian Aged Care Workforce is something that must be coordinated by the Australian Government.

A lack of carefully considered coordination at a national level in the area of aged care has meant that the current system is heavily geared towards the provision of residential care over home or community based care[2]. This residential skew is problematic given that the vast majority of Australians would prefer to receive care at home[3]. The Australian Government's commitment both to a policy of 'ageing in place' and consumer directed care means that it is imperative aged care providers are able to respond to the growing

[2] Report on the operation of the Aged Care Act 1997 for 2014-2015: 83,800 people accessed home care packages, while 231,000 people accesses residential aged care (not including respite care).
[3] CPSA Members' Aged Care Survey (2014): in response to the question 'If you needed some kind of aged care, where would you prefer to receive care?' 95% of respondents answered 'At home' and 5% of respondents answered 'In a nursing home'

demand for home care over residential care. Consumer satisfaction with home care already appears to be far greater than with residential aged care. Official complaints relating to home care are dramatically lower in both absolute and relative terms than they are in residential aged care settings[4].

Further, home care is significantly cheaper to deliver than residential care. It offers government a viable means of addressing Budget concerns around the costs of caring for an ageing population. The potential savings to the public purse can be maximised when policymakers consider the care needs of an ageing population when developing policy in the areas of housing, infrastructure, transport and technical innovation. For example, relatively straightforward technology that is available today can serve the triple purpose of producing better outcomes for care recipients, relieving staffing pressures and lowering care costs. The same can be said of smarter home design, supported by specific housing policy measures, which can allow people to remain in their own home (or move into more suitable housing arrangements as they age if they wish to do so). Housing policy should be designed to support the delivery of home care through co-location. This level of coordination across policy areas can only come about through Government direction.

- **Recommendation 1:** That the Australian Government take responsibility for developing an Aged Care Workforce Strategy, that recognises the Government's central role in the operation of the aged care sector.

- **Recommendation 2:** That the Aged Care Workforce Strategy takes into consideration the shifting balance of residential vs home care and the growing need for appropriately trained workers to provide care in the home.

- **Recommendation 3:** That the Australian Government develop and implement an active housing policy to enable the focus in aged care to shift from institutional care to home care.

[4] Report on the operation of the Aged Care Act 1997 for 2014-2015: of the 3725 complaints received in 2014-15 88.1% (N=3281) related to residential aged care services, 8.5% (N=316) related to home care services.

The Aged Care Workforce

This section of CPSA's submission draws heavily on the results of the Aged Care Workforce Census and Survey (ACWCS), which was first conducted in 2003, then again in 2007 and 2012. The ACWCS provides critical information about the aged care workforce and allows for longitudinal comparison, thus highlighting significant trends affecting the workforce. The latest results show more than 240,000 people work in direct care roles in Australia's aged care sector, up from 116,000 when the ACWCS was first run in 2003[5]. The workforce predominantly consists of women, with a median age of around 48 in the community sector and 50 in the residential sector[6]. The majority of aged care workers are employed on a permanent part-time basis[7].

What do workers need to deliver good care?

CPSA rejects the claim that staff shortages in the aged care sector come about because the work is inherently unattractive or undesirable. The findings of the ACWCS show that aged care workers report high levels of overall job satisfaction, despite a marked dissatisfaction with pay[8]. Subsequent studies have highlighted job satisfaction as the most significant factor influencing worker retention[9] and that job satisfaction is maximised when workers are able to provide what they understand to be high quality care[10]. The ACWCS results indicate that although aged care workers view themselves as sufficiently skilled to do their job, few feel they have adequate time to spend with each care recipient and frequently report feeling under pressure at work, both of which undermine their capacity to deliver good care. This suggests that issues around the retention of aged care workers do not stem from the work itself being of poor quality, but rather from the conditions under which the work is carried out. Thus, efforts to promote the attraction of new workers to the sector and retention of existing workers should be focused on ensuring that working conditions support staff to deliver high quality care.

The delivery of high quality care requires that aged care workers have sufficient time to spend with each care recipient in order to carry out the tasks necessary to fulfil their

[5] King et al (2013) 'The Aged Care Workforce, 2012 – Final Report' p.2 [accessed 28 January 2016] available: https://www.dss.gov.au/ageing-and-aged-care-publications-and-articles-ageing-and-aged-care-reports/2012-national-aged-care-workforce-census-and-survey-the-aged-care-workforce-2012-final-report
[6] Ibid p2
[7] Ibid p2
[8] Ibid – see tables 3.35, 3.36, 5.35 and 5.36.
[9] King, D. Wei, Z. & Howe, A. (2013) 'Work satisfaction and intention to leave among direct care workers in community and residential aged care in Australia' *Journal of Aging & Social Policy*, 25(4), p301-319.
[10] Edvardsson, D. Fetherstonhaugh, D. Mcauliffe, L. Nay, R. & Chenco, C. (2011) 'Job satisfaction amongst aged care staff: exploring the influence of person-centred care provision' *International Pyschogeriatrics*, 23(8), p1205-1212.

needs[11]. Because care work is inherently labour intensive, any attempt to reduce the amount of time spent caring, or increase the number of people being cared for by one worker in a given timeframe, will reduce the quality of care being provided. The delivery of high quality care also requires continuity in terms of long-term, secure employment[12]. This allows workers and care recipients time to build positive relationships, which in turn facilitates the sharing of information, meaning that workers can deliver care according to care recipient wishes. Autonomy over the working day allows aged care workers to reorganise tasks, such as feeding and showering, according to the needs and desires of care recipients[13]. Research has also shown that autonomy over the working day sends workers the message that their employer trusts their skills and ability to do the job, which in turn improves job satisfaction[14].

The sorts of workplace provisions that allow aged care workers sufficient time, continuity and autonomy are generally determined by the aged care providers that employ them. However, the operating budgets of these providers and subsequently the workplace provisions they can afford, are largely shaped by the Australian Government through the funding and accreditation process. Despite declarations by the regulator to the contrary, these accreditation standards are process rather than outcomes based, meaning they assume that procedures and processes at an organisational level can be used as a proxy to gauge the quality of care being provided to care recipients. Further, compliance against these standards is only assessed in-person by the Australian Aged Care Quality Agency every three years, with all announced and unannounced site inspections occurring during business hours.

The nature of the accreditation process and standards mean that aged care facilities may formally meet all standards and hold full accreditation while there is overwhelming anecdotal evidence that the care outcomes that care recipients experience strongly suggest serious deficiencies in care. The accreditation standards are not specific enough to ensure quality care is actually delivered. For example, in 2012 a Queensland nursing home was found to have no staff rostered on between the hours of 8pm and 6.30am[15]. Residents were found absconding, falling and wandering. It is unclear how long this home had been running without overnight staff. No sanctions were put in place against the nursing home, as it was deemed management had taken steps to address the

[11] Adams, V. & Sharp, R. (2013) 'Reciprocity in caring labour: nurses work in residential aged care in Australia' *Feminist Economics*, 19(2) p100-121.
[12] Ibid.
[13] King, D. (2012) 'It's Frustrating! Managing Emotional Dissonance in Aged Care Work' *Australian Journal of Social Issues*, 47(1), p51-70.
[14] Martin, B. (2007) 'Good jobs, bad jobs?: understanding the quality of aged care jobs and why it matters' *Australian Journal of Social Issues,* 42(2), p183-197.
[15] Aged Care Standards and Accreditation Agency (2012) 'Southport Lodge' *Audit report* October 2012, p. 10

identified failures. This included rostering PCA/AINs overnight, but not an RN. The home remains fully accredited.

In 2009, Ms Jean Boyd died after contracting a urinary tract infection that was inadequately treated by the NSW nursing home responsible for her care[16]. At the time, the home was charged with the care of 160 recipients, 83 of whom were classified as high care. The Coroner reviewing her death, Magistrate Geraldine Beattie, was critical of the home's staffing during Ms Boyd's decline over a period of four days as her deteriorating condition was not adequately assessed by care staff. Only one member of care staff was rostered on weekends and at night in the cottage where Ms Boyd resided and there was only one registered nurse overseeing the entire facility at those times. As a consequence, Ms Boyd was not seen by a registered nurse or doctor for some 26 hours between Friday 2 and Saturday 3 October because the sole registered nurse was busy attending to other residents.

Magistrate Beattie criticised the policy of only one registered nurse on at nights and weekends, stating that it was "insufficient to deal with residents' needs". She recommended that the Aged Care Standards and Accreditation Agency (now the Australian Aged Care Quality Agency) conduct a review of the ratio of nursing staff to high care residents at the home. Some staffing changes were made in response to Ms Boyd's death, but there were no additional registered nurses rostered on, and there continued to only be one registered nurse on duty from 4.30 pm on Saturday to Monday morning. The nursing home was given full accreditation in 2008, 2011 and 2014, despite these shocking staff to resident ratios[17]. These case studies highlight the shortfalls of the accreditation standards and the fact that a home may meet all accreditation standards while still failing to provide a reasonable standard of care.

The issue with accreditation standards is thus twofold. On one hand, the input-based nature of the accreditation standards encourage aged care providers to implement standardised procedures and processes wherever possible in order to establish a clear chain of accountability. These working arrangements actually undermine the autonomy of care workers by mandating the order, manner and time at which particular tasks must be done. This diminishes the capacity of workers to deliver care according to recipient

[16] Magistrate Geraldine Beattie (2013) 'Inquest into the death of Jean Boyd' Wollongong Local Court, Coronial Jurisdiction, 15 October.
[17] Aged Care Standards and Accreditation Agency (2008) 'IRT William Beach Gardens Residential Care Facility' Audit Report
Aged Care Standards and Accreditation Agency (2011) 'IRT William Beach Gardens Residential Care Facility' Audit Report
Australian Aged Care Quality Agency (2014) 'IRT William Beach Gardens Residential Care Facility' Audit Report

wishes and needs, which in turn threatens the quality of care available to recipients. This also reduces the satisfaction workers derive from providing good care, which can reduce the motivation to continue working in the aged care sector.

However, at the same time the accreditation standards, which are input-based, cannot possibly support the delivery of high quality care unless they consider the outcomes experienced by aged care recipients. If the accreditation standards do not consider the outcomes of care, that is the clinical care outcomes and experiences of care recipients, then there is no accountability for quality of care because quality is not actually being measured at all. Accordingly, CPSA believes the accreditation standards must be redesigned so that measurable care outcomes experienced by recipients are incorporated into the accreditation process. This is the only way to guarantee that the accreditation standards can facilitate quality care.

- **Recommendation 4:** That the accreditation standards be redesigned to include the outcomes experienced by care recipients.

The feminised aged care workforce: building a profession

As noted, the 2012 ACWCS paints a picture of the aged care workforce as consisting predominantly of mature women employed on a part time basis. The feminised nature of the workforce itself has been a significant barrier to achieving improvements in working conditions and wage increases for aged care workers. This is due in part to the devaluation of caring work through its historical association with women and in part to the fact that the mechanisms for achieving improvements in wages and working conditions are geared towards sectors characterised by high levels of full time employment and unionisation[18].

In 2012 Fair Work Australia ruled in favour of the Social, Community and Disability Services Industry (SCHADS industry)[19] Equal Remuneration Case, finding that the pay gap between SCHADS and other comparable industries was undeniably tied to gender[20]. CPSA notes that this ruling highlights the gendered nature of industrial dispute mechanisms, which mean that some industries struggle to achieve wage gains through traditional models. In particular, CPSA notes the emphasis on individual and collective bargaining in industrial disputes is prohibitive to the aged care workforce. The fact that

[18] Kaine (2012) 'Collective Regulation of Wages and Conditions in Aged Care: Beyond Labour Law' Journal of Industrial Relations, 54(2), p204-220
[19] Previously Social and Community Services Award (SACS)
[20] Fair Work Australia (2012) Decision, Equal Remuneration Case. FWAFB 5184, Sydney, 22 June. Available: https://www.fwc.gov.au/documents/decisionssigned/html/2012fwafb5184.htm

the aged care workforce is low-paid, low-status and poorly unionised means that workers face pronounced difficulties when organising for collective action[21]. The dependent nature of aged care recipients also limits the capacity of aged care workers to engage in strike action, as such action is likely to have severe negative consequences on those who require aged care[22].

Aged care workers experience a pronounced wage penalty, compared with their counterparts working in acute care. For example, the Australian Nurses and Midwives Federation notes that the average full-time Registered Nurse (RN) working in the aged care sector earns $200 less per week than their colleagues in the hospital sector. This is a serious disincentive to work in aged care that must be rectified. It's not just RNs though, with the vast majority of aged care workers expressing dissatisfaction with remuneration levels[23]. Workers do not believe that the wages they are paid are commensurate with the level of skill necessary to perform the work, the level of responsibility they hold, or the social value of their work more broadly[24]. In Australia, the median hourly wage for a Personal Care Attendant (PCA), sometimes called an Assistant in Nursing (AIN) depending on the state, is $19.00[25]. The median wage for a bartender also happens to be $19.00[26] an hour. The work of PCAs/AINs arguably involves a much greater level of responsibility, with the lives and wellbeing of frail, vulnerable older people in their hands. It also requires the completion of tertiary education to at least Certificate III level. As the improvements necessary to shore up Australia's aged care workforce have failed to come about without intervention, CPSA calls on the Australian Government to ensure that minimum wages and working conditions form part of the accreditation process.

- **Recommendation 5:** That accreditation standard '1.6 Human resource management' is rewritten to include minimum annual wage increases for staff and to specify the basic working conditions required to support the delivery of high quality care

[21] Kaine (2012) 'Collective Regulation of Wages and Conditions in Aged Care: Beyond Labour Law' *Journal of Industrial Relations*, 54(2), p209.
[22] England, P. Budig, M. & Folbre, N. (2002) 'Wages of virtue: the relative pay of care work' Social Problems, 49(4), p455-473
[23] King et al (2013) 'The Aged Care Workforce, 2012 – Final Report' – see table 3.35 and 5.35
[24] Austen et al. (2015) 'Recognition: applications in aged care work' Cambridge Journal of Economics, [Accessed 28 January 2016] Available: http://cje.oxfordjournals.org/content/early/2015/08/30/cje.bev057.abstract
[25] PayScale (2016) 'Personal Care Attendant (PCA) Salary (Australia)' [Accessed 29/02/2016] Available:http://www.payscale.com/research/AU/Job=Personal_Care_Attendant_(PCA)/Hourly_Rate
[26] PayScale (2016) 'Bartender Salary (Australia)' [Accessed 29/02/2016] Available: http://www.payscale.com/research/AU/Job=Bartender/Hourly_Rate

Does it matter who does the work?

The mix of staff charged with delivering care is a key factor underpinning the quality of care available to care recipients in an aged care setting. 68% of residential aged care workers and 81% of community care workers are employed as PCAs or AINs depending on the state in which they work. While the majority of these workers do hold a tertiary-level qualification[27], their job is to provide basic personal care and support. RNs as well as Enrolled Nurses (ENs) practicing within the scope of their training are charged with providing specialised clinical and medical care to aged care recipients. The Nursing and Midwifery Board of Australia oversees the training and registration of these nurses.

CPSA notes there is no minimum qualification requirement for PCAs/AINs and is concerned that training varies substantially between providers. A 2013 audit of registered training organisations (RTOs) offering vocational aged and community care qualifications found that 87.7% did not comply with at least one of the national training standards necessary for a program to be classified under the Australian Qualifications Framework[28]. Some RTOs were found to be offering a Certificate III in Aged Care to be completed in just 11 weeks[29]. CPSA has found additional instances of RTOs offering the same Certificate III in Aged Care in as few as 6 and a half weeks[30]. Of a randomly selected sample, only 20% of RTOs provided the minimum 1200 hours of training[31]. Establishing national training standards for aged care workers is critical and specifying the minimum qualifications each worker is expected to hold as part of the accreditation process is an avenue for enforcing these standards. Moving forward, it will be increasingly important for aged care workers to competently and respectfully provide care to a diverse group of care recipients, including Aboriginal and Torres Strait Islander peoples, members of the LGBTIQA community and those of culturally and linguistically diverse backgrounds.

- **Recommendation 6:** That accreditation standards 1.3, 2.3, 3.3 and 4.3, which deal with education and staff development, specify the particular qualification, skills and training each staff member is expected to hold in order to perform their role effectively.

CPSA views the establishment of a dedicated board to oversee the training and registration of PCAs and other aged care workers as an important step in

[27] King et al (2013) 'The Aged Care Workforce, 2012 – Final Report'. See Tables 3.12 and 5.12
[28] Australian Skills Quality Authority (2013) 'Training for aged and community care in Australia' available:http://www.asqa.gov.au/verve/_resources/Strategic_Reviews_2013_Aged_Care_Report.pdf
[29] Australian Skills Quality Authority (2013) 'Training for aged and community care in Australia' p.40.
[30] For example: http://www.myflexhealth.com.au/training-listing/cert-iii-aged-care
[31] Australian Skills Quality Authority (2013) 'Training for aged and community care in Australia' p.41.

professionalising aged care work. Such a body would boost the perception of these aged care workers as skilled professionals by clearly delineating their role in the delivery of high quality care. This in turn may serve to enhance the capacity of the aged care workforce to leverage wage increases and improvements in working conditions. It could also be charged with performing police checks, so that all aged care workers are vetted before being allowed to work with vulnerable care recipients. This would hopefully reduce the chances of individuals, such as the two staff members of a NSW home currently facing murder charges[32], from entering the aged care industry in the first place. Such a body could also keep a record of aged care workers who have previously had their employment terminated as a result of failing to provide care of an acceptable standard.

- **Recommendation 7:** That a National Board, similar to the Nursing and Midwifery Board of Australia, be established to oversee the training, registration and background checks of PCAs and AINs.

The shrinking number of nurses in aged care is also a significant concern. According to the ACWCS, fewer RNs are being employed as a proportion of the overall direct care workforce. This is alarming given the importance of their specialised clinical knowledge and experience in the delivery of high quality aged care. This shift is particularly evident in the residential sector, where RNs have decreased from 21% of the direct care workforce in 2003 to just 14.9% in 2012. Enrolled nurse numbers have also decreased, falling from 13.1% of the residential aged care workforce in 2003 to 11.5% in 2012. CPSA is deeply concerned about the impact this shifting staff mix is having on the quality of care provided to those living in residential aged care.

In the aged care sector, RNs perform a central role in coordinating and managing each care recipient's care plan. Their extensive training and expertise in the management of patients with complex care needs means they can identify and treat issues proactively. This is crucial in the aged care sector, where, unlike in hospitals, there is generally no immediate access to a doctor and where a care recipient's condition can deteriorate rapidly with little warning. RNs also perform an important leadership and supervisory role, providing care staff with advice to support the delivery of care and acting as a point of escalation when issues arise. Around the clock nursing care is increasingly important given that people are staying at home for longer, meaning that by the time they enter residential aged care their care needs are higher and more complex. In 2004/05 the

[32] 'Newcastle Nurse to stand trial over resident murders' (2 December, 2015) *ABC News Online*, available: http://www.abc.net.au/news/2015-12-02/newcastle-nurse-to-stand-trial-over-death-of-residents/6994290

number of residential aged care recipients classified as high care was 64%[33], in 2012 80%[34] of care recipients were classified as needing a high level of care.

New South Wales is the only Australian state or territory that requires nursing homes to have an RN on duty at all times, a requirement that CPSA strongly supports. This requirement recently came under scrutiny at a NSW Parliamentary Inquiry, with consumer advocacy groups and representatives of the aged care workforce sending a clear message that this requirement must be retained. CPSA argues that this requirement should be extended to apply nationally, as access to nursing care around the clock is critical if care recipients are to receive care of a reasonable quality. NSW has the lowest rate of sanctions against residential aged care providers compared with other states[35]. Although it is not possible to attribute this to the requirement for RNs to be on duty at all times, there is evidence to suggest that the RN staffing level is a predictor of care quality.

A study of 1,099 nursing homes in California showed that those who rostered on more RNs received fewer penalty notices compared to those with fewer RNs rostered on[36]. There is also evidence to suggest that RNs reduce unnecessary transfers to hospital emergency departments. A Victorian study investigating the transfer of residential aged care recipients to hospitals found that up to one third of transfers were unnecessary[37]. The analysis suggested that limited staff skill mix in residential aged care settings was a factor contributing to the decision to transfer recipients to hospital.

Similarly, a 2009 study examining the role of RNs on patient outcomes in Canberra hospitals found that a 10% increase in RN hours reduced adverse events that could be linked to nursing care by between 11% and 45%[38]. An American study of hospital settings support these findings, highlighting that increasing the number of RNs as a proportion of those charged with providing bed side care significantly reduces patient

[33] Department of Social Services (2005) 'Report on the Operation of the Aged Care Act 1997' p13.
[34] Australian Institute of Health & Welfare (2012) 'Care needs of permanent aged care residents', [Accessed 15/02/2016] available at: http://www.aihw.gov.au/aged-care/residential-and-community-2011-12/permanent-residents/.
[35] Baldwin, R., Chenoweth, L., dela Rama, M., Zhixin, L (2014) 'Quality failures in residential aged care in Australia: The relationship between structural factors and regulation imposed sanctions' Australasian Journal on Ageing, 34(4) pE7-E12.
[36] Hongsoo, K., Kovner, C., Harrington, C., Greene, W., Mezey, M. (2009) 'A Panel Data Analysis of the Relationships of Nursing Home Staffing Levels and Standards to Regulatory Deficiencies' *Journal of Gerontology* Series B: Psychological Sciences and Social Sciences, March 69B, available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2655170/.
[37] Morphet, J. Innes, K. Griffiths, DL. Crawford, K. Williams, A. (2015) 'Resident transfers from aged care facilities to emergency departments: Can they be avoided?' *Emergency Medicine Australasia*, 27(5), p5.
[38] Duffield, C. Roche, M. O'Brien-Pallas, L. Diers, D. Aisbett, C. Aisbett, K. Homer, C. (2009) 'Nursing workload and staffing: impact on patients and staff' Centre for Health Services Management, University of Technology Sydney, p14.

mortality[39]. The study also revealed an inverse correlation between nurse experience in clinical care and patient mortality rates. The evidence builds a strong case for the introduction of federal legislation requiring that residential aged care facilities have an RN on duty at all times.

- **Recommendation 8:** That **all** residential aged care facilities be required to have a Registered Nurse on duty at all times.

CPSA also notes that the lack of mandated staff to resident care ratios does not support workers in delivering high quality care. The need for mandated staff ratios links back to the labour intensive nature of care work and the fact that regardless of skill or experience, a worker can only provide high quality care to a few care recipients at any one time. Staff to resident ratios must apply on overnight and weekend shifts as well as on shifts during normal business hours, as the care needs of care recipients do not change according to the time of day or availability of staff. These staffing ratios must also specify the level of supervision required by RNs, ENs and PCAs on each shift, based on the range of tasks each is qualified to carry out. They must also consider the level of care required by care recipients. Staffing ratios also need to account for the additional supervision and support required by new staff members. CPSA believes it is essential that staff are adequately supervised and supported to deliver high quality care. Supervision is also necessary to ensure that the few uncommitted workers who do enter the aged care sector for the wrong reasons are quickly identified and removed. It is essential that the actual staff to resident ratios and supervisory structures of each aged care provider is publically available to care recipients and their relatives.

- **Recommendation 9:** That there should be mandatory staff to resident ratios, which specify the number of care recipients an RN, EN and PCA/AIN can reasonably be expected to care for at one time and the level of supervision required to do so.

CPSA understands that implementing mandatory staff to resident ratios across the aged care sector will be a significant undertaking that will require careful planning and extensive consultation with clinical experts. In the interim, CPSA proposes that aged care facilities be required to publicise the staff to resident ratios they operate under. This information should be available on provider websites, as well as MyAgedCare. Providers should be required to publish a separate staff to resident ratio for RNs, ENs and PCAs/AINs and should also indicate how these ratios change depending on whether the shift falls during normal business hours, overnight, or on the weekend. Given the move

[39] Tourangeau, AE. Cranley, LA. Jeffs, L. (2006) 'Impact of nursing on hospital patient mortality: a focused review and related policy implications' *Quality & Safety in Health Care*, 15(1), p4-8.

towards consumer directed care (CDC), it is critical that specific information about staffing levels is made available to prospective care recipients and their relatives. Transparency on the part of aged care providers is crucial if CDC is to function as intended. Presently, care recipients cannot make informed decisions about where they wish to receive care as the information necessary to make this decision is not available. The mandatory disclosure of staff ratios empowers care recipients to make better decisions about their care and also means that aged care providers will be incentivised to increase staffing levels.

- **Recommendation 10:** That aged care providers be required to publish the staff to resident ratios they operate under so that it is accessible by the public.