9 October 2019

Mr Rodger Prince
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Royal Commission Into Aged Care Quality and Safety

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Dear Mr Prince

University of Wollongong (UoW) Report: How Australian residential staffing levels compare with international and national benchmarks

This letter is in response to your letter of 27 September 2019 and the invitation for us to review and comment on the University of Wollongong's report, How Australian residential staffing levels compare with international and national benchmarks. We thank you for the invitation.

This is a joint letter from both Robert Bonner and Paul Gilbert. We have each previously provided Statements to the Commission relating to minimum staffing in residential aged care (WIT.0488.0001.0001 and WIT.0430.0001.0001). This letter has been prepared in consultation with officers and staff of the Australian Nursing and Midwifery Federation.

The ANMF has proposed to the Commission a staffing model for safe care and best practice (Butler: Exhibit 1-16 WIT.0020.0001.0001; Exhibit 1-20 ANM.0001.0001.3151; and ANM.0001.0001.3341). The proposal is for an evidence-based methodology, which, taking account of residents' care needs and the time and personnel required to meet those needs, that recommends that aged care residents require an average of 4 hours and eighteen minutes of care per day, delivered by a skills mix of 30% registered nurses, 20% enrolled nurses and 50% personal care workers. Mandating minimum staffing requirements as proposed by the model would ensure safe, best practice and dignified care for those living in residential aged care.

As noted above, Mr Bonner has also more recently provided the Commission with a Statement providing a calculator and associated tools developed from the initial ANMF staffing research work (WIT.0488.0001.0001).

We welcome the opportunity to review the UoW's Report and assess the findings' compatibility and degree of congruence with the ANMF's proposed staffing model. While the UoW report reviewed a number of international...
staffing profiles, our commentary mainly focuses on the CMS Nursing Home Compare system as the UoW report recommends this system as the most useful to inform Australian staffing requirements.

Review of the UoW report:

1. We note the UoW report’s suggestion that the purpose of considering staffing levels in aged care should be to ensure that the needs of aged care residents are met and agree with the report’s finding that currently these needs are not being appropriately met. In fact, the report recognises that internationally, the changing clinical profile has not been matched by a commensurate increase in resources, either in terms of dollars or skill mix, which in Australia has been hampered by a culture that conceptualises residential aged care facilities simply as a person’s home.

2. We also agree, as ANMF has previously submitted to the Commission, with the report’s assessment of this reconceptualisation of aged care which has inadvertently encouraged the development of a workforce that is less clinically skilled and oriented with greater reliance on lower skilled personal care workers ... resulting in a residential aged care sector that is challenged by the need to support residents with higher and more complex needs ... and a staff profile that has been increasingly de-skilled over time.

3. There is a consensus shared by us and as identified by the report, that the current aged care funding measure, the Aged Care Funding Instrument (ACFI), is not a dependency, acuity or complexity measurement tool and is no longer fit for purpose for assessing care needs in residential aged care. We also agree that it does not provide a basis for determining appropriate staffing levels for the sector. The ACFI is not a dependency, acuity or complexity tool. However before the ACFI is replaced it is critical that the shortfalls in nursing and care hours recognised by both the UoW report and the ANMF research project be addressed and mandated. The role of the registered nurses in assessing, coordinating, managing and delegating care is critical, but for many employers sadly, the role of the registered nurse is, in many cases, a burden imposed by an industrial instrument, or in the current context, a necessary tool to achieving higher ACFI scores. Absent the financial motivation or industrial obligation to have a registered nurse, experience suggests that approved providers would no longer engage registered nurses, or substantially reduce their hours and once lost they are unlikely to return.

4. We are therefore supportive of the need to implement a new funding model to replace the ACFI and consider the proposed Australian National Aged Care Classification (AN-ACC) model to be a promising replacement providing that it is properly resourced and carefully implemented; accurate pricing will be integral to ensuring the successful implementation and maintenance of the AN-ACC.

5. However, it must be noted that while the AN-ACC model provides a suitable alternative funding measure for residential aged care it is not a model for determining safe staffing requirements. The AN-ACC will not provide for staffing allocation and assignment at a facility level on a daily or weekly basis as would be achieved by the ANMF’s proposed staffing model. We strongly recommend that a new funding model should not be implemented before a suitable staffing model has been mandated.
6. In addition, although recognising that the changes that have occurred to the sector have resulted in an aged care workforce that is insufficient in both number and skill to meet the current needs of those living in residential aged care, the UoW report fails to recommend changes that would fully address current staffing inadequacies. Instead, the report concludes that the CMS Nursing Home Compare system is the most appropriate available on which to build an Australian system to ensure reporting on quality of care and to build a contemporary Australian aged care staffing model.

7. Of particular concern is the Report's references to the further development of models, and ongoing policy and program development and the American system providing "a basis on which to build a contemporary Australian aged care staffing model". The CMS Nursing Home Compare system, given its characteristics as discussed below, does not provide the basis for a staffing model. In our view the Commission has an opportunity now to recommend mandated staffing and skills mix. The time for kicking the can down the road is over. Further delay, to develop an Australian version of the CMS Nursing Home Compare system that will still not ensure minimum staffing, cannot be supported.

8. The next section of this letter outlines in a summary form concerns with the report's proposed adoption of the CMS Nursing Home Compare system.

**CMS Nursing Home Compare is not a framework for informing staffing levels**

9. The purpose of the CMS Nursing Home Compare system (the system) is to provide consumers with a multi-dimensional rating system that includes registered nurse (RN) and general direct-care staffing levels to inform their selection of facilities. The system is a retrospective report on both demand (care required and provided) with the supply of labour over the same period. It does not provide clear reporting on residents' care needs mapped against the interventions and associated timings required to meet the assessed needs and is therefore not a staffing model. Furthermore, the system operates in the context of state imposed minimum staffing regulation.

10. The CMS system should not be thought of as a direct intervention designed to improve the quality of resident care or RACF staffing levels. As explicitly a rating system, CMS is neither designed to nor effective in improving resident outcomes. We are of the firm view that Australian residential aged care facilities and their proprietors will continue to fail residents unless a mandated minimum staffing system is introduced.

11. While the system is not a staffing model, there is merit in the suggestion that the system could form the basis of a suitable quality reporting system for Australia. Such a system could work in conjunction with the ANMF's proposed staffing model. A rating system may be useful within the Australian context to allow improved public reporting and provider transparency regarding staffing levels and skills mixes (as well as other indicators as reported by the NHC rating system in the US) and assist consumer decision-making regarding the selection of residential aged care providers. It is not the solution and it is not the priority. Consumer
choice and decision making is heavily circumscribed in the aged care sector. In reality it is a mechanism to rank care hours from 'least worst' through to 'most worst' at a moment in time. There is no evidence based benchmark upon which those ratings are made, it lends itself to industry gaming, and in fact could mislead those it is intended to inform.

12. Such a system could not be relied upon to ensure that aged care providers would appropriately or safely staff RACFs. While an element of competition and public responsibility may be engendered through the mechanism of a transparent and public staffing rating system, public reporting alone will not ensure safe staffing and may also inadvertently result in a growing divide between high- and low-rated providers. Only mandated minimum staffing levels and skills mix as proposed by the ANMF's staffing model will ensure safe staffing across the system.

13. A possible public reporting system comparable to the CMS Nursing Home Compare system could be established in Australia based upon legislated requirements for residential aged care facilities similar to those proposed by the Private Members Bill - Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018. The proposed AN-ACC aged care funding model, which groups aged care consumers with similar levels of complexity and care needs, could be used to explain the relationship between care need, activity and cost, to provide a platform upon which to base an Australian public reporting system. As the UoW report notes:

"Where staff ratios have been implemented internationally, the aged care system has been funded using a case-mix model that classifies residents according to their clinical need and associated resource utilisation and that is adjusted for contextual factors."

Providers could then be required to publish their staffing and skills mixes and demonstrate how they have aligned these with the changing needs of their residents. If this occurred in the context of mandated minimum staffing levels and skills mixes, the public could be informed of where providers were understaffing in relation to their residents' needs. Public funding tied to the provision of care could also be reported under this system allowing even greater transparency for consumers.

Technical Commentary attached and Victorian legislated nurse to patient ratios

14. The ANMF in conjunction with us has prepared a technical commentary for the consideration of the Commission which analyses in greater detail the CMS Nursing Home Compare system comparing it with the ANMF staffing and skills mix data and recommendations. The Commentary is attached to this letter.

15. The Commentary also provides an overview of the Victorian legislated nurse to patient ratios as they apply to Victorian government run nursing homes. This legislated scheme is referred to in the UoW Report but discarded on the basis that it does not apply to personal care workers. However, as the commentary makes clear, the scheme does provide the foundations for an option to address minimum staffing.
Thank you again for the opportunity to provide feedback on the UoW report, *How Australian residential staffing levels compare with international and national benchmarks.*

Yours sincerely,

Robert Bonner
Director, Operations & Strategy
Australian Nursing and Midwifery Federation (SA Branch)

Paul Gilbert
Assistant Branch Secretary
Australian Nursing and Midwifery Federation (Victorian Branch)
ANMF Commentary

An analysis of the Centre for Health Service Development Report (UoW Report) and comparison of the Nursing Home Compare rating system with the ANMF Staffing and Skills Mix data and recommendations and the Victorian Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act

9 October 2019
Introduction

1. This paper provides a commentary on the University of Wollongong (UoW) Report, *How Australian residential staffing levels compare with international and national benchmarks* and its key findings regarding international and national staffing profiles for residential aged care services. The paper assesses the findings' compatibility and degree of congruence with the ANMF's proposed staffing model, *National Aged Care Staffing and Skills Mix Project Report 2016*, and provides an overview of the Victorian safe staffing legislation, *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*.

2. The ANMF's position is that the model proposed by the UoW report, the CMS Nursing Home Compare system, would not ensure safe staffing in Australian residential aged care. The following provides a detailed analysis of why the ANMF considers this to be the case.

3. It should be noted at the outset that the CMS Nursing Home Compare system did not build its staffing profiles based on an assessment of needs, but rather on analysis of supply against outcomes. Harrington et al.¹ argue that the staffing levels in many US facilities are dangerously low and that enforcement of the existing standards is weak despite state-based minimum staffing standards that are higher than the federal minima. That review also states that higher state standards than the federal standards, have been demonstrated to have significant positive effects on staffing levels and quality outcomes.

4. As alluded to above, the CMS Nursing Home Compare system operates in the context of (State based) mandated minimum staffing requirements. Such a position is consistent with the ANMF's proposals.

5. The purpose of the CMS Nursing Home Compare system is to rate relative performance of each facility against benchmark criteria, rather than to determine and allocate actual staffing levels and mix in that environment at facility level.

6. The operation of a casemix and quality reporting system such as that proposed by the study and in the CMS Nursing Home Compare system does not serve to invalidate the case for mandatory safe staffing levels and skills mix. Both the US nursing homes system and the Australian acute care system have components within them that reflect the relative cost weights that reflect the nursing costs relative to the episode of care. However in both cases there are mandatory staffing standards that operate as a function of state determinations and statutes or as mandatory and enforceable standards within industrial agreements that bind employers to minimum staffing levels and mix.

Staff hours per resident per day may not reflect actual or direct care

7. Staff (RN, licensed practical nurse/licensed vocational nurse, and certified nursing assistant) hours per resident per day are calculated based upon data collected quarterly via the Payroll Based Journal (PBJ) system.² Data regarding residents is also derived from daily resident

² Facilities are required to submit this data by Section 6106 of the Affordable Care Act (ACA). These data are submitted quarterly and are due 45 days after the end of each reporting period. Only data submitted and accepted by the deadline are used by CMS for staffing calculations and in the Five-Star Rating System.
census from Minimum Data Set, Version 3.0 (MDS 3.0) assessments, and are case-mix adjusted based on the distribution of MDS 3.0 assessments by Resource Utilization Groups, version IV (RUG-IV group). Not all states use the RUGS-IV system so there are inconsistencies across the US for classification system used to allocate funding. The staffing hours reported through PBJ and the daily MDS census are both summed across the quarterly reporting period. The quarterly reported staffing hours per resident per day (HRD) are then calculated by dividing the aggregate reported hours by the aggregate resident census.\(^3\)

8. The number of hours each type of staff worked each day in this period, inclusive of administrative time, is divided by the number of residents at the facility. This approach does not account for the actual direct care hours that staff spent with residents. There is considerable evidence indicating that due to factors such as low staff numbers and administrative demands, staff may spend considerable amounts of time undertaking non-direct care tasks. There is also evidence that administration of the system, coding and assessment, and administrative work for care staff, increased workload demands by 5-10%. Simply counting the number of hours different staffing groups worked during a reporting period is unlikely to provide a realistic picture of the actual hours these staff spend providing direct resident care or the needs of the residents concerned.

The NHC rating system does not address issues with over-reliance on temporary agency staff

9. While it is understood that residential aged care facilities (RACFs) may be required to employ temporary or agency staff to provide adequate staffing for their residents' needs where permanent staff are not available, over-reliance upon this temporary workforce who may not be as familiar with other staff, local processes, or the residents and their families is not desirable or in line with best-practice care. The NHC PBJ staffing data includes both facility employees (full-time and part-time) and individuals under an organisation (agency) contract or an individual contract. This means that under an NHC system, temporary and agency staff can be used to boost a facility's staffing profiles and ratings. Such a system would not be desirable in Australia.

A similar rating system may be useful in the Australian context

10. Acknowledging the stated purpose of the NHC rating system, a similar rating system may be useful within the Australian context to allow improved public reporting and provider transparency regarding the quality of care along with consideration of the staffing levels and skills mixes supplied at the facility level (as well as other indicators as reported by the NHC rating system in the US). There is evidence to suggest that despite some confusion regarding the relationship between the specific domains measured by the system and a desire for greater information regarding data sources, consumers find the NHC rating system helpful for decision-making (Schapira, Shea et al. 2016).

11. A similar rating system, if adopted in Australia, may result in changes in consumer decision-making regarding the selection of residential aged care providers and corresponding improvements to provider quality as they move to improve ratings to attract greater consumer market share (Werner, Stuart et al. 2010). There is evidence that suggests that

\(^3\) Only days that have at least one resident are included in the calculations. There are also a set of exclusion criteria that exclude facilities with improbably high or low staffing or care hours per day.
lower-rated facilities can experience reductions in market share in compassion to higher-rated facilities which may increase market share (Cornell, Grabowski et al. 2019).

12. Such a system, however, could not be relied upon to ensure that aged care providers would appropriately or safely staff RACFs. There is evidence demonstrating that even within the context of the US NHC system, considerable daily staffing fluctuations, low weekend staffing, and daily staffing levels that are often below the Centers for Medicare and Medicaid Services (CMS) expectations still occur (Geng, Stevenson et al. 2019). While an element of competition and public responsibility may be engendered through the mechanism of a transparent and public staffing rating system, evidence suggests that public reporting may also inadvertently result in a growing divide between high- and low-rated providers (Werner, Konetzka et al. 2009), and disincentivise the provision of care for sicker clients who require higher levels of care and staffing (Tamara Konetzka, Grabowski et al. 2015). Furthermore, the proposition that informed consumer choice is a significant and practical element in addressing shortcomings in the aged care system ignores the heavily circumscribed character of that choice (not least because of geographic and resource reasons.)

A suitable public reporting system for RACF staffing could be based upon the RUCS and legislation requiring publication of staffing levels and skills mixes.

13. A possible public reporting system comparable to the US NHC rating system could be established in Australia based upon legislated requirements for residential aged care facilities similar to those proposed by the Private Members Bill - Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018. The proposed Resource Utilisation and Classification Study/ Australian National - Aged Care Classification (RUCS/AN-ACC) aged care funding model, which is a case-mix model, which as the UoW report highlights, groups aged care consumers with similar levels of complexity and care needs which, in turn, can be used to explain the relationship between care need, activity and cost, may be a useful platform upon which to base an Australian public reporting system. As the UoW report notes:

"Where staff ratios have been implemented internationally, the aged care system has been funded using a case-mix model that classifies residents according to their clinical need and associated resource utilisation and that is adjusted for contextual factors."

14. Briefly, RUCS/AN-ACC is designed to identify the case mix of each Australian RACF, and if implemented as proposed, would ensure that facilities' case mixes are updated regularly. These case-mixes, which define government funding thresholds, and which are also (initially) separate from staffing and care planning could be used to guide recommended staffing levels and skills mixes to provide the required care. Providers could then be required to publish their staffing and skills mixes and demonstrate how they have aligned these with the changing needs of their residents. If this occurred in the context of mandated minimum staffing levels and skills mixes, the public would then be informed of where providers were understaffing in relation to their residents' needs.

15. An additional requirement that is recommended would be to hold providers accountable to the allocation of government funding that is provided upon the basis of RUCS/AN-ACC assessments. Briefly, under RUCS/AN-ACC proposes that a baseline 50% of government funding would be provided to cover the shared care needs of residents. Additional funding that would be designed to cover the individual care needs of residents would also be provided based on the results of external assessments of individual residents. It would be desirable for providers to publicly and transparently demonstrate how this funding is used to
deliver both shared and individual care to residents in part by ensuring best-practice staffing levels that align to the needs of residents.

Mandated minimum staffing ratios and skills mixes would ensure an appropriate and flexible level and skills mix of staffing

16. While a public-reported rating system could be useful to inform members of the public and consumers regarding the staffing levels and skills mixes of RACFs in Australia, mandated minimum staffing and skills mix ratios would set a 'floor' to what Australian providers would be legally able to staff. Our calculations indicate that only a facility that would receive a 5-star rating for staffing under the NHC system where staffing is able to provide 78 minutes of registered nurse care time and 258 minutes of overall staff care time is able to ensure that residents receive the recommended average of 4.3 hours of care per day from a skills mix of 30% registered nurses, 20% enrolled nurses, and 50% care workers not counting the time needed for other direct-care staff (e.g. allied health, specialists, medical doctors) to provide care.

17. While in some cases, 3-star and 4-star staffing may be able to ensure appropriate levels of staff to provide care, this could exclusively occur only when care is provided at the highest end of the ranges stipulated and/or when the residents being cared for have the lowest care needs. This is discussed in further depth below and presented in Figures 1 and 2. Based upon the evidence, we know that most residents of RACFs tend to have higher care needs and that these care needs increase over time. (AIHW) 2018) Mandated minimum staffing levels and skills mixes for registered nurses, enrolled nurses, and care workers (plus the necessary additional direct care staff from allied health, specialist care, and medicine) would ensure that there are enough of the right kind of staff available at any one time to; proactively provide best-practice care to all residents, respond to accidents, emergencies, and sudden increases in care needs, ensure that RACF residents and their families receive a desired amount of face-to-face time with staff, and ensure that RACFs are staffed in a manner that would enable improved attraction and retention of qualified and experienced staff.7

There is no causal relationship between the CMS rating system and better quality or improved resident outcomes

18. The CMS system should not be thought of as a direct intervention designed to improve the quality of resident care or RACF staffing levels. As explicitly a rating system, CMS is neither designed to nor effective in improving resident outcomes. A study examined all 16,623 United States nursing homes included in public reporting between 2000 and 2009 in OSCAR and the nursing home Minimum Data Set. This study evaluated the extent to which improvements in outcomes of care could be explained by changes in nursing home

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4 Poor staffing and skills mixes are associated with reduced ability to provide personal and clinical care to residents (See 2019 ANMF National Aged Care Survey [RCD.9999.0203.0054]).
5 Poor staffing and skill mixes are associated with reduced ability for staff to respond to sudden increases in care needs or unexpected incidents (See 2019 ANMF National Aged Care Survey [RCD.9999.0203.0054]).
6 Poor staffing and skill mixes are associated with a lack of time for staff to spend with residents and their families which is desired by both staff, residents, and their families. (See 2019 ANMF National Aged Care Survey [RCD.9999.0203.0054]).
7 Poor staffing and skill mixes are associated with staff not wishing to work in aged care due to lack of support, lack of training (e.g. during clinical placements), and supervision. (See 2019 ANMF National Aged Care Survey [RCD.9999.0203.0054]).
processes. (Werner, Konetzka et al. 2013) Of five selected outcome measures, only the percentage of residents experiencing moderate or severe pain appeared to be associated, in part, with changes to RACF care processes. Overall, most improvements in resident outcomes were not found to be associated with changes in measured processes of care. This suggests that processes of care typically measured in RACFs do little to improve performance on outcome measures. The authors highlighted that they did not observe changes in factors such as RACF organisational culture, staff structure, satisfaction, assignments, quality, or training that could result in improvements in clinical outcomes. The authors called for the development of quality measures that are related to improved resident outcomes as a necessary step to improving care quality.

19. Research has also found that public reporting in the setting of post-acute care can have mixed effects on areas without public reporting (Werner, Konetzka et al. 2009). Improvements in unreported care were particularly large among facilities with high scores or that significantly improved on reported measures, whereas low-scoring facilities experienced no change or worsening of their unreported quality of care. While the benefits of public reporting may theoretically extend beyond areas that are being directly measured, public reporting initiatives may also widen the gap between high-rated and low-rated facilities as consumers may tend to select high-rated providers which increases their market share and revenue.

20. Similar conclusions were also indicated in another study which found that while when CMS was introduced, US 'dual eligibles' (residents dually enrolled in Medicare and Medicaid) chose higher-rated RACFs initially, over-time, the increased likelihood of choosing the highest-rated homes was substantially smaller for dual eligibles than for non-dual eligibles (Tamara Konetzka, Grabowski et al. 2015). This indicates that more vulnerable consumers with fewer resources may have been priced-out of higher-rated facilities. Furthermore, the benefit of the five-star system to dual eligibles was largely due to providers’ improving their ratings, not to consumers’ choosing different providers. Evidence appeared to suggest that supply constraints played a role in limiting dual eligibles’ responses to quality ratings, as high-quality providers tended to be located closer to relatively affluent areas.

**Consumer ability to pay may drive higher staffing and higher ratings**

21. Based on the findings of research described above (Werner, Konetzka et al. 2009) (Cornell, Grabowski et al. 2019) consumer ability to pay may drive higher facility ratings but also greater divides between high- and low-rated facilities. In an even playing field where all RACFs facilities are appropriately maximising their RUCS/AN-ACC derived government subsidies and implementing care plans with the correct staffing requirements, all facilities should hypothetically attract the same star rating. That is, residents’ needs, as assessed in line with the process proposed by RUCS/AN-ACC, would align to care plans and staffing resulting in each resident receiving a necessary amount of care.⁸

22. In this situation, market competition between providers could be expected to be driven by a desire for a higher star rating to attract a higher revenue. Providers that can afford to staff their facilities to levels exceeding what is supported by government subsidies provided via the proposed RUCS/AN-ACC system (i.e. ‘premium facilities’) would then attract higher

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⁸ As highlighted within the RUCS/AN-ACC report, payments under the system would be determined by the government using National Weighted Activity Units (NWALUs) which must be calculated correctly to ensure reasonable funding levels for base care tariffs, variable components, and entry adjustment period payments.
ratings – this would be likely to occur in areas where consumers are able to pay more (i.e. more affluent areas).

23. The above situation becomes an issue if the ‘average’ government subsidised and staffed facility which does not charge consumers significant amounts on top of government funding is not providing an appropriate or safe level of staffing. The nature of market competition may result in facilities that can’t afford to occupy the higher star rating space due to lower revenue move towards occupying lower-rating tiers with potentially lower/unsafe staffing.

Australia’s aged care sector should aim to deliver ‘best practice’ care – only 5-stars will do

24. According to the UoW report, a facility that delivers ‘three-star’ staffing would be considered to be providing an ‘acceptable’ level of staffing, while ‘four-stars’ would be considered ‘good’, and ‘five-stars’ would be ‘best practice’. According to our calculations derived from mapping the results of the ANMF Staffing and Skills mix project onto the NHC data presented in the NHC study (see Figures 1 and 2), residents would not be acceptably served by a ‘three-star-staffed’ facility (Willis, Price et al. 2016). This is because in most instances, facilities are able to achieve a three-star rating for staffing due to higher overall staffing but in the absence of sufficient registered nurse staffing per resident.

25. The ANMF’s evidence supports the delivery of an average of 4.3 hours of care (or 4 hours, eighteen minutes) per day for each resident delivered by workforce comprised of 30% registered nurses, 20% enrolled nurses, and 50% care workers. Added to this average care time is the time required by other direct-care staff including allied health care professionals, specialists, and medical doctors which as yet has not been factored into the ANMF’s recommendations. Further, our calculations are based on the skills mix project table which did not include the extra 30-minutes recommended by expert focus group members and based on the results of the MISSCARE Study. Without the additional 30-minutes added to the care times stipulated in the staffing and skills mix table, some 3- and 4-star rated staffing timings are appropriate to some resident profiles, but when the extra 30-minutes is included, only staffing that would receive a 5-star rating would be expected to provide sufficient care time for residents.

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9 The staff timing brackets/ranges presented in the NHC rating system are described as being based upon the results of the ‘STRIVE Study’, however based on our assessment to date, we have not yet been able to clearly interpret exactly how the ranges have been calculated. As such, different brackets/ranges could result in different rating categories.
### Total Residential and Personal Care Minutes Per Resident

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th>RCHPD (min)</th>
<th>RN (min)</th>
<th>EN (min)</th>
<th>PCW (min)</th>
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<tbody>
<tr>
<td>1</td>
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<td>150</td>
<td>45</td>
<td>30</td>
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<td>54</td>
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<td>6</td>
<td>5</td>
<td>300</td>
<td>90</td>
<td>60</td>
</tr>
</tbody>
</table>

**Figure 1:** Nursing and personal care hours/resident/day pre-focus groups and MISSCARE survey (Willis, Price et al. 2016).  

26. Only total staff care timing and registered nurse care timing have been used from the ANMF study (highlighted in Figure 1). Colour coding has been added to Figure 1 above to clearly identify how resident profiles from the ANMF study have been mapped to the NHC staffing rating groups in Figure 2 below. ANMF Study resident profiles have been assigned the same Total nurse staffing rating and minutes (RN, LPN and nurse aide)

<table>
<thead>
<tr>
<th>RN Rating and Minutes</th>
<th>Total nurse staffing rating and minutes (RN, LPN and nurse aide)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;186</td>
</tr>
<tr>
<td>1</td>
<td>&lt;19</td>
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<td>2</td>
<td>19 - 30</td>
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<td>44 - 63</td>
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<tr>
<td>5</td>
<td>≥63*</td>
</tr>
</tbody>
</table>

The values in Figure 1 above do not include a recommended additional 30-minutes of care per day as recommended by focus groups and results of the MISSCARE survey within the report.
Figure Legend

- Values provided by CHSD Report, interpreted as >63 / >264 to maintain mutual exclusivity. Where Resident Profile 3 requires 63 minutes of RN staffing per day, different interpretations of ≥63 / ≥264 rate Resident Profile 3 significantly differently.

* Resident Profile 3 is only allocated this star rating where RN Staffing is maximised within the category (i.e. 63 minutes), if not maximising RN staffing in this scenario (i.e. ≤63 minutes) then * indicates star ratings that would not be appropriate for Resident Profile 3.

- Cross-hatched cells indicate where an ANMF resident profile staffing requirement is exceeded either by additional RN minutes or additional total staff minutes.

-- Broken-outline cells indicate a rating required to deliver minimum best-quality care (inclusive of the additional recommended 30-minutes of care) as determined by the ANMF Study.

Figure 2: Table adapted from the UoW Report (originally adapted from the CMS Technical Users’ Guide April 2019) with ANMF Study resident profiles mapped onto NHC staff ratings.

27. Mapping resident profiles of the 2016 ANMF Study and associated minimum staffing requirements to the NHC rating system for staffing indicates that the highest 5-star ratings attainable (Cells 5/4 and 5/5) are the minimum star-ratings that would be required to meet the minimum staffing requirement (including the extra 30-minutes) as recommended by the ANMF.

28. If the additional recommended 30-minutes is not included, other NHC rating system staffing timings could be considered to adequately satisfy ANMF profile requirements:

- Resident Profiles 1 and 2 would require at a minimum the second highest 3-star rating (Cell 4/1).
- Resident Profile 3 would require at a minimum 3-star rating (Cell 4/2). For Resident Profile 3 to be appropriate to this star rating, then a facility must maximise their RN minutes for that category (i.e. 63 mins/resident/day).
- Resident Profile 4 would require at a minimum the highest attainable 4-star rating (Cell 5/3).
- Resident Profile 5 would require at a minimum the highest attainable 5-star ranking within the CMS system (Cell 5/5).
- The total staffing requirement for Resident Profile 6 (as indicated by the ANMF Skills mix project) is only satisfied where a facility staffs 300 total care minutes and 90 RN care minutes per-day, this staffing requirement significantly exceeds the 264 total care minutes and 63 RN minutes required to achieve the highest 5-star best-practice ranking (Cell 5/5) as determined by the NHC rating system.

29. The calculations above highlight that if the additional recommended 30 minutes is included with 4.3 hours (on average) of care provided per resident per day, facilities would need to staff to what would be a minimum 5-star staffing rating to be considered as delivering the minimum requirement for best quality care. Of the two 5-star ratings attainable (Cells 5/4 and 5/5), a facility must staff above 258 minutes/resident/day to ensure an appropriate level of care is being delivered in line with evidence-based ANMF recommendations. As such, at the 'lower end' of the 5-star rating in Cell 4/5 would not meet requirements for best-practice care.
30. In Australia, we should be striving to achieve 'best-practice' care rather than 'acceptable' or 'good' practice staffing, as illustrated above, for many residents, 'acceptable' and 'good' practice staffing would be neither safe nor adequate for their needs. As the UoW report highlights, more than half of all Australian aged care residents (57.6%) are in homes that according to the CMS system would be allocated 1- or 2-star staffing levels. This staffing level is unacceptable for the vast majority of residents and should not be tolerated.

31. Of the remaining 42.4% of Australian residents, currently 27.0% would be classified as residing in homes that would achieve a 3-star staffing rating, 14.1% of residents are in homes that would receive a 4-star staffing rating, and 1.3% of residents are in homes that would receive a 5-star staffing rating. The ANMF contends that only the highest-end of what would be classed by the NHC rating system as 5-stars could be considered for 'acceptable' practice.

An overview of the Victorian safe staffing legislation

Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015

32. The UoW report considers, but rejects, the Victorian legislated model on the basis that it does not apply to personal care staff.

33. The legislated ratios were extracted from and improved upon comparable provisions in the Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise Agreement 2012–2016, which in turn evolved from earlier enterprise agreements and recommendations of the Australian Industrial Relations Commission.

34. The effect of the ratios in Victoria requires an understanding of the interaction between the applicable enterprise agreement and the Act:

a) Commonly each employer operates multiple health service campuses. The current enterprise agreement requires that an employer have a full time Director of Nursing who is a registered nurse for each campus of a health service, including a stand-alone aged care facility. The Director of Nursing is the chief nurse for the campus, typically working Monday to Friday day shifts. These registered nurses are not part of ratios numbers. In many cases there is also an Executive Director of Nursing who is the principal nurse for the health service. In the off-duty periods of the Director of Nursing—typically being afternoon shifts, night shifts and weekend day shifts, an After Hours Coordinator who is a registered nurse becomes responsible for the campus. The After Hours Coordinator in all but campuses with two wards or less is supernumerary to ratios.

b) A Campus is made up of one or more wards. The current enterprise agreement requires that an employer have one FTE of Nurse Unit Manager (NUM) who is a registered nurse per ward or unit. Wards and units while not defined in the enterprise agreement are typically functionally and geographically discrete sections of a campus. The Agreement also requires the appointment of five FTE of Associate Nurse Unit Managers (ANUM) per ward or unit, who are registered nurses, to assume responsibility for ward or unit in the off-duty periods of the NUM. The ANUM FTE is more than is required to cover the off duty shifts of the Nurse Unit Manager, resulting in occasions where the ward will have
both a NUM and an ANUM on the same shift. Where the Act refers to "one nurse in charge" this is the role filled by the NUM or ANUM. Read together, the requirements for night shift are one nurse to each 15 residents, one of whom must be the registered nurse in charge of the shift.

35. At the time the aged care ratios were mandated in 2000/01, a public sector aged care ward typically contained 30 beds and the staffing compliment was almost exclusively registered and enrolled nurses. To the extent there were unregulated workers delivering nursing care, the ANMF and the employers worked together to facilitate the employee reaching the standard to become regulated as an Enrolled Nurse, during which time they were, by agreement, counted as a nurse in meeting ratios. The ratios historically only applied to those wards that were nursing homes, as distinct from hostels, and did not apply to specialist psychogeriatric sites that were funded as such. The staffing for the latter remains in the relevant industrial instruments and comprises 'roster lines' setting out the actual staffing requirement for each named site.

36. The Agreement also regulates minimum shift lengths. The most common shift length pattern is known as an 8:8:10 roster, comprising 8 hour day and evening shifts, and 10 hour night shifts. Each shift has a 30 minute meal break, usually unpaid. Within that, each aged care ward may use a maximum of three 'short shifts' across a day or evening shift. A 'short shift' is 6 hours plus an unpaid 30 minute meal break. Putting aside short shifts, which are a maximum and not necessarily utilised, each nurse generated by the ratio results in 26 nursing hours per day, plus the Director of Nursing/After Hours Coordinator.

37. The ANMF recognises that the skill mix requirements in the Act for aged care is not reflective of the skill mix commonly found in private aged care, or in public aged care that is not subject to ratios. The Agreement committed the ANMF and the Victorian Hospitals Industrial Association (on behalf of the employers) to reviewing this, with the anticipated result that ratios would also apply to public aged care not currently covered (i.e. old Hostels) with a skill mix to be determined to apply to both. The public sector could be described as more risk averse than the private sector, and hence is attracted to a regulated workforce.

38. In any event, the ratio model as used in Victoria is readily adaptable to private residential aged care, the terminology would only need to change to accommodate a ratio that reflected the nursing hours required via the evidence previously submitted by the ANMF, with appropriate definitions around minimum skill mix, for example a ratio requirement of a registered nurse per 30-45 beds, plus 6 nursing/care staff, two of whom must be enrolled nurses. The remainder may be care staff, appropriately regulated, in parallel as discussed in Mr Gilbert's Statement to the Commission (WIT.0430.0001.0001). Ratios are an input based minimum staffing obligation that is readily understood, tried and tested over nearly 20 years, expanding rapidly across the world, embraced by the profession and the community. The community, and those that work in aged care, are almost universally calling for the mandating of minimum ratios and skill mix to restore public and professional confidence in this critical area.
References


