Submission by the New South Wales Nurses and Midwives' Association

Senate Inquiry into the future of Australia's aged care sector workforce

March 2016

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes assistants in nursing (who are unregulated), enrolled nurses, registered nurses and midwives at all levels including management and education.

The NSWNMA has approximately 61,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

We welcome the opportunity to make submission to this important Inquiry and the opportunity for wider discussion that this provides.

This submission is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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"Most aged care residents are only discharged when they die. They should not have to suffer. They should not have to sit, isolated in their room, because there is nothing to do and no one to talk to. They should not become incontinent because there are too few staff to assist them to the toilet; or immobile because there is not enough staff and not enough time for assistance with walking and exercise programs. And they should not have to suffer because untrained staff don't recognise problems, or are not able to quickly assess pain and provide relief."

Registered Nurse
Aged Care

Introduction

The NSWNMA has 9,967 members directly employed in aged care within NSW comprising of: 3,852 Registered Nurses; 770 Enrolled Nurses and 5,345 Assistants in Nursing. Membership covers all Local Health Districts within the State and 750 workplaces within the public, private and not for profit sectors. Our members make up a significant number of the NSW aged care workforce and are a valuable resource in terms of enhancing our understanding about the nature and extent of workplace issues.

There is a rich diversity of experience and cultural background within our aged care membership, most are 45 years and over and originate from 44 countries including Australia. We have consulted with them about the terms of reference in relation to this Inquiry and wish to acknowledge their valuable contribution in highlighting significant issues and creating a body of expert knowledge to inform future policy direction.

As the NSW branch of the ANMF we have focused this submission on issues that mainly relate to NSW. For Federal matters we refer the Inquiry Committee to the ANMF submission, which we fully support.

Brett Holmes
General Secretary
NSW Nurses and Midwives' Association

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List of Abbreviations:

AACQA	Australian Aged Care Quality Agency
ACFI	Aged Care Funding Instrument
AiN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Federation
CDC	Consumer Directed Care
CSU	Charles Sturt University
CQC	Care Quality Commission (England)
EN	Enrolled Nurse
NDIS	National Disability Insurance Scheme
NGO	Non Governmental Organisation
NHS	National Health Service (UK)
NSW	New South Wales
NSWNMA	New South Wales Nurses and Midwives' Association
NT	Northern Territory (Australia)
RACF	Residential Aged Care Facility
RN	Registered Nurse
RM	Registered Midwife
UK	United Kingdom
US	United States

Summary of the terms of reference

On 1 December 2015, the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report:

The future of Australia's aged care sector workforce.

The terms of reference are:

a. the current composition of the aged care workforce;
b. future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers;
c. the interaction of aged care workforce needs with employment by the broader community services sector, including workforce needs in disability, health and other areas, and increased employment as the National Disability Insurance Scheme rolls out;
d. challenges in attracting and retaining aged care workers;
e. factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths;
f. the role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded;
g. government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;
h. relevant parallels or strategies in an international context;
i. the role of government in providing a coordinated strategic approach for the sector;
j. challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people;
k. the particular aged care workforce challenges in regional towns and remote communities;
l. impact of the Government's cuts to the Aged Care Workforce Fund; and
m. any other related matters

Summary of Recommendations

1. The NSW *Public Health Act (2010)* should be amended. This legislation should be strengthened to require the provision of RNs on site at all times in any residential aged care facility where there are people accommodated who have high care needs.
2. Action should be taken to address the wage disparity between public and private sector aged care workers.
3. A comprehensive review of safe staffing levels in aged care should occur and minimum staffing ratios established which values the role of RNs and ENs and does not further diminish skill mix. This should inform safe staffing levels for the purpose of accreditation of aged care facilities and subsequent quality reviews.
4. The current system for monitoring and regulating quality in residential aged care facilities should be reviewed so it effectively ensures sufficient numbers and skill mix of staff are provided to meet resident's high care needs.
5. Any transfer of long term disability service workers should occur with the option for them to take voluntary redundancy or to pursue a pathway into the public health system or the service of another government agency to prevent transfer to another sector where workers conditions of employment are reduced and there is limited security of employment.
6. Enhanced pre-employment checks should be implemented for <u>all</u> aged care workers.
7. All AiNs (however titled)* should be registered and subject to regulation.
8. There should be a minimum standard of qualification for AiNs (however titled).
9. Minimum standards of qualification for AiNs (however titled) should be linked to the Australian Qualifications Framework and include a requirement for a recognised level of training to at least certificate III level within specified timescales upon induction to the aged care workplace.
10. There should be career pathways for RNs, ENs and AiNs (however titled) in aged care, including the development of leadership opportunities for RNs and increased numbers and scope of nurse practitioners employed in aged care. Career pathways for workers in aged care should retain a direct care focus.

* Including all personal care workers however named

11. There should be additional incentives created to develop and retain a skilled workforce in rural and remote locations including the development of nurse practitioners, retention incentives for older workers and appropriate remuneration for nursing models that use Telehealth as a means of supporting the role of rural and remote RNs.
12. Initiatives aimed at supporting newly graduated RNs in the workplace should be developed and implemented.
13. There should be further incentives to retain older workers within the aged care workforce.
14. Further federal and state funding should be allocated to: enhance knowledge about the needs of older Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people; strengthen local communities and provide career opportunities for specialist aged care workers.
15. There should be a review of training providers and the curriculum to ensure an affordable quality framework for career development is available to aged care workers.
16. There should be funding assistance for the training and engagement of RNs and ENs, particularly at rural and regional universities, and graduate placement opportunities in rural, regional and remote areas.
17. The potential impact on the workforce and older people arising from the 'Uberisation' of community based aged care services should be investigated and necessary safeguards developed.
18. Consistency in legislation across all states should be achieved to reduce duplication in legislation, increase safeguards and enhance transparency in aged care.
19. Funding should be provided for the development of national benchmarking of quality in aged care including investment in research aimed at improving quality.
20. A coordinated response within Australia with funding to explore international projects that could have relevance for the development of an aged care workforce is required.

The current composition of the aged care workforce

Within Australia 10% of the total number of RNs and around 32% of ENs are employed in aged care and most are permanent part time staff[1]. However, as a combined total these two groups account for less than a third of the workforce within residential and community based aged care. This means the majority of direct patient care in these areas will be delivered by unregulated workers. Around 10% of the total number of RNs and ENs are male[2] and this trend also applies within the aged care sector workforce within NSW.

Between 2011 and 2014, there were more nurses and midwives in the 50–54 year age group than any other age group working in aged care[2]. This is consistent with NSWNMA statistics which show that most members working in the aged care sector are over 45 years old.

In 2014, there were 3,036 nurses and midwives employed in Australia who identified as an Aboriginal or Torres Strait Islander. This represents 1 % of all employed nurses and midwives who provided their Indigenous status which was consistent with figures for NSW[2]. Most of those employed in aged care are AiNs or personal care workers. It is unclear from data whether this is because of a shortage of Aboriginal or Torres Strait Islander workers with RN or EN qualifications, or whether people with these qualifications choose not to work in aged care roles[3]. However, we know that more generally AiNs make up the majority of the aged care workforce which could account for this trend.

There is high cultural diversity within the workforce. NSWNMA aged care members originate from 43 countries outside Australia. Workers born in the Philippines, India, Nepal, Fiji, UK and China respectively represent the largest numbers of overseas born aged care members and make up well over half of the total number of aged care workers.

There are more nurses working in aged care than any other area of nursing[4] and it is the highest area of employment for ENs[1].Therefore it should be providing a wealth of career opportunities for workers. Sadly, our members tell us that rather than being career enhancing, this area of work is often career limiting.

Future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers.

Australia already has over three million people aged over 65 years[5] and this figure will continue to rise given advances in health due to new technologies, advances in medications and treatments and enhanced diagnostics. The 2015 Intergenerational report projected that by 2045 two million Australians will be over 85 years and 40,000 would be aged over 100[6]. Coupled with the fact that there will be fewer available workers to care for our future older generations we are facing not only a financial but a workforce crisis in aged care that requires urgent attention.

It is already widely anticipated there will be an acute shortage of nurses in the Australian workforce[7, 8, 9] which will impact significantly on the provision of healthcare within NSW and other States. Although this phenomenon is not unique to nursing, its impact is greater due to the nature of healthcare being a service based rather than technological industry relying on people power to a greater extent[7]. It is even more acutely felt in the aged care sector which is commonly perceived to be an unattractive option for workers[10].

Increased focus on community care provision as a result of government changes in aged care inevitably means that people remaining at home will have increasingly complex care needs and higher vulnerability. There will be challenges in terms of how well community based staff, largely an unregulated workforce, can be supervised and how effectively accreditation and audit processes will be able to monitor quality outcomes for people. There will be increased use of unregulated community workers and 'Uber' type introduction services which may not provide ongoing staff development, safety, quality and supervision. As CDC and the NDIS takes effect there will be greater consumer power and potential for a less defined workforce as more use is made of informal support and bespoke service packages.

Advances in technology will not only impact on quality of life for older people but also in the way their care is delivered. Health informatics and assistive technology is helping to not only prolong life, but also to reduce healthcare errors and improve efficiency. There is an inherent risk that the rise in technologically delivered care will diminish the core activities of aged care workers. It is imperative that skills in observation, assessment and compassionate care delivered by RNs, ENs and AiNs are not diminished and that they are given adequate training to keep pace with developments.

Increased growth in the long term residential aged care sector and rising acuity in these services have led to the need for higher staffing ratios in aged care and more clinical oversight by RNs. It is concerning that despite the fact that most people entering RACFs have high care needs[11] the number of RNs employed in them is declining year on year[12]. There is good evidence to link quality patient outcomes to the availability of RNs[13, 14] yet the system for monitoring aged care services would appear lacking in the ability to link quality care indicators to lack of sufficient staffing.

> ***"We have had what we believe are several episodes of missed care. These can result in hospitalisation of the resident; undue stress to the resident and family; and death. RN on duty is unable to monitor the health of over 100 individual residents and we feel that we are missing early signs of decline."***
>
> ***RN - RACF***

The interaction of aged care workforce needs with employment by the broader community services sector, including workforce needs in disability, health and other areas, and increased employment as the National Disability Insurance Scheme rolls out.

There will be increased focus on non nursing models of care within community based services as changes to the disability sector continue to take effect. Our members are concerned that this will mean the removal of RNs and replacement by unregulated community care workers.

Furthermore, our members are concerned about the decision of the Government to forcibly transfer their employment to the NGO sector where the future of nursing models of care is uncertain. This forcible transfer will occur without the option to take voluntary redundancy or to pursue a pathway into the public health system or the service of another government agency. Ultimately our members, many of whom have dedicated their careers to the provision of quality disability services, are being forced to transfer to another sector where their conditions of employment are reduced and there is limited security of employment.

Community based care must not be viewed as a cheap alternative, rather it should be viewed as an enhancement of quality of life for people with long term disability. People relocating from large institutions deserve to have their care delivered by RNs, ENs and AiNs with whom they hold a significant relationship and who know them and their care needs.

Personalisation means thinking about care and support services in an entirely different way. This means acknowledging the person as an individual and recognising their strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices, including which people they want to care for them. This must be a primary consideration in the restructuring of any long term disability service.

Challenges in attracting and retaining aged care workers.

Many new graduate nurses fail to enter the aged care sector seeing it as a career limiting move that is secondary to other specialist nursing roles. Of those limited number of student nurses considering a career in aged care, many change their mind by the time they graduate[15]. Whilst not uncommon for undergraduates to change their minds, the sheer numbers opting out of aged care does warrant further attention if there is any chance of building a well qualified and highly skilled aged care workforce.

There is a lack of clinical supervision within RACFs as many operate on minimal RN ratios. Our members tell us that undergraduate nursing students are often placed with AiNs giving them little insight into the RN role. As a consequence, they have limited opportunities to explore the types of clinical interventions they can implement to improve the quality of life of older people. Similarly there are so few nurse practitioners employed in RACFs, undergraduates rarely gain insight into career pathways and the potential for future professional advancement within aged care. New graduate RNs require ongoing clinical supervision in the workplace, an option that almost excludes them from entering RACFs due to low staffing ratios and skill mix.

> ***"By reducing the RN to one per shift, there is no-one to consult with or tool box with. I think this is a significant risk factor for safe decision making."***
>
> ***RN - RACF***

Despite this, a recent small scale survey undertaken by the NSWNMA showed that around 10% of new graduate RNs did enter aged care at the point of qualifying. Although this survey yielded a relatively small sample, it can be reasonably assumed that a percentage will start their career in aged care.

Our members currently employed in RACFs tell us it is not uncommon for one RN to be working in isolation with no clinical supervision and can be responsible for over 100 residents. It is essential that these newly qualified and relatively inexperienced staff are given proper support when they enter the workforce. Initiatives aimed at supporting them professionally will not only increase safeguards for older people, but provide incentives for skilled workers to remain in aged care.

> ***"There is a need for much higher level of staff in aged care. Less of the lower educated staff. This is a specialty area that requires highly trained staff."***
>
> ***Registered Nurse Educator***

The quality and length of undergraduate and new graduate registered nurses aged care experiences will be a key consideration for nurse educators and any workforce development initiatives. A recent pilot study for an undergraduate workplace learning program in aged care undertaken by CSU has shown the possibilities for enhancing nursing students experience and suggests a way forward in terms of new graduates entering the aged care sector which warrants further attention[16].

"*The option to study aged care in high school could offer an incentive to those wanting to enter the caring profession, but who would be better to do this through a vocational rather than academic pathway. A VET approved aged care certificate to level 2 or 3 would open up opportunities for direct employment in the aged care workforce with an accredited skill set. This would also raise standards of quality within the sector and motivate workers to continue to advance their qualifications through an established pathway. Similarly a core care qualification could be studied to level 2 at high school, which could then be built upon through experience and further training in a care sector of the person's choice such as the community disability service."*

(Suggested by a Nurse Practitioner NSWNMA member)

The percentage of nurses (RNs and ENs) aged 55 years and over increased substantially between 2003 to 2009 and in 2009 this age bracket accounted for a fifth of all nurses employed[17,18] . In NSW the number of full time equivalent nurses and midwives in the 55 years and over age bracket within the workforce rose from 12,228 in 2011 to 17 565 in 2014[19] a rise of over 1000 workers per year. Given life expectancy post retirement is increasing there is a need to completely re-evaluate not only optimal retirement ages and access to superannuation but also how people can continue to be actively engaged and feel fulfilled within the workforce.

A qualitative study of nurses and managers aged over 50 years in the NT highlighted that their years of experience were not valued and would be a barrier to them re-entering the workforce post-retirement. However, many felt that with training, flexible working patterns, affordable accommodation, reduced workloads and financial incentives they could still remain in the workforce and considered themselves to be physically fit enough to do this[20].

In 2015 the NSWNMA conducted a targeted survey of older members (aged 60 years and over) as part of the: '*Willing to Work: National Inquiry into Employment Discrimination against Older Australians and Australians with Disability'* Inquiry. 48% of respondents said that age discrimination had impacted on their participation in the

workforce, including: Being overlooked for career opportunities in favour of younger workers; false perception of employers that older workers would be more costly e.g. having more sick days; cheaper to have younger less experienced workers because their hourly rate was less, and the perception that there was no use in training older workers because they would leave the workplace soon and it was not cost-effective.

Other issues impacting on older workers included the fact that they were not given any accommodation for their age or health issues, whereas younger workers with family responsibilities had many including paid maternity leave and flexible work arrangements. This occurred specifically in relation to shift loads, night duty options, shift patterns, amount of heavy work assigned and lack of flexibility. There was a perceived lack of acknowledgement of workers years of service and the load they had carried for many of their younger years. Their experience and expertise in mentoring younger workers was not considered as an option[21].

> ***"If it is practical for the facility, rather than lose the valuable experience mature age nurses can provide perhaps some positions could be made which allows teaching/mentoring of junior staff and less physically demanding tasks e.g. ACFI documentation and claiming, NCP formulation and reviews , Wound care, Continence Nurse etc."***
>
> ***RN/RM Aged Care***

To retain older, more experienced nurses, employers will need to develop innovative policies and strategies to encourage older workers to stay in the workforce[22]. Effective human resource management is pivotal to ensuring there is no mass exodus from the workforce in the near future as the current 55-65 year nursing population reaches traditional retirement age. Older workers are looking for challenging roles such as mentoring but with flexible work patterns and targeted training[23]. They not only have extensive knowledge and expertise, but also the time to undertake work to a very high level[8]. The loss of these skills due to a lack of forward planning would be a sad loss to the aged care sector.

Factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths.

The factors impacting on aged care workers must be considered in relation to the quality of care they can deliver to our older population. The ability of aged care workers to deliver high quality care is intrinsically linked to the culture and environment in which they work. Research undertaken on a significant sample of NSWNMA members by Flinders University during 2014-15 highlighted that inadequate staffing levels and high patient acuity in aged care settings were main factors in missed care episodes[24]. In relation to RNs in particular, it was highlighted that the extra demands of completing paperwork to increase ACFI funding also means less time to complete direct care duties, leading to gaps in care provision.

These findings mirrored earlier research with RNs and RMs who also cited staffing shortfalls as a major contributor to missed care episodes, mainly in relation to tasks perceived to be of lesser importance such as encouraging mobility and psychological support[4]. However, failure to attend to these lesser perceived care needs draws parallels with the basic care failures identified by the Mid-Staffordshire Inquiry in England. This Inquiry highlighted that low numbers of RNs and poor supervision and training of unregistered care workers in a public hospital contributed to systemic failures at a basic care level[25, 26].

Of particular importance in both the Mid-Staffordshire Inquiry findings[26] and findings by Flinders University and NSWNMA[24] is the reduction in quality of patient care caused by shifting the focus of RNs attention away from direct patient care and onto paperwork and administrative tasks. Whilst nurse leadership is a prerequisite for enhancing quality care, any attempts to develop career pathways for RNs in aged care must retain a direct patient care focus rather than an administrative one.

Staffing levels are continually cited by our members as a major factor in relation to the quality of care they can deliver and have far reaching consequences. A recent survey undertaken with our aged care members revealed that most consider staffing and skill mix shortfalls to be a major factor in the incidence of abuse both of

residents and staff in RACFs[27]. Over 90% of aged care workers had been subject to some form of aggression from residents so it is unsurprising that workers are not only demotivated to work in aged care, but quickly seek alternative employment in lower risk environments.

> ***"My elderly mum (now 92) has been in aged care (off and on) for about 4 years. Her facility which has both low and high care residents has 1 RN on duty in each section overnight, however (from around 9:30 pm) there is only 1 RN on for the whole facility which has about 110 residents. This is really a shocking statistic especially when you consider that most residents have complex medical conditions."***
>
> ***Concerned relative***

Many aged care workers are employed in RACFs and the NSWNMA represents almost 10,000 members in this sector. Members employed in these areas constantly tell us that they are understaffed and underpaid for the duties they perform. A typical AiN educated to certificate III level can earn almost $1.60 less per hour than a supermarket cashier. Experienced RN's in aged care can earn almost $5 less an hour compared to their counterparts in the public health system.

The NSWNMA calls for the establishment of minimum ratios in aged care consistent with other healthcare sectors, parity of pay with the public health system and fair remuneration for the isolated nature of their work and level of responsibility.

"We need ratios in aged care. On night shift, one RN is responsible for the nursing home and the hostel which is in another adjacent building!"

RN - RACF

"My mother was in an aged care facility… and during that time there was only 1 RN on duty for over 100 residents, both high care and low care and the low care residents were located in a separate building on the same premises. I saw on many occasions staff running around looking for the RN for advice/ care needs and residents having to wait for care as the one RN was run off her feet. S8 Medications were sometimes administered late as the RN was attending to life threatening care needs and there were times when I couldn't (wouldn't) go home as I was waiting for the RN to see Mum first as I was concerned about her. An RN needs to be on duty 24/7".

Concerned relative

Many of our members stay in aged care because they have a genuine passion for caring for older people and strive to raise standards of quality. Many workers have been employed in aged care for over 10 years and have a wealth of both work related and life experiences. However, they are stifled in their roles due to a lack of a structured career pathway and very few nurse practitioner and/or leadership opportunities. Despite aged care being one of the main specialties within nursing, there are very few 'expert' roles for aged care workers which is reflective of the value society generally has in relation to older people.

The acuity of people entering RACFs is rising. The latest statistics show that over 80% of all people living in RACF's are funded at a high care level having high care needs across all three domains (behaviour, daily living and complex healthcare)[11]. This rising acuity means that staff will require higher skills in palliative care and management of complex conditions. Aged care providers will need to meet this demand through improved access to specialist training across all sections of the workforce. The development of the nurse practitioner role in RACFs will be vital to bridge the gaps between acute and longer stay services.
Having a local source of expertise across a small group of services would provide a valuable resource for staff, raise standards of care and allow for career progression in the specialism particularly in rural and remote communities. Targeted Government funding would enable these roles to be developed and should be a primary focus.

It is recognised that AiNs play a vital role in aged care and contribute positively to improved care outcomes[28]. However, their ever increasing presence within the workforce means they are often required to undertake roles that are outside of their scope of practice[29] and feel unprepared for the duties they are asked to perform[30]. This is particularly concerning due to the vulnerability of people in aged care and the inherent potential for harm in the delivery of care[31]. In Australia there are no specific requirements in relation to minimum standards of qualification for AiNs. However, local studies have shown there are improved patient outcomes where AiNs have received additional training in their field of specialism[32, 33].

"Cert IV trained staff have limited training, and theoretically, are only meant to <u>assist</u> those they care for to take their medications. But, when you are dealing with frail aged with unstable medical conditions, it is more than just simple assistance that is required."

RN - RACF

"Theoretically, staff are meant to be supervised by an RN when giving medications. But due to the extremely poor ratios of RNs to care staff, and staff to residents, there is little or no supervision actually happening. Staff in general are too busy, and need to get things done as quickly as possible.

RN - RACF

"A resident's ability to swallow can change rapidly. So can their well-being. If there is trouble swallowing, it is quicker and easier to crush tablets. A crushing device is on most medication trolleys. But some tablets are not meant to be crushed. As an RN, I have several times become aware that medication has been inappropriately crushed by minimally trained care staff. The consequences of this could easily be overlooked: a slow release analgesic being absorbed all at once; the resident may become a little more sleepy than usual. But other consequences could be more serious - a crushed slow release tablet for diabetes could result in a serious hypoglycaemia. Other medications lose their effectiveness when crushed, still others can cause harm to the upper gastrointestinal tract. Then there is the administration of eye drops, inhaled medications and even insulin."

RN - RACF

As a direct result of findings of the Mid-Staffordshire Inquiry[25] several key recommendations were made in relation to unregistered AiNs in England. These called for the registration of AiNs, a national code of conduct and a national set of common training standards for them[26, 34]. In response, the CQC who is the national care regulator for England requires all AiNs working in RACF's and in the community to achieve a minimum standard of qualification upon induction[35].

"I am a strong believer that all classifications should be registered with APRHA so that inappropriate staff conduct by staff at AIN level does not go unpunished and that they cannot move on to another aged care facility and commence offending there. I have had staff that engaged in bad behaviour but did not meet the classification of abuse but definitely put residents at risk. These staff are now working for other organisations who are none the wiser. If they were an RN or EEN they would have been deregistered. This is a real flaw with our current system. "

RN - RACF

Having a licensed, regulated and well trained workforce of AiNs would not only provide a career structure for many workers, but would also improve safeguards and raise standards of care for our ageing population regardless of the setting in which care is delivered. Whilst not a replacement for RNs and ENs, a suitably skilled and regulated AiN workforce can take responsibility for many of the personal care duties performed in aged care and are a valuable asset.

I am a AiN with 15 years experience, all AiNs deserve training as we are at the forefront of aged care, we are the most unrecognized in any nursing sector. It should be mandatory that anyone working in aged care should have at least done a certificate 3 in aged care or similar, which at times is not the case.

AiN - RACF

Of relevance is the emergence of 'Uber' style care introductory agencies that seek to match clients to care workers including RNs and ENs. These workers are not directly employed by the agencies and therefore not subject to the rigorous recruitment and training requirements of regulated services. The emergence of these unregulated services raises concerns on many levels about the quality of care people might receive and also how well protected both the workers and public are. As providers of direct personal care consideration should be given as to whether individuals should be required to become accredited with the AACQA as service providers, therefore becoming accountable for the quality of care they deliver, a system already in place in England[36].

The sector will only continue to grow as 'Ageing in Place' changes continue to support people in their own homes for longer and funding systems give them greater autonomy to choose their own care packages and even the potential scope to employ their own staff. Whilst the Association would support these reforms in principle, we suggest that this area is examined as a matter of urgency in relation to the future aged care workforce and public protection.

The role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded.

Our members tell us that they are concerned by the quality of training they receive and have found courses to be highly variable in content and delivery. They tell us that their training is often delivered online with no safety checks on how much they have learnt or whether they can apply learning to practice. Whilst online education has value, it must be accompanied by a substantive quality control system to ensure that it adequately prepares workers for direct patient contact and assesses their ability to provide compassionate care.

"Many facilities rely on (named online learning chanel) for the ongoing training of staff. This is mostly done in the workers own time. Motivation is poor, resentment high. It is fairly easy to go through the training and get checked off as having done it. But with no initiatives from management to implement new skills or reinforce learning, little or no improvement is made.

It costs money to allow staff to spend time not working on the floor. But training sessions where staff are able to discuss individual residents and how new approaches could apply and improve their care are by far the best way to continually improve. As it is, there is no time for proper hand over between shifts. Care staff are sent onto the floor with little or no information about those they care for our any changes that may have occurred. There are the ones in the best position to notice change in a resident's condition - if only they knew what to look for."

RN - RACF

"Aged Care training is an area where unscrupulous training organisations can try and get as many students as possible - without considering suitability. Those without compassion and patience have no business considering such a caring role. And what standards are there for competence?"

RN - RACF

Our members are dedicated to providing high quality care but are restricted by a lack of consistency in relation to their training requirements. Having a standardised approach to accreditation of training providers and properly certified training to meet nationally consistent standards would remove this disparity and provide a consistent highly skilled workforce.

"…Medication training being offered to AINs/ PCAs. The comments I heard from the carers who have done some training were: "The trainer left us a workbook to do by ourselves…so we copied each other's homework…" The AINs/ PCAs felt they were not trained adequately to administer medications, training time varied greatly depending on who provide the training and training being offered to people with literacy problems."

RN - RACF

Factors such as changing demand, new technology, increasing patient acuity, nursing shortages and the need to contain costs have meant that skill mix is a critical part of workforce planning and its development. Having the right 'mix' of workers means the quality of patient care will be safe and appropriate. Although not specific to aged care, recent Australian[37,38], US[39] and UK[40] workforce studies have identified the importance of increasing RN hours and having higher nurse (including EN) staffing levels, therefore providing a more productive skill mix with optimal patient care outcomes.

ENs, in their capacity as registered and regulated nurses are advocates for RNs and are a valuable part of the aged care workforce. Although they must work under the direction (direct or indirect) from the RN they are responsible for and autonomous in their own scope of practice. The excessive reliance of the aged care sector on AiNs (who are unregulated workers) goes against the research on appropriate skill mix levels and this has the potential to compromise quality patient care.

"In terms of medication management they understand the principles of pharmacology and again provide a greater level of expertise for medication administration. Since medication incidents lead to many adverse effects and related hospitalisations this is an important benefit of the role.

Enrolled nurses work under the direction of a registered nurse. By increasing the numbers of Enrolled nurses in aged care we can significantly improve the skills mix of staffing in Aged care without arduous cost burden".

Nurse Practitioner

"Endorsed Enrolled Nurses would be able to administer medications safely, and are more able to assess residents and alert RN of changes. But facilities mostly only employ the minimal number of RNs they can and no EENs at all – relying on the minimally trained staff to administer medications. (Often with little or no supervision due to lack of RNs employed.) Most facilities I know have done away with EENs & ENs completely, putting minimally trained care staff in positions that would previously have been taken by ENs. This is a backward step."

RN -RACF

"AINs/ PCAs are supposed to administer medications with RN supervision but is often not the case. Are they supposed to administer medications with the RN right next to them? How many RNs are rostered during that shift to provide 1:1 supervision?"

RN - RACF

The number of ENs in the workforce is declining, a trend that needs to be reversed so that they continue to take their place alongside RNs in aged care. Our members tell us that rising costs of EN training and cuts to TAFE means that many who see this as a potential career pathway simply cannot afford the initial cost of this training. There would be a good argument for TAFEs in NSW to remain in the forefront and retain majority control of EN education through the provision of increased government funding arrangements[41]. It is only through government intervention in vocational education and training that adequate EN numbers will be provided so that, with increased patient acuity, the right skill mix of staff will be available in the future.

"In terms of professional development, enrolled nursing provides a great career pathway for nurses who can begin their training as an AIN then complete Cert 4 and move on to the Diploma to become an Enrolled Nurse and then possibly go to university and train as a Registered Nurse. This pathway provides opportunities and esteem for nurses. It gives a healthy regard of increased knowledge and skills in partnership with financial reward. We will raise up a healthy generation of skilled enrolled nurses and registered nurses by continuing to promote the enrolled nurse role in aged care."

Nurse Practitioner

Government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce.

The *Aged Care Act 1997* and guidance for monitoring ongoing compliance with standards for accreditation in RACFs have done little to raise standards of quality in aged care, despite reports from the AACQA that most providers achieve 'high levels of compliance'. Our members frequently tell us that they have inadequate staffing ratios and skill mix to provide the high quality care they strive for. It is not uncommon for members to cite circumstances where there is a single RN to care for 130 residents during the night (often a 12 hour shift), accounting for half of the total day for people in RACFs. We also hear that AiN's are employed on the basis of 1: 30 residents. Given the level of acuity in RACFs, this requires urgent attention.

Recent amendments to the *Aged Care Act 1997* removing the distinction between high and low care RACFs have effectively rendered classification of a RACF as a 'nursing home' within the *NSW Public Health Act 2010* inoperable. This has a potentially devastating outcome for the people of NSW, who have relied on the protective legislation which requires all RACFs that were classed as 'nursing homes' offering high care to have a RN on site at all times.

"24/7 Clinical care oversight & preventative management by RNs is essential for supporting our frail, vulnerable aged residents. Unnecessary trips to hospital and preventing minor issues escalating to major one, possibly leading to fatal outcomes , shortening of life"

RN Public Hospital

This protective NSW legislation is neither restrictive nor excessive, but as a minimum standard affords the most vulnerable people in our society a degree of protection.

It is without doubt that a failure by the State Government to retain this important piece of protective legislation will provide a window of opportunity for some aged care providers to reduce their overheads by removing RNs from their workforce. This will not only increase the burden on the public health system[42, 43, 44] but have serious consequences for the health and wellbeing of aged care residents[45].

> ***"Residential aged care is not suitable for anything but the medical model. Those in residential aged care are there because their condition is such they can no longer live at home. Their health, unlike those in disability, is unstable and likely to deteriorate. They deserve to be cared for by qualified staff who can monitor their condition; staff who are trained to know what a change means and can anticipate needs to reduce suffering."***
>
> ***RN - RACF***

We draw your attention to the NSWNMA submission to the recent Upper House Inquiry into registered nurses in NSW nursing homes. This highlights concerns from members who already struggle to provide a quality care environment due to constant erosion of RNs within staffing rosters by many aged care providers. It is vital that the recommendations of the Upper House Inquiry into RNs in NSW nursing homes are upheld, and that the legal requirement to have a RN on duty at all times where people have high care needs is continued. We suggest that this protective legislation should be extended to all States and Territories across Australia.

Relevant parallels or strategies in an international context.

The imminent shortfall of aged care workers is a global phenomena necessitating innovation in the workplace. We support the implementation of good practice initiatives developed in other countries if they are of benefit to our members and the aged population. We have identified the following initiatives which could have benefit to both, subject to further research undertaken in NSW to evaluate their effectiveness.

New Zealand developed several initiatives to improve the ability of the workforce to meet the demands of an ageing population following the Canterbury Earthquake. Gerontology nurse specialists were created to bridge the gap between acute and community care services, some of whom had been managers of RACFs. This project evaluated well in an early study into its effectiveness with high levels of both patient and multi-disciplinary team satisfaction[46]. A further project to educate RNs in this field of specialism incorporates a' fast track' system using a 12 month specialist postgraduate program in aged care which enables them to further advance their careers in this chosen field[47]. More broadly, there are current initiatives to increase the scope of RN practice and to increase prescribing abilities, which could prove useful in rural and remote areas within Australia.

NHS Professionals in the UK has a workforce program that facilitates the employment and retention of older nurses. There is no age limit at which they are obliged to stop working, provided they are registered to practice with the regulatory body, physically fit and clinically able. They undergo supportive health checks at five yearly intervals after age 40 years. Nurses are offered a selection of shifts to suit their needs, can choose when and where they work and have pay that is equal to that in other parts of the NHS. This type of flexible working enables nurses to work less at the end of their career, or after retirement if they choose to do so. They have the opportunity to reduce their hours, responsibility and pressure without losing their experience within the workforce[48].

The US have initiatives aimed at peer mentoring RNs as a means to aid retention of workers by valuing their role[49], and nurse practitioners and medical staff have aged care elements to their core educational curriculum in recognition of the increase in aged care as a proportion of workloads[50, 51].

It is without doubt that most countries recognise the impact of ageing societies on the future workforce and many new initiatives are emerging. A coordinated response within Australia, with funding to explore those projects that could have relevance is required.

The role of government in providing a coordinated strategic approach for the sector.

There needs to be better consistency in approach in relation to aged care between federal and state government. Much of the legislation governing RACFs is centered around a federal model which means there is little scope to develop localised approaches to improving the workforce. There is opportunity to remodel the entire legislation that governs aged care workers and to develop national benchmarking in this area. Funding should be allocated to this as a matter of urgency.

There are two main issues impacting on the aged care workforce. Firstly there is much variation in relation to legislation governing staffing and skill mix in aged care, the way medications are handled and local safeguarding protocols. This creates a divide and rule system for aged care providers and is not conducive to consistency in quality across Australia. Secondly, there are many excellent local initiatives aimed at retaining staff in aged care, furthering the role of nurse practitioners and rural and remote projects that facilitate coordination of local services. However, there is lack of federal oversight in relation to the sharing of best practice and benchmarking standards. The Association calls for the federal government to develop consistency in legislation across all states and further national benchmarking in aged care including investment in research aimed at improving quality.

Challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people.

It would be short-sighted to believe that only people from a particular section of society can care adequately for others of the same background or community. However, there is the need to give due regard to what can be learnt from members of these communities in order to provide individualised care. Due regard must also be given to the well recognised health inequalities within certain Indigenous, CaLD and LGBTI communities.

As diversity within Australian society increases there will be no standardised approach that fits all, therefore the needs of the aged care workforce will always be determined by the communities in which they serve. This will require greater emphasis on local experts and building community capacity.

Within aged care specialist Nurse Practitioners and Educators would be ideally placed to work within local communities and who could support the aged care workforce within those communities as part of a wider multidisciplinary team. There are already examples of good practice in this regard. Further federal and state funding would enable this good practice to be widened, strengthen local communities and provide career opportunities for aged care workers.

The particular aged care workforce challenges in regional towns and remote communities.

Health outcomes for people living in regional and remote areas are generally worse than those living in the city. It is also clear that the challenges for health professionals are also exacerbated by remoteness, including lack of support, higher operating costs, difficulty recruiting and stress. These issues are particularly salient in the aged care sector as the population is ageing faster in rural areas, costs of living are higher, incomes are lower and demand for aged care is growing. These factors pose significant challenges for the implementation of 'Ageing in Place' Government changes.

Palliative care is an increasingly important aspect of aged care and rural and remote people should have the option of spending the end of their life in their local community surrounded by family and friends. Nurses providing palliative care in rural and remote areas report limited access to specialist palliative support and limited professional development opportunities due to workload, isolation and lack of backfill.

There are limited aged care training opportunities for local people in rural and remote areas and training providers are becoming rarer and more expensive as the vocational training sector increasingly privatises and the profit imperative makes rural and remote areas less attractive to training providers. We know that students from rural and remote areas are more likely to return to practice in these areas and we support incentives for rural and remote students to undertake education in the health field. Similarly, it is clear from the trends that students who undertake well-supported rural and remote placements are more likely to join the rural and remote health workforce. This requires investment is assistance measures such as supported accommodation.

There must be effective work to ensure that aged care nurses are able to work to their full scope in rural and remote areas. It is essential that nursing leadership is valued in supported in RACFs and in the community and even more important as direct and prompt access to GP's is more difficult to achieve in

remote areas. There is vast scope for the nurse practitioner role to flourish in rural and remote aged care services and we urge the government to establish effective incentives to attract nurse practitioners and support others to work toward this level.

We also recommend that arrangements are implemented that would allow senior, experienced aged care nurses who have extremely valuable knowledge but wish to move away from clinical duties to mentor and support rural and remote nurses in aged care.

We strongly support implementation of Telehealth that supports quality care. Telehealth should enable the aged care workforce to interact effectively within multidisciplinary teams and enable effective video consultations and professional supervision sessions. Appropriate remuneration models for Telehealth are essential, and they should not detract from situations where people require 24 hour on site access to a RN.

"Telehealth is another great possibility for rural/remote communities in terms of RN cover. This should be provided as full 8 hr shift coverage, dedicated to that facility not just ½ hr day or as required. If facility determines that they do not have access to RNs due to their rural remote location then a Registered nurse should be engaged just as they would be if they were present in the facility. The contract of employment could include travelling to the facility for a certain number of hours per month so that the Registered Nurse can physically meet the residents/families and staff and see the physical layout of the building etc. I think many people who enjoy the flexibility of this mode of working, it would also be useful for RNs with disabilities to offer them a new way of working. This would be easily randomly audited by accreditation processes and the auditor could use the same process to log in to ask the staff member a question and verify they are in place."

Nurse Practitioner

Impact of the Government's cuts to the Aged Care Workforce Fund.

The aged care workforce fund was intended to provide funding for a range of initiatives to raise standards within the eligible aged care workforce in areas such as training, research and programs specifically targeted to meet the development needs of priority groups, such as Aboriginal and Torres Strait Islander people.

Our members are concerned that there has been no demonstrable benefit to them from any redirected funding since this fund was cut. Our members continually strive for better standards of care through increased levels of affordable and available training. Higher levels of professional standards can only be achieved if staff feel valued and are supported to develop themselves through a career pathway in aged care.

There is already a lack of research in aged care so to remove a budget designed to build a body of knowledge in this area is at best shortsighted and potentially life limiting and is an area that required urgent attention. It is in our members interests that federal funding is reallocated as a matter of urgency and a coordinated strategy is put into place to avert future shortfalls in staffing numbers, skill mix and education.

Any other related matters.

Currently aged care workers are required to have a Criminal Records Check to ensure they have not been convicted of an offence. However, unless they are employed in the public sector, there is no requirement for staff to have detailed background checks of their work history. This means that AiNs can move between RACFs, not for profit and private community based homes care services even if they have been dismissed for misconduct in a previous employment. A system that requires aged care providers both in residential and community settings to perform checks on staff (including volunteers) prior to appointment, similar to the Service Check Register which is in operation within the NSW Public Health system would provide additional safeguards for our older population.

"I know of one girl who was dismissed from one facility because she was rough and rude with residents (not quite bad enough to be charged with assault). Since then, she has worked at 3 different facilities in the area. And left each after being spoken to about the same issue. When she has gone through all the facilities in the area, she will probably move to a new area."

RN - RACF

"Many facilities are desperate for staff, and don't check references. Or will give a good reference, to be rid of the person. A register of those who work with such vulnerable people would mean that such incidents could be reported. This would make it more possible for our vulnerable elderly to be protected from such people. And those who are likely to do harm would not be able to go from one facility to another."

RN - RACF

References

1 Health Workforce Australia (2013) *Australia's Health Workforce Series – Nurses in focus*, Adelaide: Health Workforce Australia.

2 Australian Institute of Health and Welfare (2015) *National Health Workforce Data Set: nurses and midwives 2014.* Available at: http://www.aihw.gov.au/workforce/nursing-and-midwifery/additional/ Accessed online at: 12.1.16 15:52.

3 King, D. et al (2012) *The Aged Care Workforce 2012*. Canberra: Australian Government Department of Health and Ageing, 2012.

4 Australian Institute of Health and Welfare (2016) *Work characteristics of nurses and midwives*. Available at: http://www.aihw.gov.au/workforce/nursing-and-midwifery/work-characteristics/.

5 Australian Bureau of Statistics (2012) *Who are Australia's Older People? Reflecting a Nation: Stories from the 2011 Census*. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2071.0main+features752012-2013

6 Henderson, J, et al (2013*) After Hours Nurse Staffing, Work Intensity and Quality of Care – Missed Care Study. Final Report to the Australian Nursing and Midwifery Federation South Australian Branch: South Australia*, Adelaide: Flinders University.

7 Graham, E.M. and Duffield, C. (2010) An ageing nursing workforce, *Australian Health Review*, **34**, pp. 44-48.

8 Jackson, D. (2008) Editorial: The ageing nursing workforce: how can we avoid a retirement brain drain? *Journal of Clinical Nursing*, **17**, pp. 2949-2950.

9 Australian Government Productivity Commission (2013) *An Ageing Australia: Preparing for the Future*, Victoria: Productivity Commission.

10 Campbell, S.L. (2005). Conceptual model of attractiveness as a factor influencing quality of care and outcomes of residents in nursing home settings. *Advances in Nursing Science,* **28**(2), pp.107-115.

11 Australian Institute of Health and Welfare (2014) *Care needs of permanent aged care residents*. Available at http://aihw.gov.au/aged-care/residential-and-community-2012-13/permanent-residents/ Accessed on 15.1.16 12:22.

12 Australian Institute of Health and Welfare (2013) *Nursing and midwifery workforce 2012*, National Health Workforce Series No.6 Cat. HWL 52, Canberra.

13 Sasichay-Akkadechanunt,T., Scalzi, C.C. and, Jawad, A.F. (2003) The relationship between nurse staffing and patient outcomes. *Journal of Nursing Administration,* **33**(9), pp.478-85.

14 Needleman, J. et al (2002) Nurse-staffing levels and the quality of care in hospitals, *New England Journal of Medicine*, **346**(22), pp. 1715-1722.

15 Stevens, J. (2011) Student nurses' career preferences for working with older people: A replicated longitudinal survey, *International Journal of Nursing Studies*, **48**, pp. 944-951.

16 Bernoth, M., Lawless, A., Croxon, L., Anderson, J. (2015). *Enriching Community: Partnerships for Learning and Mentoring in Aged Care*. A report for the West NSW ICTN.

17 Australian Institute of Health and Welfare (2009) *NATIONAL HEALTH LABOUR FORCE SERIES Number 31 Nursing and Midwifery Labour Force Survey 2009*, Canberra: Australian Institute of Health and Welfare

18 Australian Institute of Health and Welfare (2009) *NATIONAL HEALTH LABOUR FORCE SERIES Number 43 Nursing and Midwifery Labour Force Survey 2009*, Canberra: Australian Institute of Health and Welfare.

19 Australian Institute of Health and Welfare (2014) *Nursing and Midwifery workforce data and additional material*. Available at: http://www.aihw.gov.au/workforce/nursing-and-midwifery/additional/. Accessed on 15.2.16 14:42.

20 Voit, K. and Carson, D.B. (2012) Retaining older experienced nurses in the Northern Territory of Australia: a qualitative study exploring opportunities for post-retirement contributions, *Rural and Remote Health*, **12**:1881. Available at: http://www.rrh.org.au.

21 NSWNMA (2015) *Willing to Work: National Inquiry into Employment Discrimination against Older Australians and Australians with Disability*. Sydney: NSWNMA.

22 Schofield, D.J. and Beard, J.R. (2005) Baby boomer doctors and nurses: demographic change and transitions to retirement, *MJA*, **183**(2), pp. 80-83.

23 Armstrong-Stassen, M. (2008) Organisational practices and the post-retirement employment experiences of older workers, *Human Resource Management Journal,* **18**(1), pp. 36-53.

24 Blackman, I. et al (2015) *After hours nurse staffing, work intensity and quality of care – missed care study: New South Wales public and private sectors. Final report to the New South Wales Nurses and Midwives' Association*. Adelaide: Flinders University.

25 Mid Staffordshire NHS Foundation Trust Inquiry (2010) *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust: January 2005-March 2009. Volumes I and II.* London: The Stationary Office.

26 Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* London: The Stationery office.

27 NSWNMA (2016) *Who will keep me safe? Elder Abuse in Residential Aged Care.* Sydney: NSWNMA.

28 Cavendish Review (2013) *An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*. London: Department of Health.

29 Holloway, K. and McConigley, R. (2009) Understanding nursing assistants' experiences of caring for older people in pain: the Australian experience, *Pain Management Nursing*, **10**(2), pp. 99-106.

30 Munn, Z., Tufanaru, C. and Aromataris, E. (2013) Recognition of the health assistant as a delegated clinical role and their inclusion in models of care: a systematic review and meta-synthesis of qualitative evidence*, International Journal of Evidence-Based Healthcare*, **11**, pp. 3-19.

31 Australian Nursing Federation (2009) *Balancing risk and safety for our community: unlicensed health workers in the health and aged care systems*. Canberra: Australian Nursing Federation, ISBN 978 0 909599 58 4.

32 Chow, J., San Miguel, S., LiDonni, M. and Isbister, J. (2010) The introduction of Assistants in Nursing in an Australian haemodialysis service, *Renal Society of Australasia Journal*, **6**(2), pp. 81-87.

33 Murray, E. (2012) Bridging the theory-practice gap in pressure injury prevention for assistants in nursing: the impact of a formal education program at St Vincent's Private Hospital, *Wound Practice and Research*, **20**(3), pp. 124-128.

34 Cavendish Review (2013) *An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*. London: Department of Health.

35 Health Education England (2015) *The Care Certificate Framework Guidance Document*. Available at: http://hee.nhs.uk/work-programmes/the-care-certificate-new/ Accessed on 14.01.1615:47.

36 Care Quality Commission (2015) *Registration under the Health and Social Care Act 2008: The Scope of Registration, March 2015*, Available at: www.cqc.org.uk.

37 Duffield et al (2009). Nursing Staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research,* **24**(4), pp. 244-255.

38 Duffield, C., Roche, M., Diers, D., Catling-Paull, C., Blay, N. (2010) Staffing, skillmix and the model of care. *Journal of Clinical Nursing.* **19**, 915-16, pp. 2242-2251.

39 Aiken, L.H. (2003). Workforce policy perspectives on advanced practice nursing. In M. Mezey, D. McGivern, & E. Sullivan-Marx (Eds.), *Nurses, nurse practitioners: Evolution to advanced practice (4 Ed.)*. New York: Springer.

40 Griffiths P., Ball, J., Murrells, T., Jones, S., Rafferty, A.M. (2016) Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study*, British Medical Journal Open.* Available at: http://bmjopen.bmj.com/content/6/2/e008751.full. Accessed on 18.02.2016 10:20.

41 Yu, S. & Oliver, D. (January 2015). *The Capture of Public Wealth by the For-Profit VET Sector*. A Report prepared for the Australian Education Union. Workplace Research Centre: The University of Sydney Business School.

42 Bowman, C.E., Elford, J., Dovey, J., Campbell, S., Barrowclough, H. (2001) Acute hospital admissions from nursing homes: Some may be avoidable. *Post Graduate Medical Journal*, **77**, pp. 40-42.

43 Carter, L., Skinner, J., Robinson, S. (2009) Patients from care homes who attend the emergency department: Could they be managed differently. *Emergency Medicine Journal*, **26**, pp. 259-262.

44 Finn, J.C., Flicker, L., MacKenzie et al. (2006) Interface between residential aged care facilities and a teaching hospital emergency department in Western Australia. *The Medical Journal of Australia*, **184**, pp. 432-435.

45 Ibrahim, J.E., Briony, J. Murphy, B.A., Bugeja, L. and Ranson, D. (2015) Nature and Extent of External-Cause Deaths of Nursing Home Residents in Victoria, Australia, *Journal of the American Geriatrics Society*, **63**, pp. 954-962.

46 King, A. et al (2011) *Evaluation of a Gerontology Nurse Specialist in Primary Health Care: Case Finding, Care Coordination and Service Integration for At-Risk Older People*, Workforce New Zealand Innovation Projects Funding in collaboration with: Waitemata PHO, Waitemata DHB, The University of Auckland. Available at: http://www.health.govt.nz/system/files/documents/publications/evaluation-of-a-gerontology-nurse-specialist-in-primary-health-care.pdf.

47 Stodart, K. (2014) Fast-tracking a gerontology career, *Kai Tiaki Nursing New Zealand*, **20**(10), pp. 12-13.

48 Carlowe, J. (2015) Flexible working after retirement can help older workers adjust, *Nursing Times.net.* Available at: http://www.nursingtimes.net/flexible-working-after-retirement-can-help-older-workers-adjust/5001791.article.

49 Bryant, A, Aizer Brody, A, Perez, A, Shillam, C, Edelman, L, Bond, S, Foster, V, & Siegel, E (2015) 'Development and Implementation of a Peer Mentoring Program for Early Career Gerontological Faculty, *Journal Of Nursing Scholarship*, **47**(3), pp. 258-266.

50 Auerhahn, C., Mezey, M., Stanley, J., & Wilson, L. D. (2012). Ensuring a nurse practitioner workforce prepared to care for older adults: findings from a national survey of adult and geriatric nurse practitioner programs. *Journal Of The American Academy Of Nurse Practitioners*, **24**(4), pp.193-199.

51 Simpson, C. F., Durso, S. C., Fried, L. P., Bailey, T., Boyd, C. M., & Burton, J. (2005). The Johns Hopkins Geriatric Summer Scholars Program: a model to increase diversity in geriatric medicine. *Journal Of The American Geriatrics Society*, **53**(9), pp.1607-1612.