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ABN 41 816 898 298

6 September 2017

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
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Dear Committee Secretary,

**Submission to the Inquiry into the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised.**

Having made a submission to many of the recent reviews and inquires relating to the Aged Care Sector of late, the Australian Nursing and Midwifery Federation (ANMF) welcome the opportunity to provide the following information to this Inquiry.

Established in 1924, the ANMF is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing, with Branches in each state and territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership, which now stands at more than 267,000 nurses, midwives and assistants in nursing, our members are employed across all urban, rural and remote locations, in both the public and private health and aged care sectors.

The ANMF takes a leadership role for the nursing and midwifery professions by participating in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, workplace health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

Nurses and midwives together comprise more than half the total health workforce. They are the most geographically dispersed health professionals in this country, providing health care to people across their lifespan and in all socio-economic spheres.

Approximately 40,000 ANMF members are currently employed in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors, depending on their health needs. As such, the ANMF welcomes the opportunity to significantly contribute to this Inquiry.

**Terms of Reference**

**1.** the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised;
**2.** the adequacy and effectiveness of complaints handling processes at a state and federal level, including consumer awareness and appropriate use of the available complaints mechanisms;
**3.** concerns regarding standards of care reported to aged care providers and government agencies by staff and contract workers, medical officers, volunteers, family members and other healthcare or aged care providers receiving transferred patients, and the adequacy of responses and feedback arrangements;
**4.** the adequacy of medication handling practices and drug administration methods specific to aged care delivered at Oakden;
**5.** the adequacy of injury prevention, monitoring and reporting mechanisms and the need for mandatory reporting and data collection for serious injury and mortality incidents;
**6.** the division of responsibility and accountability between residents (and their families), agency and permanent staff, aged care providers, and the state and the federal governments for reporting on and acting on adverse incidents; and
**7.** any related matters.

The ANMF New South Wales Branch, the New South Wales Nurses and Midwives' Association and the ANMF Queensland Branch, the Queensland Nurses and Midwives' Union have already made a submission to this Inquiry. It is essential that the committee strongly consider these documents along with this national ANMF submission.

The aged care sector has recently undergone an extensive number of reviews, reforms and inquiries. As we have already highlighted, with our large membership working in and around the sector, we have a strong commitment to see the change required to improve the care being provided to older persons in community and residential settings. As such we have provided responses to multiple reviews in both written and verbal forms. The ANMF are very concerned that these reviews are occurring in isolation and it is imperative the outcomes and recommendations are considered as a whole. As these are important reforms, these reviews should be mapped to form a complete picture of aged care. This Inquiry needs to consider all the findings of these recent reviews when providing recommendations.

Although the ANMF have not responded to each point under the Terms of Reference for this Inquiry, our recent responses to other aged care sector

reviews address them all. We provide the following relevant submissions to the committee for consideration:

- Submission to the Australian Law Reform Commission (ALRC) Consultation on issues paper: Elder Abuse
- Submission to Australian Law Reform Commission Elder Abuse Inquiry: response to Discussion Paper released December 2016
- Submission to the Senate Inquiry, The future of Australia's aged Care Sector Workforce
- Submission to the Independent Aged Care Legislated Review
- Submission to the Single Aged Care Quality Framework - Draft Aged Care Quality Standards Consultation Paper 2017 and the Single Aged Care Quality Framework - Options for Assessing Performance against Aged Care Quality Standards, Options Paper 2017

The ANMF have also provided an online written submission and given evidence to the *Independent Review of the Aged Care Quality Regulatory Processes* being led by Ms Kate Carnell and Professor Ron Patterson.

The other information relevant to this Inquiry is three documents the ANMF have produced. These include:

- ANMF National Aged Care Staffing and Skills Mix Project, **Attachment A**
- ANMF National Aged Care Survey Final Report **Attachment B**
- Nursing Guidelines for the Management of Medicines in Aged Care **Attachment C**

Lastly, the ANMF provide the initial findings of a national workforce survey that we are conducting to determine the true extent to the cuts of care hours currently occurring in residential facilities across the country.

The survey was launched in early August 2017 and over 744 aged care nurses and carers have responded to date.

Some initial findings show:

- 92% of respondents are being asked to care for the same number of residents with less staff, less hours;
- 90% say current staffing levels aren't adequate;
- 71% don't think the ratio of registered nurses to other care staff is adequate;
- 89% don't think the ratio of AIN's/carers/PCW's to residents is adequate.

Please refer to the following link for further information on this survey http://anmf.org.au/media-releases/entry/media_170829

The submissions, research and information provided clearly demonstrate the current aged care crisis. It is essential, that along with the extensive number of reviews currently occurring within the sector, action is taken to ensure safe, quality care is provided to older persons. We must ensure situations like that which occurred at Oakden, are not occurring elsewhere and will never occur again.

If you have any further questions regarding this submission please contact Julianne Bryce, Senior Federal Professional Officer, ANMF Federal Office, Melbourne on 03 96028500 or julianne@anmf.org.au.

Yours sincerely

**Lee Thomas**
Federal Secretary

# Attachment A

# National Aged Care Staffing and Skills Mix Project Report 2016

## Meeting residents' care needs: A study of the requirement for nursing and personal care staff

Australian Nursing & Midwifery Federation
Flinders University
University of South Australia

# Foreword

Lee Thomas,
ANMF Federal Secretary
and Project Sponsor

Australians are living longer and they are enjoying good health for an increasing number of those extra years. But as we live longer, the need for formal aged care services has increased too.

Over the past two decades, the number of Residential Aged Care places nearly doubled from 134,810 in 1995 to 263,788 in 2014. The increasing aged population will continue to present us with a number of challenges – perhaps most critically the need to provide a skilled aged care workforce.

Over the same two decades, there have been numerous Productivity Reports and Senate Inquiries which have consistently recommended there is a need to establish

.

Despite these recommendations, there has been a monumental failure of

and skills mix hat provide a minimum safe standard of quality care to vulnerable older Australians.

The current Aged Care Act 1997 indicates the numbers of care staff should be adequate to meet the assessed care needs – however, it provides no parameters on what the volume or skill mix of workers must be based on to safely meet the needs and care requirements of residents.

A growing body of national and international research and evidence clearly

f leads to an increase in negative outcomes for those in their care, which results in increased costs. In

shown to prevent adverse incidents and outcomes, reduce mortality and prevent readmissions thereby cutting health care costs. It is widely agreed that the same improvements could be achieved in the aged care sector – but this is reliant on appropriate number and mix of skilled and experienced staff – which includes RNs, ENs, and assistants in nursing/PCWs.

In the acute sector, two

or nursing/hours per patient day), ensuring transparency and are enforceable by industrial instruments. However, there has been little focus on the impact of nurse

studies.

aged care sector, the ANMF Federal Executive funded and commissioned Stage 2 of the National The established Aged Care Industry.

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Date: 2016

Citation: Willis, E., Price, K., Bonner, R., Henderson, J., Gibson, T., Hurley, J., Blackman, I., Toffoli, L and Currie, T. (2016) Meeting residents' care needs: A study of the requirement for nursing and personal care staff. Australian Nursing and Midwifery Federation

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**Flinders University Research Team:**
Professor Eileen Willis
Dr Julie Henderson
Dr Ian Blackman

**University of South Australia:**
Dr Terri Gibson
Associate Professor Kay Price
Dr Luisa Toffoli

**ANMF SA Branch**
CEO/Secretary Adjunct Associate Professor Elizabeth Dabars AM
and the Project Team:
Rob Bonner
Jennifer Hurley
Trish Currie

A special thank you to all contributors who enabled the development of resident

survey and Delphi respondents, without whom the development and validation of

These include the Aged and Restorative Care Expert Group, the National Aged Care Expert Group, and the Timings Working Group.

# Table of Contents

# Executive Summary

## 1. Introduction

by the Productivity Commission (2011a) that aged care sector organisations were experiencing

due to lack of competitive wages, limited or poor educational opportunities, lack of opportunities for career development, poor management of Residential Aged Care facilities, and excessive regulation of scope of practice (Productivity Commission 2011b: 347).

The recommendations of the Productivity Commission were largely limited to addressing education and training opportunities. Strategies for dealing with workplace conditions and the retention

not yet been systematically addressed. There is evidence that Residential Aged Care in Australia is

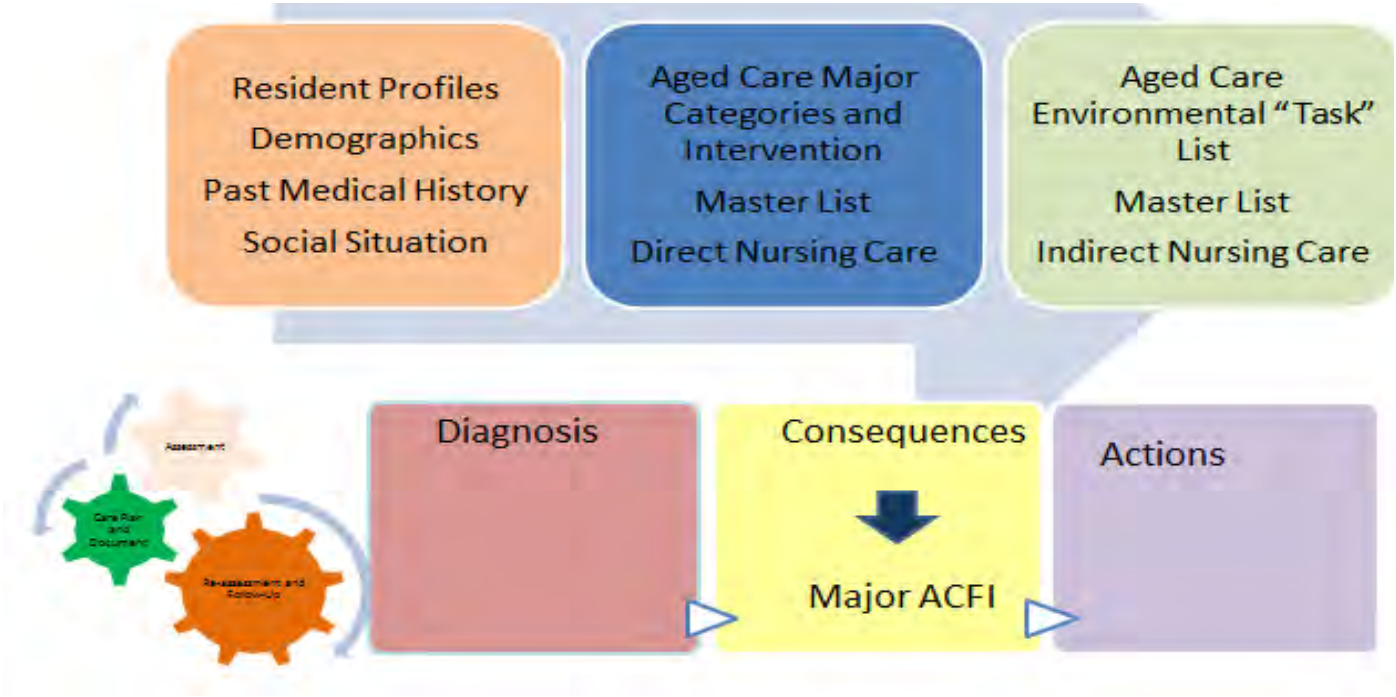
fewer licensed nursing staff, and increased resident acuity (Allard 2014; Chenoweth et al., 2014; Gao et al., 2014; Henderson et al., 2016a; King et al., 2013). Recent budget decisions, along with the implementation of consumer-directed care from 2017 onward,s are likely to further reduce the funds available under the Aged Care Funding Instrument (Ansell, Cox & Cartwright 2016).

levels and skills mix in Residential Aged Care,

(2011a) and reported by the National Institute of Labour Studies (King et al., 2013). This is the second stage of a two-part study that has

skills mix for Residential Aged Care.

The data components of the methodology which underpins this study are represented in the diagram below:




These are combined to form the following

Assessment and reassessment of <u>each</u> resident **+** direct nursing and personal care time ***per*** intervention ***per*** resident **x** frequency ***per*** shift **+** indirect nursing and personal care time ***per*** intervention ***per*** resident **x** frequency ***per*** shift **=** total resident nursing and personal care time ***per*** day.

Data collection for the second stage of the study involved three methods:

1. V
   that were developed in Stage One of the project.

   determined the percentage of nursing and personal care (skills mix) time needed

   interventions to be completed over a 24 hour period, and the time taken to complete those interventions inclusive of time for indirect and environmental tasks. These

   national focus groups across the country to determine the validity of the interventions and timings.

2. Administration and analysis of a **MISSCARE** staff in Residential Aged Care. This survey collected information from 3,206 participants about the interventions they believed were being missed and the reasons why these interventions were missed.

3. A third evaluative component was a Delphi survey undertaken with 102 invited experts (residential site managers) about changes
   Aged

   and skills mix. It also sought agreement on the principles, but not timings, underpinning the methodology used in the focus groups.

## 2. Findings

Aged Care, following the application and evaluation of

1.

survey found that residents received 2.84 hours of care/day from nurses, care workers, and therapy staff (Allard 2016). This compares with 2.5 hours for residents with the lowest assessed nursing and personal care needs and 5 hours for residents with the highest assessed nursing and personal care needs using the

Stage One and trialled in this evaluative study.

2. Resident direct nursing and personal care needs have been validated with 0.5 indirect

following **National Focus Group** consultations and a review of the **MISSCARE survey data**.

3. Only 8.2% of respondents to the **MISSCARE survey**
adequate.
4. The **MISSCARE survey** found that all nursing services and personal care interventions were missed at least some of the time.
5. Inadequate staff numbers was the most

6. The types and frequencies of missed care were consistent across 24 hours; i.e., staff shift did

care in Residential Aged Care.

7. The reported number of residents cared for on the last shift worked by the respondent was associated with incidents of missed care (e.g., higher resident numbers are associated with more missed care).
8. Staff:resident ratios are highest in government-

9. Factors that were reported as adding to the time needed to deliver care were administrative

load; communication needs of residents and their families; inadequate skills mix; size of facility and access to resources; and working with special needs groups (people with dementia, Culturally and Linguistically Diverse (CALD) background, and people receiving palliative care).

*methodology: impact of skills mix*

1. Applying the Residential and Aged Care desktop modelling calculation (Stage One) for 200 residents resulted in an average of 4.30 Resident and Personal Care Hours Per Day (RCHPD), and a skills mix requirement of RN 30%, EN 20%, and PCWs 50%, based on the twenty-four nursing and personal care assessment requirements of residents.

2. Participants in the **Focus groups** and **Delphi survey** indicated that Residential Aged Care facilities are admitting a greater volume of residents with more complex needs who have shorter lengths of stay than previously.
3. Participants in the **Focus groups** associated an inadequate skills mix comprising a low ratio of RNs to PCWs with poor reporting and delayed management of emerging resident health issues.
4. Participants in the **Focus groups** stated that the administrative load undertaken by RNs limited their ability to provide direct nursing care.
5. Findings from the **MISSCARE survey** show that RNs identify more missed care related to Activities of Daily Living (ADLs) and complex health care than ENs and PCWs.

**Focus**

**groups.**

6. The **MISSCARE survey**

and that staf

staff: resident **ratios**
likely to report missed care. Where staff were able to request extra staff when needed, less care was missed. The interventions which are least frequently missed are: ‘providing stoma care’, ‘maintaining nasogastric or PEG tubes’, ‘suctioning airways’, measuring and monitoring blood glucose levels’, and ‘maintaining IV or subcutaneous sites’; However, when these occur, it is at the expense of other complex health care interventions that RNs undertake.

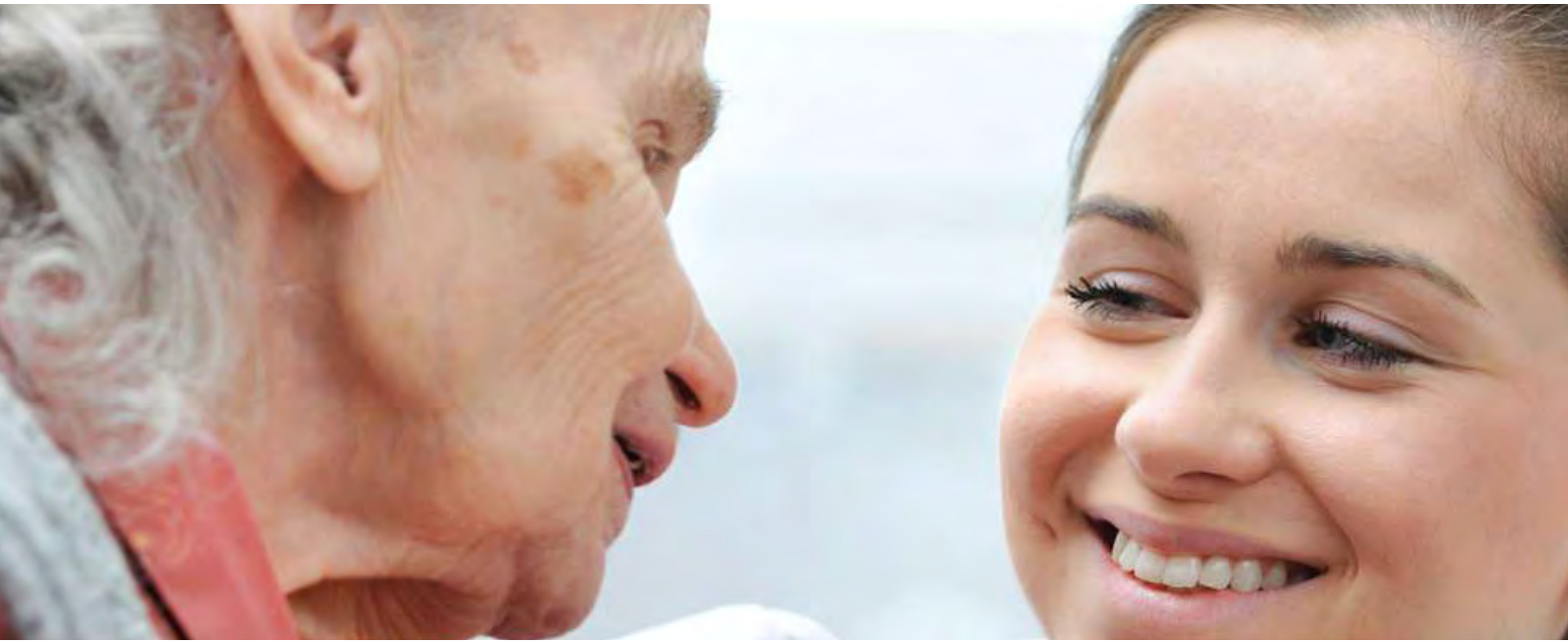
7. A minimum of 80% consensus was achieved through the **Delphi survey** on the need for RNs to assess and reassess residents in Residential Aged Care facilities.
8. Consensus was also achieved on the need for all aspects of the methodology during the **Delphi survey.**

**Recommendations on the basis of findings**

1. Residential Aged Care Facilities (RACFs).
2. to incorporate the time taken for both direct and indirect nursing, and personal care tasks and

   the level of care required by residents.
3. That the average of 4.30 (RCHPD) or 4 hours and eighteen minutes of care per day, with a skills mix requirement of RN 30%, EN 20% and Personal Care Worker 50% is the evidence based minimum care requirement and skills mix to ensure safe residential and restorative care.

# CHAPTER 1
# Establishing an Evidence-Based Methodology for Staffing and Skills Mix in Residential Aged Care



## 1.1 Introduction

This study reports on an Australian Nursing and Midwifery Federation (ANMF) funded project aimed at providing an evidence-based methodology Aged Care. The goal of the study was to evaluate a methodology designed as part of a previous study (referred to as Stage One and reported in Chapter 2), using three validating methods: focus groups, Aged Care sector, and a Delphi survey with experts took account of resident acuity and staff skills mix.

The report provides stakeholders with evidence of allocation and skills mix, linked to a range of f.

A methodology of the type proposed in this report estimates of care costs to be passed on to the pricing authority.

The organisation of this evaluation study is outlined below. This chapter includes a literature review on key issues dealing with staff:resident ratios in Residential Aged Care in Australia and internationally. Chapter 2 outlines the design of the evidence-based aged care resident complexity frequency of interventions over a 24 hour period. The methods used to conduct the focus groups,

the MISSCARE survey, and the Delphi survey are also included in this chapter. Chapters 3, 4 and 5 group interviews, the Residential Aged Care MISSCARE survey, and the Delphi exercise respectively. Chapter 6

drawn from the research methods to validate the

Residential Aged Care.

The study was conducted in two parts. Part One outlines the development of the complexity *Total Residential Aged and Restorative* ). We report the process in detail in the methodology chapter as it has not been published elsewhere. This work was conducted under the auspices of the ANMF. The second part of this report outlines the evaluation process used to verify the methodology used in devising the *Total Residential Aged and* ©. This occurred between June 2015 and June 2016 and was conducted by a team of researchers from Flinders University and the University of South

research working closely with, but independently of, the ANMF team. While the overarching research design was determined in consultation with the ANMF, all three data gathering methods used

and conducted by the university research teams operating at arm's length from the ANMF. Ethics approval was gained from both universities for all three components of the evaluation study.

The evaluation arm of the study included a three-step process:

1. The conduct of seven focus groups, primarily with Nurses (RNs) [N=29], to

   acuity, required care, timings, and skills mix. The focus groups provided qualitative triangulation of the resident complexity

2. Over 3,000 RNs, ENs, and PCWs) from the aged care sector completed the missed care survey. This survey was an adaptation of the Kalisch MISSCARE survey (2009) and drew on the Aged Care Funding Instrument (ACFI) to align it with Residential Aged Care. It was designed by the university team, and the process of

   The MISSCARE survey was conducted to establish if, in the view of nurses and PCWs, care was being missed;

3. A Delphi exercise was conducted with Residential Aged Care managers for their views on the factors which impact on workload within aged care, as well as to gain agreement about the building blocks underpinning the development of a

Following this process, a draft of the report

produced in response to the reviewers' comments.

### 1.2 Background to the Study: Literature Review

This study was designed to evaluate a

levels in aged care, based upon the care needs of residents and the time taken to perform care interventions. This study is in direct response to issues raised by the Productivity Commission (2011a) about attracting and retaining a workforce for the aged care sector when government funding is restricted. The Productivity Commission sought to reform aged care delivery in light of increasing demand for aged care associated with the ageing of the population, the burden of chronic illness,

and increasing expectations about service choice and support for independent living. Underpinning the review was the need to expand the aged care workforce at a time when the ageing of the workforce has resulted in fewer people providing care (King et al., 2013) and low wages which make working in aged care unattractive (Productivity Commission 2011a). The terms of reference required the Productivity Commission to:

- explore regulatory and funding options which were sustainable and allowed for alternate revenue sources to ensure continued access to aged care services;
- explore future workforce requirements for aged care;
- adjust regulatory mechanisms in aged care to promote continuity of care;
- examine the regulation of retirement living options to bring them in line with the rest of the aged care sector; and
- to aged care roles and responsibilities (Productivity Commission 2011a).

The key recommendations of the Productivity Commission included a removal of restrictions around the licensing of aged care beds; the re-establishment of the accommodation bond and introduction of savings and credit schemes to allow older people to pay the bond; a greater focus upon the reablement of residents; removal of the distinction between high and low care services; and a reduction in reporting requirements (Productivity Commission 2011a). Many of these changes were instituted in the Commonwealth Aged Care (Living Longer Living Better) Act 2013 (McCullagh 2014).

in relation to the aged care workforce addressed

workforce in the light of increasing demand for services. Strategies for attracting and retaining

paying fair and competitive wages; improving access to education and training; development of a career structure and better management of aged care; extending the scope of practice; and reducing regulation. The Productivity Commission stated that the pricing of aged care should take

required to deliver quality Residential Aged Care (Productivity Commission 2011b: 347). This recommendation echoes concerns raised by the Productivity Commission in 1999 when establishing a national subsidy rate. At that time, they recommended that the government should subsidise aged care at a rate that would meet

rates and conditions applicable in the aged care sector" (Productivity Commission 1999: XVI). The primary difference between the two reports is the recommendation of the addition of a user pays system rather than relying solely upon government subsidies.

The recommendations of the Productivity Commission in relation to the aged care workforce were primarily focused on education and training for aged care. They recommended:

1. an expansion of education and training opportunities for aged care workers at all levels;
2. a greater focus on aged care in health professional education; and
3. a review of registered training organisations (RTOs) who provide vocational education and training (VET) for the aged care workforce to ensure that VET educators have contemporary skills; that students acquire the competen

needed; and that mechanisms for ongoing regulation of the sector are in place (Productivity Commission 2011a).

Strategies for addressing workplace conditions and the retention of aged care workers were not systematically addressed in the recommendations of the Commission.

There are currently no guidelines in relation to Australian Residential Aged Care Facilities (RACFs). A report by Access Economics noted that "The current ACFI does not provide any guidance on the most appropriate nursing mix within a facility. This is problematic because residents assessed as needing the same level of care may require different types of nurses to administer that care (Access Economics 2009: 45). Further, the accreditation standards administered through the Australian Aged Care Quality Agency when data was collected only had two standards

organisation comply with "all relevant legislation, regulatory requirements, professional standards and guidelines", while standard 1.6 stated that f

accordance with these standards and the residential care service's philosophy and objectives"

number or skills mix of staff required. This contrasts with other jurisdictions where quality is ensured

establishment of minimum hours per resident day of care, or alternately, minimum levels of licensed nursing staf

one RN for 8 consecutive hours for 7 days a week (e.g., DON) and a licensed staff member (RN, LVN, or LPN) for the remaining shifts. Likewise, all but one Canadian province require an RN to be on duty 24 hours per day (Harrington et al., 2012). In contrast, Australia has no mandatory requirements of New South Wales, with Angus and Nay (2003) noting that the Act only requires facilities to provide 'adequate and appropriate'

### 1.3 Use of Residential Aged Care Facilities in Australia

As noted by the Productivity Commission (2011a & 2011b), demand for aged care services is increasing. In Australia, the ageing of the baby boomer population in conjunction with post-war migration is projected to lead to an increase in people over 65 from 14% in 2012 to around 19% of the population by 2031. This increase is accompanied by a doubling of the population of people aged 85 and over, who are the main consumers of Residential Aged Care facilities (ABS 2013). Demand for Residential Aged Care services is also increasing. The number of people using aged care services increased by 36% between 2002-03 and 2010-11 (AIHW 2015b). The Australian Institute of Health and Welfare (2015b) estimates that 62% of the population who died aged 65 years and over during 2010-11 were using either community or Residential Aged Care services at their time of death. The use of Residential Aged , it has been estimated that up to 7% of the population aged 65 and over used Residential Aged Care in 2010-11 with 5.6% being permanent residents. The use of Residential Aged Care is more common in the last year of life, with 54% of people aged 65 and over who died in 2010-11 having used Residential Aged Care within their last year of life (AIHW 2015b).

**'In Australia, the ageing of the baby boomer population in conjunction with post-war migration is projected to lead to an increase in people over 65 from 14% in 2012 to around 19% of the population by 2031'**

### 1.4 Dependence of Residents in Residential Aged Care Facilities in Australia

Increasing demand for Residential Aged Care has been accompanied by higher levels of resident dependence. A number of recent studies have

Aged Care in Australia associated with increased resident acuity due to hospital avoidance strategies which result in earlier discharge from hospital and management of residents in-situ, but due also to later admission (Chenoweth et al., 2014; Gao et al., 2014; Henderson et al., 2016a). Chan et al. (2014) argued that admission of higher acuity residents is supported by the ACFI model which provides

with higher needs, as facilities receive the most funding for residents who are incontinent, confused, and not ambulant. Movement towards the admission

proportion of residents who are rated as high across the three ACFI care domains of activities of daily living (ADLs), behaviour, and complex health care needs. In June 2012, these residents accounted for 18% of all residents. This number had risen to 27% by June 2015 (AIHW 2016a; 2016b). In the same period, the proportion of people with dementia had increased from 52.1% of the entire Residential Aged Care population to 59% (AIHW 2016b; 2016c).

Aged care residents often have multiple co-morbidities and complex care needs. Data on co-morbidities is not readily available from Residential Aged Care, but can be gained from hospital studies. Arendt et al. (2010), in a study of residents from Residential Aged Care admitted through emergency departments in six public hospitals in New South Wales, found that the majority were high acuity (triaged as category 1-3). Likewise, Dwyer et al. (2014), in a review of articles addressing hospital admissions from Residential Aged Care, found that residents transferred from a RACF had between 3.4 and 4.5 separate diagnoses. Hopgood et al. (2014) explored co-morbidities and medication use among 206 older people discharged from hospital to a RACF. The mean number of co-morbidities that this population experienced was 6 (±2.2), with residents taking a mean of 8.1 (±4.0) medications upon discharge to a RACF.

Residential Aged Care facilities are also increasingly providing end-of-life care. Broad et al. (2014), in a comparative review of location of death data from 45 countries, argued that population ageing in high-income countries has resulted in a higher proportion of older people dying in institutional care. In Australia, approximately one-third of people aged over 65 die in Residential Aged Care (Lane & Phillis 2015), often shortly after admission. Drawing on Australian Institute of Health and Welfare (AIHW) data, Parker and Clifton (2014) noted that 6.8% of admissions to RACFs in Australia die within 4 weeks and 17.8% within 6 months. Short-term admission for end-of-life care creates additional work demands which Residential Aged Care staff are poorly equipped to meet (Lane & Phillips, 2015).

hours per patient day (Parker & Clifton 2015). While palliative care only accounts for part of the workload in Residential Aged Care, this number compares

in RACFs in Australia outlined below.

### 1.5 Residential Aged Care Staffing in Australia

While demand for, and the dependence of, residents in RACFs in Australia is increasing, changes in the skills mix have resulted in employment of a greater proportion of unlicensed care workers. The 2012 National Aged Care Workforce Census and Survey conducted by the National Institute of Labour Studies (NILS) for the Federal government concluded that there were 147,086 workers in Residential Aged Care in Australia in 2012 providing direct care services, comprising 73% of the entire Residential Aged Care workforce. Of these, 7,649 provided allied health services with the remaining 139,437 provided nursing and personal care

services (King et al., 2013). This equates to 94,823 FTE positions in Residential Aged Care (ACSA 2014). Table 1.1 below shows the composition of the Residential Aged Care workforce providing direct care, with the majority being employed as personal care attendants (PCA/PCW/AiNs) (68.2%), with RNs comprising 14.9% of the workforce, and ENs 11.5% (King et al., 2013).

**Table 1.1: Composition of the Residential Aged Care workforce providing direct care (30 March 2012)**

| Employees | Number | Percentage |
|---|---|---|
| RN (RN) | 21,916 | 14.9 |
| EN (EN) | 16,915 | 11.5 |
| Nurse practitioner (NP) | 294 | 0.2 |
| Personal care attendant (PCA) or Personal care worker | 100,312 | 68.2 |
| Allied health professional (AHP) | 2,648 | 1.8 |
| Allied health assistant (AHA) | 5,001 | 3.4 |
| Total | 147,086 | 100% |

*Source: Based on data from the 2012 National Aged Care Workforce Census and Survey conducted by the National Institute of Labour Studies (NILS).*

This is a change from 2003. Figure 1.1 demonstrates changes in the ratios of direct care workers reported in the 2003 and 2012 National Aged Care Workforce Census and Surveys. While

completion rates for both rounds of the survey, the data suggests a movement away from employment of registered nursing staff towards PCWs (Department of Social Services 2014; Richardson & Martin 2004).
number of Full Time Equivalent (FTE) positions.

FTE RN positions in Australian RACFs between 2003 and 2012; and a growth of 21,726 FTE in employees providing personal care services.

**‘The data suggests a movement away from employment of registered nursing staff towards PCWs’**

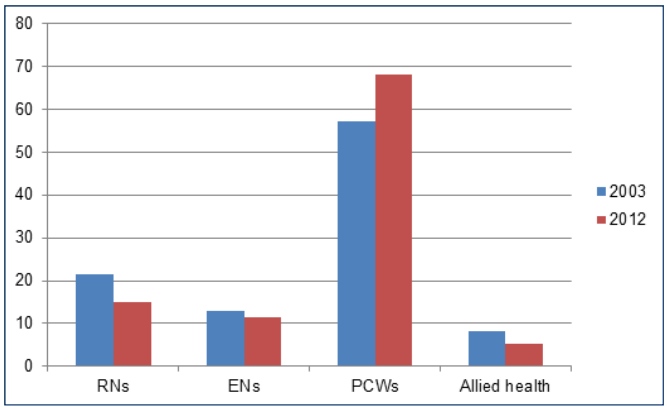



**Figure 1.1: Comparison of direct care workforce by percentage reported in the 2003 and 2012 National Aged Care Workforce Census and Survey**

. It was estimated that residents in RACFs in Australia in 2015 received 39.8 hours of direct care/fortnight in which averages to 2.86 hours/resident/day (Allard 2016).
by nurses, PCWs, and therapists, and is less than the recommended time allocations. For example, Zhang et al. (2006), in a literature review of

Aged Care, recommended from 4.55 to 4.85 hours/resident/day, which is almost double the current Australian

have implications for care outcomes. Research suggests that the amount of RN time to deliver care is directly related to improved care outcomes in Residential Aged Care (Zhang et al., 2006). A number of observational studies (Paquay et al., 2007; Munyisia et al., 2011; McCloskey et al., 2015) have highlighted the role of the RN in caring for higher acuity residents, performing complex tasks, and in co-ordinating care. Given the level of co-morbidities and the dependence of residents in RACFs, the demand for these tasks is likely to increase rather than decrease.

### 1.6 Relationship between Staffing and Care Delivery

There are many studies which explore the

in aged care. The quality of service delivery in aged care is often studied using a framework developed by Donabedian which explores three interrelated aspects of quality: structure, process,

al., 2011). Structure refers to organisational and

levels, skills mix, facility size and ownership, and resident acuity. Process measures identify what is done with residents and may include interventions to improve care, while outcome measures explore the end results of care and may involve objective measures such as mortality rates, or alternately, perceptual measures such as, resident satisfaction 1). A further distinction can be made between quality of care and quality of life outcomes. Quality of care outcomes relate to clinical outcomes and the safety of care delivery while quality of life has been orld Health Organization (WHO) as being concerned with “an individual’s perception of his or her position in life in the context of culture and value systems where they live and in relation to their goals, expectations, standards and concerns” (Havig et al., 2011; Van Malderen et al., 2013). Van Malderen et al. (2013) associate quality of life with meaningful leisure activities and resident control over aspects of the care delivered.

Research exploring the relationship between

objective outcome measures. For the most part, performance is determined on the basis of the incidence of complications that are viewed as being amenable to nursing care (nurse sensitive indicators) or
citations arising from aspects of care which do not meet Health Care Financing Administration standards upon audit (Needleman et al., 2002; Shin & Bae 2012). RACFs in Australia have been audited through the Australian Aged Care Quality Agency. The accreditation standards used were reviewed by Nakrem et al. (2009) for use as a proxy for nurse sensitive indicators and were found

in research. As such, there are a limited number of large-scale research studies on care outcomes in RACFs in
of this review are determined on the basis of total , on the basis of nursing hours per resident per day.

The evidence generally demonstrates a positive

outcomes. Spilsbury et al. (2011), in a review

were associated with a reduction in the reporting

mixed. They argued that the measurement of total

activities performed, the quality of RN input, and

the number of hours of direct care performed. Likewise, Shin and Bae (2012) found a relationship

total hours per resident day with reduced fall rates. Conversely, Backhaus et al. (2014), in a review of

outcomes, while Havig et al. (2011) found that

f, or using observational methods.

been found through perceptual outcomes in studies exploring care which is missed or delayed and the factors which contribute to this. Three studies

care. Zuniga et al. (2015) found that aged care staff gave priority to activities of daily living such as eating, drinking, elimination, and mobilisation over documentation and rehabilitation, with the social needs of residents often being overlooked.

also reporting less missed care. Similar results were obtained by Henderson et al. (2016) in a study of missed care in RACFs in three Australian states. They found that unscheduled tasks such as answering call bells and taking residents to the

missed care. Knopp-Shiota et al. (2015) explored missed care in Residential Aged Care through a survey of Canadian health care aides. They

with the tasks most commonly missed being, in the following order, talking to patients, walking with patients, nail care, mouth care, and toileting. The

study.

- T
  quality of care and the quality of life of residents
-
- The care that is most likely to be missed is rehabilitative and social care

### 1.7 Skills Mix

More commonly, studies addressing the impact of

and the impact of staff ratios on care outcomes. A number of observational studies (Paquay et al., 2007; Munyisia et al., 2011; McCloskey et al., 2015) have explored the role of the RN in aged care. Paquay et al. (2007) divided tasks into primary care tasks (e.g., hygiene, positioning, transfers); logistic tasks (e.g., making beds, preparing meals); communication tasks (e.g., talking to doctors and family); practical nursing tasks (e.g., wound care, medications, observations); supportive tasks (e.g., activities, patient education, counselling); and administrative tasks (e.g., documentation). RNs were found to

tasks, communication tasks, and administrative tasks than other members of staff. They also spent

dependency or dementia than did unlicensed staff. In an Australian study, Munyisia et al. (2011) divided tasks into direct care (e.g., all activities performed in the presence of a resident or relative); medication administration; communication activities (sharing information, phone calls, discussions with allied health); documentation activities; indirect care activities (not related to residents; e.g., stocking, ordering supplies); personal activities; moving between tasks and other activities. This study made allowance for the performance of more than one task at the same time.
as being performed by RNs working in high care

areas were communication (48.4%), medication management (18.1%), and documentation (17.7%). A third study by McCloskey et al. (2015) divided tasks into direct care (e.g., assessment, hygiene, feeding, medications); indirect care (e.g., documentation and communication with other health professionals); non-value added activities (e.g., looking for equipment, restocking); and other activities. They found that RNs on average spent 29.4% of their time on direct care, 42.8% on indirect care, and 14.7% on non-value added activities on day shifts. On evening shifts, RNs performed less indirect care activities (38.4%), more direct care activities (35.2%), and spent 15.9% of time on non-value added activities. The

role in planning and evaluating care, with the time

resident care.

**'RNs were found to spend significantly more time on practical nursing tasks, communication tasks, and administrative tasks than other members of staff'**

There are also a number of studies which have

resident outcomes. The outcomes of these studies are not conclusive, but are generally positive. Mueller and Karon (2003) argued that nursing performance in long-term care can best be measured by resident falls, pressure ulcers, satisfaction with care, satisfaction with education, and satisfaction with pain management. Backhaus

associated with decreases in pressure ulcers, infections including Urinary Tract Infections (UTIs), complaints of pain, and rates of hospitalisation, but was negatively associated with incontinence and decline in ADLs.  Similarly

pressure ulcers, lower restraint use, decreased hospitalisation and mortality rates, fewer UTIs, and

explored the impact of RN time per resident day

relationship between increasing RN time and avoiding the development of pressure ulcers, deterioration in ADLs, rates of hospitalisation, and use of nutritional supplements. Mueller et al. (2016) associated fewer RNs with the greater likelihood of 'failure to rescue' due to limited time for assessment and timely interventions by RNs; an issue, they argue is becoming more likely with earlier discharge from hospitals to RACFs. In contrast, Spilsbury et al. (2011) found that while RN

improved administrative outcomes through

mixed for a number of clinical outcomes, including quality of care, mortality, incontinence, weight loss and malnutrition, hospitalisation, pressure ulcers, restraint use, mental status, and catheter use. Likewise, Havig et al. (2011) found no impact of RN

staff, or through observational methods.

- *Studies exploring roles in aged care have found that RNs spend time on complex care, communication, medication management and documentation.*
- *RN ratios are related to better outcomes in relation to nurse sensitive indicators, including reduced UTIs, pressure ulcers, hospitalisation and mortality rates.*

There is less research on the impact of EN (EN)

Corazzini et al. (2013) explored the relationship between licensed practical nurses' (LPN) scope of

practice in relation to assessment, care planning, delegation, and supervision, as outlined in state-based Nurse Practice Acts in the US and care outcomes. They found that states/jurisdictions in which LPNs conducted focused assessments had higher incidents of restraint use, and that, when the LPN role involved data collection, residents were reported to experience higher levels of moderate to severe pain. Conversely, in states where LPNs are prohibited from performing assessments, residents had higher catheter use. Other studies explored the relationship between EN and LPN numbers (as measured by FTE, numbers, or hours of resident care) and care outcomes. The results from these studies are less conclusive than those associated

likely to be associated with poor outcomes. In a review of the literature exploring studies which

Spilsbury et al. (201
levels had no impact for 28 outcomes. Mixed results were found for 6 outcomes (pressure ulcers, composite outcomes, ADL function, mortality, weight loss, malnutrition and catheterisation). In a review of the more recent literature, Shin and Bae

,

feeding assistance, incontinence, eating patterns, exercise, pain management, and restraint use outcomes. Likewise, Backhaus et al. (2014) found a

and decreased pressure ulcers and fewer reports of pain.

- *care outcomes have mixed results*

A
unlicensed care worker (PCWs, assistants in

for unlicensed care workers were found to be positively associated with process outcomes, such as less use of restraints and fewer incidents of hospitalisations (Backhaus 2014), and better outcomes in relation to quality of care, quality of life, and resident satisfaction (Spilsbury et al., 2011). Hyer et al. (2011) found, for example, that hours per resident day provided by unlicensed staff

day provided by licensed staff (RNs, LPNs) had

contrast, Havig et al. (2011) found that the ratio of unlicensed staff (compared with licensed staff)

The
dif ferent

of numbers of staff or hours per resident day are calculated without reference to other staff, while

staff ratios implying fewer licensed staff. The results
f
on clinical outcomes are less conclusive. Higher
f have been
associated with fewer infections and pressure ulcers, fewer fractures, and fewer complaints of pain, but are not associated with other clinical outcomes (Backhaus et al., 2014; Spilsbury et al., 2011).

- *associated with improved quality of care and quality of life as well as increased resident satisfaction unless these changes come at the expense of fewer RNs and ENs, in which case, the results are inconclusive*

### 1.8 Purpose of this Study

This study provides an evidence base for a

skills mix for aged care.
to provide the Aged Care Financing Authority (ACF

mix in Aged Care. Chapter 2 provides an overview of the methodology used in this evaluation study. It includes a comprehensive description

methodology as well as the three data gathering approaches used to test its reliability.

**‘They found that RNs on average spent 29.4% of their time on direct care, 42.8% on indirect care, and 14.7% on non-value added activities on day shifts.’**

# CHAPTER 2
# Study Method

## 2.1 Introduction

This study adopted a mixed-methods approach consisting of four stages to allow for the , and evaluation of the principles underlying the methodology. The methodology was developed by the ANMF, while the evaluation component of the study was conducted by the University research team who are also responsible for reporting the

The data presented here includes an account of the development of the methodology and the evaluation.

These are:

- Development of an evidence-based aged

  interventions, timings, and frequency over a 24 hour period. This is the *Total Residential*

  *Skills Mix Model©*;
- Testing of the timings associated with

  across Australia with nurses working in Residential Aged Care;
- Administration of the MISSCARE survey reworked for the Residential Aged Care context to ascertain what care interventions are currently missed;
- A , and

  .

Each of these methods will be discussed below.

### 2.2 Establishment of Evidence-Based Aged Care Resident Complexity Profiles with Indicative Interventions, Timings, and Frequency of Interventions Over a 24 Hour Period

The *Total Residential Aged and Restorative Care* was created, designed, and developed to address the critical gaps that currently exist in evidencing residential

and skills mix required in Australia. Outlined below is the step-by-step process which led to the establishment of the evidence-based aged

and skills mix requirements over a 24 hour representative period.

*Total Residential Aged and Restorative Care*

The *Total Resident and Skills Mix*© is a matrix model that has been informed by international and national nurse

developed in consultation with clinical nurse leads in South Australia. The *Total Resident Aged and* is made up of

impacting on nursing and personal carers' work.

- **Direct Nursing and Personal Care** is the provision of nursing care to a resident which involves all aspects of the health care of a resident, including assessments, re-assessments, activities of daily living, treatments, counselling, self-care, education, complex care, management and administration of medication, and documentation. Personal care is the provision of the activities of daily living and management, including personal hygiene, grooming, dressing, and assistance with mobility
- **Indirect Nursing and Personal Care** is the care that nurses and personal carers undertake that is not directly related to the resident, but has a relationship to the care provided to the resident, such as GP consultations, case conferencing and restocking of equipment.
- **Resident Environmental Care** includes the activities that nurses and carers undertake to ensure a safe environment, such as staff allocation, shift-to-shift handovers, occupational health and safety activities and the checking of emergency equipment.


There are a number of assumptions that underpin the model:

- Variation does exist between different aged and restorative care resident types, as ageing is a unique experience
- Variation does exist between experience, expertise, and the skills of nurses and carers;
- Variation does exist between models of care and support models; and
- Variation does exist between care environments and settings

## 2.3 Methodology: Building the Residential Aged and Restorative Care Profile

*Establishment of the Aged and Restorative Care Subject Matter Experts and National Aged Care Expert Group*

The following three groups were established, as follows:

1. The National Aged Care Expert Group's role was to provide oversight, consultation, advice, and support for Stage One of the study. Membership comprised of nominated representatives from the aged care sector, the university sector, and from a range of professional and industrial bodies.

2. The Aged and Restorative Care Subject Matter Expert Group's role was to utilise their expert knowledge, skills, and experience in aged and restorative care to review the assessments, care plans, intervention lists, timings, statistical modelling, and to assign minimum skills mix requirements for assessments, interventions, and desktop modelling. This group was comprised of senior experienced nurses working in the aged care, and the acute and rehabilitative care sectors.

3. The Timings Working Group's role was to develop the approach, models, methodology, processes, and tools for Stage One of the study. This group's membership comprised experts in health statistics; project management; nursing informatics; acute, rehabilitative, and aged care nursing; data management; data collection; data analysis; and desktop modelling.

The above three groups were operational throughout Stage One of the study and worked in consultation and collaboration with key stakeholders.

*Establishing the Population and Sample Size for the 'Typical' Resident*

In 2015, the Australian Institute of Health and Welfare indicated that 172,828 people were living permanently in Residential Aged Care (AIHW 2015a). A high proportion (61%) of these people were aged 85 years and over, with 6,400 people (4%) aged under 65 years and 570 (0.3%) aged 50 years or younger. Data from the Commonwealth Department of Health shows that 17,678 people lived in South Australian Residential Aged Care facilities in 2015. Two-thirds (68%) of people in permanent Residential Aged Care at 30 June 2015 were women. On average, women live longer than men; for example, a woman aged 65 years has a life expectancy of 22.1 years, compared with 19.2 years for men of the same age. Women in permanent Residential Aged Care were more likely to be widowed (62% compared to 24% of men), and less likely to be currently married (23% compared to 45% of men) (AIHW 2015a). Aboriginal and Torres Strait Islanders represent only 1% of people living in permanent Residential Aged Care in Australia with a substantially younger The majority of people (90%) living permanently in Residential Aged Care speak English at home, with people born in Italy and Greece representing the largest proportion of the remaining 10%. Further, the majority of people born overseas in permanent Residential Aged Care were born in Europe (76%), followed by Asia (10%) and Oceania (4%) (AIHW 2015a).

The Department of Veterans' Affairs reported that 21,000 people with a DVA health care card living in permanent resident aged care are female (AIHW 2015a). The majority of people living in Residential Aged Care facilities are in the metropolitan areas (69%) with the remainder living in rural, remote, and peri-urban outskirts between urban and rural areas (AIHW 2015a).

*Residential*

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resident care plans, and ACFI Domain scores) were randomly sourced from South Australian residential care facilities in the public, private,

sectors Representing the age, gender, cultural, and linguistic characteristics of people living permanently in Australian Residential Aged Care facilities. The sampling was limited to South Australia because of the availability of the data sets, funding, and timeframes. Excluded from the sample were people living permanently in Residential Aged Care facilities aged less than 65 years, and Aboriginal and Torres Strait Islander people because of the lower representation of these cohorts. These exclusions resulted in two

in stage one of the study.

*Establishing the ACFI 'Common' Groupings*

detailed their relevant past social and medical history, assessments, nursing and personal care plans, and
by the sites as a 'true' representation of the 'actual nursing and personal care' requirements provided to each of the residents in the preceding four week period. To establish the ACFI 'common' groupings based on ACFI scores, the resident's individual ACFI Domain Scores for Activities of Daily Living (ADL), Behaviour (BEH), and Complex Health Care (CHC) were analysed. The results showed that 20 common groups, as detailed below, had ACFI Domain Scores ranging from High-High-High (22.5%) to Low-Low-Low (2.5%) (see Table 2.1) on following page.

**Table 2.1: Twenty common ACFI groups with domain scores from High-High-High to Low-Low-Low**

| ACFI Score Matrix No. | Activities of Daily Living (ADL) | Behaviour (BEH) | Complex Health Care (CHC) | No. of Residents ACFI Scores | % of Total ACFI Scores |
|---|---|---|---|---|---|
| 1 | High | High | High | 45 | 22.50% |
| 2 | High | Medium | Medium | 10 | 5.00% |
| 3 | High | Medium | Low | 10 | 5.00% |
| 4 | High | High | Medium | 15 | 7.50% |
| 5 | High | Medium | High | 5 | 2.50% |
| 6 | High | High | Nil | 5 | 2.50% |
| 7 | Medium | High | High | 5 | 2.50% |
| 8 | Medium | Medium | Medium | 15 | 7.50% |
| 9 | Medium | Medium | Low | 5 | 2.50% |
| 10 | Medium | High | Medium | 15 | 7.50% |
| 11 | Medium | High | Low | 15 | 7.50% |
| 12 | Medium | Low | High | 5 | 2.50% |
| 13 | Medium | High | High | 5 | 2.50% |
| 14 | Low | High | High | 5 | 2.50% |
| 15 | Low | Low | Medium | 10 | 5.00% |
| 16 | Low | Low | High | 10 | 5.00% |
| 17 | Low | Nil | High | 5 | 2.50% |
| 18 | Low | High | Low | 5 | 2.50% |
| 19 | Low | High | Medium | 5 | 2.50% |
| 20 | Low | Low | Low | 5 | 2.50% |
| Total | | | | 200 | 100.00% |

*Establishing the Aged Care Resident and Assessments, and Nursing and Personal Care Interventions*

common conditions, assessments, and the direct nursing and personal care interventions. The nursing and personal care intervention (direct and indirect) lists were mapped to the Major ACFI Domains, Categories, and Accreditation Standards. For example, *Activities of Daily Living – Intervention of Showering with minimal assistance* was mapped to ACFI 3 Personal Hygiene, Accreditation Standards 2 Health and Personal Care, and Standard 3 Care Recipient Lifestyle. Assessment of the resident's direct and indirect nursing and personal care needs led to the

that were able to be observed and timed, as well as the allocation of the minimum skills level.

Through the analysis and review of the individual resident care plans, it was apparent that the resident's physical, nutritional, medication, and specialised care (i.e., wound management) needs were described and detailed. However, there was little or no evidence of rehabilitation, or restorative health interventions and/or activities being provided or recorded for a population with a chronic disease

National Aged Care Expert Group and the Aged and Restorative Care Subject Matter Expert Group.

### *Approach to Determining the Nursing and Personal Care Skills mix*

Determining the 'right' mix of RNs, ENs, and PCWs was critical to the development of the third element of the 'Total Resident Aged and

A review of the international literature describes a number of approaches on how to determine the skills mix in health care, such as task analysis, activity analysis/activity sampling, daily diary, casemix/patient dependency

professional judgement (Buchan & May 2000). Using the 'Professional Judgement' Model, the Timings Working Group, in consultation with the Aged and Restorative Care Subject Matter Experts and National Aged Care Expert Group, assigned the minimum skills level required, i.e., RN, EN, or PCW, to the nursing and personal care direct and indirect interventions required by each resident.

Model is that it uses a consultative process to determine the 'right' mix for the 'right' intervention through consensus.

### *Establishing the Aged Care Resident and Restorative Care Environment Resident Care Environment Surveys*

The Resident Care Environment is the fourth element of the *Total Resident Aged and Restorative*

and recognises the relationship between resources, skills mix and/or nursing education, work environment, and patient/resident outcomes, and is supported by a number of national and international research studies (for example Aiken, Sochalski & Lake 1997; Leiter & Laschinger, 2006; O'Brien-Pallas, et al., 2001; Tourangeau, et al., 2007).

The resident care environment acknowledges a number of aspects within the unit/ward/house context and environment. To establish an overview of the resident and restorative care environment, an organisation-wide survey was developed to capture the residential aged and restorative

The information gathered included the different types of facilities, their size, geography

types of resident care environments including secure dementia, cultural, and linguistic; and access to restorative and lifestyle programs and allied health residential supports. Other clinical support services such as in-reach Palliative Care, Diabetes, Continence, and Behavioural Specialists, administrative and other services, were also captured.

Daily routine activities and tasks undertaken by RNs, ENs, and PCWs/PCAs/AINs, such as counting of Drugs of Dependence (DDAs), shift-to-shift handovers, and meal list checking were

The collated survey results provided the source information for the indirect nursing and personal care and residential care environment.

The indirect nursing and personal activities and tasks listed the items for 'timing', such as 'handovers' and 'counting of DDAs' that had been sourced from the care environment surveys. The following table provides a snapshot of the composite list of the environmental indirect resident care activities that were captured in the observation, timing, and motion study:

**Table 2.2: Composite List of the Environmental Indirect Resident Care Activities**

| Major Category | Facility Environment |
|---|---|
| Communication and Liaison | Answering and Responding to Call Bells |
| Communication and Liaison | Clinical Handover |
| Communication and Liaison | DDA / Drug Checks |
| Communication and Liaison | Security Checks |
| Communication and Liaison | GP Consultation, re: Resident Condition |
| Pharmacy | Counting of DDA's |
| Equipment, Linen, and Stock Management | Restocking Linen |
| Communication and Liaison | Answering Call Bells |

*Summary*

ACFI Domain Scores, nursing assessments, nursing and personal care interventions and activities, and the care environment survey results provided the evidence and building blocks for the development of the model.

## 2.4 Resident Aged and Restorative Care Matrix Model – Timing Studies Methodology

The third step in developing the model required the establishment of a statistically sound and robust time and motion study of the nursing and personal care indirect and direct assessments, interventions, and environmental factors.

*Developing the Observational Timing and Motion Model*

The SA Health - 'Flinders Medical Centre - Nursing Works' Observation, Time and Motion Model' underpinned the timings study. Senior RNs in acute, rehabilitation, and aged care with a experience were recruited, educated, trained, and skilled in how to:

- Conduct and undertake the timings study;
- Engage with staff and residents;
- Undertake the observations;
- Time (stop watch); and
- Record (hh:mm:ss:) the direct and indirect nursing and personal care interventions.

The Timings Working Group developed standardised forms, tools, and processes to ensure consistent capture of the direct and indirect nursing and personal care assessments, interventions, and activities data as well as the resident characteristics (such as level of co-operation, infectious status, bariatric, cognitive status).

Composite lists of nursing and personal care

resident care assessments and care plans were grouped into major ACFI categories with each assessment or intervention given a primary category , an intervention descriptor, and an assigned minimum skill level.

The following table provides a snapshot of the composite list of the observation, timing, and motion database.

### Table 2.3: Sample from Observation, Timing and Motion Database

| ACFI | Primary Category | Unique # | Intervention Descriptor | Assigned Minimum Skills Mix |
|---|---|---|---|---|
| ACFI 3 Personal Hygiene | Activities of Daily Living | ADL - 4 | Pressure care | PCW/ PCA/ AiNs |
| ACFI 3 Personal Hygiene | Activities of Daily Living | ADL - 5 | Shave resident | PCW/ PCA/ AiNs |
| ACFI 3 Personal Hygiene | Activities of Daily Living | ADL - 6 | Shower - minimal assistance (1 person) | PCW/ PCA/ AiNs |
| ACFI 3 Personal Hygiene | Activities of Daily Living | ADL - 7 | Shower - moderate assistance (2 persons) | PCW/ PCA/ AiNs |
| ACFI 12 Diagnosis Assessment - Assessment | Assessment | ASS - 3 | Admission - Assess Activities of Daily Living Needs | RN |
| ACFI 12 Diagnosis Assessment - Assessment | Assessment | ASS - 6 | Admission - resident admission history and assessment | RN |
| ACFI 12 Diagnosis Assessment - Assessment | Assessment | ASS - 26 | Falls Risk - assessment | RN |
| ACFI 12 Complex Care - Care Planning and Documentation | Documentation | DOC - 2 | Care plan - formulated | RN |
| ACFI 12 Complex Care - Care Planning and Documentation | Documentation | DOC - 4 | Casenote - resident entry | PCW/ PCA/ AiNs |
| ACFI 5 Continence | Elimination | ELM - 10 | Toileting - minimal assistance with toileting (1 person) | PCW/ PCA/ AiNs |
| ACFI 11 Medication - Administration - DDA | Medication | MED - 2 | DDA - Oral Administration | RN |
| ACFI 11 Medication - Oral | Medication | MED - 15 | Oral medication ≤ 6 medications administration | EN |
| ACFI 1 Nutrition | Nutrition | NUT - 2 | Meals - complete feed | PCW/ PCA/ AiNs |
| ACFI 12 Complex Care | Observation | OBS - 1 | Assess - blood glucose level | EN |
| ACFI 12 Complex Care - Procedure | Procedure | PRO - 12 | Wound Care - wound reviewed, dressing changed | EN |

*Conducting the Observation, Timing, and Motion Study*

Over a six month period, a series of 'Timings Studies' were conducted in over 250 individual wards/units/resident areas across South Australian public hospitals, rehabilitation centres, and Commonwealth and state-funded residential aged care facilities, thus ensuring a diverse range of settings and care contexts in accordance with the agreed methodology, tools, and processes. A minimum of 20 timings (representative sample) of each assessment, intervention, or activity was captured across diverse settings with all levels of

mix. This data was collected by the trained senior RN timers. Data integrity checks were conducted by the trained senior RN timers, and the data

All data discrepancies were investigated prior to being entered into the access timings database. Ongoing auditing and accuracy integrity checks were conducted independently by the health statistician. Sampling sizes were checked to ensure statistical validity, while variations between different areas, resident/patient types, nurses and carers, and 'outlier' timings were investigated and subsequently excluded from the study. In total, 1,927 nursing and personal care interventions were timed, and over 110,000 individually validated timings were analysed, to provide the basis for the statistical modelling by the health statistician.

The Timings Working Group in consultation with the Aged and Restorative Care Subject Matter Expert Group and key stakeholders developed and tested the following four statistical observation, timing, and motion models:

1. SA State Average Model
2. Ward/Unit/Resident Area Type 1 (e.g., Speciality) Average Model
3. Ward/Unit/Resident Area Type 2 (e.g., adult, country, mental health, rehabilitation, aged care) Average Model
4. Hospital/Residential Site Average Model

The outputs from each of the four statistical models were applied to the timings database. The Timings Working Group reviewed each of the statistical models, the timings database, and their outputs. The outcome of the review showed that the SA State Average Model, with the largest sample size, was the most stable and the least volatile in comparison with the other three models. The consensus of the Timings Working Group and the Aged and Restorative Care Subject Matter Expert Group was that the SA State Average Model was the most statistically sound, providing the evidence and individual values (average time hh:mm:ss) for all assessments, and nursing and personal care interventions or activities for the purposes of the study.

The Timing Working Group established the

and formulae for the model, as follows:

The *Total Resident (Nursing and Personal) Care Hours Per Day* were calculated on a shift-by-shift basis and totalled for the 24 hour period as the:

- Assessment and reassessment of each resident, plus
- Direct nursing and personal care time per intervention per resident times by frequency per shift, plus
- Indirect nursing and personal care time per intervention times by frequency


The fourth step was to bring all the elements of the *Total Residential Aged and Restorative Care* together to test if evidence-based aged care resident complexity This was done in two-parts:

Firstly, the Resident Aged and Restorative Care

resident data such as name, and relevant social, physical, religious, and medical histories, co-morbidities, nursing assessments, and social and family supports. The observation, timing, and motion database was imported and linked to the Resident Aged and Restorative Care Matrix Database. A care planning tool was designed and developed within the database to enable the capture and modelling of the required resident, nursing, and personal care requirements on a shift-by-shift basis for a 24 hour period. The agreed

accuracy of the outputs.

The SA Health Resource and Skills Mix Calculation Model provided the basis for the next part of the process with a desktop modelling exercise that included the following data elements:

- nursing assessments, and care plans with interventions and frequency for a 24 hour period;
- 
- Aged Care Major Categories, individual interventions, and validated timings for direct and indirect nursing, and personal and environmental care interventions and activities, including frequency and minimum skill sets required;
- Observation, timing, and motion database; and the
- Calculation.

Residents were randomly assigned to a number of

being created and modelled to show individual resident nursing and personal care needs over a 24 hour period.

The individual modelled care plans enabled the resource calculation to inform the nursing and personal care needs for the total population (200 residents).

*External validation of the desktop modelling*

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and outputs were representative of the aged and restorative care needs for a 24 hour period, the desktop modelling outputs were reviewed and validated independently by Aged and Restorative Care Subject Matter Experts and subsequently by the National Aged Care Expert Group.

### 2.5 Discussion

Six common groupings emerged from the desktop modelling of the 200 care plans, with a 30 minute difference between each group. Subsequently, the 6 common groupings were mapped to the 20

ACFI Common Groupings established in Step 1 of the study, to examine whether a clear relationship exists between the ACFI Domain Scores and the calculated resource requirements, as shown in the table below.

**Table 2.4: Twenty common ACFI groups with domain scores from High-High-High to Low-Low-Low and resident profiles**

| ACFI Score Matrix No. | Activities of Daily Living (ADL) | Behaviour (BEH) | Complex Health Care (CHC) | No. of Residents ACFI Scores | % of Total ACFI Scores | Resident Profile Common Grouping | Resident Nursing and Personal Care Hours Per Day (RCHPD) |
|---|---|---|---|---|---|---|---|
| 1 | High | High | High | 45 | 22.50% | 6 | 5 |
| 4 | High | High | Medium | 15 | 7.50% | 6 | 5 |
| 7 | Medium | High | High | 5 | 2.50% | 6 | 5 |
| 6 | High | High | Nil | 5 | 2.50% | 6 | 5 |
| 5 | High | Medium | High | 5 | 2.50% | 6 | 5 |
| 2 | High | Medium | Medium | 10 | 5.00% | 5 | 5 |
| 13 | Medium | High | High | 5 | 2.50% | 5 | 4.5 |
| 10 | Medium | High | Medium | 15 | 7.50% | 5 | 4.5 |
| 14 | Low | High | High | 5 | 2.50% | 5 | 4.5 |
| 3 | High | Medium | Low | 10 | 5.00% | 4 | 4.5 |
| 8 | Medium | Medium | Medium | 15 | 7.50% | 4 | 4 |
| 11 | Medium | High | Low | 15 | 7.50% | 4 | 4 |
| 9 | Medium | Medium | Low | 5 | 2.50% | 4 | 4 |
| 12 | Medium | Low | High | 5 | 2.50% | 3 | 3.5 |
| 19 | Low | High | Medium | 5 | 2.50% | 3 | 3.5 |
| 18 | Low | High | Low | 5 | 2.50% | 3 | 3.5 |
| 16 | Low | Low | High | 10 | 5.00% | 2 | 3 |
| 15 | Low | Low | Medium | 10 | 5.00% | 2 | 3 |
| 17 | Low | Nil | High | 5 | 2.50% | 1 | 2.5 |
| 20 | Low | Low | Low | 5 | 2.50% | 1 | 2.5 |
| Total | | | | 200 | 100.00% | | |

**Table 2.5: Stage 2 - Step 1 Study - Initial Residential Care Profiles with Resident (Nursing and Personal Care) Hours Per Day**

| | | | Skills Mix | | |
|---|---|---|---|---|---|
| Resident Profile | RCHPD | Total Residential and Personal Care Hours Per Day | RN (Min) | EN (Min) | PCW/AiN (min) |
| 1 | 2.5 | 150 | 45 | 30 | 75 |
| 2 | 3 | 180 | 54 | 36 | 90 |
| 3 | 3.5 | 210 | 63 | 42 | 105 |
| 4 | 4 | 240 | 72 | 48 | 120 |
| 5 | 4.5 | 270 | 81 | 54 | 135 |
| 6 | 5 | 300 | 90 | 60 | 150 |

The National Aged Expert and the Aged and Restorative Care Subject Matter Expert Groups reviewed the Desktop Modelling, and the care plans and outputs, including the resource and skills mix calculations. Consensus was reached by the two expert groups, stakeholders, and the research

and personal care hour intervals were deemed to be true representations of the delivered care requirements. This outcome informed the basis for

Focus Group consultation.

Unlike the acute care setting, in the Residential

nursing/personal carer skills mix or the minimum skill level requirement. The *Aged Care Act 1997* and the *Aged Care Accreditation Standards* stipulate the principles of adequate care based on the assessed resident needs, but the Act remains

skills mix requirements to meet the needs of older Australians living in residential care facilities.

Currently, the aged care industry receives funding based on the national average of 2.8 RCHPD (Brown 2015), with 3.18 hours (based on staff hours worked) for residents with the 'highest' care needs with only 22 minutes of RN care per 24 hours; and for residents with 'lower' care needs receiving 1.76 hours with just six minutes of RN care over three shifts (ANMF 2016: 12). The Bentleys National Aged Care Survey (2015) that provides the national average care hours per resident/per fortnight for all facilities reported the total care staff hours per resident/per day were calculated at 2.86 hours, equating to 57 minutes of care per resident/per shift. This is for residents with high nursing and personal care needs, co-morbidities, complex medication, and health and behaviour management requirements (Bentley 2015).

In South Australia, the public sector is the largest provider of Residential Aged Care services in the state with an agreed average of 3.2 hours per residents per day (SA Health 2015). South Australian aged care residents living in private, not-

2.8 and 3.2 hours of nursing and personal care per day. In Western Australia, Tasmania, and Northern Territory, aged care residents receive 4.0 hours per day for patients awaiting aged care placement or aged care; and in Victoria, a ratio model of 1 nurse to 7 aged care residents plus in charge on the early shift; 1 nurse to 8 aged care residents plus in charge on the late shift; and 1 nurse to 15 aged care residents for a night shift applies. In New South Wales, most of the aged care sector is

levels or skills mix.

It is apparent that the Aged Care Financial Performance Survey published by Stewart Brown (2015) and the Bentleys National Aged Care Survey (2015) benchmark and report existing

evaluation of the demand for care associated with those numbers.

The *Total Residential Aged and Restorative* enabled the establishment of evidence-based aged care

The next step was the

requirements by the National Focus Group and the Delphi study.

### 2.6 Evaluating the Resident Aged and Restorative Care Matrix Model and Methodology

Once the methodology had been developed, there was a requirement to evaluate the timings to determine whether or not there was agreement within the industry for this approach. To achieve this outcome, three data gathering methods were instituted: seven focus groups to qualitatively evaluate the timings, the MISSCARE survey to determine if care interventions were currently being missed, and a Delphi survey to measure . The processes and rationale for all three methods are outlined below and represent Stage 2 of this study.

### 2.7 National Focus Groups

methodology was the conduct of National focus groups with Residential Aged Care staff to validate

personal care interventions, and the timings. While the methodology and timings were developed as part of a rigorous time and motion exercise, there is always the possibility that experienced nurses and PCWs will reveal tasks, or environmental issues, not accommodated in studies that are limited to time and task exercises. Hence, the primary aim of the focus groups was to capture

time, and motion study that informed the desktop modelling calculations of the care matrix, as well as the omitted activities.
out the 'time and motion' analysis takes account of the realities of care in context, but also assisted The advantage of using focus groups to gain this sort of information is that the group dynamics ensure that participants

Group dynamics play an important role in focus group data collection, particularly if the participants share a similar culture enabling comparison of experiences and views (Kitzinger 1994). The focus groups for this study concentrated on the

different timings, with discussion being centered on the validity of the nursing services, personal care interventions, and associated timings required for a

#### *Recruitment*

The participants were recruited through an expression of interest to participate in the focus groups on the ANMF national project website. The website was an open access site which was not restricted to ANMF members. Potential participants were asked demographic questions about their

location, size and ownership status of facility, type

organisation. Employer names were not collected.

potential focus group participants on the basis of the sampling strategy outlined below. These nurses were contacted by the research team via email with an information sheet to ascertain their ongoing

interest and availability to attend a focus group.

It was the intention of the research team to use a purposeful sampling strategy of maximum variation heterogeneity to recruit nurses for the focus groups; however, all volunteers were accepted into the study. RNs (RNs) were recruited as the *RN standards for practice* (NMBA 2016) identify this group as being more likely to have the knowledge, understanding, and experience of care planning to provide comprehensive feedback about the

The participants were purposefully sought from a range of facilities within the public and private sector and from metropolitan and rural and remote settings. In total, seven focus groups were conducted with one in South Australia, two in Victoria, two in New South Wales, one in Queensland, and a national teleconference with participants from rural and remote regions. A total of 29 RNs, 1 EN, and 2 Assistants in Nursing/ PCWs from a range of RACFs participated in the focus group discussions.

Table 2.4 below.

## Table 2.6: Description of focus group participants

| Role | Location | RACF | Other |
|---|---|---|---|
| RN | South Australia | 195 bed facility | In charge of the afternoon shift, Supervises 9 ENs/RNs |
| RN | South Australia | 100 bed facility | by ENs |
| RN | South Australia | | Works as CN, 2 ENs and 1 RN on morning and late shifts |
| RN | South Australia | 90 bed facility | Works as CN and educator<br>1 RN and 3 ENs in morning and 1 RN and 1 EN in afternoon |
| RN | South Australia | 60 bed facility | 1 RN and 2 ENs on morning and late shifts |
| RN | South Australia | 126 bed facility | 4 ENs morning and afternoon shift, 1 at night |
| RN | South Australia | 101 bed facility | In charge on weekends<br>2 sides 1 RN and 1 EN for each side on day shifts,<br>1 RN on nights |
| RN | Victoria | Relieving work | Previously worked in 90 bed facility |
| RN | Victoria | 120 bed facility | Education component to role |
| RN | Victoria | 120 bed facility | In charge, Relieving work at a second facility |
| RN | Victoria | 95 bed facility | 2 RNs and 2 ENs in morning and 1 RN and 2 ENs on late shift |
| RN | Victoria | 120 bed facility high and low care | 1 RN for 65 beds in high care on days |
| RN | Victoria | 60 bed government facility | RNs and ENs employed only 2 RNs and 6 ENs on days |
| RN | Victoria | Smaller facility | Previous experience in remote aged care |
| RN | Victoria regional | Government-owned facility | |
| Clinical Nurse Educator | Victoria | Works across many facilities | Lack of RNs to provide student supervision |
| EN | Victoria | 118 beds (63 low care) | |
| RN | Victoria Rural | Public Sector 45 beds MPS | 1 RN and 5 ENs |
| RN | New South Wales | 120 bed facility<br>High and low care | 1 RN and 2 carers in high care |
| Instructional Designer | New South Wales | | Education for aged care staff. Previously an RN in aged care |
| RN | New South Wales | Works across 17 facilities | Palliative care clinical-based consultant. Management and education about end of life care |
| RN | New South Wales regional | 100 bed facility<br>High and low care | Works in high care. 1 RN to manage high and low care on nights |
| RN | New South Wales | | Specialist consultant nurse (mental health) |
| Assistant in Nursing | Queensland | 69 bed facility<br>High care | 2 RNs on morning and late shifts |
| RN | Queensland | 72 bed facility | 2 RNs on morning and late shifts |
| RN | Queensland | 400 resident retirement village | Care manager |
| RN | Queensland | Private facility | |
| RN | Queensland regional | 170 bed facility<br>High and low care | 3 RNs on mornings |
| RN | Tasmania rural | 52 bed facility<br>\|(2 medical beds) | 1 RN on late and night shift, No ENs employed |
| RN | Northern Territory remote | Approx. 35 beds<br>High and low care | Service for Indigenous residents, 1 RN and care workers |
| Assistant in Nursing | New South Wales | 120 bed facility | |
| RN | New South Wales | Independent living service (NSW and ACT) | Clinical governance role |

*Focus Group Schedule*

The focus groups commenced with an outline of the project and an invitation to participants

workplace, the number of residents, and the typical

These

as outlined above using the aged care complexity

during the focus groups; however presented in Chapter 3 focus on the six most

most extensive feedback.

The participants were guided through a discussion

A):

1. the percentage of residents in their facility
2. typical for a resident in their facility who
3. if not, what the differences were; and
4. whether the total number of care hours per

adequate.

*Analysis*

The focus group data were analysed by the university research team using qualitative content analysis, also referred to as qualitative descriptive analysis (Sandelowski 2000). This approach is ideal for analysis when "… straight description of phenomena is desired … [and] … is especially useful for researchers wanting to know the who, what and where of events" (Sandelowski 2000: 339). The key to this form of qualitative analysis is that researchers do not move too far from, or into, their data. In relation to this research, qualitative description resulted in a comprehensive summary

everyday language of the participants. As noted by Maxwell (1992, cited in Sandelowski 2000: 335):

> "Researchers conducting such studies seek descriptive validity, or an accurate accounting of events that most people (including researchers and participants) observing the same event would agree is accurate, and interpretive validity, or an accurate accounting of the meanings participants attributed to those events that those participants would agree is accurate".

Drawing on the above, the analytical framework was as follows:

1. Initial reading of each transcript by two researchers to gain a sense of the whole.
2. The two researchers then re-read each transcript, statement by statement to identify the recurring descriptive statements of

   the following:

   - Percentage of residents who matched each
   - Whether care/interventions carried out for this type of resident in the participants'
   - What the differences were, and the
   - Whether the total resident care hours per

     hours per day for this type of resident in the participants' organisations over a 24 hour period.

The NVivo Qualitative Analysis Program was used

of the coded data to inform the analytic process.

### 2.8 MISSCARE Survey

The MISSCARE survey was used in the absence of datasets which demonstrate care outcomes in Residential Aged Care. It is not an independent audit or an evaluation of nurse sensitive outcomes. The MISSCARE survey was used to collect data

skills mix, and other factors on perceived capacity to deliver care. This information was used to

were adequate to perform the care interventions

Registered and Enrolled Nurses and PCWs and is presented as evidence that both nurses and PCWs

currently missed.

*Developing the Survey*

The MISSCARE survey was originally developed by Kalisch and Williams (2009), based on earlier qualitative work conducted by Kalisch (2006) to identify nursing care that is missed in acute care settings and the reasons why it is missed.

as "required patient care that is omitted (either in part or in whole) or delayed" and acknowledges that it is a response to "multiple demands and inadequate resources". The original MISSCARE survey included three components: demographic and workplace data; missed nursing care; and questions identifying the impact of events that impact on the capacity to deliver care. These events are associated with three antecedents: 1) the labour resources available to provide patient care; 2) access to the material resources needed to provide patient care; and 3) relationship and communication factors which have an impact on the capacity to deliver care (Kalisch et al., 2009; Kalisch & Williams 2009). The MISSCARE survey was used in this study to explore the types and extent to which nurses and PCWs perceive that

Aged Care and to determine the reasons why they are missed.

all care needs and to determine other factors which contribute to missed care in Residential Aged Care.

The MISSCARE survey was redeveloped for this project drawing upon the processes outlined by Kalisch (2006; 2014) in the development of the MISSCARE and Patient MISSCARE instruments (Kalisch 2014). This included a preliminary drawing up of possible missed care tasks based on the literature, the conduct of focus groups to verify and capture the missed tasks, and the trialling of

For this study, a search of the literature was undertaken for factors which have an impact on the quality of care in Residential Aged Care for nursing and care worker roles. In addition, data from previous MISSCARE surveys of Australian nurses (Blackman et al., 2015; Verrall et al., 2015; Willis et al., 2015) was re-analysed using multivariate analysis to identify the reasons given for missed care by nurses working in aged care. The review of the literature, along with the re-analysis of the data, informed the demographic questions and those relating to factors having an impact on missed care in aged care. A preliminary list of possible nursing and care tasks that could be missed was created from the tasks included in the Aged Care

which was supplemented by information from the UK Royal College of Nursing Assessment Toolkit (2004) to identify assessment tasks undertaken by RNs in aged care. Additions were made to this list

by members of the research team based on their experience of aged care and knowledge of the

basis for discussion in the focus groups.

The draft survey was then subjected to expert review by members of the National Aged Care Expert Group supporting this project. Written feedback from members of the advisory group highlighted two central issues relating to survey length and the accessibility of the wording for Residential Aged Care staff from Culturally and Linguistically Diverse (CALD) backgrounds. The

team to review the survey for any questions that could be removed. To address the issue of accessibility for CALD aged care staff, the survey was reviewed by a language expert with expertise in teaching international students who suggested simplifying the sentence structure and using more accessible language. These issues were also to be put to a focus group of staff working in aged care. However
was replaced by asking CALD PCWs to individually review the survey and provide advice on the suitability of the wording/terminology for aged care and the readability of the questions. This resulted in the removal of questions that were viewed as repetitive and the rewording of other questions to increase clarity.

28 were related to demographic and workplace factors, 37 to care tasks that may be missed, and 2 to reasons for the missed care.
two questions required the respondents to rank the importance of the impact of the 27 factors on missed care in aged care, while the second question invited the respondents to provide any additional comments they had about missed care in their workplace. The survey was offered online via *Survey Monkey*® between 15th December 2015 and 5th February 2016 (Appendix B).

*Recruitment*

Promotion of the survey occurred through the ANMF branches. An email was sent to all eligible people who expressed an interest in the study

online survey. The survey was also promoted to ANMF members via federal and local branch websites and social media by way of invitation to access the link to the university Survey Monkey site for missed care. This invitation was posted on the publicly available national

ANMF. The survey was completed by 3,206 aged care employees working in a range of roles from management to care work.

*Analysis*

The survey data was analysed using frequencies and cross-tabulations to describe the data in

to determine which tasks were most likely to be missed and the relative importance placed upon the factors which had an impact on missed care. Multivariate analysis was then conducted using all variables to determine which personal and organisational factors contributed to missed care.

comments on missed care in RACF were analysed using qualitative content analysis (Mayring 2014). Qualitative content analysis involves thematic coding using systematic rules and subsequent

generalisability of the themes (Mayring 2014).
In this case, the data was read for statements addressing the causes and impacts of missed care. Each response was allocated one or more descriptors which were then collated to determine the dominant themes.

## 2.9 Delphi Survey

The third component of this project involved the administration of a Delphi survey. A Delphi survey is a structured, indirect interaction method that employs a sequence of rounds to collect data about a topic/issue until consensus is reached by a panel of experts (Hasson, Keeney & McKenna 2000; Laustsen & Brahe 2015). The purpose of the

have an impact on workloads within Residential Aged Care as well as to achieve a consensus

methodology. The Delphi survey was conducted online via *Survey Monkey*®. The survey comprised 20 descriptive statements with members of the panel of experts being asked to indicate the level of agreement with each statement and to provide comments about each statement.

### *Participants – Panel of Experts*

A panel of experts from Residential Aged Care services in Australia were invited to participate in the Delphi study. An expert is 'a person who is very knowledgeable about or skillful in a particular area' (Soanes & Stevenson 2005: 610) and they

topic of enquiry (Moseley & Mead 2001; Powell 2003). In this study, the expert panel comprised Residential Aged Care site managers or their nominees who, through legislation (*Aged Care Act*

for the delivery of nursing services and day-to-day operations at a residential site. The role of a residential site manager is to ensure that the

of care outcomes to meet residents' needs and to

of the facility is within the allocated budget. The Australian Institute of Health and Welfare (AIHW 2015c) stated that as of 30th June 2015, there were 2,681 Residential Aged Care facilities providing care in Australia, with each required to have a residential site manager. A purposeful sample of a targeted group rather than randomisation was used.

### *Recruitment*

Residential site managers of all residential aged facilities in Australia were invited to participate in, or nominate a staff member who was suitable to be a participant on the panel of experts. There is

size of a panel of experts, although Murphy, Black, Lamping, et al. (1998) considered that the more respondents there are, the better. A larger number of respondents increases the trustworthiness of a combined opinion and, given that the participants are nominated due to their expertise, this increases the possibility of content validity.

A letter of invitation with an information sheet explaining the study was posted to the publicly available address of all residential care facilities in

number of respondents for the survey, but the research team sought to secure responses from residential site managers, or their nominees, from the diversity of types of facilities and locations. The letter explained the purpose of the Delphi survey to ensure that the potential participants understood the possible time commitment (up to three rounds) required and to obtain demographic information about the residential care facility and the 'expert' to ensure that the panel covered the dif

ferent sizes, metropolitan, rural, and remote locations) in Australia. The letter also provided a link to the online survey. The respondents were required to make their email address known to receive the results of each round via email correspondence and to include the link to complete the next survey. Further rounds of the Delphi study depended upon the levels of consensus achieved in the earlier rounds.

*Delphi Study Analysis*

102 participants. As the data is both quantitative and qualitative, the appropriate analysis for each type of data was undertaken. The purpose of the quantitative analysis was to determine the level of consensus with each statement. The literature is limited as to what a suitable level of consensus should be, so in this study, the consensus level was set at 80% of members whose responses fell within the two categories of agree and completely agree on a Likert scale.
the most frequently chosen percentage response in the related literature. Quantitative analysis of the

of 80% and more was achieved on all statements; hence, no further rounds were conducted.

### 2.10 Conclusion

Chapters 3 through to 5 provide the details of the focus group discussion, and the MISSCARE and Delphi surveys respectively. The focus of these three data gathering exercises was to validate

which care interventions were being missed, and to gain approval for the need for a staff-resident

# CHAPTER 3
# Focus Group Findings

## 3.1 Introduction

A series of seven focus groups was conducted across the country to determine the validity of interventions and timings for six typical resident

were based on real-life examples. Focus group participants across all groups, in considering these

## 3.2 Overall findings

Participants across all focus groups recommended that the baseline resident nursing and personal

increased by half an hour per day on average due to the impact of indirect care services on the delivery of direct nursing care. Recurring issues that increased indirect care time included:

- 
- Administrative load and communication needs of residents
- Geography of the facility and access to resources
- Special needs groups and related matters (people with dementia, CALD background, and residents requiring end of life care)

In addition, the participants were asked about models of care and the capacity to support healthy

ageing and reablement. Generally, reablement was not seen as part of current nursing practice, with respondents citing workload and the acuity of residents as preventing reablement strategies.

### 3.3 Skills Mix/Staffing Models

Within each focus group, many participants discussed what they considered to be inadequate skills mix in their Residential Aged Care Facility (RACF) and their view of the resultant impact on the quality of care for residents.
models described by the participants varied, but there was often one RN to manage large numbers of care workers and residents, irrespective of the size and geographical layout of the facility. One participant from the Adelaide focus group described her work situation:

> *"I work in a 100 bed facility, in charge the same situation all afternoons, we have 1, 2, 3, 4 ENs that I need to oversee; I have my own*
>
> *do. And so I've got to do all the DDAs. They are prescribed that we have to have 2 people*
>
> *it's become very untenable actually and quite dangerous I feel".*

One of the consequences of having limited RNs

f – carers – to report emerging issues with residents. This may be problematic if time is allowed for change of shift reporting or handovers. One participant from the morning focus group in Melbourne reported:

> *"Some of the facilities are cutting out the PCW handover time – even no handover technically. Just come and go, but the thing is, you don't have enough time reporting to the nurse – no matter EN or RN".*

It may also be problematic if the knowledge and

emerging issues and to manage the complexity of having many residents. Some participants

among care workers which may compromise care. Another participant from the morning focus group in Melbourne stated that:

> *"The falls because they are in a rush – in a hurry because – the tasks that's why that happens".*

The employment of care workers from culturally and linguistically diverse (CALD) backgrounds may contribute to poorer communication with residents, with some residents refusing to be cared for by some staff. One participant from the Adelaide focus

f when this occurred:

> *"There's also an issue with a lot of the carers we have now are male or from other countries and this often comes into it, where females will refuse to be cared for by a male. … This can cause a lot of problems when that's all the*
>
> *staff around".*

In other instances, tasks that might be undertaken by RNs in other settings were performed by ENs and care workers. One participant from the

policy, law, and registration competencies with regard to the administration of DDA medications:

> *"Yes it's policy – the legality under the Queensland policy says, and I've gone through this, that we are allowed to give them the keys – they [medication endorsed ENs] had the keys – they had the keys to the DDAs*

*and they can write it out and give it out if they are medication endorsed and it really in fact a RN doesn't truly by law need to have anyone check it out with her".*

Tensions between policy and law contributed to concerns about being held legally accountable if a medication error occurred.

### *Administrative Load and Communicative Needs of Residents*

The administrative load undertaken by RNs limited their ability to provide direct nursing care. This issue was particularly evident after hours and on weekends when other staff, such as reception and diversional therapists, worked reduced hours or not at all. A participant from the afternoon focus group in Melbourne, when asked about the time required to provide nursing and personal care, stated that:

*"It's actually geography and in the resourcing and set up with your diversional therapists, whether you've got admin support, whether you've got whatever, service does impact on it and that' s such a diverse mix … so, I think all of that impacts on the*

The need to provide emotional support and the promotion of social interaction for residents was also a recurring theme, with participants indicating

and resident care hours per day. The participants from the Adelaide focus group commented on increasing family expectations. One nurse stated that, for example:

*"Baby boomer children my, my age children, have got great expectations of how, what care they want for their families these days".*

Additional time with family members was needed upon admission when adult children, the spouse, or relatives were relinquishing their responsibility for family members, but also at the end of life. The responsibility for providing this support fell largely on the RNs. A nurse from the Sydney morning focus group noted that additional RN time is required for families of residents receiving end of life care. She stated:

*"Now obviously because she's [the resident is not really engaging. It's more - that's with the family the support and counselling time".*

### *Geographical Location and Access to Resources*

Many participants said that they were responsible for care delivery in more than one geographically dispersed site, or had to cover care for residents in facilities widely spread out over one level or on

dispersion is remote decision-making, in which the RN is required to make decisions about care without seeing the resident. A participant in the Adelaide focus group described disciplinary action arising from their refusal to provide pain relief at a distance:

*"The night duty RN said, "Well no … I can't do that because I can't assess, I can't remotely assess the resident". How can I say whether she needs an Endone?".*

A second consequence is the time spent in

equipment. A participant who worked on night duty described the impact of the time spent travelling around the facility:

*"I'd be down one end of the building with somebody who'*
*and then they'd say this lady needed to go to*

*building … it's quite a few minutes before I can get to her and that's, and I don't think they account for the travelling time".*

Lack of appropriate resourcing to provide optimum care was a recurring theme across the focus groups. This included discussion about

inappropriate chairs, and the lack of availability of imprest/stock items and pharmaceuticals. The focus group participants argued that time chasing missing equipment needed to be factored into environmental or indirect timings.

### *Residents with Special Needs*

A

Among these groups are people with dementia from culturally and linguistically diverse backgrounds who often lose their second language skills as their dementia progresses, leading to the use of alternate communication strategies requiring additional time. An RN from the morning focus groups in Sydney pointed out that:

> *"When they're agitated, sometimes it's hard to communicate, even with a picture book."*

Another group of residents requiring additional care were those receiving end-of-life care. The

ferentiate between palliative care and end-of-life care, with appropriate recognition of the associated care required to be delivered by nurses. It was noted that Residential Aged Care facilities were increasingly receiving short-term admissions of residents requiring end-of-life care without the

This is discussed in greater depth in Norma's

.

### *Reablement and Healthy Ageing*

The focus groups also asked nurses what time and activities focused on healthy ageing and reablement. Healthy
'the process of developing and maintaining the functional ability that enables well-being in older age' (WHO 2015: 28). This is a separate concept from that of reablement. The Productivity Commission report (2011c:

generally time-limited programs aimed at restoring function. Services provided as part of a reablement approach can include physiotherapy, psychosocial and other education programs,

activities". Restorative and reablement approaches focus on what needs to happen for an older person who has an issue/problem following an injury or illness. Providing services that focus on healthy ageing such as ensuring continuing functional ability for an older person differs from providing restorative care following an illness or injury. However, both ways of thinking and services are needed.

Reablement and healthy ageing were not generally viewed as occurring in aged care, and where they did occur, it was often viewed as the responsibility of other professions rather than of nurses. A participant from the Brisbane focus group noted that her facility was addressing healthy ageing through:

> *"An exercise physiologist coming in and looking at the diets and menus … but we are only in the very early stages because we're looking at more preventative and through the exercise … preventing falls".*

More commonly
as to why reablement and healthy ageing were not occurring, with both workload and the acuity of

Underpinning much of the discussion in the focus groups was a tension between the care that can be given and the care that participants would like to give. This was particularly evident in relation to the reablement and social aspects of care. The participants argued that current workloads promote a task orientated- rather than a person-oriented model of care. One participant from the Melbourne morning focus group decried the lack of time for

social care noting the focus on tasks rather than on comprehensive care:

> *If you are going to work in a nursing home, you don't want to just have task, task, task, but it is all task, task, task …*

The focus group participants suggested that a task-orientation is promoted by the manner in which the work is organised for care workers. An Assistant in Nursing described being given a list of residents with the tasks outlined at the commencement of the shift. When asked what was provided by way of handover, she stated that she received a:

> *"Resident list and the task is there; this is for the two people shower".*

A second concern was the increasing acuity of the residents. It was noted that Residential Aged Care increasingly provides hospice and end-of-life care. Changing acuity in aged care has been exacerbated by the removal of distinctions between high- and low-care and the establishment of accommodation bonds which have the potential to delay admission (Henderson et al., 2016b).

# CHAPTER 4
# Six Typical Resident Profiles

## 4.1 Introduction

The following section presents six discussed as part of the focus groups and provides feedback on the tasks that were considered to be required for optimal nursing care.

determined the percentage of nursing and personal care (skills mix) time needed for each resident

over a 24 hour period, and the time taken to complete those interventions inclusive of time for indirect and environmental tasks

demographic information:

- 
- Social History
- Family Support
- 
- Alerts/Allergies

Care Hours Per Day (RCHPD), which are based

interventions.

# Resident Profile 1: Voula

**Evidenced Based:** 2.5 RCHPD

**Focus Group Moderation:** 3.0 RCHPD

**Profile description**

Voula is 83 years of age, widowed, and speaks and understands Greek (native) and English.

Prior to admission, Voula lived alone at home with a community aged care package, but had required admission to a Greek residential care facility

**Social History:** Voula was born in Greece and migrated to Australia in her early teens.

**Family Support:** Voula has a supportive family who visit on weekends and on special occasions.

**Significant Medical History:** Dementia, hypertension (well controlled on medications), and osteoarthritis (regular pain management and therapy).

**Alerts/Allergies:** Nil.

### Resident Profile 1: Care Needs

| Care category | Deconditioned – restorative focus |
|---|---|
| Cognition<br><br>Psychosocial | Alert, some confusion (needs re-orientation and re-direction) – language barrier – reverting to native language at times. 'Sun downer'.<br><br>Wanders at night (variable). |
| Nutrition | Generally good. Needs assistance with setting up for meals due to arthritic hands. |
| Hydration | Of fee. |
| Activities of Daily Living | Shower one assist<br><br>Walks without aids |
| Elimination Bladder and Bowels | Continent most of the time – needs assistance with toileting<br><br>Has regular aperient for constipation |
| Skin Health | Intact but fragile, bruises easily |
| Falls History | Nil |
| Pain Management | Requires regular analgesia + prn |
| Medication | Daily regular medications + prn |

### Resident Profile 1: Care Provided Across Shifts

| AM: | PM: | NIGHT: |
|---|---|---|
| Shower - minimal assistance | Diversional activities supervised | Sleep patterns observed |
| Oral hygiene, including dental care | Meals set-up | Fluids - assist and/or provide |
| Toileting - minimal assistance | Fluids - assist and/or provide | Toileting - minimal assistance |
| Oral medication ≤ 6 medications | Pain assess +/- scale | Reassured and supported |
| Meals set-up | Pain - oral analgesia administered | |
| Fluids - assist and/or provide | Pain - assess analgesia effect | |
| | Toileting - minimal assistance | |

### Resident Profile 1: Evidence Based Resident and Personal Care Hours Per Day

| Total Time (minutes) Direct + Indirect Care Time | RCHPD (hours) |
|---|---|
| 150.00 | 2.50 |

*Q1. The percentage of residents in facility matching*

While some participants indicated that their

Voula, (ranging from 10-50% of their resident population), the general view across all the focus

would not be admitted to a RACF and were more likely to remain in the community supported by care packages, only receiving respite care in a RACF. An exception may be when a spouse is admitted, in which case the partner may also be admitted.

*Q2. Are the interventions typical?*

Participants who indicated that their facilities

oula,

requirements as a consequence of Voula's ethnicity and the diagnosis of dementia, suggesting that these factors would have an impact on the time required to provide her care.

Participants noted that there were few ethnic-

Australia; hence, the majority of residents similar to Voula'

Culturally and Linguistically Diverse (CALD) focus. Where this is the case, additional time would be required for communication and management of behaviours associated with dementia. Participants

suggested that the interventions and associated care required to appropriately manage a similar resident. This was particularly evident on the evening and night shifts.

Care interventions that participants considered to be missing from Voula'
Box 3.1.

*Q3. Resident Care Hours Per Day (RCHPD)*

The majority view across all the focus groups was that a person who was actually a resident

2.5 hours of care per 24 hour period, as indicated in the discussion of the interventions. Across all focus groups and interviews, estimates of the time required ranged from 2.5 to 4 hours. Variations included: 2.5, 3.5, 3, 3.5, and 4 hours with the

minimum of 3 hours per 24 hour period for each resident.

**Box 3.1: Care interventions missing from Voula's profile:**

- Managing 'sundowning' which would typically occur with residents with dementia requiring

  .

- Time needed to direct, re-direct, and re-orient the resident who would, because they are mobile, often wander and enter other residents' rooms, causing stress and anxiety to these other people.

- 

  time spent by the nurse or care worker settling a resident who may become agitated along with others who may have been disturbed. Care could include making and administering hot drinks and undertaking other settling activities to calm one or more residents.

- oula

  had an interested and concerned family, this often increased demands on the nursing staff, and in particular the RN, to provide information about their family member.

# Resident Profile 2: Gwen

**Evidenced Based:** 3.0 RCHPD

**Focus Group Moderation:** 3.5 RCHPD

**Profile description:**

Gwen is 87 years of age, a widow, and speaks and understands English.

Prior to admission, Gwen had moved in with her daughter following increasing hospitalisation due to recurrent cardiac episodes and exacerbation of a respiratory condition. Gwen has a long-standing history of depression.

**Social History:** Gwen was born in England and migrated to Australia in her early twenties.

**Family Support:** Gwen has a supportive daughter who visits on weekends. No other relatives.

**Significant Medical History:**
controlled on digoxin) and asthma (inhaler with spacer), depression.

**Alerts/Allergies:** Nil.

### Resident Profile 2: Care Needs

| Care category | Assessment |
|---|---|
| General | When asthma exacerbated – shortness of breath and distressed<br>Deaf – wears hearing aids |
| Cognition /Psychosocial | Alert, anxious and withdrawn at times |
| Nutrition | Generally good –<br>Needs assistance with setting up for meals |
| Hydration | Of |
| Activities of Daily Living | Shower - one assist (breathless and safety)<br>W<br>easily) |
| Elimination Bladder and Bowels | Continent most of the time |
| Skin Health | Intact – very dry |
| Falls History | Nil |
| Pain Management | Requires regular analgesia (in oral medications) and prn |

### Resident Profile 2: Care Provided Across Shifts

| AM: | PM: | NIGHT: |
|---|---|---|
| Shower - minimal assistance | Toileting - minimal assistance | Sleep patterns observed |
| Denture hygiene | Meals supervision | Reposition in bed or chair |
| | Fluids - assist and/or provide | Toileting - minimal assistance |
| Toileting - minimal assistance | Oral medication ≤ 6 medications | Inhaled - nebuliser |
| Oral medication ≤ 6 medications | Inhaled - nebuliser | |
| Inhaled - nebuliser | Resident support for depression provided | |
| Meals supervision | | |
| Fluids - assist and/or provide | | |

### Resident Profile 2: Evidence Based Resident and Personal Care Hours Per Day

| Total Time (minutes) Direct + Indirect Care Time | RCHPD (hours) |
|---|---|
| 180.00 | 3.00 |

*Q1. The percentage of residents in facility matching*

While some participants indicated their facilities

a relatively low percentage of the overall resident population in those facilities, with one participant

account for 10% of their population.

*Q2. Are the interventions typical?*

Participants who indicated that their facilities

the impact of Gwen's comorbidities, particularly her depression and asthma on the time required for care. Participants whose facilities included

interventions and associated timings did not,

appropriately manage this type of resident, with additional time required across all three shifts for the encouragement of social engagement and the management of depression, particularly during the night shift. Other issues that the participants

assessment to prevent shortness of breath and exacerbation of asthma, monitoring of pain, and evaluation of mental health status. These care activities were seen as necessary additional timings for every shift for residents with this type of

Care interventions that participants considered to be missing from Gwen'
Box 3.2.

Participants noted that not all staff have the knowledge to understand the complexity of

resident's breathlessness can be exacerbated if a worker rushes the showering or toileting to meet completion requirements. The participants indicated that a preventive focus on care was very important with these types of residents and that the timings should allow for this.

*Q3. Resident Care Hours Per Day (RCHPD)*

Participants in all focus groups indicated that a

more than 3 hours of care per 24 hour period. Across all focus groups and interviews, estimates of the time required ranged from 3 to 5 hours of care. Variations included: 3.5, 3, 4, 4, 3.5, 4, 4, 3,

baseline should be a minimum of 3.5 hours per 24 hour period for each resident.

**Box 3.2: Care interventions missing from Gwen's profile:**

- Residents with depression often experience sleeplessness and anxiety at night and require additional emotional support.
- Showering, toileting, and other activities of daily living would take longer to prevent shortness of breath and to maintain continence and hygiene.
- One-on-one communication to provide ongoing emotional support and encouragement to socialise to prevent exacerbation of depression and to encourage appropriate nutritional intake.
- Time taken to settle a resident at night after toileting who may, once awake, suffer from sleeplessness and anxiety related to their depression and possible shortness of breath related to their asthma. This could include making and administering hot drinks, undertaking other settling activities to calm the resident, and the possible administration of nebulisers.
- Additional time would be required earlier in the admission to reassure families and to settle the resident.

## Resident Profile 3: George

**Evidenced Based:** 3.5 RCHPD

**Focus Group Moderation:** 4.0 RCHPD

**Profile description**

George is 84 years of age, married (wife living with son), native language Italian – English as a secondary language.

Prior to admission, George lived with his wife until hospitalisation with a stroke – Right CVA (thrombolysis), rehabilitation (extension), residual weakness in left leg, has short attention span and is impulsive, speech unclear at times.

**Social History:** George was born in Italy and migrated to Australia at the age of 42.

**Family Support:** George's wife visits every second day (lives close by).

**Significant Medical History:** Right CVA, Hypertension, Behaviour – Agitation, TIAs, Back Pain (musculoskeletal)

**Alerts/Allergies:** Penicillin.

### Resident Profile 3: Care Needs

| Care category | Assessment |
|---|---|
| General | Maintaining health and reassurance – behaviour support |
| Cognition /Psychosocial | Alert, agitated at times – needs reassurance and support |
| Nutrition | Special soft diet – partial assist |
| Hydration | Of |
| Activities of Daily Living | Shower two assist<br><br>Walks with tripod |
| Elimination Bladder and Bowels | Variable continence/incontinence |
| Skin Health | |
| Falls History | Nil recent – risk of falls |
| Pain management | Requires regular analgesia (oral and DDA patch + prn) |
| Medication | Daily regular medication and prn |

### Resident Profile 3: Care Provided Across Shifts

| AM: | PM: | NIGHT: |
|---|---|---|
| Shower - minimal assistance | Toileting - minimal assistance | Sleep patterns observed |
| Shave resident | Toileting - pad check and change | Toileting - minimal assistance |
| Oral hygiene and denture care | Meals partial assistance | Toileting - pad check and change |
| Toileting - minimal assistance | Fluids - assist and/or provide | Fluids - assist and/or provide |
| Toileting - pad check and change | Oral medication ≤ 6 medications | Distress management and treatment |
| Oral medication ≤ 6 medications | Distress management and treatment | |
| DDA patch | | |
| Meals partial assistance | | |
| Distress management and treatment | | |
| Fluids - assist and/or provide | | |

### Resident Profile 3: Evidence Based Resident and Personal Care Hours Per Day

| Total Time (minutes) Direct + Indirect Care Time | RCHPD (hours) |
|---|---|
| 210.00 | 3.50 |

*Q1. The percentage of residents matching the*

The participants indicated that all their facilities

these residents made up a large percentage of the overall resident population in those facilities.

*Q2. Are the interventions typical?*

Participants who indicated that their facilities

for the required interventions as a consequence of his behavioural issues. Overall, the participants suggested that interventions to manage the

The participants indicated that residents with

*'unpredictable'* in terms of their behaviour, and managing the resident's distress, agitation, and/or aggression constituted a large component of the nursing care time. The participants indicated that managing care for George required a skill set beyond that of a PCW because of the potential for, and mitigation against, aggressive and/or agitated

communication as a consequence of his diagnosis.

Care interventions that participants considered to be missing from George'
Box 3.3.

*Q3. Resident Care Hours Per Day (RCHPD)*

The majority view across all the focus groups

more than 3.5 hours of care per 24 hour period, as indicated in the discussion of interventions that would be required. Across all focus groups and interviews, estimates of the time required ranged from 4 to 4.5 hours of care. Variations included: 4, 4, 3.5, 4, 4.5, 4, and 4.5 hours, with the general

of 4 hours per 24 hour period for each resident.

**Box 3.3: Care interventions missing from George's profile**

- 
- Assessment and management of skin tears and falls as a consequence of the behavioural issues
- Repositioning overnight
- Time for management of the reactions of other residents when he becomes distressed and agitated
- Assessment of pain management
- 

  Australia and that this would impact on the

  timings

# Resident Profile 4: Walter

**Evidenced Based:** 4.0 RCHPD

**Focus Group Moderation:** 4.5 RCHPD

**Profile Description**

Walter is 82 years of age, married with wife living at home, born in Australia.

Prior to admission, Walter lived with his wife supported by an aged care community package. Walter's dementia has progressed with behaviour, falls, incontinence, and wandering - his care needs could not be met at home and he was admitted to a residential care facility (dementia-

**Social History:** Walter is a war veteran, married for 50 years, has two adult children and four grandchildren.

**Family Support**: Walter's wife is elderly, visits weekly with siblings and extended family.

**Significant Medical History:** Walter has diabetes type 2 (oral hypoglycaemics now on daily s/c insulin - stable), osteoarthritis, and hypertension.

**Alerts/Allergies:** Aspirin.

### Resident Profile 4: Care Needs

| Care category | Assessment |
|---|---|
| General | Maintaining health, safety, reorientation, and reassurance – behaviour support |
| Cognition /Psychosocial | Needs re-orientation, anxious++ |
| Nutrition | Diabetic diet – partial assist and supervise |
| Hydration | Of |
| Activities of Daily Living | Has frame – needs reminder to use |
| Elimination Bladder and Bowels | Variable incontinent – regular toileting+ |
| Skin Health | Intact but at risk |
| Falls history | Nil recent falls but has hip protectors as a preventative measure |
| Pain management | Requires regular oral analgesia |
| Medication | Daily regular medications + prn + daily s/c insulin |
| Diabetes management | Diabetic diet, BD BGL checks |

### Resident Profile 4: Care provided Across Shifts

| AM: | PM: | NIGHT: |
|---|---|---|
| Shower - minimal assistance | Toileting - minimal assistance | Sleep patterns observed |
| Shave resident | Toileting - pad check and change | Toileting - minimal assistance |
| Oral hygiene and denture care | Meals partial assistance | Toileting - pad check and change |
| Toileting - minimal assistance | Fluids - assist and/or provide | Fluids - assist and/or provide |
| Toileting - pad check and change | Oral medication ≤ 6 medications | Distress management and treatment |
| Oral medication ≤ 6 medications | Agitation behaviour management | Reposition resident in bed or chair |
| Subcutaneous medication | Diversional activities supervised | |
| Meals partial assistance | Assess blood glucose level | |
| Agitation behaviour management | | |
| Fluids - assist and/or provide | | |
| Hip protectors applied and maintained | | |
| Assess blood glucose level | | |

### Resident Profile 4: Evidence Based Resident and Personal Care Hours Per Day

| Total Time (minutes) Direct + Indirect Care Time | RCHPD (Hours) |
|---|---|
| 240.00 | 4.00 |

The participants indicated that their facilities all alter. These

the overall resident population in those facilities, ranging from 10%, to one respondent who argued that Walter' *50% of the men'* in the RACF where she worked.

*Q2. Are the interventions typical?*

Participants who indicated that their facilities

consequence of the interventions required to manage his mental health issues. They noted

veterans, as war neuroses often emerged as these residents aged, making their care and management particularly demanding of nursing

routinely have a mini-mental state examination (MMSE) to determine their cognitive state because of their dementia, it was suggested that additional assessment by an RN was required to identify other problems such as a diagnosis of Post-Traumatic Stress Disorder (PTSD) and associated care implications. Time demands are exacerbated by the lack of expertise in, and challenges of,

staff with the requisite knowledge and skill to recognise and manage residents with mental health problems.

Care interventions that participants considered to be missing from Walter'
Box 3.4.

While participants indicated that the interventions

to manage mental health issues as described above, and therefore, further time for behaviour management should be added.

*Q3. Resident Care Hours Per Day (RCHPD)*

The majority view across all the focus groups

more than 4 hours of care per 24 hour period, as indicated in the discussion of the interventions that would be required. Across all focus groups and interviews, estimates of the time required ranged from 4.5 to 5 hours of care. Variations included 4, 4.5, and 5 hours, with the general view that the

per 24 hour period for each resident, with additional time likely to be needed for behaviour management bringing it to 4.5 hours.

**Box 3.4: Care interventions missing from Walter's profile:**

- Assessment of mental state
- Additional time for behaviour management and settling at night
- Potential for wandering at night which will require further time to prevent him disturbing other residents and settling

# Resident Profile 5: Sarah

**Evidenced Based:** 4.5 RCHPD

**Focus Group Moderation:** 5.0 RCHPD

**Profile Description**

Sarah is 82 years of age, a widow, and born in Scotland.

Prior to admission, Sarah lived with her family. Sarah had a major fall at home – Right NOF – conservative management (not able to bear weight). Sarah has dementia (10 year history), wandered at home, and has a recent history of increasing falls prior to her major fall.

**Social History:** Sarah was a school teacher, married for 40 years, has four adult children and ten grandchildren.

**Family Support:** Sarah's family is very supportive and visits 2-3 times per week.

**Significant Medical History:** Sarah has rheumatoid arthritis (30 year history), renal impairment, anaemia,

fractured right neck of femur + Redo (10 years ago).

**Alerts/Allergies:** Morphine.

### Resident Profile 5: Care Needs

| Care category | Assessment |
|---|---|
| General | Maintaining health, safety, reorientation, and reassurance – behaviour support |
| Cognition /Psychosocial | Needs re-orientation and re-orientation. Sundowner |
| Nutrition | Normal partial assist and supervise (arthritis) |
| Hydration | Of |
| Activities of Daily Living | Shower maximum assist + lifter<br>Needs regular repositioning in chair and bed |
| Elimination Bladder and Bowels | Variable continence, needs aperients (constipation and immobility) |
| Skin Health | Intact – at risk – closely assess and monitor |
| Falls history | Nil recent falls, but has hip protectors as a preventative measure |
| Pain management | Has had falls 2 months ago – nil recent falls – has hip protectors (preventative measures) |
| Medication | Requires regular analgesia (oral + DDA) |

### Resident Profile 5: Care Provided Across Shifts

| AM: | PM: | NIGHT: |
|---|---|---|
| Shower - moderate assistance (2 people) | Meals set up | Sleep pattern observed |
| Oral hygiene and denture care | Meals supervise | Toileting - moderate assistance |
| Transfer maximum assistance (3 people) with lifting machine | Oral medication ≤ 6 medications | Toileting - pad check and change |
| Meals set up | Fluids - assist and/or provide | Fluids - assist and/or provide |
| Meals supervise | Transfer maximum assistance (3 people) with lifting machine | Reposition resident in bed or chair |
| Oral medication ≤ 6 medications | Toileting - minimal assistance | Pressure area care |
| DDA patch | Toileting - pad check and change | |
| Toileting - minimal assistance | Diversional activities supervised | |
| Toileting - pad check and change | Reposition resident in bed or chair | |
| Fluids assist and/or provide | | |
| Pressure area care | | |

### Resident Profile 5: Evidence Based Resident and Personal Care Hours Per Day

| Total Time (minutes) Direct + Indirect Care Time | RCHPD (hours) |
|---|---|
| 270.00 | 4.50 |

All the participants indicated that their facilities ranging from one facility with all residents having a overall resident population in those facilities (5 or 6 residents).

*Q2. Are the interventions typical?*

Participants discussed the implications on timings

required to manage Sarah's comorbidities; in particular, her rheumatoid arthritis and associated knee replacements, dementia, obesity, and variable continence. They suggested that the

the care required to appropriately manage a similar resident, with additional time required across all shifts.
has dementia, the participants stressed that interventions related to continence management on the night shift were not 'simply toileting'. For

time spent by the nurse settling a resident who may, once awake, suffer from sleeplessness and anxiety related to their dementia. This could include making and administering hot drinks and undertaking other settling activities to calm the resident, as well as the possible administration

A

experiencing pain. Assessment, pain and symptom management, and dealing with dementia-related

from the RN, who the participants considered had the knowledge and skill to manage these care activities.

It was again noted that staff with minimal education, such as PCWs, could not be expected to have the knowledge to understand the

risk rushing showers or toileting, focusing on the completion of tasks which increased the risk of falls. It was also noted that where nurses did not

to residents was often reactive leading to an escalation of resident behaviour and increasing care requirements.

Care interventions that participants considered to be missing from Norma'
Box 3.5.

*Q3. Resident Care Hours Per Day (RCHPD)*

The majority view across all the focus groups

more than 4.5 hours of care per 24 hour period, as indicated in the discussion of the interventions. Across all focus groups and interviews, estimates of the time required ranged from 5 to 6.5 hours of care. Variations included: 4.5, 5, 5.5, 6, and 6.5 hours, with additional time required for the number of staff required for transfers, toileting, and showering.
baseline should therefore be a minimum of 5 hours per 24 hour period.

**Box 3.5: Care interventions missing from Sarah's profile**

- Assessment of pain and provision of additional pain relief
- Range of movement exercise to maintain mobility of joints
- Regular 2 hourly repositioning when in bed and at night
- Time spent in settling the resident after toileting at night Management of the confusion associated with dementia

# Resident Profile 6: Norma

**Evidenced Based:** 5.0 RCHPD

**Focus Group Moderation:** 6.0 RCHPD - End Stage Palliative Care

**Profile description:** Norma is 85 years of age and married (husband lives at home).

Prior to admission, Norma lived with her husband.

Norma has end stage breast cancer (metastases). Norma'
past six weeks. Admitted from hospital for palliative and end-of-life care.

**Social History:** Norma was a RN, has been married to
grandchildren.

**Family Support:** Norma's family and friends are very supportive and stay with her most of the day and night.

**Significant Medical History:** Norma has had bilateral mastectomies, chemotherapy, and radiotherapy. Breast cancer (recurrent) and hypertension. Has pressure sore right buttock.

**Alerts/Allergies:** Morphine.

### Resident Profile 6: Care Needs

| Care category | Assessment |
|---|---|
| General | Palliative, debilitated, cachexia |
| Cognition /Psychosocial | Delirium |
| Nutrition | |
| Hydration | Offer as assessed and tolerated |
| Activities of Daily Living | Sponge in bed, pressure care, repositioning |
| Elimination Bladder and Bowels | Incontinent |
| Skin Health | Pressure Ulcer – wound management and care |
| Falls history | Nil – risk due to delirium – family with Norma 24/7 |
| Pain management | s/c DDA analgesia (Graseby - 1/24 pump) |
| Medication | Subcutaneous prn |

### Resident Profile 6: Care Provided Across Shifts

| AM: | PM: | NIGHT: |
|---|---|---|
| Sponge in bed | Pressure area care | Pressure area care |
| Oral hygiene and denture care | DDA subcutaneous | DDA subcutaneous |
| DDA subcutaneous | Pain assess +/- scale | Pain assess +/- scale |
| Pain assess +/- scale | Pain assess analgesia effect | Pain assess analgesia effect |
| Pain assess analgesia effect | | |
| | Counselling and support provided | Counselling and support provided |
| Spiritual comfort | Toileting - pad check and change | Toileting - pad check and change |
| Wound dressing attended | Reposition resident in bed or chair | Reposition resident in bed or chair |
| Pressure care attended | Oral medication ≤ 6 medications | Oral medication ≤ 6 medications |
| Toileting - continence pad check and change | Fluids assistance and/or provide | Fluids assistance and/or provide |
| Assess family and social support | | |
| Fluids assistance and/or provide | | |

### Resident Profile 6: Evidence Based Resident and Personal Care Hours Per Day

| Total Time (minutes) Direct + Indirect Care Time | RCHPD (hours) |
|---|---|
| 300.00 | 5.00 |

All participants indicated that their facilities had

end-of-life palliative care. While the percentage varied, it was normal to have a number of residents

All participants indicated that there was an increase in admissions of older people from the community and/or the acute care sector for end-of-life palliative care.

*Q2. Are the interventions typical?*

Participants who indicated that their facilities

consequence of the complexity of holistic care required for caring for a resident requiring end-of-life care. It was noted that palliative care within Residential Aged Care required the same resources and level of care as in the acute sector The participants also stressed the importance of RN assessment and management of residents with

and personal care was given, emphasising the complexity of nursing required for the delivery of quality end-of-life palliative care. While the RN may

needed to closely supervise PCWs/Assistants in Nursing (AiNS) to ensure the required standard of personal care was given, even basic ADLs such as mouth care. Counselling the family was seen as requiring the knowledge and skill of an RN and was noted to be a particularly demanding, but important, aspect of end-of-life care. Participants also stressed the need to ensure that the residents did not die alone and were supported by a staff member at this time.

Care interventions that participants considered to be missing from Norma'
Box 3.6.

*Q3. Resident Care Hours Per Day (RCHPD)*

The majority view across all the focus groups

more than 4.5 hours of care per 24 hour period, as indicated in the discussion of the interventions that would be required, with the general view being

hours per 24 hour period. All participants held the view that the hours allocated to care for residents requiring palliative care should be the same as

or hospice setting, as the care requirements are the same regardless of the care setting, that is 6.0 RCHPD palliative standards for care.

**Box 3.6: Care tasks missing from Norma's profile:**

- Counselling and emotional support for the family who were often present 24/7.
- Symptom management requiring pain assessment and pain management by the RN on a regular basis, ranging from half-hourly infusion checks to 1 to 2 hourly assessment of the resident's pain Care interventions that participants considered to be missing from Norma'
  in Box 3.6. status.
- and supervision, particularly in relation to the administration of DDAs.
- Comfort and hygiene care, and repositioning at least two hourly were described as essential, requiring a two person assist at all times.

### 4.2 Conclusion

Overall, there was consistency in the additional timings recommended by participants in the focus groups. While there was variation in the hours

across all focus groups supported an additional half

The additional timings were primarily centred around the 'real time' to perform a task given the resident' e.g., additional time taken to settle a resident with dementia at night-time who needed toileting, or additional time needed for dealing with the behaviour of a resident with dementia in the evening. Given the rigour underpinning the development of the Aged Residential and Restorative Care Conceptual Model, as outlined in Chapter 2, it is not surprising that the increase in timings was less than an hour.

# CHAPTER 5
# Results of the MISSCARE survey

## 5.1 Introduction

The survey was offered online for two months, closing on 5 February 2016 (accounting for staff annual leave) and was undertaken by 3,206 participants (see Appendix B for questions). As noted in Chapter 2, PCWs, as well as Registered and Enrolled Nurses responded to the survey. In this chapter, we refer to carers as PCWs, although we are aware that a variety of other terms are used across the sector. The key demographic characteristics of the respondents are summarised in Table 4.1 on the following page.

**Table 4.1: Summary of Demographic Characteristics of the Respondents to the MISSCARE Survey**

| Demographics | N=3206 |
|---|---|
| **Gender** | |
| Female | 2916 (91.4%) |
| Male | 273 (8.6%) |
| **Age** | |
| Under 25 years old | 124 (3.9%) |
| 25-34 years old | 367 (11.5%) |
| 35-44 years old | 517 (16.2%) |
| 45-54 years old | 990 (31.1%) |
| 55-64 years old | 1030 (32.3%) |
| Over 64 years old | 160 (5.0%) |
| **Role** | |
| RN/Division 1 | 1119 (34.9%) |
| Enrolled Nurse/Division 2 | 939 (29.3%) |
| Personal Care Worker/Assistant in Nursing | 1092 (34.1%) |
| Nurse Practitioner | 56 (1.7%) |
| **Years of experience in current role** | |
| 0-12 months | 166 (5.2%) |
| 1-4 years | 759 (23.8%) |
| 5-9 years | 782 (24.5%) |
| 10-20 years | 782 (24.5%) |
| Greater than 20 years | 706 (22.1%) |
| **Original nursing/PCW qualification from Australia** | |
| Yes | 2951 (92.7%) |
| No | 232 (7.3%) |

The majority of respondents (91.4%) were female,

caring workforce as a whole. The sample was skewed towards people aged 45 years and over who comprised 68.4% of the respondents. The , but slightly older

undertaken in 2012, which found that 59.9% of the aged care workforce were aged 45 years and older (King et al., 2013). The greater proportion of people

in the sample. The median age range for all staff is 45-54 years of age; however, PCWs were found to

≤ 0.001), with 63.4% of PCWs being aged 45 years and older compared with 70.4% of RNs.

Of the respondents, 1,119 were employed as RNs/ Division 1 nurses. This number comprises 5.1% of FTE aged care positions for RNs employed in aged care in Australia in 2012 (King et al., 2013). In total, 939 respondents were employed as Enrolled/ Division 2 nurses (5.6% of the FTE EN workforce in 2012) and 1,092 as PCWs/AiNs (1.1% of the FTE PCW workforce in 2012). In addition, the survey was undertaken by 56 Nurse Practitioners (19%). The sample is evenly spread across categories in relation to years of experience. When comparisons are examined across organisation type, no difference is found in the level of experience of employees in rural and metropolitan services; however, employees in larger sites and in private-

of experience since qualifying than employees

working at other sites (p ≤ 0.001). King et al.

of people from culturally and linguistically diverse (CALD) backgrounds. They found that 35% of people providing direct care in Residential Aged Care in 2012 were born overseas. While this question was not asked in this study, two questions in this survey indirectly addressed the country of origin of the respondents: one asking where

obtained, and a second asking whether English was the respondents' Answers to both questions suggest that people from Culturally and Linguistically Diverse (CALD) backgrounds are under-represented in the results presented here. Of the respondents, 92.7% received their Australia. A similar

language (97.4%), while 240 respondents indicated that they spoke a language other than English. The most commonly spoken languages suggest that the majority of CALD respondents were from China, the Philippines, or India, with Chinese/ Cantonese/Mandarin, Tagalog/Filipino, and Hindi

languages. Shona, a Bantu language and German were also common languages.

Figure 4.1 below shows the jurisdiction/State or Territory where the respondents come from. This data shows that over one-third of responses were received from Victorian nurses and PCWs. Table 4.2 compares the proportion of the aged care workforce by State and Territory in 2012 with this sample. From this data, it can be seen that Victorian, Queensland, South Australian, and Tasmanian nurses are over-represented, while nurses and PCWs from New South Wales and Western Australia are under-represented. This ictoria has a

of Residential Aged Care facilities.

**Figure 4.1: State and Territory of respondents**


**Table 4.2: Comparison of Aged Care Workforce by State from the 2012 National Survey and the MISSCARE Survey (per cent)**

| State/Territory | Direct care employees 2012 | Our sample |
|---|---|---|
| ACT | 1.0 | 0.6 |
| NSW | 31.0 | 18.4 |
| Victoria | 27.8 | 42.4 |
| Queensland | 17.7 | 19.7 |
| SA | 10.4 | 12.5 |
| WA | 8.6 | 1.9 |
| Tasmania | 3.2 | 4.1 |
| NT | 0.3 | 0.3 |

Table 4.3 summarises the characteristics of the workplaces of the respondents to the MISSCARE survey. The majority of the respondents worked in facilities which offered both high and low care beds (92.4%), with a smaller group working in facilities which previously only provided low care beds (4.7%) or dementia care (2.9%). While data on employee numbers by ownership of facilities was not collected as part of the National Aged Care workforce survey in 2012, data on the allocation of aged care beds in 2012 found that the private-not-

al., 2015).

are over-represented in this sample. Baldwin et al. (2015) argued that there was a decline in smaller, government-owned, rural and remote aged care

services between 2003 and 2012. Rural residents are over-represented in this sample (24.0%), with 1,335 (41.6%) respondents indicating that they were from metropolitan regions. This compares with 65.6% of respondents who designated major cities as their location in the National Aged Care Survey (King et al., 2013).

**Table 4.3: Characteristics of Workplaces of Respondents to the MISSCARE Survey**

| Characteristics | N=3206 |
|---|---|
| **Services offered** | |
| High and low care | 2963 (92.4%) |
| Previously low care only | 151 (4.7%) |
| Dementia care | 92 (2.9%) |
| **Ownership** | |
| Multi-Purpose Service (MPS) | 84 (2.6%) |
| | 1322 (41.2%) |
| | 1163 (36.3%) |
| Government | 426 (13.3%) |
| **Location** | |
| Metropolitan | 1335 (41.6%) |
| Regional | 1096 (33.3%) |
| Rural | 770 (24.0%) |
| Remote | 32 (1.0%) |
| **Size** | |
| 1 to 20 beds | 80 (2.5%) |
| 21-60 beds | 794 (24.8%) |
| 61-100 beds | 1098 (34.2%) |
| 101 or more beds | 1093 (34.1%) |

## 5.2 Staffing and Skills Mix

Figure 4.2 highlights staff perceptions of the . Of the staf
was always adequate. Just under one-third

adequate 75% of the time (30.6%), while 27.2%

levels were viewed as never adequate. Perceptions of staff adequacy varies via organisational type

frequently ($p \leq 0.001$), and respondents from rural and remote services reporting fewer issues with

of providers and the predominance

a number of jurisdictions.

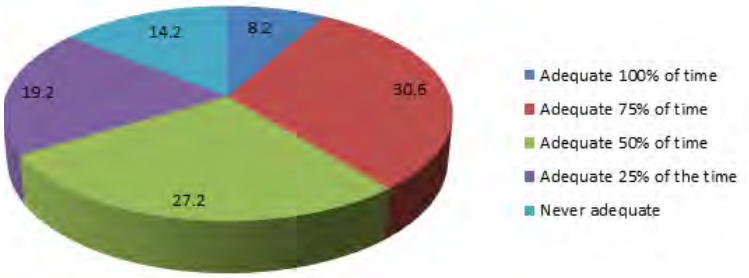



**Figure 4.2: Perceptions of adequacy of staffing (n=2542)**

The participants were also asked to indicate the maximum number of residents they were responsible for on their last shift. Answers varied

undertaken by the respondents. The mean number of residents managed by all respondents was 38.05 (±34.48), with RNs reporting higher ratios of 1 RN to 59.25 residents (±45.85) than enrolled nurses of 1 to 31.39 (± 24.05), and PCWs 1 to 24.19 (±15.73). Mean scores for Nurse Practitioners fell between those of RNs and Enrolled Nurses.
performed by these nurses which may contribute to lower resident ratios than other RNs. See Table 4.4.

**Table 4.4: Mean number of Residents Staff Member was Responsible for on the Last Shift they Worked by Role**

| Role | Mean | Number | Standard Deviation |
|---|---|---|---|
| RN | 59.25 | 886 | ±45.85 |
| Enrolled Nurse | 31.39 | 834 | ±24.05 |
| PCW/AiN | 24.19 | 962 | ±15.73 |
| Nurse Practitioner | 40.72 | 32 | ±28.58 |
| All staff | 38.05 | 2714 | ±34.48 |

**Table 4.5: Comparison of mean staff:resident ratios on last shift by facility ownership and role**

| Ownership | Role | Mean | Number | Standard Deviation |
|---|---|---|---|---|
| Government/MPS | RN/NP | 32.62 | 140 | 28.357 |
| | EN | 18.26 | 198 | 13.704 |
| | PCW | 20.30 | 69 | 13.973 |
| | Total | 23.55 | 407 | 21.046 |
| | RN/NP | 66.38 | 402 | 54.322 |
| | EN | 36.04 | 310 | 19.870 |
| | PCW | 25.07 | 412 | 15.327 |
| | Total | 42.87 | 1124 | 39.690 |
| | RN/NP | 61.94 | 310 | 36.261 |
| | EN | 36.01 | 272 | 31.084 |
| | PCW | 23.69 | 387 | 15.768 |
| | Total | 39.38 | 969 | 32.463 |

When compared across organisation, mean staff:resident ratios were highest in private not-

employees in all roles reporting higher staff:resident

to 39.38 (±32.46 across all roles), and government-owned and funded facilities at 1 to 23.55 (±21.04) (see Table 4.5).

Respondents were also asked to indicate whether there was an RN on duty and on-site during their last shift. The majority of respondents (n=2932, 91.5%) indicated that there was an RN on duty and on-site during their last shift. Respondents

more likely to report that an RN was unavailable ($p \leq 0.001$), with respondents from private not-for-

$\leq 0.05$). It is not clear from the responses whether there were no RNs employed, or RNs were not available to respond as requested. As Table 4.5 indicates, the skills mix varies across the three modes of ownership with government facilities

A

additional staff can be requested if the work area becomes busy, and if staff are provided when such a request is made. The majority of respondents indicated that they could not request additional staff (n=2462, 76.8%). Only 306 respondents (10.0%) indicated that extra staff were provided when requested. Respondents working in private-

, and receiving,

extra staff when compared to both government

f ($p \leq 0.05$), but facility size did not have an impact on the likelihood of receiving additional staff.

Respondents were invited to comment on both questions. The responses suggested that extra staff were provided in some facilities when unexpected events occurred (i.e., falls, ambulance

behaviours needed extra monitoring, when admissions occurred, or if the unit was managing residents receiving end-of-life care. Often, the need for additional staff was managed by reorganising the roster to free up staff at peak times, offering extended shifts to RNs and ENs, or through short-term relieving from other areas.

### 5.3 Missed Care

Table 4.6 shows the mean scores and standard deviations for how frequently nurses and PCWs believed a task was missed. Data are presented across three domains of ADLs, Behaviour, and Complex Health Care. A score of 1 indicates that this task is never missed and a score of 5 that it is always missed.

**Table 4.6: Mean and standard deviations for frequency of missed care tasks identified by nurses and carers in Residential Aged Care via domain**

| | Early shift | Late shift | Night shift |
|---|---|---|---|
| **Behaviour** | | | |
| Intervening when residents' behaviour is inappropriate or unwelcome | 3.08 ±0.88 | 3.24 ±0.88 | 2.91 ±0.98 |
| Intervening when residents say inappropriate or unwelcome things | 2.88 ±0.89 | 3.01 ±0.90 | 2.80 ±0.96 |
| Intervening when residents are physically agitated | 2.52 ±0.96 | 2.61 ±0.98 | 2.36 ±0.99 |
| Encouraging residents' social engagement | 2.88 ±1.02 | 3.11 ±1.00 | 2.97 ±1.16 |
| Encouraging residents' participation in decisions about their care | 2.96 ±1.09 | 3.04 ±1.06 | 2.96 ±1.11 |
| Interacting with residents when they have problems with communication | 2.90 ±0.99 | 2.96 ±0.99 | 2.84 ±1.02 |
| Identifying residents' underlying moods or social states | 3.00 ±0.93 | 3.07 ±0.93 | 2.99 ±0.97 |
| Maximising residents' dignity | 2.33 ±0.98 | 2.35 ±0.99 | 2.35 ±0.98 |
| Ensuring residents are not left alone when supervision is required | 2.95 ±1.02 | 3.03 ±1.01 | 2.92 ±1.07 |
| Supporting residents to maintain their interests | 3.11 ±1.03 | 3.26 ±1.01 | 3.16 ±1.07 |
| Providing residents with activities to improve their mental and physical functioning | 3.06 ±1.03 | 3.33 ±1.00 | 3.28 ±1.09 |
| Providing emotional support for residents' and/or family and friends | 2.65 ±0.99 | 2.70 ±1.00 | 2.59 ±1.03 |
| **Activities of Daily Living** | | | |
| | 2.72 ±1.03 | 2.77 ±1.03 | 2.60 ±1.06 |
| Assisting residents with mobility | 2.58 ±0.99 | 2.64 ±1.00 | 2.55 ±1.02 |

| | | | |
|---|---|---|---|
| Assisting residents' toileting needs within 5 minutes of request | 3.36 ±0.99 | 3.42 ±0.96 | 3.22 ±1.04 |
| Preparing residents for meal times | 2.22 ±0.90 | 2.25 ±0.01 | 2.11 ±0.94 |
| Making sure residents are safe | 2.43 ±0.93 | 2.52 ±0.96 | 2.42 ±0.97 |
| Assisting with residents' hygiene | 2.22 ±0.90 | 2.34 ±0.91 | 2.24 ±0.94 |
| Assisting with residents' mouth care | 2.97 ±1.05 | 3.06 ±1.03 | 2.88 ±1.08 |
| Ensuring own hand hygiene | 1.89 ±0.91 | 1.91 ±0.92 | 1.89 ±0.91 |
| Assessing residents for healthy skin | 2.55 ±0.95 | 2.61 ±0.96 | 2.58 ±0.98 |
| Responding to call bells within 5 minutes | 3.20 ±1.01 | 3.24 ±0.99 | 3.00 ±1.04 |
| **Complex Health Care** | | | |
| Taking vital signs as ordered | 2.34 ±0.92 | 2.38 ±0.93 | 2.30 ±0.94 |
| Monitoring residents' | 2.49 ±0.96 | 2.52 ±0.96 | 2.42 ±0.05 |
| Assessing and monitoring residents for presence of pain | 2.78 ±0.96 | 2.83 ±0.97 | 2.79 ±0.99 |
| Full documentation of all care | 2.89 ±0.99 | 2.52 ±0.99 | 2.30 ±1.00 |
| Providing wound care | 2.31 ±0.89 | 2.39 ±0.90 | 2.32 ±0.94 |
| Providing stoma care | 1.88 ±0.82 | 1.91 ±0.84 | 1.92 ±0.86 |
| Maintaining nasogastric or PEG tubes | 1.78 ±0.81 | 1.79 ±0.82 | 1.80 ±0.84 |
| Providing catheter care | 2.06 ±0.91 | 2.09 ±0.92 | 2.02 ±0.90 |
| Suctioning airways/tracheostomy care | 1.73 ±0.82 | 1.75 ±0.83 | 1.74 ±0.85 |
| Measuring and monitoring residents' blood glucose levels | 1.79 ±0.79 | 1.80 ±0.80 | 1.78 ±0.80 |
| Reassessing residents to see if their care needs have changed | 2.70 ±0.99 | 2.74 ±0.99 | 2.66 ±1.01 |
| Maintaining IV or subcutaneous sites | 1.78 ±0.81 | 1.81 ±0.84 | 1.79 ±0.83 |
| Ensuring PRN medication acts within 15 minutes | 2.47 ±1.00 | 2.51 ±1.00 | 2.42 ±1.01 |
| Giving medications within 30 minutes of scheduled time | 2.84 ±1.11 | 2.82 ±1.09 | 2.55 ±1.05 |
| Evaluating residents' responses to medication | 2.68 ±1.03 | 2.71 ±1.03 | 2.62 ±1.03 |
| Providing end-of-life care in line with residents' wishes | 1.94 ±0.96 | 1.95 ±0.98 | 1.92 ±0.96 |

Table 4.6 demonstrates that, on average, all tasks were reported missed at least some of the time with many tasks being missed more frequently. The tasks that were reported as most frequently missed across all shifts were assisting residents with toileting needs within 5 minutes of request and answering the call bell within 5 minutes. This suggests that staff are not free to undertake these unscheduled, but essential, tasks. The activities which are least likely to be reported as frequently missed are some of the more complex care tasks undertaken by nurses, including providing stoma care, maintaining nasogastric or PEG tubes, suctioning airways, measuring and monitoring blood glucose levels, and maintaining IV or subcutaneous sites. Schubert et al. (2013) argues that nurses prioritise those tasks that have a direct impact on patient outcomes or which are ordered by the doctor. While doctors are not part of Residential Aged Care, their absence is double-edged. On the one hand, they do not make frequent requests that nurses must respond to and, on the other hand, they are not readily available when nurses need to consult them.

The frequency with which other complex care tasks occur, such as assessment, documentation, and evaluation of nursing care, suggests that these tasks may be given a lower priority when resources are stretched; this points to an inadequate skills

Activities within the behavioural domain were most commonly reported as being missed, with support to maintain residents' interests, and providing activities to improve mental and physical function occurring most infrequently.

limited time for reablement activities. Of the other activities of daily living, routine tasks such as hygiene and preparing residents for meal time are missed infrequently, while the tasks that are missed more frequently are assisting with mouth care and moving residents who cannot walk.

**Table 4.7: Mean and Standard Deviations for Frequency of Missed Care Tasks in Residential Aged Care via role (RN/NP/EN/AiN/PCW)**

| | RN/NP | EN | AiN/ PCW |
|---|---|---|---|
| **Behaviour** | | | |
| Intervening when residents' behaviour is inappropriate or unwelcome | 3.09 ± 0.88 | 3.05 ±0.86 | 3.09 ±0.91 |
| Intervening when residents say inappropriate or unwelcome things | 2.90 ±0.86 | 2.89 ±0.90 | 2.86 ±0.92 |
| Intervening when residents are physically agitated | 2.49 ±0.93 | 2.46 ±0.95 | 2.58 ±0.99 |
| Encouraging residents' social engagement | 2.88 ±0.99 | 2.86 ±1.02 | 2.90 ±1.05 |
| Encouraging residents' participation in decisions about their care | 2.95 ±1.04 | 2.91 ±1.07 | 2.99 ±1.15 |
| Interacting with residents' when they have problems with communication | 2.94 ±0.97 | 2.84 ±0.97 | 2.89 ±1.03 |
| Identifying residents' underlying moods or social states | 3.12 ±0.93 | 2.95 ±0.93 | 2.92[a] ±0.97 |
| Maximising residents' dignity | 2.41 ±0.93 | 2.20 ±0.95 | 2.34[a] ±1.04 |
| Ensuring residents are not left alone when supervision is required | 3.01 ±0.98 | 2.94 ±1.01 | 2.87 ±1.07[b] |

| | | | |
|---|---|---|---|
| Supporting residents to maintain their interests | 3.12 ±0.97 | 3.09 ±1.03 | 3.12 ±1.08 |
| Providing residents with activities to improve their mental and physical functioning | 3.00 ±1.03 | 3.07 ±1.00 | 3.10 ±1.09 |
| Providing emotional support for residents' and/or family and friends | 2.66 ±0.99 | 2.56 ±1.00 | 2.70[b] ±1.03 |
| **Activities of Daily Living** | | | |
| | 2.76 ±1.00 | 2.69 ±1.00 | 2.69 ±1.09 |
| Assisting residents with mobility | 2.67 ±0.97 | 2.55 ±0.98 | 2.50[c] ±1.02 |
| Assisting residents' toileting needs within 5 minutes of request | 3.43 ±0.95 | 3.33 ±0.94 | 3.32 ±1.06 |
| Preparing residents for meal times | 2.31 ±0.88 | 2.20 ±0.88 | 2.13[a] ±0.94 |
| Making sure residents are safe | 2.50 ±0.89 | 2.40 ±0.94 | 2.38 ±0.96[a] |
| Assisting with residents' hygiene | 2.28 ±0.89 | 2.17 ±0.92 | 2.18 ±0.99[b] |
| Assisting with residents' mouth care | 3.01 ±1.01 | 2.95 ±1.01 | 2.94 ±1.12 |
| Ensuring own hand hygiene | 2.02 ±0.92 | 1.84 ±0.87 | 1.79[a] ±0.91 |
| Assessing residents for healthy skin | 2.63 ±0.93 | 2.47 ±0.90 | 2.54 ±1.00[a] |
| Responding to call bells within 5 minutes | 3.25 ±0.99 | 3.18 ±0.96 | 3.15 ±1.06 |
| **Complex Health Care** | | | |
| Taking vital signs as ordered | 2.47 ±0.92 | 2.24 ±0.87 | 2.27 ±0.96[a] |
| Monitoring residents' | 2.59 ±0.91 | 2.40 ±0.93 | 2.44 ±1.00a |
| Assessing and monitoring residents for presence of pain | 2.80 ±0.94 | 2.71 ±0.95 | 2.83 ±1.00 |
| Full documentation of all care | 3.05 ±0.94 | 2.83 ±0.97 | 2.74 ±1.05a |
| Providing wound care | 2.42 ±0.87 | 2.22 ±0.87 | 2.26 ±0.94a |
| Providing stoma care | 1.96 ±0.80 | 1.79 ±0.76 | 1.85 ±0.86[c] |
| Maintaining nasogastric or PEG tubes | 1.84 ±0.81 | 1.69 ±0.73 | 1.74 ±0.84[b] |
| Providing catheter care | 2.17 ±0.90 | 1.95 ±0.80 | 2.01 ±0.94[a] |
| Suctioning airways/tracheostomy care | 1.81 ±0.76 | 1.62 ±0.80 | 1.68 ±0.86[b] |
| Measuring and monitoring residents' blood glucose levels | 1.87 ±0.76 | 1.70 ±0.77 | 1.76 ±0.82[a] |
| Reassessing residents to see if their care needs have changed | 2.81 ±0.95 | 2.60 ±1.00 | 2.65 ±1.03[a] |
| Maintaining IV or subcutaneous sites | 1.84 ±0.80 | 1.70 ±0.74 | 1.74 ±0.85[b] |

| | | | |
|---|---|---|---|
| Ensuring PRN medication acts within 15 minutes | 2.48 ±0.95 | 2.35 ±0.97 | 2.58[a] ±1.08 |
| Giving medications within 30 minutes of scheduled time | 3.07 ±1.07 | 2.83 ±1.12 | 2.52 ±1.07[a] |
| Evaluating residents' responses to medication | 2.83 ±0.99 | 2.58 ±1.01 | 2.58 ±1.07[a] |
| Providing end-of-life care in line with residents' wishes | 2.01 ±0.94 | 1.85 ±0.91 | 1.94 ±1.02[a] |

p ≤ 0.001; b. p ≤ 0.05; c. p ≤ 0.01

Table 4.7 above examines care tasks by role. This table demonstrates little difference in responses across the different roles in relation to the behavioural domain of care; however, PCWs recorded the least missed care in relation to 'recognition of underlying mood or emotional state' and 'ensuring residents are not left alone

lower resident allocations, greater time spent with residents, or perhaps lack of training to note these

missed care in relation to 'maximising residents' dignity' and 'providing emotional support for

differences were found more frequently in the domains related to ADLs and complex health

obtained, RNs were more likely to report care as being missed, except in relation to 'ensuring prn medications act within 15 minutes'. In this case, PCWs reported missed care more frequently.

## 5.4 Reasons for Missed Care

The reasons for missed care have been calculated in two ways. First, the respondents were asked to rate 27 nominated items for the impact they had on missed care on a four-point scale, where 1 was 'not

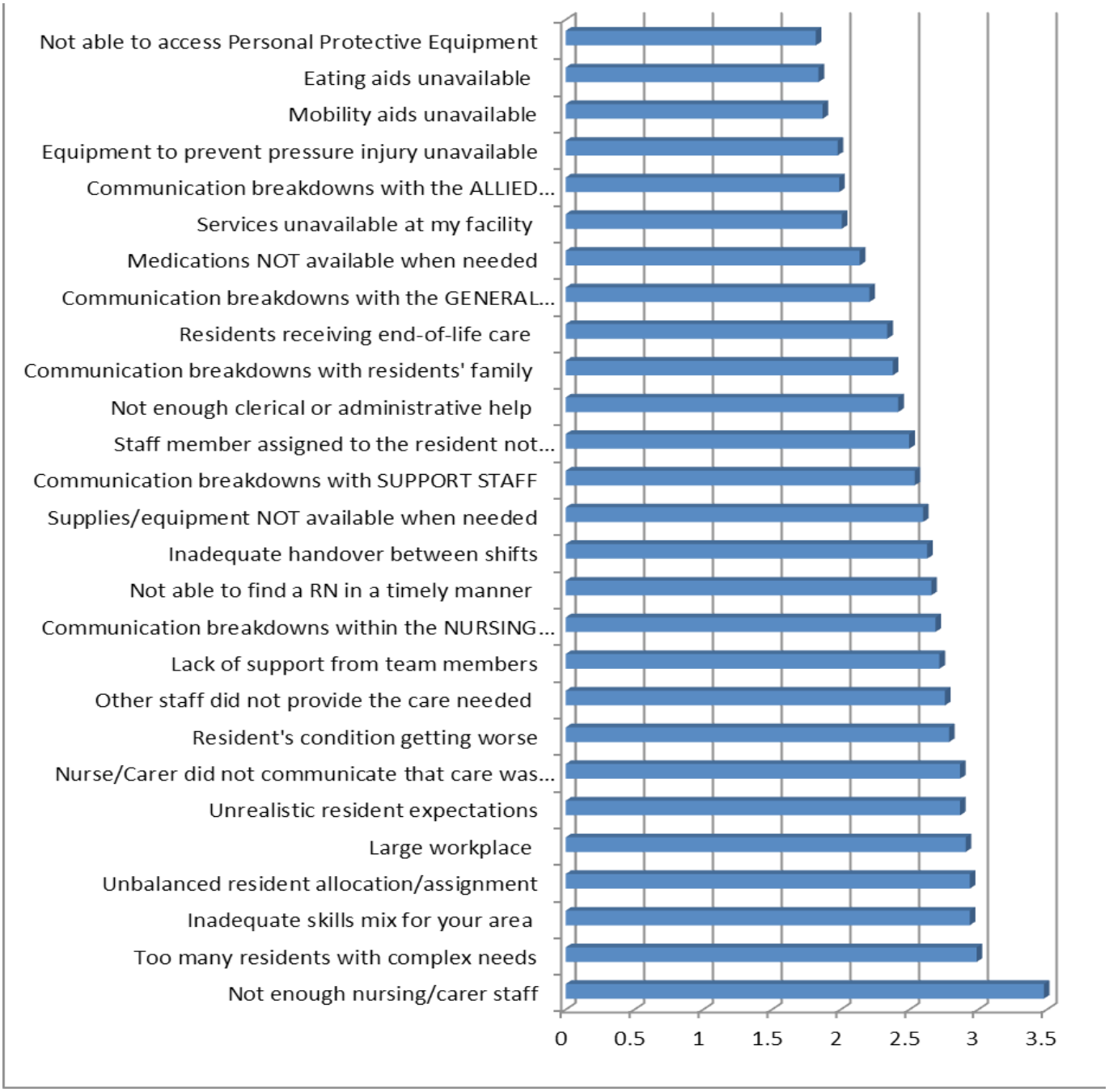
Table 4.8 reports on the mean scores for each item. This table demonstrates that, of the 27 items, a lack of nursing and care staff is the most commonly cited reason for care being missed, followed by 'have too many residents with complex needs', 'inadequate skills mix for your area', and 'unbalanced resident allocation'. The availability of equipment and poor communication with allied health staff were least cited as having an impact on missed care. Figure 4.3 provides the *mean*

that care is missed.

### Table 4.8: Means scores for reasons for missed care

| | Mean | Number | Standard deviation |
|---|---|---|---|
| Not enough nursing/carer staff | 3.48 | 2294 | 0.82 |
| Too many residents with complex needs | 2.99 | 2200 | 1.03 |
| Inadequate skills mix for your area | 2.94 | 2256 | 1.05 |
| Unbalanced resident allocation/assignment | 2.94 | 2193 | 1.01 |
| Large workplace | 2.91 | 2173 | 1.10 |
| Unrealistic resident expectations | 2.87 | 2201 | 1.03 |
| Nurse/Carer did not communicate that care was missed | 2.87 | 2241 | 0.94 |
| Resident's condition getting worse | 2.79 | 2262 | 1.03 |
| Other staff did not provide the care needed | 2.76 | 2237 | 1.03 |
| Lack of support from team members | 2.72 | 2249 | 1.01 |
| Communication breakdowns within the nursing team | 2.69 | 2245 | 1.03 |
| | 2.66 | 2180 | 1.09 |
| Inadequate handover between shifts | 2.63 | 2244 | 1.05 |
| Supplies/equipment NOT available when needed | 2.60 | 2235 | 1.06 |
| Communication breakdowns with support staff | 2.54 | 2226 | 1.03 |
| Staff member assigned to the resident not available | 2.50 | 2123 | 1.07 |
| Not enough clerical or administrative help | 2.42 | 2162 | 1.12 |
| Communication breakdowns with residents' family | 2.38 | 2220 | 0.95 |
| Residents receiving end-of-life care | 2.34 | 2198 | 1.05 |
| Communication breakdowns with the General Practitioner | 2.21 | 2152 | 0.99 |
| Medications NOT available when needed | 2.14 | 2150 | 0.97 |
| Services unavailable at my facility | 2.01 | 2133 | 1.06 |
| Communication breakdowns with the Allied Healthcare Professional | 1.99 | 2164 | 0.93 |
| Equipment to prevent pressure injury unavailable | 1.98 | 2190 | 1.02 |
| Mobility aids unavailable | 1.87 | 2184 | 0.95 |
| Eating aids unavailable | 1.84 | 2162 | 0.97 |
| Not able to access Personal Protective Equipment | 1.82 | 2169 | 0.98 |

**Figure 4.3: Means for Impact of Factors on Missed Care**




## 5.5 Organisational Factors Associated with Missed Resident Care

A second means of determining the reasons for missed care was a path analysis based on multi-variate analyses. The path analysis explored the impact that all the variables had on missed care with modelling based upon factors which had a

.

$p \leq 0.05$ this is indicated in the text. As already demonstrated, there was little variance between the frequencies and types of care missed in Residential Aged Care over the four time periods surveyed (early, late, night, and weekend shifts), so this analysis focused on the variance of missed residential care on early shifts, as this is the time when care demands and staff interactions between themselves, colleagues, and residents are at their highest.

Organisational variables were found to have a

care missed (see Figure 4.4 below). The factors which are bolded are those with a direct impact on missed care.

Other factors increase missed care indirectly through impacting those factors which increase missed care. Among the variables that were found

- Jurisdiction (State and Territory);
- Location (metropolitan or rural);
- Size of facility;
- Ownership of facility;
- Maximum number of residents that staff cared for on their last shift;
- 
- Presence of an RN on-site during last shift;
- Number of hours worked;
- Capacity to ask for extra staff; and
- Workplace satisfaction.

*Impact of Jurisdiction*

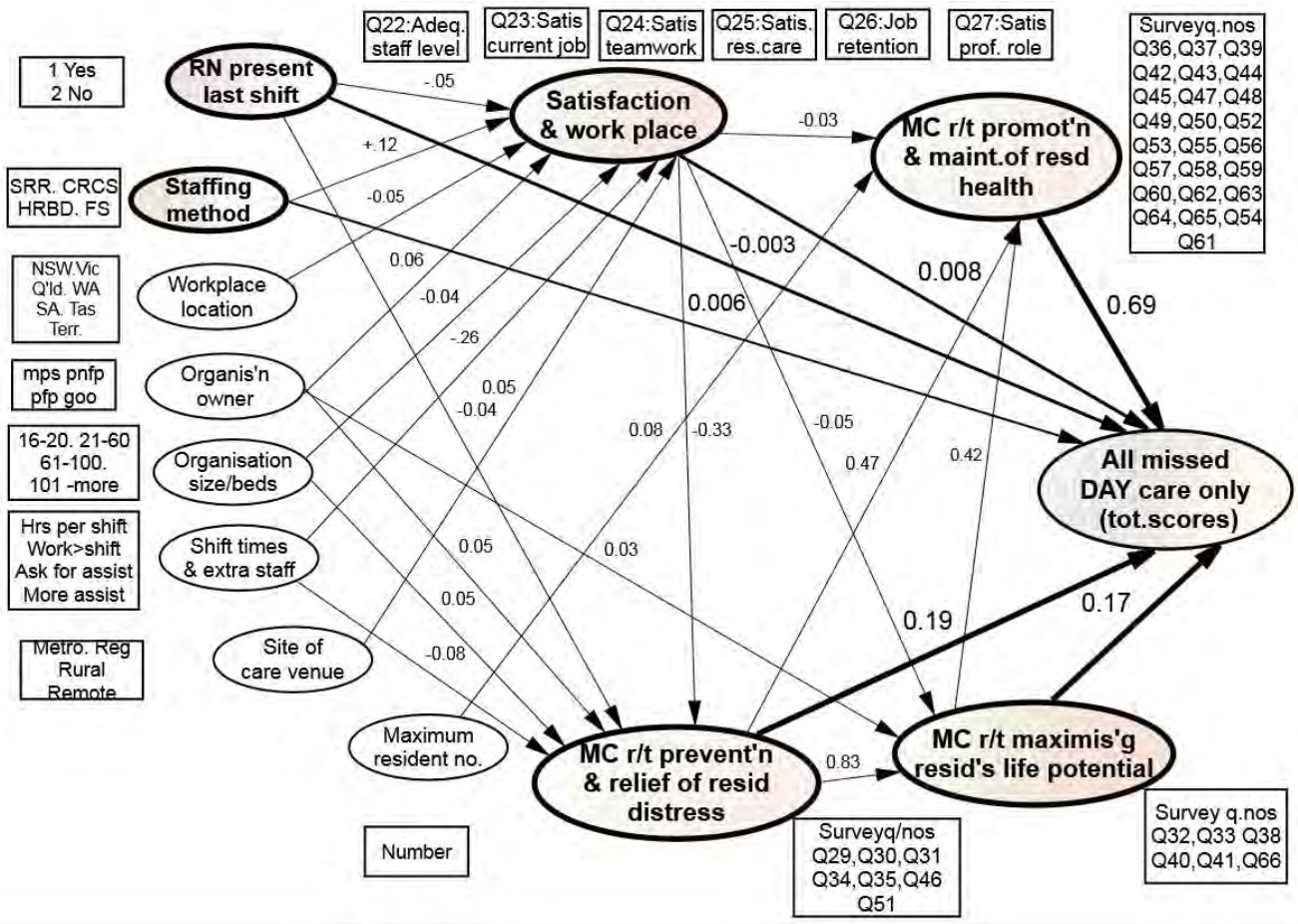
The State or Territory in which the respondent was employed had an impact on their satisfaction with

with the quality of care they delivered. State of origin was also related to intention to leave aged care. Staff from the Australian Capital Territory, Western Australia, and Tasmania indicated the least satisfaction with their current job. However, it should be noted that these samples are smaller than those from the other states, so the results should be viewed with caution. Victorian nurses showed

the extent of the role of public delivery of aged care services in Victoria which is associated with better mean staff:resident ratios (1 to 23.55 staff members/

42.87 staf
(1 to 39.38 staff members/resident).

**Figure 4.4: Final model predicting demographic and organisational effects on the frequency and types of missed residential day care.**



*Impact of location*

The location of the facility within a metropolitan or rural setting also had an impact on workplace satisfaction. Respondents from rural and

their current role ($p \leq 0.001$), and with the quality of care they were providing ($p \leq 0.001$).

*Impact of size of facility*

The size of the facility was related not only to workplace satisfaction but also to the capacity to deliver care that prevents and relieves resident distress. This care domain broadly relates to the behavioural domain in the ACFI. According to the Royal College of Nursing (2004), this domain includes assessing mental health, preventing and treating resident pain, and providing essential care including palliation. Staff from larger facilities were

f

levels ($p \leq 0.001$) and lower levels of satisfaction with resident care ($p \leq 0.001$). Respondents from larger facilities were also more likely to indicate that care which prevents and relieves distress was missed.

*Impact of ownership of the facility*

Ownership of the facility has a direct impact on workplace satisfaction, the capacity to deliver care that prevents and relieves resident distress, and care that maximises the residents' life potential. This domain highlights staff responsibilities to provide health education to residents, to foster meaningful relationships between residents, to allow residents to satisfy their own developmental or life tasks and to cope with diversity (RCN 2004). Perceptions of staff adequacy varied via organisational type, with respondents from private-

These

respondents were also more likely to report greater levels of dissatisfaction with resident care ($p \leq 0.001$), with their current role ($p \leq 0.001$), and with teamwork in their workplace ($p \leq 0.05$) than those

facilities.

*Impact of maximum number of residents' staff cared for on their last shift*

This variable acts as a proxy for staff:resident ratios and was found to have a direct impact on the capacity to deliver care that promoted and maintained the residents' health, although no single shift differed from another. The goal of this domain of care is to maximise residents' health status through the use of health assessment, preventing chronic disease complications by managing resident risk, and/or providing a rehabilitative focus to care activities (RCN 2004). The domain encompasses many activities of daily living, but also many complex health care tasks. Lower

to deliver this care and are associated with lower

and with current role and standards of practice ($p \leq 0.001$).

missed care ($p \leq 0.01$). Conversely, facilities with staff:resident ratio methods reported less missed care.
resident allocation (computerised residential models and hours per resident per day) were not predictive of missed care.

*Presence of an RN onsite during last shift*

When an RN was not available onsite during the last shift, staff expressed less workplace satisfaction. In addition, lower levels of staff satisfaction with their current job ($p \leq 0.001$), lower

levels of workplace teamwork ($p \leq 0.001$), and reduced intention to stay in their current job ($p \leq 0.001$) were all associated with the absence of an RN in the workplace. The absence of an RN also had a direct correlation with reported care delivery, with higher levels of missed care reported when an RN was not on-site. This points to issues

questions about the quality of care.

*Number of hours worked*

Staff working shifts of less than 4 hours and more than 8, reported less satisfaction with their current role. As the path analysis shows the length of the rostered shift increasing, so too do the incidents of missed care relating to responding promptly to patient call bells and the prevention and relief of resident distress.

*Capacity to ask for extra staff*

Workplace dissatisfaction is associated with a perceived capacity to ask for additional staff. According to the path model (Figure 4.4 above) in the experience of staff, when they do ask and receive extra assistance to provide care to prevent and relieve patient distress, all frequencies of

when busy staff ask for extra assistance, but none is provided ($p \leq 0.001$).

*Workplace satisfaction*

Levels of staff satisfaction are related to the frequency of missed care. Staff who are less

profession are more likely to identify missed care. A similar pattern emerges for levels of teamwork and missed care, staff satisfaction with the standards of resident care, and staff intention to leave their current job. In all cases, reduced satisfaction is

Staff satisfaction levels are also related to all domains of care. As staff satisfaction levels decrease, there is an associated rise in missed care.

### 5.6 Personal Factors Associated with Missed Residential Aged Care

impact on the volume and type of missed care on an early shift at $p \leq 0.05$. As previously, when

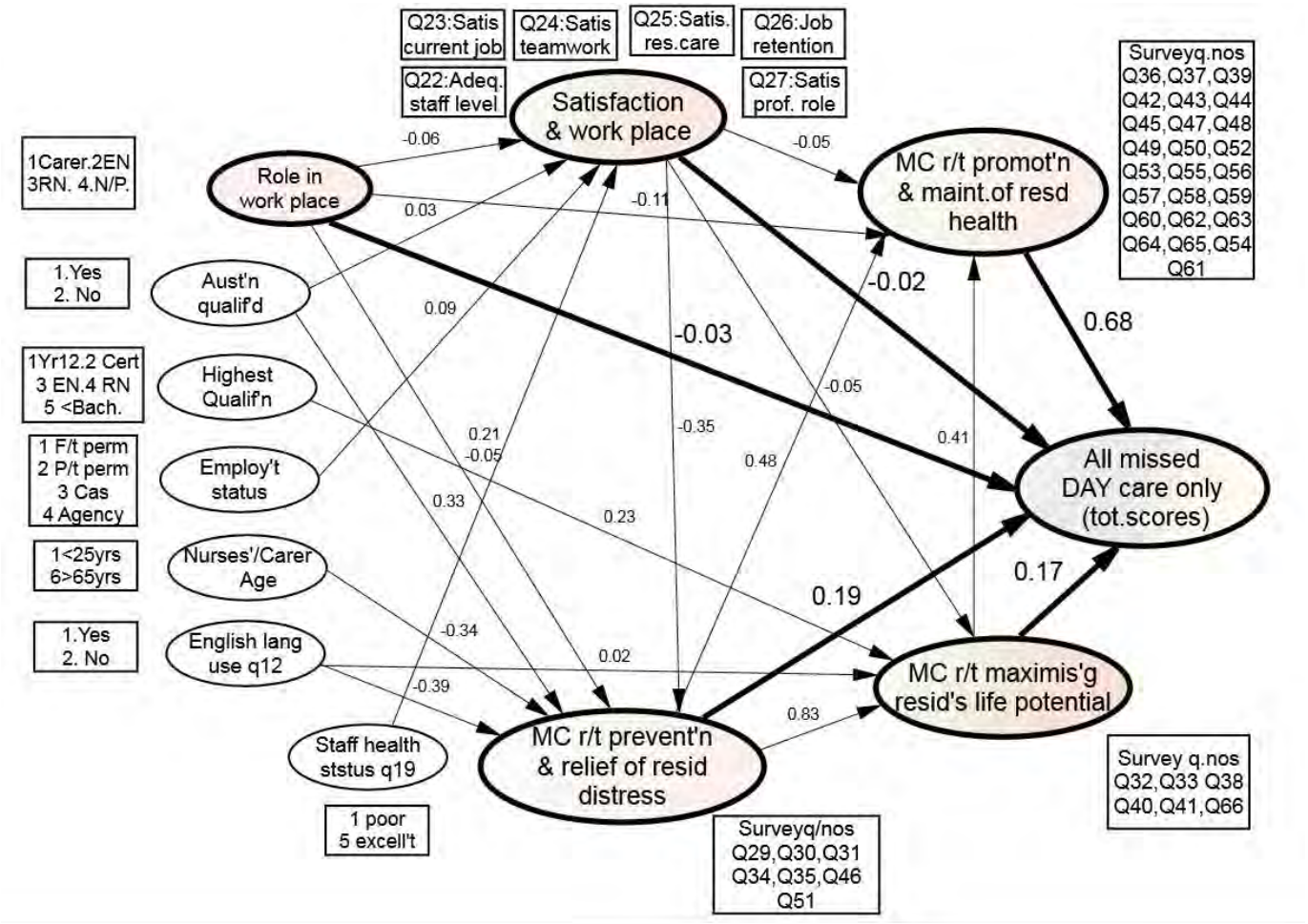
indicated in the text (see Figure 4.5). These factors are:

- Role in the workplace;
- Australia or elsewhere;
- 
- Employment status;
- Age of employee; and
- English as a second language.

Factors such as the gender of staff and their length

and frequencies of missed residential care.

**Figure 4.5: Final model: Staff factors as predictor variables for the frequency and types of missed residential day care.**




*Role in the workplace*

Role in the workplace had a direct impact on workplace satisfaction, on activities to promote and maintain residents' health, and on activities to prevent and relieve residents' distress. Work

care. Rates of job satisfaction and satisfaction with role were highest among ENs and lowest among PCWs. Levels of satisfaction with teamwork were highest among RNs and lowest among PCWs ($p \leq 0.001$). PCWs also expressed the highest levels of dissatisfaction with the quality of care ($p \leq 0.001$)

aged care ($p \leq 0.01$).

RNs were also more likely to report missed care related to the promotion and maintenance of residents' health care status, particularly in relation to meeting residents' toileting needs, ensuring resident safety, providing resident mouth care, and assessing residents' mood (or affect). RNs also reported higher levels of missed care in relation to prevention and relief of resident distress, both in

and in assessing and managing pain when residents lack the capacity to communicate a need for pain relief.

*Australia or elsewhere*

in Australia reported greater dissatisfaction with their work, particularly in relation to standards

They also

of

missed care related to prevention and relief of residents'

Australia.

and outside of nursing. It was related to care tasks which maximise the residents' life potential, with f reporting more missed care in relation to activities that promote reablement and healthy ageing. We note that some PCWs may not be fully aware of the implications of missing some ADLs, or other care tasks, or may not see it as their responsibility, pointing once again to the need for a skills mix that can adequately deliver quality care.

*Employment status*

Employment status relates to full-time, part-time, or casual employment. Employment status was related to work satisfaction. Full-time staff were found to have lower reported levels of satisfaction with work in aged care.

*Age of employee*

The age of the employee was related to the reporting of missed care in relation to prevention and relief of resident distress. Younger employees reported more missed care in this domain.

*English as a second language*

Respondents who have English as a second language report higher levels of missed care in relation to preventing and minimising resident distress, and with care tasks which maximise the residents' life potential. Both may be related ferences in cultural nuances.

### 5.7 Why Care is Missed: Qualitative Responses

A fered participants a chance to provide any further information in relation to missed care. This question was completed by 813 respondents and primarily addressed the causes of missed care. The data was analysed and coded for the reasons why care is missed. Two central themes dominated the analysis.
to the manner in which management in aged care facilities were perceived to be responding to systemic and workplace issues, while the second

mix, and workload.

The governance of aged care has undergone a number of changes which have contributed to greater private ownership of facilities, increases in resident acuity, particularly in facilities which were previously low care, and greater focus on

contribution by residents in the form of a refundable accommodation bond. While respondents generally focused upon workplace rather than wider issues, these changes were acknowledged as contributing to missed care. There is a perception by many nurses, particularly those working in private-for-

cost savings or For example, one respondent stated that:

> *"I work for a private company – a money-making machine. Upper management and*
>
> *high care, and the government let's them do it" (#58).*

For many respondents, poor care was exacerbated by increasing resident acuity. Another respondent noted that:

> *"The acuity of residents is increasing. You can see a shorter length of stay to prove this. They have chronic and complex".disease and their families also need lots of support. There is no funding for this in our good facility … our older people deserve better (#134).*

The respondent quoted below alluded to a third sub-theme, increasing expectations from both families and residents about the quality of care they should receive, given the increasing resident contributions to accommodation costs. A third respondent noted for example that:

> *"A*
> *other residents is a concern as a particular resident family are very demanding regarding their mother's care; they maintain that their mother does not get the care they pay for" (#54).*

These concerns were also expressed by some nurses and PCWs who believe that other residents are not getting the care they pay for and deserve.

More commonly, however, responsibility for these issues was placed upon the management of individual aged care facilities or groups, and related to managerial decision-making about the use of resources. It needs to be acknowledged that what constitutes 'management' is relative to individual respondents, with some referring to all services that do not provide direct care, others to site managers, and a third smaller group,

.

For those respondents identifying concerns with management, there is a common belief that management is unsympathetic to the realities of care delivery and unwilling to listen to staff. A frequent response was that management had unrealistic expectations of what could be achieved.

> *"Lack of realistic goals from management; UNREALISTIC EXPECTATIONS FROM MANAGEMENT (#785: emphasis in original quote)".*

> *"Somehow, the residents who need the most*

> *Yet the management and the families seem to think that those residents should be getting one-on-one care for their waking hours, or even 24/7. This quite simply is impossible" (#771).*

This is accompanied by a belief that responsibility for quality of care has been shifted from systemic determinants, such as increased resident acuity and funding shortfalls, to the individual nurse or carer.

> *"Management tends to blame staff for missed work and mistakes without considering the workload and the limited ability of some staff or suitability for the job" (#602).*

> *"There is low moral[e], no cohesion in cares (sic) provided, and staff are defensive and shifting blame. Management put more and more pressure on us to provide care to our residents in a timely manner. There is no time. Medication errors, lack of reporting, poor handovers, and neglected wounds have unfortunately become commonplace" (#649).*

W

issues.

both the number and skills mix of staff. There was a common perception that cost savings are being made through the reduction of staff hours and replacement of nursing staff with less costly staff.

> *"Our residents are not dollar signs. … The*

> *money for themselves and shareholders sending out email "cut staff numbers". Now they are going to remove Enrolled Nurses from aged care homes and use medication competent care workers …" (#8).*

> "*RNs facing the sack to replace them with ENs. Not valued at all in our aged care by*

*management. Having no RNs in the day-time from April - demoralising and degrading" (#202).*

consequences for both the quality and safety of care. Lack of staf
leading to poorer outcomes for residents. One respondent said for example that:

*"I feel there is not enough staff to attend to residents' needs, therefore there is an increase in UTI's, wounds, falls, and limited emotional support. I would like there to be a*

*needs and, most importantly, their emotional support to ensure their transition into age care [is] more amenable" (#91).*

Other respondents highlighted the impact of

task orientation towards care delivery, which was viewed as having negative consequences in terms of rushing residents and cutting corners, but also in relation to responsiveness to residents' preferences for care. For example, one respondent stated that:

*"Staff are rushed to have ADLs completed by a particular time, the PCAs are having to rush residents through the process in order to complete as many residents as they can. This in turn leads to residents being missed/ left to their own devices (leading to falls risks) or receiving inadequate care whilst the residents that scream the loudest or are more demanding get all the care" (#308).*

RNs, in particular
workload expectations. RNs reported that nurse to resident ratios are such that, if something unexpected occurred, they would be unable to complete their regular tasks. For example, one RN stated:

*"I think as an RN, some care is missed or late because I have to prioritise - urgent issues (sick or palliative residents, falls, and hospital*

*have to be attended later. Without fail on a daily basis, I am not able to attend to all cares or tasks because there are simply not enough hours in the day" (#734).*

hours means that staff, and RNs in particular, work unpaid overtime to complete all tasks.

*"All the RNs/ENs go above and beyond their time, working overtime trying to provide the best care possible for the residents. Staff know they will not get paid for their overtime, but it would be greatly appreciated to receive some positive acknowledgement for the hard work provided" (#33).*

### 5.8 Conclusion

This chapter has reported the results from the missed care survey. The study has found that missed care was reported by participants across all care activities in aged care in Australia, with some activities, notably answering bells and toileting residents along with the management of social and behavioural aspects of care, being missed more frequently. Medically-ordered complex health care tasks were least likely to be missed; however, this care was delivered at the expense of other complex health care tasks. The primary reason for missed
f, increasing
resident acuity, the skills mix, with unbalanced resident allocations also being implicated. Workload,

the qualitative responses to the survey, as was a perception that the management of aged care was out of touch with the realities of care delivery. As noted in Chapter 2, the MISSCARE survey was undertaken to establish that, under the current

# CHAPTER 6
# Results of the Delphi Survey

## 6.1 Introduction

The aim of the Delphi survey was to determine whether there was/was not agreement on the

the intent to provide quality outcomes of care for people living in Residential Aged Care in Australia.

a mechanism that covers all the factors that must be taken into account to calculate the nursing and personal care hours per day needed for each

The Delphi did not seek consensus on the timings.

consensus was sought was:

Assessment and reassessment of each resident **+**

Direct nursing and personal care time ***per*** intervention ***per*** resident **x**

Frequency ***per*** shift **+**

Indirect nursing and personal care time ***per*** intervention ***per*** resident **x**

Frequency ***per*** shift **=**

Total resident nursing and personal care time ***per*** day.

Previous chapters have described the

nursing and personal care interventions were

conceived and discussed in focus groups with nurses working in Residential Aged Care. The Delphi survey sought consensus from a panel of experts on the following question: *What are the*

*for*
*address the assessed need of different residents living in a Residential Aged Care facility?*

In the conduct of the Delphi survey, the following methodological considerations were adopted:

- To involve members of the panel of experts, aged care staff who through their roles would

  skills mix, as well as management decision-makers who would utilise the outcomes of the Delphi survey.
- To seek responses from a diverse panel of experts including considerations of jurisdictions in Australia, different age ranges, years of experience, and different types and sizes of aged care facilities.
- To make visible scores for how strongly the majority and minority felt about descriptive statements.
- To emphasise the importance of anonymity

  experts.
- To set a consensus at a level that is supported in the literature as appropriate.

To begin, a description of the panel of experts is provided.

### 6.2 Panel of Experts

Choosing the appropriate persons as members of

in the Delphi survey process (Hasson, Keeney & McKenna 2000; Hsu & Sandford 2007; Laustsen & Brahe 2015). The panel of experts for this Delphi survey were residential site managers (RSMs)/ person in charge (however titled) of aged care facilities or their nominee. RSMs are responsible through legislation for the day-to-day operations of a Residential Aged Care facility. In situations where the RSM was not a RN, the RSM was informed that they could nominate their senior RN manager to be their nominee if they chose to do so. While most RSMs are RNs, being a RN was not an inclusion criterion.

Support received from the ANMF was limited to advertising on their website http:// _____ that the Delphi survey had commenced. The ANMF did not, at any time, advertise the link to *Survey Monkey*®. This was done in order to maintain the integrity of the Delphi survey as being open only to invited RSMs.

RSMs received an invitation by post from Associate Professor Kay Price on behalf of the research team to participate if the Residential Aged Care facility they managed was listed in a publicly available document through the Commonwealth at the time of the study. RSMs interested in engaging in the Delphi survey were required to type the Survey Monkey link into their browser and proceed to complete it.

The research team had no control over the accuracy of the publically available list. Emails

receipt of the invitation. In addition, emails (n=3)

indicating that facilities aligned to the services would not be participating. Also, 38 letters were 'returned to sender'. As at 30 June 2015, the AIHW (2015) state that there were 2,681 Residential Aged Care facilities providing care in Australia. A total of N=102 RSMs participated in the panel of experts.

To provide a description of participating members of the panel of experts, RSMs were asked the following demographic questions:

1. Age
2. Years of experience
3. Type of facility in which they worked
4. Size of the facility in which they worked
5. The state in which they worked
6. Where in the state they were located

The panel of experts was not intended to be representative. A non-probability purposive sample, rather than randomisation was sought. As Tables 5.1 to 5.3 below illustrate, RSMs (N=102) who completed Round 1 of the Delphi survey came from a diversity of states and territories in Australia. They were of different age ranges and years of experience, and worked in a variety of aged care facilities in terms of size and type.

**Table 5.1: Age range and years of experience of the panel of experts**

| | | | | | |
|---|---|---|---|---|---|
| **Age** | 25 – 34 years | 4.9% n=5 | **Years of experience** | 0 – 1 | 4.9% n=5 |
| | 35 – 44 years | 17.6% n=18 | | 1 – 4 | 23.5% n=24 |
| | 45 – 54 years | 25.5% n=26 | | 5 – 9 | 11.7% n=12 |
| | 55 – 64 years | 48.0% n=49 | | 10 – 20 | 31.3% n=32 |
| | Over 65 years | 4.0% n=4 | | Over 20 | 28.4% n=29 |

**Table 5.2: Type and size of facility where panel of experts worked**

| | | | | | |
|---|---|---|---|---|---|
| **Type** | Religious/charitable organisation | 28.4% n=29 | **Size** | 1 – 20 beds | 4.0% n=4 |
| | organisation | 2.9% n=3 | | 21 – 60 beds | 41.1% n=42 |
| | Government-owned organisation | 41.1% n=42 | | 61 – 100 beds | 29.4% n=30 |
| | Multi-purpose service (MPS) | 19.6% n=20 | | 101 or more | 23.5% n=24 |
| | | 7.8% n=8 | | Unsure | .98% n=1 |
| | Unsure | 0% n=0 | | Other (2 x RACs on site. 1 x 40 bed; 1 x 60 bed) | .98% n=1 |

**Table 5.3: State and location of panel of experts**

| State | | | Location | | |
|---|---|---|---|---|---|
| | New South Wales | 28.4% (n=29) | | Metropolitan | 42.1% (n=43) |
| | Victoria | 19.6% (n=20) | | Regional | 52% (n=53) |
| | Queensland | 23.5% (n=24) | | Remote | 4.9% (n=5) |
| | Western Australia | 8.5% (n=9) | | | |
| | South Australia | 11.7% (n=12) | | | |
| | Tasmania | 4.0% (n=4) | | | |
| | Northern Territory | 0% (n=0) | | | |
| | Australian Capital Territory | 4.1% (n=4) | | | |

The majority of RSMs (80%) were 45 years of age and over, and seventy four per cent (74%) had over 5 years of experience. RSMs from all States and Territories, except the Northern Territory, and from across different regions were involved. RSMs

organisations constituted eleven per cent (11%) of the panel of experts; however this number does not include people who work in religious or charitable organisations. , and a discussion of, each descriptive statement is provided below.

## 6.3 Descriptive Statements on Delphi

Round 1 descriptive statements focused on the assessment of, and addressing the needs of, different residents living in aged care facilities and the need for
methodology. These statements were, in turn, presented to a panel of experts to identify their agreement or disagreement. As with all survey questions, the evaluation of the reliability of the descriptive statements (or their capacity to estimate what they are supposed to be measuring) was undertaken. The statistical approach used for this purpose was the Cronbach Alpha index, which ranges from 0 to 1, with the latter score indicating strongest reliability. The index for the Delphi

other words, the statements measured what they were intended to measure.

As described in Chapter 2, the consensus level sought for the 20 descriptive statements was set at 80% of members whose responses fell within the two categories of *agree* and *completely agree* on a Likert scale.
frequently chosen percentage response in the related literature (Green et al., 1999; Hasson et al., 2000; Keeney et al., 2001; Marshall et al., 2007).

**Table 5.4: Descriptive Statements on which consensus was sought**

| Descriptive statement | | Consensus | Figure |
|---|---|---|---|
| **The need to assess and address needs of residents** | | | |
| 8 | Thinking of your resident resident care needs have increased in volume and complexity and, over time, continue to increase. | √ | **5.1** |
| 9 | Thinking of your resident a person with complex care needs who comes to live in Residential Aged Care is now living a much shorter time given the complexity of their care needs. | √ | **5.2** |
| 10 | Thinking of your resident residents require more frequent and complex assessments to be undertaken by the staff team to ensure the safety and quality outcomes of care of all residents. | √ | **5.3** |
| 11 | Thinking of your resident residents require more frequent and complex interventions and interactions to be implemented to meet their assessed needs. | √ | **5.4** |
| 12 | Thinking of your residents' assessment and reassessment of them is required precisely because of the potential for unplanned events; for example experiencing a change or deterioration in their health status. | √ | **5.5** |
| 13 | Thinking of your residents' assessment and reassessment of them generally new or additional interventions precisely because of the potential for unplanned events; for example, experiencing a change or deterioration in their health status. | √ | **5.6** |
| 14 | Thinking of your residents' assessment and reassessment of them is required precisely because of changes or challenging behaviours; for example, extreme agitation, being withdrawn or unsettled. | √ | **5.7** |
| 15 | Thinking of your residents' assessment and reassessment of them generally new or additional interventions precisely because of changes or challenging behaviours; for example, extreme agitation, being withdrawn or unsettled. | √ | **5.8** |
| 16 | Direct nursing and personal care includes any intervention that a RN, Enrolled Nurse, Personal Care Worker/Carer and/or Assistant in Nursing undertakes that is directly related to assessing or meeting the assessed needs of residents. | √ | **5.9** |
| 17 | Indirect nursing and personal care includes where a RN, Enrolled Nurse, Personal Care Worker/Carer and/or Assistant in Nursing is required to liaise with General Practitioners, Allied Health professionals, lifestyle personnel, Pharmacy and Pharmacists, or with the resident's others, Staff Handover, DDA | √ | **5.10** |
| **The need for, and structure of, a staffing methodology** | | | |
| 18 | A methodology is needed to be built around assessing and meeting the assessed needs of residents for morning (am), afternoon (pm), and night shifts, and on an ongoing basis. | √ | **5.11** |
| 19 | A methodology must include the building block of identifying the lowest level in the skills mix of staff who can perform the activities to meet the assessed needs of dif | √ | **5.12** |
| 20 | A methodology must include the building block of identifying the time and frequency of interventions per shift required to assess and meet the assessed needs of dif | √ | **5.13** |
| 21 | To calculate the total resident nursing and personal care time per day for each resident, a methodology must include the building blocks of identifying direct and indirect nursing care work. | √ | **5.14** |

| | | | |
|---|---|---|---|
| 22 | The table provided correctly for the major category of 'Activities of Daily Living', the activities and the number of staff required to perform that activity for the different levels of assistance a resident may need. | √ | **5.15** |
| 23 | A methodology must include the building block of identifying the number of staff required to meet the different levels of assistance a resident may need. | √ | **5.16** |
| 24 | The table provided correctly the different levels of assistance different residents or a resident over time may require to meet their nutritional | √ | **5.17** |
| 25 | A methodology must include the building block of identifying the different levels of assistance a resident may need over time. | √ | **5.18** |
| 26 | To meet expected outcomes of the accreditation standards and Aged Care Act 1997, an evidenced-based methodology that can calculate resident care hours per day (RCHPD) for the diversity of complex resident Aged Care is needed. | √ | **5.19** |
| 27 | The formulae provided included the necessary building blocks to appropriately identify the total resident nursing and personal care time per day required. | √ | **5.20** |

### 6.4 The Need to Assess and Address the Needs of Residents

descriptive statements that focused on the

Aged Care and the need to assess and address these needs.

Responses based on the percentage of members from the panel of experts were grouped into those who *agreed* and *completely agreed* / those who *disagreed* and *completely disagreed* / and those who responded *unsure* to the descriptive statement.

**Figure 5.1: The percentage of experts who agree resident care needs have increased in volume and complexity and over time, and continue to increase**

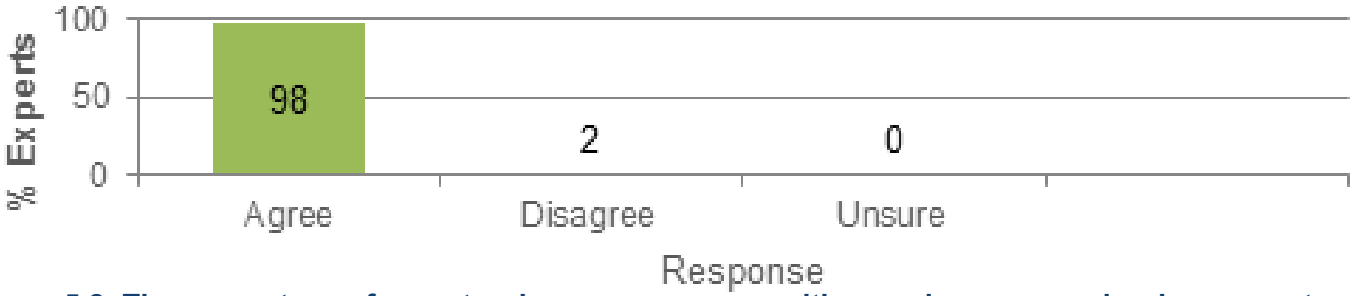



**Figure 5.2: The percentage of experts who agree a person with complex care needs who comes to live in Residential Aged Care is now living a much shorter time given the complexity of their care needs**

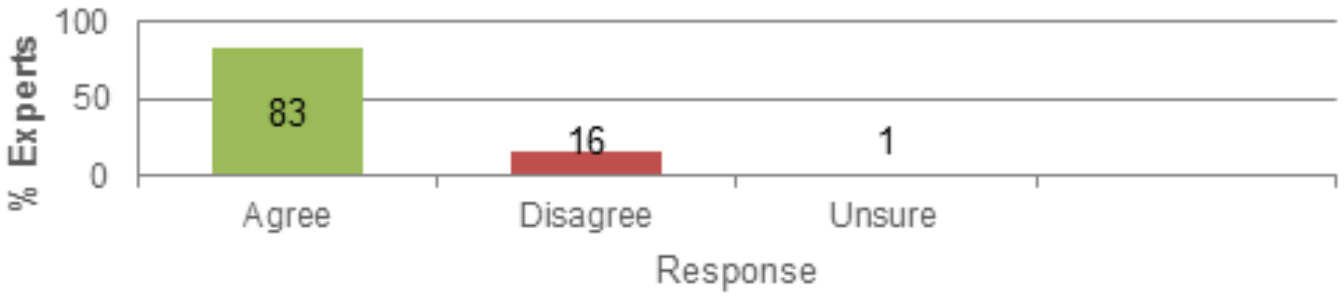


**Figure 5.3: The percentage of experts who agree residents require more frequent and complex assessments to be undertaken by the staff team to ensure the safety and quality outcomes of care of all residents**

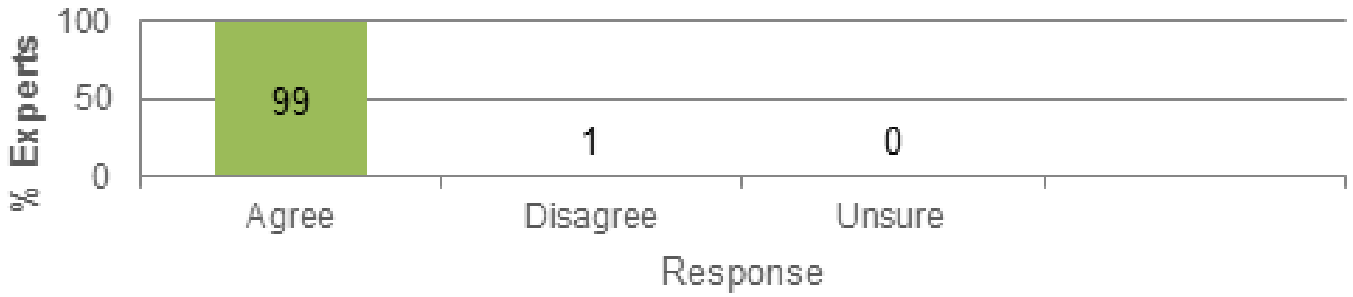



**Figure 5.4: The percentage of experts who agree residents require more frequent and complex interventions and interactions to be implemented to meet their assessed needs**

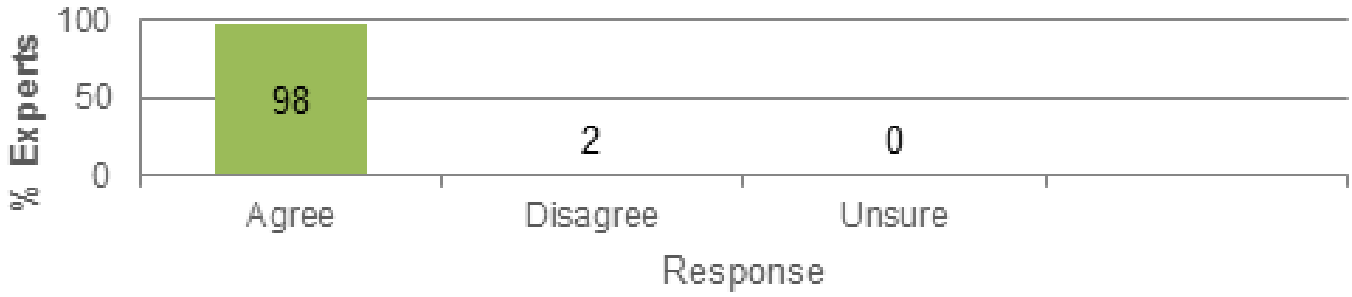



**Figure 5.5: The percentage of experts who agree assessment and reassessment of residents is required precisely because of the potential for unplanned events**

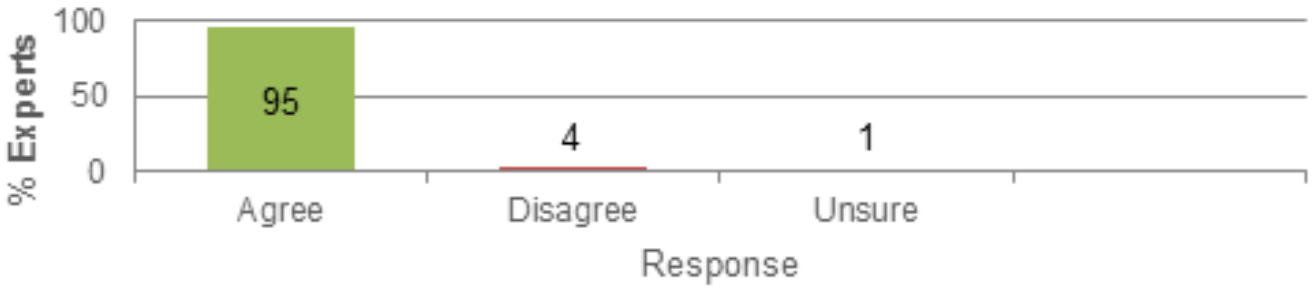



**Figure 5.6: The percentage of experts who agree assessment and reassessment of residents generally identifies new or additional interventions precisely because of the potential for unplanned events**

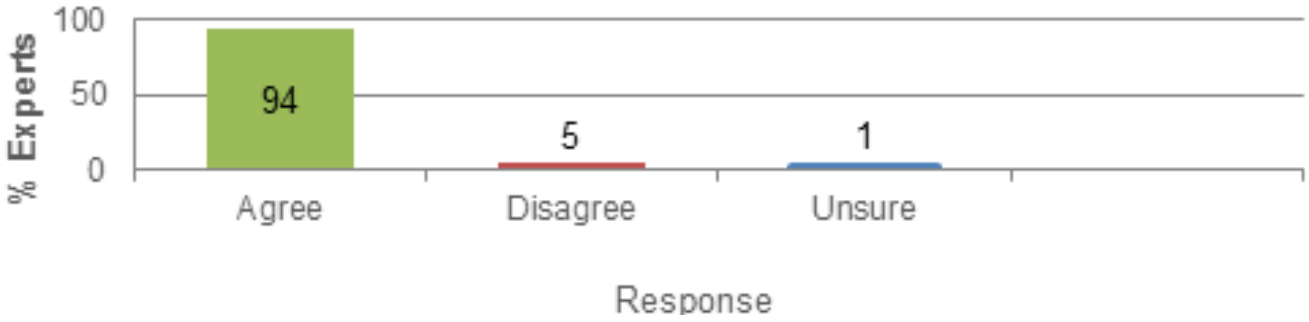


**Figure 5.7: The percentage of experts who agree assessment and reassessment of residents is required precisely because of significant changes or challenging behaviours**

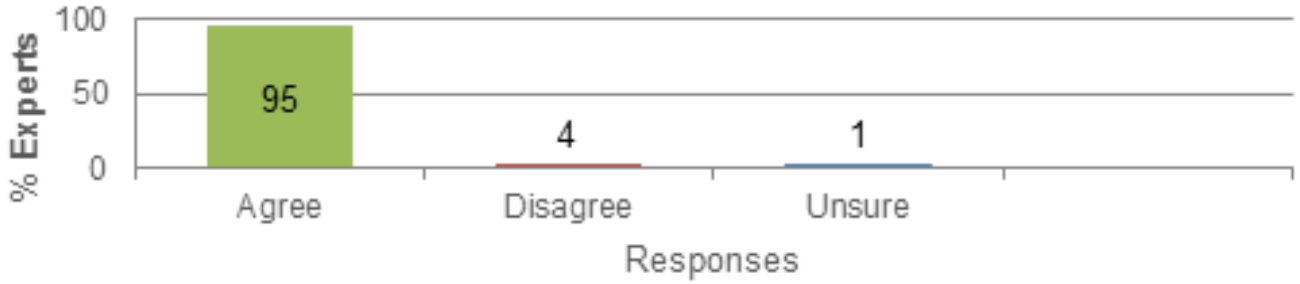



**Figure 5.8: The percentage of experts who agree assessment and reassessment of residents generally identifies new or additional interventions precisely because of significant changes or challenging behaviours**

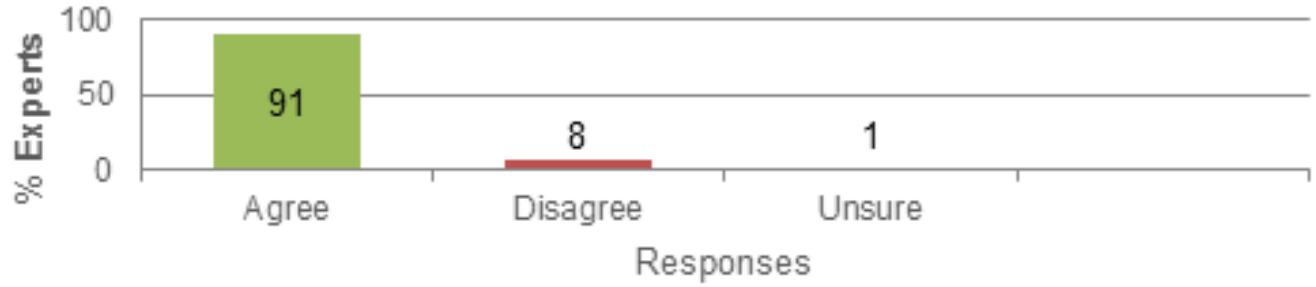
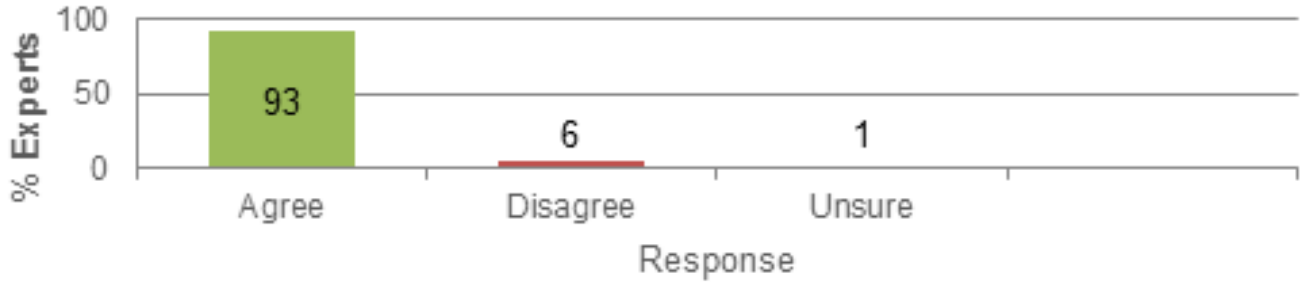



**Figure 5.9: The percentage of experts who agree direct nursing and personal care includes any intervention that a RN, Enrolled Nurse, Personal Care Worker/Carer and/or Assistant in Nursing undertakes that is directly related to assessing or meeting the assessed needs of the resident**


**Figure 5.10: The percentage of experts who agree indirect nursing and personal care includes where a RN, Enrolled Nurse, Personal Care Worker/Carer and/or Assistant in Nursing is required to liaise with General Practitioners, Allied Health professionals, or lifestyle personnel**



Figures 1

methodology. Responses from members of the panel of experts were grouped by percentage into those who *agreed* and *completely agreed* / those who *disagreed* and *completely disagreed* /and those who responded *unsure* to the descriptive statement.

**Figure 5.11: The percentage of experts who agree a staffing methodology is needed to be built around assessing and meeting the assessed needs of residents for morning (am), afternoon (pm), and night shifts and on an ongoing basis**

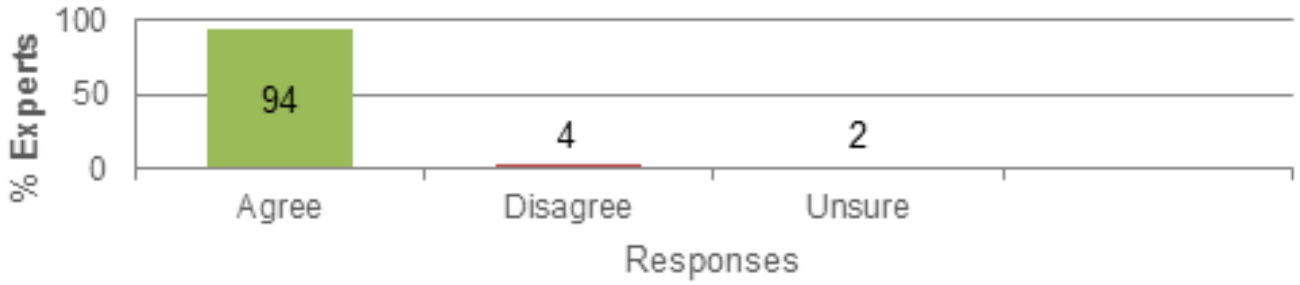



**Figure 5.12: The percentage of experts who agree a staffing methodology must include the building block of identifying the lowest level in the skills mix of staff who can perform the assessed activities a resident requires**

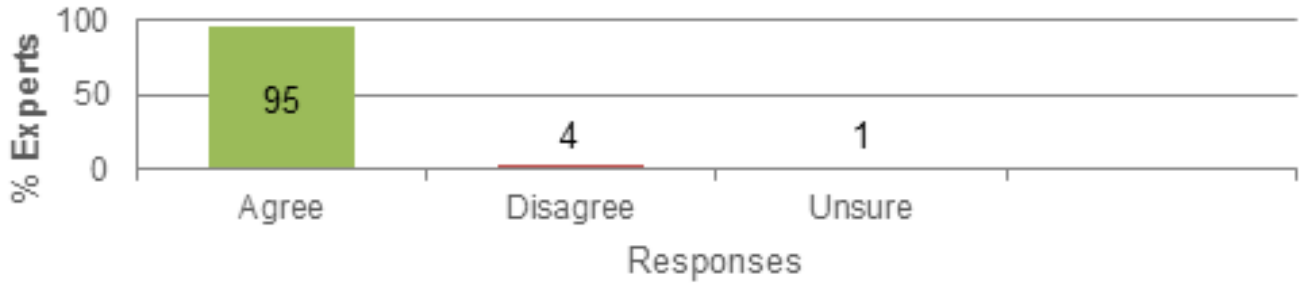



**Figure 5.13: The percentage of experts who agree a staffing methodology must include the building blocks of identifying the time and frequency of interventions required per shift**

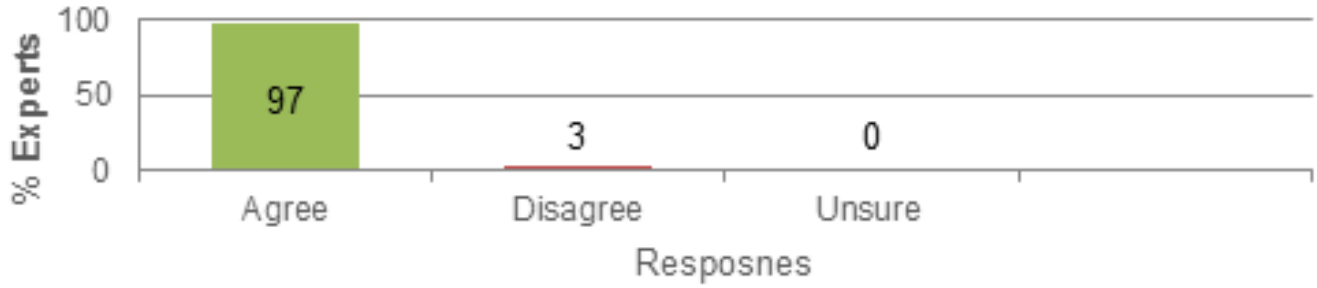


**Figure 5.14: The percentage of experts who agree a staffing methodology must include the building block for identifying direct and indirect nursing care work**

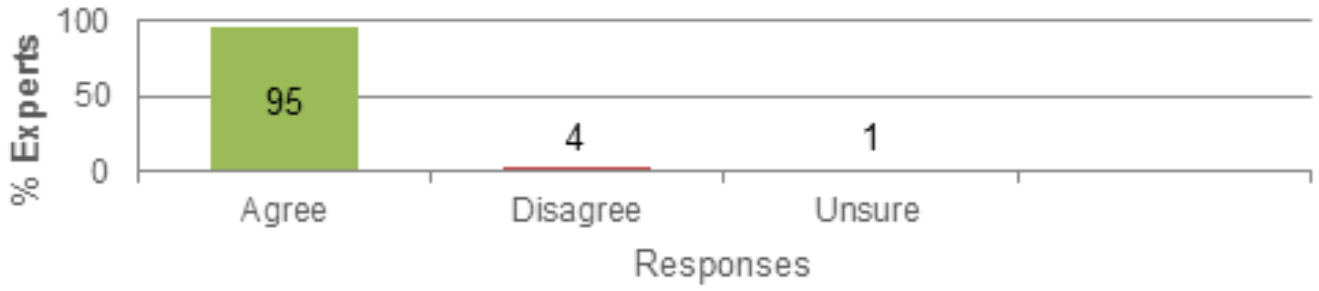



**Figure 5.15: The percentage of experts who agree the table provided correctly identifies for the major category of 'Activities of Daily Living', the activities and the number of staff required to perform that activity for the different levels of assistance a resident may need**

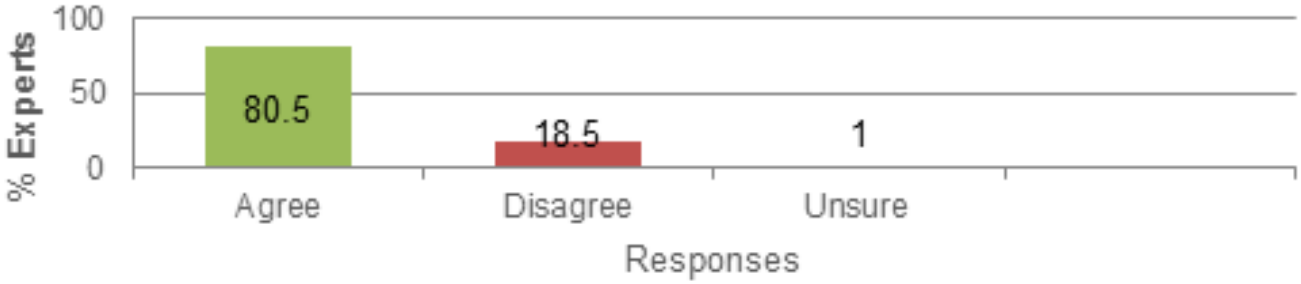



**Figure 5.16: The percentage of experts who agree a staffing methodology must include the building block for identifying the number of staff required to meet the different levels of assistance a resident may need**


**Figure 5.17: The percentage of experts who agree the table provided correctly identified the levels of assistance different residents over time may require to meet their nutritional and fluids needs**

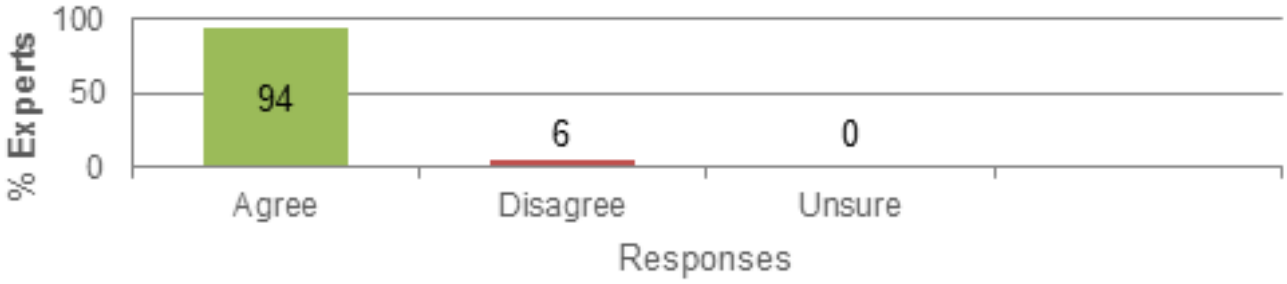


**Figure 5.18: The percentage of experts who agree a staffing methodology must include the building blocks for identifying the different levels of assistance a resident may need over time**


**Figure 5.19: The percentage of experts who agree an evidence-based staffing methodology that can calculate resident care hours per day (RCHPD) for the diversity of complex resident profiles is required to meet expected outcomes of the accreditation standards and *Aged Care Act 1997***

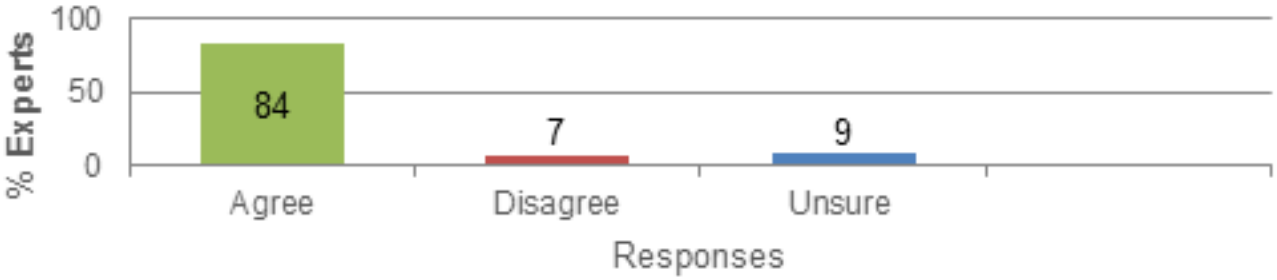
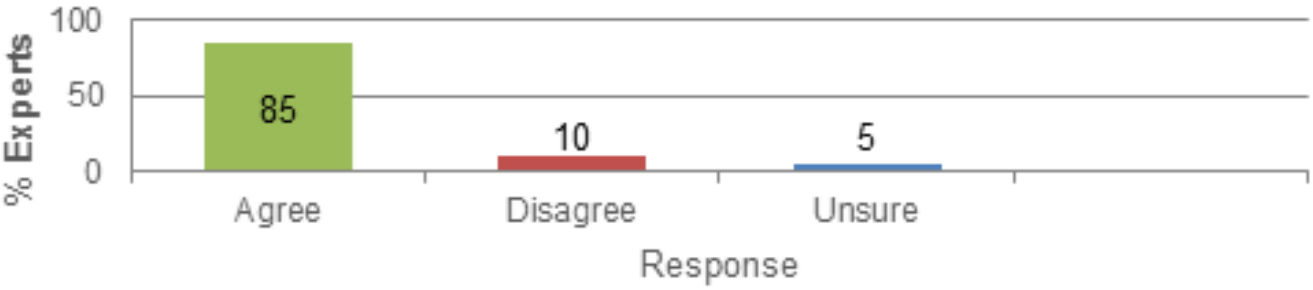



**Figure 5.20: The percentage of experts who agree the staffing methodology formulae provided included the necessary building blocks to appropriately identify the total resident nursing and personal care time per day required**




In addition to the quantitative data collated from the descriptive statements, written comments provided by members of the panel of experts were sought and a discussion of this qualitative data follows.

### 6.6 Written Comments to Descriptive Statements

Members of the panel of experts were provided a space to offer written comments to each descriptive statement. The written comments generally supported the descriptive statement, or provided the members of the panel who disagreed, with an opportunity to state why. The number of panel members providing a written comment to each descriptive statement is displayed in the following table (Table 5.5).

Descriptive statements 15 and 20 received 20% or more members offering a written comment.

**Table 5.5: Number of members of the panel of experts offering comments to a descriptive statement**

| Descriptive statement | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of members | 13 | 12 | 7 | 7 | 10 | 6 | 10 | 6 | 5 | 10 | 14 | 10 | 4 | 11 | 24 | 5 | 16 | 5 | 16 | 27 |
| >20% | | | | | | | | | | | | | | | * | | | | | * |

**Descriptive statement 15:** *The table provided*

*'Activities of Daily Living', the activities and the number of staff required to perform that activity for the different levels of assistance a resident may need*.

A recurring view expressed by the participants for descriptive statement 15 noted that it was unusual to require three (3) staff to assist residents, with two (2) usually being the maximum. However,

4 staff to assist with 'Activities of Daily Living'.

**Descriptive statement 20:** *The formulae provided included the necessary building blocks to appropriately identify the total resident nursing and personal care time per day required.*

A recurring view expressed by the participants for descriptive statement 20 focused on the variations that members of the panel of experts considered existed among residents, geographies, and layout

level of staff. In addition, there was a view that timings needed to include time for the residents to make their own decisions so that staff could take direction from them about what they wanted to do. This view was expressed in comments to other questions as well.

Another view provided in response to several statements noted that persons with particularly challenging behavioural issues were not 'admitted' to a facility in an attempt to control costs and improve staff and resident satisfaction.

### 6.7 Discussion of the Delphi Findings

The Delphi survey is a widely used group communication process which aims to achieve a

issue and attempts to address "what could/should be" (Hsu & Sandford, 2007; Miller, 2006). Round 1 of the Delphi focused on the assessment, and addressing the needs, of different residents living in aged care facilities and the need for, and structure

.

Choosing RSMs as members of the panel of experts was in recognition that this group is

are the management decision-makers who will utilise the outcome of the Delphi. The diversity

of the panel is described above and the N=102 membership is more than the n=50 normally cited as an approximate size for Delphi surveys (Hsu & Sandford 2007). Larger numbers of participants increases the trustworthiness of a combined opinion and, as already noted, the questions had a high degree of reliability. Clearly, the importance of focusing on Residential Aged Care

to descriptive statement 1. Ninety-eight per cent (98%) of members of the panel of experts completely agreed
resident care needs had increased in volume and complexity and, over time, these needs continue to increase. There is complete agreement across the diversity of RSMs, jurisdictions/States and Territories, and diversity of size of facilities. There is complete agreement that a focus on Residential

Consensus was set at 80% of members whose responses fell within the two categories of *agree* and *completely agree* on the Likert scale. This level of consensus was reached for all descriptive statements supporting the view that there are minimal, if any, opposing views in relation to the assessment and addressing of the needs of different residents living in aged care facilities. There are also minimal, if any, opposing views on

,

and on the structural features of what needs to be

quality of care outcomes in Residential Aged Care. As the tables demonstrate, the majority of responses were higher than 80%. The written

to include adequate time to allow a resident to make their own decisions so that staff took direction from what residents themselves wanted to do.

It is acknowledged that more than one round of a Delphi survey is usually required for consensus-building through increasing the percentage of consensus among the members of a panel of experts (Green et al., 1999; Hasson et al., 2000; Keeney et al., 2001; Marshall et al., 2007). The conduct of focus groups prior to the Delphi survey, and the extensive review of the literature informing this study could be constituted as Round 1 of the Delphi survey. Generally, Round 1 of a Delphi survey asks open-ended questions from which to

panel of experts to inform the development of the structured questions. As with this Delphi survey, it is both acceptable and common practice to use a structured questionnaire for Round 1 (Hsu & Sandford 2007). Three rounds of participation were planned and ethics approval was granted for this number of rounds, identifying that 'extended' consent would be sought. Extended consent was approved as it was anticipated that consensus

statements around direct and indirect nursing and personal care.

To achieve consensus on all descriptive statements among a diverse group of resident site managers (RSM) across the diversity of States, Territories, and regional locations in Australia provides the ANMF with agreement on the building

Assessment and reassessment of each resident **+**

Direct nursing and personal care time ***per*** intervention ***per*** resident **x**

Frequency ***per*** shift **+**

Indirect nursing and personal care time ***per*** intervention ***per*** resident **x**

Frequency ***per*** shift **=**

Total resident nursing and personal care time ***per*** day

# CHAPTER 7
# Staffing and the Need for Action

## 7.1 The Evidence

The goal of this study was to test the need for a staf
methodology for Residential Aged Care. The methodology was developed in a previous study, but is reported in this study as the basis for the evaluation. The evaluative data were collected through three major research activities as outlined in Chapter 2. These included:

1. Seven national focus groups of nurses working in Residential Aged Care to seek feedback on the appropriateness of the nursing and personal care interventions assigned and associated timings that formed part of the methodology;
2. The administration of a MISSCARE survey
   Aged Care
   sector to determine the tasks that are routinely missed, by who, and the reasons why they are missed; and
3. A Delphi survey which sought consensus from experts in Residential Aged Care

   impacting on Residential Aged Care outcomes and agreement about the principles underpinning the development of the methodology.

**The key findings of the study:**

1. ensure safe, quality aged care;
2. Current skills mix does not address the increasing complexity and acuity of residents in Residential Aged Care and leads to missed care;
3. 
4. The principles underpinning the methodology tested in this study are appropriate for Residential Aged Care.

Aged Care are

*on the methodology, results from the focus groups and MISSCARE survey*

Validated evidenced-based resident complexity

a 24 hour period were developed on the basis of assessed nursing and personal care needs, building on Stage One of the study. These are reported in Chapter 3. Six typical residential care

nursing and personal care interventions ranged from 2.5 to 5.0 hours per day with focus group participants suggesting that an additional 30

more than is currently being provided. Drawing upon data from the Bentley survey of Residential Aged Care, Allard (2016) noted that in 2015, residents received 39.8 hours of direct care/ fortnight in Australian Residential Aged Care facilities which averaged up to 2.86 hours/resident per day

### 7.2 MISSCARE survey

The second component of the evaluation was the MISSCARE survey which sought to identify what care was being missed and why it was missed. The survey builds upon work undertaken in determining timings for care through demonstrating that current

completed. A
that all aspects of care were reported as missed at least part of the time. Care was divided into the three domains underpinning the ACFI funding tool. Tasks related to the management of behaviour and provision of social support were most commonly missed.
surveys conducted in Switzerland and Canada (Zuniga et al. 2015; Knopp-Shiota et al, 2015), and may be associated with the prioritisation of measurable or medically-ordered tasks (Schubert et al. 2013; Blackman et al, 2015a). Similar results were obtained by Henderson et al, (2016b) in a qualitative study of rural aged care in South Australia. This study found that opportunities

fell. With regard to support for activities of daily living, the tasks most frequently missed involved responding to resident requests (toileting within 5 minutes of request and answering call bells within 5 minutes). Both suggest a lack of staff to undertake

domain of complex health care, some tasks are missed infrequently (suctioning tracheostomies,

maintaining IV or subcutaneous sites, and checking blood glucose levels). Other complex health care tasks, particularly those related to assessment, medication management, and documentation, are missed more frequently. This suggests that RNs

them.

reason for missed care in this survey. Both

undertaken in this survey. Participants were asked

to need. Only 8.2% of staf
needs were always adequate. Respondents were also asked how many residents they were responsible for on their last shift. Across all staff, the mean was 1 staff to 38.05 residents, while RNs managed 59.25 residents on their last shift. This number was highest across all professional groups

lower in government-owned facilities. Table 6.1 shows hours/resident/day for different roles across mode of ownership calculated on the basis of time for each resident/hour using mean resident numbers calculated over a 24 hour day. Means were calculated on the basis of maximum residents

number of residents managed across the whole shift, which may result in an underestimation of care worker time. However, the table demonstrates considerable variation in time available for resident care on the basis of facility ownership and raising

incidents of missed care.

**Table 6.1: Hours/resident /day based upon mean resident numbers by role and ownership of facility**

| Ownership | Mean Resident No. | Hours/resident/day |
|---|---|---|
| Government | | |
| RN/NP | 32.62 | 44 mins |
| EN | 18.26 | 1 hr, 19 mins |
| PCW | 20.30 | 1 hr, 11 mins |
| **Total** | | **3 hrs, 14 mins** |
| RN/NP | 61.94 | 23 mins |
| EN | 36.01 | 40 mins |
| PCW | 23.69 | 1 hr, 1 min |
| **Total** | | **2 hrs, 4 mins** |
| RN/NP | 66.38 | 22 mins |
| EN | 36.04 | 40 mins |
| PCW | 25.07 | 57 mins |
| **Total** | | **1 hr, 59 mins** |

**Across all staff, the mean number of residents managed per shift was 38.05 while RNs managed 59.25 residents on their last shift**

The number of residents managed on the last shift had a direct impact on missed care through failure to perform care which promotes and maintains the residents' health. For Schubert et al. (2008: 228)

mix or time" is associated with "implicit rationing" in which nurses withhold, or do not provide, all

For Papastavrou et al. (2014), implicit rationing is associated with priority setting with nurses deciding

which care to give to optimise patient outcomes. This appears to be occurring in Residential Aged Care with tasks that are more immediately essential to health missed less frequently. Findings from the MISSCARE survey are presented in Chapter 4.

*Current skills mix does not address the increasing complexity and acuity of residents in Residential Aged Care*

Increasing acuity has occurred alongside changes in skills mix that have resulted in fewer RNs and a higher proportion of PCWs. Brennan et al. (2012) argue that changes in skills mix in Residential Aged Care should be understood in the context of cost savings made on the basis of employment of less

f. Respondents to all three phases of

with those residents having more complex co-morbidities upon admission. In the 2013-14

, for example, 19.93% of all residents

dependence across all three domains (Department of Social Services 2015). After the introduction of

27% by June 2015.

**The number of RNs had decreased between 2007 and 2012 raising questions about adequate staffing skills mix. The Residential and Aged desktop modelling calculation tested in this study resulted in a skills mix requirement of RN 30%, EN 20% and Personal Care Worker 50% based on the twenty-four nursing and personal assessment and care requirements. These findings are reported in Chapter 3.**

Table 6.2 outlines the hours of care provided by RNs, ENs, and PCWs calculated as being needed

. The allocated times do not include

of the MISSCARE survey.

**Table 6.2: Nursing and personal care hours/ resident/ day pre-focus groups and MISSCARE survey**

| | | | Skills mix | | |
|---|---|---|---|---|---|
| Resident Profile | RCHPD | Total Residential and Personal Care Minutes Per Day | RN (Min) | EN (Min) | PCW/AIN (Min) |
| 1 | 2.5 | 150 | 45 | 30 | 75 |
| 2 | 3.0 | 180 | 54 | 36 | 90 |
| 3 | 3.5 | 210 | 63 | 42 | 105 |
| 4 | 4.0 | 240 | 72 | 48 | 120 |
| 5 | 4.5 | 270 | 81 | 54 | 135 |
| 6 | 5.0 | 300 | 90 | 60 | 150 |

calculated as being required for high acuity

able

comparable studies. For example, Zhang et al.

levels for Residential
recommendations ranging from 4.55 to 4.85 hours/resident/day which is almost double the current Australian estimates. Furthermore, the time provided for care by RNs is less than that calculated on the basis of care interventions (data from the survey suggests that RNs who are spending time completing essential complex care activities where there is legal compliance or non-completion may jeopardise health at the expense of other care activities e.g., monitoring intravenous lines rather than assessing the impact of medications and/or documentation).

with decreases in pressure ulcers, infections including UTIs, complaints of pain, rates of hospitalisation (Backhaus 2014), lower restraint

deterioration in ADLs, and use of nutritional supplements (Horn 2005).

In this study, the focus group participants associated inadequate skills mix with poor reporting and delayed management of emerging issues, along with poor understanding of the health impacts of some tasks e.g., rushing residents, or not identifying all that is required in attending to a resident. Likewise, 80% consensus was achieved for a statement from the Delphi survey which addressed changes in acuity and complex health care needs, focusing on the role of the RN in assessing and reassessing care needs. The

Chapter 5.

provide support for the importance of skills mix.

frequently reported important reason for missed care in Residential Aged Care, with RNs reporting more missed care related to both complex health care needs and ADLs than ENs and PCWs. This

tasks as the performance of ADLs is not usually

awareness of, or sensitivity to, care which is not completed. The most commonly missed tasks were meeting residents' toileting needs, ensuring resident safety, providing resident mouth care, and the assessment of residents' mood (or affect).

### *Health Impacts of Inappropriate Skills Mix on Missed Care*

The importance of ADLs and basic nursing care for resident health cannot be over-estimated. This is widely accepted in acute care settings and has resulted in management strategies to ensure that basic care is completed, such as rounding (Willis et al., 2015b). For example, the need to prompt a resident to use the toilet (a carer function) is done for resident comfort, but also to reduce the risk

tract infection, response to diuretic medication, or prostatic enlargement or/and an acute bowel obstruction. Understanding these risks is outside of the knowledge and skill level of PCWs to assess and/or evaluate; they can only be expected to respond to residents' more immediate elimination requests. PCWs will not have the knowledge of unusual excretory patterns unless they have been briefed or trained.
toileting needs suggests that non-nursing staff are unable or unaware to engage in on-going

re-evaluation skills to determine if the residents' unmet needs have reduced in acuity. Similarly, staff may not be aware of the implications of missed mouth care beyond the discomfort experienced by

the resident. PCWs may not be aware of the long-term implications of inadequate mouth hygiene such as increased saliva viscosity and vulnerability to oral infection and ulceration. These issues impact on dental health and the maintenance of dentures which, in turn, potentially affects nutrition (Lewis et al., 2015). Staff need to be alert to these implications and to assess and re-evaluate residents for these factors. If issues such as these

care will have long-term implications.

**Missed personal care AND missed ASSESSMENT AND REASSESSMENT BY RNs can lead to increased infections in residents, and other complications leading to the need for more intensive care.**

appear to be simple, such as attending to Activities of Daily Living, and well within their scope, the broader implications for health suggest the need to give serious consideration to the skills mix in Residential
numbers of RNs to provide required initial and on-going assessment and evaluation of resident care. The role of the RN involves the provision

,

delegating aspects of care to others according

practice. This includes monitoring the care, who it is delegated to, and the implications for resident health should some tasks be missed. This may

f

ratio is incompatible with professional expectations.

### A staffing methodology and defined methodology is needed in Residential Aged Care to ensure safe staffing levels

Residential Aged Care. Further evidence is

.

Residential Aged Care, with staff requesting additional staff which may or may not be provided

increased levels of missed care, while facilities using staf

### The principles underpinning the methodology tested in this study are appropriate for Residential Aged Care

A

Residential Aged Care. The methodology which underpinned this research was based on the following components:

Assessment and reassessment of each resident **+** direct nursing and personal care time ***per*** intervention ***per*** resident **x** frequency ***per*** shift **+** indirect nursing and personal care time ***per*** intervention ***per*** resident **x** frequency ***per*** shift **=** total resident nursing and personal care time ***per*** day

Two aspects of data collection explored the feasibility of this methodology developed as part of Stage One of this study: the focus groups and the Delphi survey. A
groups was that the s developed on the basis of the methodology consistently underestimated the time needed to provide optimal care for the

was related to the performance of additional activities to settle or provide emotional support for

residents e.g., providing drinks when toileting at night. Further
in each facility was skewed towards residents requiring more complex care. Factors which were viewed as increasing the time allocated largely related to the time taken to complete indirect tasks. Four recurring issues in particular
as increasing nursing and carer time. These were:

1.
2. Administrative load and communication needs of residents
3. Geographical location and access to resources
4. Special needs groups and related matters (people with dementia, CALD background, palliative care)

Skills mix is addressed above. In addition, focus

support, particularly after hours, which led to the use of RN time for answering phones and other administrative tasks as well as spending time communicating with residents' families. Geographical location related to the size of the facilities and the time taken moving between areas to deliver care. Special needs groups relates to the additional time required for communication and providing culturally sensitive care for these residents.
summarised in Chapter 3.

**Focus group participants identified the need for, on average, an additional 30 minutes per resident profile for indirect care interventions.**

A
agreement on the principles underpinning the
.
methodology on which consensus was achieved include:

- shifts;
- Inclusion of skills mix through determining
  undertake each intervention;
- Timings for interventions;
- Inclusion of direct and indirect tasks;
- Using this data to determine NHPRD; and
- levels and skills mix on the basis of RCHPD.

### 7.3 Conclusion

This study has explored the impact of staff numbers on care in Residential Aged Care arguing

upon the assessed nursing and personal care

the time taken to complete the care needed, the study has demonstrated that current staff hours/resident/day are not adequate to meet care needs and that the current skills mix is compromising the quality of care given the rising levels of resident acuity. A
the MISSCARE survey which demonstrates that all aspects of care are currently missed at least

as the major causal factor. Recent changes in funding and regulation of Residential Aged Care

and reduced funding for complex health care needs despite compelling evidence of increasing resident acuity and complexity. This is occurring alongside reduced employment of nursing staff and increasing use of PCWs to deliver many aspects of care. Results from the Delphi study demonstrate an ongoing need for resident assessment built upon a solid health knowledge base that is not part of care workers' training.
components of this study strongly support a need

aged care.

The proposed methodology includes time to:

Assess and reassess each resident **+**

Direct nursing and personal care time ***per*** intervention ***per*** resident **x**

Frequency ***per*** shift **+**

Indirect nursing and personal care time ***per*** intervention ***per*** resident **x**

Frequency ***per*** shift **=**

Total resident nursing and personal care time ***per*** day

# List of Tables

# List of Figures

# List of Abbreviations

| | |
|---|---|
| **ACFI** | Aged Care Funding Instrument |
| **ACT** | Australian Capital Territory |
| **ADL** | Activities of Daily Living |
| **AIHW** | Australian Institute of Health and Welfare |
| **AIN** | Assistants in Nursing |
| **ANMF** | Australian Nursing and Midwifery Federation |
| **AM** | Before Noon |
| **CALD** | Culturally and Linguistically Diverse |
| **CEO** | |
| **DDA** | Dangerous Drug Act |
| **DoHA / DOH** | Department of Health |
| **DON** | Director of Nursing |
| **DVA** | Department of Veteran Affairs |
| **EN** | Enrolled Nurse |
| **FTE** | Full Time Equivalent |
| **Hh:mm:ss** | Hours:minutes:seconds |
| **LPN** | Licenced Practical Nurse |
| **LVN** | Licenced Vocational Nurse |
| **MMSE** | Mini-Mental State Examination |
| **MPS** | Multi-Purpose Service |
| **NHPRD** | Nursing Hours per Resident Day |
| **NSW** | New South Wales |
| **NILS** | National Institute of Labour Studies |
| **NNM** | Nursing Non-Management Time |
| **NOF** | Neck of Femur |
| **NP** | Nurse Practitioner |
| **NT** | Northern Territory |
| **PCA** | Personal Care Assistants |
| **PCW** | Personal Care Worker |
| **PTSD** | Post-Traumatic Stress Disorder |
| **PM** | After Noon |
| **RACF** | Residential Aged Care Facility |
| **RA&RCD** | Resident Aged and Restorative Care Database |
| **RCHPD** | Resident Care Hours per Day |
| **RCN** | Royal College of Nursing |
| **RN** | RN |
| **RSM** | Residential Site Managers |
| **RTO** | Registered Training Organisation |
| **SA** | South Australia |
| **TIA** | Transient Ischaemic Attack |
| **UTI** | Urinary Tract Infection |
| **VET** | Vocational Education Sector |
| **WA** | Western Australia |
| **WHO** | World Health Organization |

# Glossary

| Term | Description |
|---|---|
| **Box Plots** | The middle line in the box represents the median (50% of scores are above and below this line), the box itself covers around 50% of the scores (the lower box line is the 25th percentile and the upper box line is the 75th percentile), and the 'whiskers' below and above the box indicate the lowest adjacent value and the upper adjacent value. Circles represent outliers in the distribution. |
| **Carers/care workers** | Unlicensed and unregulated workers providing personal care under direction and indirect supervision of an RN. Includes Assistants in Nursing, PCWs, and Personal Care Assistants. Throughout the report, the term used is PCWs. |
| **Direct Nursing and Personal Care** | The provision of nursing care to a resident which involves all aspects of the health care of a resident, including assessments, re-assessments, activities of daily living, treatments, counselling, self-care, education, complex care, management and administration of medication, and documentation; personal care is the provision of activities of daily living and management, including personal hygiene, grooming, dressing, assistance with mobility, meals, and |
| **Domains of care** | The three domains of care used in the ACFI to categorise care e.g.: ADLs, behavioural and complex health care needs were used to classify tasks for the MISSCARE survey. |
| **Enrolled/Division 2 nurses** | Enrolled nurses, also known as Division 2 Nurses in Victoria, are persons registered under the *Health Practitioner Regulation National Law* —<br><br>(a) to practise in the nursing and midwifery profession as a nurse (other than as a student); and<br><br>(b) in the enrolled nurses division of that profession. |
| **Environmental Care** | Activities that nurses and carers undertake to ensure a safe environment, such as staff allocation, shift-to-shift handovers, occupational health and safety activities, and checking of emergency equipment. |
| **Government facilities** | Facilities owned and operated by State and Territory governments, including multi-purpose services which provide a range of services often including aged care in rural regions using a combination of State and Federal funding. |
| **Indirect Nursing and Personal Care** | The care that nurses and personal carers undertake that is not directly related to the resident, but has a relationship to the care provided to the resident, such as GP consultations, case conferencing, and restocking. |
| **Private-for-profit facilities** | |
| **Private-not-for-profit facilities** | |
| **RN** | A RN, or division 1 nurse in Victoria, is a person registered under the *Health Practitioner Regulation National Law* —<br><br>(a) to practise in the nursing and midwifery profession as a nurse (other than as a student); and<br><br>(b) in the RNs division of that profession. |
| **Residents** | The recipients of care in Australian Residential Aged Care Facilities. |
| **Resident Care Needs** | Assessed care needs as described in the ACFI data, ACFI assessments, and other facility assessments. |

| Term | Description |
|---|---|
| **Resident Environmental Care** | Activities that nurses and carers undertake to ensure a safe environment, such as staff allocation, shift-to-shift handovers, occupational health and safety activities, and checking of emergency equipment. |
| **Resident Profiles** | Residential Aged Care which have an associated time for care delivery based on the methodology underpinning this research. |
| **Skill mix** | Mix of range and types and levels of staff providing nursing and personal care. |
| **Staffing Inputs** | Determined by staff rosters and role descriptions.<br>• the staff skills required to provide nursing and personal care;<br>• types of professional staff required to provide nursing and personal care; and<br>• the staff numbers required to provide nursing and personal care. |
| **Staffing methodology** | Formula used to determine hours of care required to ensure basic care needs are met. |
| **Work Periods (used for analysis)** | Day shift (approx. 7am-3pm)<br>Late shift (approx. 3pm-11pm)<br>Night duty (approx. 11pm-7am) |

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# APPENDIX A - FOCUS GROUP QUESTIONS

**Questions asked in relation to each typical resident profile and associated nursing care/interventions using Implementation Fidelity Framework**

Do you have residents who match this profile? If yes, would you say it is a typical profile of many residents?

Do the care/interventions carried out in your facility correspond with those in this typical resident profile?

**(1) adherance to intervention protocols,**

In general, are you able to provide all care/interventions (at the right time) for this type of resident in your current staffing/skill mix?

**(2) dose/intensity, or amount of intervention delivered, and**

How much time would you generally spend over each shift providing care to this type of resident?

(morning, afternoon, night shifts)

Describe the usual staffing/skill mix on each shift in your organisation

Which aspects of care are carried out by ENs, Careworkers, RNs: (describe)

If the care/interventions carried out in your facility do not correspond with this resident profile, describe the care/interventions that would typically be provided to residents with this profile in your organisation

**(3) program differentiation, or the presence of critical distinguishing features of the intervention.**

If you are not able to provide all care/interventions (at the right time) for this type of resident, what care would you prioritise to ensure that it is provided? Why? How do you decide which care to prioritise? Do you discuss this issue with other staff? (Explore)

**Summative Checking Question after going through all typical profiles**

Thinking about these profiles that we have just discussed, do you have any residents whose care needs are different from these profiles? If yes, describe the resident profile, and associated care needs/interventions. Then work through above series of questions (1,2,3)

Thinking about your current staffing profile, are there care requirements that you are unable to meet for any types of residents in your facility? Describe these resident types and associated care requirements.

What staffing/ skill mix would you need to meet all care requirements on every shift?

**Service Delivery Model**

Care delivery can be approached from a number of different perspectives or models. For example, this can be rehabilitative, restorative, curative, palliative, management and consumer directed. How do you understand (any of) these terms?

Thinking about work place and/or role, what model of service delivery is used in your workplace? Are some, all or different approaches used? Can you please provide an example(s) of the approach that is mainly used in your workplace/role?

How do you understand the approach used in your organisation? Do you consider that the service delivery model used in your organisation promotes healthy ageing? Does the approach/model facilitate a consumer directed care approach? Give an example of how it does this?

Thinking about the approach/model used in your organisation, what nursing skill mix (RN/EN/PCW) is required for care delivery using this model to be effective?

Are there issues/problems with the service/care delivery model used? If there are issues/problems with using this approach describe these issues/problems and how they have come about?

What in your opinion is not being addressed? What in your opinion needs to be addressed for the approach to work successfully?

What are the implications for the facility/you of delivering/not delivering care using/not using a particular service delivery approach? What are implications for residents of no specific service delivery model being used? What are the implications for residents if care is not consumer directed? What strategies are available to you to question the model of service being used in your workplace?

# APPENDIX A - PLANNER

| Stage | Notes |
|---|---|
| Part 1<br>Presentation of Resident profiles Jenny Hurley | Copy of individual profiles given out to participants to refer to during the focus group discussions<br><br>**Need to be collected at the end - cannot leave the room** |
| Part 2<br><br>Terri go through each of the 3 resident profiles asking these questions in relation to each profile<br><br>Luisa add probes as relevant | State Name of Profile<br><br>**1. Do you have residents who match this profile?**<br>**If yes, would you say it is a typical profile of many residents?**<br>**If no – elaborate**?<br>2. Do the care/interventions carried out in your facility for this type of resident correspond with those in this profile?<br>If yes explore<br>If no why not?<br>**3. What is different/additional/less – explore & describe what the care interventions**<br>4. In general, are you able to provide all care/interventions (at the right time) for this type of resident in your current staffing/skill mix?<br>Follow up on response<br>**5. How much time would you generally spend over each shift providing care to this type of resident? (morning, afternoon, night shifts)**<br>6. Describe the usual staffing/skill mix on each shift in your organisation (morning, afternoon, night shifts<br>**7. If interventions match, indicate the aspects of care are carried out by ENs, Careworkers, RNs – probe responses as necessary**<br>8. If the care/interventions carried out in your facility do not correspond with this resident profile, describe the care/interventions that would typically be provided to residents with this profile in your organisation<br>**9. If you are not able to provide all care/interventions (at the right time) for this type of resident, what care would you prioritise to ensure that it is provided?**<br>**Why? How do you decide which care to prioritise?**<br>**Do you discuss this issue with other staff? (Explore)** |
| Part 3<br>Terri - Summative Checking Questions after going through all profiles | 1. **Thinking about the profiles we have just discussed, do you have any residents whose care needs are different from these profiles**?<br>**If yes, describe the resident profile, & associated care needs/interventions**.<br>**Then work through above series of questions**<br>2. Thinking about the current overall staffing profile per shift in your organisation, are there care requirements that you are unable to meet for any types of residents in your facility?<br>If yes, describe these resident types and associated care requirements.<br>What staffing/ skill mix would you need to meet all care requirements on every shift? |

| | |
|---|---|
| Part 4<br><br>Luisa | General introduction explaining that care delivery can be approached from a number of different perspectives or models. For example, this can be rehabilitative, restorative, curative, palliative, management and consumer directed.<br>**1. Are you familiar with any of these terms/approaches/models – How do you understand them?**<br>2. Are some, all or different approaches used? Can you please provide an example(s) of the approach that is mainly used in your workplace/role? Probe/expand<br>**3. Do you consider that the service delivery model/approach used in your organisation promotes healthy ageing? Yes How : No why not**<br>4. Does the approach/model facilitate a consumer directed care approach? Yes How : No why not<br>**5. Thinking about the approach/model used in your organisation, what skill mix (RN/EN/PCW) is required on any given shift for care delivery using this approach/ model to be effective?**<br>6. Are there issues/problems with the service/care delivery model used? Describe the issues How/why they have come about?<br>**7. What in your opinion is not being addressed in terms of resident care within your service delivery approach ? Why Not?**<br>8. What in your opinion needs to be addressed for the approach to work successfully to achieve desired outcomes for residents?<br>**9. What do you think are the implications for the facility of delivering care using a particular service delivery approach?**<br>10. What do you think are the implications for the facility of not delivering care using a particular service delivery approach?<br>**11. What are implications for residents of not using a specific service delivery model? What are the implications for residents if care is not consumer directed?**<br>12. What strategies are available to you to question the model of service being used in your workplace?<br>13. What evidence based tools do you use in assessment on admission of a resident to the facility – please name? If no tools used, why not<br>14. How do you justify assessments on ACFI audit?<br>15. Do you have an RN on every shift very day of the week? Explore |
| Section 4<br>Closing<br><br>Terri & Luisa | Thanks for your participation.<br>Any concluding comments |

# APPENDIX B - MISSCARE SURVEY

**Developing an evidence base for aged care staffing and skill mix**

**Description of the study:**
**This survey is part of the project entitled 'Developing an evidence base for aged care staffing and skill mix'. This project will investigate and develop recommendations for optimum staffing levels and skill mix for aged care. This project is supported by the Department of Social Health Sciences and School of Nursing & Midwifery at Flinders University and the School of Nursing & Midwifery at the University of South Australia in conjunction with the Australian Nursing and Midwifery Federation (ANMF).**

**Purpose of the study:**
**This project aims to determine appropriate safe staffing levels for aged care. Specifically, it will explore:**

**-The adequacy of staffing scenarios for particular populations of clients in Residential Aged Care.**

**-Factors (other than cost or availability) that influence decision making around staffing levels and mix in Residential Aged Care.**

**-The relative importance/value of resident's care requirements (direct care demand), indirect care requirements and environmental factors (such as design, support staff availability).**

**-Confirm the validity of the example indicative resident profiles established in step one.**

**-Establish a profile of care time per acuity type**

**What will I be asked to do?**
**You are invited to complete a survey about care which is missed/delayed in Residential Aged Care and the reasons why it is missed. The survey will take no more than 30 minutes.**

**What benefit will I gain from being involved in this study?**
**Sharing of your ideas will help us understand staffing needs in Residential Aged Care and to make recommendations upon evidence-based staffing levels..**

**Will I be identifiable by being involved in this study?**
**Your answers will be anonymous and will not be identifiable in reports or any published works from this study..**

**Are there any risks or discomforts if I am involved?**
**The investigators anticipate few risks from your involvement in this study and you are free to stop answering the survey at any time.**

**How will I receive feedback?**
**Outcomes from the project will be summarised in a final report.**

**This research project has been approved by the Flinders University Social and Behavioural**

1. Gender

- ◯ Female
- ◯ Male

2. Age

- ◯ Under 25 years old (<25)
- ◯ 25 to 34 (25-34)
- ◯ 35 to44 (35- 44)
- ◯ 45 to 54 (45-54)
- ◯ 55 to 64 (55 - 64)
- ◯ Over 64 years old (65+)

* 3. From list below, please select one that best shows where you work

- ◯ Multi-purpose Service (MPS)
- ◯ Private not-for-profit organization (eg: religious and charitable organisations)
- ◯ Private for-profit organisation
- ◯ Government-owned organisation
- ◯ Unsure

* 4. Size of your work area: how many beds or residents are at your facility?

- ◯ 1 to  20 beds
- ◯ 21 to 60 beds
- ◯ 61 to 100
- ◯ 101 or more
- ◯ Unsure
- ◯ Other (please specify)

* 5. What type of residential care facility do you work in?

- Residential Aged Care: formerly both high care and low care
- Residential Aged Care: formerly low care only
- Dementia only

Other (please specify)

* 6. Thinking about the last shift you worked, was there a Registered Nurse on duty and on site?

- Yes
- No

7. Thinking about the last shift you worked, what was the maximum number of residents that you looked after?

* 8. From the options below, where is your workplace?

- Metropolitan
- Regional
- Rural
- Remote

* 9. In which State or Territory do you currently work?

- New South Wales
- Victoria
- Queensland
- Western Australia
- South Australia
- Tasmania
- Northern Territory
- Australian Capital Territory

10. Please select your highest qualification?

- ◯ Did not complete Year 12
- ◯ Completed Year 12
- ◯ Certificate III aged care
- ◯ Enrolled Nurse Certificate (Hospital trained)
- ◯ Certificate IV aged care
- ◯ EN Diploma in Nursing
- ◯ Registered General Nurse Certificate
- ◯ RN Diploma in Nursing or equivalent
- ◯ Bachelor Degree in Nursing
- ◯ Bachelor Degree in Midwifery
- ◯ Bachelor Degree/Honours outside of Nursing
- ◯ Graduate Diploma in Nursing/Midwifery
- ◯ Graduate Diploma outside of Nursing/Midwifery
- ◯ Master's degree in Nursing/Midwifery
- ◯ Master's degree outside of Nursing
- ◯ PhD/Professional Doctorate

Other (please specify)

11. Was your original nursing/carer qualification from Australia?

- ◯ Yes
- ◯ No

If no, list country where you were first qualified as a nurse/carer

12. Is English your first/primary language?

- ◯ Yes
- ◯ No
- ◯ If no, list the language(s) you use other than English?

* 13. What are you employed as?

- ◯ Registered Nurse
- ◯ Enrolled nurse/ Division 2
- ◯ Care worker/ Assistant in nursing
- ◯ Nurse Practitioner

14. What is your job title?

15. What is your employment status

- ◯ Full-time permanent
- ◯ Part-time permanent
- ◯ Casual
- ◯ Agency

Other (please specify)

16. Experience in your role

- ◯ 0- 12 months
- ◯ 1 - 4 years
- ◯ 5 - 9 years
- ◯ 10 - 20 years
- ◯ Greater than 20 years

- ◯ greater than 8 hours

Other (please specify:eg; shifts times  vary according to needs of the residents)

18. How many times in the past 3 months did you work more than your rostered shift length (paid and unpaid)?

- ◯ Less than 5 times
- ◯ 5-10 times
- ◯ 11-15 times
- ◯ 16-20 times
- ◯ Greater than 20 times
- ◯ Never

19. In general, would you say your health is:

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

20. If your work area becomes busy, can you ask for extra staff to meet that demand?

- ◯ Yes
- ◯ No

If you answered yes, please describe the situation which you can ask for extra staff?

21. If you ask for additional staff are they usually provided?

- ◯ Yes
- ◯ No
- ◯ Other (please specify)

22. Overall, how often do you feel that staffing in your work area is adequate?

- ◯ 100% of the time
- ◯ 75% of the time
- ◯ 50% of the time
- ◯ 25% of the time
- ◯ 0% of the time

23. How satisfied are you in your current position?

- ◯ Very satisfied
- ◯ Satisfied
- ◯ Dissatisfied
- ◯ Very dissatisfied

If dissatisfied, please say why you are dissatisfied.

24. How satisfied are you with the level of teamwork in your workplace?

- ◯ Very satisfied
- ◯ Satisfied
- ◯ Dissatisfied
- ◯ Very dissatisfied

If dissatisfied, please say why you are dissatisfied.

25. How satisfied are you with how residents are cared for in your workplace?

- ◯ Very satisfied
- ◯ Satisfied
- ◯ Dissatisfied
- ◯ Very dissatisfied

If you are dissatisfied please say why?

26. Do you plan to leave your current position?

- ◯ Yes
- ◯ No

27. Overall, how satisfied are you with being a nurse/carer as a professional choice?

- ◯ Very satisfied
- ◯ Satisfied
- ◯ Dissatisfied
- ◯ Very dissatisfied

If dissatisfied, please say why.

28. What staffing model/method does your facility use?

- ◯ Staff-to-resident ratio
- ◯ Computerised Resident Classification System eg: icare
- ◯ Hours per Resident Bed/Day
- ◯ Fixed staffing
- ◯ I don't know

## SECTION A: MISSED CARE

**Nurses/carers often have multiple demands on their time which require them to reset priorities and not complete all the care needed. To the best of your knowledge in the past three (3) months, how frequently are the following elements of care MISSED (not done, omitted, left unfinished) by staff (including you) on the shifts below. The times indicated in this section refer to the standard shift length times in your workplace i.e.: early, late and nights worked Monday to Friday with a separate response for weekends. Thinking about the different residents in your workplace during this time which of the following care was missed. Please mark all that apply. If you do not think this apect of care applies to your role, please use the not applicable (N/A) column**

29. Intervening when residents' behavior is inappropriate or unwelcome (e.g. wandering into other person's rooms or interfering while wandering)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

30. Intervening when residents say inappropriate or unwelcome things (e.g. verbal refusal of care; disruptive to others, verbal sexually inappropriate advances directed at staff, other residents or visitors)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

31. Intervening when resident is physically agitated (e.g. biting, spitting, throwing things, destroying property, kicking, pushing, screaming)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

32. Encouraging residents' social engagement

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

33. Encouraging residents' participation in decision-making about their care

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

34. Interacting with resident when he/she has problems communicating

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

35. Assessing and monitoring resident for presence of pain (when they are not able to tell you they are in pain)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

36. Making sure residents are safe

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

37. Identifying the residents' underlying mood or emotional state (when they are unable to tell you how they feel)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

38. Maximising residents' dignity (eg: ensuring their privacy)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

39. Ensuring residents are not left alone when supervision is required

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

40. Supporting residents to maintain their interests

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

41. Providing resident activities to improve their mental and/or physical function

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

42. Moving residents confined to bed/chair who cannot walk by themselves (eg: pressure area care)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

43. Assisting residents with mobility (e.g. one person transfers, supervision of walking)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

44. Assisting residents toileting needs within 5 minutes of request

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

45. Preparing residents for meal times

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

46. Providing emotional support to resident and/or family and friends.

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

47. Assisting with residents' general hygiene (dressing / washing / grooming)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

48. Providing residents' oral hygiene/ teeth/mouth care

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

49. Ensuring your own hand hygiene

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

50. Assessing and monitoring resident for healthy skin

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

51. Responding to call bell/call alerts initiated within 5 minutes

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

52. Taking vital signs/observations as ordered/required

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

53. Assessing and monitoring residents' food/fluid intake (includes people with feeding tubes)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

54. Full documentation of all care including assessments and/or tasks

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

55. Providing wound care (includes chronic wounds such as varicose, pressure ulcers and diabetic foot ulcers)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

56. Providing stoma care (includes temporary stomas)

| | Never missed | Rarely missed | Occasionally missed | Fequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

57. Maintaining nasogastric (NG) / Percutaneous Endoscopic Gastrostomy (PEG) tube care as ordered

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

58. Providing catheter care (Urinary)

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

59. Suctioning airways/tracheostomy care

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

60. Measuring and monitoring residents' blood glucose levels.

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

61. Reassessing the resident to see if their daily care/requirements needs to be changed

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

62. Maintaining IV/sub-cutaneous sites and devices care according to residential facility policy

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

63. Ensuring PRN medication requests are acted on within 15 minutes

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

64. Giving medications within 30 minutes before or after scheduled time.

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

65. Evaluating resident's response to medications

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

66. Providing end-of-life care in line with residents' documented wishes

| | Never missed | Rarely missed | Occasionally missed | Frequently missed | Always missed | N/A |
|---|---|---|---|---|---|---|
| Early or day shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Late or evening shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Night shift | ○ | ○ | ○ | ○ | ○ | ○ |
| Weekend | ○ | ○ | ○ | ○ | ○ | ○ |

Comment

## SECTION B: REASONS FOR MISSED NURSING CARE

67. Indicate from your perspective/view which of the following reasons contribute to MISSED care in your work place. Please mark one box for each item.

| | Not a reason | Minor reason | Moderate reason | Significant reason | N/A |
|---|---|---|---|---|---|
| a.Not enough nursing/carer staff | ○ | ○ | ○ | ○ | ○ |
| b. Inadequate skill mix for your area (eg: RN/EN/carer ratio) | ○ | ○ | ○ | ○ | ○ |
| c. Resident's condition getting worse/deteriorating | ○ | ○ | ○ | ○ | ○ |
| d. Not enough clerical or administrative help (e.g. reception staff to answer telephone) | ○ | ○ | ○ | ○ | ○ |
| e. Unbalanced resident allocation/assignment | ○ | ○ | ○ | ○ | ○ |
| f. Medications NOT available when needed | ○ | ○ | ○ | ○ | ○ |
| g. Inadequate handover between shifts | ○ | ○ | ○ | ○ | ○ |
| h. Services unavailable at my facility (e.g. podiatrist, hairdresser, lifestyle skills staff) | ○ | ○ | ○ | ○ | ○ |
| i. Other staff did not provide the care needed (e.g. lifestyle staff not available) | ○ | ○ | ○ | ○ | ○ |
| j. Supplies/equipment NOT available when needed | ○ | ○ | ○ | ○ | ○ |
| k. Lack of support from team members. | ○ | ○ | ○ | ○ | ○ |
| l. Tension or communication breakdowns with SUPPORT STAFF (e.g. catering staff) | ○ | ○ | ○ | ○ | ○ |

| | Not a reason | Minor reason | Moderate reason | Significant reason | N/A |
|---|---|---|---|---|---|
| m. Tension or communication breakdowns within the NURSING TEAM | ○ | ○ | ○ | ○ | ○ |
| n. Tension or communication breakdowns with the GENERAL PRACTITIONER | ○ | ○ | ○ | ○ | ○ |
| o. Tension or communication breakdowns with the ALLIED HEALTHCARE PROFESSIONAL(eg: O.T or Physiotherapist) | ○ | ○ | ○ | ○ | ○ |
| p. Tension or communication breakdowns with residents' family or significant other | ○ | ○ | ○ | ○ | ○ |
| q. Nurse/Carer did not communicate that care was missed | ○ | ○ | ○ | ○ | ○ |
| r. Staff member assigned to the resident not available | ○ | ○ | ○ | ○ | ○ |
| s. Not able to find a RN in a timely manner OR RN is not available | ○ | ○ | ○ | ○ | ○ |
| t. Large work place needing increased staff time to move between areas to provide resident care | ○ | ○ | ○ | ○ | ○ |
| u. Not able to access PPE (Personal Protective Equipment such gloves/gowns/masks) | ○ | ○ | ○ | ○ | ○ |
| v. Mobility aids unavailable | ○ | ○ | ○ | ○ | ○ |
| w. Equipment to prevent pressure injury unavailable | ○ | ○ | ○ | ○ | ○ |
| x. Eating aids unavailable eg: non-slip place mats | ○ | ○ | ○ | ○ | ○ |

| | Not a reason | Minor reason | Moderate reason | Significant reason | N/A |
|---|---|---|---|---|---|
| y. Too many residents with complex needs | ○ | ○ | ○ | ○ | ○ |
| z. Residents receiving end-of-life care care | ○ | ○ | ○ | ○ | ○ |
| Z2. Unrealistic resident expectations | ○ | ○ | ○ | ○ | ○ |

68. is there anything else you would like to tell us about missed care at your work?

## THANK YOU

**We appreciate your time. If you would like more information about the study you are welcome to contact**

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# APPENDIX C - DELPHI SURVEY

Delphi Survey Round 1

**Thank you for your support to this research project.**

**As explained to you in the Information Sheet, this Delphi Survey is Phase 2 of a larger mixed methods study. This study is part of the project entitled 'Developing an evidence base for aged care staffing and skill mix'. This project will investigate and develop recommendations for optimum staffing levels and skill mix for aged care and is being conducted by a collaboration between the University of South Australia and Flinders University.**

**The invitation to participate has been sent to you because of your role as residential site manager for a residential aged care facility. Your participation (and email address) or that of your nominee will be kept confidential and anonymity of responses is guaranteed.**

**Your expert opinion is sought on the need for, and structure of, a staffing methodology to assess and address the assessed needs of different residents living in residential aged care in Australia in order to provide quality outcomes of care. Staffing methodology in this context is defined as understanding the considerations that must be taken into account to calculate the nursing and personal care hours per day needed for each specific resident and at the same time calculate the staffing and skill mix requirements needed.**

**A series of descriptive statements follow. For each descriptive statement listed, you are invited to indicate your opinion from five possible choices, namely, completely disagree, disagree, agree, completely agree and unsure. Please select the most appropriate response and mark the box which most closely represents your opinion. Please try to avoid not answering or selecting unsure unless you really are unsure.**

**At the end of each statement additional space is available for you to write comments and you are encouraged to use this. If you require more space for writing your comments you can write more at the end of the questionnaire. Be sure to indicate clearly what specific descriptive statement you are commenting on.**

**Before you begin please provide some demographic details about you, the type of residential care facility you manage and please provide an email address so that you can be involved in the subsequent rounds of the Delphi Survey. Please be assured that you will be anonymous and will not be identifiable in reports or any published works from this study.**

## About You

1. Return email address for your continued participation in the Delphi Survey

2. Age

- Under 25 years old (<25)
- 25 to 34 (25 - 34)
- 35 to 44 (35 - 44)
- 45 to 54 (45 - 54)
- 55 to 64 (55 - 64)
- Over 65 years old (>65)

3. Experience in your role

- 0 - 12 months
- 1 - 4 years
- 5 - 9 years
- 10 - 20 years
- greater than 20 years (>20 years)

4. From the list below, please select one that best shows where you work

- Religious/charitable organisation
- Multi-purpose service (MPS)
- Private not-for-profit organisation
- Private for profit organisation
- Government owned organisation
- Unsure

5. Size of your work area: How many beds or residents are at your facility?

- 1 - 20 beds
- 21 - 60 beds
- 61 - 100 beds
- 101 or more
- Unsure
- Other (please specify)

6. From the options below where is your workplace?

- Metropolitan
- Regional
- Remote

7. In which State or Territory do you work?

- New South Wales
- Victoria
- Queensland
- Western Australia
- South Australia
- Tasmania
- Northern Territory
- Australian Capital Territory

Delphi Survey Round : Descriptive Statements

**Let us begin Round 1. There are twenty (20) descriptive statements for you to review and offer your opinion on.**

8. Thinking of your resident profile, resident care needs have increased in volume and complexity and over time, continue to increase.

| Completely disagree | Disagree | Agree | Completely agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

9. Thinking of your resident profile, a person with complex care needs who comes to live in residential aged care is now living a much shorter time given the complexity of their care needs

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

10. Thinking of your resident profile, residents require more frequent and complex assessments to be undertaken by the staff team to ensure the safety and quality outcomes of care of all residents.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

11. Thinking of your resident profile, residents require more frequent and complex interventions and interactions to be implemented to meet their assessed needs.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

12. Thinking of your residents' profiles, assessment and reassessment of them is required precisely because of the potential for unplanned events; for example experiencing a significant change or deterioration in their health status.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

13. Thinking of your residents' profiles, assessment and reassessment of them generally identifies new or additional interventions precisely because of the potential for unplanned events; for example experiencing a significant change or deterioration in their health status.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

14. Thinking of your residents' profile, assessment and reassessment of them is required precisely because of significant changes or challenging behaviors; for example extreme agitation, being withdrawn or unsettled.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

15. Thinking of your residents' profile, assessment and reassessment of them generally identifies new or additional interventions precisely because of significant changes or challenging behaviors; for example extreme agitation, being withdrawn or unsettled.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

16. Direct nursing and personal care includes any intervention (for example, showering a resident) that a Registered Nurse (RN) Enrolled Nurse (EN) Personal Care Worker/Carer and/or Assistant in Nursing (AiN) undertakes that is directly related to assessing or meeting the assessed needs of resident.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

17. Indirect nursing and personal care includes where a Registered Nurse (RN), Enrolled Nurse (EN), Personal Care Worker/Carer and/or Assistant in Nursing (AiN) is required to liaise with General Practitioners (GP), Allied Health professionals, lifestyle personnel, Pharmacy and Pharmacists, liaise with resident's significant others, Staff Handover, DDA count, Staffing Shift Management.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

18. A staffing methodology is needed to be built around assessing and meeting the assessed needs of residents for morning (am), afternoon (pm) and night shifts and on an ongoing basis.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

19. A staffing methodology must include the building block of identifying the lowest level in the skill mix of staff who can perform the activities to meet the assessed needs of different resident profiles.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

20. A staffing methodology must include the building block of identifying the time and frequency of interventions per shift required to assess and meet the assessed needs of different resident profiles.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

21. To calculate the total resident nursing and personal care time per day for each resident, a staffing methodology must include the building blocks of identifying direct and indirect nursing care work.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

## Activities of Daily Living

**There a two (2) tables in this section for you to consider about Activities of Daily. The first table relates to activities of personal hygiene,mobility and ambulation. The second table relates to activities in relation to nutrition and fluids.**

**In this section you are being asked to give your opinion about the activity and the level of assistance required by staff to carry out these activities. The following questions asks your opinion about the accuracy of the categories identified.**

22. The table below correctly identifies for the major category of 'Activities of Daily Living', the activities and the number of staff required to perform that activity for the different levels of assistance a resident may need.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

23. A staffing methodology must include the building block of identifying the number of staff required to meet the different levels of assistance a resident may need.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

24. The table below correctly identifies the different levels of assistance different residents or a resident over time may require to meet their nutritional and fluids needs.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

Activities of Daily Living_Nutrition and Fluids

25. A staffing methodology must include the building block of identifying the different levels of assistance a resident may need over time.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

26. Developing a staffing methodology that is evidenced based and which can calculate the resident care hours per day (RCHPD) for the diversity of complex resident profiles living in residential aged care, will assist in meeting expected outcomes of the accreditation standards and *Aged Care Act, 1997*

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

27. The following formulae includes the necessary building blocks to appropriately identify the total resident nursing and personal care time per day required.

(Assessment and reassessment of each resident) + (direct nursing and personal care time per intervention per resident x frequency per shift) + (indirect nursing and personal care time per intervention per resident x frequency per shift) = total resident nursing and personal care time per day.

| Completely Disagree | Disagree | Agree | Completely Agree | Unsure |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

Other (please specify)

28. Is there anything you would like to tell us? If so, please be sure to specify clearly what descriptive statement you are commenting on.

Also, a reminder that if you have not provided your email address please do so.

# Attachment B

# ANMF NATIONAL AGED CARE SURVEY

FINAL REPORT

July 2016

Australian Nursing & Midwifery Federation

# CONTENTS

# EXECUTIVE SUMMARY

Over the last decade Australian Nursing and Midwifery Federation (ANMF) members have been campaigning for improvements in aged care with increasing intensity in an attempt to ensure quality care for residents and decent conditions for those working in aged care. But despite multiple reviews, inquiries and investigations no real improvements have been forthcoming.

Consequently, safe staffing in aged care, including a mandated requirement for 24 hour registered nurse cover for all high care residents, was one of the ANMF's four key issues for the 2016 Federal Election and was one of the central planks in the ANMF's Federal Election campaign, *If you don't care, we can't care*.

Underpinned by research undertaken for the ANMF's submission to the Senate Inquiry into *The future of Australia's aged care sector workforce*[1] and an economic analysis of the impact of the budget cuts announced in the 2016-17 Federal Budget[2], the ANMF's Federal Election campaign included a national survey and phone-in of aged care workers and community members.

The survey explored how the funding cuts are, or would, impact the delivery of care in residential care facilities across the States and Territories, with the aim of gathering information to place aged care as a key election issue and gain the attention of voters, and thus, politicians.

The survey, which ran from 17 – 21 June 2016, was conducted primarily online with a national phone-in held on 18 June 2016. A total of 2,423 people, comprising 1,724 aged care nurses and care workers and 699 community members, mostly relatives of people in aged care, participated. This report provides an outline of their views on:

- current key concerns in aged care;
- the adequacy of staffing levels and staffing skill mixes in aged care;
- the adequacy of care delivery in residential facilities;
- improvements needed in aged care; and,
- voting intentions relating to aged care.

The overwhelming theme to emerge from both the aged care worker and community group responses to the ANMF's aged care survey was the participants' belief that the elderly deserve much better care than they are currently receiving. This belief related to care in every aspect: personal care, physical care, medical care, psychological care, and emotional and social care.

The picture of residential aged care painted by the stories and comments of participants is one approaching despair. Participants state that resources in facilities, both human and otherwise, are becoming so scarce that on many occasions it is just not possible for residents to be cared for safely or, as reported by many participants, even humanely.

Their accounts describe a situation of widespread substandard care which offers little or no dignity to the elderly at the end of their lives. A situation which shows no recognition or regard for the contribution the elderly have made to Australian society and which, they believe, represents a profound lack of respect for Australia's elderly. They believe the elderly are not treated as individuals, not treated as real people or, on occasion, not even as human beings.

[1] ANMF's Submission to Senate Inquiry: The future of Australia's aged care sector workforce. Available online: http://www.anmf.org.au/documents/submissions/ANMF_Aged_Care_Inquiry_2016_Report.pdf
[2] ANMF Estimation of impacts of 2016-17 Budget and MYEFO Cuts to Aged Care Funding in Marginal Seats.

The findings of the ANMF's National Aged Care Survey outline an appalling lack of regard from Australian governments and politicians for our elderly. The findings describe a systemic failure to ensure safe and adequate care to all aged care residents and suggest governments and providers are forsaking the elderly the dignity they deserve at the end of their lives.

The survey's participants, and ANMF members more broadly, questioned the kind of society that Australia has become to condone such disrespectful treatment of our elderly. They were firmly of the view that such a society is not a moral and compassionate one.

However, this is what they would like to see, a moral and compassionate approach to care for our elderly, which would ensure them safe, dignified and respectful care at the end of their lives.

The survey's participants believe that this will require:

- Adequate Government funding;
- Appropriate mechanisms to ensure that funding is directed to care for residents;
- Appropriate mechanisms to ensure that funding is directed to ensuring safe staffing levels;
- Mechanisms that ensure genuine accountability and transparency from aged care providers;
- A mandated requirement for minimum training and regulation of all staff, including a sufficient supply of registered nurses and nursing staff specialised in the delivery of aged care; and,
- A commitment from governments, providers and the community to improving care for the elderly.

They believe these changes must happen because, quite simply,

***"The elderly deserve a whole lot better."***

# INTRODUCTION

As a prelude to Australia's Federal Election, on 3 May 2016 the Federal Coalition Government announced, for the third consecutive year, a Federal Budget with significant cuts in funding for vital health and aged care services in the midst of funding boosts for businesses and those on higher incomes.

While these announcements were all deeply concerning to nurses and midwives, most alarming were proposed new cuts to the residential aged care sector. The 2016/17 Federal Budget included significant changes to the Aged Care Funding Instrument (ACFI) used to assess the base-line level of public funding for the care of individual residents.

The Budget Papers indicated the changes to ACFI would lead to a reduction of $1,152m in ACFI related funding over next four financial years. These cuts followed on from $607m in cuts announced in the Mid-Year Economic and Fiscal Outlook in December 2015. The Australian Nursing and Midwifery Federation's (ANMF) analysis of these cuts concluded that in total, close to $1.8b cuts to aged care funding were forecast over the next 4 years.

The alarm at the cuts expressed by ANMF members was due to the fact that, in their vast experience, the sector was already approaching crisis point with a range of critically significant issues needing urgent attention. It could ill afford to be drained of further resources.

Over the last decade ANMF members have been campaigning for improvements in aged care with increasing intensity in an attempt to ensure quality care for residents and decent conditions for those working in aged care. But despite multiple reviews, inquiries and investigations no real improvements have been forthcoming.

The aged care sector remains a sector characterised by:

- low wages and poor conditions;
- inadequate staffing levels and workload issues;
- unreasonable professional and legal responsibilities;
- lack of career opportunities;
- stressful work environments;
- poor management practices;
- a poor perception of aged care in general,[3] and most disturbing of all,
- growing reports of substandard care.

These factors are not new, unknown or misunderstood. They are however, ignored. There has simply been a lack of will by governments and industry to address these matters seriously.

Consequently, safe staffing in aged care, including a mandated requirement for 24 hour registered nurse cover for all high care residents, became one of the ANMF's four key issues for the 2016 Federal Election and was one of the central planks in the ANMF's Federal Election campaign, *If you don't care, we can't care*.

Underpinned by research undertaken for the ANMF's submission to the Senate Inquiry into *The future of Australia's aged care sector workforce*[4] and an economic analysis of the impact of the budget cuts outlined above[5], the ANMF's Federal Election campaign included a national survey and phone-in of aged care workers and community members.

The survey explored how the funding cuts are, or would, impact the delivery of care in residential care facilities across the States and Territories, with the aim of gathering information to place aged care as a key election issue and gain the attention of voters, and thus, politicians.

The survey, which ran from 17 – 21 June 2016, was conducted primarily online with a national phone-in held on 18 June 2016. A total of 2,423 people, comprising 1,724 aged care nurses and care workers and 699 community members, mostly relatives of people in aged care, participated. The presentation of data that follows provides an outline of their views on:

- current key concerns in aged care;
- the adequacy of staffing levels and staffing skill mixes in aged care;
- the adequacy of care delivery in residential facilities;
- improvements needed in aged care; and,
- voting intentions relating to aged care.

[3] CEPAR, *Aged care in Australia Part ll – Industry and practice*, CEPAR research brief 2014/02.
[4] ANMF's Submission to Senate Inquiry: The future of Australia's aged care sector workforce. Available online: http://www.anmf.org.au/documents/submissions/ANMF_Aged_Care_Inquiry_2016_Report.pdf
[5] ANMF Estimation of impacts of 2016-17 Budget and MYEFO Cuts to Aged Care Funding in Marginal Seats.

# SURVEY RESPONSES

A total of 2,423 people, comprising 1,724 aged care nurses and care workers and 699 community members, mostly relatives of people in aged care, participated in the ANMF's national phone-in and online survey on the impact of funding cuts in aged care. The survey, which ran from 17 – 21 June 2016, was conducted both online and via a national phone-in held on 18 June.

The national phone-in, which received calls from across the country, provided for those not equipped to participate in the online process and who felt more comfortable speaking directly to an ANMF officer. 680 of the survey's total respondents participated in the national phone-in, 500 aged care nurses and aged care workers[6], and 180 community members.

Two surveys were used, one for those working in aged care and one for community members, mostly people with relatives in aged care. The surveys contained 16 common questions, with each survey containing further questions specific to each group; an additional 8 questions were included in the survey for those working in aged care and an additional 2 questions for community members.

The surveys collected a small amount of demographic data, which focused on participants' states or territories, their relationship to aged care for community members, and simple workplace data for those working in aged care. Figures 1 – 3 provide details of participants by state and territory, overall and by group, i.e. aged care workers or community members.

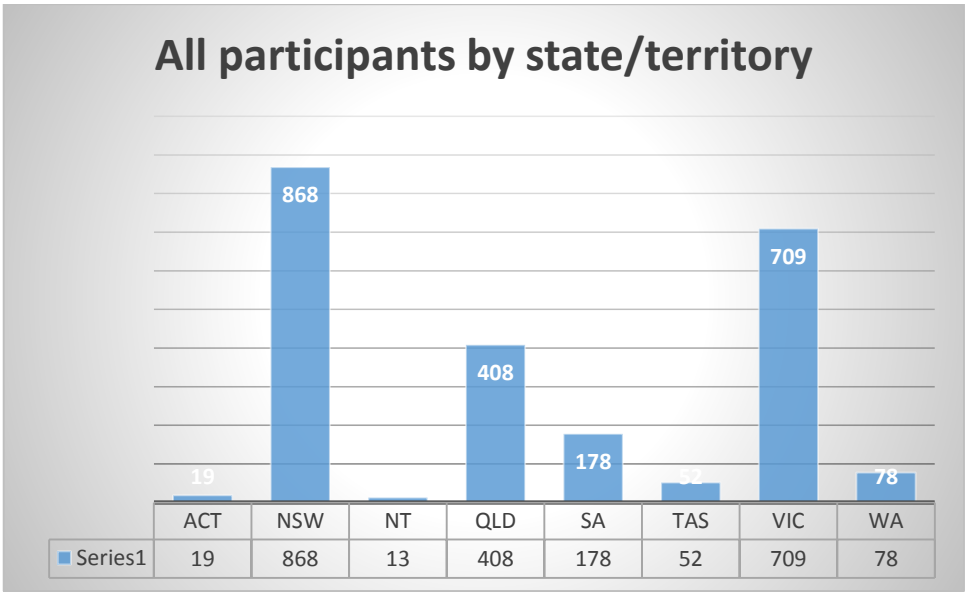


*Figure 1 All participants by state/territory*

[6] For ease of readability, aged care nurses and aged care workers are collectively referred to as the aged care worker participant group at times in this report.

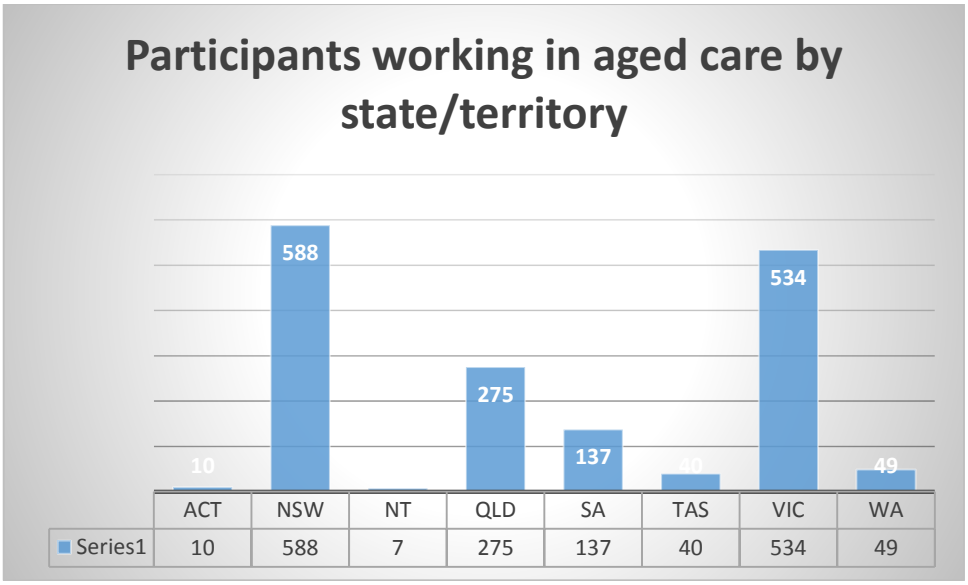


*Figure 2 Participants working in aged care by state/territory*

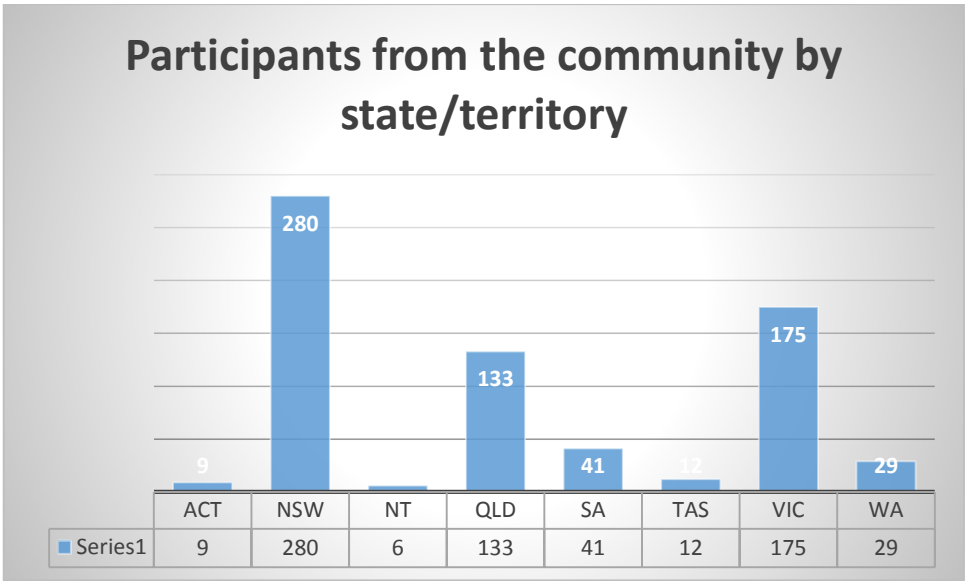


*Figure 3 Participants from the community by state/territory*

Participants from the community were asked to identify their relationship with aged care, i.e. if they were a resident in aged care, a relative or friend of someone in aged care, a community visitor or had another relationship with aged care. As shown in figure 4, the majority of community participants were relatives of someone in aged care, 61%, with the second largest group, 25%, identifying as having another relationship with aged care, largely comprising nurses who worked in acute care or other settings.

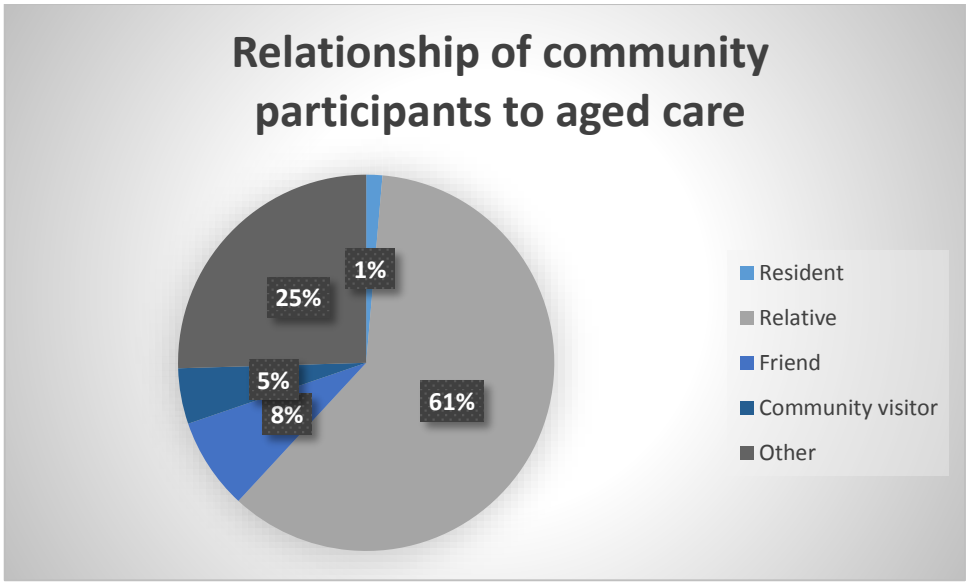


*Figure 4 Relationship of community participants to aged care*

Participants working in aged care were asked to identify the areas in which they worked and lived, i.e. metropolitan, regional, rural or remote, their employment classification and the sector in which they were employed. There was a relatively even distribution of participants across metropolitan and regional areas, 38.3% and 39.7% respectively, with 20.8% from rural areas. The final 1.2% were from remote areas. The vast majority of participants also worked in the area in which they lived (see figures 5 & 6).

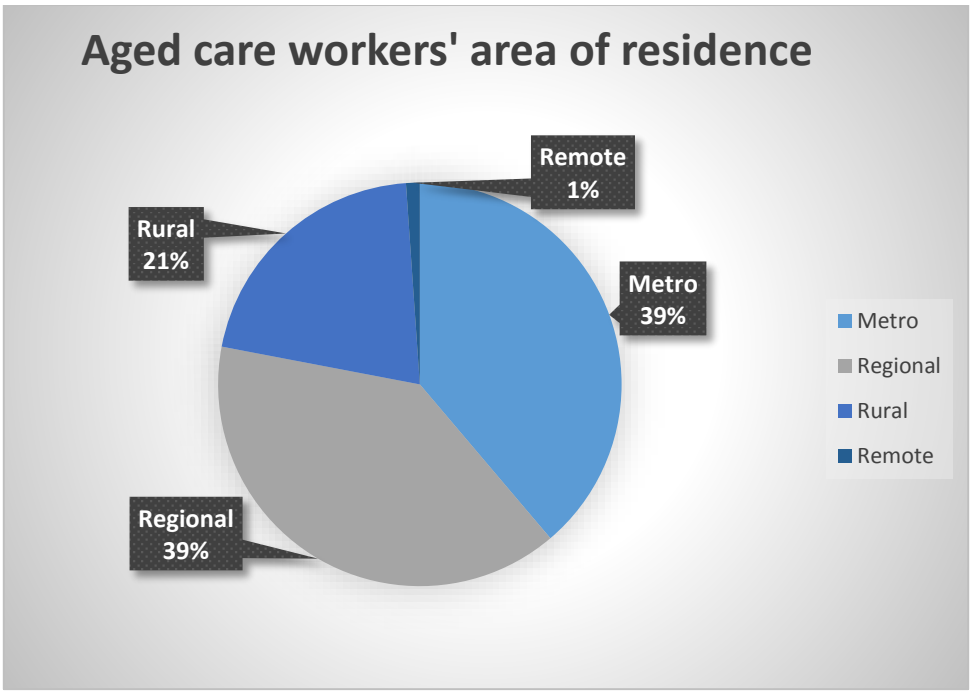


*Figure 5 Aged care workers' area of residence*

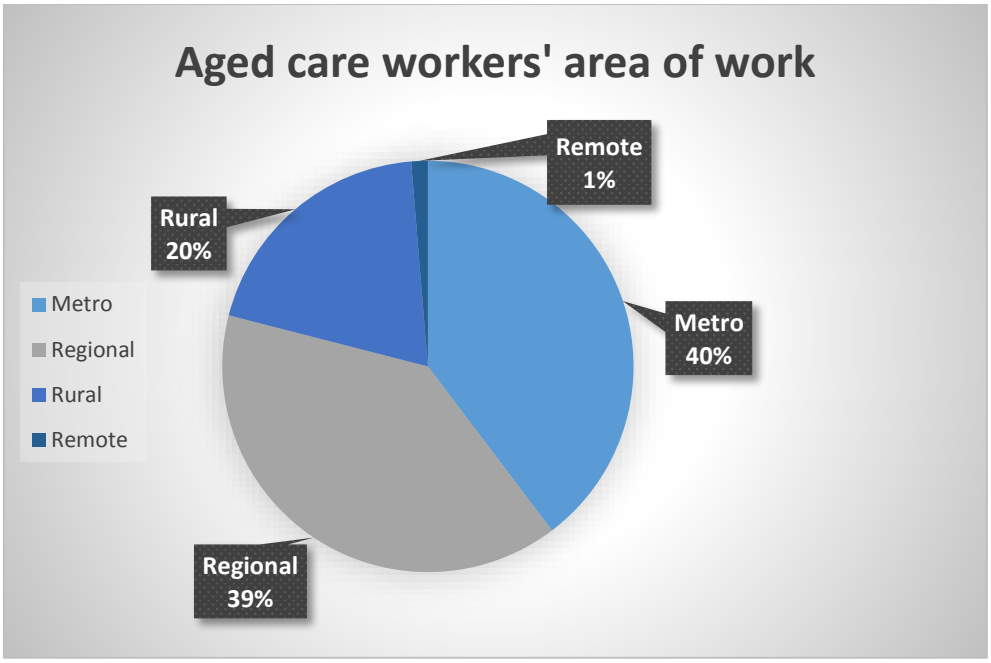


*Figure 6 Aged care workers' area of work*

The great majority of participants working in aged care were nurses and assistants in nursing/personal care workers, over 86%, with the greatest proportion working in the not-for profit residential aged care sector, 32.3% (see figures 7 & 8).

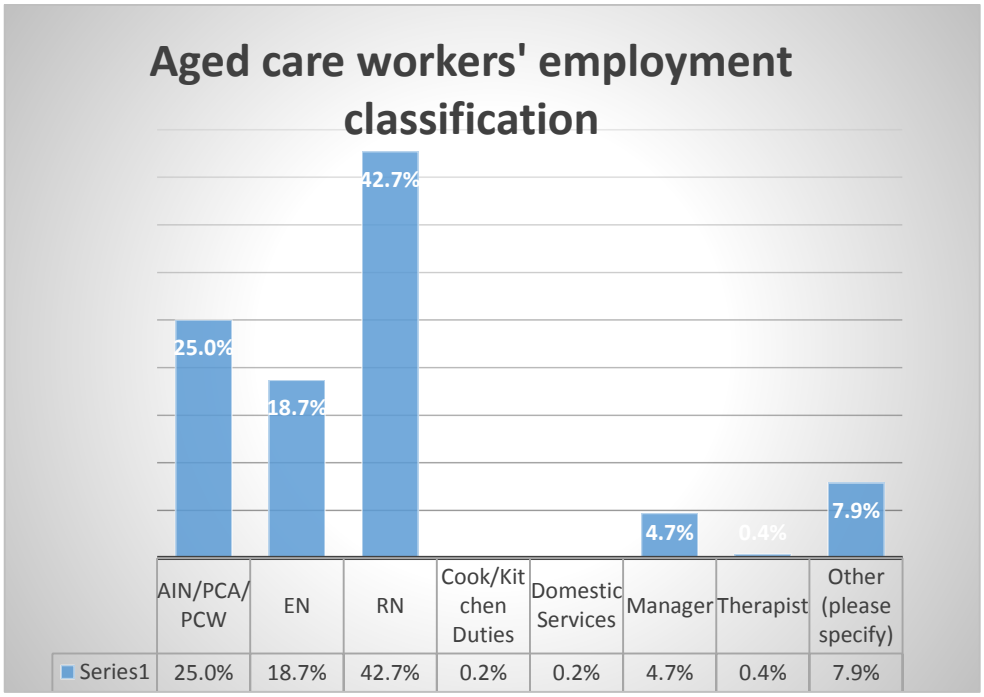


*Figure 7 Aged care workers' employment classification*

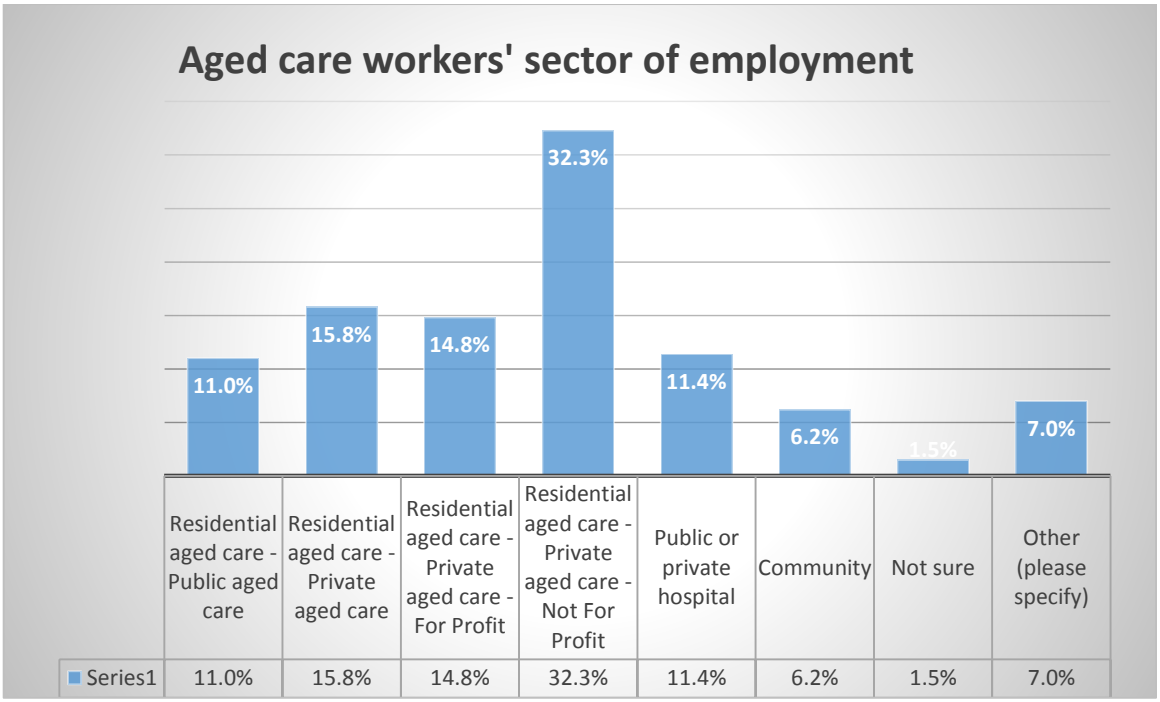


*Figure 8 Aged care workers' sector of employment*

## CONCERNS REGARDING AGED CARE

Participants in both groups were asked to identify the issues in aged care that were currently causing them the most concern. They were asked to select issues from a list of options and were given the opportunity to select more than one issue. Figure 9 provides a comparison of responses from both aged care workers and community members.

Both participant groups expressed very high levels of concern about a range of issues in aged care, with the greatest concern relating to Commonwealth funding cuts and staffing levels. Community participants indicated a greater level of concern than aged care workers in almost every category, most significantly with respect to qualifications of staff, food quality and domestic services.

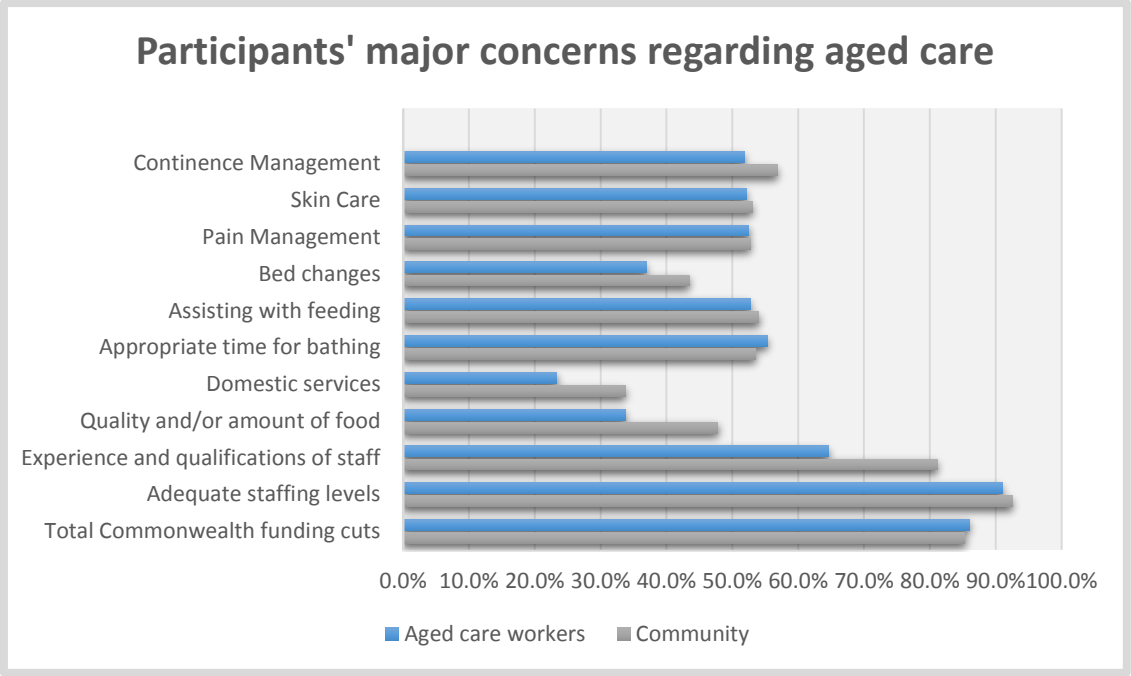


*Figure 9 Participants' major concerns regarding aged care*

Participants in both groups were asked whether they believe the current funding of aged care is adequate to meet the needs of aged care residents. The response was overwhelmingly in the negative, with a slightly stronger response from community participants, 96%, than aged care worker participants, 94% (see figure 10).

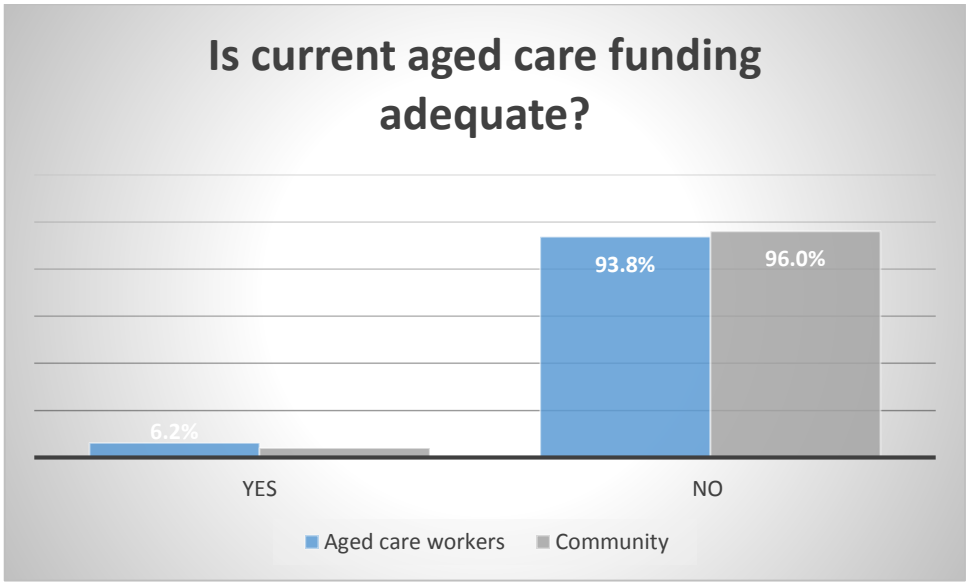


*Figure 10 Participants views on adequacy of current aged care funding*

Participants were also asked whether they believed the funding cuts planned over the next four years would have an impact on the level of care within aged care facilities and to indicate the scope of the impact. Both groups indicated that they believed the cuts would have a significant impact with

more than 90% of community members and aged care workers suggesting the cuts would have a considerable or greater impact.

Both groups were asked whether their employer, for aged care workers, or facility owner, for community members, had had any discussion with them about - cuts to staffing or the effect on care provision for their relative/friend – because of the Commonwealth funding cuts. 32% of aged care workers responded that their employers had indicated that there would be cuts to staffing, but only 10.5% of community members had had any discussion with their facility owners about impacts of the Commonwealth cuts on care for their relative.

This was followed by a question to both groups on whether cost shifting had started to occur at their facilities, i.e. were residents or their families now required to pay for items which had previously been provided by the facility. A reasonable proportion of both groups, close to half of aged care workers, indicated that this had already started to occur (see figure 11).

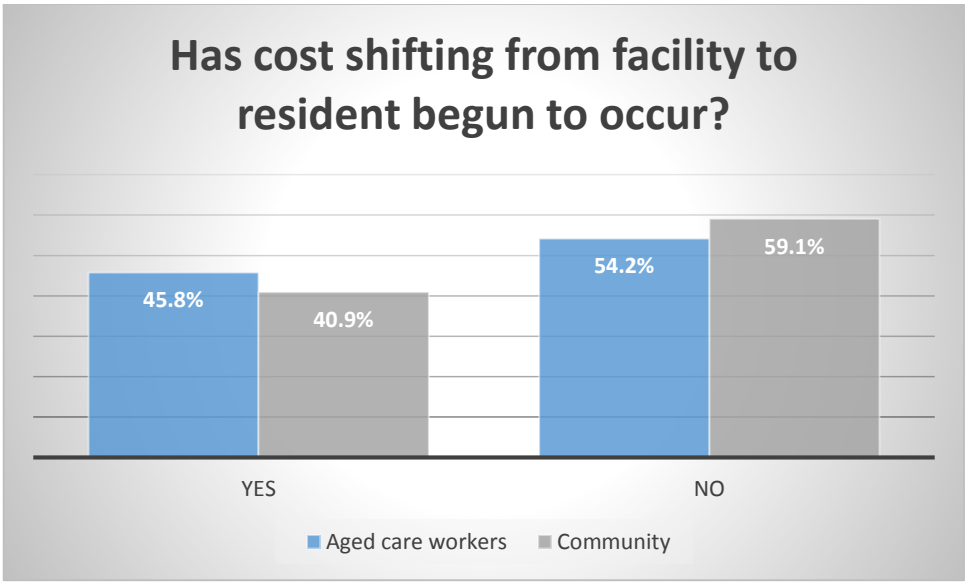


*Figure 11 Incidence of residents or their families now required to pay for items previously provided by aged care facilities*

## STAFFING LEVELS AND SKILLS MIX

Participants in both groups were asked two questions specifically related to staffing; whether they believe the current staffing levels at their aged care facilities were able to provide an adequate standard of nursing care and whether they considered the ratio of registered nurses (RNs) to other care staff to be adequate. Consistent with responses related to adequacy of funding, the responses from both groups to staffing questions were overwhelmingly in the negative.

Interestingly, 80% of participants working in aged care indicated that they did not believe current staffing levels were sufficient to provide an adequate level of care to their residents. This an honest but concerning reflection from aged care workers on the current level of care they feel they are providing. This issue is discussed in more detail later in the report.

There was some variation between the participant groups with regard to their views on the adequacy of RN staffing at their facilities, with community members strongly negative, 85%, and aged care workers somewhat less, though still significantly negative, at 68%. This may be partially explained by the composition of the aged care worker participant group, which comprised more

than 50% of workers other than registered nurses who may have significant concerns about their own staffing ratios (see figures 12 & 13).

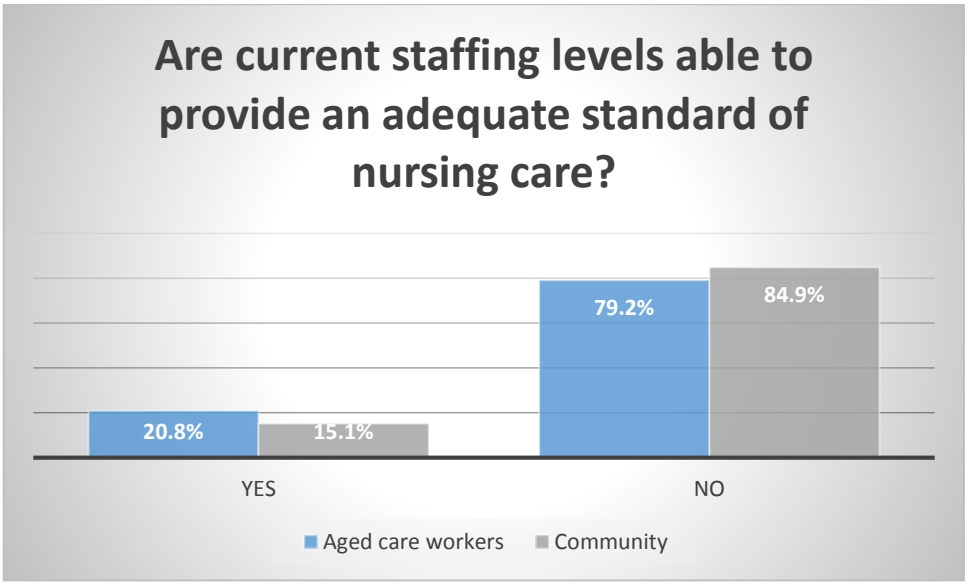


*Figure 12 Capacity of current staffing levels to provide an adequate standard of nursing care*

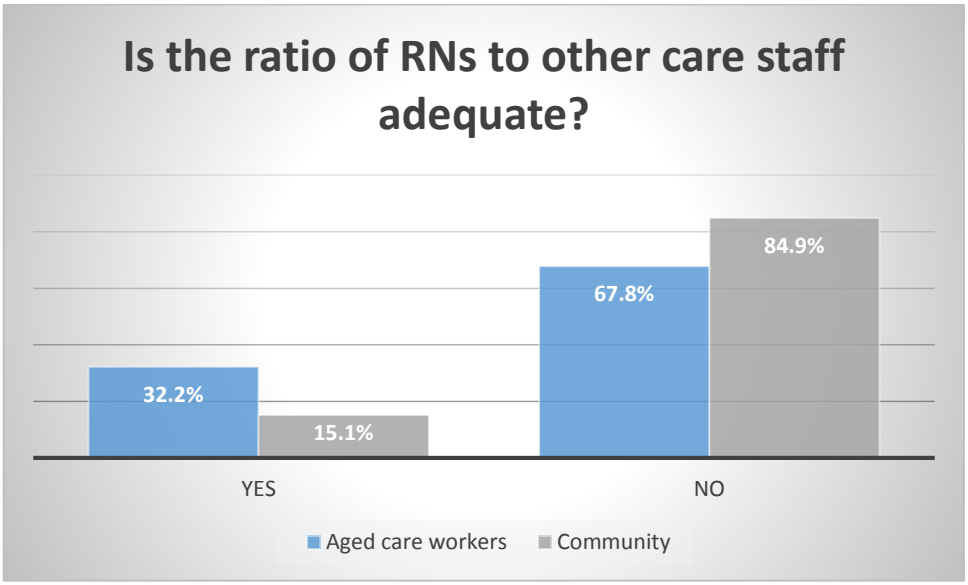


*Figure 13 Adequacy of ratio of RNs to other care staff*

Participants in the aged care worker group were asked two additional questions related to staffing: whether residents were transferred to hospital for care that could be provided at the facility with a more qualified staffing mix and what they believed was the main contributor to nurses leaving or not wanting to work in aged care.

Just over half, 53%, indicated that residents were being transferred to hospital for care that should be able to be provided at the facility if appropriately qualified staff were available. And almost half,

47.5%, identified workloads as the single greatest contributor to difficulty in recruitment and retention for the aged care sector (see figure 14).

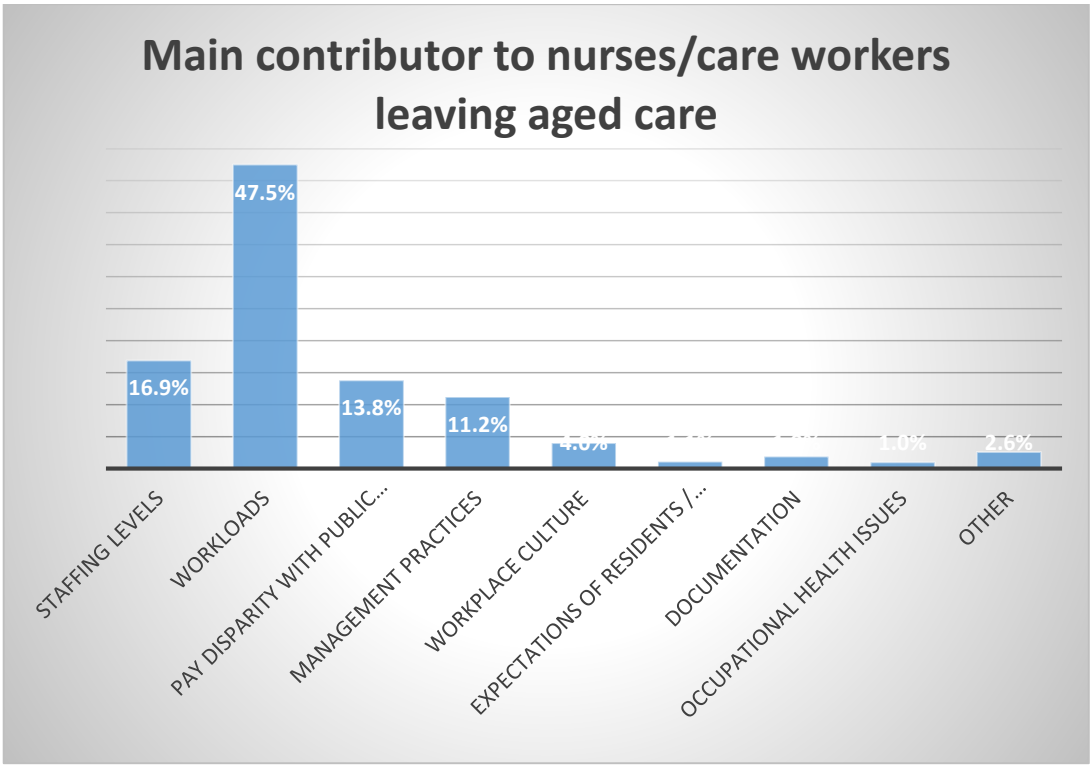


*Figure 14 Main contributor to nurses/care workers leaving aged care*

## IMPROVEMENTS NEEDED IN AGED CARE

Participants in both groups were asked to identify what they believe needs to be done to improve aged care services. They were asked to select issues from a list of options and were given the opportunity to select more than one issue. Figure 15 provides a comparison of responses from both aged care workers and community members.

Excepting the need for increased government funding, community participants registered a stronger response on all options provided than aged care worker participants. This was particularly evident with respect to their views on the need for more vigorous accreditation inspections and the imposition of financial penalties on providers who failed to ensure a minimum standard of care to residents.

The disparity between the groups regarding these two issues may be partially explained by the following: aged care workers believe the accreditation process to be deeply flawed and therefore see little use in further investment in the process; and, they already believe the sector to be starved of funds, therefore to restrict funds further through financial penalties may serve only to exacerbate existing problems.

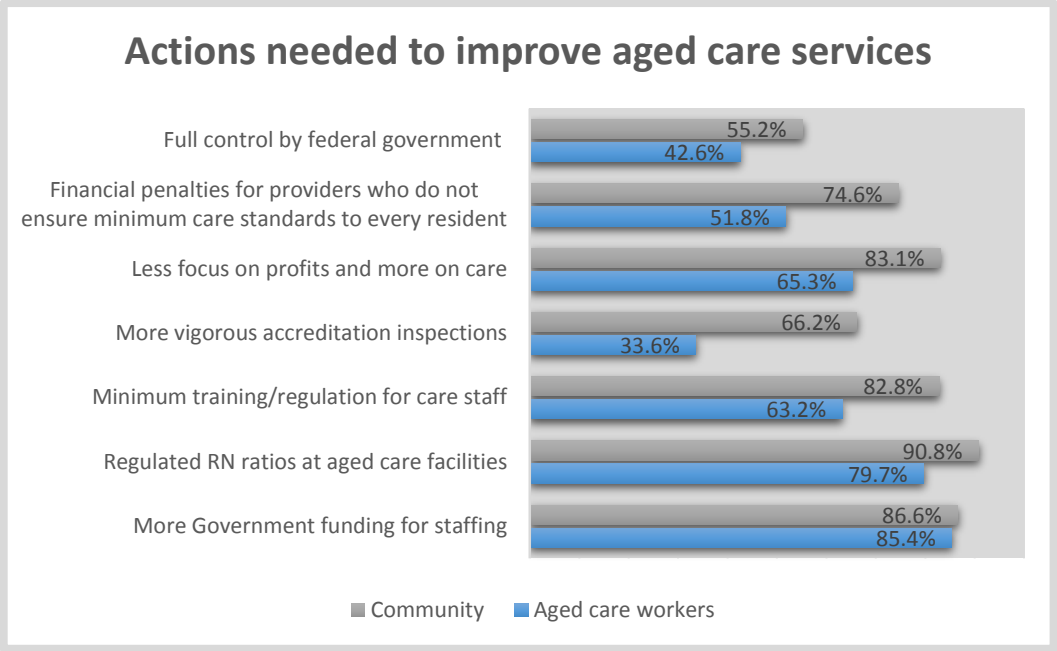


*Figure 15 Actions needed to improve aged care services*

As the survey formed part of the ANMF's Federal Election Campaign, both participant groups were asked whether they would change their vote to support a party that made an election announcement to restore funding to improve services and care to residents in aged care. A significant majority in both groups indicated that they would as shown in Figure 16.

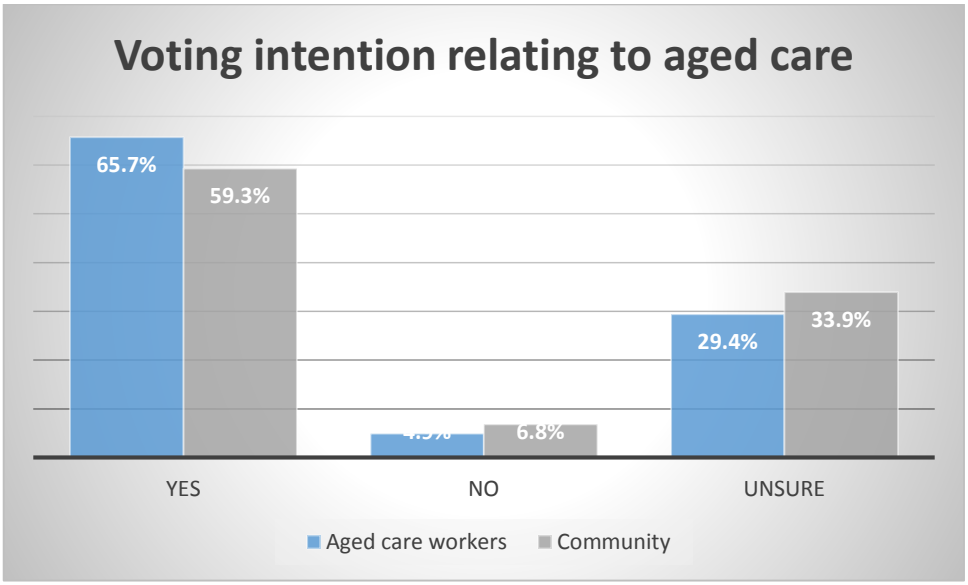


*Figure 16 Voting intention relating to aged care*

In addition to the responses outlined above, participants were offered the opportunity to provide further information on a number of questions and were given a final opportunity to add any further general comments they wished to make or to tell their story to the ANMF. The remaining section of this report discusses their responses in detail.

# THE ELDERLY DESERVE BETTER

The overwhelming theme to emerge from both the aged care worker and community group responses to the ANMF's aged care survey was the participants' belief that the elderly deserve much better care than they are currently receiving. This belief related to care in every aspect: personal care, physical care, medical care, psychological care, and emotional and social care.

The picture of residential aged care painted by the stories and comments of participants is one approaching despair. Participants state that resources in facilities, both human and otherwise, are becoming so scarce that on many occasions it is just not possible for residents to be cared for safely or, as reported by many participants, even humanely.

Their accounts describe a situation of widespread substandard care which offers little or no dignity to the elderly at the end of their lives. A situation which shows no recognition or regard for the contribution the elderly have made to Australian society and which, they believe, represents a profound lack of respect for Australia's elderly. They believe the elderly are not treated as individuals, not treated as real people or, on occasion, not even as human beings.

> *Basically the whole situation shows very poor form. Our frail and elderly citizens should be shown respect and supported in their twilight years. They have worked hard and paid taxes, fought for their country (in many cases) and now they are an easy target.*
>
> *My elderly father's and mother's days are TOTALLY BORING and the activities are MIND NUMBING. They are an insult to people who have lived very RICH and REWARDING LIVES. There are also NO PSYCHOLOGICAL SERVICES for grieving families who have to deal with the traumatic effects of watching their parents cry day and night, suffer depression, and make suicidal comments over and over again.*
>
> *I think it is disgusting that people of this country who have contributed so much during their working life can be treated in this way in their old age.*
>
> *Not good enough, our frail aged deserve much better. They deserve respect, dignified care, and mostly, professional care.*

The situation participants describe is what is currently happening, that is, before the implementation of $1.8 billion in government cuts to funding. They are deeply concerned about what will happen if these cuts are implemented.

This is not to suggest, however, that participants believe lack of appropriate government funding to be the only concern or the only cause of the woeful situation they are experiencing in aged care. They are also extremely cynical about aged care providers and their approach, or lack thereof, to the provision of quality care for aged care residents. In fact, many of them claim that there is no semblance of 'quality' in the care that is being provided to the elderly.

It should be noted that this was the overwhelming and consistent view of the majority of participants; less than 20% expressed satisfaction or better with their experience of aged care. Given the large sample size of respondents for the survey it can be reasonably assumed that the results have significant general applicability.

The participants' principle claim is that aged care funding, irrespective of its source (from government or from residents and their families), is not being, nor is it required to be, directed to ensuring safe and adequate care for aged care residents.

> *Aged care providers are not held accountable for how the received government funding is being spent, especially on staffing levels, continence management and food. The aged care providers have always been crying 'poor' or about inadequate funding. I guess it depends on how much profit*

*the providers want to make.*

*Providers are interested in profits and care is secondary. Huge conflict between quality of care and being a for profit provider.*

*It's a business now to make profit. Staffing is not adequate, it takes the care out of the nursing. The staff do care but without adequate time there isn't enough to go around. Communication is lacking. There is no empowerment and advocacy for the general rights of residents.*

*I'm also aware that there is a substantial amount of money given that is not being wisely spent. This is about managers … making decisions that affect staff on the floor e.g. not enough continence products available to use... The money might be there but is not being delegated to staff to use as they should - has knock on effects down the line and becomes a big issue.*

Participants explained that even when residents and their families paid extra fees and made additional contributions to aged care providers, they were not assured of high quality, or as reported in many cases, even reasonable, care for their relative.

*Why is it that hefty ingoing fees are paid, plus or minus daily service fees - the management and owners are making a great profit whilst the government and families are paying top dollar for services - we pay $50 a DAY for my mother for "extra" services - she is ambulant, continent, showers herself - if I don't pay this fee, I would need to find an alternative place for her, which is nigh on impossible.*

*But the funding goes to profit not to care. We paid $380,000 to get into a home then pay another $500 per week.*

*The facility for Dad's permanent residence is a private one. The bond we were asked for was exorbitant… The fees we pay for Dad's care are very high and they increase at least twice per year. Despite this injection of private funds from mine and other families, the facility is still failing to provide some basic care and still doesn't have RNs rostered 24/7. My own experience, and the experience of others in my community indicate a massive problem with aged care funding.*

While the vast majority or participants believed that aged care is significantly under-funded and more funding is needed, they expressed concerns about increasing government funding to providers without much better accountability for how those funds were spent.

*I would only support the idea of further government funding to aged care if the providers' expenditure is transparent to the Australian public. After all, aged care funding is tax-payers' money.*

Many participants went further, suggesting that the lack of accountability allowed providers to present an image of the care that residents and families could expect from their facility which was inconsistent with the reality.

*The aged care facility I currently work in is so intent on "presenting" a picture to the public of a facility that provides wonderful "care" and "respect" for their residents. But beneath the surface of the "lovely" uniforms that staff wear and the big posters on the wall with loving pictures of residents and staff there is the true story of incontinent pads not being changed when they should because staff who called in sick have not been replaced; of residents sitting in chairs for hours on end without being walked or moved because there is not enough staff to assist them; skin tears occurring on frail skin because residents are being transferred in a hurry from bed to chair and then the wounds not being reported. Broken and red skin on the bottoms of those residents who*

*are unable to walk and not given the adequate pressure area care because of time.*

*My mother-in-law (93) is blind - a meal tray is put in front of her - she stabs at the food - exhausted she gives up - tray taken away. Commode chair next to her bed every time I visit - so undignified. So much effort put in to making front entrance and coffee shop look fantastic - if only that money was spent on residents.*

Participants believed the lack of any genuinely effective requirement for aged care providers to direct funding to the provision of care is leading not only to a lack of safe and adequate care but also to the occurrence of many preventable incidents, illnesses and conditions, and even unnecessary or premature deaths.

*My mother who is paralysed left side and suffers memory loss due to a stroke is often left in bed all day, often not showered, rarely has teeth cleaned and was left unsupervised twice resulting in ambulance to hospital and further brain injury and surgery. More staff would allow adequate care.*

*Residents often were not showered, looking constantly uncared for. Teeth not cleaned, basic care not attended. On a few occasions they just left my Nan in her room rather than getting her for meals as they forgot as they were too rushed.*

*Not enough staff on esp. overnight. My mother fell in her room when getting up to toilet and was lying on floor a long time with fractured femur. Only 2 or 3 staff on for 50 residents. Not enough!*

*When my mother was in a nursing home I found it difficult to comprehend that it was me identifying her health problems and not the staff looking after her. It seemed to me it was alright while you could fend for yourself and were continent, but when more care was needed there just wasn't the staff. My mother ended up with pressure areas very quickly once she became less mobile. A skin tear to her leg became very badly infected as it was not being dressed properly.*

*My Dad has only been in an aged care facility for 6 months, but I feel as his advocate, my concerns are not always taken seriously. The meals are often cold… He has lost weight and this has also affected his health. He's a type 2 diabetic and was having frequent hypoglycaemic episodes, because he was not/is not eating. His skin care had been neglected and his skin was breaking down, which had never been an issue. Because there was so many different staff involved in his care, I had to put signs up in the bathroom and bedroom to remind them to moisturize his legs morning & night. I feel like I have to be his nurse & not just his daughter.*

*My father was put into a home aged 68 with dementia, the care was appalling. He had a fall and cut his head open, they gave him 2 Panadol. My sister went there the next day and he was put into hospital at my sister's insistence. My mother… went on the Monday at lunch time which she did every day to feed him and found him unconscious in a restraining chair. Ambulance was called and dad had asphyxiation pneumonia, never regained consciousness and died 7 days later.*

*A resident died a slow agonizing and undignified death because management refused to allow RNs to send residents to hospital after a serious fall possibly causing terminal injury.*

These are not just isolated comments, there were hundreds of comments from participants outlining cases of inadequate and unsafe care. They described countless instances of residents being left "wet, dirty, hungry, thirsty, dehydrated, and in pain". They explained that residents were "bored, lonely, ignored, invisible, depressed, humiliated, belittled and dehumanised". The lack of emotional and social care for residents described by participants was deeply disturbing.

Some comments described situations that in virtually any other context would constitute neglect and even abuse.

> *I worked as an agency nurse in an aged care facility. The PCAs told me the gent in such and such room required panadol routinely at night, to sleep. I asked further, and was told the gent, who was aphasic, post CVA (very vulnerable) has a sore penis. He was grimacing as I approached and asked if I might look. He nodded. He had a [urinary catheter], and instead of exiting from the meatus, the glans had a split down the side, to the level of the shaft. It looked like a split hot dog. I am still horrified to this day - the wound was not new, it took time to erode through, with pressure from the IDC tunnelling into his penis… The GP had not been informed, and obviously I faxed them a message there and then for urgent review. A follow up shift - he was in hospital, for an urgent urology review… I am… blown away the staff did not report the erosion as it was happening, take steps to prevent it, more educated staff had not looked at the source of his pain - he had panadol every night!*

Despite the above, in general participants did not blame staff for the systematic lack of safe and adequate care currently being provided in aged care facilities. They explained that there are simply not enough staff with the right mix of skills to care for the number and type of residents in facilities.

Many participants explained that aged care is now a complex area requiring specialised skills in order to provide safe and appropriate care for residents. Staff need to have skills and knowledge of the common co-morbidities affecting the elderly, in the management of dementia and other mental health and behavioural issues, in palliative and end of life care, pain management and wound care. Staff also need to be able to assess the condition of residents effectively to prevent deterioration and avoid illnesses and incidents with early intervention and appropriate clinical management.

However, in the view of the participants, these skills are sorely lacking. There are too few registered and enrolled nurses; and assistants in nursing/personal care workers simply do not possess this level of skill even if they are qualified and well trained. And often, they are not.

> *We are sticking people with 8 weeks training to give direct care - we are sending the message that anyone can give direct care, we don't demonstrate that we care about people's bodies through money and staffing. PCAs are not properly trained but are delivering physical care. This is an ethical issue. Looking after people with advanced dementia is one of the most ethically complex things I have done.*

Most significant of all was the issue of workloads; for both nursing and care staff. Nurses explain that with current staffing levels it is just not possible to deliver quality care.

> *1 RN to 52 residents is too much, not enough quality time spent with each resident.*

In fact, the staffing ratios in many facilities go well beyond hindering the provision of quality care, they are unsafe; the ratios of registered nurses (RNs) and enrolled nurses (ENs) to residents described by aged care worker and community participants alike seem almost impossible to believe.

> *When doing aged care as the only night RN on duty I would have 150 clients in my care with 6 AINS on. On occasion I would have an enrolled nurse on duty with 5 AINS.*
>
> *1 RN for 50 residents AM shift (morning only). No RN in the evening or night.*
>
> *Our registered nurses are responsible for 5 staff and approximately 90 residents on a night shift. How can they possibly be able to do their job properly, considering the changeable nature of the job? On a good night, they're run off their feet with normal duties, if there happens to be an incident then they undoubtedly have to stay after their shift.*

*Workloads and complex care needs have increased but where I work there is 1 RN for 86 residents.*

*51 residents and 2 ENs. RN is only part-time*

*1 EN for 52 residents on afternoon shift....disaster waiting to happen.*

*Night shift only one RN to 98 residents.*

*1 RN to 60 residents or sometimes 120 residents is grossly understaffed and not safe.*

*1 RN in a 94 bed facility.*

*1 RN in charge of a 90 bed facility across all shifts, also has to care for 30 residents including medication rounds.*

*80 residents to 1 RN.*

*One RN to 150 residents on pm or night shifts is not adequate or safe.*

*1 RN to 75 residents - high and low care.*

*Only 1 RN to care for 120 residents*

*Sometimes 100 - 150 residents only 1 staff nurse when short. A.M shift 1 RN and 1 EEN for 72-75 residents, P.M shift 1 RN for 72-75 residents, Night shift - 1 RN for 145-150 residents.*

Very few participants described a workplace or facility with nurse to resident ratios they believed were satisfactory. However, in some facilities, they do exist.

*We currently have 1 RN for every 22 or 23 residents which I think is more than enough.*

*One RN for 28 Residents.*

For the significant majority of participants, ratios of care staff[7] to residents are equally concerning. The best and therefore, in the view of participants, safest ratio described was one care worker to six or seven residents, with one to seven cited more frequently. However, the experience of participants was that the ratio of care staff to residents is very often much worse.

*In nursing home; [morning shift] 2 RNs & 10 care staff; [evening shift] 1 RN & 8 care staff; night duty 1 RN & 6 care staff for 150 residents.*

*1 RN for 90 residents, 2 care workers for 24 high care residents , 1 laundry person for 90 residents. Ratio is 12:1 for care workers in meeting hygiene care, nutritional needs, mobility needs and the list goes on.*

*1 RN to over 80 residents on [morning shift], same for PM shift, most times no RN overnight, care staff… 1 to 10 residents in the AM, 1 to 20 on PM, and 1 to 40 overnight.*

[7] *Care staff* are referred to variously by participants as *PCAs* (personal care assistants), *PCs* (personal carers) and *AINs* (assistants in nursing).

*I am an EEN looking after 60 residents on [an afternoon] shift in a hostel with 4 care staff, my employer is now bringing in high care residents to the hostel; these residents should be in the nursing home environment where there is a registered nurse.*

*My staff are wonderful and give 200% and it still is not enough. 4 carers on [evening shift] for 60 high care residents is disgusting.*

Despite their best efforts and intentions, staff simply cannot manage the workload demanded of them. Hundreds of participants commented on the overwhelming workload that currently exists in aged care facilities for both nurses and care staff. Both aged care worker and community participants described, as a consequence, how 'rushed' the staff often are and how detrimental this situation can be for their residents.

*There were 53 residents, including an 8 bed special care unit, and 85% of these required high care (according to their ACFI scores). Overnight, there were only 2 PCAs rostered, and an RN on call. These staff were expected to wake residents at 0500 to commence the personal hygiene tasks. If they didn't do this, the morning PCAs would be openly angry because they didn't have time and weren't able to help all the residents with their personal hygiene according to their needs. Both morning and afternoon staff were rushed and, therefore, the residents were rushed. There was an RN rostered on both morning and afternoon shifts. The afternoon RN was required to administer all medications during all the evening shift rounds. As a result of the staffing levels, the facility has a high rate of falls and medication errors; the RNs are too rushed to monitor the staff, leading to a culture of bullying; and there is no safe handover process for the RNs, given the gap during the night.*

*Residents are made to go to breakfast if they don't want to. Residents are showered at 6am - some still sleeping on the shower chair. Some residents fall asleep at the breakfast table. The AINs are so rushed in the mornings that skin tears that occur during transfers are not reported at the time that they occur. Residents' feeds are not finished due to not enough time and often drinks - especially water - are left on the bedside tables of the residents who cannot feed themselves because the AINs/PCs do not have the time to help them.*

*[With just] two and a half PCA shifts there is no way adequate care can be provided in a timely manner. Care staff try to push themselves up to a point and when they cannot they go for the short cuts which do not result in good care.*

*My mother is left to wet herself as no staff come to toilet her, she becomes dehydrated due to water or trolley not left near her, bell not near her to call staff. No skin care so my mother has bedsores now. All due to no experienced [carers], and no nurse as [there's] one nurse to 100 patients.*

*My mother was in aged care for around 6 months with MND before her death on May 8 2016. On numerous occasions she would be forced to wait to be assisted by carers and RNs to be toileted, hoisted, given pain medication and fed using PEG feeds etc. due to the lack of staff present and therefore not able to help her high maintenance care needs. These circumstances were very distressing for her and for us as a family.*

*Once I visited my Nan at 11:45 am and she was still in bed and hadn't even had breakfast. They staff said she was being a little difficult and they didn't have time for her. She hadn't even had a drink. It was absolutely terrible.*

*Staff who are always rushing between tasks cannot give quality time and care to frail elders. The food is also a problem, it is often not nutritious and well presented. Food is important when you are in aged care, the meals break up the day and good meals provide pleasure and nutritional value. Hygiene is an issue; dirty hair, infrequent showers. Residents have the right to refuse, but when does a refusal become neglect? Qualified staff are expert as working around refusal, they have the skills to persuade an elder that a shower or bath is needed and afterwards the resident is clean, happy and cared for. Relatives can then feel assured their loved one is being well looked after. Toe nails and finger nails are another problem, staff just don't have time in the day to do these tasks; so family end up having to help.*

*Having to rush frail, anxious, vulnerable, perhaps demented, persons in order to attend to their most basic requirements instead of maximising their remaining abilities, hearing their concerns and honouring who they are, or - at worst - allowing the cover-up of cruelties & neglect, is a disgrace and poor reflection on the society that ignores or fails to address such issues.*

The workload is increased further by providers requiring staff to undertake additional tasks that, not only do not directly involve the delivery of personal and other care activities, but distract staff from providing adequate care to residents.

*I work in a 60 bed facility, 1 RN and 2 PCA's on night shift… Us PCA's CANNOT give proper care to these residents because of the extra duties load. We do full laundry, wash-dry-fold, [clean] and also a computer program that can take up to 2 hours. Our care to these residents is very limited and we practically rush their requests and cannot spend time with them because of the duties that we have to do.*

Registered nurses described at length the amount of documentation and paperwork they were required to complete and the impact this had on care delivery for residents.

*The quality of care that is delivered in aged care has declined markedly in the last 10 years. Everything is based on what is documented. Sadly we spend so much time writing about what should be done that we have no time to actually do what we say that we do.*

Participants explained that staffing was not the only resource in short supply; incontinence aids are frequently “rationed”, wound care products are often selected by cost rather than clinical efficacy, and food is often “inadequate”, “unappetizing” and “not nutritious”. One participant explained that in her facility “party pies and saveloys [were] being blended up as a meal”.

“Extra” services were also being cut, access to allied health services and, most significantly, to medical services had disappeared for many residents.

When nurses and care workers raised their concerns about staffing and other resources with their management they were frequently ignored. They reported feeling unsupported by their facility management and, on occasion, blamed for the problems.

*The [registered nurses] are under so much pressure to do ACFI documentation - no time for assessment or wound management. AINs with no experience doing meds after a couple of days. Lots of medication errors - reported but not responded to - management very difficult to deal with. Our Facility Manager was an AIN for 3 years and prior a hairdresser and now FM.*

*I worked in the acute secure dementia ward, 2 AINs were responsible for 19 fully mobile [patients] who had a high level of aggression towards staff and other residents with incidents occurring daily, it was common to complete 7-10 incident reports on a shift. When we complained and asked for additional staff we were labelled troublemakers and given less shifts.*

*At the time I was working in a high care facility, feeding procedures stated that we must give patients adequate time to eat with sufficient drinks to assist with the patient dysphagia. Yet between 2 AINs we were given 14 high care patients and were expected to feed them dinner within 45 minutes. If you could not meet these expectations you were labelled incompetent and given less shifts.*

*One RN to 60 residents for day hours only. What happens when our residents are sick during the night? The policy is to call the ambulance. The paramedics get very upset with us because we are "wasting their time", however this is what we must do for action to be taken.*

*Most aged care workers want to provide the best care possible but are just not afforded the time. I remember as an AIN I would plead with management, doing the math, and showing them that I would only have 15 mins with each patient in the morning. I would be expected to shower and dress and attend to the needs of high care dementia patients. I was just told to work on my time management. It is sad that such love and passion goes into a career in aged care but so many are chased away by lack of support, worse wages, but such high expectations, I hope that things can change for the better.*

*We have spoken up, night staff is run down, neglected and [receive] broken promises all the time.*

*We scream for additional staff to meet the care needs of the residents - but nothing changes.*

Many participants explained, however, that when accreditation is due circumstances change.

*For my work I go to various aged care facilities and educate staff on wound and continence care - I am constantly flummoxed by the variants of who may be making decisions for residents under these standards, the fact that they may or may not make the residents families pay for wound and continence care, the level of experience and knowledge is so varied. Overall the "pot luck" of it - for some facilities they strive for best practice, for others it's a cheap and cheerful approach, unless they are coming up for accreditation and then they focus on an approach to show what they… have in place for accreditation purposes.*

*During annual accreditation inspections additional staff were rostered to ensure procedures were followed. We were also encouraged to fill in ACFI forms to maximise funding as this would help keep our shifts!*

Participants regarded this all too common approach from providers as disingenuous and even deceitful but especially, for staff, disheartening. When coupled with constant “cost-cutting”, a persistent failure to address staff concerns and what can only be described as a profound lack of respect for the elderly in many circumstances, the situation for many nurses and care workers has become unbearable.

Consequently, they are leaving the sector in droves.

*On my last shift before quitting I was the RN in charge for 120 residents, a pill load, a schedule 8 round across three buildings and not enough staff to manage the secure unit. At the same time I had two very serious falls and one inexperienced new graduate RN. I rang the General Manager and said she is going to have a coroner's case on her hands if she doesn't sort something out. I left after being routinely stuck with dangerous staffing levels shift after shift. It was downright reckless and shameful as I knew residents were at risk due to poor staffing. The residents stay in faeces longer than is acceptable, had delayed assessments and sat on toilets waiting for help inhumane lengths of time night after night. I couldn't be part of that anymore. I lost sleep over it and felt my soul was being destroyed by being part of such an industry.*

*While studying towards my bachelor of nursing 2013 - 2015 I worked in private aged care as an AIN. Working there was soul destroying and I will never work in aged care again as an AIN or RN due to the poor level of care, staffing ratios and poor pay levels.*

*I have been a registered nurse since 1972 and working in aged care since 1988 and for almost all of that time worked in senior management positions running large aged care facilities for the same not for profit organisation. Last year there was a roster review at the facility I was running and the organisation made the decision to cut 16 hours per day from my care staff roster. The only option I had was to resign as I could not stay and work under those conditions knowing that the care I would be responsible for delivering would not be of a high standard. I am now working as a registered nurse 7 shifts per fortnight in an aged care facility for another not for profit organisation and they have just reviewed their staffing hours and are going to cut 9 hours per day from the care staff roster. I am saddened and disillusioned with aged care and fear for our vulnerable residents and the standard of care they are going to receive.*

*I resigned last week as my pleas for one more hour of carer time on a pm shift were ignored have now decided to retire as I can't continue to see the neglect of the residents.*

*We have a 44.4 percent turnover rate of staff. First you need everyone to turn up. It is that hard to get staff from anywhere, we are left doing doubles and taking on double of the work load. There was one RN looking at doing a triple due to lack of staff. If there is no one there then you are stuck! Kitchen staff are hard to keep as well.*

*In my facility, there were 7 RNs who resigned in just a year because they can't cope with under staffing and the workloads. Most of us are very stressed [which is] resulting [in] poor health… It's just impossible when you don't have adequate staff, it's so frustrating that no one cares about adequate staffing and yet expecting quality care? It makes me cry.*

Many participants described how the factors outlined above combine to create an unhappy 'home' culture for residents and an intolerable workplace culture for nurses and care staff. Residents, families and staff reported feeling bullied, abused and neglected.

All this is currently sanctioned by the Australian people.

*Aged care residents are sadly locked away and forgotten by the community when they have very real healthcare and life needs, and because they can't fight for their rights they miss out on funding. Just providing an existence for those that spent a lifetime accumulating that pension for the latest politician to retire on, is not appropriate.*

Surely, the only conclusion that can be drawn is that the residential aged care sector has reached crisis point.

# CONCLUSION

The findings of the ANMF's National Aged Care Survey outline an appalling lack of regard from Australian governments and politicians for our elderly. The findings describe a systemic failure to ensure safe and adequate care to all aged care residents and suggest governments and providers are forsaking the elderly the dignity they deserve at the end of their lives.

The survey's participants, and ANMF members more broadly, questioned the kind of society that Australia has become to condone such disrespectful treatment of our elderly. They were firmly of the view that such a society is not a moral and compassionate one.

However, this is what they would like to see, a moral and compassionate approach to our elderly, which would ensure them safe, dignified and respectful care at the end of their lives.

The survey's participants believe that this will require:

- Adequate Government funding;
- Appropriate mechanisms to ensure that funding is directed to care for residents;
- Appropriate mechanisms to ensure that funding is directed to ensuring safe staffing levels;
- Mechanisms that ensure genuine accountability and transparency from aged care providers;
- A mandated requirement for minimum training and regulation of all staff, including a sufficient supply of registered nurses and nursing staff specialised in the delivery of aged care; and,
- A commitment from governments, providers and the community to improving care for the elderly.

They believe these changes must happen because, quite simply,

***"The elderly deserve a whole lot better."***

# Attachment C

# Management of Medicines in Aged Care

## Nursing Guidelines

Australian Nursing & Midwifery Federation

Nursing Guidelines: Management of Medicines in Aged Care

Author: Australian Nursing and Midwifery Federation (ANMF).

Prepared by Julianne Bryce and Elizabeth Foley, ANMF Federal Professional Officers

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## Index

## Foreword

The review of the *Nursing Guidelines: Management of Medicines in Aged Care* has been a collaborative project between the Australian Nursing and Midwifery Federation (ANMF) and Royal College *of* Nursing *Australia* (RCNA). Now published by the ANMF, this document aims to ensure the safe and competent delivery of medicines to older people.

The *Nursing Guidelines* provide support and direction for registered and enrolled nurses[1] in the administration of medicines in aged care[2]. These guidelines inform providers, consumers and families, medical practitioners, pharmacists, and allied health professionals of the expectations of registered nurses, enrolled nurses and assistants in nursing (however titled), in quality use of medicines.

The guidelines also establish the quality of care to which consumers of aged care services and the community are entitled, in relation to the competent use of medicines by nursing professionals.

A review of this document has been undertaken to ensure currency and relevance to both aged care and to nursing practice.

While this edition is primarily focused on care provided in residential aged care settings, it is also applicable to aged care services provided in the community.

**Lee Thomas**
Federal Secretary
Australian Nursing and Midwifery Federation

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1 Enrolled nurses have completed the education to allow them to administer medicines. Those who are not educated to this level will have a condition on their registration which prohibits them from administering medicines.

2 Aged care settings include residential facilities and the community setting.

## Background

Safe, quality care, reinforced by accreditation and funding requirements for aged care facilities, demands a safe medicines delivery system. As stated in previous editions of these *Nursing Guidelines* (APAC, 2002), registered or enrolled nurses, in consultation with medical practitioners and pharmacists, are the appropriate professionals to administer medicines to older people who are unable to self-administer their medicines. Management of medicines by appropriately qualified health professionals gives greater assurance of quality use of medicines.

**Registered nurses** are educated to be aware of the benefits and potential hazards in the use of medicines and to administer medicines safely and legally, as well as to monitor their efficacy and identify any adverse effects. Additionally, registered nurses have the necessary skills to assess the changing needs of the older person and their care; evaluate the person's response to medicines; and accurately communicate that information. In this way, registered nurses provide a vital link between the older person and other health professionals such as medical practitioners, pharmacists, enrolled nurses and allied health professionals.

**Enrolled nurses** work under the direction and supervision of registered nurses and practice within legislative and regulatory requirements. Under the *Health Practitioner Regulation National Law Act 2009* (the National Law), all enrolled nurses may administer medicines except for those who have a notation on the register against their name which reads 'Does not hold Board-approved qualification in administration of medicines' (NMBA, 2010). Employers and facility staff need to be aware of national legislation and state and territory drugs and poisons legislation relating to enrolled nurses and medicines administration, as well as professional scopes of practice.

The role of **assistants in nursing** (however titled) in medicines use is that of assisting older people with self-administering their medicines from pre-packaged dose administration aids. They should not be directed by employers or facility staff to practice outside of this role.

The following practices pose risks to quality use of medicines:

- polypharmacy and the excessive use of tranquillisers and psychotropic agents;
- lack of processes for medicines review; and
- the administration of medicines by unqualified or inappropriately qualified staff.

Registered and enrolled nurses are increasingly concerned that in some circumstances assistants in nursing (however titled) and other unqualified or inappropriately qualified care workers are being directed to administer medicines to residents in aged care facilities.

While unqualified or inappropriately qualified care workers *can* be made aware of correct procedure for medicines delivery, they do not have the necessary education and knowledge required for making clinical judgements on *why* they are administering a medicine or *when* not to administer. It is for this reason that medicines administration by unqualified or inappropriately qualified staff has the potential for error and possible dire consequences. Without the necessary education, staff will be unable to identify side effects or adverse reactions requiring intervention.

Adequate resources should be made available by both governments and service providers of aged care to ensure medicines are able to be administered safely and within legislative requirements.

## 1. Introduction

While medicines make a significant contribution to the treatment of ill health, the prevention of disease, increasing life expectancy and improving health outcomes, they also have the potential to cause harm. The quality use of medicines requires that the appropriate medicine is prescribed; that it is available at a price the individual can afford; and that it is prescribed, dispensed and administered correctly. The goal of any medicines service for older people is to promote quality of life.

Age-related changes in physiology affect the manner in which the body responds to and metabolises medicines. In addition to pharmacokinetic changes that occur as a result of normal healthy ageing, the effects of pathology must also be considered. A significant number of older people suffer from more than one chronic illness. The concurrent use of multiple medicines (or polypharmacy) occurs due to co-morbid chronic disease processes and is characterised by complex medicine regimens which can have equally complex interactive patterns. This makes evaluation of adverse drug reactions difficult, particularly as the incidence of these reactions increases with age.

Polypharmacy also increases the risk of adverse medicines events such as falls, confusion and functional decline. Older people are more likely to experience poor vision, hearing and memory loss and have altered metabolic rates, such as declining renal function. Changes in physiology, as well as to social and physical circumstances, can also contribute to the risk of adverse medicines events in older people. However, adverse reactions may go undetected because symptoms may be similar to problems associated with older age such as forgetfulness, weakness or tremor. Adverse reactions may also be misinterpreted as a medical condition and lead to the prescription of additional medicines.

These altered pharmacokinetic and pharmacodynamic changes associated with age and polypharmacy in older people require the specific pharmacological knowledge and skills of medical practitioners, pharmacists, registered nurses and enrolled nurses. The following are best practice guidelines for registered nurses and enrolled nurses in medicines management in aged care and are regarded as **minimum** standards for safe care and competent practice.

The **overriding principles** on which these best practice guidelines are based are as follows:

a) all persons receiving aged care services have the right to quality use of medicines;

b) medicines have the potential for harm if not prescribed, dispensed and administered correctly;

c) the right medicine in the right dose must be administered to the right person at the right time by the right route;

d) all medicines administration should be documented;

e) the person administering the medicine/s must know when and how to administer the medicine/s, why to administer, and when not to administer; and

f) the person administering the medicine/s must be able to recognise adverse effects and respond appropriately, including reporting any adverse effects to the registered nurse or prescribing practitioner.

## 2. Rights of older people

2.1 Every person receiving aged care services is entitled to quality use of medicines through:

a) ongoing assessment by a health professional who is qualified to assess the physical, mental and socio-emotional status of the person and the ways in which medicines may affect them;

b) care from a health professional who is able to exercise clinical judgement with regard to medicines, integrating physical, mental and behavioural assessment with relevant contextual variables;

c) care by a health professional who is competent to act alone with regard to medicines in a situation where medical advice is not available;

d) care by a health professional who is able to collaborate with the person prescribing medicines (the prescribing practitioner) regarding the appropriateness of medicines in response to the older person's changing physical, mental and behavioural needs;

e) care by a health professional who is skilled and experienced in communicating with the older person, their families and other health personnel with regard to medicines;

f) care by a health professional who is skilled and experienced in teaching and assisting the older person and their families to use medicines in a way which enhances quality of life, and promotes the safe use of medicines; and

g) care by a health professional who recognises the dynamic nature of the older person's health status and is constantly evaluating the need for a response to any health status change.

2.2 Recipients of aged care services have a right to:

a) consent, or refuse consent, to a medicine;

b) management of medicines by appropriately qualified health professionals;

c) manage their own medicines regimen where possible;

d) regular review of their medicines regimen by appropriately qualified health professionals;

e) confidentiality in relation to their medicines regimen;

f) a medicines storage system which maintains their privacy as well as the efficacy and security of their medicines;

g) education, counselling and advocacy in relation to their medicine/s use;

h) the administration of medicines by appropriately qualified registered nurses and enrolled nurses in a manner which maintains personal dignity and safety;

i) know which pharmacist is dispensing their medicines; and

j) nominate their preferred pharmacist.

2.3 All older people have a right to a medicines regimen that is characterised by regular reviews and re-issuing of their medicines instructions by their treating and prescribing practitioner. Regular reviews should address issues of polypharmacy. It is the prescribing practitioner's responsibility to ensure that such reviews and instructions are attended at regular intervals or in accordance with state or territory legislative or regulatory requirements.

## 3. Service provider's responsibilities

3.1 Aged care service providers have a responsibility to ensure quality use of medicines by:

a) employing registered nurses and appropriately qualified enrolled nurses to safely undertake the management, administration and (where appropriate) review of medicines;

b) providing resources to enable the medicines and the medicines chart to be available at the time and place of administration of the medicines. This may include use of the *National Residential Medication Chart* (NRMC)[1] and the *National Interim Residential Medication Administration Chart* (NIRMAC)[2] where these are legally permissible in the state or territory;

c) providing current medicines information (for example, on-line medicines information), which includes the name of each medicine, the schedule, the reason for its use in particular circumstances, the expected outcomes, contraindications for use, and possible side effects;

d) providing staff with current information and education on relevant drugs and poisons legislation and regulation;

e) providing registered nurses and appropriately qualified enrolled nurses with regular education regarding current trends in the use of medicines for older people and in specific age related health conditions;

f) providing a system for documentation of all medicines administration and medicines incidents where errors are accurately reported, assessed, and remedial action taken in a timely manner; and

g) providing a system of safe storage for all medicines, including those being self-administered by older people in residential aged care settings, which complies with relevant legislation and regulation.

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1 www.medicareaustralia.gov.au/provider/pbs/fifth-agreement/supply_and_pbs_claiming.jsp

2 www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/national-interim-residential-medication-administration-chart/

3.2 Aged care service providers have a responsibility to ensure there are written policies and protocols, which reflect relevant legislative and regulatory requirements and which include:

a) the specific responsibilities of each health professional involved in medicines management, including the provision of information, prescribing, dispensing, administration, storage, disposal, and evaluation;

b) an acknowledgment of the arrangement of medicines into schedules, by clearly stating the organisation's policy, consistent with relevant legislation for each applicable division of the schedule, with particular and separate requirements for drugs of addiction and other restricted substances;

c) the specific requirements for the different routes of medicines administration;

d) the mechanism by which each older person can be correctly identified (for example, names or photographs); and

e) the mechanism by which medicines and medicines charts can accompany older people throughout the continuum of their care across a range of settings: if they are discharged from acute care; if they are receiving care in a community setting; if they are transferred to another facility, including a hospital; or if they are usually in residential care but are absent from the facility for any reason. This could be achieved by use of the *National Interim Residential Care Medication Administration Chart* (NIRMAC) where this is legally permissible in the state or territory.

3.3 Aged care service providers have a responsibility to provide medicines charts which contain:

a) the older person's identifying information;

b) a record of allergies or medicines sensitivities;

c) the consent of the older person or their representatives to their medicines regimen (where possible);

d) the name, strength, dose, route and frequency of the medicine/s;

e) the date of commencement of a medicine/s and duration where applicable;

f) an identified space for the signature of the prescribing practitioner (unless using the NIRMAC where this is permissible in the state or territory; and

g) the date of the medicines review.

## 4. Medicine advisory committee

4.1 Each aged care service should have a medicines advisory committee, whose objectives are to develop, promote, monitor and evaluate activities which support quality use of medicines.

Such a committee should include:

- a nurse practitioner (where available);
- registered nurses - more than one position whenever possible (for example, Director of Nursing, Clinical Nurse Consultant, registered nurse) due to the extensive role they play in medicines administration;
- a medical practitioner;
- a pharmacist;
- a representative of the aged care provider; and,
- a consumer representative/s.

4.2 The responsibilities of the medicines advisory committee should include:

a) promotion and support of intra and interdisciplinary communication, collaboration and co-operation;

b) development and review of medicines policies and protocols;

c) development and review of a list of medicines, including unscheduled substances, able to be initiated by registered nurses;

d) maintenance of a register of incidents or errors related to medicines to enable analysis on trends and action taken;

e) monitoring of compliance to medicines policies and protocols;

f) monitoring of compliance to the review of older person's medicines regimens;

g) the review of medicines usage generally within the facility;

h) provision of advice on the implementation of national policies and relevant legislation and regulation;

i) implementing and overseeing education programs related to quality use of medicines; and

j) implementing and overseeing medicines quality improvement activities.

4.3 All activities of the committee must comply with requirements of the *Privacy Act 2001* and the privacy principles outlined in the Act.

## 5. Prescribing

5.1 Medicines should not be administered without a legible, signed and dated instruction from the prescribing practitioner, including: a nurse practitioner; medical practitioner; or dental practitioner, in the aged care service's designated medicines chart (this includes prescribing by electronic means).

Such instructions include:

a) full name of the older person;

b) name and strength of the medicine/s;

c) dose, route and frequency of the medicine/s; and

d) date of commencement and duration where applicable.

5.2 The *National Interim Residential Care Medication Administration Chart* may be used where this is permissible in the state or territory.

## 6. Dispensing and supply

6.1 Each aged care service should have access to a community pharmacist who can provide a medicines service, which includes:

a) the dispensing and supply of medicines;

b) the provision of information and advice;

c) involvement in medicines education for the older person, health professionals and staff;

d) involvement in the medicines advisory committee; and

e) involvement in relevant quality improvement activities.

## 7. Management of medicine regimens

### 7.1 Administration

The registered nurse is the appropriate person to manage the medicines regimen for the older person receiving aged care services and is key to quality use of medicines in aged care. Registered nurses are educated and competent to understand the therapeutic action of medicines, including the reason for their use, the effects of their use and to recognise adverse reactions and respond appropriately. Registered nurses use clinical judgement to assess whether medicines should be administered or withheld with regard to the consumer's health and family history, diagnosis, co-morbidities and health status. Under the supervision of registered nurses, enrolled nurses also administer medicines unless there is a notation on their registration to the contrary.

### 7.2 Consent

Every individual, or their representative, has the right to consent, or refuse consent, to a medicine. Any refusal of medicines, even medicines which are self-administered, must be documented in the medicines chart, and the registered nurse in charge and the prescribing practitioner advised. The treating medical practitioner, prescribing practitioner (if different) and aged care service provider should also be notified so appropriate intervention can be undertaken if required.

The registered nurse is able to provide information and education to individuals to encourage compliance. The registered nurse exercises professional judgement in assessing non-compliance and recommending appropriate interventions.

### 7.3 Self administration

When an older person has been assessed by a registered nurse and prescribing practitioner as capable of safely administering their own medicines, the individual should be enabled to do so, within written policies and protocols. Assessment that the older person may self-administer their medicines should be documented in their health record and/or medicines chart. Persons other than registered nurses or enrolled nurses, such as enrolled nurses not authorised to administer medicines or assistants in nursing (however titled), may **only** assist the older person to self-administer their medicines.

All medicines administration should be documented, including self-administered medicines. Secure storage of medicines for self-administration must be provided. This is the responsibility of the aged care service provider.

### 7.4 The role of the registered nurse and enrolled nurse

7.4.1 Enrolled nurses may administer medicines unless there is a notation on their registration to the contrary. They must comply with relevant state and territory legislative requirements, and be covered by written organisational policies and protocols. Enrolled nurses work under the direction and supervision of registered nurses. At all times, the enrolled nurse retains responsibility for their actions and remains accountable to the registered nurse for all delegated functions.

7.4.2 Registered nurses may delegate medicines administration to appropriately qualified enrolled nurses, having regard to state/territory legislation and regulations and the Nursing and Midwifery Board of Australia (NMBA) policies, standards and guidelines.

7.4.3 Registered nurses and enrolled nurses have a duty of care to older persons receiving aged care services, are accountable for their actions within legislation and regulation, and have a professional responsibility within national nursing codes of professional conduct, codes of ethics and standards for practice.

7.4.4 In order to ensure safe care and competent practice, registered nurses and enrolled nurses must be provided with the resources and an appropriate environment to fulfill their responsibilities according to these best practice medicines management guidelines.

7.4.5 The role of the registered nurse and enrolled nurse includes:

a) administration of medicines;

b) supervision of individuals who are self-administering medicines;

c) recording of any medicines administered, withheld or refused;

d) compliance with legislative requirements and organisational policies and protocols, in particular, medicine incident and error recording and reporting requirements;

e) participation in medicines quality improvement activities;

f) maintenance of competence, contemporary knowledge and skills in relation to pharmacology and health assessment; and

g) a knowledge of pharmacokinetics, pharmacodynamics and pharmacogenetics, as well as polypharmacy issues for older persons.

7.4.6 Additionally, the role of the registered nurse in relation to quality use of medicines includes:

a) assessment of the health status of the older person;

b) exercising decision making skills and professional judgement in relation to medicines use, including knowing why to administer, how to administer, when to administer, when not to administer, and when to report or refer to a medical practitioner, other prescribing practitioner, such as a nurse practitioner, or a pharmacist;

c) coordination, implementation, supervision, ongoing monitoring and evaluation of safe medicines administration practices;

d) monitoring and evaluation of medicines use, including reporting and recording of reactions to medicines and the initiation of required interventions in consultation with medical practitioners or other prescribing practitioners, and pharmacists;

e) monitoring and encouragement of compliance with medicines use;

f) consideration of utilisation of nursing interventions which do not involve medicines use, particularly in relation to medicines ordered 'when required', or in the situation where consent to medicine use has not been given or has been withdrawn by the older person;

g) provision of information and education to consumers of aged care services in relation to medicines use;

h) provision of education to carers, other health care workers and students in relation to all aspects of medicines use;

i) provision of advocacy on behalf of consumers of aged care services in relation to all aspects of their use of medicines; and

j) delegation of medicines administration to enrolled nurses.

7.4.7 No medicine is to be administered to an older person unless it has been prescribed by a prescribing practitioner and dispensed by a pharmacist into an individual container or pack labelled with the person's name, the name and strength of the medicine and the dosage, frequency and route of administration. The only exception is for nurse initiated medicines, given in accordance with legislative regulation and organisational policy, for example, paracetamol, glycerine suppositories, coloxyl or coloxyl with senna.

If registered and enrolled nurses are administering medicines from a Dose Administration Aid (DAA), which can consist of an individualised medicine regimen blister pack, bubble pack or sachet, then the DAA must be packaged and fully labelled by a pharmacist. Nurses take responsibility for identifying each individual medicine to be given, prior to administration. Registered and enrolled nurses must not administer from DAA's where individual medicines cannot be clearly identified. Where this occurs, nurses must consult the pharmacist and return the DAA to them for repackaging.

7.4.8 Ideally medicines must be administered to older persons from their own dispensed medicine containers (see 7.4.7). The nurse who removes the medicine from the dispensed medicines container must also administer the medicine to the person and sign the medicines chart at the time of administration.

7.4.9 Medicines dispensed for one person must not be administered to any other person.

7.4.10 All medicines must be administered with consideration for infection control and standard precautions principles.

7.4.11 Work health and safety principles must be observed during medicines administration.

7.4.12 In addition to regular reviews by the prescribing practitioner of each person's medicines regimen, the registered nurse will exercise clinical judgement to determine if more frequent reviews, or instructions, are required.

7.4.13 Questions or concerns of the nurse regarding a person's medicines must be directed to either the prescribing practitioner or the pharmacist prior to administration.

### 7.5 The role of the nurse practitioner

Nurse practitioners are authorised to prescribe medicines and must meet the same standard of care that applies to medical practitioners and dentists. In aged care settings nurse practitioners have an important role in educating service providers, consumers and other nurses about quality use of medicines; and, being involved in quality improvement activities, including the review and evaluation of medicines systems.

### 7.6 'When required' (PRN) medicines

'When required' or PRN medicines are those which are ordered by a prescribing practitioner for a specific person and recorded on that person's medicines chart to be taken only as needed. The registered nurse, using clinical judgement, initiates, or delegates to an enrolled nurse to administer the medicine/s, when necessary. The administration of PRN medicines must be recorded on the person's medicines chart.

### 7.7 Nurse initiated medicines

Registered nurses may use their clinical assessment and judgement to initiate, or delegate to an enrolled nurse in certain circumstances, Schedule 2 (S2) medicines, in accordance with their state or territory legislation and organisational guidelines. When deciding to initiate a medicine for a person the nurse should consider the context of the resident's total daily medicines regimen, any known allergies or previous adverse medicines events or adverse drug reactions experienced by that person. All adverse medicines events or adverse drug reactions should be reported in accordance with the service provider's policy. The policy should specify that any doses of nurse-initiated medicine administered to a person should be recorded in a document that is accessible to other health care professionals and care workers. This documentation should include comment on the outcome of the medicine. A record of any nurse initiated medicines should also be included on the person's medicines chart.

## 7.8 Standing orders

Standing orders, covering Schedule 4 (S4), Schedule 8 (S8) medicines and other restricted substances, may be written by a prescribing practitioner for the administration of a medicine to an individual in the case that a particular circumstance arises. Currently all medicines in aged care services (with the exception of nurse initiated medicines detailed in 7.7) are dispensed for individuals on the written instructions of the prescribing practitioner, including: a nurse practitioner, medical practitioner, or dental practitioner. The absence of general stocks of S4, S8, or other restricted substances in aged care services makes the use of standing orders for the administration of these medicines in aged care services, inappropriate. Where standing orders are required in special circumstances in the community, service providers should have policies and procedures in place for their use.

Standing orders must be in accordance with state and territory drugs and poisons legislation.

## 7.9 Emergency medicine instructions

7.9.1 In an emergency, a medicine instruction may be given by telephone, facsimile or by email. Emergency medicines instructions are only for emergency use.

These instructions are not an acceptable substitute for a comprehensive medicines policy for the regular and routine management of medicines which is responsive to predictable changes in medicines requirements.

7.9.2 The registered nurse or enrolled nurse taking an emergency medicine instruction by:

- *telephone*, should verify the prescriber, write the instruction in permanent ink directly onto the person's medicines chart, confirm the instruction with the prescriber, and sign and date the chart. Best practice requires a second nurse be present to check the instruction with the prescriber.

Any emergency telephone medicines instruction must be confirmed in writing by the prescribing practitioner. It is the responsibility of the prescribing practitioner issuing an emergency telephone medicines instruction to notify the pharmacist, and to confirm the emergency medicines instruction in writing within 24 hours, or according to the requirements of state or territory legislation.

- *facsimile or email*, should write the instruction directly onto the person's medicines chart in permanent ink, and sign and date the chart. The facsimile or email should be placed in the person's medicines chart.

### 7.10 Monitoring

7.10.1 Registered nurses and enrolled nurses have a professional responsibility to participate in medicines audits as a part of routine quality improvement activities.

7.10.2 Registered nurses and enrolled nurses have a professional responsibility to report misuse or misappropriation of medicines. Organisations should have in place written policies and protocols which clearly identify the process by which this is to be undertaken, and the expected outcomes.

### 7.11 Evaluation

Registered nurses and enrolled nurses should monitor each person receiving a medicine/s, and exercise professional judgement to:

a) evaluate all medicines use for appropriateness, unwanted side effects, allergies, toxicity, medicines intolerance, medicines interactions and adverse reactions, and document and report them; and

b) ensure that medicines instructions are regularly reviewed for each individual, in conjunction with the provider of aged care services, the prescribing practitioner and the pharmacist.

### 7.12 Non prescription and unscheduled substances

7.12.1 An individual has the right to request a non-prescription substance, including herbal, homeopathic, non-Australian manufactured and 'over the counter' S2, S3, and unscheduled substances.

7.12.2 Older people and their carers have a responsibility to inform health professionals of all medicines being taken, including complementary, alternative or self-prescribed medicines.

7.12.3 The registered nurse or enrolled nurse should identify these medicines on the person's medicines chart.

7.12.4 It is important that the ingredients contained in the non-prescription substance are assessed by the prescribing practitioner and the pharmacist to determine compatibility with other medicines being taken by the person. The prescribing nurse practitioner, medical practitioner, or dental practitioner must document endorsement of the use of such substances in writing on the medicines chart.

7.12.5 The registered nurse or enrolled nurse should:

a) not initiate, supply or administer non-prescription substances unless they have been approved in writing by the prescribing nurse practitioner, medical practitioner or dental practitioner or included in the list of nurse-initiated medicines by the medicines advisory committee; and

b) document the use of any such substances.

## 8. Documentation

8.1 All medicines administration must be documented in the medicines record or chart. Such documentation should occur simultaneously with administration and be legible, accurate and meet legislative and organisational requirements, as well as any specific policy requirements of the facility.

8.2 The medicines chart should contain at a minimum the complete name and date of birth of the older person, and, where possible, a current photograph for identification purposes. Older people with similar or the same names must have alerts written on their charts.

8.3 The medicines chart should have a separate section for PRN medicines; nurse-initiated medicines; once only doses of medicines; medicines which are self-administered by the individual; any complementary, alternative or self-prescribed medicines being taken; and emergency telephone/facsimile/email instructions. The medicines chart should also note any allergies or previous adverse drug reactions; and indicate when medicines review is required.

8.4 If alternative methods of administering medicines are appropriate, for example, crushing or dispersing tablets, this should also be indicated on the medicines chart. Nurses should be aware of the medicines which can or cannot be reconstituted for administration. (SHPA, 2011)

8.5 The transcription of medicines orders increases the margin for error, and should only be carried out where it is supported by legislation and organisational policies and protocols.

## 9. Dose administration aids

9.1 A Dose Administration Aid (DAA) may consist of a blister pack, bubble pack or sachet system. These were developed to make it easier for the older person to **self-administer** their medicines by arranging the medicines into individual doses according to the prescribed dose schedule. Assistants in nursing (however titled) may only **assist** the older person to **self-administer** their own medicines.

9.2 Assessment of a person who is likely to benefit from the use of a DAA should be undertaken by the prescribing practitioner in collaboration with other members of the medicines team who may include: nurse practitioner, registered nurse, medical practitioner, and pharmacist.

9.3 Confirmation that a person is competent to self-administer their medicines using a DAA should be documented in the person's health record and/or their medicines record, by the prescribing practitioner.

9.4 Where the person is not self-administering medicines, a registered nurse or enrolled nurse should administer **all** medicines (whether by use of a DAA or not).

9.5 DAAs are not intended to give direction to the person administering the medicine as to why a particular medicine is being administered, when not to administer the medicine, nor information about the appropriateness of a particular medicine, including: toxicity, intolerance, interactions and potential adverse reactions.

9.6 DAA packaging should ensure that:

- individual medicines can be readily identified,
- information is of a size and layout that permits people with poor eyesight to read,
- the quality and integrity of the medicines for each time slot is preserved,
- medicines cannot become mixed with those not yet due, and
- any tampering with the medicines is evident.

9.7 As per 7.4.7 the DAA should be packaged and fully labelled by a pharmacist.

9.8 If the prescribing practitioner alters the medicine instruction for a person and the medicines are being administered from a DAA, the DAA must be returned to the pharmacist for repackaging, at the time of the medicines change.

9.9 As per 7.4.7 all medicines administration by a registered nurse or enrolled nurse to an individual should, ideally, be from the original dispensed container. If registered nurses and enrolled nurses are administering medicines from a DAA, the DAA should be packaged and fully labelled by a pharmacist. These nurses take responsibility for identifying each individual medicine prior to administration. Registered nurses and enrolled nurses must not administer from DAA's where individual medicines cannot be clearly identified; there is evidence of tampering with the packaging; or, there are signs of deterioration of medicines (such as changes in colour or disintegration of the medicine/s). Where any of these occur, nurses must consult the pharmacist and return the DAA to them for repackaging.

## 10. Compartmentalised medicine box

In special circumstances where a registered nurse needs to provide medicines for the older person in a compartmentalised medicines box [dosette box], to self-administer, then they should only fill the box where:

a) this is permitted by state or territory law;

b) the person requiring the medicine is competent to self-administer. (It is recommended that no more than a seven day supply be provided in this way at any one time);

c) the medicines are from the person's dispensed medicines; and,

d) the box is then labelled with the:

- full name of the person;
- name and strength of the medicine;
- dose, route and frequency of the medicine; and
- date of commencement and the duration where applicable.

A registered nurse must not fill a compartmentalised medicines box with a person's own medicines for either themselves or another worker to administer. The purpose of filling the compartmentalised medicines box is for the older person to **self-administer** these medicines.

## 11. Storage

11.1 The provider of aged care services is responsible for ensuring there is provision for all medicines to be securely stored in a manner that meets legislative and manufacturer's requirements, which protects the individual's safety and privacy, and promotes the safety of staff. This may be in a cupboard or other designated area which should be locked and secure, when not in use. The provision of an alarm system should be considered.

11.2 Some medicines will need to be kept refrigerated. These should be kept in a secure refrigerator, only used for medicines. The refrigerator should be kept at correct temperature, which is monitored regularly.

11.3 The registered nurse in charge should be in possession of the keys to the medicines cupboard or other designated area, at all times while on duty.

## 12. Disposal

12.1 There must be a mechanism in place for the disposal of returned expired and unwanted medicines.

12.2 Medicines belonging to a person who is deceased, or any medicines that are out of date or discontinued should be returned to the pharmacist, or collected by the pharmacist, for disposal. S8 medicines must be disposed of according to legislative requirements.

## 13. Information

13.1 Older people have the right to information about their medicines regimen at their level of understanding, which takes into account any specific disability (such as visual impairment, poor literacy), and which is in their language of choice, using an interpreter if necessary.

13.2 The prescribing practitioner has the primary responsibility for informing the individual about their medicines regimen. However, the provision of information and education to older people in relation to their medicines is also a function of other members of the medicines team including the nurse practitioner, medical practitioner, pharmacist, registered nurse and enrolled nurse.

13.3 Consumer Medicine Information (CMI) should be made available to each individual in relation to their medicines - for each new medicine and when medicines are reviewed. Written policies and protocols should be in place to identify the process by which this is to be achieved. The responsibility for the provision of CMI rests with the prescribing practitioner and/or the pharmacist . Nurses should have ready access to CMI. Consideration should be given to computer linked CMI to facilitate access and ensure accuracy.

## 14. Quality Improvement

14.1 Formal quality assurance programs must be established which are able to:

a) evaluate the degree to which best practice standards have been met;

b) evaluate the satisfaction level of those involved in the delivery of medicines (individual, provider of aged care services, nurse practitioner, pharmacist, medical practitioner, registered nurse and enrolled nurse); and

c) make recommendations for better practice.

## References


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## Additional Resources

Australian Nursing Federation relevant policies, position statements and guidelines. Available from: http://anf.org.au/pages/anf-policies

Australian College of Nursing (formerly Royal College of Nursing, *Australia*) relevant position statements. Available from: http://www.acn.edu.au/position_statements

## Glossary

**Administration of medicines -** The process of giving a dose of medicine to a person (in this case a resident) or a person taking a medicine.

**Assistant in nursing (however titled), (AIN) -** An unlicensed health care worker providing direct care in the aged care environment. **Some** workers may have completed vocational training. They are supervised by the registered nurse and are accountable to both the registered nurse and their employer for delegated actions.

**Dose administration aid (DAA) -** A device or packaging system such as blister packs, bubble packs or sachets for organising doses of medicines according to the time of administration, which has been prepared and labeled by a pharmacist.

**Compartmentalised medicine box -** A reusable device that is usually filled by the user or a carer (family member); sometimes filled by qualified health professionals. There are many varieties, with one, two or four compartments for each day of the week. Some devices have the days and times labelled in brail for people with vision impairment. Some contain a built in alarm that can be set to remind the user when it is time to take their medicines. Unlike other types of device, these are usually not tamper-evident.

**Consumer Medicine Information (CMI) -** Brand-specific leaflets produced by a pharmaceutical company in accordance with the Therapeutic Goods Regulations to inform consumers about prescription and pharmacist-only medicines. Available from a variety of sources, for example, enclosed with the medicine package, supplied by a pharmacist as a leaflet or computer printout, provided by a doctor, nurse or hospital, or available from the pharmaceutical manufacturer.

**Consent -** The procedure whereby a person consents to, or refuses, an intervention based on information provided by a health care professional regarding the nature and potential risks (consequence and likelihood) of the proposed intervention.

**Enrolled nurse (EN) -** A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Nursing and Midwifery Board of Australia to practice as an Enrolled Nurse, under the *Health Practitioner Regulation National Law Act 2009*, and its Regulations.

**Medicine advisory committee (MAC) -** A group of advisors to the Residential Aged Care Facility (RACF) who provide medication management leadership and governance, and assist in the development, promotion, monitoring, review and evaluation of medication management policies and procedures that will have a positive impact on health and quality of life for residents.

**Nurse Practitioner (NP) -** A registered nurse endorsed by the Nursing and Midwifery Board of Australia to function autonomously and collaboratively in an advanced and extended clinical role as a Nurse Practitioner, under the *Health Practitioner Regulation National Law Act 2009*, and its Regulations.

**'When required' (PRN) medicines -** are those which are ordered by a prescribing practitioner for a specific person and recorded on that person's medicine chart to be taken only as needed.

**Quality use of medicines (QUM) -** The National Strategy for Quality Use of Medicines is part of the *National Medicines Policy* (2000). QUM involves selecting management options wisely, including non-medicine alternatives; choosing suitable medicines if a medicine is considered necessary; and using medicines safely and effectively to get the best possible health results.

**Registered nurse (RN) –** A person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered by the Nursing and Midwifery Board of Australia to practise as a Registered Nurse, under the *Health Practitioner Regulation National Law Act 2009*, and its Regulations.

**Self-administration of medicines –** where a person administers their own medicines. They must be assessed by a registered nurse and prescribing practitioner as capable of safely being able to self-administer, and this must be within written policies and procedures.

**Standing orders -** Legal written instructions for the administration of medicines by an authorised person. The authorised person must have a valid and current written instruction for the specific use of the standing order. A standing order is NOT the same as a 'When required" (PRN) order.

For additional definitions refer to:

Australian Government, Department of Health and Ageing. 2012. *Guiding principles for medication management in residential aged care facilities.* Commonwealth of Australia. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-pdf-resguide-cnt.htm