



australian
nursing federation

Initial Submission to the Productivity Commission Inquiry - Caring for Older Australians

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Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses and midwives in Australia with branches in each State and Territory. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing in Australia.

The ANF's 175,000 members are employed in a wide range of enterprises in urban, rural and remote locations in the public, private and aged care sectors, including hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industries.

The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veteran's affairs, education and training, occupational health and safety, industrial relations, immigration and law reform. The ANF has also taken a positive role and active leadership in many of the Federal, State/Territory and local activities relating to aged care. ANF is represented on many relevant national committees including the Aged Care Workforce Committee, and the Aged Care Advisory Committee, the National Agency Liaison Group. The ANF also took a lead role in the establishment of the National Aged Care Alliance which ANF as Secretariat brings together a number of the key aged care stakeholders to develop consensus positions on matters of mutual interest and concern in relation to aged care.¹

ANF members have consistently raised with us their concerns about the current delivery of aged care services both in residential and community care settings. Inadequate staffing levels, inappropriate skills mix, excessive workloads, declining standards of care, and excessive documentation, are frequently reported. These concerns, combined with the differences in wages between the aged care and acute sectors, have all contributed to difficulties recruiting and retaining qualified nursing staff to work in aged care. Although many of these issues are common to both residential and community aged care settings, due to time constraints, the ANF has focussed our submission on the area of greatest concern which is the provision of care for older Australians in residential aged care. Clearly there is a need for more discussion on the detail of matters pertaining to funding and delivery of services in the community for the elderly. The ANF will take other opportunities to raise issues relating to community aged care during the consultation phase of the Productivity Commission's study.

The introduction of the policy of ageing in place has had significant implications for those providing care in residential facilities. Professor Warren Hogan, in his 2004 report² found that the age, dependency and acuity of people in residential aged care facilities have increased and that as a direct result of the ageing in place policy, there are an increasing number of high care residents in low care facilities.

1 See www.naca.asn.au

2 Hogan W Pricing Review of Residential Aged Care 2004

The National Health and Hospitals Reform Commission (NHHRC 2009) has forecast the number of aged care places will need to double as a minimum by 2030 to meet projected demand. Also, the Australian Government's third intergenerational report projects that over the next 40 years the number of Australians aged 85 years and over will quadruple from 400,000 in 2010 to 1.8 million by 2050.³

A national shortage of nurses and the wages gap between nurses working in the aged care sector and nurses working in the public hospital sector is exacerbating recruitment and retention difficulties in the aged care sector. The wages gap currently stands at 44.6% or \$393.77 per week national average under an Award and 15.2% or \$168.52 per week national average under an Enterprise Bargaining Agreement (EBA).⁴

Given the ageing of the Australian population and the shortage of nurses in this sector, the ANF believes the state of the aged care industry nationally is of such concern that it must be a priority for all people in the Australian community and the Federal Government. As a result of this ageing population, there is a changing face of care. It is projected that the number of people who have dementia will increase from around 230,000 in 2008 to 465,000 in 2030 and to over 730,000 in 2050.⁵ The aged care sector will need more qualified nurses to care for this growing number of residents with dementia.

Nurses, midwives and Assistants in Nursing, (however titled) are the backbone of service provision in health and aged care. Long term reform in the aged care sector will not succeed without the provision of a robust, highly educated and skilled nursing workforce, transparency and accountability of funding, additional funding for wages and attractive career paths in aged care.

3 Treasury 2010, Productivity Commission Issues Paper – *Caring for Older Australians* P.1

4 Australian Nursing Federation – Nurses' Public Sector and Aged Care Wage Outcomes January 2002 -2010 (Based on rates for RN Level 1 top increment)

5 Access Economics for Alzheimer's Australia , *Making Choices: Future dementia care: projections, problems and preferences*. April 2009m Executive Summary

Recommendations

- 1 That the Australian Government fund the ANF to develop minimum standards that provide for staffing levels and skills mix in aged care settings.
- 2 That there is recognition of the professional skills of Assistants in Nursing, (however titled) through a national licensing system regulated by the Nursing and Midwifery Board of Australia (NMBA)
- 3 That there is a mandated/legislated Federal requirement for 24 hour registered nurse cover for all high care residents in aged care facilities, inclusive of those low care facilities with ageing in place.
- 4 That the Australian Government fund the development of a workload management tool for use in residential aged care to be linked to the existing Aged Care Funding Instrument (ACFI).
- 5 That the ACFI funding model be reviewed by the Australian Government to enable the incorporation of Nurse Practitioners in aged care.
- 6 That the current regional and rural undergraduate and postgraduate scholarships, funded by the Australian Government for nurses working in aged care, be extended to include urban areas.
- 7 That a mechanism be developed by the Australian Government to monitor the use of funds by Residential Aged Care Facilities (RACF) to develop and implement Graduate Nurse Programs in aged care.
- 8 That, in line with Recommendation 7, there is an acquittal system implemented to ensure the money made available for the graduate nurse programs is directed to wages and educational support for Graduates.
- 9 That the Australian Government determine a benchmark of the cost of care in aged and community care.
- 10 That the Australian Government close the wages gap between nurses and Assistants in Nursing, (however titled), working in aged care and their public hospital counterparts.
- 11 That dedicated funding is made available by the Australian Government to close the wages gap, and that provision of the funding is conditional on the achievement and maintenance of wage parity.
- 12 That the Australian Government legislates for the introduction of annual reporting on the way aged care providers spend their funding, particularly on care activities and staff.

- 13 That the funding arrangements for accommodation and care components of aged care services be accounted for separately, using the ACFI model.
- 14 That the aged care standards agency is required to use professional guidelines as benchmarks during accreditation.
- 15 That a national education program be developed by the Aged Care Standards and Accreditation Agency (ACSAA) to ensure consistent application of national benchmarks of their Accreditation Standards and Quality Care Principles to enable alignment of all processes, with the end result being to the assurance of high quality care to our frail elderly citizens.
- 16 That compulsory benchmarks are federally legislated by the Australian Government in relation to occupational health and safety in residential and community aged care.
- 17 That an independent Aged Care Complaints Commission be established with an Aged Care Complaints Commissioner appointed who will report directly to the Federal Minister for Ageing.

Staffing and Skill Mix

Staffing and skill mix is the terminology the ANF use to facilitate the discussion around the crisis in the care standards in aged care. This language is widely accepted by nurse academics and representatives of government and most importantly nurses working in the sector. In a professional context, the concept of skill mix relates to the ways in which variously qualified nurses and assistants in nursing have organised nursing work so that professional standards of nursing are met. This is by applying a range of accepted qualifications and experience of nursing and Assistants in Nursing, (however titled), to achieve a standard of care. Specifically, the term “skill mix” in the aged care sector means, *the provision of direct and indirect aspects of nursing care to a resident*⁶. The adoption of an agreed skill mix in the aged care sector enables workers with qualifications other than nursing or with minimal/no qualifications, to work under the supervision and delegation of registered nurses in the provision of aspects of nursing and personal care.

Statistics indicate there are increasing numbers of older Australians entering residential aged care who have a high degree of frailty and present with both acute and chronic health conditions that require specialist professional nursing⁷. At a time when residents of nursing homes are requiring more complex care, there has been a reduction in the overall skill mix and a marked depletion of nursing workforce, that has resulted in some care homes no longer employing registered nurses on all shifts. Where they are employed, they work in relative isolation from other health care professionals and are often required to manage Assistants in Nursing, (however titled).

The ANF is taking a leadership role in attempting to address the aged care workforce issues through a national campaign launched in 2009. The, *Because We Care*, campaign has four key aims:

- *The right balance of skills and nursing hours so that nursing and Assistants in Nursing, however titled, can provide quality care for every resident*
- *Fair pay for aged care nurses and Assistants in Nursing, however titled who are paid up to \$300 per week less than nurses in other sectors*
- *Recognition of the professional skills of Assistants in Nursing, however titled through a national licensing system*
- *A guarantee that taxpayer funding is used for nursing and personal care for each resident.*⁸

6 New South Wales Nurse's Association. 2001. *What do Nurses Think About Aged Care?* [Report]

7 Australian Institute of Health and Welfare. 2008. *Residential aged care in Australia 2007-8: a statistical overview*. Aged Care statistics series 28. Cat.no. AGE58. Canberra: AIHW

8 Australian Nursing Federation. 2009. National Aged Care Campaign. *Because we care: quality care for older Australians*. Available at: <http://www.anf.org.au>

The ANF considers that the achievement of these aims would result in an improvement in the quality of care for older Australians.

The ANF has a primary interest in issues relating to the aged care workforce, including available numbers, qualification, and employment standards of nurses and Assistants in Nursing, (however titled). Many factors have increased the intensity of nursing care relevant in aged care at a time when registered and enrolled nursing numbers have diminished. Much of the nursing care is being provided by assistants in nursing, however titled, who may not have the qualifications or skills commensurate with the care needs of the resident profile.

Residential aged care is meeting the care needs of an increasingly more dependent group of people. By far, the majority of residents at 30 June 2008 were assessed as high-care (70%). By way of contrast, 58% of residents were classified as high-care in 1998. In addition, 66% of permanent residents who were admitted during 2007–08 were classified as high-care.⁹

The numbers of residential aged care places increased by 5,401 in the twelve month period from 30 June 2007 to 30 June 2008. The age profile of the resident population continues to increase. Over half (55%) of the 157,087 residents at 30 June 2008 were aged 85 years or older, and over one-quarter (27%) were aged 90 years and over. Overall, only 4% of residents were less than 65 years of age.¹⁰

At the same time as numbers of residents are increasing, so is their dependency; while the numbers of registered and enrolled nurses employed in residential aged care has fallen from 38,633 in 1995 to 30,640 in 2007, a decline of 7,993.¹¹ This significant decline in the number of registered nurses has resulted in substantial skill loss from the residential aged care sector, and this, combined with the increase in dependency levels, places further pressure on this sector. Staffing levels and the skill mix of staff impact directly on the workloads of nurses, and ultimately on the quality of health outcomes for residents.

It should be noted that overall, the average number of full time equivalent (FTE) qualified nursing staff per occupied bed in private acute and psychiatric hospitals is ten times that in the aged care sector. The average number of FTE nursing staff (including RN's and EN's) per occupied bed is 1.4 whereas in aged care, the average EFT of RN's and EN's per occupied bed is 0.14.¹²

9 Australian Institute of Health and Welfare. 2008. *Residential aged care in Australia 2007-8: a statistical overview*. Aged Care statistics series 28. Cat.no. AGE58. Canberra: AIHW. P39.

10 Ibid. p39.

11 Australian Institute of Health and Welfare, 2009. *Nursing and Midwifery Labour Force 2007*. AIHW Cat. No. HWL 43. Canberra: AIHW.

12 Australian Bureau of Statistics. *Private Hospitals, Australia 2008-2009*. Canberra; ABS 2010, Table 2.11 p.31
AIHW 2009 *Residential Aged Care in Australia 2007-2008: A Statistical Overview*. Canberra; AIHW 2009 p.vi NILS
re EFTs in aged care

The ANF is concerned by the practice of replacing registered and enrolled nurses with assistants in nursing, however titled in order to provide a 'cheaper' alternative workforce. The NILS survey on the aged care workforce found that there had been a substantial substitution of assistants in nursing, however titled for nurses in recent years.¹³

The ANF is supportive of the use of assistants in nursing, however titled in residential aged care facilities, and views them as an integral component of the nursing family in their work with registered and enrolled nurses, to provide nursing care at a professional standard. Indeed, the ANF provides industrial coverage and representation for these workers and includes them in all areas of ANF activities. We are, however, opposed to the replacement of registered and enrolled nurses with assistants in nursing, however titled where the work requires the skills and knowledge of either a registered or enrolled nurse.

Assistants in nursing (however titled) generally are educated and competent to provide a basic range of personal services and some are competent to be delegated other aspects of nursing care by registered nurses. However, assistants in nursing (however titled) are not able to always recognise serious problems including changes in the health status of an increasingly frail and vulnerable cohort of residents who often live with multiple chronic conditions and who are at high risk of injury and side effects of complex medication and health treatment regimes on top of old age and in some instances acute on chronic health issues. Approximately 30 % of assistants in nursing, however titled do not have formal aged care qualifications.¹⁴ These care workers require supervision and support from registered nurses. In fact, some Hospital Admission Risk Programs (HARP) have now been extended to include registered nurses visiting residential aged care facilities to provide nursing advice and plan nursing care for aged care providers as they do not have adequate numbers of registered nurses employed to undertake 'grass roots' nursing.

It is therefore critical there are minimum staffing levels in all aged care facilities, 24 hour registered nurse coverage wherever there is one or more high care residents; and for each facility employing nurses that a full time director of nursing (or classification equivalent) is employed. It is also critical that national benchmarks of care are developed that are directly linked to relevant skill mix of staff required to deliver appropriate care.

¹³ Richardson S 2004 The Care of Older Australians: A picture of the residential aged care workforce National Institute of Labour Studies Flinders University Adelaide Australia

¹⁴ 2007 National Aged Care Workforce Census

In a decision of the Coroners Court of Victoria, (**Attachment A**) Coroner Audrey Jamieson says:¹⁵

The absence of Registered Nurses – a regulated profession – is not readily understood by reference to “high level care” and “low level care” beds or indeed “hostel”/“nursing home”. The “degree” of supervision may vary between the differently classified facilities but what is common to them is a class of people who are otherwise unable to independently attend to their activities of daily living and who are reliant upon others to supervise and come to their aid in the event of a medical emergency. In the delivery of services to this reliant, vulnerable and increasingly dependant group of people there is a compelling argument in my opinion, for all of these facilities-regardless of what we call them- to have registered nurses on the premises on every shift. The presence of Registered Nurses would help to support the residents of these facilities and the Personal carers who increasingly, are the group of employees providing the majority of care in the aged care setting. PCAs do have a level of training....however in the absence of regulation there lacks, in general terms, an ability to monitor the standard of delivery of care. PCAs receive basic training which does not empower PCAs to deal with a medical emergency.

The combination of high care resident needs and an underskilled, understaffed workforce are, in the opinion of the ANF, a major factor in quality of care problems which arise in aged care facilities. The obligation placed on the provider in the Accreditation Standards (Schedule 2 of the Quality of Care Principles 1997) requires that:¹⁶

There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.

Yet the Aged Care Standards and Accreditation Agency reported in August 2008:¹⁷

...that a significant proportion (of non-compliant homes) did not maintain appropriate numbers and types of staff, with many of them not being able to ensure that staff skills and qualifications were the right fit for the work required and to reflect their residents' needs.

...in homes where workloads are unrealistic, or where staff are unqualified, poorly trained or poorly deployed, then process malfunctions will occur across a wide range of expected outcomes. Employment of staff without appropriate skills may exacerbate any staff shortages as this may lead to inefficiencies in time and effort and place greater work related stresses on staff.

15 State Coroner Victoria: *Record of Investigation into the Death of Annunziata Fedele*, Case No. 4545/05, 28 April 2008, p9-10.

16 Attorney General's Department. *Quality of Care Principles*. 1997. Federal Register of Legislative Instruments. Canberra. P17. Available at:
[http://www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrumentCompilation1.nsf/0/FE2DB3472E447CA25741200168B72/\\$file/QualityofCarePrinciples1997.pdf](http://www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrumentCompilation1.nsf/0/FE2DB3472E447CA25741200168B72/$file/QualityofCarePrinciples1997.pdf).

17 Aged Care Standards and Accreditation Agency. *The Standard*. August 2008. p3.

Increasing numbers of residents with higher and more complex care needs have added to the workloads of nursing care staff in residential care settings. The available nursing and aged care staff numbers per resident have in many instances decreased despite this increase in the proportion of residents classified as requiring 'high care'. As a result, a 2003 survey reported that over two-thirds of direct care employees in residential facilities felt they were not able to spend enough time with each resident and were too rushed to do a good job.¹⁸

A 2007 Australian study found skills mix was a significant predictor of patient outcomes. Reinforcing the findings of other international studies, a skills mix with a higher proportion of registered nurses produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers; gastrointestinal bleeding; sepsis; shock; physiologic/metabolic derangement; pulmonary failure; and failure to rescue. The study found one extra registered nurse per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients, of pneumonia by 16 per 1000 patients, and of sepsis by 8 per 1000 patients. Patients are also less likely to fall and suffer injury as registered nursing hours increase.¹⁹

In 2009 the ANF commissioned Access Economics to examine changes in the residential aged care (RAC) workforce over recent years and the implications of these for the future.²⁰ The following extract contains information which the ANF considers useful for the Productivity Commission review of Aged Care Services in Australia:

In the acute sector there is evidence that more nursing hours for patients bring quality of care and economic benefits (Duffield, 2008; Needleman et al, 2002; Kane et al, 2007; Aiken et al, 2003) through decreased complications, higher care standards and improved outcomes, measured using various indicators (e.g. behavioural and pain management, sleep, infection control, emotional support and so on). Studies similarly show that care delivered by RNs in RAC settings is strongly related to better resident outcomes (Horn et al, 2005). An implication is that future residents should be made aware of a facility's resident-nurse ratio when considering a place.

The report noted quality of care implications centred around skills mix issues in the RAC sector which include the inability to ensure adequate staffing and inadequate preparation of staff for their roles. A particular problem is the limited availability of specialised nursing care and thus clinical care limitations, which can have serious adverse consequences for the frail aged.

18 Richardson, S. and Martin, B 2004. *The Care of Older Australians: A Picture of the Residential Aged Care Workforce*. National Institute of Labour Studies for the Department of Health and Ageing. Flinders University, Adelaide.

19 Duffield, C., Roche, M., O'Brien-Pallas, L., Diers, D., Aisbett, C., King, M., Aisbett, K. and Hall, J. 2007. *Glueing it together: Nurses, their work environment and patient safety*. Final Report. Centre for Health Services Management, University of Technology, Sydney.

20 Australian Nursing Federation. 2009. *Nurses in residential aged care*. Report by Access Economics Pty Ltd. Available at: <http://www.anf.org.au>

The reduction in the number of nurses and the subsequent changes to skill mix is leading to a lower level of safety and quality of care and putting these vulnerable residents at risk.²¹ The aged care accreditation data on failed standards reveals this reduction in the numbers of nurses has led to a decline in quality of care with residents exposed to serious risk from neglect, poor infection control, malnutrition and dehydration, and assault.²²

With the introduction of ageing in place, high care is not the only level in aged care that has complex care needs and polypharmacy requirements, inclusive of administration of schedule 8 and 9 medications and intravenous drug therapy. Residents in low care also require complex nursing care and have polypharmacy requirements.

The Bentley's 2009 National Residential Aged Care Survey provides a breakdown of average "care staff" hours per resident. "Care staff" includes Director of Nursing, different experience levels of Registered Nurse, Enrolled Nurses, Assistants in Nursing, Assistant Nurses, Activities staff, Personal Care Workers and Therapists. Based on the survey data, the average hours of care (ie provided by all care staff) per resident per day totals 2 hours and 36 minutes per day (24 hours). On average just 36 minutes of care per resident per day is provided by Registered and Enrolled Nurses.

A comparison with the Bentley's 2004 data shows total care staff hours averaged 3 hours and 14 minutes per resident per day, with 63 minutes of that care provided by Registered and Enrolled Nurses. Not only do the figures indicate an alarming decrease in total care hours since 2004, it also demonstrates that Registered Nurses and Enrolled Nurses are currently providing almost fifty percent less of the care now than in 2004.

High quality residential aged care directly correlates to the skills and education associated with people who provide that care, namely registered and enrolled nurses and assistants in nursing, however titled. Enabling career development through continuing education and upskilling opportunities is a pre-requisite to ensuring the skills mix responds to changing care needs (more high and chronic type care), including more specialised training, such as dementia care programs. Upskilling enrolled nurses and assistants in nursing, nursing assistants and personal care workers (however titled) is critical given their share of the residential aged care workforce. The number of undergraduate nursing places should be increased such that they are adequate to meet future demand, and should emphasise aged care specific places and encourage graduates to enter the aged care sector. Graduate nurse programs should be implemented into the aged care sector as a matter of priority and the graduates should be supported financially and educationally to not only complete the program but have a defined career path in aged care. Existing regional and rural Government scholarships for undergraduate and postgraduate aged care study should be extended to include metropolitan areas to encourage and prosper recruitment in these areas.

21 Aged Care Standards and Accreditation Agency. The Standard, August 2008.p.3

22 Department of Health and Ageing. Report on the operation of the Office of Aged Care Quality and Compliance, 1July-31 December 2007.

In addition, the ANF strongly supports the role of the nurse practitioner in aged care. Nurse practitioners are registered nurses with the education and extensive experience, as recognised by the Nursing and Midwifery Board of Australia, required to perform in an advanced clinical role. A nurse practitioner's scope of practice extends beyond that of the registered nurse. The nurse practitioner role includes assessment and management of clients using extensive nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.²³

In aged care settings, nurse practitioners have an important role in providing support and direction to registered nurses and enrolled nurses in the complex care needs and chronic disease management of residents such as diabetes, respiratory conditions, urinary conditions, and cardiac disease, and providing timely intervention to prevent unnecessary admission to tertiary health care facilities.

Also, ANF argues that assistants in nursing, however titled should be regulated by the same regulating body that regulates registered nurses, midwives and enrolled nurses, namely the Nursing and Midwifery Board of Australia. The licensing of this group of care workers will afford them benchmark education and make them accountable to the public for their practice, as is the case for all professional health workers. This is also the recommendation of the Coroners Court of Victoria in Case no: 3662/03 (**Attachment B**) where Coroner Audrey Jamieson states:²⁴

The demarcation between the provision of care and services by Registered Nurses and those provided by Personal Care Attendants is in many respects, an artificial one created and driven by economics. PCAs are not regulated as is the nursing profession. Regulation of health professionals provides a systematised ability for the monitoring of standards of delivery of care. As the demand for all levels of health care, supportive and residential facilities increases with our ageing population, I **recommend that the appropriate bodies including the Minister for Health, the Nurses Board of Victoria and the Australian Nursing Federation collaboratively review whether PCAs can be "regulated" in a similar manner as other health professionals.**

Similar general recommendations have again been made by Coroner Jamieson in Case No. 4545/05 (**Attachment A**).²⁵

23 Australian Nursing Federation (2009). *A snapshot of nurse practitioners in Australia*. Melbourne: ANF. Available at: <http://www.anf.org.au>

24 State Coroner Victoria: *Record of Investigation into the Death of Kathleen Joyce Barnes*, Case No. 3662/03, 1 April 2008, p13.

25 State Coroner Victoria: *Record of Investigation into the Death of Annunziata Fedele*, Case No. 4545/05, 28 April 2008, p12.

In licensing or regulating assistants in nursing (however titled) we need to define the worker and the role. The introduction of complementary regulation will protect the worker and the role and prevent the introduction of yet another tier of health worker. The ANF believes there also needs to be national benchmarking of the courses that lead to becoming an assistant in nursing, however titled and mapping of the existing worker to transition to the new national benchmarked course. (The Federal Government has already announced \$1000 per worker in aged care for training to occur).

The licensing of assistants in nursing (however titled) is also in the interest of protection of the public. Registered nurses, midwives and enrolled nurses are registered with their regulatory body which makes them accountable for their scope of practice. Registered health practitioners have to attend mandatory continuing education, hold professional indemnity insurance, demonstrate recency of practice, and obtain the required English language skills standard.

The ANF supports the reservation and protection of title. This requires that there is a formal classification and naming of craft groups, for example health care support workers. Under this option particular titles of the craft group can only legally be used by those who are licensed by the relevant registration board. A statutory registration board establishes qualifications and character requirements for entry to the profession, develops standards of practice, and receives and investigates complaints of unprofessional conduct, poor health or performance and applies sanctions, if necessary, including deregistration. It is difficult for a deregistered worker to practice because if they advertise their services to the public or use the reserved title they can be prosecuted through the courts for committing an offence. This form of regulation assures consumers that workers are qualified to provide services and their practice is subject to the scrutiny of a registration board.

This form of licensing is consistent with the current system for the registration of health professionals which could be modified to add another level of health and aged care worker to an already established model of regulation that is understood by community and the health and aged care industries.

Recommendations

- 1 That the Australian Government fund the ANF to develop minimum standards that provide for staffing levels and skills mix in aged care settings.
- 2 That there is recognition of the professional skills of Assistants in Nursing (however titled) through a national licensing system regulated by the Nursing and Midwifery Board of Australia (NMBA)
- 5 That the ACFI funding model be reviewed by the Australian Government to enable the incorporation of Nurse Practitioners in aged care.

- 6 That the current regional and rural undergraduate and postgraduate scholarships, funded by the Australian Government for nurses working in aged care, be extended to include urban areas.
- 7 That a mechanism be developed by the Australian Government to monitor the use of funds by Residential Aged Care Facilities (RACF) to develop and implement Graduate Nurse Programs in aged care.
- 8 That, in line with Recommendation 7, there is an acquittal system implemented to ensure the money made available for the graduate nurse programs is directed to wages and educational support for Graduates.

The nursing shortage

Over the past decade a number of reports have been produced examining the nursing workforce and various specialist components of the nurse workforce.

Although each of the national nursing workforce reports differ slightly in their findings due to the various data sources and methodologies, there are consistencies in both identification of key drivers of supply and demand and findings in terms of projected supply and demand. These include:

- the general inadequacy of numbers of nursing graduates produced over recent years to meet demand (in terms of both replacement and growth in demand for health services);
- the ageing of the nursing workforce (and projected retirements), decreasing hours worked and turnover and the effect on the ability of the nursing workforce supply to replace itself; and
- growth in demand for health services expected to increase especially in the aged care sectors but also across acute care sectors.
- Increasing demands from state and federal governments to increase the health sector productivity

While there is some variation in the projected supply and demand in each report, they all show this shortage becoming more marked.

The reports also find that there is a shortage across all states and more significantly in the aged care sectors. The preference of nurses to work in acute hospitals sectors with younger people and the existence of comparatively low rates of pay (ie comparable EBA wage levels) and heavy work load requirements are factors which make nursing less attractive in the aged care sector.

While assessing the level of demand and the numbers of workers that are therefore needed is not straightforward and requires sophisticated modelling it has been estimated that there was a shortage of between 10,000 and 12,000 nurses for 2006, rising to an expected shortage of between 10,000 and 13,000 in 2010 (AHWAC 2004).

The Australian Nursing Federation is of the view that aged care nursing must be at the forefront of the health care profession as a specialist area of clinical practice. A specialist area that is attractive to all nurses and offers an entry to nursing practice opportunity for people interested in assisting nurses in caring for older people, who require both complex nursing care and assistance with personal care.

The aged care sector is well placed to offer:

- traineeships in nursing to assistants in nursing, however titled
- promote images of registered nursing work in aged care to undergraduate and post graduate nursing education preparation as dynamic and exciting
- develop robust graduate registered and enrolled nurse programs in aged care settings
- formalise preceptor and mentorship programs for nurses at all stages of their career
- upskilling of existing aged care workforce, including carers into nursing programs like traineeships in enrolled nursing or nationally recognised training programs at certificate III and IV in aged care for assistants in nursing

Workload Management Tool

The ANF recommends that a tool be developed that nominates/estimates minimum staffing levels and skill mix for use in residential aged care.

Care planning and documentation of care in residential aged care facilities and aged care hostels is a professional process²⁶. The principles underpinning documentation and planning for residential aged care are done by registered nurses in accordance with legislation, and guiding principles²⁷. The current funding mechanism for aged care is the Aged Care Funding Instrument (ACFI) that was introduced in 2008 to replace the former Resident Classification Scale (RCS). The ACFI focuses on health professionals – usually registered nurses, answering a range of specific questions and completing checklists that are directly related to the provision of a resident's care that best assesses the resident's dependency. However the ACFI doesn't exactly prescribe or imply the type of (nursing) care a resident is to be provided, nor does it prescribe the qualification of the person that is required to administer care to a resident of a residential aged care facility.

26 Cheek, J., Ballantyne, A., Jones, J., Roder-Allen, G., Kitto, S. 2002. *Ensuring Excellence: An Investigation of Issues that Impact on the Registered Nurse Providing Residential Aged Care to Older Australians*: University of South Australia

27 Aged Care Act 1997. 2004 & Aged Care Principles. *Commonwealth of Australia* 2004

The ANF asserts that the ACFI lends itself to an easy transition from solely focusing on the needs of residents, to including the demand for, and funding of, nurses. With minimal adjustments, the ACFI is used to assess the care needs of residents and could easily with some modification determine the best type of skills required to provide the optimal level of assessed care, with the appropriate level of education, knowledge and skill to do so. Hence, every resident in an aged care facility would not only be assessed in terms of their low, medium or high level care needs, but also on different types of services that are provided by registered and enrolled nurses and assistants in nursing, however titled.

The designer of the ACFI, Richard Rosewarne has developed a framework that will allow the development of staffing and skill mix outcomes that is linked to ACFI assessment suite for residential aged care. The tool will develop a relationship between staffing levels, skills mix and the care needs of residents in aged care. The tool can use the ACFI profiles to show the range of basic staffing level mix to high level staffing mix needed for a given facility, thus developing methods to calibrate staffing levels to particular resident types and needs.²⁸ The ANF supports the further development and trialling of this framework.

It is the view of the ANF that the ACFI funding model should also enable aged care facilities to incorporate the role of nurse practitioners. There is evidence that shows nurse practitioners and nurse practitioner candidates can save governments hundreds of thousands of health care dollars. The New South Wales Department of Health estimates that the work of a nurse practitioner candidate working in aged care treating the elderly in their homes and in RACF's has saved the hospital \$1.5m in averted hospital admissions for the over 65 year age group.²⁹

An analysis of two ACT nurse practitioners showed a substantial cost savings by admission of residents into RACF's directly from home and not from hospital. In six months the nurse practitioners saved 350 bed days at a cost of \$1,265 per day or a total of \$44,750.³⁰

This ACFI staffing proposal has not been considered by the Department of Health and Ageing (DoHA) for implementation and the ANF call on the Australian Government to explore the possibilities of implementing it.

The ANF undertook a survey of its members employed in residential aged care services across the country to ascertain the most current and clear picture from the coalface of residential aged care, in order to formulate a considered response to the key questions posed in the December 2009 Discussion Paper: *Review of the Aged Care Funding Instrument*. Members found that ACFI does not recognise the substantial time spent by staff and particularly senior staff supporting and managing the care of partners/family. Often this time commitment is considerable in high care when managing complex issues and end of life care. The ACFI also fails to recognise the need for interdisciplinary consultation and management of individual residents and development of complex care needs documentation.

28 Rosewarne R 2009 *Researching Staffing and Skills Mix in Residential Aged Care* Applied Aged Care Solutions

29 Australian Nursing Federation (2009). *Primary Health Care in Australia: A nursing and midwifery consensus view*. P31.

30 Ibid. P 32

The other aspect is that the funding levels do not allow for the numbers and qualification levels of staff required to provide complex care, particularly in end of life and behaviourally challenging residents.

Other respondents to our survey expressed that in most instances it is difficult to score a resident to reflect their 'true' care needs as the ACFI assessment does not permit some areas of care to be captured. The ANF acknowledges that this is because the ACFI is a funding tool, rather than a care tool. However, respondents stated that the impact of this is that some residents miss out on the highest quality of care that they deserve.

The majority of respondents to the ANF survey did not consider that the ACFI recognised the various roles of staff involved in the delivery of residential aged care, including enrolled nurses, assistants in nursing, nursing assistants and personal care workers, however titled and allied health professionals.

Particular mention was made of the extensive role of registered nurses in medication management and that the time for all of the aspects of this was not appropriately reflected in the ACFI.

Medication management by RN is not recognised. Medication management is more than the time it takes to give a person a tablet. That is the end result. RNs spend many hours chasing up INR reports [international normalised ratio for determining clotting tendency for patients on 'blood thinning therapy'], following up lab results for infections none of which is reflected in the tools. Even following up phone orders and monthly reviews of DDA [dangerous drugs of addiction] take huge amounts of time but cannot be claimed for under ACFI.

The ANF is acutely aware that staff levels and skills mix in residential aged care is extremely important for the future of the sector. There are a variety of models and indeed outcomes and the ANF is very cognisant of the differences.

The ANF has endorsed as policy the provision of appropriate standards of nursing care in the RAC sector that require:

- A minimum of 4.5 hrs of nursing care per resident per day;
- 24 hour registered nurse cover where there is ageing in place
- Each facility which employs nurses to employ a full time Director of Nursing (or classification equivalent);
- The provision of safe nursing care in the aged care sector requires a designated number of registered nurses, enrolled nurses and assistants in nursing, (however titled) at an appropriate skill mix. The skill mix must reflect the care needs and acuity of residents and is calculated using an ANF supported mechanism.

In order to determine appropriate skill mix within the staff/resident ratio a skill mix tool needs to be developed which is based on the ACFI funding tool. The ANF is continuing work in this area. The principles for the design of such a staff/resident/skill mix tool are as follows:

- it is transparent and can be easily understood by managers, nursing and care staff, the ACSAA and residents/families
- it will be used as the primary indicator of whether a provider has met its obligations under the Aged Care Principles in providing an adequate number of appropriately qualified nursing and care staff
- the calculation of minutes/hours of care per resident per day for different resident needs within the skill mix tool is evidence based and sufficient to ensure quality care
- the staffing requirements are expressed as EFT per day for RNs, ENs and licensed Assistants in Nursing, however titled, and allocated as actual staff positions on a roster which can be observed and verified (rather than less verifiable such as nursing hours or minutes per patient per day)
- care staff within the skill mix tool will only consist of RNs, ENs and licensed assistants in nursing, however titled
- the tool takes into account the ACFI score of each resident, together with weighting for other factors relevant to workload and care quality (e.g. special needs or facility design)
- the staffing needs for each facility would usually be re-evaluated four times a year to ensure stability for residents, management and staff, unless there are significant and sudden changes in acuity
- the staffing re-evaluation and a written confirmation that resultant staffing changes have been implemented must be provided to ACSAA as part of normal reporting requirements. Compliance with the evaluation will be measured in any scheduled accreditation review or spot audit

Recommendations

- 4 That the Australian Government fund the development of a workload management tool for use in residential aged care to be linked to the existing Aged Care Funding Instrument (ACFI).
- 5 That the ACFI funding model be reviewed by the Australian Government to enable the incorporation of Nurse Practitioners in aged care.

Wage disparity and Pay Equity

In nursing, the under-valuing of women's work is a significant contributor to the gender pay gap that has remained unaddressed (despite various wage cases, industrial campaigns and the widespread shortage of nurses). Although highly regarded by the community, nurses are chronically undervalued by employers. The enduring failure to remedy the situation has entrenched nursing recruitment and retention problems in all states and territories across the country.

Ninety three percent of the direct care workforce in aged care is women. Nurses and others employed in the aged care sector continue to experience the double disadvantage of working in an undervalued and underpaid occupation in a sector that does not receive adequate resources or recognition.

This issue was singled out in the recent Parliamentary report, *Making it Fair*, which notes the amount of evidence presented on the situation of women employed in the aged care sector. The Committee's chair highlights this point and states:

"Whilst the recommendations of this report do not specifically address this industry it is clear that action needs to be taken to improve wages and conditions. I am aware of the dependence on the Australian government for the funding of this sector. I urge the responsible Ministers (including the Minister for Finance) to look at how we can responsibly increase the funding for wages in this sector)." ³¹

Since the inception of enterprise bargaining, wages for aged care nurses have been significantly affected, as effective bargaining has been difficult in a segmented sector with such a large number of facilities spread across the nation. The current wage disparity between nurses working in aged care and their colleagues working in the acute care sector sends a very loud message that nurses in the aged care sector are deemed to be worth less than their nursing colleagues. This message is being sent as we encourage new graduates and their experienced colleagues to seek opportunities in gerontic nursing. This contributes to a devaluing of not only working in aged care, but of older people within our society.

Nurses, both enrolled and registered, are a significant investment that must be adequately funded. Nurses are the key to the quality of aged care and health services provided to Australians both now and in the future.

The history of nursing awards up to 1996, at both federal and state levels, was characterised principally by industrial tribunal decisions establishing and maintaining minimum common national rates of pay and conditions of employment.

31 Xiii House of Representatives Standing Committee on Employment and Workplace Relations, "Making it Fair" Pay Equity and associated issues related to increasing female participation in the workforce, November 2009 Canberra

In a series of decisions in the late 1980's and early 1990's the Australian Industrial Relations Commission (AIRC) established in federal awards professional wage rates and conditions of employment for the nursing profession in every state and territory other than in New South Wales (NSW) and Queensland (QLD). An important feature of these tribunal decisions was an acceptance by the tribunals that nurses should be remunerated in accordance with their levels of responsibility, standards of education and experience rather than based on their particular nursing sector within which they are employed.

Between 1996 and 2007 federal awards were periodically reviewed and minimum conditions reduced. This decline accelerated upon the introduction of "WorkChoices" which radically altered the role of awards. WorkChoices introduced new legislative objects concerned with the functioning of awards and the role of the Commission in relation to them. It significantly limited the extent to which awards could act as a comprehensive safety net of minimum working conditions by removing any reference to fairness and requiring that awards provide only 'a safety net of minimum entitlements'.

In contrast state tribunals, particularly in NSW and QLD periodically reviewed and adjusted state awards to ensure that they reflected community standards.

Since 1996 the actual nursing wages and conditions of employment declined in real terms and progressively fragmented those who were able to secure collective agreements and those who were not.

In March 2008 and following a formal request from the Australian Government, the AIRC commenced a process of reviewing and rationalising federal and state awards in the new national workplace relations.

At the conclusion of this exercise more than 1,500 have been reviewed and condensed or merged into 122 registry or occupational awards.

For nurses and nursing employers it meant that around 50 federal awards and 80 state awards were merged into a single occupational award applying to employers of registered, enrolled or assistants in nursing, however titled.

As a consequence of the award modernisation exercise conducted by Fair Work Australia, and to a lesser extent due to the decision by a number of states to refer specific industrial relations powers to the Commonwealth, the vast bulk of nursing staff employed in all sectors other than the state public sectors are covered by the Nurses Award 2010 (MA000034).

The Nurses Award 2010 provides terms and conditions of employment which along with National Employment Standards provide the new minimum safety net for registered nurses, enrolled nurses and assistants in nursing, however titled employed throughout Australia in the health industry.

Employers, who employ nursing staff under the terms of the Nurses Award 2010, operate in diverse parts of the community and health sector including hospitals, prisons, residential aged care facilities, medical clinics, factories and in people's homes.

In establishing an occupational award for nurses, the Nurses Award 2010 is an award that applies to the occupation of nursing. These awards commenced on 1 January 2010 and generally will phase in changes to wages and other penalties over a five year period.

The modern Nurses Award establishes wages and conditions of employment that broadly reflect federal instruments rather than state instruments. There is a significant wage differential between the two instruments which is to be absorbed over a five year period commencing 1 July 2010. The amount to be absorbed for a Registered Nurse employed in an aged care facility in Queensland may be up to \$124 per week and up to \$294 per week for Registered Nurses employed in aged care in New South Wales.

The consequence of this decision has meant that firstly Registered Nurses remain unable to enter into collective agreements with their employers which better reflect their work value as there is little or no incentive for employers to bargain because of the sizeable wages gap. They will have their wages effectively frozen for up to five years. Secondly, the decision of the AIRC to set new national minimum rates for nurses based on federal awards has resulted in a significant devaluing of the role of aged care nurses in both Queensland and New South Wales. In both cases, such outcomes will have strong adverse consequences for the provision of care for the aged.

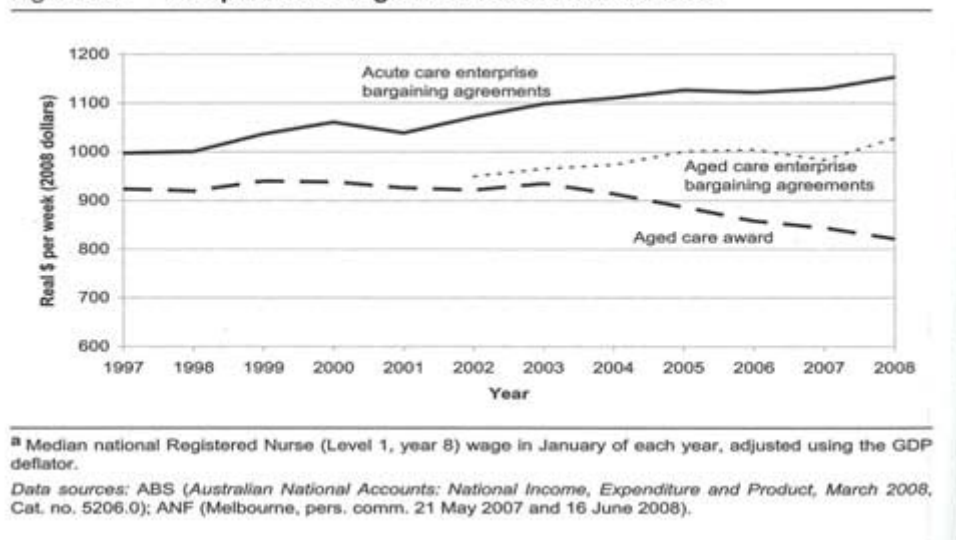
It is in the public interest that this trend is reversed.

Despite the notional obligation on industrial tribunals to establish and maintain a safety net of fair minimum wages and conditions of employment, for the thousands of nurses who continue to rely on awards, their entitlements have been in decline over the past two decades.

This decline accelerated upon the introduction of "Work Choices" in 2005 which radically altered the role of awards. Work Choices introduced new legislative objects concerning the function of awards and the role of the Commission in relation to them. It significantly limited the extent to which awards could act as a comprehensive safety net of minimum working conditions by removing any reference to fairness and requiring that awards provide only 'a safety net of minimum entitlements'.

As the table below³² demonstrates the Productivity Commission has concluded that real weekly award wage rates (as adjusted by the GDP deflator) for a nurse (level 1 Year 8) employed in the aged care sector, are less in 2008 than they were in 1997.

Figure 6.2 Comparison of registered nurse remuneration^a



In addition to the growing disparity in wages, data collected by the Bentleys National Aged Care Financial Survey shows that the wages costs for care staff (including RN, EN, AIN (however titled) and therapists) have gone from an average of \$62.03 per resident per day in 2004 to an average of \$63.64 per resident per day in 2008/09, an increase of just \$1.61 per resident per day over four to five years. While part of the explanation is a reduction in the employment of care staff per resident per day over that period, it shows a lack of growth in wage costs, (and therefore wages), for care staff over that period.³³

Bargaining outcomes in the aged care sectors can be best described as patchy with collective agreements generally providing remuneration arrangements that fall well short of those provided for in both public and private health settings.

While the content of federal safety net awards covering nursing staff in both the acute and aged care sectors remains broadly comparable, enterprise bargaining outcomes have led to significant differences in remuneration levels.

This difference is primarily due to the inability of aged care employees, including nurses, to secure comparable agreements to those in the acute sectors.

In response to claims by employees and unions employers have argued that enterprise bargaining is unsuited to the sector due to the lack of funding and the strict controls on the employers ability to raise revenue. The aged care industry is primarily funded by the Commonwealth and such funding does not recognise agreement outcomes.

32 Productivity Commission 2008, *Trends in Aged Care Services: some implications*, Commission Research Paper, Canberra, p.44

33 Bentleys 2009 *National Aged Care Financial Survey, National Averages – All Services and Bentleys 2004 National Aged Care Financial Survey, National Averages – High Care Facilities*.

The constraints of the funding arrangements and the employer's slavish reliance on such arrangements to decline to participate in effective bargaining with their employees have been subject to comment by the AIRC.

In granting a claim to adjust wages for nurses employed in aged care in the Northern Territory in 1999 a Full Bench of Munro J, Duncan DP and Eames C in decision Print S6646 stated:

It is essentially unjust for the community to be so dependent on not-for-profit service providers and essential service nursing staff, but to fail to supply adequate funding to meet what we consider to be a base level movement in the rates of pay to ensure equitable treatment between comparable groups of nursing staff.

(at page 23)

The inferior enterprise bargaining outcomes for nurses employed in the aged care sector not only results in a growing disparity in wages but also in conditions of employment covering allowances, leave and other entitlements. Like the acute health sector, aged care is a 24 hour, 7 days a week operation where shift allowances and penalty rates make up a substantial part of an employee's income.

The growing disparity in entitlements in this area compounds the inequity in remuneration overall and the consequent attraction and retention problems in the aged care sector. Similarly, other entitlements such as clauses covering staffing and workload management, professional development leave, occupation health and safety and opportunities for career advancement increase the disparity and inequities between the aged care and other sectors of employment for nurses.

Aged care providers argue that they are not adequately funded to provide wage parity for nurses, however there has been two large injections of Australian Government funds into aged care that have been specifically earmarked to address the wages gap issue. In the 2002/2003 federal budget, \$211.1m was provided over 4 years to 'close the wages gap'. Of this funding \$110m was dispersed over the next two years, yet despite that the wages gap has doubled (from \$84 per week when the initiative was introduced to \$170 currently). In the 2004/2005 Federal budget, \$877.8m (over four years) was again allocated to assist aged care providers to 'pay competitive wages'. Although receiving the funds was provisional on a number of conditions, there was no requirement for aged care providers to direct the extra funding towards paying higher wages and therefore not one of those conditions closed the wages gap. In 2010 the Australian Government has allocated a \$132 million aged care sector workforce package, and again we see that none of this money has been provided to address and close the wages gap.

The 2005 New South Wales aged care wages case in the New South Wales Industrial Relations Commission found that the use of 'creative accounting' methods by some aged care providers raised serious questions about claims of their inability to pay competitive wages.

The ANF is calling for the development of a mechanism to ensure the aged care sector achieves and maintains wage parity with the acute care sector; a mechanism that responds to changes in wage rates and is accommodated by an effective indexation system that provides employers with adequate funds when wage rises are negotiated. A mechanism which incorporates a transparent and accountable process/framework.

Wages and conditions must improve to attract nurses into the sector. More fundamentally, since there is an evidence base to show that more nurses in the skills mix lead to better health outcomes, the intensity of nursing care requirement should be linked to the ACFI scale and this may assist in achieving adequate provisioning for wages.

Recommendations

- 10 That the Australian Government close the wages gap between nurses and Assistants in Nursing, (however titled), working in aged care and their public hospital counterparts.
- 11 That dedicated funding is made available by the Australian Government to close the wages gap, and that provision of the funding is conditional on the achievement and maintenance of wage parity.

Separation of costs of care and costs of accommodation and funding accountability

The ANF is calling for a system that will monitor the funds provided for residential aged care to ensure that these funds are used to provide care to the residents of aged care facilities. Funding arrangements in residential aged care should include a transparent and accountable allocation for the health and aged care component. Accommodation and other 'extra' services as well as other funds should attract a separate allocation of funds that are accounted for independently.

Cost of care needs to be benchmarked and these care costs should be fully subsidised and separated from accommodation costs. Accessibility is an important aspect of accommodation costs and as such the maintenance of a basic subsidy for all is vital. The funding structures in aged care do not provide opportunities to be creative in brokering more needs based care and services.

It is therefore critical that we define direct and indirect care. Direct care has been defined as all nursing care activities performed in the presence of the patient and /or family. Indirect care has been defined as all nursing care activities done away from the patient but on a specific patient's behalf.³⁴

Transparent and accountable funding arrangements must be implemented. A single funding stream across the health and aged care services would help with prioritisation and access issues. Program managed funding is also a consideration for enabling greater equity and access to service provision. The Government must legislate for the annual reporting by aged care service providers as to how and where Government subsidies are spent.

The ANF recommends that to encourage increased transparency and efficiency in respect to the expenditure of Commonwealth funds that the Australian Government:

- require annual financial reporting by providers in respect to both operating budget and accommodation bonds
- require that a minimum proportion of Commonwealth subsidies (we propose 70%) be expended exclusively on nursing care, but higher expenditure if necessary to be compliant with the minimum staffing levels and skill mix tool
- establish benchmarks for other categories of expenditure to ensure consistency between providers (of like type and size) and regions
- develop a risk profile for providers and in each year undertake spot or unannounced financial audits of approximately 90 providers who are identified as being 'at risk'. Such an audit would measure financial health, measure expenditure against benchmark measures and compliance with bond management requirements
- monitor compliance with statutory obligations e.g. compulsory superannuation and industrial instruments, which may indicate 'at risk' providers. The Commonwealth should require providers to provide access to such information from the ATO and superannuation funds

To strengthen the capacity of small providers to provide improved quality of care the ANF recommends that the Commonwealth play a more active role at a regional level in resourcing and supporting small providers and those in networks of three or less facilities. The aim is to improve quality of care, reduce avoidable admissions to public hospitals and support staff in smaller facilities/networks. This could be achieved by DOHA establishing a number of regional support units in each state or the Commonwealth funding the state hospital networks to perform this role. This initiative is not a substitute for improved skill mix within each facility, but will provide additional expertise to managers and staff.

³⁴ *Nurses Economics, Jan-Feb 1996*. Comi McCloskey, J., Bulechek, G. M., Moorhead, S., Daly, J. Nursing Economics

Such support would include initiatives such as:

- regional nurse practitioners (to be piloted during 2011-2013 with funds from the 2010 Budget)
- specialist palliative care in-reach
- IT infrastructure and software support

The ANF considers that the current funding arrangements for aged are inadequate and that there needs to be an injection of government funds to adequately provide care and that any user pays portion is restricted to accommodation costs, is well regulated and means tested. Further, given the realities and anomalies of the current funding system, alternative funding arrangements will need to be investigated for example; there is merit in exploring a voluntary long term savings plan to fund aged care similar to the current superannuation arrangements.

It is the understanding of the ANF that the current ACFI classification and funding system was developed from a number of different options proposed to the Australian Government – Department of Health and Ageing (DoHA).

Once all the options were tested the final model was selected that included three domains of care – and three levels of Activity or options within a domain. Specifically, three levels of Activity of Daily Living; plus three (3) levels Behaviour; plus three (3) levels Complex Health category. We also believe there was another option that was rejected by DoHA at the time the ACFI tool was being developed, that included four levels in the 'base' ADL category.

It is the view of the ANF that it is now time to review the four levels of the base ADL category as the lowest level in this category was intended as a proxy for an accommodation charge as the person in this category would have minimal care needs but in all probability, an accommodation need. The implementation of a new base category would enable the *rolling-up* into the three (3) level ADL module with care costs for the final three level ADL domain.

The care and non care aspects that reflect grandfathering provisions from the previous funding tools carried over from the RCI and did not include PCAI (care indices), were combined into the total funding pool when the RCS system was developed and were continued to be incorporated into the ACFI funding model. The benefit is that ACFI does allow for a separation of the types of care (personal care, complex health, behavioural) as well as a split to be made around base costs (accommodation or hotel services) and care costs. It will also allow for this to be estimated on the basis of a low care and higher care person and combinations.

The ANF is of the view that the separation of care and non care costs is a viable alternative to the current funding model, that could easily be achieved by adapting the current ACFI tool. The calculation of the care and non-care costs from within the current ACFI funding model is required, using the assumption that non care costs are included in the ACFI funding system from the previous RCS and RCI systems.

A practical way of achieving this task would be to undertake a statistical analysis of the ACFI/RCS financial data, to determine the cost of things like the financial items related to the recurrent subsidy payment, the estimated contribution of these items compared to the subsidy payment and the relationship between subsidy related items and 'care' and 'hotel' services, including any possible variance relationship (varies independent of care, varies dependent on care, fixed and independent of care).

Once this analysis is completed it would be possible to determine an accommodation or non-care base cost (hotel services) for both low and high care residents. When the accommodation (hotel costs) have been estimated, the amount could be removed from across the ACFI ADL funding domain and placed in a separate module called the ACFI Accommodation Domain. This module could be categorised and calibrated for the type of resident classification (high and low care), accommodation models (supported residential services etc) and community care if required in future. A person assessed with ACFI may require minor modification for their care aspect.

If ACFI were to be included as a community aged care funding and care tool in a domestic setting, it could be adapted to have any type of health care payment reduced by a discount factor as the services will not be 24 hour coverage in a private home. Further a discount of payment could be varied against the ACFI domain funding amount to provide more flexibility (for example: ADL discount factor 50%; Complex Health discount factor 0%). The discount factor could then be calibrated on the current community care high care program models.

Once all these adjustment were made it would be possible for the ACFI to function as a care need and associated cost need predictor and funder. Depending on the accommodation the "fixed" level non care amount is then added to the ACFI care need funding figure to comprise the total recurrent subsidy payment.

To implement this approach there does not appear to be a huge fundamental change required to the current ACFI system. Care and Accommodation costs are separated in a national system that already exists. The approach can then be applied universally to all aged care and community care programs. The model will facilitate choice for older Australians in terms of their care and support options. The system can be calibrated on the existing support approaches and modelled extensively before introduction. The cost of the approach will be predictable and the levers are in place to allow government control over outlays as the population ages. Attached is a model for the proposed splitting of care and accommodation costs (**Attachment C**)

Recommendations

- 9 That the Australian Government determine a benchmark of the cost of care in aged and community care.
- 12 That the Australian Government legislates for the introduction of annual reporting on the way aged care providers spend their funding, particularly on care activities and staff.
- 13 That the funding arrangements for accommodation and care components of aged care services be accounted for separately, using the ACFI model.

Reporting on Aged Care Standards

The ANF seeks the development of professional guidelines by the Aged Care Standards and Accreditation Agency to be used as national benchmarks during accreditation. We believe that there should be education programs provided to auditors/assessors to ensure consistent application of these national benchmarks to ensure alignment of all processes, with the end result being to better ensure high quality care to our frail elderly citizens.

The ANF believes that there needs to be an independent Aged Care Complaints Commission with a presiding Commissioner who will report directly to the Minister for Ageing. The Aged Care Complaints Commission as an independent body needs robust powers imbedded in legislation and regulation.

Recommendations

- 14 That the aged care standards agency is required to use professional guidelines as benchmarks during accreditation.
- 15 That a national education program be developed by the Aged Care Standards and Accreditation Agency (ACSAA) to ensure consistent application of national benchmarks of their Accreditation Standards and Quality Care Principles to enable alignment of all processes, with the end result being to the assurance of high quality care to our frail elderly citizens.
- 17 That an independent Aged Care Complaints Commission be established with an Aged Care Complaints Commissioner appointed who will report directly to the Federal Minister for Ageing.

Occupational Health and Safety

Occupational health and safety (OHS) outcomes for workers in aged care should also be considered by the Productivity Commission in its review. Healthy and safe workplaces need to be one element of an appropriate aged care system.

The ANF considers that OHS risks in aged care are one significant reason for the decline in the numbers of registered and enrolled nurses employed in residential aged care. OHS hazards that place staff at risk invariably also place residents at risk, particularly issues related to violence / aggression and manual handling.

The following are significant areas of concern:

- Manual handling and violence and aggression are major problems in aged care.
- Lack of staffing and inappropriate skill mix increase the risk of injury arising from these hazards. For example, there is frequently insufficient staff to safely restrain violent or aggressive residents or to undertake an adequate duress response if required.
- Duress equipment is often unsuitable, does not have person-down or location finding capability and may be rendered ineffective as there is no adequate internal or external response capability should an emergency situation arise.
- Lack of consultation and the failure to conduct risk assessments before changes are made to staffing levels, skills mix and systems of work impacts on risks arising from manual handling and violence and aggression.
- Inadequate or inappropriate admissions policies which result in admission of residents whose complex needs cannot be safely met by the receiving facility, particularly in relation to severe challenging behaviour resulting in staff and other residents being placed at risk.

The current accreditation standard relating to OHS (item 4.5 of the Accreditation Standards) is incapable of ensuring a safe and healthy working environment for aged care staff. The bulk of post-incident investigations undertaken by unions identify significant areas of OHS non-compliance in organisations who have achieved compliant status for this standard in their latest accreditation audit.

The ANF considers that compulsory benchmarks need to be set in relation to occupational health and safety and the way they are assessed needs to be improved to ensure legislative compliance and to promote pro-activity and continuing improvement. For example, the evidence base and verification process need to be improved to ensure that compliance with OHS legislation, consultation and risk management provisions conform to current requirements.

Independent accreditation bodies assessing aged care facilities against these standards (eg. the Aged Care Standards and Accreditation Agency) should ensure that their assessors are well trained in OHS legislative requirements and have the skills and knowledge to adequately assess the benchmarks. An alternative would be for the Agency to enlist expert assistance from the relevant OHS regulator to assist in assessment of this specialist area.

Recommendation

- 16 That compulsory benchmarks are federally legislated by the Australian Government in relation to occupational health and safety in residential and community aged care.

Conclusion

Reform of Australia's aged care system is the key to meeting the care needs of a growing population of older Australians. Containing costs will be essential, as will enabling more older Australians to remain in their own home and communities.

Residential care will remain a reality for many Australians., The care these frail elderly citizens receive must be delivered by a skilled and sufficient workforce and by an industry that is well resourced and accountable.

Regardless of where they reside, as a well resourced country, Australia must place the care of the oldest members of our society as a priority.

Accordingly, through the foregoing submission the ANF has presented compelling evidence that the profile of the elderly in the community and in aged care facilities is one of increased numbers of older, frailer people with complex care needs including complicated medicines regimes. The case has been made in this paper for the Australian Government to intervene to ensure that the care of these elderly people is undertaken by sufficient numbers of qualified nurses and other aged care workers, to provide safe and competent care. The ANF argues that essential elements to achieve this are the implementation of a workload management tool which determines care needs, staffing skill mix, staff numbers, and concomitant funding; and a minimum safe staffing ratio system.

Other components which will lead to improving the care of older people are: addressing excessive workloads, unnecessary documentation and lack of professional development opportunities helps improve retention, facilitated through: flexibility in rostering hours, time off from work to study, and financial assistance to cover incurred costs; promoting workplace safety and cultural sensitivity; and encouraging a better work/life balance.

The ANF looks forward to continuing dialogue with the Productivity Commission and attending the hearings to further elaborate on the issues outlined in our submission.



CORONERS REGULATIONS 1996

Form 1

State Coroners Office
 57-83 Kavanagh Street
 Southbank 3006
 Telephone: (03) 9684 4380
 (All Hours)
 Toll Free: 1300 309 519
 (Only Country Victoria)
 Fax: (03) 9682 1206

Case No: 4545/05

RECORD OF INVESTIGATION INTO DEATH

I, **AUDREY JAMIESON**, Coroner,

having investigated the death of ANNUNZIATA FEDELE with Inquest held at the Coroners Court, Coronial Services Centre, Southbank on 20 August 2007, 21 August 2007 and 31 January 2008, **find that** the identity of the deceased was **ANNUNZIATA FEDELE** and that death occurred on **12 December 2005** at the **Royal Melbourne Hospital** from:

1(a). HYPOXIC BRAIN INJURY DUE TO ASPIRATION OF FOOD

in the following circumstances:

Mrs Annunziata Fedele was admitted to the Royal Melbourne Hospital from Villa del Sole Hostel, a supported accommodation facility in Glenroy, subsequent to choking on a sandwich. She died the following day.

The death of Mrs Fedele was *reportable* as defined in the *Coroners Act 1985*.¹

The investigation into Mrs Fedele's death raised issues in relation to her supervision and the level of training and competence of staff at the facility. An Inquest was held under section 17(2) *Coroners Act 1985*.²

¹ "reportable death" means a death-

- (a) where the body is in Victoria; or
- (b) that occurred in Victoria; or
- (c) the cause of which occurred in Victoria; or
- (d) of a person who ordinarily resided in Victoria at the time of death-

being a death-

- (e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or.....

- (i) of a person who immediately before death was a person held in care; or.....

² s.17(2) A coroner who has jurisdiction to investigate a death may hold an inquest if the coroner believes it is desirable.

BACKGROUND CIRCUMSTANCES:

Mrs Annunziata Fedele was also known as "Nancy" Fedele. She was 58 years old at the time of her death. Mrs Fedele suffered from frontal lobe dementia. She was unable to effectively communicate. She did not speak.

Mrs Fedele had lived at the Villa del Sole Hostel since 28 October 2003. Villa del Sole is a 52 bed aged persons low level care facility, at 73 William Street, Glenroy. The Hostel is dedicated to members of the Italian community. The staff at Villa del Sole include registered nurses in Division 1 and 2 of the Register and personal carers also known as Personal Care Attendants / Personal Care Assistants) with Certificate 3 in Community Services (Personal Care). All personal carers working at the Hostel had basic first aid training.

After her admission to the Hostel, Mrs Fedele's condition continued to deteriorate. She developed behavioural problems including an obsessive eating habit which included stealing other resident's food and "shovelling" or gorging food into her mouth but without any recorded incident of choking. An assessment of Mrs Fedele's eating and nutrition needs on 1 August 2005, noted no difficulties with chewing or swallowing however, the Hostel was concerned about its ability to provide for her increasing needs and deteriorating condition. She was requiring full supervision at all times which the facility felt unable to provide.

On 5 August 2005, the Hostel wrote to the Aged Care Assessment Service requesting that Mrs Fedele be assessed for relocation to a high level care facility.

On 10 October 2005, Mrs Fedele was assessed by North West Aged Care Assessment Service (NWACAS) as requiring transfer to a high level care facility. The report of Olwyn Backhouse, Social Worker/Aged Care Consultant, recommended that Mrs Fedele be transferred to Ward AC1 at Royal Melbourne Hospital - Royal Park Campus so she could be *assessed in another environment for a longer period to establish where her care needs would best be met.*

The recommendations were discussed with Mrs Fedele's daughters, Adrianna Zurzolo and Ornella Guerra.

Mrs Fedele's behaviour continued to deteriorate.

On 14 November 2005, Villa del Sole implemented 1:1 supervision of Mrs Fedele during the day.

Ms Zurzola and Ms Guerra rejected NWACAS recommendation for assessment to occur at the Royal Park Campus and were seeking alternative residential accommodation for their mother.

Villa del Sole continued to liaise with NWACAS and Mrs Fedele's family regarding alternative living arrangements.

SURROUNDING CIRCUMSTANCES / HOW DEATH OCCURRED:

On Sunday 11 December 2005, Villa del Sole Hostel was staffed by Personal Care Attendants (PCAs) Frank Reginato - acting as Team Leader, Grace Gavillucci and Amilia Carlone. PCA Carmel Jacobs was employed through an Agency, called "Alpha", to provide 1:1 care to Mrs Fedele.

Villa del Sole did not employ Registered Nurses at the weekends.

At around midday, the Hostel residents were seated in the dining room for lunch. PCA Jacobs sat with Mrs Fedele at a table while she ate bread and soup for her lunch.

At approximately 12.10pm, PCA Gavillucci relieved PCA Jacobs from her supervision of Mrs Fedele. PCA Gavillucci sat down at the table with Mrs Fedele.

Around the same time, PCA Frank Reginato was in the dining room performing the medication round. PCA Amilia Carlone was also in the dining room, cleaning up around the tables.

At approximately 12.20pm, PCA Reginato approached Mrs Fedele to administer her medication. He noticed that she had food in her mouth. Anxious to complete his medication round, he gave the medication cup to PCA Carlone and requested that she attend to the administration of Mrs Fedele's medication. As PCA Carlone approached Mrs Fedele's table she noticed that Mrs Fedele was staring blankly and had a piece of bread hanging out of her mouth. PCA Gavillucci noticed Mrs Fedele staring at the same time. Mrs Fedele was not coughing or making any discernible noise.

PCA Carlone alerted their team leader, PCA Reginato. PCAs Carlone, Gavillucci and Reginato decided to remove Mrs Fedele from the other residents in the dining room to facilitate removing the food from her mouth. They assisted Mrs Fedele to walk to the office, approximately 20 paces from where she had been seated. Mrs Fedele walked to the office without apparent difficulty.

Once in the office, Mrs Fedele was seated in a chair. PCA Reginato attempted to open Mrs Fedele's tightly clenched jaw to remove the bread that was visibly protruding from her mouth. He was unable to open her jaw and she did not respond to his requests to open her mouth. Mrs Fedele's condition noticeably deteriorated - her body appeared to go tense, she *started to turn blue* / appeared cyanosed. The staff recognised that she was choking. PCA Reginato directed PCA Carlone to call for an ambulance.

At 12.31pm³ Emergency Services received the call from PCA Carlone requesting ambulance assistance. A Broadmeadows Ambulance crew consisting of Paramedics Bobby Jennings and Grant MacGregor were dispatched at 12.33pm. A Mobile Intensive Care Ambulance (MICA) was dispatched at the same time. The call taker remained on the telephone while the ambulance was in transit. PCA Carlone was distraught - screaming at the call taker to help them. She stated:

³ the exact time was 12.31 and 43 seconds

*I was panicking a little bit and the operator was trying to get me to calm down so I could explain what was going on.*⁴

PCA Reginato directed PCA Carlone to go outside to wait for the ambulance to arrive. PCA Gavillucci took up the communication with the Emergency call taker. PCA Gavillucci was asked questions about Mrs Fedele's conscious state, and whether a pulse and respirations were still present. She conveyed the questions to PCA Reginato who remained at Mrs Fedele's side, attempting to take the bread from her mouth and patting her on the back. PCA Reginato replied that her pulse and respirations were present but *very faint*. The call taker instructed PCA Gavillucci to keep Mrs Fedele sitting upright in the chair with her head tilted back. PCA Reginato stated:

*Nancy was still conscious with her eyes opened but after a short amount of time she all of a sudden slumped back in her chair where she was sitting and there was no more reaction from her until the ambulance arrived.*⁵

The Broadmeadows Ambulance crew arrived at Villa del Sole at 12.38pm. They entered the office area to find Mrs Fedele held upright in her chair but not breathing. She was lowered to the floor and paramedics began to clear her airway of the food matter.

Once her airway was cleared ventilation was commenced. Paramedics were unable to detect a pulse. The Electrocardiogram (ECG) showed Electro Mechanical Dysfunction (EMD). Cardio-pulmonary (CPR) was commenced.

At 12.51pm the MICA crew arrived at Villa del Sole. The MICA paramedics achieved Intravenous access and intubated Mrs Fedele. A cardiac output was re-established.

At 1.23pm Mrs Fedele was loaded into an ambulance and transported to the Royal Melbourne Hospital, arriving at 1.40pm. On arrival in the Emergency Department Mrs Fedele's pupils were noted to be fixed and dilated, she was making some respiratory effort and was haemodynamically stable. She was transferred to the Intensive Care Unit (ICU) with a diagnosis of *cardio respiratory arrest likely secondary to aspiration, with a background diagnosis of frontal lobe dementia. She sustained hypoxic brain injury from this arrest.*⁶

There were no signs of neurological improvement over the following 24 hours. Following consultation with the family, palliative care was initiated. Mrs Fedele was extubated at 6.00pm on 12 Decemeber 2005. She died shortly thereafter at 7.17pm.

⁴ See Exhibit 9

⁵ See Exhibit 4

⁶ See Statement of Dr Alison Hickman dated 12 April 2006, contained within Exhibit 14 (Balance of the Inquest Brief).

THE ROLE OF THE CORONER:

The statutory role of the Coroner is prescribed in the *Coroners Act 1985*. It is a role that is investigative and inquisitorial rather than adjudicative and adversarial, that is, the role most often associated with judicial officers. Coroners are required to investigate matters in their jurisdiction and, in the case of death, determine the identity of the deceased, how the death occurred, and the cause of death and the particulars needed to register the death.

The primary function is to direct the investigation into and make findings concerning the relevant facts. It is not the role of the Coroner to lay or apportion blame, but to establish cause.

In appropriate circumstances a Coroner may exercise a secondary function by commenting on any other matter connected with the death under investigation including issues related to public health or safety or the administration of justice.

A Coroner is not permitted to include in a finding any statement that a person is or may be guilty of an offence. Similarly, it is not the role of the Coroner to make any specific findings on whether there has been any negligence giving rise to the death under investigation.

However, a Coroner may report to the Attorney-General on a death which she/he has investigated or make recommendations to any Minister or statutory body on any matter connected with or similar to the death and a Coroner must report to the Director of Public Prosecutions if she/he believes that an indictable offence has been committed in connection with the death.

INVESTIGATIONS:

(a) An Objection to Autopsy (section 29 *Coroners Act 1985*), was lodged by Adriana Zurzolo, daughter of Mrs Fedeles. The application was accepted.

(b) Dr David Ranson, Forensic Pathologist and Deputy Director of the Victorian Institute of Forensic Medicine, performed an external examination and review of available records. In the circumstances, Dr Ranson attributed the cause of death to hypoxic brain injury due to the aspiration of food but also commented that in the absence of a full post mortem examination, he could not unequivocally exclude the presence of potentially significant disease processes or injury that could have contributed directly or indirectly to death.

(c) The Police Brief of Evidence contained a number of witness statements. Some of the statements raised issues about the supervision of Mrs Fedeles and the capacity of the rostered staff to deal with a medical emergency.

(d) Additional information was sought from the Manager of Villa del Sole. The information was not forthcoming.

An Inquest was not mandated by the Act.⁷ Mrs Fedele was not *a person held in care*⁸ however, I considered it *desirable* in the circumstances to hold an Inquest when regard was had for some issues identified by the investigation. In addition, the failure of the facility to respond, in a timely manner, to a request for information, left a gap in the investigation. Furthermore, I also considered Mrs Fedele's reliance on her carers, by virtue of her condition, to be analogous to that of *a person held in care*.

THE INQUEST:

In *Harmsworth v The State Coroner*⁹ Justice Nathan broached the subject of the limits of a coroner's power and observed that the power of investigation is not *free ranging*. Justice Nathan commented that unless restricted to pertinent issues an Inquest could become wide, prolix and indeterminate. He stated:

Such an Inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death.... Such an Inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.

At the outset of the Inquest, I stated that it was not necessary for the purposes of my investigation, to receive evidence about Mrs Fedele's behavioural problems other than her eating problems. The particular issues for the Inquest to explore were all linked to Mrs Fedele's eating problems - how they were managed by the facility, how effective was her supervision and how she was managed once she got into difficulty as a result of those eating problems.

I also accepted that Villa del Sole had put a system in place to address Mrs Fedele's eating problems by employing a PCA specifically to provide individual supervision of Mrs Fedele.

⁷ s.17(1)A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and-

- (a) the coroner suspects homicide; or
- (b) the deceased was immediately before death a person held in care; or
- (c) the identity of the deceased is not known; or

⁸ "person held in care" means-

- (a) a person under the control, care or custody of the Secretary to the Department of Human Services; or
- (ab) a person-
 - (i) in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or
 - (ii) in the custody of a member of the police force; or
 - (iii) in the custody of a protective services officer appointed under the Police Regulation Act 1958; or

(b) a patient in an assessment or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968;

or

- (c) a patient in an approved mental health service within the meaning of the Mental Health Act 1986;

⁹(1989) VR 89

Viva voce evidence was obtained from Marivien Ciceron, Manager, Villa del Sole Hostel, PCA Frank Reginato, PCA Grace Gavillucci, PCA Amilia Carlone, PCA Carmel Jacobs, Paramedic Bobby Jennings, Paramedic Grant MacGregor, Ian Bruce Hyatt, Manager, Quality Review Team, Metropolitan Ambulance Service.

Having previously accepted that the Hostel had a system in place to supervise Mrs Fedele, I also accept that it was in place that day. PCA Jacob was employed for that purpose. I also accept that *there was a seamless transition from one carer to another* when PCA Gavillucci relieved PCA Jacobs so she could have her own lunch break. How Mrs Fedele managed to "gorge" her sandwich so as to bring about choking is not clear. The adequacy of the supervision maybe questionable however, the gorging of itself was consistent with her eating problems and I accept that she did not have an opportunity to appropriate bread from another resident. I have no reason to doubt the evidence of PCAs Gavillucci and Jacobs.

The PCAs did recognise that Mrs Fedele was in some difficulty. Their decision to remove Mrs Fedele from the dining area was made with the best of intentions for Mrs Fedele and for the other residents of the Hostel. At that point in time it was not apparent to the PCAs that Mrs Fedele's condition maybe life threatening.

Once in the office, Mrs Fedele's condition rapidly deteriorated. PCA Reginato had been trying to remove the food from Mrs Fedele's mouth but when she started to turn blue he recognised the need for additional medical assistance. There were no nurses on the premises that could be called upon to provide that assistance. PCA Reginato thus directed that Emergency Services be called. Once on the telephone and providing direction, PCA Reginato followed the call takers instructions. He did not attempt any additional first aid measures but deferred to the expertise of the Emergency Services call taker.

The evidence of PCA Reginato and PCA Gavillucci were consistent in relation to the instructions they were given by the call taker - to keep Mrs Fedele sitting upright with her head tilted back. Early on into the call, while PCA Carlone was still on the telephone, the call taker was going to provide instructions on how to perform a Heimlich manoeuvre¹⁰ but did not follow through with this instruction once PCA Gavillucci took over, advising the call taker that Mrs Fedele was unconscious and her breathing was faint. Throughout the call, the instructions to the PCA remained the same. They were not instructed to attempt a Heimlich manoeuvre or initiate cardio-pulmonary resuscitation.

When Ambulance Paramedics Jennings and MacGregor arrived at the Hostel it appeared to them that nothing had been done to try to assist Mrs Fedele. She was in a state of cardio-pulmonary arrest while being held upright in a chair. It appeared that no first aid had been administered or attempted. They were unaware that the PCAs had been following instructions from the call taker. They were not aware of all of the surrounding circumstances when they prepared their statements for the purposes of this investigation. The "tone" of their statements was understandable in the circumstances.

Paramedics Jennings and MacGregor were in Court when the PCAs gave evidence. Paramedic MacGregor conceded that they do not always get a *correct story* when they arrive

¹⁰ See Exhibit 15 @ p.2 of Transcript of the Emergency call.

at a critical situation. His impression of the surrounding events changed after hearing the evidence of the PCAs.

The evidence of Paramedic Jennings also highlighted the difficulty she experienced in clearing Mrs Fedele's airway despite her extensive experience and having the benefit of equipment in the form of Macgills forceps, a laryngoscope and suction to assist her with the process. Ventilation could not be achieved until Mrs Fedele's airway had been cleared of the food boluses and this took Paramedic Jennings 2 attempts before she could adequately provide ventilation, delivering 100% oxygen to Mrs Fedele.

The other apparent cause for concern / criticism made by the Paramedics in their respective statements, related to the behaviour of the PCAs while resuscitation attempts were underway. I was left with the distinct impression that the PCAs and in particular, PCA Reginato, impeded the Paramedics ability to administer medical attention to Mrs Fedele. This impression was dispelled upon hearing from Paramedics Jennings and MacGregor.

Having the benefit of hearing from PCAs Reginato, Gavillucci and to a lesser extent, PCA Carlone who was still clearly affected by the events of 11 December 2005; and from Paramedics Jennings and MacGregor it became apparent that the instructions from the call taker to the PCAs needed to be examined.

To that end, the Inquest was adjourned. A copy of the recording of the call, the transcript of the call and operating manual / procedures were requested from MAS. The Inquest resumed on 31 January 2008.

Mr Ian Hyatt, Manager of the Quality Review Team of the Metropolitan Ambulance Service (MAS) appeared to provide information regarding call taker instructions. From an historical perspective, Mr Hyatt informed the Court that MAS commenced a structured call taking system at the end of 1996. The system is used in over 3000 emergency systems worldwide. Version 10.2 was in place at the time of Mrs Fedele's death. Version 11.3 came into operation in August 2007 following suggestions by the Australian and New Zealand Standards Council. Version 11.3 included changes to the "Choking" instructions. Version 10.2 instructions directed that there be no interference with the airway in the partial choking situation where breathing was still evident. The instructions would have changed if the call taker had been advised that Mrs Fedele was not breathing. The Heimlich manoeuvre was not warranted because the call taker was advised that Mrs Fedele was unconscious but still breathing. The call taker gave instructions in accordance with Version 10.2. An ambulance was dispatched promptly. The instructions in the new version are more reliant on the conscious state of the patient. If the patient is described as unconscious or beginning to faint, the call taker instructs for the patient to be placed on their side and the airway to be cleared.

Version 11.3 also has a tool built within the system that can count the respirations of the patient which assists the call taker to identify if further immediate action, such as artificial respirations, is required. An ambulance is despatched immediately the words "choking" are used to describe the incident.

Mr Hyatt provided additional general information regarding call takers - that they are employed by the Emergency Services Telecommunication Authority (ESTA), they are not

medically trained but first aid trained. The first aid training includes emergency choking situations and this was the case also in 2005. The system used by the Emergency call taker is accessed via the call taker's computer to the program which guides the call taker by answers to questions, depending on the nature of the request for assistance.

Mr Hyatt informed the Court that the ESTA had reviewed the call and found that the call taker had complied with the instructions prescribed in Version 10.2. He was also prepared to express an opinion that had Version 11.3 been in place on 11 December 2005, the outcome may have been different. Mr Hyatt stated that Mrs Fedele's faint respirations, as identified by the PCAs may have in fact been agonal breathing. The respirations tool in Version 11.3 assists in identifying agonal breathing compared to true respirations, and responds by directing the caller to adopt alternative measures-an obstructive airways manoeuvre, if the patient is conscious, to attempt to dislodge the obstruction, such as the bread in Mrs Fedele's case. However, as Mrs Fedele was unconscious for almost the duration of the 7 minute call, the alternative instructions to the caller, if the "faint respirations" had been identified as agonal breathing, would have been to clear the airway and commence CPR.

The evidence of the Ambulance paramedics was that the airway was difficult to clear even with the benefit of their emergency equipment.

Ultimately, the evidence was equivocal on whether Version 11.3 would have made any difference to the outcome. The application of the Heimlich manoeuvre in a choking situation has a limited time frame. The patient must be conscious but not breathing.

The facts remain, Version 10.2 was in place at the time.

Comment:

PrimeLife have implemented some changes to their practises and procedures in response to Mrs Fedele's death.

A Registered Nurse is now rostered to work on weekend shifts.

I acknowledge this action as a positive response by Villa del Sole to Mrs Fedele's untimely death. As a Hostel providing low level care with a "degree"¹¹ of supervision, the presence of Registered Nurses was not, and is still not, mandated. The absence of Registered Nurses - a regulated profession - is not readily understood by reference to "high level care" and "low level care" beds or indeed "hostel" / "nursing home". The "degree" of supervision may vary between the differently classified facilities but what is common to them is a class of people who are otherwise unable to independently attend to their activities of daily living and who are reliant upon others to supervise and come to their aid in the event of a medical emergency. In the delivery of services to this reliant, vulnerable and increasingly dependant

¹¹ As used by Ms Magee of Counsel in final submissions.

group of people there is a compelling argument in my opinion, for all of these facilities - regardless of what we call them - to have registered nurses on the premises on every shift.

The presence of Registered Nurses would help to support the residents of these facilities and the personal carers who increasingly, are the group of employees providing the majority of care in the aged care setting. PCAs do have a level of training and in this case, Villa del Sole has demonstrated a commitment to ongoing education of its staff by providing first aid training through MAS however in the absence of regulation there lacks, in general terms, an ability to monitor the standard of delivery of care. PCAs receive basic training which does not empower PCAs to deal with a medical emergency. PCA Carlone's response to the critical situation is an example of how disempowered the carer can be when faced with a medical emergency.

Although mindful of the limitations of my jurisdictional role, I have recently made similar general comments in relation to a matter involving the maladministration of medication by a PCA in a Hostel setting.¹²

APPLICATION OF LEGAL PRINCIPLES:

On many occasions, the Supreme Court of Victoria has emphasised that the test expounded in the matter of *Briginshaw v Briginshaw* should apply to findings of causation and contribution where the questions relate to individuals or other entities *acting in their professional capacity*.¹³ In *Briginshaw* Justice Dixon stated:

*The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matter 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, on indirect references ...*¹⁴

The test is applicable where the performance of a medical practitioner or other health care provider is under scrutiny. Any finding in relation to causation is a matter of great seriousness. In December 2007, The Victorian Court of Appeal in *Clark v Stingel*¹⁵ confirmed that this *seriousness* must be considered when applying the appropriate standard of proof. Their Honours Chief Justice Warren and Chernov and Kellam JJA stated:

...the matters to be considered by the tribunal of fact may be of such seriousness that strong evidence - clear and cogent - may be required before reasonable

¹² See *Record of Investigation into the Death* of Kathleen Joyce Barnes - Case No: 3662/03

¹³ (1938) 60 CLR 336

¹⁴ See also *Anderson v Blashki* (1993) 2 VR 89; *Health and Community Services v Gurvich* (1995) 2 VR 69 and *Chief Commissioner of Police v Hallenstein* (1996) 2 VR 1.

¹⁵ [2007] VSCA 292

*satisfaction that the allegations have been made out can be attained on the balance of probabilities.*¹⁶

In *Chief Commissioner of Police v Hallenstein* Justice Hedigan concluded that the principles in relation to causation in cases of negligence are applicable to the concept of death in coronial proceedings. He stated:

For an act or omission to be the cause, or one of several causes, of a death the logical connection between the act and /or omission and death must be logical, proximate, and readily understandable; not illogical, strained or artificial. In theory it is a difficult complex concept, but one which in my view is manageable in practice.

In final submissions, Ms Magee referred me to the matter of *Gurvich* and in particular to page 79 of the judgement where Justice Southwell stated:

That to say to professional people that they have contributed to the cause of death of another person in the course of their professional duties is to make a very serious allegation, an allegation of negligence that by breach of professional duty owed to the deceased they contributed to the death.

Such a finding - an adverse finding, is not to be made lightly. Amendments to the Act have removed the requirement to make a specific reference to *contribution* but at times it is unavoidable. Similarly, although it is not the role of the Coroner to make specific findings of negligence it can unavoidably be implied particularly when the professional persons duty to the deceased has been breached in some way.

In relation to the three PCAs responsible for managing Mrs Fedele's critical incident, Ms Magee submitted, again referring to Justice Southwell in *Gurvich* :

The effect of a finding would be so devastating that no such adverse finding should be made unless there exists a comfortable satisfaction that negligence has been established which contributed to the death.

FINDINGS:

I find that **Annunziata Fedele** died from hypoxic brain injury due to aspiration of food. The cause of the aspiration of food is directly linked to the eating problems Mrs Fedele developed, consequential of the progression of her frontal lobe dementia. Hypoxic brain injury occurred despite attempts by her carers to remove food from her mouth and despite their diligence in following the instructions of the Emergency Services call taker.

I make no adverse finding in relation to PCAs Reginato, Gavallucci or Carlone. In the absence of professional trained expertise on the premises, they acted appropriately in the circumstances. The presence of a Registered Nurse may have altered the management of the situation but I cannot conclude on the evidence that it would have altered the outcome.

¹⁶ Op cit @ paragraph 37

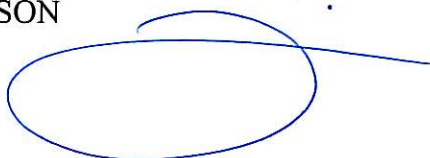
I make no adverse finding in relation to the Emergency Services call taker who responded professionally in the face of a certain level of hysteria and in accordance with procedures in place at the time.

I find that the Ambulance Paramedics Jennings and MacGregor acted swiftly to remove the food obstructing Mrs Fedele's airway and that in all probability, the hypoxic brain injury which caused Mrs Fedele's death, had already occurred prior to their arrival at Villa del Sole Hostel.

I make no recommendations in this matter as I am satisfied that Villa del Sole has responded appropriately to Mrs Fedele's tragic death.

I repeat the more general recommendations I made in Case No: 3662/03 for a review by the appropriate Ministers and professional organisations to introduce a system of regulation for Personal Care Attendants.

AUDREY JAMIESON
CORONER
28 April 2008



APPEARANCES:

Senior Constable Matt Watts / Senior Constable King Taylor - Assisting the Coroner
Ms A. Magee of Counsel on behalf of PrimeLife Corporation (Minter Ellison)

DISTRIBUTION OF FINDING:

The family of Annunziata Fedele - Adrianna Zurzolo and Ornella Guerra
PrimeLife Corporation.
Department of Human Services
Minister for Health (Victoria)
Department of Health and Ageing

09-089809



CORONERS REGULATIONS 1996

Form 1

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1st April, 2008
 Case No: 3662/03

RECORD OF INVESTIGATION INTO DEATH¹

I, **AUDREY JAMIESON**, Coroner,

having investigated the death of **KATHLEEN JOYCE BARNES** with Inquest held at the Coronial Services Centre, Southbank on 9 October 2006 and 10 October 2006, find that the identity of the deceased was **KATHLEEN JOYCE BARNES** and that death occurred on **30 October 2003**, at Box Hill Hospital from:

1(a) ACUTE MYOCARDIAL INFARCTION IN A LADY WITH ISCHAEMIC HEART DISEASE DUE TO CORONARY ARTERY ATHEROSCLEROSIS FOLLOWING ADMINISTRATION OF NIFEDIPINE, ATENOLOL, TRAMADOL, CALTRATE, ASPIRIN AND TELMISARTAN

CONTRIBUTING FACTORS

2. BRONCHOPNEUMONIA

in the following circumstances:

On 27 October 2003, Kathleen Joyce Barnes was administered the wrong medication. She later became bradycardic and hypotensive necessitating transfer to Box Hill Hospital. Her condition gradually deteriorated and she died on 30 October 2003.

¹ The Record of Investigation / Finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon includes statements and documents tendered in evidence together with the Transcript of Proceedings. The absence of reference to any particular piece of evidence either through a witness or tendered document does not infer that it has not been considered.

The following model is proposed for splitting care and accommodation in the ACFI System

A. Accommodation Domain (ACFI-A)

Step 1 – create an ACFI Accommodation Domain (ACFI-A)

- analyse existing data from care providers together with ACFI/RCS profiles
- determine an agreed accommodation domain costing
- determine if the accommodation amount varies with the type of person supported (e.g. low or high care). Include if variation statistically significant.

Table 1: ACFI-A Classifications

ACFI-A Classification	Accommodation/Hotel Subsidy (theoretical only)
Low Care person (ACFI determined)	\$30 per day (theoretical - to be determined)
High care person (ACFI determined)	\$40 per day (theoretical - to be determined)
Supported accommodation person	\$15 per day (theoretical - to be determined)
Community Care person (domestic environment)	Not eligible for this payment (to be further considered)

B. Care Domain (ACFI-C) Calculations

Step 2 – create an ACFI Care only funding allocation (ACFI-C). This would be achieved by removing the ACFI-A funding amount from the total ACFI funding pool (most likely from the ADL layer).

Table 2: ACFI-C Classifications

ACFI-C Domain	Category (e.g.)	Funding Calculation	
		Living in Residential Care	Living in Domestic Setting
ADL	C	\$ amount	\$ amount x discount factor ¹
Behaviour	A	\$ amount	\$ amount x discount factor ¹
Complex Health	C	\$ amount	\$ amount x discount factor ¹
Total ACFI-C funding		\$ ACFI-C total funding	\$ ACFI-C total funding x discount factor ¹

¹ To be determined from calibration with current high level community care programs

C. Total Funding (ACFI-F) Calculations

Step 3 – The total funding for an individual will then equal the = ACFI-A + ACFI-C. The ACFI-C funding would be discounted for people living in community care.