FIXED STAFFING RATIOS IN RESIDENTIAL AGED CARE

SUBMISSION TO THE ROYAL COMMISSION INTO AGED CARE QUALITY & SAFETY – MAY 2019

“For every complex problem, there is a solution that is neat, simple and wrong.” H.L. Mencken 1917
1. INTRODUCTION

At this early stage of the Royal Commission into Aged Care Quality & Safety (Royal Commission), the Commissioners have heard evidence on an aged care system in need of substantial overhaul and transformation. In the face of the greatest demographic shift in our history, Australia is unprepared for the service needs of the Baby Boomer generation and must move quickly and decisively to ensure that our aged care sector is adequately resourced and sustainable.

At the same time, the Commissioners are hearing first-hand accounts of the system failing individuals. In some instances, the issues reflect under-resourcing driven by funding cuts, while others are examples of intentional abuse by individuals. In these circumstances, it is not surprising that many are seeking immediate answers to address the problem and the argument for Fixed Staffing Ratios is being heavily promoted by the Australian Nursing Midwifery Federation (ANMF).

This paper considers the practical application of Fixed Staffing Ratios in residential aged care and leverages international research as well as our team’s own experience working under these systems overseas. We have also examined the assumptions used by the ANMF and Flinders University in its modelling of costs and benefits of the ANMF proposal.

In arriving at our conclusions, Ansell Strategic has consulted extensively with operators of residential aged care services across Australia. Interviews have been conducted with the Clinical Leaders (primarily nurses) responsible for the care of over 15,000 people in residential aged care.

ABOUT ANSELL STRATEGIC

Ansell Strategic is a professional advisory firm focussed solely on the aged care and retirement living sectors. Working with government authorities, aged care providers and investors, we provide advice that ultimately aims to enhance the lives of the end consumers, our elders. Our team’s passion, experience and skillset drive us to provide solutions that result in meaningful outcomes and a more positive experience as our elders live the last chapter of their lives. This research has been conducted on an independent, unfunded basis.
2. KEY FINDINGS

Through consultation, international research and literature reviews, we have demonstrated that fixed staffing ratios are not appropriate for residential aged care. The following key elements have been considered in support of this finding:

1. Variability of Resident Needs and Staff Skills
2. Overinvestment in Clinical Resources
3. Evolving Models of Care
4. Scarcity of Registered and Enrolled Nurses
5. Economic and Administrative Burdens
6. Implications for Consumer Choice

The ANMF has accurately articulated a key challenge within the aged care sector – the workforce is under-resourced, inadequately trained and undervalued. It is undisputed that resident outcomes are enhanced through improved skills mix, training and recognition. Delivering on this will require a substantial investment, not only in the workforce, but in the reallocation of our sector’s resources between residential aged care and home care.

Broadly, we believe the solution to the key challenge identified above lies in:

1. Improving the focus and resourcing of home care to reduce future pressures on residential aged care;
2. Improving the training, education and recognition of the aged care workforce; and
3. Realigning the relationship between aged care stakeholders to create a unified partnership.

We are facing a monumental point in Australia’s aged care sector where we strive for consumer choice and dignity within the context of unprecedented demand growth. To effect lasting change, the industry requires an innovative and flexible solution that recognises the dynamic and unique life experiences of our elders and how this translates into individualised and flexible services.
3. CONTEXT & BACKGROUND

Over the past decade, the diversity and complexity of consumer needs in aged care have reached levels never before experienced. People are entering services later in life, often with severe comorbidities and more diverse physical and cognitive issues. At the same time, consumers’ expectations for lifestyle and quality accommodation are constantly increasing.

Within this evolving environment, nurses have a critical role. The level of clinical knowledge required and the ability to apply critical thinking concepts is paramount, but more than that, they are routinely expected to take on leadership roles to ensure that resources are directed to best support their vulnerable consumers. As leaders and clinicians, nurses must be afforded flexibility in the way they address consumer needs which vary greatly from home to home, and within each home.

The availability of nurses in the aged care sector is extremely low. The projected growth in consumer numbers means that the sector will need to leverage this scarce resource effectively and efficiently.

As a result of challenges facing the sector, the call for a solution to reduce systematic issues in the sector is resounding. The ANMF has proposed the introduction of fixed staffing ratios for the aged care workforce and a substantial increase in the number of Registered and Enrolled Nurses. The ANMF has recommended a 240% increase in nurse FTE equivalents with the representation of nursing hours increasing from around 25% to 50% of the workforce. Combined with a minimum allocation of recommended hours per resident, this would require an additional 57,000 FTE nurses in a sector that currently employs around 24,000 FTE nurses.

The ANMF argues that the recommended strategy is supported by international research, practices and literature.

To support the economic merits of the fixed staffing ratios proposal, the ANMF commissioned Flinders University to undertake an economic analysis. The report concludes that the ANMF’s proposal of a 73% increase in the sector workforce (costing an estimated $5.7 billion) would be offset by indirect and social benefits.

Flinders University argues that financial savings, additional taxation revenue and quality of life outcomes support the ANMF’s proposal on economic grounds. The ANMF has used these findings extensively in their lobbying activities.

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1 ANMF, National Aged Care Staffing and Skills Mix Project Report, 2016
2 On an FTE basis
3 Flinders University, Financial and Cost Benefit Implications of Recommendations of the National Aged Care Staffing and Skills Mix Final Report, 2017
4. IMPLICATIONS OF FIXED RATIOS

To evaluate the practical application of fixed staffing ratios, we have examined international literature on aged care resourcing, as well as the research conducted by the ANMF and Flinders University. We have also conducted interviews with clinical and care experts from a wide range of operators (incorporating not-for-profit, for-profit, smaller and larger organisations) across Australia, most of which are Registered Nurses. This involved gaining feedback on current practices, their suggestions for improvements and obtaining opinions on the implications of fixed staffing ratios.

Our examination of international research indicates that fixed staffing ratios are not widely supported in the literature cited by the ANMF. We have reviewed practices of the leading OECD countries with comprehensive data of aged/long term care and only two of these countries (Germany and Japan) employed fixed ratios. Notably, Germany possesses the most stringent staffing ratio and qualification regulations whilst operating under a universal funding environment. While international research does advocate for more effective resourcing to secure improved consumer outcomes, there is no direct evidence supporting the benefits of fixed staffing ratios in aged care.

We found that the ANMF and Flinders University financial modelling does not substantiate the assumptions underpinning the forecast economic and social benefits. Estimates of reduced hospitalisation are unsupported and the “quality of life” financial benefits are incapable of being measured.

Our consultation with the Care Leaders of over 160 homes across Australia highlighted industry concerns associated with fixed staffing ratios. The majority interviewed argued that the regime would undermine the flexibility needed to deliver to a highly diverse and constantly changing consumer cohort from a workforce with inconsistent skills and experience.

Importantly, most argued that there are simply not enough nurses currently within the sector and it would not be possible to meet the arbitrary thresholds proposed (approximately 240% increase in nurse FTEs). This reality will be exacerbated with an ageing population, an ageing workforce and other competing industries.

The following sections outline the six key reasons staff ratios are not appropriate in residential aged care.
4.1 VARIABILITY OF RESIDENT NEED AND STAFF SKILLS

The overwhelming feedback from industry care leaders is that resident profiles and needs are too dynamic, diverse and complex to set mandatory ratios. There are serious concerns that resident risk would be increased if there were not sufficient flexibility to adjust the workforce to meet their needs. Furthermore, it was argued that fixed ratios make no provision for variability in staff expertise, experience and competence.

“Rosters should be based on the skills, knowledge and experience of staff rather than fixed numbers of RNs to residents. Rosters should also be based around enabling less experienced staff to work with more experienced staff to foster knowledge, professional development and improve job satisfaction. This flexible staffing model helps to retain capable staff who deliver high quality care and ultimately enhance resident outcomes.”

“More staff does not simply equate to better care. We need staff to better practice consumer focussed care rather than trying to achieve personalised care through higher staffing numbers.”

Both the ANMF and Flinders University reports cite research in their argument for fixed staffing ratios. We have examined the studies referenced in these reports and have conducted further research on the impact of staffing resources on care outcomes.

Through our research, we have discovered that:

There is little support for fixed staff ratios in any of the literature cited by the ANMF. Most of the studies conclude that resident outcomes are impacted by a variety of circumstances and environmental influences.

Australian and international research overwhelmingly supports the importance of a well-resourced workforce in securing positive consumer outcomes and the critical role of nurses. However, they consistently emphasise the need to adapt these resources to the consumers and environments in which services are provided. A major United States of America (USA) study cited by the ANMF found that:

- Nurse staffing is a major concern in these settings because of the challenges in determining the appropriate numbers and type of staff required to meet the multidimensional and complex needs of nursing home residents.
- Other staffing factors, such as turnover, staffing levels, worker stability and agency staff use, as well as training or experience of individuals, or ways in which care is organised and managed may determine the effectiveness of professional and support performance and their relationship to quality of care to residents.

Further USA research demonstrates the importance of quality over quantity of nursing inputs:

"The significance of RN experience demonstrates the importance of looking beyond nursing hours or patient-to-nurse ratios in the promotion of safe patient outcomes."

Ansell Strategic management has worked in the USA at a time when several States had implemented fixed staffing ratios in nursing homes. Our consultations with senior Executives with homes in these States strongly advocated against fixed ratios based on their practical experience. Our researchers were presented with the following arguments:

1. **Resident Risk and Use of Scarce Resources** – Over time the fixed ratios become a standing roster. When resident acuity is low, staff are under-utilised – this becomes both a taxpayer and consumer cost because fixed rosters must be funded. The practice can also create a culture of low productivity. The greater issue arises when resident acuity elevates above fixed rosters – in this circumstance, the floor often becomes the ceiling, and static rosters create a risk to residents and staff when resources are stretched. The theoretical counter argument is that the ratios are a "minimum", however, the practical reality is that they are usually set at a generous level in response to a major policy change and/or sector failure events. Operating under fixed ratios, providers are rarely capable of quickly adapting to the critical resource driver (resident acuity) as it changes.

2. **Resident Social Activities and Personalised Care** – The commitment to minimum ratios has tended to discourage investment in resident activities and socialisation. Because ratios are initially set at artificially high levels, flexibility for non-clinical services is limited and services tend to align to medical models. There is less focus on individual resident requirements – this seems to be true for both the care and social programs – and plans are not as person centred. Nursing homes built under fixed ratio legislation in the USA operate much less like homes and more like hospitals.

3. **Home Design** – Because rosters are set to fixed ratios, the design efficiency of the home becomes the focus of capital development planning. This again tends to revert toward more institutionalised models that improve staff productivity rather than creating home-like environments for residents. Where they have not been designed to maximise efficiency (multi-storey, household model, etc.), the risk of under-resourcing (item 1 above) becomes more acute.

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The ANMF report does concede that variation exists between:

- Different aged and restorative care and resident types, as ageing is a unique experience;
- Experience, expertise and the skill sets of nurses and carers;
- Models of care and support models; and
- Care environments and setting.

Their resident profiling and MISSCARE study also acknowledge the influence of other variables on resident outcomes, including service location, facility size, ownership type, experience and skills of staff, level of qualification, age of employees, staff origin and background and employment status.\(^6\)

\textit{Despite recognising all of these variables, the ANMF study provides a simple recommendation for the introduction of a single fixed staffing ratio and proposes the same thresholds to apply to all homes across Australia.}

### 4.2 OVERINVESTMENT IN CLINICAL RESOURCES

The ANMF has conducted a MISSCARE survey to collect data on the relationship between staffing numbers, skills mix, and other factors on perceived capacity to deliver care. Over 3,200 Registered Nurses, Enrolled Nurses and Personal Care Workers completed the study to identify the most commonly missed care tasks in residential aged care.

Consistent with international studies, the ANMF MISSCARE research identified that the most frequently missed tasks are associated with activities of daily living (ADL), specifically:

- Responding to call bells;
- Taking residents to the toilet;
- Talking to residents;
- Moving residents that cannot walk independently;
- Ensuring resident safety; and
- Nail and dental care.

The MISSCARE study concludes that the least frequently missed tasks are:

- Providing stoma care;
- Maintaining nasogastric or PEG tubes;
- Suctioning airways;
- Monitoring and measuring blood glucose levels; and
- Maintaining IV or subcutaneous sites.

The report states that medically-orientated, complex healthcare tasks were least likely to be missed.

The ANMF report recognises that the "performance of ADLs is not usually undertaken by Registered Nurses" and that they predominantly “spend time on complex care, communication, medication management and documentation”.

Despite this heavy weighting of MISSCARE events toward ADL deficiencies, the Australian Nursing and Midwifery Federation Union has recommended a doubling of the representation of nurses and a proportional decrease in the Personal Care Workers that would ordinarily perform the missed care tasks their own research has identified:

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<tr>
<th>Staff Mix</th>
<th>Current</th>
<th>ANMF Proposed</th>
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</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>Personal Care Worker/Other</td>
<td>72%</td>
<td>50%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>Nil</td>
</tr>
</tbody>
</table>

Both the international and ANMF research highlights that the greatest investment (missed care events) is required in personal care tasks and activities of daily living which would not ordinarily require the clinical expertise of a nurse. Arbitrary allocations of more costly clinical staff to undertake non-clinical tasks would divert available resources away from this priority.

Those working within the industry argue that the role of nurses as leaders and clinicians is too valuable to be misdirected in this way.

4.3 EVOLVING MODELS OF CARE

As part of the Federal Government’s Living Longer, Living Better aged care reform legislation, industry focus has been directed toward the provision of consumer directed services. Providers have developed service models that celebrate the consumer as an individual rather than defining them by their disability. This approach addresses the importance of investment in services based on consumer lifestyle choices, rather than allocating resources primarily at addressing their clinical condition.

Person-centred care is now reflected in the Aged Care Quality Standards contained in the Quality of Care Amendment (Single Quality Framework) Principles 2018. The foundation of these standards surrounds the consumer’s right to dignity and respect, and their capacity to make informed choices about care and lifestyle. Inherent in this objective is the need for flexibility – not only between individuals but for any individual whose needs and personal preferences may change as they experience ageing.

7 ACFA, Fifth report on the Funding and Financing of the Aged Care Sector, July 2017
Providers across the country have been structuring their services to deliver on a person-centred care model. These models are underpinned by regular consultation with consumers, their families, staff and external health professionals. There is regular communication undertaken with staff around their workloads, which allows them to identify if they are understaffing or overstaffing for the changing needs of their consumers. There is also frequent consultation with consumers and their families that allows them to respond to their feedback and preferences on staffing. Their rostering practices rely heavily on this feedback, which they believe supports consumer engagement to enable a person-centred approach to care delivery.

Our consultation with operational and care leaders revealed concerns that the introduction of inflexible, ratio driven clinical models would result in homes becoming more like hospitals and shift the sector focus from one of lifestyle preferences to a medical regime in an institutional environment. Our consultation with industry leaders overwhelmingly highlighted that rostering flexibility is key in a provider’s ability to deliver flexible, person-centred care and improved outcomes for consumers. Some insights from our consultation include:

“Implementing staffing ratios works against our movement away from institutional aged care models. The ability to deliver person-centred care is reliant on both nurses and carers taking ownership of their roles.”

“Any staffing model needs to account for variability in resident acuity, resident turnover, building designs and the location of a facility.”

“Our staffing model is based on multi-disciplinary training and the use of student and graduate nursing staff to enable greater flexibility. Mandated staff ratios would restrict our ability to staff flexibly with multi-disciplinary teams.”

In the absence of positive examples from international practice, the ANMF has also argued that fixed staffing ratios have been successful in achieving positive patient outcomes in hospitals. This report demonstrates the dangers of adopting simplistic assumptions across sectors that are not the same.

As highlighted above, residential aged care provides long term, holistic care and personal activities for people with highly variable needs and preferences. Hospitals are resourced to deliver short-term, episodic interventions in a managed care pathway environment that is more conducive to predicting clinical needs and care inputs. *Residential aged care is a home, not a hospital.*
4.4 IMPLICATIONS FOR CONSUMER CHOICE

The move towards consumer directed care aims to empower individuals to choose how, when and from whom they receive care. The notion supporting this is the acknowledgment that each person has basic human rights, regardless of their age, disability or background. It also follows trends that have taken place in other parallel industries, including the NDIS, and a movement away from medical paternalism.

In addition to moving towards consumer directed care, the Government and the Aged Care Sector Committee have signalled future reform that will enable more seamless transition between services within the aged care system. Effectively, all care delivered will be portable to suit the consumer, without being constrained to built form. The Aged Care Roadmap depicts a future where we will “remove distinction between care at home and residential care, creating a single aged care system — agnostic as to where care is received.”

Introducing staff ratios will inhibit any future reform towards person-centred, flexible aged care services.

4.5 SCARCITY OF REGISTERED AND ENROLLED NURSES

Our interviews with Care Executives confirmed that the shortage of nurses in the residential aged care sector is one of the most critical concerns facing the sector. As the population of older people grows exponentially, a major campaign and partnership with other Government Departments will be needed to encourage new enrolments and attract nurses from overseas. One provider explained:

“There needs to be greater support from the Government investing in workforce training and education across the aged care sector. Educating consumers and their families around the roles of staff may also help to adjust their expectations that more nurses equal better care. The image that the media and the unions are currently painting on the role of nurses is inaccurate. If providers are forced to adopt fixed staff ratios in the current regulatory framework, this will be unsustainable for the sector in the future.”

There is a national shortage of nurses across the acute, primary and aged care sectors in Australia. It will require a major national drive to increase enrolments of new nurses just to keep up with the demands required for our rapidly ageing population. It is not possible to source the 57,000 new nurse FTE’s proposed by the ANMF, nor is it appropriate to roster these scarce resources to arbitrary ratios and non-clinical roles.

*Aged Care Sector Committee, Aged Care Roadmap, 2016*
In a mandated environment, providers would be unable to meet the threshold staffing requirements, particularly in regional and remote locations.

“*The Royal Commission has dampened interest from the labour market to apply for positions in residential aged care. Regional locations also have labour pool shortages and strong competition for staff coming from the hospital, home care and disability sectors.*”

“*Registered Nurses are our scarcest resource and we need to use them to the best effect. We work on the principle that a Registered Nurse should only do, what only a Registered Nurse can do. By providing better training and developing better observation skills in our carers, we find that carers are identifying emerging issues earlier, enabling the RNs to address the issue before it escalates, resulting in improved care outcomes.*”

### 4.6 ECONOMIC AND ADMINISTRATIVE BURDEN

The Flinders University concludes that by implementing the recommendations of the ANMF Staffing Report, there would be an increase in the base wages and other costs in the residential aged care sector of $5.7 billion (based on 2016 outlays).

While there is little doubt that a greater level of investment is required in the sector, it seems unrealistic to assume that such an investment would be made in an arbitrary allocation of scarce staff resources that cannot be sourced.

The Flinders University Report argues that the costs would be “offset by indirect benefits totalling $2.4 billion and intangible quality of life benefits totalling $3.4 billion”. The conclusion implies that the investment in increased staffing will result in a net saving to the economy.

The University concedes there is little direct evidence to underpin the key assumptions used in the modelling. Our discussions with the authors of the Flinders University study confirmed that there is little empirical data to support the material assumptions used, nor the forecasted impacts of the ANMF’s proposed staffing ratios.
FLINDERS UNIVERSITY - INTANGIBLE & INDIRECT BENEFITS

<table>
<thead>
<tr>
<th>Key Assumption</th>
<th>Assumed Saving</th>
<th>Commentary</th>
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<tbody>
<tr>
<td>Quality of life</td>
<td>$1.36b</td>
<td>The researchers have attributed a value for the reduced stress and depression of residents, relatives and carers. In our opinion, these benefits cannot be measured in financial values and the case study evidence referred to in the Flinders University report provides no linkages to monetary outcomes.</td>
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<tr>
<td>Offset in Tax Take</td>
<td>$1.25b</td>
<td>The researchers have assumed that the wages of additional staff represent &quot;new&quot; income to the sector and therefore create additional income tax revenues for the Government. Given that the proposed investment is predominantly in skilled workers, it seems unrealistic to assume that these people would not already be employed in another sector and contributing income tax.</td>
</tr>
<tr>
<td>Reduced Hospitalisation</td>
<td>$813m</td>
<td>There is no substantiation for assuming a 50% reduction in hospitalisation of residents. Research literature referred to in the report does imply some linkages between greater nurse representation and reduced hospitalisation but most studies have been inconclusive – and none are able to quantify the relationship. There is no correlation demonstrated between the ANMF proposed staff mix and the incidence of hospitalisation of residents.</td>
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The assertion that additional clinical resources would significantly reduce hospital transfers is to adopt a simplistic view to a complex issue.

Registered Nurses are just one member of the health care team that identifies and responds to the clinical needs of consumers. An integral member of this team is the General Practitioner (GP). The business model for General Medicine Practice does not generally support a rapid response to a residential care facility by the GP to provide immediate medical assessment and intervention.
Complex conditions experienced by the older person requires expertise that many GPs consider to be beyond their primary capability. This limitation and the lack of available time to commit to managing acutely ill consumers often results in a preference by GPs to transfer the consumer to hospital to ensure they get the medical expertise they need.

In addition to this, it is rare for GPs to provide an after-hours service with homes relying on a Locum Service, which again is rarely able to provide a rapid response. The nature of the Locum Service does not usually provide adequate time to make an assessment, nor spend a prolonged period at the home stabilising an acutely ill resident. Therefore, a Locum will often recommend a transfer to hospital.

Based on this and other evidence in this report, we contend that fixed staff ratios will not deliver the level of reduction of hospital admissions stated in the ANMF paper.

We would agree that greater investment in the aged care sector would result in savings and intangible benefits elsewhere in the sector. However, such benefits require more robust consideration and modelling to ensure that taxpayer funds are directed toward the solutions that best address the needs of older people in care.
5. CONCLUSION & RECOMMENDATIONS

The Australian aged care sector requires major structural reform to address the needs of future generations of consumers. Regardless of the changes introduced, there will continue to be risk inherent in a service model which relies on people looking after people. To manage and mitigate this risk we need multi-dimensional solutions and strategies.

The ANMF has correctly articulated that the sector workforce is under-resourced, under-trained and undervalued. As highlighted in this report, the solution to these challenges will not be achieved through simplistic staff ratios.

Through our research, consultation process and operational experience, we believe the solutions will come from:

1. **Expansion of Australia’s Home Care services and Improved Investment in Residential Aged Care.**

   By OECD standards, a comparatively large proportion of Australians are admitted to residential aged care services. Research commissioned for the Royal Commission has demonstrated that improved investment in home care services can reduce dependence on residential aged care as the volume of consumers grows. With more realistic means testing arrangements, future consumers will be able to exercise their preference to age at home and access improved residential aged care services later in their ageing journey. The full findings from this analysis can be found here.

2. **Improving the training, education and recognition of the aged care workforce.**

   It is widely accepted that additional training, education and remuneration of the workforce sector is needed. The opportunity to address this requirement is comprehensively addressed in Australia’s Aged Care Workforce Strategy prepared by the Aged Care Workforce Strategy Taskforce. The report can be found here.

3. **Changing the relationship between aged care stakeholders to represent a partnership.**

   The Royal Commission has already highlighted the conflict and disparity of views between stakeholders in the aged care system. We have heard from a vast array of stakeholders and it is evident that the relationship between many of these parties is strained.

   The sector must move away from what has previously been a program based, silo approach to caring for our elders. The establishment of a holistic and integrated model requires that stakeholders act in partnership to ensures that our elders live with dignity, choice and continue to derive a sense of self-worth as contributing members of society.

The Royal Commission provides a unique opportunity to present recommendations that will have a lasting effect on the aged care sector. Resourcing, from both a workforce and funding perspective, is a major issue that needs to be addressed while we still have a window of opportunity for change.