AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA submission to the Standing Committee on Health, Aged Care and Sport – Inquiry into the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018

Health.reps@aph.gov.au

The AMA supports the intent of the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 (the Bill) but suggests that the wording of the amendment be strengthened.

Suggested amendments

The publication of staffing ratios in residential aged care facilities (RACFs), including staff qualifications will increase the transparency of likely quality care provided in each facility. However, these metrics are at risk of being misunderstood if they are not contextualised by data on the level of care needs of the RACF's residents. For this reason, contextual data to describe the mix of resident's level of care should be mandated, not optional. Production of this metric for publication is not an onerous requirement on the industry.

While residents living in RACFs typically have high care needs[1], the level of care, and therefore staff to resident ratios, vary between RACFs. For example, a RACF that has a lower staff to resident ratio and few nursing staff may still provide high quality care if most of the residents have low care needs. Conversely, a facility may offer a relatively higher resident to staff ratio with few nursing staff, but the quality of care is poor because the needs mix of the residents is consistently high. The most widely understood expression of level of care per resident is the Aged Care Assessment Team (ACAT) assessment[2].

Similarly, contextual data could include the level of need of residents in peak periods of the day. For example, mornings are particularly busy as staff must get residents out of bed, bathe or shower them, feed them, and assist in toileting. Conversely, residents require less assistance while asleep and staffing levels may reduce at this time.

[1] Australian Institute of Health and Welfare GEN aged care data (2017) – *People's care needs in aged care*. https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care
[2] https://www.myagedcare.gov.au/eligibility-and-assessment/acat-assessments

The proposed Bill, if amended to include contextual data, has the potential to generate benefits beyond increased transparency for the older people who require care in a RACF. It also has potential to precipitate the market pressures needed to break the detrimental cycle of low staff ratios/poor quality of care and negative workplace culture that diminishes the workplace appeal of RACFs.

The government should also provide information on the roles of the different staff categories. This includes information on what the different types and levels of nurses entails. This would ensure consumers are able to make an informed choice. The AMA is presuming that the staffing ratios and subsequent information will be published on My Aged Care, as this is where consumers will look to compare RACFs.

There should be more information on the roles and mix of allied health professionals. Many RACFs do not employ allied health professionals but instead engage with them externally, and this should be reflected in the reporting mechanisms. Allied health professionals are an essential part of the aged care workforce and their availability is crucial to resident care. The different types of allied health professionals should also be categorised, as older people may seek certain types of allied health support when choosing their RACF.

Context

As noted by the AMA in a previous submission to the Aged Care Workforce Strategy Taskforce (see submission here), the aged care system, and its workforce in particular, is ill prepared to respond to the projected increased demand for aged care in the future. Fifty –two per cent of residents in RACFs have dementia[3]. Projections estimate the number of Australians with dementia could reach 1.1m by 2056[4] and demand for qualified staff will increase in lock-step with it.

Currently, the aged care system, and its workforce, does not have the capacity or capability to adequately deal with this growing, ageing population and their complex care needs. The Productivity Commission estimates the number of nurses and personal care attendants in the aged care workforce must quadruple by 2050 to meet demand for aged care services[5]. This level of projected demand in the aged care workforce will put enormous pressure on a system already facing recruitment and retention issues. A large part of the difficulty faced by the industry to attract and retain qualified staff is the negative, stressful workplace culture that poor staffing ratios precipitate.

Market pressures driven by increased transparency of staff ratios and qualifications has the potential to re-direct demand away from poor quality RACF providers and over time create a new higher baseline of expected quality of care in RACFs. To maintain viability, RACF providers in large metropolitan areas will need to lift their staffing ratios and staff qualifications to meet the new

[3] Australian Institute of Health and Welfare GEN aged care data (2017) – *People's care needs in aged care*. https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care
[4] Alzheimer's Australia (now Dementia Australia) (2017) *Economic cost of dementia in Australia,* p6 https://reports.dementia.org.au/costofdementia
[5] Productivity Commission (2011) *Inquiry report – Caring for older Australians*. Pp XLV

baseline 'normal' in the industry. RACFs in rural, regional and remote areas may have less competitive pressures, but local citizens will have the transparency they need to pressure their local members to do more to increase the staff ratios/qualifications of their local RACF providers. In theory as staffing ratios increase, workplace culture would also be expected to improve and the appeal of the RACF sector should improve.

Next steps

While the Bill is a good first step in addressing aged care workforce issues, there should be a regulated minimum staff to resident ratio, including registered nurses and all other categories of staff described in the Bill. The AMA believes that, instead of being a 'blunt instrument', the ratio would be more practical if it reflected the care needs of the residents in the RACF. Ratio models should be developed by using care needs assessed through ACAT assessments and include that registered nurses should be available 24 hours a day.

The AMA is concerned that publishing staffing ratios alone may potentially result in setting a 'poor standard' of staffing as the commonly accepted 'minimum'. Whereas, a *regulated* minimum staff ratio, developed in consultation with the medical profession and other key stakeholders, would prevent this. Staffing ratios need not stifle innovation, but rather can lay the foundation on which better quality care standards can be built.

A regulated minimum will, in our strong opinion, still allow RACFs to find innovative ways to care for their residents, through a different mix of staff, above the minimum 'safety net' of staff required. Studies identify that the main reason for missed care, or low-quality care in RACFs is that there is not enough staff available[6,7,8]. More registered nurses in RACFs have been shown to improve medical care and reduce costly unnecessary hospital transfers[7].

Government should also consider mandating a minimum qualification for people to work in aged care. This would ensure the aged care workforce has the capability to provide the services that are expected of them.

It is important to acknowledge this sequence of events will take time and it will not be a 'silver bullet' to address the multiple barriers to quality care in RACFs. This is an industry that requires substantial new and additional funding and considered reform. The lack of progress to date indicates the industry is unlikely to drive the needed reforms via self-regulation.

Reform should not stop at establishing mandated minimum staffing ratios. The aged care system desperately needs better outcome measures, which are monitored, to drive an improvement in

[6] Castle, N and Engberg, J (2005) *Staff turnover and quality of care in nursing homes*. Medical Care. 43:6, pp616-626.
[7] Dellefield, M et al (2015) *The relationship between registered nurses and nursing home quality: an integrative review (2008-2014)*. Nursing Economics. 33:2, pp95-108.
[8] Henderson,J et al (2016) *Missed care in residential aged care in Australia: An exploratory study*, Collegian, 24:5, pp411-416.

quality of care, without it imposing an undue administrative burden on staff, who should be focussed on caring for residents.

To that end, the AMA affirms its convictions about quality and person-centered outcomes in the aged care sector. This will require a range of meaningful and transparent measures on outcomes and the experience of people and families are developed in a co-designed methodology. As input measures may be a proxy for access, outcomes and experience; the AMA still calls for public transparency about consumer costs, access to health professionals and staff ratios. Quality of care and outcome measures of quality cannot be achieved without adequate staffing ratios. We have been informed that understaffing is the biggest barrier to aged care staff who want to provide quality care. Adequate staffing ratios alone might not ensure quality, but inadequate staffing certainly prevents it[9,10,11].

For a summary of the full scale of resourcing and workforce measures required to deliver quality of care in aged care facilities refer to the *AMA Resourcing Aged Care Position Statement* found here.

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Contact
Hannah Wigley
Policy Adviser
Medical Practice Section
hwigley@ama.com.au

[9] Castle, N and Engberg, J (2005) *Staff turnover and quality of care in nursing homes*. Medical Care. 43:6, pp616-626.
[10] Dellefield, M et al (2015) *The relationship between registered nurses and nursing home quality: an integrative review (2008-2014)*. Nursing Economics. 33:2, pp95-108.
[11] Henderson, J et al (2016) *Missed care in residential aged care in Australia: An exploratory study*, Collegian, 24:5, pp411-416.