Australian College of Nursing

AGED CARE WORKFORCE

Public Consultation submitted to the Royal Commission into Aged Care Quality and Safety

General Comments

For this submission, the term 'Unregulated Health Care Worker' (UHCW) will be used to describe the nursing support workforce within the Australian aged care sector. The Australian College of Nursing (ACN) is aware that considerable confusion surrounds the role of the UHCW in the community. This misunderstanding is due to three things. Firstly, a lack of publicly available data regarding the UHCW workforce. Secondly, extensive interstate and intrastate variability regarding scope of practice, supervisory requirements, minimum educational requirements, and staff skill mix models. Thirdly, UHCWs can either be replaced (substitution-model) or used alongside (complementary-model) Registered Nurses (RNs) or Enrolled Nurses (ENs), who are university educated and/or regulated under the Nursing and Midwifery Board of Australia (NMBA).

There is a common misconception that shortages in the regulated nursing workforce have led to an increased reliance on UHCWs. While UHCWs make up a considerable proportion of the workforce in aged care environments, this is not exclusively due to issues around RN supply. In many instances, aged care settings are employing business models that entail employment of a greater number of UHCWs as they are financially advantageous in comparison to RNs.[1] [2] Senior Australians generally present to aged care environments with higher acuity (severity of resident illness) because of higher rates of cognitive impairment, chronic disease, co-morbidities and poly-pharmacy. Unlike a RN or EN, a UHCW does not have the qualifications or educational preparedness to assess and use their critical thinking skills to make informed decisions regarding residents' complex health care needs.

ACN is unequivocally of the view that the UHCW workforce should be regulated to achieve nationally consistent nomenclature/titles, minimum educational and ongoing professional development requirements and standards for scope of practice. Such regulation is essential to provide a level of safety for all health care consumers across all health care settings, for the UHCW themselves and the RNs and ENs responsible for supervising them. Regulation would also ensure a sustainable UHCW workforce that can be utilised consistently across Australia and all health care settings. ACN believes this can be achieved, without compromising safe nurse staffing levels (i.e. ensuring appropriate skills and 'skill mix') or diluting the qualified nursing workforce (i.e. ensuring UHCWs are not employed in a 'substitution' staff mix model).

ACN recommends policy reform to provide minimum safe RN staffing levels and appropriate skills and 'skill mix' in all health care settings as well as to amend the Aged Care Act 1997 (Cth) to mandate safe

staffing and skill mix levels. This would need to consider the level of acuity and complexity that each person has at individual aged care service providers.

ACN's response to Workforce Consultation Questions

I. methods for determining and implementing the minimum staffing levels and appropriate skills mix for aged care services, including for nursing, personal care, allied health and others

Some of the biggest challenges faced in the aged care sector are due to poor staffing levels, fewer RNs, increased resident acuity,[3 4 5 6 7] and ongoing reduced funding.[8] The increasing ageing population means that aged care service demand is also increasing and therefore the need to provide a skilled aged care workforce is becoming more critical. Between 2003 and 2015, the number of residential aged care places increased by 30% and dependency levels of residents increased from 64.4% assessed as high care in 2003 to 89% in 2015.[9] Despite these facts, the current *Aged Care Act 1997* (Cth) has failed to establish and legislate safe staffing levels and skill mix (proportion of regulated RNs to ENs and UHCWs) in the aged care sector to meet the needs and care requirements of our most vulnerable Senior Australians. For UHCWs, inadequate staffing levels mean that they are overworked, rushed, under pressure and basic care needs are often delayed or not met. There is a requirement to staff RACFs to ensure that there is time to provide adequate person-centred care.

The proportion of RNs and ENs in the nursing skill mix of the Australian aged care sector has declined in recent decades. Increasingly RNs and ENs are finding their services substituted by unlicensed and unqualified workers, where UHCWs now represent the bulk of the workforce providing care. This can be problematic, as they have a limited and varied degree of training and preparation. At present the current aged care resident in Australia receives roughly 2.5 hours of care per day and the staffing mix is usually comprised of 70% UHCWs and 15% of both RNs and ENs.[10]

At a time of increasing aged care service demand, retaining the number of nurses should be a key priority and ACN's position is that regulation of *RACFs should mandate a requirement that an RN be on-site and available at all times* to promote safety and well-being for residents;[11] and that the Australian government must *amend the Aged Care Act 1997 (Cth) to reflect safe RN staff levels and appropriate skill mix* required in aged care settings.

The introduction of skill mix, staffing levels and the mix of staffing needs to be sufficient to ensure safe quality care is provided to all residents. Just as with hospitals, nursing research has demonstrated clear links between nurse staffing levels and the quality of nursing home care.[12] An

important factor in relation to methods for determining minimum staffing and appropriate skill mix is *resident acuity (increasing complexity and comorbidities that require nursing and or specialised care),* as this is the major determinant of the complexity of care required. Due to the growing prevalence of co-morbidities associated with physical and cognitive decline, polypharmacy, and greater professional accountability, increasingly the residential aged care population requires more complex care that can only be provided under the direct supervision of RNs. High acuity residents and health care consumers can present with medical conditions that are unpredictable, require significant attention and more frequent observation. Such care can only be safely managed and provided by baccalaureate prepared RNs supported with an appropriate skill mix and with adequate staffing levels. Having the right mix of qualified and experienced nurses available to monitor residents' conditions and who can intervene to prevent the development of complications and deterioration of illness is vital. Queensland Health has recently introduced new legislation to provide a minimum of 3.65 hours (219 minutes) of nursing care per resident day, of which 30% (66 minutes) are to be provided by RNs, 20% (44 minutes) by ENs and 50% (109 minutes) by UHCWs.[13]

ACN takes the stance that to reach a proposed minimum staffing levels care per resident day, aged care facilities must also achieve the RN, EN and UHCW minimum hours per resident / health care consumer day and the minimum requirements by staffing type. The nursing workforce needs to include Nurse Practitioners (NPs) and Advanced Practice RNs as well as ENs to ensure high quality non nursing and UHCW care provision. Not only do skill-levels need to increase, but also skill mix needs to increase to factor in the category mix of the residents and acuity of other illnesses/ailments that require nursing and or specialised care.

Overall, ACN is of the view that a nationally consistent dataset is required for effective workforce modelling in aged care settings as well as across the whole health care system. While this does not currently exist, there has been a global move towards developing this dataset to assist with determining staffing and minimum skill mix, to ensure the right data is accessible for safe and effective value-based care for health care consumers and residents in aged care settings.

Recommendations

- ***Regulation of RACFs should mandate a requirement that an RN be on-site and available at all times.***
- ***Australian government must amend the Aged Care Act 1997 (Cth) to reflect safe RN staff levels and appropriate skill mix.***

- ***Need for a nationally consistent dataset for effective workforce modelling in aged care and health settings to assist with determining staffing and minimum skill mix.***

II. who should be covered by a registration scheme for non-clinical staff in aged care, and how such a scheme might be implemented, administered and funded?

UHCWs should be covered by regulation in line with recommendations in the Australian College of Nursing White Paper: *Regulation of the Unregulated HealthCare Workforce across the Health Care System*.[14] UHCWs are estimated to make up 70% of the aged care workforce as of 2016, compared to 56% in 2003.[15] Researchers have to estimate the numbers as there is no single data source to capture and report the full extent of the UHCW workforce.[16] Information such as the prevalence, distribution, characteristics, and qualifications of the UHCW workforce within aged care and across metropolitan and/or rural Australia is not easily or accurately available. Any information that is available is often not comparable across jurisdictions due to inconsistencies in nomenclature, scope and qualifications. This is a continued source of concern and friction, requiring urgent action to be taken by the Australian Government to assist future workforce planning and provide the necessary protective measures for safeguarding Senior Australians in aged care facilities who are at the most vulnerable time of their lives since infancy.

Recommendations on how this should be implemented and administered:

- There are a number of frameworks that are applied to inform staffing levels in residential aged care services; the employment of RNs for clinical leadership within the sector and skill mix regarding nursing and UHCW for personal care provision.
- UHCWs will continue to deliver care into the future though standardisation of their scope of practice and preparation for practice is required. It is difficult for an RN to delegate to an UHCW[17] safely when the scope of practice of unregulated workers is not clearly defined and there is variation in the underlying education preparedness. ACN's position is that all UHCWs need to be regulated under a statutory authority. There are four elements to regulation.[18] These are as follows:
    1) Admission to a register based on the preparation and scope of practice of those who are eligible for admission. Such eligibility would include (at a minimum) evidence of meeting set educational standards and criminal record checks. On annual or biannual renewal of registration, this would also include a requirement for mandatory continuing professional development and recency of practice.

2) Accreditation of the programs leading to the preparation of those who are eligible to go onto the register. This would include minimum hours, clear curriculum and clinical preparation requirements.
3) The development of guidelines for best practice. These would include a code of conduct, standards for practice and other advisory documents as necessary.
4) A clear statutory mechanism for receipt, management, investigation and prosecution of complaints about health care workers who are on the register.

Recommendations on how this should be funded

ACN has recently researched into innovative models of care and can see merit in shifting the whole system to Value Based Health Care (VBHC) which would ensure the aged care system is focused on what matters to residents. VBHC targets core issues in the system to ensure that the 'right care' is provided at the 'right time', 'right price', in the 'right place' by the 'right provider' in an 'efficient system'.[19] VBHC in nursing can be viewed as the 'value' between having adequate nurse staffing and positive resident outcomes. Higher nurse staffing levels are strongly correlated with better outcomes for residents whilst being cost effective, providing improved productivity for staff due to reduced complications and shorter lengths of stay in hospital.[20 21 22]

Recommendation:

- ***UHCWs must be regulated and nationally consistent nomenclature/titles, code of conduct, professional standards and scope of practice must be developed and implemented.***
- ***Shifting the aged and health care systems towards value-based health care.***

III. options to resolve low remuneration and poor working conditions, including how the remuneration and working conditions of aged care workers can be aligned with their counterparts in the health and disability sectors

It is concerning that nursing is in some instances viewed as low value care. Low value care refers to an intervention considered to provide little or no benefit to the patient, or risks of harm exceeds likely benefit, or, the cost to intervene do not provide measurable benefits.[23] For example, aged care nurses are often remunerated at a much lower rate than nurses in other clinical settings. It is time for nurses across all sectors to be remunerated according to skill and experience level in the award agreement. More so, NP Medicare payments must be matched against payments made to other health providers who deliver similar services. Consideration must be given to value-based funding models for NPs and community-based nursing services. These include bundled payments[24] whereby remuneration is based on outcomes; and blended payment models which incorporate elements of fee-for-service, capitated payments and pay-for-performance.[25]

ACN is of the view that a consistent approach to nursing wages be aligned to their counterparts in the health care industry, regardless of where they are employed. The difference between the average rates of pay nationally between the top rate for an RN Level 1 in the public sector and the top rate for an RN Level 1 in the residential aged care sector is currently 15% or $216.22 per week calculated on the base rate.[26] On a State/Territory basis the difference for an RN Level 1 at the top of the level one classification structure varies from 8% in Tasmania to 37% in the Northern Territory[27]. Nurses and UHCWs' pay rates need to reflect their value and contribution to delivering care. To achieve this may involve standardising role titles/definitions and grades to ensure a comparison for pay renumeration alignment.

Defined career pathways for aged care that support the delivery of more holistic models of care as well as attracting nurses and UHWCs to the aged care workforce is necessary. Nurses have an established career pathway through enrolled nursing to registered nursing, to nurse practitioner and specialising in advanced practice nurse roles. In contrast, career pathways for allied health workers and personal carers are limited or ill-defined. Registered Nurses with a Master of Nursing and/or postgraduate studies relevant to aged care must have recognition through payment of monetary qualification allowance. Residential aged care consumers require to be cared for by nursing staff who have postgraduate training in gerontology and care staff who have additional training in how to care for the older person.

Recommendations

- ***Nurses across all sectors must be remunerated according to skill and experience level in the award agreement.***
- ***NP Medicare payments must be matched against payments made to other health providers who deliver similar services.***
- ***Shift towards value-based funding models for NPs and community-based nursing services.***
- ***Defined career pathways in the aged care sector to promote attraction and retention of all types of aged care staff.***

IV. how to raise the overall skill, knowledge and competencies of all care staff (existing and new entrants) in working with vulnerable people, especially those with age related conditions and illnesses

To address the overall skill, knowledge and competencies of all care staff working with Senior Australians, requires significant investment in support of staff at the graduate, postgraduate, vocational and continuous professional development level.

Undergraduate:

Higher education providers use the NMBA's Registered Nurse Standards of Practice when developing nursing curricula and assessing student performance. Whilst the RN curriculum content is created and reviewed with input from other disciplines and consumers, it is nurse led, by nurse educators, academics, clinicians and researchers. The Australian Nursing and Midwifery Accreditation Council (ANMAC) provides the mandatory minimum components (including clinical placement hours, and the inclusion of Aboriginal and Torres Strait Islander health issues) and every degree is overseen by the national accreditation authority, with each degree unique to the higher education provider. There are currently 36 higher education providers for the Bachelor of Nursing Degree in Australia. Each of the 36 higher education providers of the RN entry to practice programs provide clinical experiences for elderly people which is underpinned by theoretical teaching and learning.

ACN's opinion is that while the national registration and accreditation system for nursing degrees in Australia is effective, a more comprehensive undergraduate curricula could be achieved by extending the Bachelor of Nursing degree to four years to include mandated aged care clinical placements and theory; with a combination of clinical simulation and placement hours above the current 800 hours (as per evidence provided by The National Council of State Boards of Nursing (NCSBN) in the US on simulation). Existing three-year programs prepare RNs with generalist skills and there is limited opportunity for specialised content (e.g. dementia specialisation is only achieved through postgraduate education).

Postgraduate:

In Australia there are a several training and educational opportunities specific to aged care in the Higher Education sector and the Vocational Educational Training (VET) sector for nurses to access postgraduate, vocational and continuing professional development (CPD).

Vocational Education Training (VET) Sector

The VET Sector provides Diploma of Nursing Programs through a Registered Training Organisation (RTO) which provides a nationally consistent approach to preparing ENs to work in a variety of settings including aged care. The Diploma of Nursing meets the Australian Qualification Framework level 5 and is a health training package with 20 core units and five elective units delivered over 18 months (occasionally over two years). One core unit is to implement and monitor care of the older person with other relevant core units relating to the older person. Students also complete a clinical practice placement in an aged care environment. There are 53 currently approved Diploma of Nursing programs consistently provided in Australia; which are nurse led and require a minimum of 400 hours of clinical placement.

The Aged Care Workforce Taskforce (ACWT)[28] has identified that the current education and training skills and qualification framework does not align with work practices, consumer-focused care and leadership required in the industry. ACN endorses the ACWT recommendation for an immediate review of current electives for the Certificate III (Individual Support) and Certificate IV (Ageing and Support) programs of study, to identify whether these electives should be changed to core units. The aged care Industry Reference Committee (IRC) is reviewing the Cert III training package relevant to aged care.

End of Life Care Competencies

There is growing evidence that Senior Australians are coming into aged care settings at a more advanced stage of their illness and that their length of stay from admission to death is reducing. Whilst this is highly positive in enabling people to stay at home longer, it nevertheless indicates that when many people are admitted to an aged care setting, they are coming in for End of Life (EOL) care. Skilled and dignified EOL care requires precision symptom management, careful titration of pain management, and compassionate management of family and loved ones.[29] This level of care requires specialised RN management, supervision and support. In the aged care setting, this is not the case and Senior Australians are receiving EOL care by UHCWs with no training in dignified EOL care that respects the wishes of these individuals (i.e. advanced care directives). This highlights the need for access to palliative care trained RNs to support UHCWs and ENs in aged care facilities.

Minority and Vulnerable Groups

An inclusive approach to the personal needs of some groups who continue to face disadvantage that affects both their mental and physical health and their opportunities for social and economic engagement within their communities is required into the future. ACN recognises the unique needs of Aboriginal and Torres Strait Islander (ATSI) peoples. Equally, due regard must also be given to the unique needs of culturally and linguistically diverse (CALD) groups and lesbian, gay, bisexual, transgender and intersex (LGBTI) people in order to provide appropriate, safe and individualised care. As diversity within Australian society increases, there will be no standardised approach that fits all, therefore the educational needs of the aged care workforce will always be determined by the communities in which they serve.

Recommendations

- ***Extend the undergraduate Bachelor of Nursing degree to four years to include mandated aged care clinical placements and theory.***
- ***Review current electives for the Certificate III (Individual Support) and Certificate IV (Ageing and Support) VET programs of study, to identify further core units.***
- ***Access to palliative care trained RNs to support UHCWs and ENs in aged care facilities.***
- ***An inclusive approach to peoples from ATSI, CALD and LGBTI communities.***

v. how to ensure service providers develop a culture of strong governance and workforce leadership

Career pathway opportunities, particularly around specialisation in aged care and/or leadership and management should be afforded to those in aged care settings. The increasing fragility of aged care populations points to the need for strong nurse leadership across the aged care sector to ensure Senior Australians have timely access to the levels of nursing expertise they require. Strong leadership is key to effective aged care service planning and delivery. RNs oversee and provide frontline clinical leadership. They assess, plan, implement and evaluate essential nursing services in aged care.

The working environment is challenging, with aged care nurses experiencing increasing workloads resulting in work-related stress, job dissatisfaction and professional burnout. Aged care nurses often report insufficient time to complete requirements for residents (missed care tasks),[30] competing work priorities[31] and excessive administrative tasks. These issues are often compounded by poor leadership characterised by a lack of appropriate management action or support,[32] and professional isolation particularly when they are the only RN on duty for a large RACF. While we have not undertaken any surveys to quantify this issue, our members have informed of instances whereby the only RN on duty is completing excessive administrative tasks and is unable to spend the time required to care for an unwell resident who could reasonably be cared for by an RN in a RACF. The only option for an RN in this situation is to call an ambulance to assess and transfer the resident to an emergency department. Providing career pathways for RNs and ENs and ensuring there is more than one RN available each shift to assess and provide care to residents will go some way to addressing these issues.

Effective leadership ensures a positive, supportive and efficient workplace culture where staff feel appreciated and that their professional development is valued. This will result in a greater stability, reduced staff turnover, higher rates of recruitment and quality patient care. [33] [34] However, managers do not always have the skills necessary for leadership roles as selection is generally based on clinical skills and level of seniority. Therefore, succession planning and mentoring at all levels of an organisation (from mid-career to millennial/Gen Y nurses) is essential.[35] [36]

The social, political and economic challenges in health care make it critical that nurse leaders are equipped to respond to these ever-changing challenges, not only today but into the future. The role of nurse executives has evolved from a focus on nursing services to broader accountability for patient or client services across aged/residential care, hospital and community settings in public and

private, not for-profit and non-government organisations. To this end, ACN has developed a Nurse Executive Capability Framework[37] to guide the development of those in, or aspiring to, nurse executive roles. Currently within Australia there is no specific framework for nurse executives. ACN is thereby setting the standard nationally on the capabilities required. The Nurse Executive Leadership Program supports participants in developing the capabilities outlined in the Nurse Executive Capability Framework.

Nurse executives work collaboratively to facilitate the undertaking of tasks by others, individuals and/or multidisciplinary teams, with the required expertise.[38] ACN explains that the term nurse leader applies to nurses who work effectively to improve health care delivery irrespective of title. Nurse leaders are individuals who have a broad knowledge of the forces shaping health care and aged care including political, societal and economic factors. Typically, they are equipped with a deep understanding of nurses' working conditions and play key roles in fostering supportive work environments and in the recruitment and retention of an appropriately skilled workforce.
Nurse leaders in executive roles use their nursing knowledge to influence the strategic direction of an organisation and to inform operational planning. Clinical nurse leaders are involved in the coordination, delivery and monitoring of evidence-based practice care and continuous quality improvement activities. Nurse leaders' decisions have a direct bearing on the development of nursing systems and these systems are inextricably linked to meeting the challenges of delivery of quality aged care.

ACN believes a culture of strong governance and workforce leadership can be achieved by:

- offering clear career pathway and professional development opportunities for specialisation and leadership management roles for nurses working in aged care.
- encouraging the NP leadership role in every RACF and alternative funding models to incentivise NPs into RACFs (particularly in remote areas). A case study review indicated an expansion of 10 NPs in aged care would cost ~$1.5 million per year but result in 5,000 avoided Emergency Department (ED) visits each year, over $5.7 million in reduced ED, hospitalisation and ambulance costs[39].
- encouraging nurse-led leadership models such as the INSPIRED trial[40]. This trial offers specialist palliative care in 12 RACFs in the ACT for those most at risk of unplanned dying, with inadequately controlled symptoms. It has demonstrated a significant reduction in length of hospital stay and in-hospital deaths with significant costs savings

to the community with better-quality death for residents, improved staff confidence in discussing death and better decision-making.

- engaging industry partners with leadership programs. ACN has established tailored leadership programs that it currently provides to meet the specific needs of individual organisations. ACN corporate affiliate members from aged care with platinum membership are provided with a free leadership day to develop their nurse workforce (60% have accessed this).

Recommendations

- ***Clear career pathway and professional development opportunities for specialisation and leadership management in aged care.***
- ***Encourage NP leadership roles and nurse-led leadership roles.***
- ***Implementation of the 'Nurse Executive Capability Framework' developed by ACN to set national standards on capabilities required for nurse executive roles.***

VI. any institutional changes needed to ensure that the Commonwealth fills its role as the system steward and exercises leadership in workforce planning, development and remuneration.

The Commonwealth will commit to the role of aged care sector steward stipulating and overseeing leadership in workforce planning and development and to ensure renumeration and conditions are suitable to maintain a skilled aged care workforce with a career pathway. The Commonwealth needs to endorse a national approach to aged care workforce stipulating specific adequate staffing requirements so that not just "sufficient" staffing is provided, whether the facility is 50 beds or 100 beds.

The aged care sector should also invest in research around nurse staffing and resident outcomes in aged care settings. Increasing nurse staff levels facilitates the enhancement of the outcomes of residential aged care, the identification of recommended nurse staffing levels becomes very important. Research questions that need to be addressed are[41]:

1. The relationship between nurse staffing and quality care outcomes, that a minimum staffing level can be ascertained.

2. The minimum staffing levels for RNs and ENs, UHCWs and the total required per rostered shift and per day. Director of Nursing and an RN per shift, Nurse Educator for nurse and UHCW education at a minimum.

3. A model, Nursing hours per resident day (30 hours per day in a RACF with 100 residents) does not stipulate specific nurse to resident staffing ratios for RNs, ENs and UHWCs, and does not require a minimum level of staffing for UHCWs.

4. The expectation is that aged care organisations have a workforce that is sufficient and is skilled and qualified, to provide safe, respectful and quality care and services[42]

5. A national database is required that can interpret data from a variety of platforms; private, public and non-government organisations for future planning of; financial, residential care outcomes, deficiency measurements and workforce analysis.

6. A national evaluation plan with set targets to facilitate quality measurement of RACFs with outcomes of care; indwelling catheters, pressure sores, physical and chemical restraints, other clinical and operational governance reporting measures.

Recommendations

- ***A Commonwealth endorsed national approach to the aged care workforce which stipulates specific adequate staffing requirements.***
- ***Investment in research around nurse staffing and resident outcomes in aged care settings.***

References:

[1] Australian Government; Department of Health (2013). Review of Australian Government Health Workforce Programs. Accessed at: http://www.health.gov.au/internet/main/publishing.nsf/Content/D26858F4B68834EACA257BF0001A8DDC/$File/Review%20of%20Health%20Workforce%20programs.pdf

[2] Duckett SJ, Breadon P & Farmer J (2014). Unlocking skills in hospitals: better jobs, more care. Grattan Institute Melbourne.

[3] Allard T (2016). Nursing home profits soar as patient care declines. Sydney Morning Herald, 1 January 2016. Accessed at: http://www.smh.com.au/federal-politics/political-news/nursing-home-profits-soar-as-patient-caredeclines-20151224-glupug.html

[4] Chenoweth L, Merlyn T, Jeon YH, Tait F & Duffield C (2014). Attracting and retaining qualified nurses in aged and dementia care: outcomes from an Australian study. Journal of Nursing Management, 22(2): 234-247.

[5] Gao F, Newcombe P, Tilse C, Wilson J & Tuckett A (2014). Models for predicting turnover of Residential Aged Care nurses: a structural equation modelling analysis of secondary data. International Journal of Nursing Studies, 51(9): 1258-1270.

[6] Henderson J, Willis EM, Xiao D, Toffoli L & Verrall CC (2016a). Nurses' perceptions of the impact of the Aged Care Reform on care services for residents in multi-purpose services and Residential Aged Care facilities in Rural Australia. Australasian Journal on Ageing, DOI: 10.1111/ajag.12343.

[7] King D, Mavromaras K, Wei Z, He B, Healy J, Macaitis K, Moskos M & Smith L (2013). The Aged Care Workforce 2012: Final Report, NILS: Bedford park.

[8] Ansell C, Cox D, & Cartwright A (2016). Budget 2016 UnitingCare Australia ACFI Modelling-Summary Findings. UnitingCare Australia, Catholic Health Australia, ACSA and Ansell Strategic, Australia.

[9] Australian Nursing and Midwifery Federation (2019). Nurses and Midwives Paycheck. June-August 2019. Volume 18 No.3. Melbourne.

[10] Australian Nursing and Midwifery Federation (2017). On the front line - April Issue. Australian Nursing and Midwifery Journal, 24(9):33. Accessed at: https://issuu.com/australiannursingfederation/docs/anmj_april_2017_issuu_254b95647bcb50

[11] Australian College of Nursing (2016). Assistants in Nursing (however titled) - Position Statement. Accessed at: https://www.acn.edu.au/policy/position-statements.

[12] Zhang NJ, Unruh L, Liu R & Wan T (2006). Minimum nurse staffing ratios for nursing homes. Nursing Economics, 24 (2): 78-95.

[13] Eagar K, Westera A, Snoek M, Kobel C, Loggie C & Gordon R (2019). How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.

[14] Australian College of Nursing [ACN] (2019). Regulation of the Unregulated HealthCare Workforce across the Health Care System. Accessed at: https://www.acn.edu.au/wp-content/uploads/white-paper-regulation-unregulated-health-care-workforce-across-health-care-system.pdf

[15] Health Workforce Australia [HWA] (2014). Australia's Future Health Workforce – Nurses (Detailed Report). Accessed at: https://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8C16AACA257D9500112F25/$File/AFHW%20-%20Nurses%20detailed%20report.pdf

[16] Australian Nursing Federation (2009). Balancing risk and safety for our community: Unlicensed health workers in the health and aged care systems. Canberra: ANF.

[17] Nursing and Midwifery Board of Australia (2013). Nursing practice decision flowchart, Accessed at: https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/frameworks.aspx

[18] Chiarella M & White J (2013). Which tail wags which dog? Exploring the interface between health professional regulation and health professional education. Nurse Education Today, 33 (11) pp. 1274–1278.

[19] Global Access Partners (2019). A vision for Australia. Accessed at: https://www.globalaccesspartners.org/

[20] Keepnews D (2013). Mapping the economic value of nursing. Washington State Nurses Association. Accessed at: http://www.wsna.org/assets/entryassets/Nursing-Practice/Publications/economic-value-of-nursing-white-paper.pdf

[21] Needleman J, Buerhaus PI, Stewart M, Zelevinsky K & Mattke S (2006). Nurse staffing in hospitals: Is there a business case for quality? Health Affairs, 25 (1): 204-11.

[22] Dall T, Chen Y, Seifert R, Maddox P & Hogan P (2009). The Economic Value of Professional Nursing. Medical Care Journal., 47(1):97-104, doi: 10.1097/MLR.0b013e3181844da8.

[23] Scott A & Duckett S (2015). In search of professional consensus in defining and reducing low-value care. Med J Aust, 203 (4): 179-181. Accessed at: https://www.mja.com.au/journal/2015/203/4/search-professional-consensus-defining-and-reducing-low-value-care

[24] The Economist Intelligence Unit (2016). Value-based healthcare in the UK: A system of trial and error. Accessed at: https://eiuperspectives.economist.com/sites/default/files/ValuebasedhealthcareUK.pdf

[25] Australian Medicine (2015). Fee for Service should be part of new pay blend: doctors. Accessed at: https://ama.com.au/ausmed/fee-service-should-be-part-new-pay-blend-doctors

[26] Australian Nursing and Midwifery Federation [ANMF] (2019). Nurses and Midwives' Paycheck June-August 2019 Vol 18 No.3 pg.34-35.

[27] ibid

[28] Aged Care Workforce Strategy Taskforce. A Matter of Care - Australia's Aged Care Workforce Strategy 2018.

[29] Becker R (2009) Palliative care 3: Using palliative nursing skills in clinical practice. Nursing Times; 105: 15.

[30] Hello Care (2016). Brain Drain – Aged Care Nurses Leaving for Greener Pastures. Accessed at: https://hellocaremail.com.au/brain-drain-aged-care-nurses-leaving-for-greener-pastures/

[31] Parliament of Australia (2017). Future of Australia's aged care sector workforce: Chapter 3 - Attracting, training, and retaining aged care workers.

[32] Australian College of Nursing (2015). Nurse Leadership White Paper, ACN, Canberra

[33] Twigg D & McCullough K (2014). Nurse Retention: A Review of Strategies to Create and Enhance Positive Practice Environments in Clinical Settings. International Journal of Nursing Studies, 51 (1) 85.

[34] Duffield CM, Roche MA, Blay N & Stasa H (2011). Nursing unit managers, staff retention and work environment. Journal of Clinical Nursing, 20(1-2):23-33.

[35] Titzer J, Phillips T, Tooley S, Hall N & Shirey M (2013). Nurse manager succession planning: synthesis of the evidence. Succession planning: a call to action for nurse executives. Journal of Nursing Management, 21: 971-979.

[36] Titzer J (2016). Three first steps for effective succession planning. American Nurse Today, 11(9).

[37] Australian College of Nursing (2019). Nurse Executive Capability Framework. Institute of Leadership. Accessed at: https://www.acn.edu.au/wp-content/uploads/Nurse-Executive-Capability-Framework.pdf

[38] ibid

[39] KPMG Cost Benefit Analysis of Nurse Practitioner Models of Care Report. Department of Health. November 2018. Accessed at: https://www1.health.gov.au/internet/main/publishing.nsf/Content/424787040165EBABCA258470001C35EE/$File/Cost%20Benefit%20Analysis%20of%20Nurse%20Practitioner%20Models%20of%20Care%20report.pdf

[40] Forbat L, Liu W, Lam L, Johnston N, Samara J, Chapman M & Koerner J. 2019. Integrating specialist palliative care into residential care for older people: a stepped wedge trial (INSPIRED trial). Final report. Australian Catholic University.

Accessed: https://www.pcna.org.au/PCNA/media/docs/Specialist-palliative-care-in-nursing-homes.pdf

[41] Zhang NJ, Unruh L, Liu R & Wan T (2006). Minimum nurse staffing ratios for nursing homes. Nursing Economics, 24 (2): 78-95.

[42] Standard 7, Aged Care Accreditation Standards, Australian Government Department of Health 2019.