

**Submission
No 113**

**INQUIRY INTO REGISTERED NURSES IN NEW SOUTH
WALES NURSING HOMES**

Organisation: Aged & Community Services NSW & ACT

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Aged & Community
Services NSW & ACT

**Submission to the NSW Legislative Council inquiry
Conducted by the General Purpose Standing Committee No. 3.
into Registered Nurses
in New South Wales Nursing Homes**

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on behalf of Aged & Community Services NSW & ACT Board of Directors
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ACS Overview

Aged & Community Services NSW & ACT (ACS) is the leading peak organisation representing not-for-profit, church and charitable providers of services in retirement living, community aged care and residential aged care in NSW and the ACT. ACS represents around 300 organisations, providing over 2,000 services to more than 100,000 people. ACS members range in size from large multisite organisations to small rural and regional stand-alone services.

ACS members are typically registered charities with not-for profit status, in recognition of the services provided to aged and frail people unable to afford fees and charges or unable to access any other form of support due to their levels of disadvantage.

Not-for-profit organisations across NSW and the ACT provide around 65% of all aged care beds and around 89% of home care packages.

Summary

ACS is supportive of 24/7 Registered Nurse (RN) cover where it is needed in those services whose residents require a high level of clinical expertise at all times.

The removal of the high/low distinction, as part of the Aged Care reforms that were introduced in July 2014, has meant that the Legislative Requirement of the Public Health Act that is linked to high care places is now obsolete.

There has been an alarmist campaign waged that asserts that without the 'safety net' of such a legislative requirement Aged Care providers would remove Registered Nursing staff from their services. This is not the case. ACS and aged care providers recognise that more, not fewer, RNs are needed and wanted, in the sector. However, they are needed in the right place to best support those residents with high or complex clinical needs and are not always readily available, especially in the rural and regional areas of our State.

No other State has this legislative imperative and there is ample evidence to show that aged care providers in the other States provide the same high standard of care and support to their residents as those in NSW. There are effective Commonwealth 'safety nets' provided through the accreditation processes of the Australian Aged Care Quality Agency (the Agency) and the Aged Care Act and Principles.

ACS is concerned that the application of unwarranted legislation could result in a requirement that will have unintended consequences with negative impact on the viability and sustainability of quality services that are providing valuable psycho-social support to people in their community.

There is no evidence to suggest that higher levels of RNs in aged care increase quality outcomes for residents and we would put the case that what is required is the flexibility to have differing skill mixes according to the needs of those residents with low needs and others higher.

As the Productivity Commission noted in its Report: Caring for Older Australians:

“While there are superficial attractions to mandatory staffing ratios, there are also downsides. An across-the-board staffing ratio is a fairly ‘blunt’ instrument for ensuring quality care because of the heterogeneous and ever changing care needs of aged care recipients — in the Commission’s view it is unlikely to be an efficient way to improve the quality of care. Because the basis for deciding on staffing levels and skills mix should be the care needs of residents, it is important that these can be adjusted as the profile of care recipients’ changes (because of improvements/deteriorations in functionality and adverse events, etc). Imposing mandated staffing ratios could also eliminate incentives for providers to invest in innovative models of care, or adopt new technologies that could assist care recipients .” (p206 Caring For Older Australians)

The other consideration of note is the imposition of State legislation on top of a Commonwealth regulated sector, at a time when governments are looking to reduce the imposition red tape causes.

ACS, therefore, considers that State legislation specifying RN requirements in aged care is unnecessary and unhelpful.

Responses to the stated matters of inquiry

1. The need for registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, in particular:

(a) the impact of amendments to the *Aged Care Act 1997 (Cth)* by the *Aged Care (Living Longer Living Better) Act 2013 (Cth)* on the requirement under s 104 of the *Public Health Act 2010* to have a registered nurse on duty at all times in a nursing home, and in particular:

(i) the impact this has on the safety of people in care.

ACS believes that there are already sufficient safeguards in place.

The amendments to the *Aged Care Act 1997 (Cth)* by the *Aged Care (Living Longer Living Better) Act 2013 (Cth)* on the requirement under s 104 of the *Public Health Act 2010* to have a registered nurse on duty at all times in a 'nursing home' will have no impact on the safety of people in care as evidenced by the situation in all the other States, none of which have State legislation of this nature.

Accreditation results for the 3 years up to March 2015 in the table below show no discernible difference between the results in NSW which has had this legislative requirement and all the other States which do not. NSW has 97% of homes accredited for 3 years which is the same as the national average.

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Provider responsibilities under the Aged Care Act (below) are clearly stated and the Accreditation processes provide the required oversight of compliance.

Aged Care Act 1997

Division 54—Quality of care

54-1 Responsibilities of approved provider

*(1) The responsibilities of an approved provider in relation to the quality of the *aged care that the approved providers are as follows:*

(a) to provide such care and services as are specified in the Quality of Care Principles in respect of aged care of the type in question;

(b) to maintain an adequate number of appropriately skilled staff to ensure that the care needs of care recipients are met;

(c) to provide care and services of a quality that is consistent with any rights and responsibilities of care recipients that are specified in the User Rights Principles for the purposes of paragraph 56-1(m), 56-2(k) or 56-3(l);

(d) if the care is provided through a residential care service—to comply with the Accreditation Standards made under section 54-2.

ACS asserts that the safety of people in care is assiduously monitored by the Commonwealth through the Accreditation and Complaints Management processes and deficiencies promptly addressed and remedied through the Aged Care Quality and Compliance Group.

The Department of Social Services reiterates this point on its [Website](#):

The Aged Care Quality and Compliance Group (the Group) provides a strong focus on the quality and accountability of aged care services delivered to care recipients and promotes compliance with the statutory obligations of approved providers.

The Group has the power to investigate aged care services funded under the Aged Care Act 1997.

The compliance activities of the Group have both a regulatory and quality improvement role. The Group manages national programs designed to ensure compliance with the Aged Care Act 1997 and also oversees the implementation of the aged care quality framework, including a package of reforms to improve quality of care and care recipient protection.

(ii) the possibility for cost-shifting onto other parts of the public health system as a result of any legislative or regulatory change to the current provisions.

On the contrary, if this requirement is not removed and is in fact further extended to capture services that were formerly considered 'low' care, it could be seen to be a cost-shifting exercise on the part of NSW. Aged care is Commonwealth funded, not to be a pseudo hospital, but rather to provide personal care or nursing care, or both personal care and nursing care.

Residential care is the continuation and extension of support that is provided to people in their own homes when their support needs are no longer able to be met by a combination of informal carers and packaged care. At times these needs are clinical but not always. It may be that assistance is required with showering or meal preparations or to address issues of social isolation.

From the Aged Care Act - 41-3 Meaning of residential care

(1) Residential care is personal care or nursing care, or both personal care and nursing care, that:

(a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:

(i) appropriate staffing to meet the nursing and personal care needs of the person;
and

(ii) meals and cleaning services; and

(iii) furnishings, furniture and equipment for the provision of that care and accommodation; and

(b) meets any other requirements specified in the Subsidy Principles.

(2) However, residential care does not include any of the following:

(a) care provided to a person in the person's private home;

(b) care provided in a hospital or in a psychiatric facility;

(c) care provided in a facility that primarily provides care to people who are not frail and aged;

(d) care that is specified in the Subsidy Principles not to be residential care.

It would be unacceptable for the State to impose an additional requirement that has a significant cost impost for providers without the provision of additional funding to cover those costs. This would put pressure on the Commonwealth Government to increase the funding of residential aged care.

(b) the requirement for a registered nurse to be on duty in a nursing home at all times, as compared with requirements in aged care hospital wards.

There haven't been nursing homes in NSW since the repeal of the Nursing Homes Act in 2004. Residential Aged Care Facilities are residents' homes in which care and support are provided, just as they may have been through Home Care packages into a person's previous home until such time as the supports available became inadequate.

People in a hospital ward are usually there because they have acute clinical needs. Not all people in Residential Care have clinical needs. Those residents with clinical needs most commonly have chronic clinical needs that do not require 24/7 RN oversight.

The models of care are quite different; hospitals work under a medical model of care whereas aged care is more focussed on quality of life and re-enablement.

(c) the administration, procurement, storage and recording of administration of medication by non-registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, as compared with hospital clinical settings.

Current legislative requirements, standards and practices are sufficient including the Poisons & Therapeutic Goods Legislation which is currently under review.

The routine assistance with medicines that is provided by trained care staff, is much the same as was provided by a family member prior to the resident's admission.

There is no evidence that those medicines that are prescribed by a doctor and dispensed by a pharmacist individually for each resident in a dose administration aid are managed less safely and correctly by appropriately trained non-registered staff than by RNs.

The current Units of Competency within the Certificate III and IV in Aged Care training packages are considered the standard for direct care workers to assist with the administration of medication in aged care:

[CHCCS305B - Assist clients with medication \(Certificate III in Aged Care\)](#)

[CHCCS424B - Administer and monitor medications \(Certificate IV in Aged Care\)](#)

The assessment process for these Units of Competency for direct care workers will be further strengthened in the new qualifications, to be released later this year.

Whilst these Units of Competency are not mandatory, most employers do not permit care staff assistance with medication, unless the care worker possesses these skills.

Assessment of the safety and correctness of the administration of medicines is routinely undertaken by the Agency in accordance with outcome 2.7 of the Accreditation Standards (attached), Medication Management, which assesses that *residents' medication is managed safely and correctly*.

The Productivity Commission Report, Caring for Older Australians, (Chapter 14,p351) argues for the benefits of increasing the skill level and scope of care staff.

While the substitution towards less skilled workers may be partly driven by financial constraints and difficulties in attracting and retaining nurses, the scopes of practice for some personal carers have also been widened (for example, undertaking medication management). Such initiatives have many benefits, including increasing the workplace satisfaction of personal carers and improving their skills.

*Importantly, as recognised by the Australia Health Ministers' Advisory Council, it meets a fundamental workforce principle that:
... to ensure the best use of scarce workforce resources, wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care. (2005, p. 9).*

(d) the role of registered nurses in responding to critical incidents and preventing unnecessary hospital admissions.

One could expect that the assessment skills of a RN would assist in the prevention of some hospital admissions. ACS takes issue, however, with the use of the word 'unnecessary'.

A residential aged care facility is the person's home and they are as entitled to ambulance and hospital support when needed as any other person in their home. As previously stated, residential aged care services are not hospitals.

2. The need for further regulation and minimum standards for assistants in nursing and other employees or carers with similar classifications.

ACS does not support the need for further regulation or minimum standards for assistants in nursing and other direct care workers however named, as current standards and practices are more than adequate.

Anecdotal evidence from employers is that their preference is to hire "for fit" with the organisation and the community they serve and then provide suitable training in accordance with the organisation's values. Most providers require their staff to undertake the Certificate III in Aged Care training and many support staff through the Certificate IV in Aged Care training.

Further regulation and minimum standards could discourage workers seeking employment in a sector where it has been clearly identified that more workers are needed.

3. The adequacy of nurse to patient ratios in nursing homes and other aged care facilities with residents who require a high level of residential care.

ACS agrees with the aforementioned comments made in the Productivity Commission's report 'Caring for Older Australians' which specifically argues against ratios as being counter-productive in the quest for innovative models of care:

"While there are superficial attractions to mandatory staffing ratios, there are also downsides. An across-the-board staffing ratio is a fairly 'blunt' instrument for ensuring quality care because of the heterogeneous and ever changing care needs of aged care recipients — in the Commission's view it is unlikely to be an efficient way to improve the quality of care. Because the basis for deciding on staffing levels and skills mix should be the care needs of residents, it is important that these can be adjusted as the profile of care recipients' changes (because of improvements/deteriorations in functionality and adverse events, etc). Imposing mandated staffing ratios could also eliminate incentives for providers to invest in innovative models of care, or adopt new technologies that could assist care recipients ." (p206 Caring For Older Australians)

The Agency monitors staffing in Residential Aged Care in accordance with outcome 1.6 of the Accreditation Standards (attached), Human Resource Management, which specifically assesses that 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.'

Under Standard 2, the accreditation requirements also specifically assess against the clinical aspects of care to ensure that all clinical needs of residents are being appropriately addressed.

Staffing ratios would deny providers the flexibility required to appropriately respond to the changing mix of care needs within their service, where at times it may be that more RNs are needed, and at other times the limited care funding might be more productively spent on additional allied health services or care staff numbers to support their residents.

4. The report by the NSW Health Aged Care Steering Committee.

ACS accepts the report made to NSW Health Aged Care Steering Committee as a fair record of the Committee's deliberations and reaffirms the ACS position, as stated as a resolution of the ACS Board:

"That the ACS position on the 24/7 RN is that the legislation is out of date and must be repealed".

5. Any other related matter.

Workforce facts pertaining to RNs and aged care

1. 72% of the workforce is permanent part time; 25-30% want to work more hours (not RNs); median age is 48 yrs. *(2012 National Aged Care Workforce Census, DoHA).*
2. Aged care providers report that many RNs seek to work the minimum number of hours they need in order to retain their practicing certificate, this restricts the shifts available; impairs continuity of care; and increases administrative and educational costs for the organisation.
3. The community care workforce will need to expand to deliver the increased number of packages funded under the reforms. In 2012, RNs were around 12% of the community direct care workers. This workforce grew from 46056 in 2007 to 54537 in 2012 and will keep growing. *(2012 National Aged Care Workforce Census, p75, DoHA).*
4. Approximately 66% of the aged care workforce is located in metropolitan areas. *(2012 National Aged Care Workforce Census, p55, DoHA).*
5. The ratio of direct care workers per residential operational place in NSW is around 0.7 although the ratio is higher in non-metropolitan locations. *(2012 National Aged Care Workforce Census, p59, DoHA).*
6. 62.5% of aged care facilities reported a shortage of RNs, with 70.3% of facilities in remote locations reporting this, *(2012 National Aged Care Workforce Census, p61, DoHA).*
7. The most difficult staff to recruit are RNs with around 33% of facilities reporting RN vacancies, a figure that has increased from 25.7% in 2003 *(2012 National Aged Care Workforce Census, p64, DoHA).*
8. Around 30% of RN vacancies took more than 4 weeks to fill, with the average RN vacancy duration being 6.9 weeks in NSW. However in outer regional areas this was 8 weeks, remote 15.2 weeks and very remote 12.6 *(2012 National Aged Care Workforce Census, p65-66, DoHA).*
9. In the face of shortages, 63% of facilities asked existing staff to work longer hours and 53% used agency (non-PAYG) staff. *(2012 National Aged Care Workforce Census, p62, DoHA).*
10. Nationally, over half of all facilities (55%) used non-PAYG workers and 31.2% of facilities had used at least one agency RN in the fortnight of the survey. The use of agency RNs was only 26% in 2003. *(2012 National Aged Care Workforce Census, p68-69, DoHA).*
11. In NSW in 2003 only 19.1% of facilities had used agency staff; in 2012 this was 26.7% *(2012 National Aged Care Workforce Census, p70, DoHA).*

Aged Care Facilities in NSW

There were 1239 facilities in NSW, and around 53% were low care.

Aged Care Facilities in NSW* – DSS Service List 2012

Location	High Care	Low Care
Inner Regional	146	194
Major Cities	354	365
Outer Regional	67	90
Remote	10	11
Very Remote	2	0
	579	660

* A facility is counted here if the DSS listed service has high care places or low care places counted respectively. AIHW (AIHW RAC A Statistical Overview 2010-11, Tables A1.2, A1.6) counts the total number of facilities for NSW as lower, ie 885 for 2011. This is because some services listed as having both high care places and low care places are counted as only once by AIHW. In the 2012 data there were 297 such double-up entries.

Consequences

A requirement to have RN cover 24/7 in every facility would be impossible to achieve, there are not enough RNs to sustain this. Failure to meet this requirement could have harsh penalties for a facility.

Those services where this requirement currently stands are struggling to fill RN positions and in some instances non-compliance is reportedly being avoided by:

- Managers being on duty for up to 24 hours at a time
- Staff being asked to work more hours than they wish to work, with burnout and resignations reported
- Where they are available, the very expensive use of agency staff, and
- All too often, less suitable staff being given a job and retaining it as they can't be easily replaced.

None of these practices are in the best interests of resident care.

Conclusions

Registered Nursing staff are a valuable, but not always readily available resource. We need new models of care and more flexible deployment of the staff available to us. Rigid rules on staff ratios or requirements for certain categories of staff can lead to poorer outcomes for clients, unnecessary costs and could expose diligent facilities to the risk of being non-compliant with subsequent penalties for no improved quality of care.

It is feared that if this requirement is expanded to include all services that have any residents assessed under the funding instrument as requiring a higher level of care that many of the formerly low care services would not be able to remain financially viable and would subsequently close.

The sad result of these closures would be that many communities would no longer have any residential aged care service at all, that the local communities would suffer as a result of the loss of employment opportunities and the supply of goods and services to the service, but most tragically that people would be forced to leave their local communities to receive the assistance that residential care is able to offer.

The following case studies demonstrate some of the potential impacts of the expansion of this requirement.

Case Studies

Presbyterian Aged Care (PAC) Case Studies Submitted by Paul Sadler, CEO

PAC runs 9 residential care services across NSW and employ a total of 66 Registered Nurses (RNs).

The implications of extending the legislative burden to have RNs in every facility 24/7 for our residential care services include:

1. PAC Gosford (39 beds)

- An increase of 128 hours per week of RN coverage required – approximately the cost increase would be \$4,920 per week or \$255,600 p.a. This would require a minimum number of 5/6 RNs per week to cover shifts.
- Alternatively we could offset the above by replacing a care staff member with an RN, thereby having an RN doing care staff work as well to cover the legislative requirement, resulting in a net increase of \$1,715 per week or \$89,190 p.a.

2. PAC Minnamurra, Drummoyne (65 beds)

- An increase of 112 RN hours per week equals \$221,400 p.a. increase. The minimum if offset against care worker hours would be \$75,800 p.a. and would require an additional minimum of 5/6 RNs per week to cover shifts.

3. PAC Haberfield (41 beds)

- An increase of 152 RN hours per week would equal \$300,352 p.a. The minimum if offset against care worker hours would be \$102,752 p.a. and would require an additional minimum of 7 RNs per week to cover shifts.

4. PAC Apsley Riverview, Walcha (31 beds)

- An increase of 152 RN hours per week would equal \$300,352 p.a. The minimum if offset against care worker hours would be \$102,752p.a. and would require an additional minimum of 7 RNs per week to cover shifts.
- There is significant shortage of RNs in the New England region in both residential and community aged care – PAC Apsley Riverview Walcha would almost certainly have to close.

To summarise, PAC would have to consider:

1. Closing low care facilities because they will be unable to comply with the legislation;
2. Removing other types of staff in order to try and find savings for the required RN cover, which would impact on the overall quality of care for residents;
3. Potentially transferring 'high care' residents, from what used to be a low care facility, to a hospital to avoid making the facility non-compliant; or
4. Stopping looking for ways to provide short term acute or palliative care in a facility, as there will not be enough RNs available to help us with these short term peaks and troughs in changing resident needs.

Bundaleer Care Services Ltd Case Studies Submitted by Dennis Marks, CEO

Currently Bundaleer (located in Wauchope, a regional area) has 2 sites. One is a high care facility (old nursing home) which already employs registered nurses 24 hours per day as per legislative requirements so if the current legislation is not repealed, there would be no difference to the operations of this facility. Due to the aged care reforms, this facility is experiencing a dramatic reduction in the length of stay of residents, so to maintain a reasonable occupancy rate, we are admitting low care residents if high care residents are not available. Presently, there are not many of this type of resident but it does have a negative effect on the operational result of the facility.

Our other facility, located on a separate site is an 84 bed ageing in place facility. Currently we have around 49 low care residents (including respite) and 34 high care (58% and 42%

respectfully) We employ registered nurses 6 days per week with a coverage of 16 hours per day. If the legislation is changed to require registered nurses 24 hours per day, it would mean an additional night shift for the 6 days per week and 24 hours on a Sunday.

My calculations (which do not include public holidays) indicate that to employ a registered nurse in our ageing in place facility would increase the total cost by \$173,142 (one additional shift (night shift) 5 days per week plus 8 hours on a Saturday and 24 hours on a Sunday) (\$46.15 per hour), increase hours by 3,752 (1.9 FTE positions).

Breaking these figures down:

- The \$173,142 increase equates to an additional \$5.65 per resident per day on the overall number of residents in the facility.
- The \$173,142 if divided by \$25 (the wage rate for a carer plus on costs) it equates to 6,926 hours or 3.5 FTE positions.
- The break-up of the resident mix is 58% low care and 42% high care.
- If we accept the fact that the current legislative requirement to provide a registered nurse for all high care level residents, then the additional cost would only be an impost on the low care level residents, therefore 58% of the \$173,142 equates to \$9.74 per resident per day, my reasoning here is that the high care level residents would be the only residents for whom we need to provide RN coverage.
- With no increase in funding, to pay for the increase in RN coverage, we would need to reduce our roster for care staff by 6,926 annually (133 hours per week, 3.5 EFT staff). We would then increase our risk of not meeting the Accreditation Outcomes relative to resident care.
- The last reality is that with every provider in NSW in the market for additional registered nurses, it would be almost impossible to find RNs willing to do night shift and weekend work. The risk of Non Compliance may mean a decision to close the facility may be real.

Other considerations

In both facilities, many residents do not require large levels of registered nurse time. Their care needs (keeping in mind we are trying to deliver a person centred care model) may be better met with 1:1 care by a carer. The Aged Care Act, User Rights Principles and the Accreditation Standards provide the legislative framework for residents to receive appropriate care, provided by qualified and skilled staff and in particular the Accreditation Standards provide a requirement for all providers to ensure that the care needs of all residents are being met and includes ensuring that registered nurses are available to residents if required. More legislation will only reduce any flexibility a provider may currently have in creating an appropriate staff roster.

Hostel Case Study – De-identified

Introduction

This Case Study is from a small rural country town in southern NSW with a population of approx 1300 people.

Case Study Hostel was a low care facility in the old classification but now manages ageing in place and more complex residents. It is a 21 bed facility divided into 3 houses of 7 each joined by common areas and facilities. Current staff of 20.

Case Study township has one other Aged Care facility – a former high care facility (16 beds). Currently the Hostel is run by a Care Manager who is also a RN and she manages both responsibilities. The Provider has found this dual role workload to be challenging and probably unsustainable and is now recruiting for a RN for 3 days a week to work during the working day and to be on call. This is considered is a sensible compromise of RN resource for clinical support and supervision. The Provider also invests in training and support for care staff to keep care standards high.

Financials

Financially the Hostel struggles mainly due to challenges with occupancy and developing a suitable wait list, but also with the extra costs of being small and relatively isolated. Infrastructure costs are also a constant pressure as the building is ageing and was built on a budget by local government so the Provider has had to constantly upgrade the infrastructure to make it more attractive and competitive. The Provider is currently undertaking capital improvements and renovations costing over \$1.5m.

The Provider's last published Annual Report ending 2014 showed the Hostel with an income of \$1.2m and an operating deficit of \$53k. Overall net deficit was \$0.1k if non-operating was taken into account. So the Hostel barely breaks even now although the Provider is working to make it more robust and attractive for the future. Any further financial pressure may cause the Hostel to close.

Closure of this Hostel would create a huge impact on the town and surrounding area as considerable distances are involved to neighbouring hostels and places are limited. Residents' families and friends would be greatly inconvenienced. Removal of a large employer in the town would also be a large issue along with the associated loss of income to the town's suppliers and contractors.

Registered Nurse role - Provider comments

The introduction of a full time RN available 24/7 would have significant consequences on this facility in terms of financial sustainability and recruitment and retention of staff. It is also debatable in terms of the overall care needs of residents and what is appropriate and sensible in terms of clinical advice and supervision.

The value of a good RN in an aged care facility is not questioned as they provide necessary clinical oversight and advice. However it is all about balance. Good care management is also critical along with appropriate socialisation, good meals, interesting activities and attractive overall environments.

At the Hostel the Provider is currently looking to employ a new RN for 3 days a week. This will cost approx \$60k per annum but strikes the right balance between demand and supply. They also have other strategies to reduce clinical risks such as maintaining an on-call RN system, network support from a senior RN and backup from other hostels. They also have a comprehensive training and orientation program for staff and a culture that is resident focussed. This manages the risk but remains affordable.

A 24/7 RN would add another \$400k pressure to the operating costs. They would also have, based on past experience, huge challenges attracting and retaining suitable RN for this service. They would also run the risk of having to accept poor quality or untested overseas trained staff creating further training and performance management overheads. They would also probably have to pay more or offer special conditions to attract new staff. This would inevitably also cause knock on issues with duties, responsibilities and pay of existing staff and may affect the quality of their work. They would also have to consider reducing care staff and other support staff in the hostel to offset a RN.

The Provider would also question the employment need. RN are highly trained and should not be treated as basic care staff. This further challenges the attractiveness of aged care as a career path for RN and threatens levels of job satisfaction for current and future RN.

Overall

The Hostel case study supports RN as an important component of the aged care system but RN should not be disproportionately introduced to need as this will degrade their job satisfaction, create financial issues, create staff issues, create recruiting and retention issues, create supervision and performance issues and not necessarily improve the overall care of residents.



Standard 1

Management systems, staffing and organisational development

Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of care recipients, their representatives, staff and stakeholders, and the changing environment in which the service operates.

Intention of standard: This standard is intended to enhance the quality of performance under all Accreditation Standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.

1.1 Continuous improvement

The organisation actively pursues continuous improvement.

1.2 Regulatory compliance

The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.

1.3 Education and staff development

Management and staff have appropriate knowledge and skills to perform their roles effectively.

1.4 Comments and complaints

Each care recipient (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.

1.5 Planning and leadership

The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.

1.6 Human resource management

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.

1.7 Inventory and equipment

Stocks of appropriate goods and equipment for quality service delivery are available.

1.8 Information systems

Effective information management systems are in place.

1.9 External services

All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals.

Standard 2

Health and personal care

Principle: Care recipients' physical and mental health will be promoted and achieved at the optimum level in partnership between each care recipient (or his or her representative) and the health care team.

2.1 Continuous improvement

The organisation actively pursues continuous improvement.

2.2 Regulatory compliance

The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care.

2.3 Education and staff development

Management and staff have appropriate knowledge and skills to perform their roles effectively.

2.4 Clinical care

Care recipients receive appropriate clinical care.

2.5 Specialised nursing care needs

Care recipients' specialised nursing care needs are identified and met by appropriately qualified nursing staff.

2.6 Other health and related services

Care recipients are referred to appropriate health specialists in accordance with the care recipient's needs and preferences.

2.7 Medication management

Care recipients' medication is managed safely and correctly.

2.8 Pain management

All care recipients are as free as possible from pain.

2.9 Palliative care

The comfort and dignity of terminally ill care recipients is maintained.

2.10 Nutrition and hydration

Care recipients receive adequate nourishment and hydration.

2.11 Skin care

Care recipients' skin integrity is consistent with their general health.

2.12 Continence management

Care recipients' continence is managed effectively.

2.13 Behavioural management

The needs of care recipients with challenging behaviours are managed effectively.

2.14 Mobility, dexterity and rehabilitation

Optimum levels of mobility and dexterity are achieved for all care recipients.

2.15 Oral and dental care

Care recipients' oral and dental health is maintained.

2.16 Sensory loss

Care recipients' sensory losses are identified and managed effectively.

2.17 Sleep

Care recipients are able to achieve natural sleep patterns.

Accreditation Standards

Standard 3

Care recipient lifestyle

Principle: Care recipients retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

3.1 Continuous improvement

The organisation actively pursues continuous improvement.

3.2 Regulatory compliance

The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about care recipient lifestyle.

3.3 Education and staff development

Management and staff have appropriate knowledge and skills to perform their roles effectively.

3.4 Emotional support

Each care recipient receives support in adjusting to life in the new environment and on an ongoing basis.

3.5 Independence

Care recipients are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

3.6 Privacy and dignity

Each care recipient's right to privacy, dignity and confidentiality is recognised and respected.

3.7 Leisure interests and activities

Care recipients are encouraged and supported to participate in a wide range of interests and activities of interest to them.

3.8 Cultural and spiritual life

Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.

3.9 Choice and decision-making

Each care recipient (or his or her representative) participates in decisions about the services the care recipient receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.

3.10 Care recipient security of tenure and responsibilities

Care recipients have secure tenure within the residential care service, and understand their rights and responsibilities.

Standard 4

Physical environment and safe systems

Principle: Care recipients live in a safe and comfortable environment that ensures the quality of life and welfare of care recipients, staff and visitors.

4.1 Continuous improvement

The organisation actively pursues continuous improvement.

4.2 Regulatory compliance

The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems.

4.3 Education and staff development

Management and staff have appropriate knowledge and skills to perform their roles effectively.

4.4 Living environment

Management of the residential care service is actively working to provide a safe and comfortable environment consistent with care recipients' care needs.

4.5 Occupational health and safety

Management is actively working to provide a safe working environment that meets regulatory requirements.

4.6 Fire, security and other emergencies

Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.

4.7 Infection control

An effective infection control program.

4.8 Catering, cleaning and laundry services

Hospitality services are provided in a way that enhances care recipients' quality of life and the staff's working environment.



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