australian nursing federation

Submission to the Department of Health and Ageing Residential Aged Care Program on discussion paper Review of the Aged Care Funding Instrument, December 2009

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1. Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia.

The core business for the ANF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership of over 175,000 nurses and midwives, members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private health and aged care sectors.

The ANF participates in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANF is pleased to provide comment to the Department of Health and Ageing Residential Aged Care Program on their discussion paper *Review of the Aged Care Funding Instrument,* December 2009.

2. The nursing profession

Nurses form the largest health profession in Australia, providing health care to people across their lifespan. Nurses are the most geographically dispersed health professionals in Australia, working in homes, schools, communities, general practice, local councils, industry, offshore territories, aged care (residential and community), retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional organisations.

There is a combined total of 244,360 registered and enrolled nurses actually employed in nursing in Australia, with approximately 32,500 of these working in residential aged care facilities.[1] Nurses comprise over 55% of the entire health workforce.[2]

Numerically then, they make up the majority proportion of the health workforce and the nature of their knowledge, skills, experience and work means they are located in most practice environments in the health and aged care sector.

3. Aged Care and Nursing

The ANF has a primary interest with issues relating to the aged care workforce, including the number of care staff available, the qualifications of the care staff and the employment standards for nurses and unlicensed health workers. Many factors have increased the intensity of nursing care in aged care at a time when registered and enrolled nursing numbers have diminished. Much of the nursing care is being provided by unlicensed health workers, 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.[3]

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.[4]

At the same time as there are increasing numbers of residents and their dependency is also increasing 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.[5] 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.

4. Quality of Aged Care

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:[6]

> *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:[7]

> *…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.*

> *A strong causal link was found between homes that were non-compliant with Human resource management (1.6) and deficiencies in other service systems, in particular Clinical care (2.4), Specialised nursing care needs (2.5), Medication management (2.7), Behaviourial management (3.7) and Information systems (1.8).*
>
> *…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.*

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.[8]

The provision of quality care requires adequate staffing levels with an appropriate skills mix. Over a quarter of aged care nurses responding to a Queensland survey stated that they did not believe that there were enough qualified staff to meet client needs.[9] Another more recent study of aged care nurses in NSW found that:

> *…just under three quarters of respondents did not support a model of care whereby registered nurses fulfil the role of care facilitator/planner only with all direct care tasks, including medication administration, delegated to unlicensed workers.*[10]

In the aged care sectors the work of registered and enrolled nurses is progressively being substituted by unlicensed health workers, which now represent the bulk of the workforce providing aged care services. The National Institute of Labour Studies (NLS) report of 2008[11] shows that numbers of these unlicensed aged care workers or 'personal carers' rose from 42,943 (full-time equivalents) to 50,542 (FTE) in the period from 2003 to 2007. This change in skills mix means that there is less access for these workers to support and supervision from registered and enrolled nurses.

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.[12]

The reduction in the number of nurses and the subsequent changes to skills mix is leading to a lower level of safety and quality of care and putting these vulnerable residents at risk.[13]

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.[14]

A survey of over a thousand ANF members working in aged care facilities was undertaken by Melbourne University in 2007. This study found that "workers are under significant stress stemming from excessive workloads and cost cutting". One respondent to the survey said:

> *I stopped working in aged care due to management cost cutting which put extra strain on workers resulting in not enough time to care properly for residents.*[15]

The ANF has long been concerned with the quality of care in aged care and its relation to employment standards for nurses and nursing care staff in the aged care sector. 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. A significant wages gap now exists between nursing care staff in the aged care sector and their colleagues in other sectors such as acute care. More fundamentally, as detailed earlier, there is now a plethora of evidence to show that more nurses in the skills mix in residential aged care facilities, leads to better outcomes for residents. We believe the intensity of nursing care requirements for aged care residents across Australia has increased with more people entering residential aged care, older and frailer and with a range of chronic conditions, and in some instances episodes of acute medical and health related conditions.

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 care staff can provide quality care for every resident
- Fair pay for aged care nurses and care staff who are paid up to $300 per week less than nurses in other sectors
- Recognition of the professional skills of Assistants in Nursing and care staff through a national licensing system
- A guarantee that taxpayer funding is used for nursing and personal care for each resident.[16]

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

The ANF urges the government to incorporate nursing and direct care hours into aged care funding assessments as part of the review of the Aged Care Funding Instrument (ACFI) to best provide the connection between residents assessed care needs and the required hours for care staff to provide the assessed care. The lack of any component in the ACFI which relates to staffing profiles in terms of numbers and skills mix is a fundamental flaw in the current system.

The ANF is of the view that positive outcomes for residents of aged care facilities are directly related to the quality and quantity of care they receive. 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 direct aged care workers (such as assistants in nursing or personal care workers). We acknowledge that the number of nurses and people with nursing skills required in each aged care facility will be different, depending on the complexity and intensity of nursing and other care required by individual residents, combined with the number of residents living in the aged care facility.

5. Residential Classification System and Aged Care Funding Instrument

The ANF was a member of the Residential Classification System (RCS) Reference Group; was integrally involved in the RCS Review and the development of the Aged Care Funding Instrument (ACFI); and has been a member of the ACFI Reference Group. The current ACFI tool does not provide guidance on how to determine nursing skills mix and staffing within a residential aged care facility. The consequence of this is highly problematic. Residents assessed as needing the same level of care may require different qualification levels of nurses to administer the assessed level of care. There is often a mismatch between funding and the cost of care that has been identified, which results in inappropriate allocation of human and capital resources in some aged care facilities.

The ANF asserts that the current ACFI framework lends itself to an easy transition from the needs of residents, to the demand for, and funding of, nurses. With minimal adjustments, the ACFI appraisal process could be used to assess the care needs of residents in terms of 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 care workers.

6. Issues for Review

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.* Approximately two hundred members from the aged care sector responded in the short timeframe the survey was posted to ANF Branch websites. Respondents were registered nurses, enrolled nurses, endorsed enrolled nurses, and unlicensed healthcare workers (however titled); with the majority being registered nurses. In addition to the short timeframe allowed for response, ANF Branches also advised that very few members in aged care facilities have access to computers in their workplace and so were either unaware/unable to complete the survey.

Of all respondents, a clear majority have been involved in undertaking resident assessments using both the Aged Care Funding Instrument (ACFI) and the previous Residential Classification Scale (RCS), with only a small number of respondents having been involved with resident assessments using the AFCI funding instrument exclusively.

6.1 Matching Funding to Care Needs

Are there particular types of care needs that are better captured under the ACFI compared to RCS?

Comments on particular types of care needs that are better captured under the ACFI compared to RCS included:

- The timing of medication rounds that are outside the "norm" for the aged care facility
- Most Activities of Daily Living (ADLs)
- Continence/incontinence assessment
- Sleep and overnight care issues to ensure adequate resources are available to provide quality care to residents with sleep disturbances
- Complex and technical health care needs
- Nutritional needs
- Pain management
- Behavioural needs/problems, including: care for the agitated resident; recognition of depression; cognitive impairment
- Nutritional needs (better defined although there remains ambiguity around nutritional supplements using ACFI)

The general statement was made that the very highest of care needs for all areas of care are captured better under ACFI.

Are there specific care needs that are not as well captured?

While most respondents thought that the ACFI had greater provision to capture some of the "extra" care needs that were missed under RCS, there were respondents who said that the "general" care needs were more identifiable under RCS. This is reflected in respondent comments:

> *ACFI takes a very broad view of residents needs whereas RCS was more time consuming but it captured all their needs.*
>
> *The accuracy of defining specific care needs for residents are not captured as well with the ACFI as they were using RCS scores..*

Common themes from respondents on specific care needs that are not as well captured under ACFI as compared with the previous RCS include:

- Time and expertise for specialised nursing care - higher acuity care needs for residents with chronic conditions
- Rapid changes in health status; particularly those residents who die within a short time period following admission to the facility
- Length of time allowed for some complex care not reflective of care provided, such as palliative care requirements
- Specific pain management such as physiotherapy treatments - heat packs or TENS (transcutaneous electrical nerve stimulation) machines
- Some behaviours that require staff time and intervention (limited in type of interventions being given), including: emotional needs (such as anxiety), wandering, aggression, different types of dementia (tool too broad to identify their very different and demanding needs)
- Feeding of dysphagic residents only by registered nurse - RCS allowed for this item to capture this level of care by allied health professionals
- Physiotherapy, mobility, diversional therapy, aromatherapy spiritual and emotional care for the resident and family
- Leisure activities and lifestyle
- Some aspects of ADLs such as: residents who require simpler routine care but who may require more staff to attend to those needs; residents who are frail but can still walk and are therefore high falls risk; a bed bound person with two hourly pressure area care needs who can be cared for in less time than a resident who is mobile and resistive to care assistance in a facility with a no restraint policy.

The time it takes for care staff to actually deliver the assessed care is not captured under ACFI, and is a huge factor in the planning and allocation of staff hours and determining

costs for human resources. This is mostly due to the fact that there are increasing numbers of frail elderly, compared to the numbers that were in aged care facilities when the previous RCS was in use. The profiles and needs of residents are changing, with the rise of dementia and longer life expectancy in our population.

The 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 does not recognise the need for interdisciplinary consultation and management of individual residents and development of complex care needs documentation.

Are the clinical instruments that have been trialled and selected for the ACFI appropriate in your facility?

While not everyone agreed, the majority of respondents to the ANF survey considered that the current clinical instruments that have been trialled and selected for use with the ACFI assessment tool are appropriate for their facility. Some respondents who believed that there are other clinical instruments that are more suitable, argued that the current clinical care 'points' do not accurately capture or reflect the level of care required, but did not know of a more suitable instrument.

Some comments in favour of the ACFI assessment tools noted that the three behavioural assessment tools (cognitive impairment, depression, bladder and bowel assessments) enable care planning and management of behaviours based on a 24 hour assessment of how many times a day the behaviour occurs. The care planning is then able to be based on clear evidence for each individual resident.

Additional comments provided:

> *The amount of time taken for direct care staff to physically undertake some care activities cannot be reflected with ACFI.*
>
> *The PAS (palliative care assessment scale) and Depression scales do not provide a true reflection of "geriatric" depression.*

Are there others more suitable?

Suggestions for more suitable clinical instruments included:

- Folstein - Mini Mental State Examination for cognitive impairment - this scale was seen by some respondents as being easy to manage and evaluate.
- Rowland Universal Dementia Assessment Scale - the benefit of this scale appears to be that it is a multicultural dementia scale with a high degree of predictive accuracy. This scale also reduces the chance of bias when used with people who have limited language or literacy skills.

It was noted that there should be an improved palliative care assessment tool but no alternative tool was suggested.

What is the impact on funding for residents at the high end in terms of care needs?

Given that the ACFI is an instrument which measures the need for care (that is, what is assessed as being needed) and not the care actually provided, it is almost inevitable that there will be a difference between the funding predicted and the funding actually needed for care delivered. This differential will almost always be with residents at the high end in terms of care needs as changes in condition may occur rapidly or the sheer nature of the complexity of their care or differing numbers of care givers required, may decrease the level of predictability in identifying care needs. 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.

The impact of funding shortfalls is evident in the frustrations expressed by respondents to the ANF survey as seen in these examples:

> *The impact on funding for residents with high care needs is often problematic where a resident is assessed as high care and may be also diagnosed with dementia and have continence and wound care needs, combined with feeding care needs like gastrostomy feeding tube.. seems to come up with an ACFI score that does not provide the real funding requirement to provide all the assessed care. A resident assessed in this category often requires two staff to provide the care as they are 'heavy' residents, but the cost of care excludes the time of the people to provide it:*

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.

> *Claiming for funding for high care residents with pain management and pain control issues that require specialised nursing care is problematic using the ACFI score, meaning the funding for the actual care needed is not realised. The current tool is described by many users as "too limited in this complex area of care".*

What proportion of residents are receiving funding over and above the highest RCS 1 rate?

Responses to this question varied, however the majority stated that approximately 0-10% of residents are receiving funding over and above the highest RCS 1 rate.

What is the impact at the low end in terms of care needs?

An overwhelming number of respondents to the ANF survey expressed views that suggest residents with low end care needs, or requiring less care, seem to miss out on their one to one time with care staff. This is often compounded in aged care facilities that have a high proportion of residents who have been assessed with high level care needs, as both nursing and care staff time is consumed by these residents. At the more extreme end there was a suggestion that some aged care providers may select out residents for admission who require low care as the funding attracted is not sufficient for their care; and even that there was "sanctioned neglect" of low care residents. Nurses expressed frustration that they are not able to give time to talking to residents with low care needs as funding levels preclude this social interaction time.

Residents with low end care needs are often left unattended as inadequate numbers of staff are rostered on duty in privately operated aged care facilities to respond to residents with low end care needs in a timely manner. Comments included:

> *Care of residents with conditions like diabetes that requires regular and ongoing monitoring can be problematic for residents assessed in this category. Nursing care provision in this area of care is often more complex and time consuming than the classification scale reflects.*
>
> *Low end residents are perceived by care staff as more demanding in some aged care facilities in relation to "extra services" like physiotherapy, lifestyle and leisure activities as they are paying extra and not always receiving what they pay for.*
>
> *Reduced funding at this level results in providers cutting staffing level to provide direct care needs.*
>
> *People at this end of the scale are not being admitted due to low funding levels.*
>
> *Yes, in our low care area residents have behavioural issues that we do not get funding for despite them taking a lot of time to nurse.*
>
> *Residents don't get assessed as needing care in residential care without need so why deny their need for support based on ACFI only. ACAT would not approve placement if it were not a necessary option. People living on their own with dementia - particularly frontal lobe - cannot cope with periods of no company - they need supervision and assistance to remain safe.*

What proportion is receiving no care subsidy or less than the lowest RCS 7 rate?

The majority of respondents to the ANF survey stated that the proportion of residents in their aged care facility receiving no care funding subsidy or less than the lowest RCS 7 rate was 0-10%.

What is the impact for residents around the middle of this spectrum?

While responses to this question were variable the majority of survey respondents commented that residents in this middle spectrum of care are missing the emotional support they require. For example, care staff are often extremely busy providing care to residents who take a larger proportion of their time (usually high care residents) and do not have resources available to spend any length of quality time with middle spectrum residents - to sit and talk to them and respond to their need for emotional, and social support and physical contact. In some instances this cohort of residents simply require encouragement and reassurance with their activities of daily life and positive reinforcement - that is likely to be missed in the ACFI assessment as there is no provision to capture this aspect of care. Some respondents indicated that these residents "get by" only with extra assistance from family and friends.

6.2 Funding Outcomes and Impact on Aged Care Providers

The ANF has no comment in relation to questions regarding the funding outcome and impact on aged care providers.

6.3 Documentation and Administrative Arrangements

The impact on paperwork and the time to justify appraisals

There is a general level of concern amongst respondents to the ANF survey that the volume of associated paperwork that is attached to undertaking an appraisal remains onerous on the assessor to justify the methodology in arriving at the appraised result. Nevertheless, the ACFI appraisal guidelines must be adhered to by the assessor when undertaking an appraisal of a resident's funding requirement. Where a health professional involved in the appraisal is of the view that particular care or funding needs are not captured by following the appraisal guidelines, there is no alternative other than to appraise a resident based on the guidelines and then to be able to justify to the Department the rationale used in coming to the appraisal outcome.

Whether documentation requirements under ACFI have been reduced? Are there reduced documentation requirements for appraisals, and if so, in which aspects?

The majority of respondents to the ANF survey considered that since the introduction of the ACFI, the level of documentation required to support an appraisal on aged care residents, had not been reduced.

It was, however, noted that the need to not repeat the ACFI annually is a positive aspect. Some comments in this area were:

> *Once the initial ACFI has been completed there is less pressure getting a re-assessment done in a certain time frame.*

...you don't need to document their ADL's every day and what they are doing to justify the amounts… the ACFI is an assessment which stays unless there is a change in their condition.

Less repetitiveness of documentation on an ongoing basis. However, further assessment and documentation required to holistically develop individual care plans.

It is much easier to assess the resident using the package than it was to constantly write conflicting notes over the 21 days RCS appraisal. It is also more time conservative when writing up a care plan.

Are there any areas where documentation requirements appear to have increased?

From the comments received from respondents to the ANF survey it would appear that the increase in time is not on completing the appraisal but rather on collating the information from the assessments and ensuring that there is correct correlation of the evidence in completing the appraisal pack. For example:

It only takes 15 minutes to complete the appraisal, which is what was the major selling point by the Government, however it takes about 4-5 hours to complete all the assessments required to claim for the ACFI as they must be specific assessments and not general documentation which was able to be used for the RCS.

Yes. More detailed recording required for all aspects, particularly complex care needs.

And, there is additional time required when all health professionals supplying information do not complete the forms correctly, for example General Practitioners:

If all of the documentation is completed then it is only about one hour from the time you start to collect the information until it is complete. If documentation is not ready and you have to chase up Medical Diagnosis then it can take considerably longer up to 3-4 hours as you have to complete the care plans as well if there has been an identified change in status.

How long does the average ACFI appraisal take to complete?

In answer to this question the majority of respondents to the ANF survey estimated that it takes between 60-90 minutes to compete an ACFI appraisal. However, as indicated previously it can take longer when follow up is required for collating information and correcting incomplete forms.

Some comments on completion time included:

40 minutes. This is only to complete the appraisal itself. The pack in total can take hours to complete when looking for documentation.

60 minutes. The 60 minutes does not include the preparation the week of assessments the photocopying of evidence… it is purely checking we have all the evidence following up on what's missing then writing up the pack for the folder that stays in the facility and then putting the data into the PC which goes through to Medicare, then following up the next day to see if it's been accepted.

120 minutes. ACFI completed over 28 day period, collation of information/ evidence onto answer sheet and creating ACFI evidence package is two hours, then is [time is] taken by administration for submission on internet.

120 minutes, depends on the cooperation of GP's etc in obtaining documentation.

Has the level of agreement between aged care staff and the Department review officers improved?

Responses to this question indicated that this is variable between aged care facilities and the numbers and acuity of residents in care.

Respondents also argue that this issue is highly subjective, being dependent upon personality traits of appraisers and Department review officers.

Other issues relating to evidentiary requirements, such as quality and usefulness of ACFI tools

Comments on the quality and usefulness of the ACFI tools varied considerably as can be seen by the following:

The tools are simple and easy to use.

The tools are good but I think in some areas residents don't receive enough funding and if you are not careful you lose a lot of money.

Until we actually get staff ratios as a requirement and are funded for that the ACFI will remain just a tool we have to use at the expense of direct care to our residents.

Flow charts are easy and simple to use. PAS and depression scale are not quite useful for residents with dementia, or non English speaking background.

The tools are generally useful except the behaviour tools. These tools do not always have the ability to show the full impact a resident's behaviour may have as the time spent with them is not taken into consideration, only that time was spent with them, that is, it may only be once or twice a week that the resident displays the behaviour however when the behaviour does present it may take staff 1-2 hours to manage it.

I think the tool is good - but the weightings and funding to care tasks required are poor.

ACFI does not match the financial needs of residents, ACFI undervalues human needs in aged care.

They [the tools] do not allow for interaction of staff with residents - everything just seems to be black and white with no grey areas.

6.4 Design Issues Including the Roles of Health Professionals

Are there any gaps or anomalies in the ACFI in relation to care needs?

Some comments on gaps and anomalies in the ACFI in relation to care needs are provided in the foregoing commentary. Additional information provided by respondents to the ANF survey is reflected in the following comments:

ACFI tools are good, but too restricted in what you can get funding for hence you only get funding for half the work that is actually done.

Only a funding tool - further assessment required to develop holistic individual care plans.

There has to be a more appropriate assessment tool that allows for rapid changes. There is a shortfall in funding to address the new needs.

Homeless people don't get in the door as they don't have funding to support themselves.

I believe that most facilities will screen those categorised as LOW care and make sure they are going to be able to get adequate funding for them before they are accepted.

We no longer take mental health clients from homeless programmes which we used to do as the money does not cover the cost of medication management eg depot injections and dealing with other issues such as shopping for clothing and cigarettes.*

*(A depot injection is an injection, usually subcutaneous or intramuscular, of a pharmacological agent which releases its active compound in a consistent way over a long period of time.)

Does the ACFI appropriately recognise the various roles of staff involved in the delivery of residential aged care, including enrolled nurses and allied health professionals?

The majority of respondents to the ANF survey did not consider that the ACFI tool appropriately recognises the various roles of staff involved in the delivery of residential aged care, including enrolled nurses, carers and allied health professionals.

One respondent said:

No. It puts a bigger work load on carers to fill out forms, not enough emphasis on nursing time, that is, wound care, medication management, extra time needed for extremely aggressive and agitated residents and their mental health issues.

And another:

> *Absolutely not. It was much more professionally managed under the RCS. Funding has to be at a certain level to maintain quality of care, if your ACFI's are low, or a person is not fully understanding how to gain maximum funding from this instrument the income suffers. How can you manage to maintain levels of appropriate staffing through this kind of system?*

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.*

Registered nurses

Of concern to the ANF is that some respondents reported that there are aged care facilities in which approved providers are directing facility staff other than those outlined in the Aged Care Act to undertake independent resident assessments, appraisal and care planning. Frail elderly residents in aged care facilities require care that is evidence based and coordinated by staff with a depth of knowledge of the special needs of older people. The ANF takes a strong position that the completion of the ACFI appraisals requires the knowledge and assessment skills of qualified registered nurses. Further, that registered nurses be supported in their assessment role by qualified enrolled nurses and aged care workers.

The ANF is particularly concerned that the ACFI tool be able to facilitate funding for appropriate numbers of qualified registered nurses in all aged care facilities. Registered nurses are educationally prepared to assess care needs and should have primary responsibility for developing the ACFI appraisals, in conjunction with other care staff.

Specialised skills

Respondents considered that design improvements must incorporate: health workers with more specialist knowledge such as, geriatricians, mental health nurses, nurse practitioners and allied health staff. Mention was also made of including people such as: massage therapists, aromatherapists, resident activities officers, physiotherapists, podiatrists, and other allied health professionals, employed chaplains, social workers, and leisure and lifestyle officers.

Nurse Practitioner

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 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 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.[17]

The nurse practitioner role is designed to augment those of other providers of health and medical services. Nurse practitioners are first and foremost nurses with advanced educational preparation and experience, with authorisation to practise in an expanded nursing role. 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 admission to tertiary health care facilities, where possible; plus taking an educative role in the quality use of medicines, being involved in quality improvement activities, including the review and evaluation of medicine systems.

It is the view of the ANF that the ACFI funding model should enable aged care facilities to incorporate the role of nurse practitioners.

6.5 Interface with Other Elements of Aged Care

The ANF agrees with the comments expressed under this heading in the December 2009 Discussion Paper - Review of the Aged Care Funding Instrument that there are areas where the ACFI arrangements are not aligned with other aspects of the aged care system. Some respondents to the ANF survey expressed frustration that there were instances where an ACAT assessment had given a resident a level of approval but that the later appraisal by the aged care facility based on this ACAT had been questioned by the Department review officers. The ANF notes that the changes introduced from 1 January 2010 may address this issue. It is pleasing to see that this has been recognised as a problem. The ANF will monitor the situation to ascertain if the introduced changes do achieve a better outcome in terms of improved integration of ACAT assessments, approved provider appraisals and reviews by Department officers.

6.6 Quality of Care Principles

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.[18]

The following extract contains information which the ANF considers useful in the review of the ACFI.

> 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.
>
> 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 (eg 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.
>
> Moreover, rationalisation of funding for human resources and administration has led to a reduction in levels of support for nurses (DEST, 2001a). Experienced RNs are spending more time undertaking menial tasks such as answering calls, chasing supplies, entering data and overcoming 'red tape'. The NILS survey found RAC nurses felt like they did not have sufficient time or opportunity to engage in the caring tasks for which they were employed and trained, with adverse impacts on both morale and quality of care. It is important to view nursing education as an investment, with failure to invest in adequate training and education resulting in patient, economic and social costs. Cost effectiveness of RAC training programs can be measured in terms of workload (efficiency before and after the training), work quality and number of people trained. It will be important to continue to monitor and evaluate the cost effectiveness of skills training and key performance indicators of quality through the RAC sector.

The ANFs Access Economics report outlines a number of ways in which the current challenges in residential aged care can be addressed and these are reproduced below to assist in the process of the review of ACFI.[19]

Closing the wages gap. Wages and conditions must improve to attract nurses into the sector. Productivity improvements can help to fill the wages gap, realised through better technology and restructuring activities e.g. more sophisticated monitoring and scheduling systems which can also allow staff to spend more time with residents and increase the quality of care provided. 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 could be linked to the ACFI scale and this may assist in achieving adequate provisioning for wages.

Better education and training. Enabling career development through continual education and training 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 ENs and personal carers is critical given their share of the RAC 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.

Improving retention - the workplace environment. A positive workplace culture where staff feel valued can increase job satisfaction. Addressing excessive workloads, unnecessary documentation and lack of professional development opportunities helps improve retention, facilitated through: flexibility in rostering hours, time off to study and financial assistance to cover incurred costs; promoting workplace safety and cultural sensitivity; and encouraging a better work/life balance.

A better regulatory environment. There is merit in a single, integrated assessment approach for care needs. There also needs to be more choice within the RAC sector and better information on how individuals use aged care services. This would involve lifting the current restrictions on the number of aged care places within a RAC facility. Information on the performance of RAC providers should help ensure residents are able to choose the better providers. The objective is to ensure RAC facilities are highly valued by residents, can increase their placements, and can attract residents from less valued facilities. The regulatory environment would be further improved by a more detailed and transparent acquittal process where RAC providers clearly account for how capital and recurrent funding is spent.

Promoting optimal levels of nursing care. The strong links between improved skills, quality of care and resident satisfaction indicates the current decline in the proportion of RNs within RAC facilities should be reversed. In the absence of nurse ratios, then an alternative is directly linking funding with the provision of nursing care, as well as implementing requirements for RN numbers based on the level of care required within a facility (through the ACFI). This would improve both the quality and quantity of care provided.

Financial reform. Major reform of financing is needed in the RAC sector. This should cover the patchworked plethora of regulated ways funding is disbursed as well as the non-transparent manner in which it is acquitted. There is a need for financial injections to make much-needed capital improvements and free up funds to improve the nursing skills mix and other factors associated with better quality of care. One option to achieve this, for investigation, could be the removal of government legislated fee caps. RAC facilities would then also have greater capacity to fund accommodation costs from accommodation charges, thereby reducing the need to cross subsidise with funds hypothecated to operational costs.

Improving the capacity of residents to meet future RAC costs. As aged care needs burgeon in future, support for RAC facilities will place significant stress on the federal government budget. It will become increasingly important that aged care costs are borne by individuals who have the capacity to pay, allowing the government to continue providing a safety net for those without the financial means to cover their RAC costs. Private sector capacity to pay must be increased and one option is the incremental transition towards introducing Healthy Ageing Savings Accounts (HASAs) to enable those with adequate means to gradually provision for their future health and aged care needs. This would provide an incentive for individuals to save for their more predictable health and aged care needs and increase the capacity to pay for RAC charges, while providing greater flexibility for RAC facilities to meet the individual needs of residents.

The ANF also requests that, in line with this review of the ACFI, there be a complete review of the Accreditation Standards and Quality of Care Principles to ensure alignment between all processes, with the end result of being able to better ensure high quality care to our frail elderly citizens.

7. Conclusion

There is substantial evidence available that demonstrates that more qualified nurses in the skills mix of aged care homes leads to better and more positive health outcomes for residents of aged care facilities, which directly correlates to the quality and quantity of care they receive. Some of the more pertinent research has been outlined in this paper.

Frail elderly residents in aged care facilities require care that is evidence based and coordinated by staff with a depth of knowledge of the special needs of older people. The ANF takes a strong position that the completion of the ACFI appraisals requires the knowledge and assessment skills of qualified registered nurses. Further, that registered nurses be supported in their assessment role by qualified enrolled nurses and aged care workers.

The ANF has presented some of the current difficulties encountered by aged care residential staff with the Aged Care Funding Instrument (ACFI). As part of the review of the ACFI the ANF urges the government to strongly consider incorporating nursing and direct care hours into aged care funding assessments, to best provide the connection between residents assessed care needs and the required hours for care staff to provide the assessed care.

The ANF considers that the current ACFI framework lends itself to an easy transition from addressing the needs of residents, to addressing the demand for, and funding of, nurses. With minimal adjustments, the ACFI appraisal process could be used to assess the care needs of residents in terms of the type of skills required to optimally provide the highest level of assessed care, with the appropriate level of education, knowledge and skill to do so.

Overall many of the respondents to the ANF survey see the benefits of the ACFI, and in particular many are satisfied with the clinical assessment tools. There are gaps however, and need for improvement, as outlined in this paper. The ANF considers that this current review provides the ideal opportunity for real reform of the funding process to benefit the recipients of aged care. The ANF offers the foregoing feedback to assist in the deliberations of the review by the Department of Health and Ageing Residential Aged Care Program.

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