High Care Residential
Aged Care Facilities in Victoria

Report of the
Ministerial Advisory Committee
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Acknowledgements

The members of the Ministerial Advisory Committee on High Care Residential Aged Care Facilities in Victoria would like to thank all of the people who provided input into the deliberations of the Committee.

This includes special thanks to the many people who prepared submissions and participated in discussions and focus groups with Committee members from July to September 2000.

This report was prepared for the Minister for Aged Care, the Honourable Bronwyn Pike, MP.
# Contents

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>iii</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Abbreviations</td>
<td>vii</td>
</tr>
</tbody>
</table>

## 1. Introduction

1.1 Establishment of the Ministerial Advisory Committee
1.2 Terms of Reference
1.3 Workings of the Ministerial Advisory Committee
1.4 Outline of the Report

## 2. Consultation Process

2.1 Written Submissions
2.2 Verbal Submissions
2.3 Focus Groups

## 3. Themes and Issues Arising from the Consultations

3.1 Need for Regulation
3.2 Related Workforce and Training Issues
3.3 Information Requirements
3.4 Complaints
3.5 Centres of Excellence and Research
3.6 Ageing in Place
3.7 Image of the Residential Aged Care Sector
3.8 Advocacy Services
3.9 Other Issues

## 4. Examination of Policy Proposals

4.1 Staffing Regulations in High Care Facilities
4.2 Information for Consumers and Carers

## 5. Other Areas Considered for Action

5.1 The Aged Care Workforce
5.2 Research and Centres of Excellence

## Appendices

One - Members of the Ministerial Advisory Committee
Two - Terms of Reference
Three - List of Written Submissions Received
Four - Consultations and Focus Groups
List of Abbreviations

AAV    Alzheimer’s Association of Victoria
ACAS   Aged Care Assessment Service
AMA    Australian Medical Association
ANF    Australian Nursing Federation
ANHECAAustralian Nursing Home and Extended Care Association
(now known as Aged Care Association of Victoria)
CACP   Community Aged Care Package
CAM / SAMCare Aggregate Module/ Standard Aggregate Module
COTA   Council on the Ageing
CSTP   Community Services Training Package
DHS    Department of Human Services (Victoria)
DHAC   Department of Health and Aged Care (Commonwealth)
DON    Director of Nursing
ECCV   Ethnic Communities Council of Victoria
HSUA   Health Services Union of Australia
NA     Nursing Assistant
NBV    Nurses Board of Victoria
OETTE  Office of Employment, Training and Tertiary Education (Victoria)
OPAC   Older Persons Action Centre
PCA    Personal Care Attendant
RCS    Resident Classification Scale
RN     Registered Nurse
TAFE   Technical and Further Education
VAHEC  Victorian Association of Health and Extended Care
VET    Vocational Education and Training
VHA    Victorian Healthcare Association
1 Introduction

This report is presented to the Minister for Aged Care, the Honourable Bronwyn Pike MP, by the Ministerial Advisory Committee on High Care Residential Aged Care Facilities in Victoria and represents the deliberations of the Committee.

Although there were divergent views on the appropriate level of State Government regulation in Commonwealth-funded high care residential facilities, all Committee members were committed to involvement in this process and to exploring the issues raised.

1.1 Establishment of the Ministerial Advisory Committee

The Minister for Aged Care established the Ministerial Advisory Committee on High Care Residential Aged Care Facilities in Victoria (referred to as the Committee) in February 2000. The Minister asked the Committee to advise her, amongst other matters, on whether there were gaps in the Commonwealth regulatory framework for high care residential aged care facilities (formerly known as nursing homes) and whether the State Government should address these gaps through the introduction of its own regulations.

In establishing the Committee, the Minister aimed to stimulate discussion about ways of increasing confidence in residential aged care services among older people and their carers.

To identify effective strategies that would not duplicate the Commonwealth Government’s role, the Victorian Government decided to consult with key stakeholders and the broader community. The Committee was convened to oversee these consultations and to provide expert advice.

The Minister for Aged Care invited members representing various parts of the residential aged care sector to serve on the Committee. Membership comprised:

- Consumer and carer advocates (Council on the Ageing, Older Person's Action Centre, Alzheimer's Association of Victoria, Carers Victoria, Ethnic Communities Council, Residential Care Rights Victoria, and the Health Services Commissioner).
- Peak Industry bodies (Australian Nursing Home and Extended Care Association, Catholic Social Services, Victorian Association of Health and Extended Care, Victorian Healthcare Association).
- Union groups (Australian Nursing Federation, Health Services Union of Australia).
- Other stakeholders in the aged care sector (Aged Care Assessment Services, Australian Medical Association, and Directors of Nursing from two nursing homes).
- A representative of the Commonwealth Department of Health and Aged Care.
- Ms Colleen Pearce, Uniting Care Victoria, who chaired the Committee.

Secretariat support was provided by the Department of Human Services.
The inclusion of Committee members represented a broad range of stakeholders and reflected the Government's commitment to encouraging various interest groups to work in partnership to improve the quality of residential care services.

A list of Ministerial Advisory Committee members is at Appendix 1. Throughout the process some members were represented by a proxy.

1.2 Terms of Reference
The Committee's terms of reference (see Appendix 2) focused on examining gaps in the regulatory framework for Commonwealth-funded high care facilities. At the outset of the process, some Committee members expressed concern that the terms of reference were limited to high care facilities. In particular, Committee members expressed views that:

• High care residents in a low care facility (formerly known as hostels) would not be afforded the same level of protection as high care residents in a high care facility by any potential regulation.

• The application of possible regulations to high care facilities only was discriminatory within the residential aged care industry.

• With the implementation of ‘ageing in place’ in some facilities, the distinction between high and low care facilities was becoming less clear, making the application of potential regulations difficult and confusing for providers and consumers.

The Committee members agreed to work within the framework established by the terms of reference; however, they requested that these views be brought to the Minister's attention.

1.3 Workings of the Ministerial Advisory Committee

The Committee provided input into the development of a consultation paper, which was released publicly in July 2000 to stimulate discussion prior to regional consultations.

Views put to Committee members during the consultation sessions were considered by the full Committee and took into account:

• The level of community concern about the issues.

• Relevance to the Committee's terms of reference.

• Ways the State Government could play an effective role in addressing the issues of concern.

In addition to information obtained through the consultations, further information was requested from the Department of Human Services to assist the Committee's deliberations on particular issues.
In developing the recommendations contained in this report, the Committee considered:

- Whether the State Government was able to, and should, play a role to address the issues of concern.
- Whether the State Government and aged care industry could develop partnership arrangements to implement strategies.
- The most appropriate mechanisms to address the key issues which included staffing of high care facilities, the provision of information to consumers, and other forms of support for the residential aged care sector.

1.4 Outline of the Report

This report summarises the process undertaken by the Committee to reach its conclusions, discusses the issues considered by the Committee, and makes recommendations to the Minister for Aged Care.

Section 2 presents an overview of the public consultation process which sought views on the regulation of high care facilities.

Section 3 outlines the key issues raised during the consultation process. Although some of these issues fell beyond the Committee’s terms of reference—and in some cases are areas where it is not possible for the State Government to take action—members considered it important to note all of the main issues that emerged from the consultations.

Section 4 examines the deliberations of the Committee regarding the policy proposal on information requirements to better inform residents and their representatives of the numbers and qualifications of staff and on the issue of staffing regulations.

Section 5 contains an overview and recommendations on aged care workforce issues and other measures that aim to improve the quality of residential aged care facilities.
2 Consultation Process

The public consultation process commenced in July 2000 with the release of the consultation paper *High Care Residential Aged Care Services in Victoria*.

The consultation paper highlighted a range of issues on which the Committee specifically sought feedback. In line with the Committee's terms of reference, these areas were:

- Staffing.
- Provision of information by service providers to consumers and their families/careers.
- Complaints processes.
- Other areas where the State Government may be able to play a role.

The consultation paper also presented an overview of the aged care system and the Commonwealth Government's framework for regulating residential aged care facilities, and a summary of other regulatory approaches within Australia and overseas.

Submissions were invited from members of the public, service providers and industry peak bodies with an interest in the possible introduction of State Government regulation for high care residential aged care facilities in Victoria.

Responses to the paper were requested either in writing or during one of the planned consultation sessions in metropolitan and regional Victoria. Both verbal and written submissions could be made to the Committee on a confidential basis if required.

Three focus groups were held with groups that had been identified by members of the Committee as being unable or unlikely to participate in the formal consultation process. These focus groups targeted carers, people from culturally and linguistically diverse backgrounds, residents of aged care facilities and interested older people. Each of the focus groups was auspiced by one or more of the peak associations represented on the Committee.

2.1 Written Submissions

Written submissions were accepted until the end of August 2000 and more than 120 were received. The table below shows the main groups that provided submissions to the Committee.

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Residential Care Providers</td>
<td>28%</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>25%</td>
</tr>
<tr>
<td>Carers/ Family Members</td>
<td>13%</td>
</tr>
<tr>
<td>Peak Bodies</td>
<td>12%</td>
</tr>
<tr>
<td>Directors of Nursing</td>
<td>5%</td>
</tr>
<tr>
<td>Individuals</td>
<td>2%</td>
</tr>
<tr>
<td>Other Service Providers</td>
<td>2%</td>
</tr>
<tr>
<td>Educators</td>
<td>2%</td>
</tr>
<tr>
<td>Assessment Services</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
</tr>
</tbody>
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Of the total submissions, 14 were provided on a confidential basis. The ‘other’ category includes submissions from industry or professional groups who were not identified in the main categories or individual members of the public who did not identify themselves as belonging to a particular category.

Appendix 3 provides details of organizations and individuals that provided written submissions.

2.2 Verbal Submissions

Verbal consultations were held between 17–28 July 2000. Two or three Committee members were present at all sessions. To allow as many stakeholders as possible to be heard at these sessions, participants were asked to contact the Department of Human Services to book a time for a verbal submission.

Twelve sessions were held in eight locations in metropolitan and regional areas of Victoria. More than 70 people provided verbal presentations to the Committee at the sessions, with 21 submissions provided on a confidential basis. The profile of people who attended these sessions is summarised below:

- Nursing Staff 47%
- Residential Care Providers 18%
- Director of Nursing & Unit Managers 15%
- Carers/ Family Members 6%
- Educators 5%
- Peak Bodies 3%
- Assessment Services 2%
- Individuals 2%
- Other 2%

Appendix 4 provides a list of the locations and dates of sessions for verbal submissions.

2.3 Focus Groups

Targeted focus groups were held in August and September 2000 to seek the views of carers, people from culturally and linguistically diverse backgrounds, and older people who are currently living in residential aged care or who have an interest in residential care issues. Members of the Committee acted as convenors of the focus groups.

The main focus for discussion was a condensed list of the issues contained in the consultation paper.

Further details of the focus groups are provided in Appendix 4.
3 Themes and Issues Arising from the Consultations

Members of the Committee considered that they had been provided with valuable information and a range of different viewpoints during the consultation process. The Committee noted the level of concern expressed by participants, particularly at the verbal consultations, and that some people were very distressed about the problems perceived in the current residential aged care system. Carers who provided verbal submissions clearly articulated their experiences with the residential aged care system and made a number of suggestions about how carers could be assisted to better navigate the system.

The issues raised during the consultation process are discussed below.

3.1 Need for Regulation

All written and verbal submissions commented on staffing issues; however, there were different views about whether there were any gaps in the Commonwealth regulatory regime and, if so, what the most appropriate State Government response should be. Even among participants who supported additional regulation of staffing levels, there were differing opinions about whether the State Government should introduce its own regulations or whether its role should be to advocate for the Commonwealth to introduce additional regulation of residential aged care facilities.

In general, nurses and professional groups felt that additional regulation of staffing by the State Government was required, while most providers of nursing home care were opposed to regulation. However, points of view on this issue were not simple or clear-cut. For example, a small number of providers—while being generally against additional regulation—indicated that the presence of a Registered Nurse Division 1 for 24 hours per day might be an appropriate minimum requirement. As the first round of the Commonwealth’s accreditation system had not been completed at the time of the consultations, some providers suggested that it was advisable to await the outcomes of accreditation and then review whether additional regulation was required by either the Commonwealth or State Government.

Many consumer and carer representatives expressed concerns about the adequacy of current staffing, care levels and the high use of agency staff. These representatives wanted to see suitably qualified staff in charge of facilities and providing 24-hour care. However, they recognised the difficulties of recruiting trained staff and the link between subsidy levels and capacity to employ staff.

There was no uniform view between representatives of consumers and carers on the approach that should be adopted by the State Government, although most saw a need for some form of additional regulation of staffing levels. As discussed below, a number of peak consumer organisations suggested the need for minimum staffing guidelines rather than regulated nurse-to-resident ratios.
Views in Favour of State Government Regulations

A significant number of submissions from nursing staff currently employed in the residential aged care sector, as well as many submissions from nurses who were not currently providing direct nursing care, supported the introduction of nurse-to-resident ratios to the same level that had existed in Victoria until 1995. Strong support for State Government regulation of nurse-to-resident ratios was expressed in the submission from the Australian Nursing Federation (ANF).

Many nursing staff indicated that their facility continued to use the previous nurse-to-resident ratios as a baseline for staffing, although some conceded they were unable to meet these ratios for a variety of reasons. In light of the compliance with the previous ratios, it was suggested that their reintroduction would have minimal financial impact on the industry while improving resident and carer/family confidence in the system.

Nursing staff also saw the introduction of regulations as a mechanism to address some of the current issues related to high staff turnover due to increasing workloads and pressures on nursing staff to supervise untrained staff (see Section 3.2).

Many submissions considered that additional regulatory requirements were necessary because the existing Commonwealth requirements were not specific enough and allowed some providers to reduce the use of qualified staff and so put resident care at risk.

Issues Concerning Implementation of Regulations

A number of submissions identified factors that would need to be considered before ratios could be implemented. These factors include:

- The impact on the aged care system of the current nursing shortage, which is creating difficulties in attracting and retaining staff in some parts of the industry.
- Pay differentials for nurses between public and non-public sector providers.
- The need for Commonwealth subsidy levels to adequately cover the costs of providing care for residents.

The broad approaches to regulation suggested in submissions were:

- **Use of minimum requirements**: for example, use of the original requirement in the Commonwealth’s Aged Care Act 1997 for onsite qualified nurses and nurse-to-high care resident ratios which has not applied since August 1998.
- **Use of specific ratios**: a range of possible ratios were suggested. Many submissions favoured use of the previous State Government nurse-to-resident ratios. Others proposed models for guaranteeing a minimum number of care hours for each resident, taking into account staffing mix and skill levels.

Views Against the Introduction of State Government Regulations

As noted above, most participants in the consultations and focus groups felt that some form of staffing regulations should be introduced. However, some participants believed that flexibility was required so that providers could adjust the staffing mix and numbers to meet the changing needs of residents.
Most submissions from providers of high care facilities argued that there were no gaps in the Commonwealth regulatory framework and that State Government action in this area was not required. Where providers acknowledged that a gap existed, they stated that the Commonwealth should address the issue rather than the State Government. Concern was expressed about the potential for duplication and diversion of funds from direct care delivery if both the State and Commonwealth Governments regulated residential aged care.

The three peak provider organizations - ANHECA, VAHEC, and VHA - expressed their opposition to the possibility of State Government regulations on staffing. They were concerned that prescriptive staffing requirements may have the unintended consequence of preventing innovative use of available staff resources and:

- That management needed to retain flexibility of staffing levels to ensure that residents’ needs can best be met within available resources (for example, by varying staffing levels throughout the day to meet peak demands).
- That providers needed to retain the ability to employ a mix of staff (for example, clinical nurse specialists on a consultancy basis, allied health professionals, activity therapists) that would enhance residents’ overall quality of life.
- That the costs of increased staff ratios required by State regulation was not likely to be reimbursed by the Commonwealth and may result in Victorian homes becoming financially non-viable if additional costs were not fully funded by the State.

The peak bodies also argued that there is no proven link between nursing staff ratios and the quality of life of residents (as opposed to the quality of nursing care) and that there are other means available for the State Government to enable and support improved quality of care, such as creation of centres of excellence.

These views were upheld by a number of submissions from providers who questioned the extent to which increased regulation of staffing levels and qualifications would result in improved quality of care. Others identified a need for further research to determine appropriate staffing levels and skills mix to address the needs of residents in different types, location and sized facilities. A number of providers expressed confidence in the Commonwealth accreditation process and felt that more time was needed to evaluate the effectiveness of the new accreditation process in improving care standards.

Some providers and staff of residential aged care facilities indicated that the previous State Government ratios are used as a guide in developing staffing rosters. In the public sector, most facilities’ staffing levels exceeded the former nurse to resident ratios, and new staffing ratios were determined for public sector nursing homes by the Australian Industrial Relations Commission on 31 August 2000. However, it was noted that public sector providers currently receive a higher level of recurrent funding, because of State Government funding supplements, than non-public sector providers. Part of this top-up funding is directed at addressing the higher wage rates paid to nurses in the public sector, and in smaller homes to cover increased costs due to economies of scale and the viability of the overall health service.

Many providers also highlighted the difficulty of meeting a prescriptive staffing ratio in light of the current nursing shortages.
3.2 Related Workforce and Training Issues

Although the consultation paper did not specifically seek input on workforce and training issues, many submissions highlighted that the regulation of staffing could not be considered in isolation from broader workforce and training issues. Of prime concern was the difficulty in recruiting and retaining nurses in residential aged care services.

Although these issues were acknowledged as being outside the terms of reference of the Committee, they were considered as being link with the issue of staffing regulation and were noted.

Workload

The majority of submissions and focus group responses referred to the high and increasing workloads of all residential care staff, and particularly nursing staff. Factors contributing to these workload issues were identified as:

- Increasing resident dependency levels and complex care needs.
- Increased documentation requirements under the Commonwealth’s accreditation and Resident Classification Scale (RCS) funding requirements.
- Difficulty attracting and retaining qualified staff.
- Over-reliance on PCAs/ NAs who often had little or no formal qualifications or training.

Shortage of Qualified Staff

The shortage of trained and qualified staff was raised frequently as a major issue facing residential aged care. Many submissions argued that the introduction of staffing regulations, in particular nurse-to-resident ratios, would be problematic without addressing this issue.

It was clear that some facilities had more difficulty than others in attracting permanent and agency nursing staff. Some submissions outlined the impact of management style and the adequacy of management training for facility and unit managers as contributing factors.

Some participants at the consultations expressed concern about an increased reliance on the acute health system. They advised that residents with particular health problems are being transferred to hospital emergency departments rather than nursing staff at the aged care facility being able to manage the condition due to a lack of resources or skill.

There were a number of suggestions to address the shortage of qualified nurses and recruitment difficulties which included:

- Increasing the number of training places available for Division 1 and 2 nurses.
- Increasing opportunities for participation in post-graduate studies in gerontic nursing for Division 1 Registered Nurses.
- Offering refresher courses to encourage staff back into the aged care workforce.
- Develop innovative approaches to link aged care providers and universities to facilitate the recruitment, training and retention of qualified nursing staff into the residential care sector.
Identifying 'best practice' models of staff management based on facilities with low staff turn-over and little difficulty attracting new and qualified staff.

Training
Training issues were considered to be strongly associated with staff recruitment and retention.

It was noted that, although the Commonwealth Government had responsibility for training of the Division 1 nursing workforce and has several long-standing workforce Committees in place, practical initiatives to address the training needs of the sector have not been forthcoming.

Training issues raised with the members of the Committee included:

- The existence of negative or stereotypical views about ageing and older people throughout the workforce and community.
- The need for facility managers and Directors of Nursing to have additional qualifications (for example, in management practice).
- Lack of encouragement from management for staff to upgrade their skills.
- Lack of access to relevant training: for example, some participants claimed that they were required to attend work-related training in their own time and at their own expense.
- The merits and differences of university-based nurse training compared to the former system of hospital-based nurse training.
- An increasing number of non-nursing staff in direct care roles with little or no training.
- The variable level and quality of training received by PCAs/ NAs, and the fact that these workers were being required to perform duties beyond their training.
- The need for immediate workforce planning and development of a staff base to meet future requirements.

Participants made a number of suggestions for addressing these issues including:

- A requirement that all managers of residential aged care facilities should be Division 1 Registered Nurses.
- Provision or requirement of specialist gerontology training for senior nursing staff.
- Review and redevelopment of appropriate curricula for managers, nurses and PCAs/ NAs.
- Establishment of a training level as a minimum requirement for working in a direct care role in aged care facilities.
- Incorporation of carer-focused issues in relevant training curricula.
- Development and funding of further training programs in managing challenging behaviours.
• Improved training on provision of palliative care in residential aged care. (It was also suggested that the Palliative Care Australia Standards should be incorporated into the Commonwealth’s accreditation process.)

• Appointment of State Government funded nurse educators to ensure a consistent approach to staff training and education.

• State Government assistance for the industry in workforce planning.

Many participants felt that nursing staff in high care facilities should be trained in aged care issues as well as clinical skills. Suggested areas for training included: communication and relationship skills; attitudes to ageing and older people; the impact of residential care on older people and their carers/families; and the promotion of ‘family friendly’ approaches in residential aged care.

**Multidisciplinary Staffing**

Many consultation participants expressed the need for aged care facilities to have a balance and mix of staff skills. Many wished to see greater use of allied health staff, appropriately trained activity officers and other therapists, in addition to qualified nursing and PCAs/NAs for both clinical and non-clinical aspects of care.

Specific suggestions were that:

• Nursing home residents should have access to allied health staff, such as physical therapists, counsellors and activity and recreation staff.

• Regulations should ensure that staff are trained to care for people with dementia.

• Aged care facilities should be required to employ dieticians to improve the diet of residents.

• Clinical nurse specialists (for example in the management of continence, diabetes, wounds) should be used on a consultancy basis to train and support staff.

**3.3 Information Requirements**

A key issue in the consultation paper was whether there were any gaps in the information that aged care facilities are required to provide consumers and their families/carers by the Commonwealth Government.

Although this issue was raised in many submissions to the Committee, its importance may have been overshadowed by concerns about staffing. Less than half of written submissions referred to information issues; however, provision of information was a major focus of discussion in the focus groups and in individual submissions from carers.

While many submissions highlighted gaps or concerns about the information currently available to prospective residents and their carers, most submissions expressed the view that these issues could be addressed without State Government regulations.
Many focus group participants commented on the need for clear, ‘plain language’ information about practical issues, such as fee structures, the services and equipment covered by resident fees, security of tenure, financial reporting on how accommodation charges were spent, details of menus, frequency of cleaning, social and physical activities for residents, complaints resolution processes, explanation of waiting lists, and rights and responsibilities of residents.

The focus groups also discussed the need for qualified interpreters and materials in a range of community languages to help families fully understand information relating to placement. Some participants were concerned about the use of bilingual staff members and family members for translations at key points (such as at admission) rather than qualified independent interpreters.

Participants noted that there are wide variations between providers in the amount and quality of information provided to prospective residents and their families/carers. Some focus group participants were also concerned that the information prepared by facilities may not be impartial and should be prepared by an independent advocacy or consumer organisation.

A perceived lack of useful information to assist families/carers find an appropriate service emerged as a significant issue. Suggestions for addressing this problem included greater use of Aged Care Assessment Service (ACAS) centralised waiting lists and the development of practical information to assist people to navigate the system and find suitable care.

Finally, a number of participants thought that information about staff numbers, qualifications and rosters in individual facilities should be provided, either on request or as a matter of course. Some people suggested that this information could be displayed in the entrance foyer of facilities or on staff identification badges.

### 3.4 Complaints

Although the complaints’ resolution system for residential aged care was highlighted in the consultation paper, most submissions did not comment specifically on this area. Where complaints issues were addressed in submissions, most issues related to the response to the complaint rather than difficulties accessing a complaints system. However, participants in the focus groups felt that internal complaints systems within aged care facilities were not well developed.

In addition, slow responses from the external complaints resolution process had presented problems for both consumers and individual service providers, and this was seen as undermining the credibility of the complaints system. Difficulties in resolving some complaints and the need to undergo a mediation process contributed to long response times.

**A Role for the State Government in the Complaints’ Process**

In the majority of submissions addressing this issue, respondents thought that providing additional resources and adjustments to the existing Commonwealth complaints process was the most appropriate response.
However, a few submissions called for an independent complaints system. For example, one submission noted that the existing Commonwealth complaints system excluded certain topics from its jurisdiction (such as staffing levels and workloads) and proposed that a Complaints Resolution Committee be established to deal with matters that fall outside the scope of the existing complaints system.

Some submissions noted that a possible role for the State Government may be to develop ‘user friendly’ information on complaints resolution and advocacy services, as the existence of these services is not well known among consumers. A small number of submissions advocated that the Health Services Commissioner should have a role in a new State Government-based complaints system.

Participants in the focus groups for culturally and linguistically diverse communities suggested that the complaints resolution scheme should be replaced with an autonomous body rather than being controlled by a government department that is closely involved with the planning, funding and regulating the residential aged care sector.

People in the focus groups related experiences that indicated variable practice and slow response times for resolution of complaints. Feedback in several of the focus groups also indicated that carers and families were wary of any possible repercussions for the resident if they made a complaint. Carers felt that the State Government should lobby the Commonwealth to improve the existing internal and external complaints' processes.

Participants also indicated that the State Government should support existing organisations such as Residential Care Rights and Carers Victoria to provide information and support to carers and represent their interests.

### 3.5 Centres of Excellence and Research

The idea of establishing Centres of Excellence was one of a number of non-regulatory options listed for comment in the consultation paper. As many respondents focused on staffing and information issues, the non-regulatory options and suggestions were not widely commented on in submissions.

Of the submissions that mentioned Centres of Excellence, most supported the concept. One response proposed a program to fund ‘lead’ agencies to work with a number of facilities (not necessarily in the same region) to develop, trial, and evaluate models of best practice in areas such as models of care, staff recruitment and retention, and financial management.

Other suggestions made about a possible focus for the Centres included:

- Creating opportunities for staff development through the provision of training and support.
- Promoting and disseminating ‘best practice’ information through publications, teaching, clinical placements, mentoring arrangements and staff exchange.
- Promoting career paths for aged care staff.
- Defining and costing a standard benchmark of care.
- Developing linkages between aged care providers and other services such as palliative care.
• Collaborating with universities and training institutions to provide additional expertise and resources for teaching, research, policy and service development/evaluation, as well as to promote aged care to undergraduate and postgraduate health professionals.

Several further issues were highlighted for consideration in any implementation of the Centres of Excellence concept, including:

• Locating Centres at multiple facilities to engage with different parts of the sector and develop models suitable to different geographic locations.

• Disseminating information about projects and research incorporating the outcomes into industry standards.

• Supporting the Centres with adequate funding and appropriate numbers of qualified staff.

• Developing the Centres as a joint Commonwealth/State Government initiative, thereby allowing effective use of existing infrastructure and encouraging a national approach.

Although the concept of a mentoring program was listed separately in the consultation paper, several respondents expressed the view that this would be a useful program to include in the focus of Centres of Excellence.

While several submissions supported the establishment of Centres of Excellence, they emphasised that a priority on State Government action was to address workforce issues. In these submissions, the Centres were seen as part of a broader strategy to address issues related to the image of the residential aged care sector and something that could make a positive contribution to staff recruitment and retention in the longer term.

Where respondents were not supportive of, or gave qualified support for, Centres of Excellence, the following reasons were noted:

• The facilities could be disruptive for residents, particularly those with dementia, if it was used for short term placement of staff or staff exchanges.

• Conferring the status of ‘Centre of Excellence’ on a particular facility would give staff unrealistic expectations and would hamper efforts by other facilities to achieve ‘best practice’ outcomes for residents.

• There would be a long lead-time required to establish Centres of Excellence.

Several submissions mentioned the need for research into various aspects of aged care, although this was not an area where feedback was sought explicitly in the consultation paper. In particular, it was suggested that research was vital for establishing nurse-to-resident ratios or measuring the association between staffing numbers and quality of care. A number of submissions called attention to the need for research that would improve the quality of aged care facilities and the image of the aged care sector more broadly.
Further suggestions on areas that could be part of a research agenda included:

- Community education campaigns promoting a balanced view of ageing and aged care.
- Community forums and continued promotion of positive research through government media outlets.
- The establishment of a ‘clearing house’ for the distribution of research information and best practice literature.
- Research into the management of dementia.

Some consumer and carer groups suggested that the State Government could have a major role in funding this type of research.

3.6 Ageing in Place

The issue of whether low care facilities with some high care residents should be included in any regulatory response was raised in a number of submissions, with a range of opinions expressed.

A view presented by one professional association in favour of including low care facilities in any State Government regulations contended that a baseline level of RN Division 1 coverage was appropriate in all low care facilities, with the level of coverage increasing once ten or more high care residents are in a facility. Most organisations representing a consumer perspective were supportive of regulations on staffing for low care facilities that provide high care services.

While arguing against the introduction of State Government regulations for high care facilities, peak bodies representing providers suggested that State Government regulation that did not cover all types of residential aged care facilities could be considered discriminatory and that defining or classifying residential care on any other basis apart from the care needed was inappropriate.

Submissions from service providers that touched on this issue, mentioned the high transitional staffing costs that would have to be absorbed when facilities move to an ‘ageing in place’ model. The practical issues of attracting and retaining qualified nursing staff in an environment of significant staff shortages were also raised.

3.7 Image of the Residential Aged Care Sector

The negative image of the residential aged care sector and of staff who work in the industry was raised as a factor that affects morale and the capacity to recruit and retain qualified staff. Some submissions also made the point that many nurses viewed aged care as unchallenging, custodial and unrewarding. One submission claimed that many nurses continued to hold negative, stereotypical views about ageing and older people.

A suggestion made to improve the image of the sector was the establishment of an ‘award’ system to recognise facilities and staff who provide high quality services. It was proposed that this system include a ‘customer care award’ to recognise excellence in staff skills, attitude and care.
3.8 Advocacy Services
Some submissions questioned whether advocacy services were adequately resourced to meet the needs of a steadily increasing number of people living in residential aged care facilities. Advocacy services, such as Residential Care Rights, are funded by the Department of Health and Aged Care.

3.9 Other Issues
A number of submissions raised other operational issues facing staff and consumers, such as:

- The administration of medication in residential aged care facilities and the applicability of the Drugs, Poisons and Controlled Substances Regulations in low care facilities.
- The amount of time taken to complete paperwork related to Commonwealth accreditation and RCS claims.
- The fact that annual Commonwealth Government approval rounds for new residential aged care places and CACPs are not well coordinated and information links are not well established.
- The need for improved care options for younger people with acquired brain injury.
- Increased reliance on the acute health care system for the management of health issues instead of within the aged care facility.
4 Examination of Policy Proposals

In line with its terms of reference, the Committee considered policy proposals based on community consultations and their own deliberations to:

- Introduce regulations including nurse-to-resident ratios for high care facilities.
- Better inform residents and their families of the numbers and qualifications of staff.

4.1 Staffing Regulations in High Care Facilities

The staffing of high care facilities was a key area for the Committee’s attention. The Committee were asked to consider whether there are gaps in the Commonwealth’s Aged Care Act and its Principles regarding staffing, whether the State Government could play a role in this area, and if so, what form a response should take.

All Committee members were committed to providing quality care for residents and spent considerable time identifying and evaluating action that could be taken by the State Government on staffing measures.

The Committee considered issues that emerged through the consultations in some detail including:

- The current shortage of skilled workers and associated difficulties experienced by many residential aged care providers in recruiting and retaining qualified nursing staff.
- Available evidence on the effect of staffing mix and levels on the quality of resident care.

The Committee also reviewed the literature available on the effect of staffing levels and staffing mix. During their deliberations, the benefits and difficulties of a range of options were debated and several regulatory and non-regulatory approaches were explored. However the Committee held a range of views on the best way to deal with the staffing of high care facilities.

Views presented to the Minister included support for the need to introduce regulations, as well as alternatives to regulation including best practice guidelines. As the Committee did not reach consensus on whether staffing was an area that required the introduction of State Government regulation, no recommendations were put to the Minister.

Committee members also spent considerable time discussing broad issues concerning the aged care workforce, particularly the need to train, recruit and retain suitable staff within the residential aged care sector. While these issues were not specified in the terms of reference, the Committee felt that they were linked to questions of staffing regulation. Section 5.1 contains a full discussion of the Committee’s deliberations on broader workforce issues.

4.2 Information for Consumers and Carers

The terms of reference required the Committee to consider policy proposals for older Victorians, including better information for residents and their families on the numbers and qualifications of staff.
While the Commonwealth requires providers under the Aged Care Act to make specified information available to people entering residential aged care, there are no requirements to provide information about staffing numbers, staff-to-resident ratios or staff qualifications available in a facility.

The Committee considered information provision to be an important issue for residents and their families but not an area that required regulation by the State Government. Rather, they considered that the industry could respond by providing information on staffing as a ‘best practice’ standard.

**Recommendation:**

That the State Government, with the support of consumer organisations, encourages service providers to provide information on staff numbers and qualifications to prospective and existing residents and their families/carers.

Committee members agreed that the State Government could support the development of additional information resources.

The Committee was impressed with a number of existing publications on residential aged care. For example, the publication: *A Guide to the How, When, What and Where of Dementia Residential Care* was considered to be a useful document to assist families/carers find quality care for people with dementia.

**Recommendation:**

That the State Government assists consumer and advocacy groups to develop practical, easy-to-understand information about residential aged care issues. This should include information about how to access services and what to look for in a good quality facility appropriate to the individual’s needs.

The Committee noted, however, several instances where useful material was specific to certain localities or was unavailable because money to produce additional copies was unavailable. The Committee considered that relatively modest initiatives could supplement the material currently available from the Commonwealth Government and other sources.

**Recommendation:**

That the State Government request the Commonwealth Government to provide resources to residential care providers and consumer advocacy groups for the provision of a range of information that is available in a range of community languages.

**Information for people of culturally and linguistically diverse backgrounds**

The Ethnic Communities Council of Victoria and other consumer and carer representatives were concerned about some residential care providers use of bilingual staff members, who are not qualified translators, to act as translators for existing and potential residents, particularly during key activities such as admission and the development of resident care plans.
Members of the Committee believed that it was best to use qualified interpreters for these purposes. However, the Committee was aware that the Commonwealth’s Guidelines for Accreditation Standards allow providers to use either a qualified interpreter or a bilingual staff member for translations. Committee representatives from provider groups argued that a requirement for providers to use qualified interpreters would be a significant cost and administrative impost beyond Commonwealth legislative requirements.
5 Other Areas Considered for Action

This section provides an overview of the issues raised that were outside the Committee’s terms of reference but related to other issues considered by the Committee. This section presents a series of options and recommendations to further improve the quality of residential aged care.

5.1 The Aged Care Workforce

Division 1 nurses, Division 2 nurses and PCAs/NAs make up the bulk of direct care staff in the residential aged care sector. Allied health professionals and diversional therapists play a smaller, but important role. Compared to low care facilities, which have a higher proportion of PCAs/NAs, high care facilities have proportionately more Division 1 and 2 nurses.

The Committee considered the workforce issues that emerged through the consultations, particularly the current difficulties experienced by many residential aged care providers in attracting and retaining qualified nursing staff, and the limitations of Commonwealth funding to employ sufficient qualified staff.

The Committee appreciated that the Commonwealth Government has responsibility for both workforce planning and training in the aged care sector. However, Committee members felt that the Commonwealth Government had yet to identify or deliver practical options in this area, which is becoming critical to the functioning of the system. Therefore, while it does not wish to see a duplication of Commonwealth and State Government roles, the Committee did try to identify areas where the State Government may be able to play a supporting or advocacy role, and work in partnership with the sector to address gaps in workforce management.

5.1.1 Aged Care Staff: Supply and Demand

Demand for appropriately qualified staff in the residential aged care sector is driven by:

- Growth in the supply of care and support services for older people.
- Growth in the number of frail, older people in need of residential care.
- The balance of residential aged care services in relation to services that support older people and their carers at home.
- The degree to which the skills of available staff are used in the most effective manner.

The availability of staff in the residential aged care system is affected not only by the availability of appropriately qualified staff in the entire health and aged care sector, but by the capacity of residential aged care services to attract and retain staff. This, in turn, depends on factors such as:

- Pay and conditions in the aged care sector compared to other parts of the health system.
- Perceptions of the residential aged care sector.
- Opportunities for career advancement and for staff to use and develop their skills.
The Committee agreed that it is imperative that the aged care workforce has adequate numbers of trained and motivated staff to meet the growing need for residential and community-based services. They acknowledged that a concerted and coordinated effort from governments, aged care service providers, professional associations and the training and education sector was required.

The Committee also noted that most forms of action to increase the availability of staff will have significant lead times before the situation improves.

**Reasons for Nurse Shortages**

In identifying possible strategies to address workforce issues, the Committee examined reasons for the nurse shortages. Research and literature available to the Committee indicated that reasons for the shortage of nurses in Australia include:

- An increasing range of alternative career opportunities for women.
- Perceptions that work in the health and aged care sectors is both hard and undervalued.

Shortages of nurses may also have been compounded in Victoria by:

- A one-third reduction in the number of nurses being educated (associated with the switch from hospital-based to university-based nurse education in the early 1990s).
- Limited Division 2 nurse education from 1993–96.

The Committee noted that the system-wide difficulties in attracting and retaining nursing staff are compounded in the residential aged care sector by factors such as:

- The significant differences in pay and conditions for nurses in the private and not-for-profit residential aged care sector compared to the public sector.  

- Increasing demand for qualified staff in other parts of the health and aged care sector, including aged care services delivered into people's homes.
- Ongoing expansion of the sector.  

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1. The difference is currently about 18–20% due to the impact of the AIRC decision of 31 August 2000 and indexation of aged care funding not keeping pace with wage costs.

2. For example, in early 2001 the Commonwealth approved over 2,800 new residential care beds (to become operational progressively over the next few years). This will require approximately 1,000 staff to provide direct care services, comprising of a mix of Division 1 nurses, Division 2 nurses and PCAs/NAs.
5.1.2 Workforce Planning

Strategies to address the shortage of staff in residential aged care services must focus on three inter-related factors:

- Increasing the supply of appropriately trained staff.
- Increasing the retention of skilled staff within the sector.
- Making best use of the skills of qualified staff.

The Committee agreed that it would be beneficial for the State Government, providers, staff and other interest groups to work together to address these issues.

Recommendation:

That the State Government develops strategies to promote aged care work and improve the industry’s practices in recruitment and retention of staff. To commence this process, a forum should be convened with key industry stakeholders.

The Committee believed that the Commonwealth Government, as the primary funding source for residential aged care, should take more responsibility for workforce planning and provide funding for initiatives to meet the growing demand for appropriately trained and skilled staff.

Recommendation:

That the State Government calls on the Commonwealth Government to:

- Work in partnership with the aged care industry and state/territory governments to identify future trends in the supply of and demand for aged care staff.
- Take a leadership role in the development of further strategies for the training and development of the aged care workforce.

5.1.3 Training of Nurses and Personal Care Attendants

The availability and content of training courses in aged care is critical to the ability of the sector to recruit and retain suitable staff.

Apart from the overall shortage of nurses, there is a widespread industry view that aspects of the existing training and curricula for nurses and other direct care workers are inadequate for the requirements of residential aged care.

The Committee’s discussions on the training needs of different types of aged care staff took account of the role of the State and Commonwealth Governments.

Division 2 Nurses

The number of Registered Nurse Division 2 training positions is determined on an annual basis by the State Government through the Office of Employment, Training and Tertiary Education (OETTE). The Department of Human Services and other key industry stakeholders provide advice to OETTE about the required number of Division 2 nurse training places.
During the mid-1990s, Division 2 education was transferred from the hospital-based system to the Vocational Education and Training (VET) sector. Since then, there has been a steady increase in graduates from the Certificate IV in Health (Nursing) course.

The Committee noted comments from industry groups that the quality of clinical training offered by training providers was variable. However, it was aware that the Victorian Nurses Board planned to conduct a review of the Division 2 training course during 2001.

Committee members were also aware of the State Government’s intention to significantly increase the number of Division 2 nurse students during 2001, but pointed out that the flow-on effect of this initiative would take at least one to two years to affect current supply levels.

The Committee considered that there was significant potential with an extended scope of practice for Registered Nurses Division 2 to allow all categories of residential aged care staff to utilise their skills to the highest possible level. The scope of practice for Division 2 nurses is being considered by a working party established by the Minister for Health. The working party will report to the Minister for Health, the Minister for Aged Care and the Minister for Community Services on the implications and implementation measures required across the health and aged care sector, the parameters for practice, necessary legislative changes, and education and communication strategies.

**Personal Care Attendants/Nursing Assistants**

Training for PCAs/NAs is also undertaken in the VET sector and the number of training places is established by the Victorian Government through OETTE and consultations with government, the industry and training providers.

The Committee noted that a national review of Community Services Training Package (CSTP) is underway and that this package includes the Certificate III course for direct care workers delivering services to older people in residential or community-based settings.

Submissions received during the consultations indicate that many PCAs/NAs working in residential aged care have little or no accredited training relevant to their role. Department of Human Services figures indicate that, while most PCAs/NAs have, or are undertaking, training relevant to their direct care role, about one-third have no qualifications.

The Committee is considering a minimum training requirement for all direct care staff as a measure to improve the overall quality of care. Committee members acknowledge that this initiative could require an expansion of the number of Certificate III training places in aged care work.

Committee members felt that there is a need for more information about current and future demand for PCAs/NAs. As is the case for nurses, the availability of training places for PCAs/NAs should take account of the increase in residential care places, as well as substantial growth in the community-based aged care sector.
Recommendation:
That the State Government give high priority to an assessment of the adequacy of training places available for Division 2 nurses and personal care attendants/nursing assistants, and put in place appropriate strategies to address current and future training needs of these workers in the residential aged care sector.

Division 1 Nurses
The Commonwealth Government largely determines the number of training places available for Registered Nurses Division 1.

Other factors that may affect the number of Division 1 graduates are:

- Decisions of individual tertiary institutions on the number of places they will offer and the duration of their courses.
- Course attrition rates.\(^3\)
- The proportion of available funding devoted to postgraduate and research programs.

The number of Commonwealth funded Registered Nurse Division 1 places has remained constant at about 4,900 for several years and has not kept pace with growth in demand in the health and aged care sectors. Any action to increase the number of funded Division 1 places will take a minimum of three years (from when the increase in places takes effect) to affect the supply of nurses.

As mentioned previously, the decisions of nurse graduates to work in the residential aged care sector may be influenced by a range of factors, including wages, conditions and perceived attractiveness of the aged care sector relative to other areas.

Work undertaken by the Victorian Nurse Recruitment and Retention Committee indicates that the experience of students during clinical placements is a critical factor in influencing final decisions about where a graduate will seek ongoing work. Therefore, a measure to improve students’ experiences during clinical placement would appear to be critical. Some Committee members thought that arranging clinical placements in residential aged care services for the later half of an undergraduate course (when students had more experience in complex care) would be beneficial in promoting aged care as a specialised area of nursing.

The Committee considered that the undergraduate curriculum for Division 1 nurses lacked sufficient emphasis on aged care, and seemed to be dedicated mainly to acute care. One possibility discussed was for a specialist gerontological nursing option in the final year.

\(^3\) Available data indicates that of those people who begin RN Division 1 training, about 67% complete their undergraduate course and that 70% of these go on to work in the health or aged care sector. These attrition rates are consistent with those in other undergraduate courses, but higher than for allied health or medical degrees.
The Committee noted that only a small number of Division 1 student placements are in aged care, compared with three-quarters of Division 2 placements. The Committee saw a need for special measures to attract Division 1 nurses to aged care, and to promote aged care nursing as an area requiring a high degree of specialist clinical skills.

Recommendation:
That the State Government lobbies the Commonwealth Government to provide, as a matter of urgency:

- A detailed analysis of future requirements for Division 1 Nurses.
- Funding to ensure that the number of student places for Division 1 Nurse training is adequate to meet current and projected demand.
- A review of the curriculum for Division 1 Nursing to ensure sufficient emphasis on non-acute nursing, and to examine the possibility of developing specialist units in aged care nursing.
- A review of clinical placements aimed at improving students' experiences in aged care.
- Support to the aged care industry to provide better supervision of clinical care placements.

5.1.4 Remuneration of Aged Care Nurses

The Committee heard many expressions of frustration about the lower level of remuneration paid to nurses working in the private and not-for-profit sector compared to those in public aged care services. This was identified as a significant factor influencing staff retention and recruitment in the non-public sector.

Wages in the public aged care sector are linked to the public acute health sector. As the State Government is the primary funding provider and regulator of the public acute health system, it has provided additional money to help address wage cost increases in recent wage settlements for nurses.

Commonwealth funding arrangements limit the capacity of non-public sector providers to offer wage increases that will match those in the public sector. The current annual indexation of the Commonwealth’s RCS subsidy includes recognition of wage and non-wage cost increases. However, the wage cost component only builds in a ‘safety net’ for increases that do not reflect actual wage cost increases in the health or aged care sectors. In the absence of opportunities for significant productivity offsets, this means that residential aged care providers can only grant wage increases above the ‘safety net’ if staff numbers are reduced, if non-wage costs (such as food, power, laundry) are reduced or if return on investment is limited.

While remuneration is not the only factor considered by staff or potential staff in their employment decisions, the Committee considered it was a key factor. The Committee recognised that funding was a national issue that could only be addressed by the Commonwealth Government.
Recommendation:
That the State Government lobbies the Commonwealth Minister to develop strategies to address wage disparities between the public and non-public sector residential aged care services.

5.1.5 Industry Support for Training and Development of Direct Care Staff
Comments made in submissions to the Committee suggest that there are considerable differences between individual service providers and/or managers in their approach to staff training and development. While some participants worked in facilities that encouraged (and paid for) staff training, others were expected to pay the fees for training and to attend it in their own time.

Most Committee members felt that it was reasonable to expect all providers to commit resources to training and developing their staff.

The Committee was aware that in other parts of Australia some providers have put in place initiatives to attract and retain qualified nursing staff in the residential aged care sector. One example of this is the Aged Care Career Pathways Consortium (ACCPC) in New South Wales which was generated by a group of interested and committed providers; with some financial investment from the providers plus a small amount of seeding money from the Commonwealth Government.

The Committee was encouraged by this type of approach and supported a similar joint venture initiative between the government, service industry and university sectors for the Victorian aged care industry. It also suggested the involvement of existing academic Chairs funded by the Department of Human Services.

5.1.6 Management Training
Directors of Nursing and service managers have a significant affect on morale, motivation and retention rates in aged care facilities. A number of submissions suggested that there was room for improvement in management training within the sector.

The Committee appreciated that accountability for nursing practice is just one aspect of the Director of Nursing’s role. Other attributes required of Directors of Nursing and management staff in aged care settings include:

- Leadership abilities.
- Communication and relationship skills.
- Expertise in human resource management.
- Sensitivity to the needs of residents and their families.

The Committee noted that management training and leadership programs for residential aged care proprietors, boards of management, Chief Executive Officers, Directors of Nursing and managers were being advanced by industry groups, the Commonwealth and State governments and the Aged Care Standards and Accreditation Agency.
5.1.7 Improving the Image of Aged Care Work

Steps to increase training places available for nurses and PCAs do not guarantee that enough people will choose to work in the residential aged care sector.

Many submissions to the Committee raised negative images of residential aged care as a factor affecting the capacity of the sector to attract staff. The Committee considered that this issue had several aspects.

Firstly, there is a tendency for the media to focus on negative stories about residential aged care, and it is difficult to gain positive media exposure. Secondly, there is a tendency for other parts of the health and aged care sector (and even academia) to undervalue the role of work in residential aged care. This can create a negative impression of the residential aged care sector for new graduates.

The Committee acknowledged the State Government’s contribution to promote the image, as well as the quality, of residential aged care.

5.1.8 Responsiveness to the Needs of Residents and their Families / Carers

Based on consultations with consumers and carers, the Committee considered that there was a need to improve the responsiveness of aged care services to the needs of older people and their families/carers. Initiatives in this area have the potential to improve both resident care and the image of the residential aged care sector.

The Committee noted research findings and current examples of good practice that could form the basis of possible initiatives. For example, a research project by Lincoln Gerontology Centre and the Villa Maria Society aimed to identify ways of increasing family involvement in residential aged care. With the support of Carers Victoria, the resulting document became a useful source of information on the experiences of families and carers when a relative or friend enters residential care. It also provided insights into the views of residential care staff and management on the role of the family in an aged care setting.

Recommendation:

That the State Government, in partnership with key stakeholders, resources and supports the:

- Development of guidelines and educational workshops aimed at improving the responsiveness of residential aged care staff to the needs of family members, carers and older people.
- Trial of innovative projects to involve families in resident care. The learning from these pilot projects could then be shared with the aged care sector.

4 Facilitating Family Involvement in a Residential Care Setting (August 2000)
5.1.9 Administrative Demands on Staff

In recent years the Commonwealth Government’s accreditation program has established a comprehensive system of quality management in residential aged care facilities. An issue frequently brought to the Committee’s attention was the amount of time that residential aged care staff had committed to this process. Service providers felt that although the process had been extremely resource intensive, and many staff devoted hours of unpaid time to assist with its implementation, this fact had not been duly recognised by the Commonwealth Government.

In addition, staff participating in the consultation process frequently expressed resentment about the increasing demands for documentation required as part of Commonwealth’s RCS funding arrangements. Time spent on administrative duties obviously reduces the time available to provide direct care of residents and is, therefore, an issue that relates to both the quality of resident care and to the work satisfaction of nurses.

The Committee agreed that changes in the Commonwealth’s documentation requirements could improve the morale of workers and provide additional time to spend on resident care.

Recommendation:

That the State Government, together with peak industry and professional organisations, lobbies the Commonwealth to simplify the documentation required for the Resident Classification Scale.

5.2 Research and Centres of Excellence

The Committee supported in-principle the development of Centres of Excellence in residential aged care. Although many members felt that the concept required further discussion and development with key stakeholders, the Committee agreed that the following principles should be adopted in further exploration and development of Centres of Excellence:

- There should be multiple Centres of Excellence rather than just one, and locations should include both rural and metropolitan areas.
- Centres of Excellence should have a primary focus on residential aged care.
- Centres of Excellence should promote innovation in resident care.
- Centres of Excellence should have an evaluation and research role, and a role in information dissemination.
- Centres of Excellence should be formed as a partnership, with the continued involvement of all key stakeholders.

Recommendation:

That the State Government investigates the development of Centres of Excellence, in partnership with key stakeholders, and undertakes a study to identify examples of good practice already in the industry.
While the Committee believed that Centres of Excellence had the potential to improve the quality of aged care by researching, developing and promoting ‘best practice’ care models, some members felt that the idea was not a “first order issue” given the range of other priorities that came to the attention of the Committee.
Appendix 1  Members of the Ministerial Advisory Committee

Ms Colleen Pearce (Chair)  Uniting Care Victoria
Ms Mary Barry  Victorian Association of Health and Extended Care
Ms Maria Bohan  Carers Victoria
Mr John Brooks  Australian Nursing Home and Extended Care Association
                 (now known as Aged Care Association of Victoria)
Ms Elizabeth Butterfield  Carnsworth Nursing Home
Fr Joe Caddy  Catholic Social Services
Ms Pauline Feegan  Health Services Union of Australia
Ms Robyn Fuller  Broughton Nursing Home
Ms Margaret Gaskin  Aged Care Assessment Service
Ms Marion Lau  Ethnic Communities Council
The Hon Jenny Lindell, MP  Member for Carrum
Ms Mary Lyttle  Residential Care Rights
Ms Lynette Moore  Alzheimer’s Association of Victoria
Ms Edith Morgan  Older Persons’ Action Centre
Ms Margaret O’Callaghan  Older Persons’ Action Centre
Ms Patricia Reeve  Council on the Ageing
Dr Gerald Segal  Australian Medical Association
Ms Hannah Sellers  Australian Nursing Federation
Ms Mavis Smith  Victorian Healthcare Association
Mr Russell Williams  Department of Health and Aged Care
Ms Beth Wilson (Observer Status)  Health Services Commissioner
Appendix 2   Terms of Reference

The Government’s policy proposals for older Victorians included the:

- Restoration of State regulations for high care residential facilities (nursing homes).
- Requirement for providers of high care to better inform residents and their families of the numbers of staff employed by their facilities and qualifications of staff.

The key functions of the Ministerial Advisory Committee are to:

- Provide input into the development of a paper being commissioned to focus on key issues for State regulation of high care (nursing home) facilities. The paper will focus on the immediate priorities for regulation identified in the Government’s policy and will also pose issues that may be considered in the future. The paper will recognise the Commonwealth role in residential care and will seek options for State Government to support this role in high care facilities (nursing homes).
- Represent the views of key stakeholders. Committee members will have an opportunity to be involved in public consultations on regulation of high care facilities (nursing homes). Consultations will be held in metropolitan and rural areas and will provide an opportunity for input from consumers/carers, members of the public, providers and health professionals.
- Report to the Minister following the conclusion of the public consultation process on the paper.
Appendix 3  List of Written Submissions Received

Organisation Submissions
Aged Care Assessment Service Liaison Group-Victoria
Alzheimer’s Association
Australian Medical Association-Victoria
Australian Nursing Home and Extended Care Association-Victoria
Australian Nursing Federation-Victorian Branch
Australian Physiotherapy Association Victoria
Australian Society for Geriatric Medicine
Ballarat Health Services
Barwon Health
Barwon Regional Aged Care Assessment Service
Brotherhood of St Laurence
Broughton Nursing Home
Carers’ Victoria
Catholic Health Australia
Caulfield General Medical Centre
Central Gippsland Health Service
City of Glen Eira
Coleraine District Hospital and Aged Care Services
Commonwealth Department of Veterans’ Affairs – Victorian Office
Council on the Ageing Victoria
D.A.M.H.S. Aged Psychiatry Program
Dieticians Association of Australia (Victorian Branch)
Donwood Community Aged Care Services Inc.
Dutch Care Ltd
East Wimmera Health Service – Birchip Campus
East Wimmera Health Service – Charlton Campus
East Wimmera Health Service – St Arnaud Campus
East Wimmera Health Service – Wycheproof Campus
Emily Lenny Private Nursing Home
Ethnic Communities’ Council of Victoria
Faculty of Health Science, La Trobe University
Geriacation (Victorian and Tasmanian Branch)
Glen Waverley Nursing Home – staff
Grandview Gardens – staff
Innisfree Residential Aged Care Facility
Judge Book Nursing Home – staff
La Trobe University, School of Nursing
Lynden Aged Care Association Incorporated
Manningham Centre Assoc. Inc. Relatives’ Group
MECWA
Melbourne City Mission
Northwest Aged Care Assessment Service
Older Persons Action Centre
Outer Eastern Aged Care Assessment Service
Palliative Care Victoria
Pastoral Initiatives and Agency
Peter James Centre Aged Care Assessment Service
Pharmacy Board of Victoria
Presentation Sisters Hostel
Pyramid Hill Bush Nursing Hospital
Residential Care Rights
Royal Freemasons’ Homes of Victoria - staff
School of Nursing, Monash University
Southern Cross Victoria Aged Care
Southern Health Care Network
St Joseph’s Tower Aged Care Facility
Tongala & District Memorial Aged Care Service – staff
Uniting Care Victoria
Vasey Housing Limited
Victorian Association of Health and Extended Care
Victorian Brain Injury Recovery Association Inc.
Victorian Council of Peak Nursing Organisations
Victorian Healthcare Association
Western District Health Service
Willsmere, Bundoora Repatriation Hospital
Yallambee-Traralgon Village For The Aged
Yarrama Aged Care Services

Individual Submissions
Ms G Addicott
Ms J Atkin
Mrs G M Best
Mr P Boardman
Ms R Bray
Ms D Brook
Mr N A Buck
Ms M Colville
Mrs C M Cook, et al
Mr J E Cornhill
H Godfrey
Ms E Gordon
Ms A Hall
Ms R Jephson
Ms J Kerrins
J A Kerrins
Ms R Law
Mrs J Leonard
Mrs A Lydall
Ms H Mann
Ms R J Maplestone
Ms M Maragos
Ms S McCaughey-Connolly
Ms J McNally
Ms C Miller
Ms A Mingan
Mrs B Mouritz
Ms A O’Flynn
Mr M O’Keefe
Ms M O’Neill
Ms M Oswald
Mrs M E Peden
Ms M Petrovich
Ms P Procter
Mrs K M Puls
Mrs D Richards
Ms K Rosborough
Ms Sarah, et al
J H Simpson
Ms C Spano
Ms R Sutton
C Welch
Appendix 4

Consultations

Ballarat
Date:  17 July 2000
Address:  Ballarat Town Hall
Sturt St, Ballarat
Time:  3pm to 7pm

Traralgon
Date:  18 July 2000
Address:  The Latrobe
Princes Hwy, Traralgon
Time:  2pm to 5:30pm

Ringwood
Date:  19 July 2000
Address:  Church of Christ
13 Bedford Rd, Ringwood
Time:  2pm to 5pm and 5:30pm to 7pm

Bendigo
Date:  20 July 2000
Address:  Bendigo Regional Arts Centre
View St, Bendigo
Time:  3pm to 6pm

Geelong
Date:  21 July 2000
Address:  The Hub, Grace Mackellar Centre
45-95 Ballarat Rd, Geelong
Time:  2pm to 5pm

Frankston
Date:  25 July 2000
Address:  Mahogany Community Centre
26-28 Mahogany Ave, Frankston North
Time:  2pm to 4:30pm and 5pm to 7pm

Benalla
Date:  26 July 2000
Address:  Raffety’s
55 Nunn St, Benalla
Time:  1pm to 4pm

Melbourne (1)
Date:  27 July 2000
Address:  Transport House
589 Collins St, Melbourne
Time:  9:30am to 5pm and 6pm to 8pm

Melbourne (2)
Date:  28 July 2000
Address:  Transport House
589 Collins St, Melbourne
Time:  1pm to 5:30pm
Focus Groups

Ethnic Communities’ Council of Victoria

Date: 1 August 2000
Address: Queen Victoria Women’s Centre
        210 Lonsdale St, Melbourne
Time: 9am to 12pm and 1pm to 5pm

Carers Victoria

Date: 2 August 2000
Address: Carers Association Victoria
        Level 5, 130 Little Collins St
        Melbourne
Time: 10:45am to 12:45pm & 1:30pm to 2:45pm

Consultation with Residents

Date: 21 September 2000
Address: Judge Brook Village
        Diamond St, Eltham
Time: 11:15am to 2:15pm