ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

AGED CARE IN THE HOME

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

1. INTRODUCTION

1.1 This submission concerns the safety and quality of aged care services delivered in the home. The Adelaide Hearings 1 identified a range of issues affecting the delivery of aged care services in the home, including but not limited to:

- The manner in which home and community care is delivered, including adequacy and timeliness of service delivery
- The funding, costs and resource allocation related to service delivery
- The uncoordinated, fragmented and overly complex nature of the delivery of aged care services in the home
- The capacity of the current workforce to deliver safe and best practice aged care services in the home
- The conditions currently experienced by those delivering aged care services in the home.

1.2 This submission will focus on these issues from the perspective of Australian Nursing and Midwifery Federation (ANMF) members delivering aged care in the home. The ANMF conducted a survey of members and non-members working in community aged care, in the first week of March 2019, to provide a snapshot of the issues currently impacting workers employed in the delivery of aged care services in the home. The results of that survey have contributed to this submission.

2. THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

2.1 The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 275,000 nurses, midwives and carers across the country.

2.2 Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

2.3 Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

2.4 Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

2.5 The ANMF represents almost 40,000 nurses and care-workers working in the aged care sector, across both residential and home and community care settings. (Care workers can be referred to by a variety of titles, which vary, for example from assistant in nursing to personal care worker or assistant. For the purpose of this submission, workers providing assistance in nursing care will be referred to as care workers.)

2.6 The ANMF recognises that people want to stay at home and connected to their community for as long as possible. The ANMF therefore supports the principle that government should support elderly people to remain in their homes as it reflects both the human desire to live a full life connected to friends, family and community and sound economic policy.

2.7 ANMF refers to but does not repeat the material attached to Ms Butler's Statement (Exhibit 1-16 WIT.0020.0001.0001) relating to the ANMF's role and background.

3. HOME/COMMUNITY BASED AGED CARE SERVICES

Aged Care Consumers

3.1 In 2017-18, over 1.3 million people received some form of aged care. Close to a million of those receive support through home based care and support.

3.2 In ten years the size of the Australian population aged 65 and over is expected to grow from 16% to 18% (5.2 million people) and from 2.0% to 2.3% for people aged over 85 (672,000 people). In 2018, there were an estimated 376,000 Australians with dementia, nearly half of whom were aged 85 years or over. The number of people with dementia is anticipated to grow to around 900,000 by 2050.[1]

4. COMPOSITION OF THE COMMUNITY AGED CARE WORKFORCE

4.1 The Aged Care Workforce, 2016 report, commonly known as the NILS report (the NILS report) provides data on the size and composition of the direct care workforce in the community aged care sector.[2]

4.2 The NILS report states the '2016 census estimates that total employment in home care and home support aged care is 130,263 workers, of which 86,463 are in direct care roles.' (p69). The tables below show firstly the headcount by occupation for the years 2007, 2012 and 2016 and secondly by Full Time Equivalent.

Table 5.2: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	201	53
		(0.2)	(0.1)
Registered Nurse	7,555	7,631	6,969
	(10.2)	(8.2)	(8.1)
Enrolled Nurse	2,000	3,641	1,888
	(2.7)	(3.9)	(2.2)
Community Care Worker	60,587	76,046	72,495
	(81.8)	(81.4)	(83.8)

[1] Australian Department of Health, *2017-18 report on the operation of the Aged Care Act 1997*, 2018, p 6.
[2] National Institute of Labour Studies, *2016 National Aged Care Workforce Census and Survey - The Aged Care Workforce*, 2016

Allied Health Professional*		3,921	4,062
	3,925	(4.2)	(4.7)
Allied Health Assistant*	(5.3)	1,919	995
		(2.1)	(1.2)
Total number of employees (headcount)	**74,067**	**93,359**	**86,463**
(%)	**(100)**	**(100)**	**(100)**

Source: Census of home care and home support aged care outlets.

** Note: in 2007, these categories were combined under Allied Health.*

Table 5.3: Full-time equivalent direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	55	41
		(0.1)	(0.1)
Registered Nurse	6,079	6,544	4,651
	(13.2)	(12.0)	(10.5)
Enrolled Nurse	1,197	2,345	1,143
	(2.6)	(4.3)	(2.6)
Community Care Worker	35,832	41,394	34,712
	(77.8)	(75.9)	(78.7)
Allied Health Professional*		2,618	2,785
	2,948	(4.8)	(6.3)
Allied Health Assistant*	(6.4)	1,581	755
		(2.9)	(1.7)
Total number (FTE)	**46,056**	**54,537**	**44,087**
(%)	**(100)**	**(100)**	**(100)**

Source: Census of home care and home support aged care outlets.

** Note: in 2007, these categories were combined under Allied Health.*

4.3 The tables show there has been a decrease in numbers in the direct care workforce between 2012 and 2016, both as measured by 'headcount' and 'full –time equivalent'.

4.4 Figure 5.1 from the NILS report (p71) shows the share of occupations for the home care and home support direct care employees as both headcount and FTE in per cent of total workforce and Figure 5.2 shows the number of occupations in headcount and FTE (p71).

Figure 5.1: Share of the occupations for the home care and home support direct care employees (headcount and FTE, per cent)

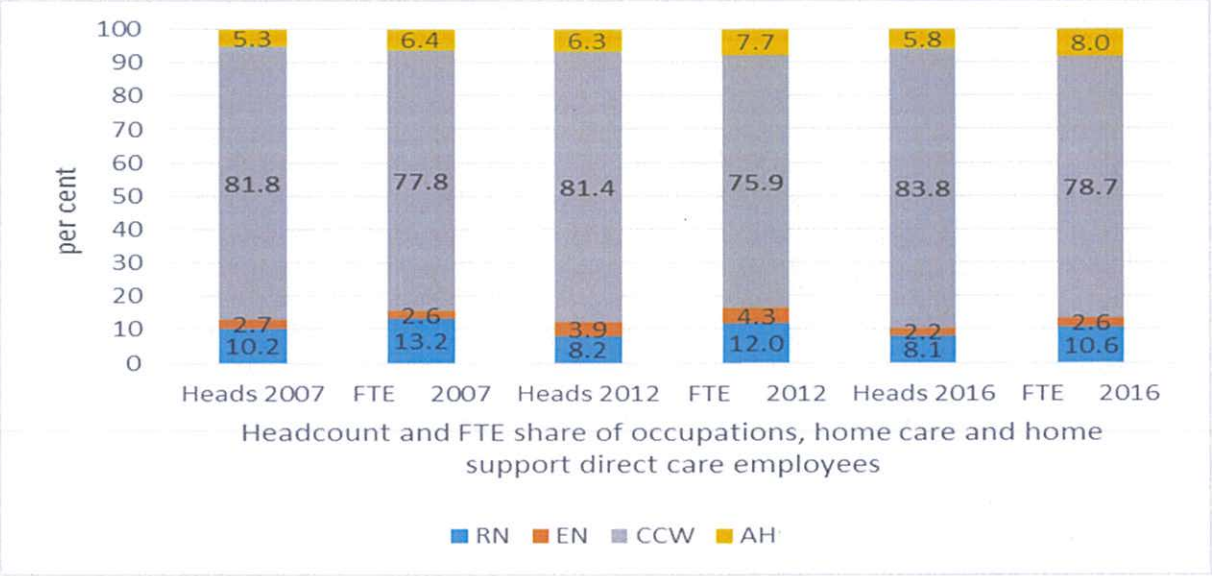
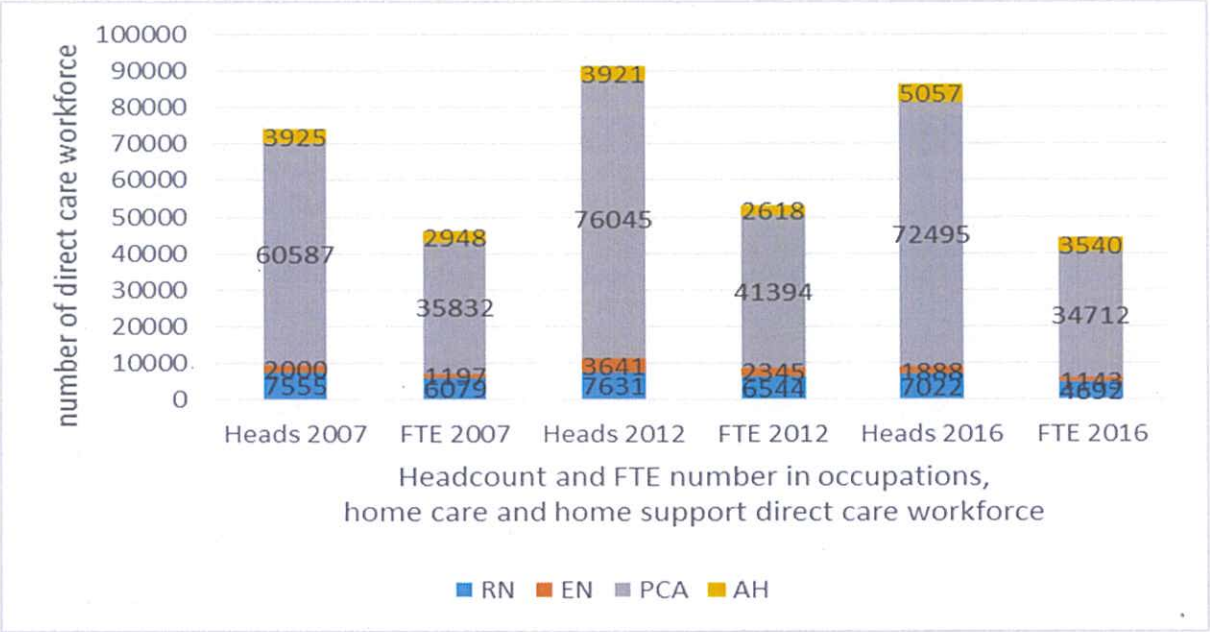


Figure 5.2: Number of the occupations for the home care and home support direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 5.1 and Figure 5.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in both 2007, 2012 and 2016 in Figure 5.1 and Figure 5.2.

4.5 The NILS report data shows that the total workforce reduced in headcount size by 13% and the total headcount size in direct care by 7% between 2012 and 2016. The NILS report estimates the reduction in full-time equivalent (FTE) to be 19% and also suggests the discrepancy between the reduction in headcount and FTE means there was an increase in the proportion of workers employed for fewer hours (p70).

4.6 The above tables show that not only has there been a reduction in the total size of the workforce, there has also been a reduction in the proportion of registered and enrolled nurses relative to the whole workforce between 2007 and 2016 and again between 2012 and 2016.

4.7 Table 5.4 shows that in non-direct care between 2012 and 2016 there was a reduction in the percentage of Case Managers in the workforce.

Table 5.4: Employees not providing direct care in the home care and home support aged care workforce, by occupation: 2016 (per cent)

Occupation	2012	2016
Care Manager/co-ordinator	33.2	29.8
Management	22.3	25.6
Administration	35.3	37.0
Spiritual/pastoral care	1.6	0.5
Ancillary care (home maintenance, modification, etc.)	7.7	7.1
Total	**100**	**100**

Source: Census of home care and home support aged care outlets.

5. EMPLOYMENT ARRANGEMENTS FOR HOME CARE WORKERS

5.1 The NILS report shows the number of workers employed under permanent part-time arrangements has increased from 62% in 2012 to 75% in 2016 (p84).

5.2 Care workers increased permanent part time from 63% to 79% from 2012-16 (p84).

5.3 In 2016, across all occupations, including Allied Health - when casual is added - nearly 90% of workers are part time or casual (p84).[3]

6. IMPLICATIONS OF WORKFORCE DATA

6.1 From 2012 to 2016 the total FTE percentage of the direct care nursing workforce has reduced from 16.3% to 13.2%. Registered nurses have reduced from 12% to 10.6% and enrolled nurses from 4.3% to 2.6%. As case managers are often registered nurses, or ideally should be registered nurses, it is likely that the reduction in qualified staff would potentially impact both the skills and numbers of case managers in the sector.

6.2 The ANMF is concerned about the reduction in overall nursing numbers and the proportional changes, as reductions in appropriately qualified care workers have direct implications for the quality and safety of the care delivered.

6.3 It is increasingly well documented that dilutions in the skills mix of nursing and care workforces lead to poorer health and care outcomes. A short summary of this evidence is at Attachment 1 to this Submission.

[3] National Institute of Labour Studies, *2016 National Aged Care Workforce Census and Survey - The Aged Care Workforce*, 2016

6.4 In addition, there is also international evidence which demonstrates the improved health outcomes in community care when delivered by qualified nurse-led models. A short summary of this evidence is at Attachment 2 to this Submission.

7. DELIVERY OF HOME AND COMMUNITY CARE – ADEQUACY AND TIMLINESS

Home Care Packages: Assessment and waiting lists

7.1 Currently, consumers can be assessed for a Commonwealth Home Support Package (CHSP) via a Regional Assessment Service and a Home Care Package (HCP) by an Aged Care Assessment Team (ACAT). The method of assessment for each package is different, using different assessment methodology and principles and the utility of any assessment is dependent on the skills and qualification of the assessor.

7.2 There are currently considerable delays in receiving an assessment for services. Consumers, who often have difficulty in navigating the system, experience frustration with having to provide information multiple times and in receiving accurate information. The subsequent delays cause difficulties for nurses and carers and also leave consumers anxious and uncertain and, worse, vulnerable to the need for acute intervention due to unmet needs which have developed into illness or injury.

> *The My Aged Care system is the most cumbersome system for elderly people to navigate. Often elderly clients are given conflicting information, there are large delays in getting assessed for care. If a client is unable to talk for themselves I have seen carers reduced to tears by the way they are treated by the call centre staff. This system has done nothing to improve aged care in the community, I believe that it has made it much more difficult!*
>
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7.3 During the course of Adelaide Hearings 1 a great deal of information was provided to the Commissioners regarding unreasonable waiting lists for receipt of services under a HCP once approved. It is not repeated here.

7.4 Delays in receipt of services often means the optimal benefit, including the prospect of improvement or maintenance of wellness and capacity is often lost or diminished. Furthermore, the delay may result in accelerated deterioration and in extreme cases death before an approved high level package even commences. The consequences of these delays for the work of nurses and carers in community aged care is an issue of significant concern for ANMF members.

> *Lack of packages in the community and changes including my aged care have made it extremely complex for clients and families! They get approved that they require extra care in the home then have to wait years to obtain it!*
>
> *Not enough packages. Clients have to wait for a higher package even though they need more assistance now.*
>
> *Customers in SA wait 18 months for services!!?*
>
> *Clients assessed at level 3/4 get offered level 2 interim and money is tight due to more needs. Time is trimmed right back at carer level and client often is rushed in all face to face areas.*

Clients wait a long time for their packages and sometimes die before they get their level 4 package.

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7.5 Deterioration in health while waiting for an approved home care package may also necessitate access to acute health services and premature entry to residential aged care. This increases the cost of care and fails the people expecting to be supported to stay at home. ANMF members also frequently report that on many occasions even once their clients have access to an approved care package, the services available do not actually meet the needs of the individual.

There are many vulnerable people slipping through huge gaps in a mind boggling system. It is costing the government more money as people are not able to access the level of care required in a timely fashion, they end up in residential or dead...

Clients are now being charged full fee for evening and weekend visits which they can't afford. So many are going without services as a result.

There is a lack of suitable packages, it does not support rural people to stay in their homes, funds are eaten up by travel costs, so they receive less care AGAIN.

I have a lot of indigenous clients. The service I work for appears to be geared toward highly educated coastal cashed up retirees. The service doesn't meet the needs of indigenous community with poor health literacy.

A lot of clients should be reviewed more often to see if they require more services.

Clients are not having their packages met to the best of ability. Clients are more isolated on a package and not being able to afford outings due to the pricing of travel, care etc. through packages.

Most clients that are assessed as requiring Level 3 or 4 Home Care Packages are allocated a Low Care package which does not meet their needs. The government then state that they have released many packages without the fact that the packages are not adequate.

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7.6 These experiences emphasise that the level of home care package may not always be adequate to meet the needs of clients even the basic needs of nutrition and hygiene, especially where the individual does not have the means to supplement care. Health care, for example wound care, may also be compromised if the level of package and available funds is not adequate.

8. FUNDING, COSTS AND RESOURCE ALLOCATION

Mismatch between client needs and care provision

8.1 Without providing a detailed analysis of funding between residential and home care, it is well understood that it is more economical and therefore less costly to governments to provide care at home than in residential care. It is also generally accepted that on many occasions it is preferable to consumers to receive care at home and to be able to stay living in their own homes as long as possible.

8.2 It is also generally recognised that as the population continues to age and demand for home care continues to grow there needs to be long term sustainability and budget planning to ensure the future needs of Australia's elderly can be met. However, this will require significant review and overhaul of the system as it is clear that the system for aged care in the home is failing to meet the current needs of elderly Australians.

8.3 ANMF members report that not only, as outlined above, do approved packages often fail to meet the actual needs of the client, but the way providers and agencies allocate delivery of services can contribute to consumers not receiving the care they were expecting or that they need. This can also be exacerbated by consumers and their families not understanding the system.

> *They are not looking at the frailty of the people we care for. And therefore not giving us enough funding for them to get the care required.*
>
> *Changes in the way the package levels are handled as they currently have someone with more money than they will ever need and some that are struggling with the level of care provided from the package funds and these people are suffering...*
>
> *Better allocation of time for services. The amount of work you are expected to do in a short frame of time obviously hasn't been considered, I've got more back pain from my community role because I was so rushed trying to complete household tasks.*
>
> *Funding needs to be based on individual needs. Example: Client 1 on level 4 package only needs domestic and transport assistance and doesn't use all their funding so are encouraged to spend it on things like recliners and beds. Client 2 on level 4 package needs multiple visits a day for medication, shower, meal prep, catheter/leg bag, domestic assistance and they are in overspend.*
>
> *There appears to an element of "poaching" clients -- other providers contacting clients currently serviced by another provider. Also, there appears to be discrepancy between services provided by different providers. Domestic assistance is 60 minutes with some agencies, and 90 minutes with others.*
>
> *Take 'profit' out of the funding criteria. If it is still cheaper to keep a client in their home than a facility then let's do it but make the client's needs the benchmark. Person centred, strength based, active lifestyle support and Dignity of Risk should mean something! Currently I see it as legislative rhetoric with no government will to apply and regulate it.*
>
> *Clients need to be aware of what they are entitled to and not to. Better communication. Some families are using packages to better their own lives and not the life of the client.*
>
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8.4 The ANMF submits that a basic tenet for taxpayer funded delivery of in home aged care services should be that all recipients of aged care services receive a level of funding and service that ensures human dignity and adequate health care appropriate to their needs as assessed by qualified staff.

Consumer Directed Care and administration of packages

8.5 Home Care Packages allocate funds to the individual according to assessed need and are offset by means testing of the individual for the ability to make a co-contribution to the cost of

services. The care recipient can either administer his or her package themselves or pay an administration fee to their chosen provider. There are a number of concerns in relation to administration of packages.

8.6 The percentage of a care package that can be spent on administration of the package is unregulated. Service providers can set administrative fees meaning there is the potential for inconsistency in fees charged and overcharging. In cases of lower level packages the cost of administration may outweigh the benefit of services. This can act as a disincentive to taking up Level 1 and 2 packages.

8.7 In addition, ANMF members suggest that funding is being redirected from care provision to other areas and recommend that the way funding is allocated by providers needs more scrutiny.

> *Regular auditing 3 monthly of the ingoing/outgoing funding. Look at the administration team's pay packet.*
>
> *The whole process for clients and carers looking into home care is very daunting and confusing. I work in the system and I find it very hard to understand. People have so many things thrown at them at once and it's too overwhelming when they are so vulnerable. A lot of providers are just out to get clients on board and not taking into account what the client actually needs. Administration costs are also a killer to clients and carers. Way too high.*
>
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8.8 The principles of consumer directed care are intended to promote choice for the consumer in the market place. Increased competition is then intended to encourage provision of quality, competitively priced services. In practice there are a range of issues in the provision of aged care services that may mean this is not the outcome.

8.9 The ability to 'shop around' depends on a number of factors. For instance, although there is range of services available to choose from there is often insufficient information available about those services to make informed choices. Consideration also needs to be given to the capacity of the individual to make those informed choices. This is often related to an individual's ability to navigate the complexity of the system rather than a cognitive decline in the individual.

8.10 These difficulties are intensified in rural and remote areas where there may be limited or no choice as to the service provider. The individual's capacity to influence the market in these circumstances is negligible. As a result, care recipients may not receive the best possible care.

> *Elderly clients are often confused or overwhelmed by the system that dictates they use the internet and online portals for accessing care. Client directed care doesn't work for people who don't understand their own needs or how to access assistance.*
>
> *Availability of packages and abuse of funds by clients who think 'consumer directed' means what they want, not what they need. Families also have unreasonable expectations often as well.*
>
> *Example of a home care package not used appropriately. 90 year old lady living in department of housing 1 bedroom unit, no heating, unsafe bed, unsafe four wheel walker, limited food, low vision, was only receiving Nursing, MOW and Home help. Case Manager didn't visit for months, Nursing had to transport client to GP, attend shopping, pick up medications from chemist, attend home visit with podiatry. Client had $35000 of unspent money in the 3 months prior to EOFY. As a result of no heating she was hospitalised due to pneumonia and died. DNS case managed client and visited 3 times a day, but had no access to finances and the case manager was difficult to contact and did not follow up requests.*

8.11 The model of consumer directed care is based on the assumption that all consumers are equal. Dr Beatriz Cardona expressed this in a recent opinion piece 'Rhetoric vs reality on consumer direction'[4]

> *The inherent assumption in an open market where older consumers negotiate their care needs is that older people are autonomous and self-motivated agents with equal capacity to make choices in their lives. This fails to recognise the profound inequalities of gender, ethnicity and socio-economic class that persist throughout old age and more specifically the vulnerabilities of frail and disabled older people who are the main users of home care programs*. (p.15)

8.12 For those who do not have capacity to make informed decisions about their own packages and who don't have family or friends to assist them, there may be an inequitable burden in needing to pay for administration and a risk of making ill-informed decisions about the use of their packages.

9. UNCORDINATED, FRAGMENTED AND OVERLY COMPLEX SYSTEMS FOR DELIVERY OF SERVICES

9.1 The view of ANMF members is that the complexity of the in-home and community aged care system and the multiple 'players' involved in the delivery of these services result in a fragmented, uncoordinated system that is leading to confusion, distress and, too often, poor care for the elderly living at home.

9.2 Traditional community nursing services intersect with a plethora of providers and agencies providing a range of services purchased for home care packages as well as providers delivering services under the NDIS. Many residential aged care providers and retirement village operators also run community aged care services. Consumers can obtain, or sometimes must obtain, different services from different providers.

9.3 In addition, there is a lack of coordination between the in home aged care system and the primary health and acute care systems and the fragmentation of the community system is further exacerbated by the recent rise of the 'uberisation' of the provision of aged care services. This is characterised by the recent growth in online platforms matching consumers to carers.

9.4 Service coordination is frequently poor, with many members reporting that while the case manager role is a good one, they are often over worked and unavailable. The workforce trying to deliver care and service within this system can also be disparate, isolated and unregulated with a lack of oversight and quality assurance. The system has given rise to a 'commodification' of care delivery. Consequently, the risks of missed and inadequate care are high.

> *Increasing workloads due to high level packages many with complex care needs. KPIs for no of clients per case coordinators [are] unrealistic.*

[4] Cardona, B (2016). Rhetoric vs reality on consumer direction. *Community Care Review*, August, pp 14-15.

These patients frequently have complex needs and the way the system is funded does not allow for adequate care planning and coordination. Carers are often not offered adequate support. The system is fragmented with so many agencies involved in care and coordination is poor.

Many coordinators are not nurses, yet coordinating clinical care and conducting assessments to determine care needs.

People are worried about the stats and not about what the clients need. Case managers are not up to date with the new improvements so need to educate themselves better. We spend too much time fighting for what the clients are entitled to. Should be easier.

Discharge rates from hospital have increased dramatically over the past few years, thus puts a lot of pressure on community nurses! The paperwork alone is hours! Clients are more complex with no more time allocated! Budgets are discussed constantly, more pressure put onto working families to care for loved ones and people with no support are our most vulnerable.

CHSP clients are being asked to contribute $10 a visit for nursing services which equates to $300 a month. This is a financial strain on disadvantaged and pensioners.

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10. WORKFORCE CAPACITY TO DELIVER SAFE AND QUALITY CARE IN ACCORDANCE WITH BEST PRACTICE

Workload Stress

10.1 As in residential care, nurses and care workers in the home and community care sector are struggling to meet the needs of their clients. ANMF members report that they feel stressed, overworked, undervalued and 'treated as numbers'. They also report that on many occasions the care needs of their clients are missed because they don't have time, because they are forced to spend too much time on tasks that aren't directly focused on the client's care needs and because the client isn't funded appropriately and doesn't have any money available to purchase 'extra' services.

Usually showers are rushed to meet roster times & if [I] have 5 domestic services, it is exhausting.

Heavy workloads unrealistic time frames. Expecting home carers to be cleaners, cooks in short time frames instead of cares.

Staff are stressed because they have limited time with clients and not enough time to get to the next client. Every minute is accounted for on your phone which you have to constantly have to look at because the daily schedule could change at any minute. Creating more stress because time is not given to find an unfamiliar address.

The last 3 roles [I had] were horrendous and we were in constant strife with timekeeping, lack of sufficient care for customers it was dangerous and unfair for them and us.

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Lack of Staff and Support

10.2 ANMF members also report that services providers are frequently understaffed, they are unsupported as employees and the way their work is organised makes it very difficult for them to provide best care, and even at times, safe care.

The total time taken for client visits when added up can seem reasonable but the difficulty is with the travel time in between the clients. This can be quite substantial on an evening shift when the distances covered by one nurse are much greater. This is very stressful and there is pressure not to hurry the visits as you want to provide quality and safe care but you still need to get around everyone. Management also say use all the time allocated for care.

Often the demand outweighs capacity. We are currently traveling in client time but no extra time given for travel. Example: client identified 30 mins face to face travel is included but often 30mins is min needed for client so we feel rushed and rushing client as well.

On the weekends there is an expectation to see clients between 8am 10am for medication management and this is not always physically possible. Workloads are unrealistic and create an environment where nursing staff feel under pressure to rush from one client to the next. I believe errors are frequently made during this timeframe as staff feel under pressure to get to their next client. We are told to call ahead to the client and inform them that we are running late, and in some instances this is not appropriate and again it puts the onus on the nurse not the employer to manage the client list and load. We are told we can call a nurse manager who may be able to offload a client for you but frequently they are often overworked and unable to take the call.

We do not work in block shifts. We work as client needs r met. Start n finish times vary every day. No comfort breaks given to worker. 8.00am till 12 noon as example and no comfort break. Schedules are too tight. 15min at start of shift and 15min end of shift to address all emails, read progress notes, timesheet n mileage completion, face to face conversation with Coordinators or Manager.

While my immediate supervisor is a nurse, the people organizing my day have no or limited clinical knowledge. A certain timeframe is allowed for each visit, but if the time runs over ... you're questioned as to why you are running late. Often no other client is taken off you to make up for the delay

We are supposed to ring our clients the day before to advise them of an approximate time of visit for the next day. And that is fine, until you log on the next day and your run has been changed; without you knowing, leaving some clients distressed because they knew you were coming and nobody has told them that you are not because your run has been charged.

The run was emailed the night before. I spent ages finding addresses so I could keep to my schedule with less stress; then next day a different run would come by phone. Very difficult.

Nurses used to start from the centre, be able to talk with the people doing the client lists each morning, and to discuss tricky clients with their team and their team leader, and the same at the end of the day. Now, nobody sees any of their colleagues. They're not encouraged to work collaboratively. They are expected to work in isolation, at their fastest speed and carry a huge amount of stress.

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Unreasonable demands

10.3 The unreasonable expectations many nurses and carers have placed on them by their employers not only leads to deficiencies in care provision to their clients but occasionally also results in risk taking behaviours.

You were expected to do transfers with the care giver who has no manual handling. No training. You were expected to do showers in the smallest of bathrooms... and all this safely for the resident and yourself. You were not able to do most of what you were asked about safely at all.

I have made a medication error and received a speeding fine ... feeling pressured and stressed.

When driving between clients. I experience stress to meet deadline times and often take risks behind the wheel. Example. Speed, risk taking at intersections, tail gating.

Driving safety - (I had to speed and talk on the phone if I was behind on appointments), and back pain - I was becoming increasingly sore due to completing household duties very fast.

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Lack of appropriately skilled workforce

10.4 ANMF members report that their capacity to deliver safe and best practice aged care in the home is affected by the lack of both a sufficient and an appropriately skilled workforce. Many care workers are untrained, or training is inadequate, yet are asked to perform higher level nursing tasks. Conversely, some care workers with training and experience were expected to spend a large portion of their time on domestic and other tasks rather than direct care tasks.

More RNs in the field supporting and educating other staff would make the quality of care even better.

The number of highly experienced CNCs was slashed from a few of each specialty at each centre, to one of each for the whole region or even across two regions. The team care managers were reduced, and replaced by ENs and then some ENs were replaced by PCAs.

Poor quality care due to lack of continuity and staffing levels at times with expertise. Low morale. Unsupportive work environments that encourage new staff to move on and which eventually wears down experienced staff and prompts them to leave.

In addition, because of the poor organisation of the sector and the work, on many occasions nurses were having to perform tasks which could be performed by other workers if they were available.

'Change in client' feedback often takes days to be addressed due to RN staffing shortages.

Enrolled nurses are underutilised and their skills are not used to full capacity.

I think care workers are over utilised and are expected to do the job of a nurse. They are valuable and necessary as part of the health care team but unfortunately often care workers provide all of the care and they are not trained for this role.

When you are in clients' homes you are unsupervised so without experience anything could go wrong. I know that an RN is at the other end of the phone but sometimes that would not be enough for a newly trained person. My company that I work for now has trainees on their own in the clients homes they have just done the basic training I am assuming it is within the law but it doesn't seem appropriate looking after the elderly especially as they don't always have a voice.

Unwillingness to provide more permanent full time job roles and not separating domestic/social support roles from PCW roles which often means I do basic domestic assistance which is not utilising my skills sets just meeting their client service requirements. There is little incentive for staff to up skill and as there are few permanent workers people will take overtime to achieve adequate take home pay levels.

Lack of time to care

10.5 One of the most significant concerns for nurses and care-workers employed in community and in-home settings was the lack of time they had to attend to the social and psychological needs of clients. This aspect of care, although crucial for an elderly person's overall health in their view, is not prioritised, or even recognised, by the system or by employers in the sector.

Individual staff work unpaid overtime every day up to 1 to 2 hours. Client social and psychological needs are greater than meets the staffing allocations causing occupational health and safety concerns for all staff and risks to clients/families.

Many clients would benefit from more Social Services -- yet most do not have the funding to cover such an extravagance?!

More packages [are needed], our clients give up social support first due to costs now involved which isolates them further.

Being unable to provide the social care many clients need -- sometimes we are the only people they have contact with each day/week.

Time frame to achieve tasks required is not enough as clients are very lonely and you need to spend extra time just speaking with them and always doing a bit extra for them.

While they are encouraged to remain independent in their own home with support, some are very lonely if they cannot leave their home. Often we are the only person they see for the day or in some cases for the week, it may be anywhere from 15 minutes for medication administration or 2 hours once a week for domestic duties and shopping.

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The conditions currently experienced by those delivery aged care services in the home

10.6 The challenging conditions facing the community aged care workforce are similar to those working in residential aged care including low wages and poor conditions of employment, inadequate staffing levels and skills mix, high workloads, unreasonable professional responsibilities, stressful work environments, poor management practices and a poor perception of the work in general.

10.7 Further to this list, we can add issues specific to the delivery of care in a home environment. The industrial landscape in this sector is far more fragmented with a lower level of enterprise agreements overall than in residential aged care covering direct care workers. Where home care programs are run from residential aged care facilities, enterprise agreements generally cover both the residential and home care services.

10.8 Among the challenges for workers in home and community care is their relatively lower bargaining capacity. This workforce is often fragmented and the nature of the work means employees may not have regular contact with one another. Many service providers with enterprise agreements also provide services in residential settings and this tends to dominate enterprise bargaining negotiations due to the single site location of the workforce.

10.9 While there is a growing number of enterprise agreements in this sector, many employees are reliant on awards, primarily federal awards such as the Nurses Award 2010 and the Social, Community, Home Care and Disability Services Industry Award 2010. Some employees may also be covered by a state award in situations where the service is run by an organisation outside the federal system, for example, local government in NSW.

WHS and work design

10.10 In the community, nurses and care workers generally work alone and are required to provide care for a short period of time in the client's home, travelling between a specific number of clients over the course of the working day. There are additional occupational health and safety issues and little control over managing or reducing the risks in their workplace.

10.11 Employees in the home and community care sector also face particular challenges relating to hours of work and the way work is organised. For example, employees may be engaged for very short time periods, i.e. 1 or 2 hours at a time; in rural areas, travel between clients entails long periods of driving; there may be long gaps between clients and last minute cancellations. Ensuring employees are treated fairly in these circumstances continues to be a challenge with some employers refusing to pay basic entitlements such as travel time between clients and not paying the correct travel allowance.

10.12 Private providers frequently pay lower salaries than comparable Council services. This creates an incentive for Councils to outsource to private providers and further push wages down. Low salaries combined with a range of working condition challenges makes recruitment, retention and the development of an experienced highly knowledgeable workforce difficult.

10.13 ANMF members reported on their experiences of working in the sector:

Inequity of pay and opportunity for nurses. No wonder nurses are leaving aged care.

Every minute is attached to a client and therefore no funding for carer meetings.

Training is provided but staff attend at their own expense & time.

No ability for consultation with peers, adequate workplace training (paid), ratios for safe and competent delivery of care to clients with moderately complex health needs. No recognition of need for specialist additional training to support clients with dementia. Too many clients to see with not enough calculated driving time between visits - or realistic documentation time allocated.

Over worked and definitely under paid.

Carers are not seeing continuity of care to vulnerable clients.

I know community nurses who feel some clients need more attention and visits but there isn't enough staff or time to see them every day.

We are very much isolated in our work and not supported through senior staff. Unrealistic expectations.

Hours irregular, not enough travel time, frequent cancellations, split shifts.

Often don't have time for a meal break or even a coffee. Rushing to get to the next client due to unrealistic travel expectations. Expected to eat your lunch while driving at 110kmh on the freeway to the next client, only a matter of time before an accident because of this.

Often breaks not taken or paid when break not taken. No support from management or CTM's.

Staff support and debriefing no longer happens in a remote work force. Staff are working longer and driving more. Stress levels appear higher.

Care workers feel unheard. The aged care industry has become all about profit. The managers do not manage their staff, they just focus on the financial side of the business.

Underpaid and undervalued by the employer.

Underpaid and not very well monitored. I have seen very poor work from other staff.

Under payed and not respected. Until management understand that they get the staff they 'pay for' and management is made accountable for the shortfalls in staffing skills it will not change. Most PCWs do the best with what they know and have at hand, to care for their clients for minimal wages. If their job role is then mapped to personal time management with no allowances made for client needs then it should not be surprising that they put their job/ pay ahead of client's needs. Management in HACC have to be 'profit dollar driven' therefore 'monkey see, monkey do' so are the staff. Where do clients fit into this?

I spent some time as a "sham" contractor. It was my only option. I was made to get an ABN and to "quote" or "tender" for jobs which meant doing my own bookwork, setting aside my own tax & superannuation, providing my own work cover insurance and setting up a home office for the admin work that accompanies all this. The highest quote that I ever won was for $35.00per hour for a 90 minute job that I had to drive a round trip of 94km to get to. I quoted one job and was laughed at because I included my travel cost in the quote. The business I worked for dictated the days (mon-fri) and the span of hours I could service my client list. The company charged me an hourly rate for the provision of liability insurance and charged an annual fee for access to company training. The work was insecure, casual & poorly paid.

We are hurting ourselves trying to help others.

Most of employers treat carer staff like machines. We don't have any voice.

We are expected to work overtime and not get paid due to understaffing.

Low pay for caring for PEOPLE. You get more money working at ALDI.

No respite & rural areas have limited access to services.

Understaffed, undertrained and underpaid staff cannot meet the requirements.

ANMF National Community Aged Care Survey 2019

10.14 And when nurses and carers raise their concerns with management, they report that management:

Won't listen. They say you have to work smarter.

11. CONCLUSIONS AND RECOMMENDATIONS

11.1 The ANMF submits that both the number and proportion of nurses in direct care and non-direct care in home care must be increased and maintained in the long term. The issues with respect to quality of care, timely, accurate assessment and effective ongoing case management will, as is the case in residential care, be significantly addressed with the appropriate numbers and skills mix in this part of the sector.

11.2 Providers should ensure case managers are suitably qualified registered nurses and have a caseload that allows them sufficient time to speak to, visit and assess needs of clients on a continuous basis- and to monitor that plans are delivering required care

11.3 Care workers must be suitably qualified and licensed, have reasonable workloads, have support in place to get assistance when problems arise, be appropriately remunerated for their work – including for travel and administration

11.4 Training and ongoing professional development for staff should be a condition of funding support and should equip care workers to deal with real life situations by the application of strategies such as mentoring and buddying.

11.5 Providers should be accountable for how packages are spent, particularly with regard to administration cost.

11.6 Information about providers' services and costs should be transparent and easily accessible

11.7 Access to packages should be facilitated to reduce waiting time, funded to meet the properly assessed required level of care, and the complexity of the application process should be reduced.

11.8 Any system changes must ensure that home and community care is integrated to enable effective transition to residential and acute, care and end of life. That means each part of care is optimal rather than crisis driven.

ATTACHMENT 1

Skills dilution in community aged care

The provision of quality aged care services depends considerably upon adequate numbers of workers with the required skills being employed in the workforce. Skills shortages are common in the aged care workforce; both in residential aged care and community aged care. In comparisons between 2012 and 2016 data however, while residential aged care skills shortages appear to have somewhat reduced, community care appears to be experiencing more persistent problems. The 2016 National Aged Care Workforce Census and Survey (NACWCS) demonstrated that the percentage of reported skills shortages in community aged care remained relatively constant between 2012 and 2016 (Mavromaras et al., 2017). This persistent shortage of skills could in part be due to reform-induced changes in the sector. In community aged care, the most commonly reported causes of skills shortages reported by employers are: lack of specialist knowledge, remote location, and slow recruitment.

In the United Kingdom, high profile cases where diluted skill mixes, that is, a lower than expected ratio of registered to unregistered staff, were implicated in significant failures in patient safety in various National Health Service (NHS) trusts (Francis, 2010, Healthcare Commission, 2007). Lower registered nurse (RN) staffing levels have been associated with changes in quality and quantity of staff/patient interactions; when RN staffing is low, increasing assistant staff levels is not associated with improved quality of staff/patient interactions (Bridges et al., 2019). In addition, The National Aged Care Staffing Skills Mix Project report (Willis et al., 2016) found that the primary reasons for missed care in residential aged care were lack of staff, increasing resident acuity, skills mix of staff, and unbalanced resident allocations, contributing to the study's overall finding that staffing numbers and skills mix lead to poorer care outcomes.

Adding less qualified nursing support staff to workforces to replace or supplement qualified nurses is a common method of addressing increased demand, staff shortages, and retention issues but does not appear to result in beneficial outcomes for patients (Duffield et al., 2018). Transferable evidence from acute care contexts clearly demonstrate that workforces with a greater proportion of qualified nurses is associated with better outcomes for both patients and nurses. Reducing nursing skill mix by adding less qualified nursing support staff (such as aged care workers) who are less able to meet the healthcare needs to patients may contribute to preventable deaths, erode quality and safety of care and contribute to nurse shortages. One study has shown that substituting one nurse assistant for a professional nurse for every 25 patients is associated with a 21% increase in the odds of dying (Aitken et al., 2016). Similar findings have also shown that for each day of registered nurse staffing below the mean, the risk of death increased by 3%.

The results were very different for healthcare assistants, demonstrating that unregulated assistants cannot make up for deficits in patient safety arising from RN shortages (Griffiths et al., 2018; Griffiths, 2019). Another study has shown that more adverse outcomes such as urinary tract infections and pneumonia occur in contexts where unregulated workers have been added to workforces (Twigg et al., 2016). Another study showed that adding unregulated support workers can increase the amount of task duplication between nurses and care workers (Roche et al., 2017). Beneficial effects from adding assistant staff are likely to be dependent on having a sufficient number and ratio of RNs to supervise, limiting the scope for substitution/dilution in workforces. These findings highlight the possible consequences of reduced nurse staffing and do not give support to policies that encourage the use of nursing support staff/unregulated assistants to compensate for shortages of fully qualified nurses.

Overall, while there is little evidence from the community aged care sector – likely due to the difficulties around designing robust studies and collecting data in such the varied and disparate environments that are peoples' homes in the community – there is considerable evidence from other similar settings with similar care needs, that clearly demonstrates that a diluted nursing workforce with heavy reliance on unregulated, less qualified care assistance staff leads to poorer quality and safety and worse health outcomes including a greater likelihood of death and injury.

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ATTACHMENT 2

The Buurtzorg Nederland (home care provider) model

The well-known Buurtzorg community nursing model was founded in the Netherlands in 2006 as a response to concerns regarding the inadequacy of community care, including its fragmented nature and inefficient delivery of care which was delivered at an hourly cost. Patients were forced to deal with multiple caregivers doing individual tasks, while higher educated nurses grew increasingly frustrated, unable to properly carry out their work (deBlok and Kimball, 2013). While financial pressures in the Netherlands within the health sector led to home care providers cutting costs by employing a lower-paid, lower skilled care workers who were unable to properly care for people with co-morbidities, leading to a decline in health and satisfaction.

The Buurtzorg model is an entirely nurse-led model. It is holistic in its approach run by qualified, experienced nurses who are supported by effective technology infrastructure, are self-managed and provide quality, evidence based care that attempts to connect people to a network of support (Monsen and deBlok, 2013). The model has been shown to have consistently better outcomes then other homecare organisations and has the highest satisfaction rates amongst people receiving care in the Netherlands (deBlok and Kimball, 2013). The Buurtzorg model is an example of where nurses, given the opportunity to provide the care they are qualified to deliver, will make a significant difference.

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