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Productivity Commission - Caring for Older Australians

ANF Submission in reply

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ANF submission in reply

Thank you for the opportunity to present the final submission of the Australian Nursing Federation on the *Caring for Older Australians*, Productivity Commission Draft Report.

The Australian Nursing Federation relies on our original submissions provided to the Productivity Commission as background to our recommendations in this final submission.

The Australian Nursing Federation broadly supports many of the recommendations in the draft report, and this submission provides our feedback on those issues, as well as recommendations in key areas which are:

1. Providing an industrial mechanism to fix the wages gap (which will assist with recruitment and retention of workers to this industry); and boost levels of service delivery;
2. The implementation of a skills mix and staffing level tool (including a preamble on why the need for nursing in aged care);
3. A national system of licencing of assistants in nursing in aged care, ensuring the protection of residents and consumers;
4. Medication management;
5. Response to the Gateway;
6. Access and equity;
7. Accommodation and care;
8. Removal of high care/low care distinction
9. Role of Nurse practitioners in aged care;
10. Teaching in residential aged care facilities

The ANF will be providing direct evidence on each of the above main points during the public hearings, predominately from registered nurses, enrolled nurses and assistants in nursing in aged care who have the experience and expertise of working in this sector.

Closing the wages gap / Comparable wages

The ANF believes that the Productivity Commission draft report recognises the issues associated with the adequacy of the aged care workforce and the levels of pay and working conditions. However, whilst the draft report recognises that the current remedy for these issues such as pay equity applications and low paid bargaining will not provide the outcome necessary to fix the problem of low pay in aged care, the report fails to set out any clear direction on how to remedy this problem in the near future.

On February 14 2011, the Hon. Mark Butler MP, Minister for Ageing, said:

The wages gap for all occupations in aged care, whether residential or community is significant. That is obviously not only an issue of fairness and equity for those who work in this incredibly important sector, but it's also an issue of being able to recruit and retain the adequately trained workers we need to provide the quality care that we expect older Australians to receive.

I know, talking to consumers and their families and doctors, that the continuity of care you get from people who are willing to work in a residential care facility for years upon years doesn't have a price. It's incredibly important to the sort of care that we're able to provide our residents. Continuity of care, fairness and the capacity to recruit and retain an adequate workforce are all wound up very clearly with this question of wages. You'll be pleased I imagine that the Productivity Commission as a start has recommended as a draft recommendation that funding for aged care be based on the notion of competitive wages, and specifically mentioned the gap between residential care nurse wages and wages paid to nurses in the public hospital system.

We also know it's very important to pay regard to the skills mix in aged care, residential and community. We know, if you've been going to aged care facilities as I have for a couple of decades that the acuity mix, the complexity of needs of the average resident in a residential facility has changed dramatically over the last couple of decades and it will continue to change over coming years.

This requires a highly skilled workforce, both nurses and PCA's and additionally some support workers as well, will need to have very broad and deep ranges of skills to be able to provide the quality of care that we expect.

1. ANF PROPOSAL - INDUSTRIAL MECHANISM TO FIX THE WAGES GAP

Competitive Wages

The Productivity Commission has recommended the Australian Aged Care Regulation Commission should take into account the need to pay competitive wages to nursing and other care staff when assessing and recommending schedule care prices.

ANF supports this recommendation and believes that the provision of competitive wages needs to be made available by way of a transparent and enforceable industrial instrument.

Discussion

The ANF supports a pricing and funding structure that allows aged care employers to compete for labour for nurses and other care staff.

An ability to offer and maintain remuneration levels is fundamental to competing in the labour market.

Competitive wages would assist in the recruitment and retention of staff thereby providing for a more stable and committed workforce, a workforce which could better collaborate with providers in support of changes that would enhance the efficiency and effectiveness of the sector.

ANF views competitive wages as wages comparable to those payable to similar workers in the public and private hospitals sectors.

While ANF supports recommendations that are intended to enhance the capacity of providers to compete for labour we believe that transparency, accountability and the acquittal of such funds needs to be delivered by way of industrial instruments.

The ANF proposes that the industry confer to develop a national industrial framework which would commit the parties to support industry wide efficiencies and other changes that would improve resident care and service delivery. The national industrial framework would specify the wages to be paid to nurses and other care staff with such wage rates to be expressed in enterprise agreements between providers, nurses and care staff.

- Recommendations** The Productivity Commission has recommended the Australian Aged Care Regulation Commission should take into account the need to pay competitive wages to nursing and other care staff when assessing and recommending schedule care prices.
1. The ANF supports this recommendation and believes that the provision of competitive wages needs to be made available by way of a transparent and enforceable industrial instrument.

Additional Materials Attachment 1 to this submission is a draft national framework agreement prepared by the ANF that provides a transparent industrial mechanism to address the wages gap for nurses and other care staff.

Attachment 2 to this submission is the estimated costs for closing the wages gap for nurses and other care staff as at 1 January 2011. The costs include annual projected costs for maintaining wages parity. Also attached are the projected costs for 2012.

2. ANF PROPOSAL - SKILLS MIX AND STAFFING LEVELS

Preamble: Why the need for nursing in aged care

The Productivity Commission's draft report (2011 p.346) acknowledges that personal care needs 'do not generally require a high level of clinical expertise compared to the delivery of health care services, but caring skills and relationship skills are very important and play a significant role in the quality of the care experience'. However, we argue that the 'clinical' and 'personal' are not so easily separated.

Care provided by qualified nurses has the capacity to save lives, prevent complications, prevent suffering, promote wellbeing, and save money (Armstrong, 2009). Using their considerable knowledge, nurses protect patients from the risks and consequences of illness, disability, and infirmity, as well as from the risks and consequences of the treatment of illness. They also protect patients from the risks that occur when illness and vulnerability make it difficult, impossible, or even lethal for patients to perform the activities of daily living - ordinary acts like breathing, turning, going to the toilet, coughing, or swallowing. Nurses are constantly participating in the act of diagnosis, prescription, and treatment and thus make a real difference in outcomes (Gordon, 2006).

The draft report further states that aged care workers 'will generally need to have a caring attitude, possess a broad range of skills and have undertaken appropriate training and experience to ensure that they can provide quality and safe care'. While we don't disagree with these tenets, we highlight the nexus between a caring attitude and the ability to undertake work that requires a high level of interpretive skill. It is the difference between a trained workforce and one that is qualified. These are important distinctions because they point to the difference between 'caring' as an attitude that most people can assume, and 'nursing' as a professional activity requiring specialist knowledge, expertise and values.

The primacy of the patient in the practice of nursing is paramount. There is clear evidence that nurse staffing and patient outcomes are connected in particular through a 'skill mix' that is proportionately higher with registered nurse hours.¹ Safe, quality care requires that health services have:

- an adequate number of nurses;
- an appropriate skill mix (proportion of registered nurses to enrolled nurses and nursing assistants);
- nurses who are educationally and clinically prepared;
- a manageable workload for nurses; and
- sufficient resources to enable nurses to deliver the best possible care (Armstrong, 2009).

There is also a sound economic case for increasing the number of registered nurses in aged care facilities. Registered nursing care is positively associated with reducing adverse events like pneumonia, a complication which adds five days to a patient's average length of stay and is estimated to cost US\$4,000 - \$5,000 per additional day (Cho, 2003). Pneumonia is responsible for increasing length of stay by 75%, a 220% increase in the probability of death, and an 84% increase in costs (Cho, 2003). In addition, poor work environments contribute substantially to nursing turnover, estimated to cost AUD\$150,000 per nurse. It is clear that investing in nursing returns better care outcomes and less use of expensive health care resources.

Clinical Governance

The draft report (2011, p.381) suggests that the focus of regulatory reform should be on reducing the extent of regulation on quantity, quality and price of aged care. The proposed Australian Aged Care Regulation Commission will be charged with a range of compliance, enforcement, monitoring and approval responsibilities, yet there is no specific reference to the level and type of clinical governance that should exist within aged care facilities. Accreditation standards provide the mechanism for ensuring compliance across a range of administrative and other matters, but this needs to be broadened and aligned with clinical governance structures.

Clinical governance is the main vehicle by which aged care providers can be held accountable for safeguarding high standards of care in the same manner as those operating within the acute sector. Clinical governance encompasses many of the activities outlined in the report such as auditing of practice and outcomes, professional education and development and quality of care, however we note that there is limited focus on the role of clinicians in this process. The introduction of clinical governance is aimed at improving the quality of clinical care at all levels of the aged care facility through corporate and clinical accountability. It moves beyond compliance and accreditation as the measures of quality in residential aged care.

Supporting clinical governance will involve more research to establish effective models for aged care, understanding key clinical risks, developing standardised evidenced based care processes and the use of clinical audit. It requires quality indicators to improve care through measurement, monitoring and reporting (Cameron et al, 2009). Importantly, it needs a clinical workforce with a robust, meaningful career structure to sustain it. Strengthening care outcomes for aged care residents will involve identifying areas of clinical risk and developing evidence-based standardised care processes and models of nursing care.

Proper clinical governance will move beyond a culture of quality based on simply meeting accreditation standards towards one that facilitates quality integrated systems. Understanding, managing, measuring and reporting against key clinical risks is an essential component of this. The difficulty in reaching this level of quality lies in no small measure with reversing the substitution of professional clinicians i.e. nurses with unregulated 'carers' that has occurred in aged care. Uncompetitive rates of pay, poor career structures, and a lack of opportunity for collegiate interactions and professional practice review make aged care unattractive to many nurses. Older people are vulnerable to clinical harm and need the attention and services of qualified clinicians when they are ill and frail. 'Caring' is an important factor, but it is not a substitute for good risk management, professional and knowledgeable 'nursing care'.

The Productivity Commission should ensure that nursing is valued in the aged care industry. It is the intrinsic value of nursing work in aged care that goes unrecognised and unrewarded, particularly in cases requiring specialist skills.

Specific care issues for older people include malnutrition, functional mobility, loss of skin integrity, incontinence, falls, delirium, dementia, medication, maintaining self-care and depression (Cameron et al, 2009).

Skills Mix And Staffing Levels Proposal

Skills Mix and Staffing Levels

The Productivity Commission has acknowledged the growing gap between the escalating care needs of clients/residents along with the number of clients/residents in care and the available workforce, now and into the future. However, the Commission has not made any recommendation/s regarding staffing levels or skills mix that should apply - particularly in residential care.

Discussion

The ANF believes that the Productivity Commission should make recommendations that will lead to the adoption of minimum staffing standards in the residential care sector as a requirement for care for every client/resident.

The ANF propose a skills mix for residential aged care facilities based on the following calculation method:

If one nurse is allocated to:

- 4 residents per day shift (which would cover assessment, care planning and provision, complex and basic care including most showering, assistance with two meals, dressing, medications, etc.) on a day shift; and
- 6 residents per afternoon shift (which would cover all assessment, complex and basic care in the afternoon/evening period including showering, assistance with one meal, undressing and preparation for sleep, medications etc.); and
- 15 residents per night shift (which would cover regular supervision, medications, care and assessment of new/ill residents).

The above requirements would result in a minimum requirement of $(2+1.33+0.5)$ 3.85 hours of nursing care per resident per day.

In addition, time is required for indirect care responsibilities (eg: managing medication including counting controlled substances at the end of each shift, nursing handover and professional communication, quality assurance/accreditation activities, providing advice and information to families, etc.) and this would equate to an additional **20% loading per shift**.

Recommendations

1. The Productivity Commission recommend that residents receive a guarantee of nursing care per resident per day. The ANF recommends based on the above method, that a minimum of 4.5 hours of nursing care per resident per day should be recommended.
2. The development of a care staff/resident and skill mix tool based on ACFI funding tool which reflects the care needs and acuity of residents.
3. The ANF appreciates that in some parts of the industry there will be a requirement to increase overall staffing numbers and this may present difficulties for providers.
4. The Productivity Commission should recommend that these difficulties be addressed by the National Aged Care Regulation Commission in a relevant and practical manner which assists providers to meet their staffing obligations.
5. The staffing needs for each facility would be re-evaluated four times a year to ensure stability for residents, management and staff, unless there is significant and sudden changes in resident acuity.
6. That the staff/resident and skill mix tool be prepared in stage 1: expedited measures within two years of the Draft Implementation Plan (XLIV draft report).
7. The Productivity Commission recommend 24 hour registered nurse cover.
8. Each facility which employs nurses must employ a full time Director of Nursing (or classification equivalent).

3. ANF PROPOSAL - A NATIONAL LICENSING SYSTEM OF CARERS

National Licensing System The Productivity Commission has rejected the ANF proposal for the national licensing of Assistants in Nursing (however titled).

The ANF believes that not only is a national licensing scheme vital to ensure quality of care, but that consumers and their families demand such quality assurance.

Furthermore, the ANF believes that the Productivity Commission and the federal government potentially expose themselves to legal implications and community criticism in the future should issues arise with unlicensed workers providing care they are not trained, regulated or monitored to provide.

Discussion The ANF strongly advocates for national licensing of Assistants in Nursing (however titled). The public interest is significant given the frailty and vulnerability of the clients/residents these care workers look after.

Regulating AINs would also protect the public by ensuring only safe, competent practitioners, who meet the 'fit and proper persons' test participate in the care of the elderly. Regulation would also put the onus on employers and treating medical officers to report AINs who were not physically or mentally fit to practice or were incompetent which currently does not occur.

The legislation governing nurses practice is the Health Practitioner Regulation National Law Act 2009. Currently AINs are not registered and are not held accountable under this Act as are nurses.

The expression 'fit and proper person' takes its meaning from the type of licencing sought and the nature of the activities that will be conducted under that licencing. A list of other workers in Australia required to meet the fit and proper person test is provided (see Attachment 3). If the Productivity Commission fails to make a recommendation accordingly, then AIN's will potentially be the only direct care staff in aged care not regulated in any form.

All children's services workers are required to meet this test, including volunteers. Why is the same level of protection not afforded to older Australian's?

Discussion

'Why the fit and proper person test'

The fit and proper person test for an AIN (however titled) as a component of licensing, would include the overall standard of educational qualifications, knowledge, skills, experience, competence, diligence, judgement, character, honesty and integrity required to satisfactorily discharge their duties and responsibilities in performing aspects of nursing care in health and aged care settings. That is, while any person of good moral character can give kind and compassionate care this is not sufficient in a situation which carries a duty of care - such as all settings in which AINs deliver care. In addition to good character, the duty of care aspect of an AINs role makes it imperative that they have a level of knowledge and skill commensurate with "their duties and responsibilities in performing aspects of nursing care in health and aged care settings".

However, approximately 30% of assistants in nursing, (however titled) do not have formal aged care qualifications. All care workers require supervision and support from registered nurses and enrolled nurses, and those without any qualification will require additional supervision.

The licensing of AINs (however titled) is not a bar to recruitment of workforce in metropolitan, regional or rural Australia. A simple process applies for registration and licensing of AIN's (however titled) which would apply to current and future workforce. There are a number of Government financial incentives in existence for workers in aged care to undertake further education and training to meet the minimum education requirements for licensing. For example, the Department of Health and Ageing offer up to \$1,000 (per AIN) under the Education and Training Incentive Program to undertake further education.

Recommendations

1. Assistants in nursing (however titled) should be regulated by the same regulating body for registered nurses, midwives and enrolled nurses, namely the Nursing and Midwifery Board of Australia.
2. National benchmarking of the courses that lead to becoming an assistant in nursing (however titled) is undertaken.
3. Clients and consumers of aged care must be assured that workers are appropriately qualified to provide services professionally.

Recommendations

4. The Productivity Commission should recommend the Nurses and Midwifery Board of Australia consider the transitional and other specific needs of AIN's (however titled), for example meeting minimum educational requirements for licensing for AINs employed in rural and regional areas in the lead up to national licensing.
5. Timeframe for implementation should be over a two year period consistent with the Draft Implementation Plan (XLIV of the draft report).

4. ANF PROPOSAL - MEDICATION MANAGEMENT

Medication
Management

Medication management is a crucial service provided to aged care residents, and those in the community.

Discussion

Nurses are licensed to provide medication administration and/or the management of simple or complex medication regimes having expanded to include significant and multifarious underpinnings of knowledge, skill and in depth understanding of disease processes, pathophysiology, pharmacokinetics, anatomy and physiology. Nurses must understand compliance, monitoring and surveillance issues associated with therapeutic dose ranges as well as an understanding of their ethical and professional responsibilities, including the knowledge of relevant legislation and professional standards in which they practice.²

Registered nurses and authorised enrolled nurses have a specific pharmacological knowledge and skill set for assessing best practice in the management of quality use of medicine in residential aged care settings.

We believe that medication management and duties must remain within a clinical practice framework and that these duties are more than task-based. The original intention of DAAs was for who could self administer, and that family or carers could direct or assist. However, DAAs are now increasingly used for people who are no longer able to self administer nor participate in the administration. There must be a guarantee of close involvement by nurses in these instances.

Discussion

In residential aged care settings, approved providers are required to demonstrate compliance with government regulations by meeting the required standard (2.7) of the Aged Care Standards and Accreditation Agency (Agency).

A nurse managing the administration of medicine may use their professional judgment as to whether or not to delegate medicine administration to another registered nurse or authorised enrolled nurse, enrolled nurse within their scope of practice, or to a suitably trained unlicensed health care worker (however titled), who they consider competent.

In some jurisdictions assistants in nursing (however titled) are required to administer medicine under the delegation, supervision and direction of the registered nurse to residents who have given an approved provider permission to supply their medication in a dose administration aid, and provided the resident is classified under the Aged Care Funding Instrument (ACFI) as low care in the absence of a registered nurse being on site.

Registered nurses have legal and professional responsibility for delegation and supervision of medication management.

Recommendations

1. Assistants in Nursing (however titled), consistent with ANF recommendation 3 - A national licensing system, must be registered by the Nursing and Midwifery Board of Australia.
2. The Productivity Commission should recommend broad best practice guidelines for medication administration in aged care, to ensure the highest quality of care and administration of medicine is afforded to each and every resident in Australia. This should be based on the following principles:
 - The right medicine in the right dose must be administered to the right person, at the right time and by the right route;
 - The person administering the medicine must not only know when and how to administer the medicine, but also why to administer and when not to administer; and
 - The person administering medicine must be able to recognise the adverse effects of the medicines administered and respond appropriately.³

5. ANF RESPONSE - GATEWAY ASSESSMENT

Creation of the 'Gateway'

The ANF supports the establishment of a single 'gateway' for older people wishing to access services.

We understand that the gateway is to undertake comprehensive assessment of clients' needs and ensure access to care/services. During discussion the Productivity Commission has agreed that the level of assessment (effectively) creates a plan of care for the client (see section 8 and in particular pp. 236-237).

This is a significant change from the present system where the ACAT assesses the level of care required and the provider assesses details of the clients' needs (under ACFI) and particular interventions that are to be provided in the care plan. If there is a material change in the client's needs 'the gateway' is to conduct the reassessment of client needs rather than the providers' staff.

Discussion

This centralisation of the assessment and care planning processes creates a number of issues from a nursing perspective:

- The composition and skills of the gateway team that will necessarily need to change with the altered focus including the need for each assessment to involve a registered nurse;
- Depending on the extent of assessment activity undertaken by the Gateway there may be a reduced capacity for nurses working for service providers to independently assess and plan care for their clients. It is the ANF's position that professional practice requires the nurse, in the course of provision of care, to independently assess and plan to meet the needs of the client.
- The reduced capacity of nurses working for service providers to independently assess and plan care for their clients given the assessment and planning work already completed by the gateway. It is the ANF's position that professional practice requires the nurse, in the course of provision of care, to independently assess and plan to meet the needs of the client.

Discussion

Clients' needs for nursing/care interventions vary as a function of their health (broadly defined) status and there is a need to adjust services and practice in order to meet those needs without reference to an external agency such as the gateway.

We accept that any lasting change that impacts on service level requirements would need to be verified or approved (as is the case already under the ACFI).

Recommendations

1. That the Productivity Commission explore and clarify within its final report the relative role of the proposed gateway agency and providers in the assessment and planning of care for clients entering community or residential care programs with a view to preserving the capacity for nurses working in these sectors to assess and plan care based on a current review of a clients need for care.
2. That assessment activity undertaken by (or for) the gateway agency leads to the identification of a bundle of care and funding packages for that care. We believe that the professional care plan should be developed by the nursing staff at the Residential Aged Care Facility and must address all of the elements of the assessment and care package identified by the gateway agency. This should include identifying changes that are necessary for the effective care and treatment of the client whether on a temporary basis (eg in response to a short term, episodic illness) and/or where there is an ongoing change to the health care status and care needs of the client.
3. That the gateway agency (or their nominee) reassess the care package requirements (and the associated funding approvals) following:
 - a. an application for review by the care recipient;
 - b. an application from a provider of care after assessment by relevant health professionals such as registered nurses demonstrates changed needs that are sustained over a period;
4. The expiration of the fixed time period approved for a bundle of care (eg restorative care package).
5. That the gateway assessment and planning processes be limited to assessing the needs of clients to enter an appropriate program of care.

6. ANF RESPONSE - ACCESS AND EQUITY

Access and equity (accommodation)

The Productivity Commission draft report recommends that accommodation become available to clients of residential care services with:

- A minimum standard of a shared room and bathroom; and
- With accommodation fees means and assets tested to ensure that those with capacity to pay do so.

Rather than the bonds system the draft report establishes a system of charges that can be levied by the providers to the limits borne by the 'market' subject to their obligation to provide a proportion of places to government funded clients (at the minimum standard).

Those government funded places would be able to be traded within regions so that particular providers could disproportionately provide for such places or, alternatively avoid the need to do so.

The uncapped number of beds would also not distinguish between the current high and low care beds and the Productivity Commission recommends that this categorisation ends.

The Commission argues that some of the reforms in this area will provide greater choice (see for example 3.5 at p 57-8) and links wellbeing to choice (p58). However the report fails to acknowledge the fact that choices are limited by constraints including wealth, knowledge, and social status etc., information that is well established within a social view of health for example.

Discussion

The ANF recognises the need to improve funding availability for the provision of residential care (nursing home type) accommodation in the future and that the present differential treatment of high and low care areas for these purposes is not sustainable.

We are therefore supportive of the Productivity Commissions intent to ensure that those people in the community, with the means to do so, pay a greater amount for their accommodation and care.

Discussion

The ANF is however opposed to differentiating the standard of accommodation and care based on that capacity to pay. People entering residential care are not doing so as an accommodation option. They are entering these facilities for round the clock provision of nursing/care services.

It is therefore, we submit, appropriate to ensure that the standards associated with care and the care environment are consistently available to clients rather than be differentiated based on capacity to pay.

This is not unlike the situation in public (and even private) hospitals. Wealthier citizens pay more in both PAYG taxation and in the Medicare levy towards their health care but are provided with access based on their assessed clinical needs. Even in most private hospitals access to private rooms is based primarily on clinical needs rather than the insurance table of the patient.

We therefore recommend that the Commission consider the collection by the Commonwealth Government of 'market based' accommodation payments of the order set out in the draft report and that these payments be distributed to providers to support capital construction/maintenance based on the agreed national standard.

As an alternative, and in the event that the Productivity Commission maintains its current position in support of payments being made directly to the providers, we urge the Commission to reject the notion of trading government funded places within regions and require instead that all providers make available their share of the regional allocation of funded places. This would ensure a more socially balanced mix of clients in particular facilities and avoid some of the concerns that we have in relation to a gradual impact on care standards based on capacity to pay.

That national standard should reflect the actual standard applicable to almost all recent construction in the sector: that is it should be based on single room with en-suite bathrooms. We confirm our earlier discussion with members of the Commission which was that there is a direct link between the care environment and in the delivery of care which is appropriate to the needs of clients. We re-iterate our position that the minimum standard of care must be the same for all residents and ensure equity for the Australian community.

7. ANF RESPONSE - ACCOMMODATION AND CARE

Access and equity (care)

The draft report provides for additional (clinical or care) services to be provided to clients in addition to those assessed as being required by the gateway. However the report is based on providing care and support 'based on assessed needs and service entitlements...'

The Productivity Commission advances its 'building block' approach to care and support (see for example Figure 8.2 at p256).

Discussion

The ANF believes that it is essential that the final report reaffirm the position that providers and their staff (including contracted staff/ professionals) are responsible for meeting all reasonable care for a client within their residential facility or that is within the scope of their care package (or service entitlement). This will be the case particularly if the current prescribed services are ultimately incorporated into the approved care bundles as discussed above.

The system must preclude any unscrupulous providers from charging for care which is within the scope of current specified care and services. We understand that the provision of care on a capacity to pay basis is currently prohibited under the additional services rules.

If the proposed market based approach to additional care services is implemented then there is a risk, in the absence of specific commentary and recommendations that:

- Clients will not receive care assessed (by the staff of the provider agency) as being required since this was not an assessed need by the gateway agency; and/or
- Clients purchasing additional care (eg additional showers, therapy sessions) to meet actual care requirements that are assessed but not funded; and/or
- Clients being encouraged/facilitated in purchasing additional care requirements that are not required under assessment - which would appear to be tantamount to facilitating over-servicing.

Discussion

The building block approach to care and support stratifies care in a way that does not reflect nursing practice and potentially disadvantages clients.

The approach isolates aspects of care from each other regardless of the inter-relationships between them. Personal care is distinguished from 'specialised care' which includes health and nursing with no discussion about the vital role and interest that nursing has in the delivery of personal care which represents the elements of basic nursing care to clients in all settings.

Similarly the relationship between pressure care and wounds/ulcers, personal hygiene and health conditioning are isolated from one another in an artificial and in a manner that could potentially create risk to client care.

We do not believe that the Commission was seeking to create such a divide in describing the approach and recommend that it be re-cast in a way that still describes many of the elements of services to clients (and carers), but avoid some of the artificial divides that are inherent in the building block model.

For example we provide the following:



This diagram maintains the elements identified by the Commission in its draft report but represents them as overlapping components of care required to meet the needs of consumers and their carers. Such a model also represents the overlapping nature of elements of care including basic support, personal and complex care that the nursing workforce provide in the sector and avoids the suggestion that nursing is not actively engaged across the continuum of the care needs of clients.

Recommendations

1. That the Commission adopt the position that providers and their staff (including contracted staff/professionals) are responsible for meeting all reasonable care for a client within their residential facility or that is within the scope of their care package (or service entitlement).
2. That any scheme that permits charging for services assessed as being required for the care of clients in community or residential care and that are reasonably incidental to the purpose of the package of care being provided by the provider be rejected.
3. That the Commission revise or clarify its building block approach to avoid interpretation of it as creating a division between personal and health care: that all clients will receive assessment and provision of their basic and complex nursing care needs.

Issues arising

The rejection of any model of social insurance means that the only alternative to increasing government's outlays for aged care is the user pays model. Social insurance provides a model where all citizens pay according to their means but government allocates those funds equitably based on need rather than advantaging those citizens with the means to purchase enhanced services and accommodation.

The model of social insurance is under consideration in the disability sector having been advocated by the (now) Assistant Treasurer when he was the Parliamentary Secretary for Disability.

The ANF will consider further the options for a social insurance and/or levy arrangement to support the aged care sector as an alternate to the user pays model at the heart of the recommended direction. The ANF will seek advice on an appropriate model that could be considered further by the Productivity Commission.

8. ANF RESPONSE - REMOVAL OF HIGH CARE / LOW CARE

High/ Low Care Distinction

Whilst we do not oppose the removal of the distinction between high and low care residents for building purposes we do not believe that the Commission has considered adequately the impact on specified services including the only existing (and extremely inadequate) regulation of nursing staffing for high care residents. Given that the vast majority of residents are in high care categories the ANF submits that, in the event that the distinction is to be removed, the specified care and services currently applicable to high care be applied to all residents.

Discussion

The current prescribed services associated with high and low could be integrated within the bundles of care with those that apply to high care at present ultimately being applied as elements of the care required to be provided to all clients receiving residential care. Such an outcome would be consistent with the actual profile of residents today along with the expected growth in acuity of care provided within the residential setting in the years ahead.

Recommendations

1. That any removal of the distinction between high and low care places for capital/construction purposes not apply to specified care and services for residents unless the principles presently applicable to high care residents are applied to all residents of aged care services.
 2. That, given changes to the operation of the current prescribed services as a function of the distinction between high and low care will impact on the operation of other laws (eg drugs and poisons legislation of the states) and other instruments (eg industrial awards and agreements). Should the Productivity Commission recommend changes, these should be made over a period of time that permits review and adaptation of regulatory schemes and review/maintenance of industrial agreements. Given that industrial agreements typically operate for 3 year periods we recommend that change be implemented over a 3-5 year period.
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9. ANF PROPOSAL ROLE OF NURSE PRACTITIONER IN AGED CARE

Why the need for nurse practitioners

The ANF is pleased that the Productivity Commission draft report acknowledges the important role of nurse practitioners across aged care.

More detail is required to ensure that nurse practitioner roles are incorporated into the funding system so that advanced and specialist nursing skills can be readily utilised at all stages of care assessment, planning, delivery and review, and across all settings where aged care is provided.

Older people should be able to choose nurse practitioner services as a component of their care and there should be effective processes to enable referral between clinicians such as nurse practitioners, registered nurses, medical officers, specialists and allied health practitioners.

Discussion

Nurse practitioners contribute to the total nursing care provided by a mix of registered nurses, enrolled nurses, and care workers. It is important that this principle is central within nursing services delivered by the "Gateway" with nurse practitioners being one component of a comprehensive nursing care model.

As a specialist and advanced practitioner, there is great scope to be able to provide primary health care, early intervention and early diagnosis and treatment, as well as advise on and provide complex nursing care for acute, chronic illnesses, and for end of life care.

A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using 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.

The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice.' Australian Nursing and Midwifery Council (ANMC) 2006:

Discussion

While this is not an exhaustive list, the nurse practitioner can:

- assess, diagnose, order tests and initiate treatments including prescription of medications and ability to dispense from own formulary stock;
- visit the older person in their own home (including in-reach to a nursing home or hostel) and initiate care and treatments that may prevent unnecessary admissions to hospital;
- assist transition between home and hospital, potentially reducing the length of stay and reducing re-admissions;
- work directly with nurses, assistants in nursing, family and other care givers to advise on or teach specific skills or approaches;
- take part in case conferencing with nurses, medical officers allied health and care givers to ensure high quality coordinated care;
- offer consultancy and education to individuals or groups involved in providing care.

Recommendations

1. That the redesign of the funding system includes mechanisms to utilise the skills of nurse practitioners at all phases of assessment and care.
2. That the principle of access to nurse practitioners is based on clinical indication and regardless of whether care is delivered in private, not-for-profit, community or home based care setting.
3. That the Gateway Agency identify nurse practitioners as one source of 'specialised care' in its 'building block' (or similar) model and describe the process to utilise nurse practitioners for assessment, planning and review.
4. That collaborative arrangements are in place to ensure NPs can readily work across home, community care, residential care and hospital settings; agreements with local health networks and aged care providers.
5. That ongoing funding be allocated (or continued) to ensure the education of aged care-specific nurse practitioners ... and rural and remote specific nurse practitioners.

10. TEACHING RESIDENTIAL AGED CARE FACILITIES

Teaching residential aged care facilities	The ANF is pleased that the Productivity Commission Draft report acknowledges, "improving access to education and training, developing well articulated career paths", "More training opportunities for staff in remote locations are needed"
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Discussion	The draft report touches on the research by Professor Andrew Robinson, Professor of Aged Care Nursing and Director of Wicking Dementia Research and Education Centre, Menzies Research Institute, University of Tasmania. Professor Robinson addresses these issues through the Teaching Nursing Home initiative in residential aged care facilities. We believe that implementing this approach and supporting this initiative is paramount to attracting and retaining qualified nursing and care staff to aged care. For the future of nursing to deal with the complex care needs and co-morbidities that are increasing through our ageing population we need to fund these models of care to promote and encourage nursing in this sector for future sustainability. The ANF strongly agree with Draft recommendation 11.3. The ANF agrees with Draft recommendation 11.4 to expand teaching aged care services. However a more detailed plan of the extent of the expansion should be further explored through Professor Robinson's model of care and trialed throughout Australia with appropriate funding to support this model.
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Recommendations	1. Fund 30 teaching nursing hubs across Australia (\$1million per hub) to build capacity, to improve student experience and recruitment. 2. Focus on hospital avoidance admissions through improved staffing and skill sets as above, and through employment of funded Nurse Practitioners in cluster groupings; fund one Nurse Practitioner for each 300 bed cluster. 3. Fund and implement clinical governance and leadership programs to move the focus away from the current business model and back to a clinical model of care.
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Footnotes

1. See for the example the work of Duffield et al (2005, 2007).
2. Australian Pharmaceutical Advisory Council (2002) *Guidelines for Medication Management in Residential Aged Care Facilities*. 3rd Ed. Commonwealth of Australia.
3. Australian Nursing Federation (2002) *Nursing Guidelines for the Management of Medicines in an Aged Care Setting*. [Booklet] ANF, RCNA, Geriaction.

DRAFT

WITHOUT PREJUDICE

NATIONAL RESIDENTIAL AGED CARE SECTOR FRAMEWORK AGREEMENT

1. Purpose

- (a) The intention of this Agreement is to provide a national framework agreement covering the commonwealth , unions , providers in the residential aged care sector and their employees who are responsible for providing or assisting in the provision of nursing services.
- (b) The Agreement sets out the framework for achieving both sector wide and enterprise level improvements in service delivery and quality of care to residents.

2. Objectives

The shared objectives of the parties are to:

- (a) Enhance the capacity of aged care providers to achieve the outcome standards as determined by the Commonwealth through increased efficiency and effectiveness;
- (b) Facilitate greater flexibility in working arrangements;
- (c) Improve employment opportunities, career path development and skill acquisition by employees across the sector;
- (d) Ensure the gains from improved productivity and changes in workplace culture are shared equitably;
- (e) Develop and pursue changes on a co-operative basis through consultative processes.
- (f) To enable .providers to pay competitive wages to nurses and other care staff.

3. Operation of Agreement

This Agreement shall operate from (insert date) and shall continue for a period of two years.

4. Application

This Agreement shall be binding on the following unions, employer organisations and the Commonwealth:

(Insert organisations)

5. Commonwealth Funding

The commonwealth agree that salary supplementary funding will be made available to employers who enter into enterprise agreements which accord with the national residential aged care sector framework agreement and with the provisions of the Fair Work Act 2009. The supplementary funding will allow providers to establish and/or maintain wages for nurses and other direct care staff consistent with Schedule A of this agreement.

6. Productivity

The parties agree that productivity measurement in the aged care sector is difficult to quantify. A multi-factorial productivity assessment approach is needed which considers organisational effectiveness, service quality and changes which promote the aged care sector as a high quality and rewarding sector in which to work. Indicators should relate to both sector wide improvements and to agreed goals for improvement at the enterprise level.

7. Sector Wide Reforms

(a) The parties agree that sector wide reforms leading to efficiency gains and improved effectiveness will be achieved through implementation of relevant recommendations from:

(Insert key reports) For example

- Productivity Commission Report - Caring for Older Australians
- House of Reps Standing Committee Report on Employment and Workplace Relations, Making it Fair, Pay Equity and Associated issues

Additional improvements sector wide will be achieved through reform programs including initiatives that improve the recruitment and retention of nurses and care staff, OHS performance improvement, targeted professional development and training initiatives for the sectors and workforce programs that promote flexibility and balance between the work and family obligations of employees.

(b) Specific reforms agreed to by the parties include:

- The development and implementation of resident care teams specifically suitable for the residential aged care sector and that are appropriate for the diverse needs of clients between and within particular services
- Occupational health and Safety

The parties agree to formulate and implement appropriate policies and

practices to achieve a sustainable improvement in the Occupational Health and Safety performance of the aged care industry.

- Portability of entitlements
- Industry Training

The parties are committed to the development and implementation of an industry wide training system which includes sector specific aged care requirements, organized under the umbrella of the relevant Industry Skills Council. Training will be based on national competency standards, and accredited training courses and programs.

8. Enterprise Level Reforms

(a) Enterprise Level Objectives

Enterprise levels reforms shall be directed towards initiatives that will achieve demonstrable improvements in the, efficiency and flexibility of the enterprise which are aimed at achieving 'best practice' outcomes.

(b) Definition of Enterprise Level

Enterprise level bargaining may result in workplace reform at:

- an individual worksite or service operated by a single provider
 - a number of sites owned by one employer group
- at an employer association level

(c) Joint Bargaining Units

Joint Bargaining Units will be responsible for negotiating enterprise level reforms. Unless otherwise agreed, Joint Bargaining Units will comprise management, union and employee representatives.

- (i) Unions and employee representatives in the enterprise will negotiate as a Single Bargaining Unit.

(d) Certification

Agreements reached at the enterprise level in terms consistent with this Framework Agreement will be submitted for certification with FWA and, once certified, lodged with DOHA.

(e) Reform Initiatives

Enterprise level reform initiatives may include, but not be restricted to:

- (i) Improvements in work organisation and job design;
- (ii) Continuous improvement programs and quality assurance;
- (iii) Optimum utilization of capital equipment and new technology;
- (iv) Introduction of consultative committees and improved communications processes leading to a more co-operative workplace culture;
- (v) Multiskilling (with the objective of increasing the skills of an employee to undertake a greater variety of rewarding functions that are compatible with their base role) and demarcation issues;
- (vi) More flexible leave provisions including arrangements for workers with family responsibilities;
- (vii) Training and skill development programs
- (viii) Rosters and hours of work;
- (ix) Extension of permanent part time work;
- (x) Annualised salaries;
- (xi) Time off in lieu of overtime;
- (xii) Occupational health and safety and equal employment policies and processes.

(x111) Industrial relations practices

(f) Principles of Change

- (i) Any changes arising out of such negotiations must be designed to further enhance the effectiveness of the organisation to improve:
 - the quality of services to the resident; and
 - the work environment of employees.
- (ii) The parties agree that any change process based on narrow criteria of cost offsets is inimical to the development of best practice and continuous improvements in the enterprise and is to be avoided.
- (iii) The parties also agree that employment security is a fundamental principle of the Agreement.

9. Wage Increases and Funding

In recognition of the improvements to efficiency and flexibility flowing from implementation of the reforms and changes outlined in the Agreement, the parties agree that the weekly wage rates shall apply in accordance with Schedule A to this Agreement and shall be reflected in the wages payable under the enterprise agreement.

10. Industry Wide Enterprise Bargaining Committee

The parties to this Agreement shall be responsible for the implementation of the reforms proposed under this Agreement. The parties to this Agreement shall meet as the Aged Care Enterprise Bargaining Committee. The Committee will meet three times per year for the purposes of implementation and ongoing assessment of the implementation of this Agreement.

11. Dispute Resolution

It is agreed by the parties that any disputes which arise as a consequence of this Agreement shall be dealt with in the following manner:

- (i) If the dispute is a localized matter the dispute should be resolved in accordance with the dispute settling procedure contained in the appropriate award.
- (ii) If the dispute relates to matters of a broader nature arising from this Agreement the matter should be directed to the Committee referred to in Clause 9.
- (iii) If the matter cannot be resolved by Committee the matter shall be referred to the Fair Work Australia.

Signatories

Schedule A (to be included)

Wages Schedule to set out the wages payable to each nursing classification in each state and territory.



**Estimates of the cost of addressing current wage differentials
for nursing staff employed in residential aged care as at January 2011**

State		Public Sector	Private Aged Care	\$ Difference	\$ x EFT	\$ x 52
NSW	3,850 EFT RN	1,382.50	1,237.28	145.22	559,097.00	29,073,044.00
	2,865 EFT EN	945.00	909.72	35.28	101,077.20	5,256,014.40
	14,690 EFT AN/PC	753.00	676.40	76.60	1,125,254.00	58,513,208.00
VIC	3,463 EFT RN	1,240.40	1,117.68	122.72	424,979.36	22,098,926.72
	2,577 EFT EN	869.50	793.66	75.84	195,439.68	10,162,863.36
	13,212 EFT AN/PC	775.00	720.85	54.15	715,429.80	37,202,349.60
QLD	2,107 EFT RN	1,343.30	1,143.93	199.37	420,072.59	21,843,774.68
	1,568 EFT EN	938.55	880.25	58.30	91,414.40	4,753,548.80
	8,038 EFT AN/PC	851.50	764.26	87.24	701,235.12	36,464,226.24
SA	1,199 EFT RN	1,299.15	1,040.06	259.09	310,648.91	16,153,743.32
	892 EFT EN	888.15	758.10	130.05	116,004.60	6,032,239.20
	4,573 EFT AN/PC	790.26	672.22	118.04	539,796.92	28,069,439.84
WA	969 EFT RN	1,244.00	1,123.52	120.48	116,745.12	6,070,746.24
	721 EFT EN	934.48	812.11	122.37	88,228.77	4,587,896.04
	3,696 EFT AN/PC	790.26	709.40	80.86	298,858.56	15,540,645.12
TAS	363 EFT RN	1,286.47	1,152.73	133.74	48,547.62	2,524,476.24
	270 EFT EN	973.05	836.17	136.88	36,957.60	1,921,795.20
	1,386 EFT AN/PC	790.26	709.40	80.86	112,071.96	5,827,741.92
NT	48 EFT RN	1,338.90	1,112.01	226.89	10,890.72	566,317.44
	36 EFT EN	981.10	791.69	189.41	6,818.76	354,575.52
	185 EFT AN/PC	790.26	709.40	80.86	14,959.10	777,873.20
ACT	109 EFT RN	1,343.60	1,201.18	142.42	15,523.78	807,236.56
	81 EFT EN	945.99	796.86	149.13	12,079.53	628,135.56
	416 EFT AN/PC	781.54	713.26	68.28	28,404.48	1,477,032.96
TOTAL						316,707,850.16
Total plus Award/Agreement Benefits						411,720,205.21
Total plus Award/Agreement Benefits plus staff on costs to close gap as at January 2011						494,064,246.25

Further annual adjustment assuming 4% increase in the public sector and 2% increase in private aged care (for subsequent year 2012)

TOTAL annual adjustment	62,812,074.49
TOTAL plus Award/Agreement benefits	81,655,696.84
TOTAL plus Award/Agreement benefits plus staff on costs	97,986,836.20



Estimates of the cost of addressing current wage differentials for nursing staff employed in residential aged care projections for 2012

Annual adjustment working document

State		Public Sector	4%	Private Aged Care	2%	\$ Difference	\$ x EFT	\$ x 52
NSW	3,850 EFT RN	1,382.50	1,437.80	1,382.50	1,410.15	27.65	106,452.50	5,535,530.00
	2,865 EFT EN	945.00	982.80	945.00	963.90	18.90	54,148.50	2,815,722.00
	14,690 EFT AN/PC	753.00	783.12	753.00	768.06	15.06	221,231.40	11,504,032.80
VIC	3,463 EFT RN	1,240.40	1,290.02	1,240.40	1,265.21	24.81	85,910.10	4,467,325.41
	2,577 EFT EN	869.50	904.28	869.50	886.89	17.39	44,814.03	2,330,329.56
	13,212 EFT AN/PC	775.00	806.00	775.00	790.50	15.50	204,786.00	10,648,872.00
QLD	2,107 EFT RN	1,343.30	1,397.03	1,343.30	1,370.17	26.87	56,606.66	2,943,546.42
	1,568 EFT EN	938.55	976.09	938.55	957.32	18.77	29,432.93	1,530,512.26
	8,038 EFT AN/PC	851.50	885.56	851.50	868.53	17.03	136,887.14	7,118,131.28
SA	1,199 EFT RN	1,299.15	1,351.12	1,299.15	1,325.13	25.98	31,153.62	1,619,988.08
	892 EFT EN	888.15	923.68	888.15	905.91	17.76	15,844.60	823,918.99
	4,573 EFT AN/PC	790.26	821.87	790.26	806.07	15.81	72,277.18	3,758,413.34
WA	969 EFT ERN	1,244.00	1,293.76	1,244.00	1,268.88	24.88	24,108.72	1,253,653.44
	721 EFT EN	934.48	971.86	934.48	953.17	18.69	13,475.20	700,710.48
	3,696 EFT AN/PC	790.26	821.87	790.26	806.07	15.81	58,416.02	3,037,633.00
TAS	363 EFT RN	1,286.47	1,337.93	1,286.47	1,312.20	25.73	9,339.77	485,668.15
	270 EFT EN	973.05	1,011.97	973.05	992.51	19.46	5,254.47	273,232.44
	1,386 EFT AN/PC	790.26	821.87	790.26	806.07	15.81	21,906.01	1,139,112.37
NT	48 EFT RN	1,338.90	1,392.46	1,338.90	1,365.68	26.78	1,285.34	66,837.89
	36 EFT EN	981.10	1,020.34	981.10	1,000.72	19.62	706.39	36,732.38
	185 EFT AN/PC	790.26	821.87	790.26	806.07	15.81	2,923.96	152,046.02
ACT	109 EFT RN	1,343.60	1,397.34	1,343.60	1,370.47	26.87	2,929.05	152,310.50
	81 EFT EN	945.99	983.83	945.99	964.91	18.92	1,532.50	79,690.20
	416 EFT AN/PC	781.54	812.80	781.54	797.17	15.63	6,502.41	338,125.47
TOTAL								62,812,074.49
Total plus Award/Agreement Benefits								81,655,696.84
Total annual adjustment plus Award/Agreement Benefits plus staff on costs								97,986,836.20

Annual adjustment assumes 4% increase in the public sector and 2% increase in private aged care (for subsequent year 2013)

ATTACHMENT 3

List of workers required to meet the fit and proper person test in Australia

Community Support Worker

Counselor

Dietician

Masseur

Paramedic

Social Worker

Speech Therapy

Physiotherapist

Children's Services (all childcare workers, centre directors, out of school hours care, and volunteers)

Doctors

Occupational Therapists

Registered and enrolled nurses and midwives

Teachers

Anyone working with children and those in care

Driving instructors

Security officers

All union officials seeking to gain right of entry to work sites

The employer further agrees to support, assist and where possible provide continuity of employment by appointment to Enrolled Nurse positions for Assistant Nurses who wish to train as Enrolled Nurses.

Where an appointment to Assistant Nurse Level 3 or Registered Nurse Level 2 position is necessary, expressions of interest will be sought from all eligible employees and the subsequent appointment made on merit.