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A SURVEY OF STAFFING SUPPLY LEVELS IN AGED CARE; IN THE COFFS HARBOUR LGA , AND MID-NORTH COAST TO BALLINA REGION

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ABSTRACT

A survey was carried out between August and October 2003 of all aged care facilities and services in the Coffs Harbour LGA and of a sample of aged care facilities in all major coastal population centres between Ballina and Forster. The survey was carried out by the Aged Care Learning and Research Collaboration, an organization based on a co-operative agreement between Southern Cross University and University of New South Wales, School of Rural Health.

The survey was conducted by face-to-face interviews with the relevant Manager or Director of Nursing of each facility. Two questionnaire sheets were utilised, in order to determine details about staff levels, staff shortfalls and turnover and ages of staff. An additional questionnaire was used to establish attitudes towards necessary skills required for aged caring staff.

Analysis of data obtained from the survey indicates that, within the next five years there are likely to be major shortfalls in all aspects of aged care for the following reasons:

* Current staffing supply levels are inadequate for existing demand, although the potential for increased staffing levels is inhibited by financial constraints;
* A large proportion of the existing aged care staff is greater than 45 years old, with up to 25% of managerial and clinical staff due to take retirement or long-service leave within the next five years;
* High turnover rates occur, with managers experiencing high stress levels, and nursing staff dissatisfied with wages and working conditions.

The shortfall predictions obtained from this survey demonstrate the need to increase the region’s number of nursing student positions, both at TAFE and University level.

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**1 INTRODUCTION**

In response to the Federal Government’s initiative to address problems of the rural medical work force, the University of New South Wales (UNSW) has set up a campus of its School of Rural Health in Coffs Harbour. It already has medical students placed and will expand over the next few years.

The Southern Cross University (SCU) has a large, well established presence at the Coffs Harbour Education Campus (CHEC). That University has a School of Nursing and Health Care Practice, a Department of Exercise Science and Sports Movement, an Institute for Action Research, a Department of Psychology, a School of Business and a Department of Information Technology. The Campus includes a TAFE College, a Senior School and an Innovations Centre.

The town itself offers, in a largely rural setting, a Base Hospital, an effective private hospital, an active Division of General Practice, domiciliary services, nursing homes, hostels and the usual compliment of voluntary and ancillary services. The City Council is most supportive of educational activities and has provided a site for the Medical School Building.

**There is general agreement that the anticipated large influx of “sea change” retirees will over-stretch existing services.** Care of the elderly is seen as a critical issue, both in medical and social terms.

**The happy co-incidence of all the above elements, all with good communication channels, has prompted the two Universities to establish an Aged Services Learning and Research Collaboration (ASLaRC).** Its function is not to duplicate biomedical research into ageing, but to examine practical ways to maximise the delivery of services to the ageing population, firstly in the region but ultimately to the ageing population in general.

**The two campuses already have the elements in place to tailor courses at all levels to meet the challenges identified by ASLaRC.**

A recent report commissioned by the Australian Local Government Association found that by 2021, the proportion of residents on the mid-North Coast aged over 55 could increase by 17%, to represent 47% of the local population. Nicholls (2003) observes that “….an explosion of the over-55 population on the North Coast, coupled with already high unemployment, means that councils may be left without enough money to fund such a high standard of aged-care facilities….”

Funding was recently made available to ASLaRC, in order to develop a survey of staffing levels in aged care facilities on the North Coast of New South Wales.

A stated function of ASLaRC is to “….examine practical ways to maximise the delivery of services to the ageing population, firstly in the region, but ultimately to the ageing population in general” (see Curran 2003).

The numbers of graduates required to provide an adequate pool for supplying all needs of aged caring is, at this stage, uncertain. Curran (2003) suggests that predictions of population growth for the 60+ age group are “….almost certainly conservative….” and points out that “….developers anticipate 2-3000 new retirees within 5 years.”

Curran (2003) concludes that “there is a strong anecdotal case that there is an acute shortage of nurses, at all levels. Precise figures are not immediately available and elucidation of this situation is a priority….”

This is a report of a project to define the regional needs for the aged nursing/caring workforce over the next 5-10 years, and to determine the caring skills that employers wish to see in their future employees.

**2 AIMS**

The aim of this survey is to collect data in order to provide information towards:

* identifying current staffing numbers in aged care facilities, from managerial to domestic levels; and
* identifying potential staffing short-falls, in the context of affecting factors such as work-place injury, retirement, leave entitlements and natural attrition.

The secondary aims are:

* To establish a list of learning outcomes to be included in courses appropriate to the aged care industry, and to make recommendations, based on analysis of the data, for developing appropriate course content; and
* To predict minimum required student places in courses appropriate to the aged care industry, in order to ensure adequate provision of qualified staff to accommodate increasing demand in the region.

**3 METHODOLOGY**

Face to face interviews were conducted with the Directors of Nursing of all residential facilities and hospitals and comparable managers of community programs in the Coffs Harbour local government area. Samples of one each of residential and community program facilities were surveyed in each town in the Mid North Coast area, south to Forster and north to Ballina. Due to the larger population of Ballina in comparison with other sampled population centres, four facilities from this town were surveyed. The survey area was considered to be the catchment area for the graduates of Southern Cross University, and North Coast Institute of TAFE students.

A total of fifty facilities delivering services to the aged in this survey area were surveyed.

Aged persons were considered to be more than 65 years of age. Generic survey forms were used to collect the data in order to ensure a consistent data set from which results could be applied to all aged care facilities.

Interviews were conducted by the same person to ensure consistency of interviewing techniques, to limit bias and to ensure consistency and reliability of the responses. The largest employer in the Coffs Harbour LGA was unable to facilitate an interview with the researchers and instead the survey form was completed via fax. It is possible that the results may have been confounded to some extent by this variation in the method of data collection

3.1 Survey Details

A set of questions required responses in relation to all workers in each age care facility, from administration to domestic and including personal care staff, nurses and diagnostic and health professionals, as well as maintenance staff.

Visiting professionals and paramedical staff were excluded, unless they were considered to be employees of the facilities.

Three questionnaires were used in the interviews in order to determine;

* Staffing levels according to occupation;
* Age of workers; and
* Skills considered necessary for work in an aged care facility.

The first two questionnaires were used to interview all selected facilities in the survey area, while the third survey form was presented to a selected, representative group of seventeen Managers.

3.1.1 Survey 1: Staffing Levels According to Occupation

A copy of this questionnaire is included as Appendix A. Questions which would elicit present and future staffing needs, as well as gaps in staffing due to leave entitlements and staff turnover are included in this survey form.

All facilities except one were able to either fully or partially respond at the interview stage. As the survey was designed to determine the size of the workforce, questions related to number of persons employed by the organisation, rather than the number of full time positions (FTE) held by each facility. In this way, the numbers of casual and contract workers was also determined.

3.1.2 Survey 2: Age According to Occupation

The second questionnaire required the year of birth of each worker in the facility.

This questionnaire was answered, either during the interview, or afterwards, by 19 participants, as some managers were unable to provide answers to this survey due to time constraints and lack of ready access to this information. A copy of this questionnaire is included as Appendix B.

* + 1. Survey 3: Skills List for Aged Care

The third questionnaire, which listed a set of skills considered appropriate to Aged Care, was presented to 17 participants across the sample of high and low band residential facilities, hospitals, and community programs, both within and outside the Coffs Harbour LGA.

Common skills were identified from the learning outcomes of the curricula of existing relevant educational courses. Each skill required a response according to a Likert Scale of Preference, so that each skill could be ranked in importance for each facility. A pilot questionnaire was presented to a manager of each type of service, then modified to accommodate suggested additions. The altered survey form was then presented to the rest of the sample participants.

A trend emerged initially, and continued throughout the following interviews. This appeared to confirm the validity of the chosen skills, so the survey was finalised.

A copy of this questionnaire, with preference scores, is included as Appendix C

1. **RESULTS**

4.1 Survey 1: Staffing Levels According To Occupation

Results of the survey indicate that there is a demonstrable shortage of adequately trained staff at present funding levels. The answers were generally consistent across all areas and facility types. The question was then asked as to whether staffing levels would be increased in the event of increased available funding. The question was worded in an attempt to encourage the manager to envisage the optimal workforce for the existing number of clients. However, there was a degree of confusion as to the concept of access to unlimited funds to pay for the increase in the workforce. Those facility managers who could espouse such a concept readily grasped the ‘pie in the sky’ plan and reached for the stars. It did engender a significant departure from the current workforce size.

The responses showed a desire for a 19% increase in staff across all job descriptions. The preferred areas of increase were in the permanent part-time staff and the casual pool of staff. The full time personnel were considered to be able to handle the current workload, with the assistance of more permanent part time staff or access to more staff at on call casual level.

Figure 1 indicates the preferred percentage staff increases according to job description.



4.1.1 Managers

Managers were generally found to be registered nurses who have sought promotion. They often do not have managerial training or formal managerial qualifications, and generally find the workload challenging and demanding. There is no relief pool to call on, with the next RN in line, also probably lacking managerial training, usually being asked to relieve. This situation may tend to cause a domino effect when staff are asked to relieve in positions above their current position without the benefit of training or mentoring to assist the process. Anecdotally, the managers advised that staff are too busy to mentor or coach a new occupant.

Of particular concern is the high accrual of long service leave by this workforce.

The average business should expect to devote 3% of gross turnover to payment of long service leave entitlements. However, 21% of the managerial staff are entitled to long service leave at the time of interview. As this leave has accrued at a lower rate of pay, the organisations may have difficulty funding the excessive leave entitlements.



Only one manager was considering maternity leave, which was in accordance with the older age range of the workforce. This age range was also reflected in that of the 95 managerial staff, five or 5.2% are considering leaving the industry or retiring in the next five years.

The rate of leave taken due to workplace injuries was slightly higher than the national rate of workplace injuries. Of the 95 staff, 3 or 3.1% have taken leave due to injury. Anecdotally, the injuries now taking place are due to factors such as the high stress levels experienced by ill-trained managers trying to work within a difficult work setting with antiquated support technology. For example, most managers were still organising rosters on paper, and did not have access to basic information regarding their staff profiles, hence the inability to provide ages of staff at short notice.

The average occupancy rate of a manager in this industry, in this area, was 3.3 years. There was a diversity of length of service depending on the type of facility. The managers of the community programs tended to stay longer (4.3 years) than the directors and managers of the residential services (2.7) years. The percentage turnover rates were greater in the facilities sampled outside Coffs Harbour in comparison with those facilities within Coffs Harbour LGA.



Although the age survey was only answered by 14 of the participants regarding their organisation, the ages of the managerial staff is as predicted, generally above 45 years of age. The oldest group are the Directors of Nursing (DoNs) and the Deputy Directors of Nursing (DDoNs). This group tended to have more than ten years of service individually, and to be trained clinical nurses. In fact, all current managers of the residential services interviewed during this survey originally trained as registered nurses (RNs).



Responses to the Questionnaires and Skills List indicate that most Managers have limited computer knowledge and management skills; “….many of the people being asked to run aged care facilities are doing so without formal management qualifications” (Suter K. & England S. 2001, p16). A number of Managers reported that they found little time to update their skills, as their position required up to 80 hours a week in working hours. Moreover, it would appear that only a small proportion of staff members have an adequate knowledge of computer technology or consider that their organisation had the funds to approve purchase of the latest in software and hardware to operate their databases.

4.1.2 Clinical Staff

Of particular interest in the short term is the shortage of clinical nursing staff, both registered nurses (RNs) and enrolled nurses (ENs). This is in accordance with the report in the National Survey for February 2002, which is based on data for the second half of 2001, and identified a national shortage of registered nurses (Duckett S as quoted in [Senate Community Affairs Committee](http://www.aph.gov.au/senate/committee/clac_ctte/index.htm), 2002). According to this current survey, the number of nurses employed to provide aged care services currently is 275 in the Coffs Harbour LGA and 356 in the facilities sampled outside Coffs Harbour.

The survey answers compared the present workforce to the preferred workforce and found a difference dependent on the type of facility. The residential and hospital managers would prefer an increase of 16% in their workforce of clinical nursing staff, while the community program managers envisaged an increase of 21% to function effectively. Managers in Coffs Harbour indicated that they preferred a higher percentage increase in Clinical Staff in comparison with facilities outside Coffs Harbour.

All managers stated that they could not employ more staff due to the shortage of trained personnel as well as existing funding constraints.



Overall, Managers stated that they were lacking in RNs and fully trained staff to handle emergency shortages of rosters. The lack of a casual pool of RNs is a major worry for the facility managers. It was reported that some RNs are working in one facility then directly after going to a different facility to work another shift.

The lack of ENs is being compensated for, to some extent, by use of strategies to enable AINs to fulfil their functions. In addition to the survey responses, it was stated that employers are responding to shortfalls by allocating more duties to unqualified or non-nurses across the aged work field. This accords with the results reported by Duckett S as quoted in the [Senate Community Affairs Committee](http://www.aph.gov.au/senate/committee/clac_ctte/index.htm) report of 2002.

The majority of clinical staff are employed on a permanent part-time basis (51.5%). Although the roster of hours was not collated, generally the nurses are working 3-4 shifts per week, totalling 20 hours per week on average. Some nurses were reported as employed in more than one facility due to the shortage of available nursing staff. This infers that some nurses would like to work more hours if the opportunities were available.

The turnover of staff was notably higher than that for the average workforce. The average turnover rate was 21.5%. Slight variations in percentage turnover, according to location and facility were recorded. Percentage turnover rates in residential facilities were 19% for Coffs Harbour and 20% in facilities sampled outside Coffs Harbour. Percentage turnover rates in community program facilities were 25% for Coffs Harbour and 22% in facilities sampled outside Coffs Harbour.



There was generally consensus in the list of skills required for the clinical nursing staff. Those skills included on the list which were identified as not being required by a majority of managers were:

* Organise relief staff;
* Perform venipuncture; and

* Insert naso-gastric tubes and intravenous tubes.

These skills were not seen as required by an employee of the facility because the client could be transferred to hospital, or a contract worker could be employed to conduct the procedure on an hourly fee basis.

The only differences which appeared between the community programs and the residential facilities regarded the importance of the client education component of the duties, as some clinical staff conduct community education programs.

Other skills seen as less essential, were administrative duties, including training other staff, and carrying out or assisting with research activities.

It is, however, apparent that current curricula do not include consideration of conflict resolution skills and managing challenging behaviours in demented clients.

Other alternative therapies which are gaining wide acceptance include pet therapy and aromatherapy. The skills to deliver alternative therapy programs are not taught in the mainstream course for clinical nursing. This need could conceivably be met by the existing School of Natural Medicine at SCU, Lismore.

The age range of the clinical nursing staff is commensurate with that of managers.

The results shown are synonymous with the State average as reported by the Profile of the nurse Workforce, 2000. 45% of Clinical Nurses in Coffs harbour and 64% of Clinical Nurses outside Coffs Harbour are 45 years or older. This means that the RNs and the ENs are on average older than the average workers in other health areas which is 40.4 years. (Taylor, Nursing Labour Force, 2001). This fact is echoed in the low rate of workers applying for maternity or paternity leave. Alternatively, fewer graduates are expected over the next few years (Taylor, Nursing Labour Force, 2001). Therefore, as the retirement age draws near, the lack of replacement staff is likely to exacerbate the existing shortfall in staff in this industry.



4.1.3 Unlicensed Carers

The largest section of the aged care workforce generally consists of unlicensed care personnel, namely Assistants in Nursing and personal care workers, as well as recreational or diversional therapists. The majority are permanent part time workers, although there is also a large casual pool.

A small proportion of Unlicensed Caring Staff work full time hours. This section of the workforce does not accrue a large amount of leave due to a high turnover rate and the low rate of allocated part time and casual work. There was little utilization of maternity or paternity leave, due to the age of the workforce. Some workers are also carers of grandchildren or their own elderly parents.



Turnover rates of unlicensed carers are consistently high; with percentage rates in both residential and community program facilities within Coffs Harbour LGA reaching 38%, and 22% in community programs and 40% in residential facilities in sampled areas outside Coffs Harbour.



The majority of unlicensed carers are over 40 years of age (Ratio 148:93). Some Managers stated that the younger workers do not stay very long and are not satisfied with the pay and conditions of the aged care industry. This is borne out by the responses to the National Nursing Review 2000, which identified pay and conditions as the main trigger to leaving the industry. An anomaly to this trend appears to be the aboriginal medical centres, whose managers stated that they have no difficulty recruiting and retaining younger staff, who are trained as Aboriginal Health Workers.

Managers reported that the option of converting the TAFE Certificate III to a Clinical Nursing qualification was only taken up by a handful of personnel. Three AINs were recorded as converting to the RN course, and none to an EN qualification.

The improvement in occupational health and safety practices as a response to the accreditation process in the industry is probably a contributing factor to a low rate of workplace injury leave. Many facilities now have a “no lifting” policy which appears to have reduced the injury rate of unlicensed carers. Anecdotally, many of the injuries now occurring are due to the (reportedly) high number of aggressive incidents in the nursing homes.

Due to factors including the existing ‘aging in place’ policy and improved medication, there is a demographic shift of the resident population to the older age bracket.

This also appears to be an increase in the ratio of elderly exhibiting challenging behaviours. National Survey estimates that 67% of residents are experiencing Alzheimer’s Disease, Dementia or challenging behaviours, due to personality disorders or psychiatric disabilities. “….2% of people aged 65-69 are affected by Dementia, but this increases to about 22 % at ages 85 to 89.” (Minichiello *et al.* 1992, as cited in Gibbs, 1994, p36).

Important occupational and health questions arise from community care. In community programs, a worker may visit several workplaces each day alone and as a result there is an increased risk of occupational hazards from the older person and their family (Suter, K. & England S., 2001, p14).

Assistants in Nursing are a section of the aged care workforce, whose versatility needs to encompass a large range of duties. Due to the high cost of weekend nursing, many facilities reported utilizing unlicensed carers to carry out a large range of activities on the weekends. The use of supervision by distance is an expanding practice, which is not addressed by the current curricula taught at the TAFE Certificate III level.

The skills taught to this section of the workforce are considered by most interviewed Managers to be inadequate for the job. Many DoNs reported that in-house training was required for a new AIN to adequately conduct their duties. The larger organisations are conducting their own Certificate III in Assistant in Nursing (Aged Care) to ensure that new personnel have the required skills. One skill considered by Managers to be lacking from curricula relates to conflict resolution.

There is little use of contracted labour in this area, except in the specialized fields of podiatry, education or occupational therapy. Overall, 52 personnel were described as working in paramedical fields in the facilities surveyed.

4.1.4 Domestic Staff

Domestic workers were also in demand in each facility, with a preferred staff increase of 10.5%. The preferred number of employees is higher in community programs, in comparison with residential facilities.

Domestic staff generally appear to be more stable in their work history, with turnover rates of 6% in Coffs Harbour and 17% outside the Coffs Harbour LGA. A substantial number of this workforce consists of permanent employees, with only 14% being employed on a casual basis.

Age is also a problem in the domestic category, with 23% of Coffs Harbour staff and 27% of staff outside Coffs Harbour eligible to take Long Service or Retirement leave within the next five years.

There were no instances of staff in this field moving to the personal care aspects of the industry.





The majority of the age distribution of this workforce, is again in the 40 years plus (73 % outside Coffs Harbour and 76% in the Coffs Harbour LGA). In residential services, most have been employed for the last five years, so over a quarter of the workforce are entitled to leave in the next five years, albeit on a pro rata basis (26%).

Domestic staff are a more accessible workforce, as they are more easily replaceable and not initially requiring specialist skills for the aged care industry. However, some Managers did consider that the occupational health and safety aspects of chemical usage and knowledge of infection control were skills that should be known prior to their employment. Some facilities are now requesting this knowledge before they employ a domestic cleaner or kitchen hand.





# 5 DISCUSSION

* 1. General

“….major restructuring of residential aged care occurred in 1997, with the move to ‘ageing in place’. In 2000, there were 84 residential aged care places per 1 000 population aged 70 years and over (a decrease from 89.3 places per 1 000 in 1997) and 11 community aged care packages per 1 000 population aged 70 years and over (an increase from 3.9 packages per 1 000 in 1994)” (Duckett S, 2002).

In the area sampled, the current managerial staff are sourced from the nursing profession. This has suited the residential facilities as they have been aligned to the medical model of service delivery. The industry is moving towards a community model, as required by the increase in community aged care packages and ACTIP funded packages. These positions may be more efficient if filled by managers who have a more corporate view of the service model. This is already happening in another regional centre with success In conjunction with these changes would be a change in the workplace culture to view the residents and clients as frail aged who are not sick, but with assistance managing their longevity and their limited ability to conduct their own affairs.

The high rate of attrition by the managerial staff, leads to a reduction in the skills that are attributable to a long term employee. The lack of education in managerial skills may be attributing to this attrition rate. There is an identifiable need for the upgrading of skills in the present workforce, as well as the education for the next level who will take on these duties. Application of these skills may lessen the turnover rate of managers, who are suffering burn out and stress from performing their job without adequate training.

Another solution to this dilemma, is to outsource these duties to a contractor who will organise the roster and pay, source employees and provide administrative support to the organisation. This option has been mooted with some acceptance by the managers.

Information Technology is about to increase in use in this industry. However, very few staff was reported as knowledgable about software. A large influx of IT training is warranted in the industry, from the managerial level to the staff walking the floor.

Again, managers were not adverse to the use of technology, but stated that an influx of funds was required to update current information support and data bases.

Specifically, community program managers would like to access a client database which listed all providers of service under the client’s name. This system would be particularly helpful for dealing with dementia and Alzheimer patients.

By meeting the educational needs of the managers, a new scope for advancement may be available. Managerial skills are in demand in every industry, which would be an advantage in smaller regional centres.

The large amount of accrued leave will be a contentious issue in the immediate future.

The high rate of accrued leave in the nursing workforce was reported as due to the shortage of readily available staff to relieve the staff on leave. As the question relating to long service leave was interpreted to apply to those with 10 years service or more. This resulted in a low response rate for the AIN group, due again to the casual nature of their tenure. Instead these workers tended to take breaks from the industry or change employers.

The survey into the years of birth of the workforce did not receive a full response as some facilities were not able to access this information easily, but those who did respond showed that the managerial workforce are nearing senior members of the workforce. Due to the high turnover rate, there will be a shift in employees as the next generation of RNs take up the managerial duties. This shift could exacerbate the shortage in nursing staff.

Receptionist and administration staff is an easily sourced as there are no specific skills required. However, knowledge of medical terminology would be an advantage in this area, as would conflict resolution skills. At present the percentage of residents with challenging behaviours including Dementia and Alzheimer’s Disease is 67%. As the resident population changes to include more residents with challenging behaviours, there will be a greater need for receptionists to master conflict resolutions skills. Another cohort entering aged care is the ‘baby boomer’ generation. The oldest group of the cohort is currently entitled to retire. This group is noted for their knowledge of their rights and willing to exert their demand for services. Again this will require skills to achieve a situation where “their different approach to aged care” (Suter,K & England, S., 2001, Alternative Futures for Aged Care in Australia) is accommodated.

In the recent [**Commonwealth Report on the Inquiry into Nursing**](http://www.aph.gov.au/senate/committee/clac_ctte/nursing/report/index.htm), 2002 “Submissions indicated that the real shortage of nurses is hidden as nursing data is incomplete and inadequate, nurses are working greater amounts of overtime” (Duckett S, 2002). This may be the case in this survey, as the managers were not asked how many hours the staff were working, just the number of workers classified as permanent part time or fulltime or casual employees.

A total of 694 nurses are reported as working in the Mid North Cost Area, as defined by the Dept of Health, 2001. This equated to 6.2% of ENs and 3.2% of RNs, registered as working in NSW. However, 15% of available RNs are required to work in the geriatric/gerontology area, (2000, Dept of Health, Profile of the Nurse Workforce). Only 11 aboriginal nurses were reported as working in the MNC area, in 2000. However, local knowledge from the MNC Area Aboriginal Health Service, advises that this data is grossly incorrect. Due to the aging workforce, and lack of readily available pool of trained nurses in this area, there is a predicted staff shortfall within the next five years.

The ages of clinical nursing staff is skewed to the mature end of the age range. Most nurses are forty-five years plus age range. This trend is greater than the national average which places only 50% of nurses above this age (2000, Dept of Health). Younger nurses are reported as preferring the more glamorous areas of acute health delivery. Research may be needed into the profile of the aged care industry to make it more acceptable to younger nurses. “Over the next 10 to 15 years, 30% of the workforce will be contemplating retirement. Nurses approaching retirement may also switch to part-time work, further exacerbating the nurse shortage.………Increasing the number of graduates is a medium to long term solution given the lead time for nursing students to come into the workplace” (Duckett S, 2002).

There is a need to ensure an adequate supply of suitably qualified nurses by locality, for example, in rural and remote Australia. In order to address these issues, adequate workforce planning is essential “to ensure that these university decisions impact positively on future workforce requirements” (Duckett S, 2002).

The skills required to work in the aged care industry are changing as does the clientele. As the current policy is to enhance the well being of the person, following a community model as opposed to a medical model is preferable. The skills required would then be linked to enhancing the wellness of the frail aged rather than the disability. Value was placed on the quality of the person’s life experiences while in the frailty and in the community. The optimal situation was seen as the nurses having time to sit with the resident and converse. Value adding therapies such as recreational activities and aromatherapies may be the skills of the future aged care personnel. “Instead, the role of the registered nurse has become more managerial. This leads to decreasing job satisfaction, alienation from their nursing work and burnout” (Duckett S., 2002). Instead, residential centres, are changing to the provision of more complex and intensive levels of care, such as palliative and post-operative care. However, some skills relating to more invasive procedures were not seen as required by the DoNs. If the resident required these procedures, the DoNs advised that they would be transferred to hospital.

The survey responses showed that the nursing staff have little time for organising educational programmes or research activities. These were seen by the DoNs as very desirable, but no time to do it. Instead the drudgery of performing the same duties every day, is seen to add to the poor conditions of service. Poor conditions were quoted as triggering a desire to leave the industry in the survey conducted by the NSW Dept of Health Ministerial Standing Committee Nursing Workforce Review 2001.

Another skill which is recognised, but not addressed to an appropriate level, is the managing of challenging behaviour. An average of 67% of the aged population requiring services is exhibiting challenging behaviours. Although identified, the demands of working with high care residents is not fully addressed to encapsulate the varied skills required to deal effectively with ongoing challenging behaviours, including depression, which as a disorder amongst women, is on the increase. “Professional attitudes and effectiveness of approaches to care need to be critically assessed.” (Bevan C. & Jeeawody B., 1998, p175).

Of concern for the future is the lack of skills and knowledge to deal with HIV positive patients. As the sufferers of Acquired Immune Deficiency and people with HIV are achieving a normal life span, they will require specialized aged care services. AIDs sufferers also exhibit dementia like behaviours that differ depending on the nature of the cause. Current curricula do not address the specific needs of this cohort of potential clients. Also results of a survey into palliative care attitudes and beliefs shows that “pre-service and in service nurse education must also incorporate material and experiences that challenges stereotypes” (Stevens, J , 1997, p 24).

Most nurses are also unaware of the technological changes being brought into the industry, and have very limited computer skills. Innovative technology is being considered from personal care offered by remote monitoring to electronic data collection. These innovations, will require skilled versatile staff who are up to date with the latest in electronic and computerized methods. The Profile of the Nurse Workforce shows 49% of nurses spend up to nine hours of their working week in an administrative role and 20% of nurse spend 20 hours per week doing administration and or management duties. Innovative use of information technology could lighten the workload reducing stress, and freeing nurse for their caring role.

Overall, as the “nursing workforce ages and patient intensity increases, attention to the physical and emotional demands of the profession and the provision of adequate, properly functioning equipment (such as patient lifters) will be an important factor in retaining and recruiting a workforce. Lack of support in the workplace (especially from management level) was a strong disincentive to work in nursing” (Nursing and Health Services Research Consortium 2000. NSW nursing workforce research project <http://www.health.nsw.gov.au/nursing/wforceres.html>).

Since 1996 there has been a 2.8% decrease in the number of RNs and a 2.7% decline in ENs. (NSW Ministerial Standing Committee, 2001) across NSW. It is unknown which classification of staff are leaving the industry and adding to the turnover rate of the clinical staff. Most of the clinical nurses are working on a permanent part time basis. The state statistics from the Nurse Workforce Profile,(2000), reports that 47% of the total state workforce is working less than 40 hours per week. Lack of a livable wage, and inability to maintain a reliable and flexible ongoing roster, is of major concern to clinical nurses who are supporting dependents. (NSW Ministerial Standing Committee, 2001)

Also, the career structure of the RN is limited. The options are to do postgraduate studies and specialize, or wait for the managerial position to become vacant. These limitations may be factors in the attrition of qualified clinical nurses. By providing a greater scope of career advancement, the current staff may consider staying in the profession, and mentoring the younger staff. Identified needs are “improved opportunities for ongoing training and professional development of mature age workers as well as more flexible working conditions” (Australian Dept of Health and Ageing, 2003). There is a need to provide a structure to encourage coaching and mentoring to facilitate new staff staying more than the 2.5 years currently being experienced.

On a macroeconomic scale, the higher participation of older workers is seen as necessary to equitably share “the financial burden of an aging population” (OECD, 1988, p60, as cited in Rowland, D.T., 1991, p 185). Potential students living in the mid north coast area, are in the 40 years plus age group. This cohort is best suited to this industry. They are already living in this are and have well established families, and desire to stay if there is available work. The need exists for a local educational facility to train residents of the mid north coast who wish to stay and work here.

The answers to the questions relating to the number of employees in the field, shows that the bulk of the workforce is unlicensed carers. Most workers have qualifications as Assistants In Nursing and there is very little utilization of ENs. This result is explained by the limitations placed on ENs in providing medication. The inference is that there is very little reason for the AIN to convert their training to EN, as there is very little change to the range of work or the career structure in the aged care industry.

Unlicensed aged care workers are also an in the older range of workers. They are slightly younger than the clinical nurses, but still predominantly in the over 40 years age group. Anecdotally, the younger workers are generally not considered to be compatible with the industry, and recently one DoN advised that she deliberately did not choose younger staff in the latest round of recruitment, due to the incompatibility of their attitude and inadequacy of the training.

Instead the workers would rather move to a new facility in the hope of obtaining a permanent roster of work The casualization of this workforce appears to be affecting the high turnover rate of at this level. One manager reported that no sooner had he completed an induction course, than his staff were ‘poached’ by another facility which was offering permanency. The argument by the traditional DoNs argument against offering permanent rosters, is that the workload is fluctuating. This argument is offset by the fact that all facilities have waiting lists and an occupancy turnover of one day.

It was not reported in this survey, which of the workers were leaving the industry, and which were going to a new facility. The unknown factor could be offset by regulation of these workers, so as to know whether they are leaving the industry or merely changing employers.

There were reported 3 cases of AINs converting to the RN course. However, the tyranny of distance was reported as a deterrent to many who would espouse this career path. Currently, the nearest school of Nursing is in Lismore, or Newcastle. The proposed School of Aged Care on the Coffs Harbour Education Campus is seen as a solution to this problem

The under utilization of the workforce appears to be related to the high turnover of staff. Those facilities which rewarded good staff with permanency, albeit part time, reported a lower staff turnover. Those facilities who also provided in-house training reported more job satisfaction among their employees and an even higher rate of retention of their staff. These results differed for the smaller regional centres, due to the limited availability of qualified personnel and therefore more stable pool of available workforce Perhaps this may be an area of research for the future

The skills of an unlicensed carer could be augmented to include more counselling skills, as often they are the frontline worker who deals mostly with the resident or client of a community program. In the community, they are often the only worker assisting the well but frail aged. This work setting tends to isolate the worker, who must be given opportunities to debrief with a supervisor. The policy to keep aged in their home long as possible will cause an increase in community programs. Work practices should be supplemented by appropriate strategies to stop burn out and stress in the front of line workers.

Stress due to attacks on the staff is now the predominantly reported workplace injury. Perusal of the curriculum on offer, do not adequately address this training need. Many facilities were conducting their own training once the person is employed. This delay in competency of staff members could be addressed by the School of Aged Care, in partnership with the School of Social Science and Boorongen training facility to complement the training providing the specific cultural aspects of the local Aboriginal tribes.

Due to the Commonwealth ‘aging in place’ policy, many unlicensed care workers operate on the own in the community. As more duties are allocated to unqualified or non-nurses in a stop gap measure to alleviate the shortage in nurses, there are more skills required by this group of workers. Changes to workplace culture include expectations that a care worker with 6 months training can initiate practices and be responsible in the field for a wide range of issues.

The lack of funding to employ nurses in these positions has been cited as reasons for employing the less skilled personnel. If this practice is to continue, there needs to be specialized training in community services which have requirements that differ from the residential services. “Most community services provide only a small spectrum of assistance” ( Bevan & Jeeawody, 1998, p79). There is a need for AINs to specialize in community or residential services which is not on offer in the current curricula.

Social capital is vital to aged to maintain links with society and encapsulated in the holistic model of wellness and health. A “whole of life view” (Aboriginal Health strategy, 1989 p ix-x) needs the skills of carers to maintain older person’s networks and inclusion in society, so that value is placed on elderly in our community. This may result in elder abuse of depersonalization being lowered.

The issues affecting the domestic staff were also an aspect of this research, albeit of secondary importance. This group is also aging, but there appears to be no problem attracting younger staff. Indeed the only problem advised, was the reluctance of long term staff to move over for younger workers. The turnover rate for domestic workers is 6% in Coffs Harbour, but 17% outside Coffs Harbour.

The facilities required multiple skills for those staff that were able to work in a variety of positions. The lack of Occupational Health &Safety training in chemical handling, knowledge of infection control and personal hygiene as it pertains to older clientele, is currently being taught in house. It was felt that these skills could be addressed by the schools currently residing at the Coffs Harbour Education Campus.

The lack of domestic personnel willing to transfer to the personal care work was not canvassed in this survey. Due to the demographics of this group, perhaps the locality of training would be perceived as an incentive to continue a career path in this industry. Of more importance at this level are the poor pay entitlements. A shift worker in the domestic field may receive a comparable wage to the personal care worker. Recent industrial action may alleviate this problem.

5.2 Future Needs Of Specific Cohorts

As the aboriginal population ages more rapidly than the mainstream population, the need for aged care is exacerbated. Aboriginal identified people consist of 4 % of the population, but use the health services more than other ethnic groups. (MNCAHS, 1999,)

“In Coffs Harbour, as in most country towns, Aboriginal people for over two hundred years have been forced as well as encouraged to be fringe dwellers, coerced into living away from main stream society.” ( Widders, R. 2000). It places people in non appropriate places when in fact they may need: close access to hospitals, disability services, bus stops, services for the elderly, as few have the economic means to fund their own transport requirements.

For many reasons, the aboriginal community prefer to have their own facilities. The aboriginal community is looking for funding to create aged care complexes at the sites of the previous local missions, Tabulam, Wongala, and in Nambucca Valley. These facilities ideally will be located within the existing communities and aim to service approximately six elders each.

Woolgoolga north of Coffs Harbour is the location of a large Punjabi Sikh community. In 2001, there were approximately 731 Punjab Sikh people living in this community. (Bhatti, R. as cited in Flanagan,K. 2003, p 13 ‘Hear our voices’ ). The community has undergone changes as the traditional carers, young women, are required to enter the workforce due to economic reasons. Currently, this community is not accessing the aged care services due to lack of access to information. This situation will continue to change due largely to the appreciation of a tertiary education for the younger generation and their drift to the large cities. A recent report into the community’s aged care needs has identified and recommended strategies to address the lack of access to utilize the services. ( Flanagan, K., 2003, p6.) Therefore, as the population ages and the traditional culture breaks down, there will be a greater need for this community to access Home and Community Care programs and residential services.

People with Disabilities are also living longer ( Ashman as cited in Bevan & Jeeawody, 1998, p 242) than initially expected. Lack of preparation and aged carers means that this group have needs beyond normal. The respective government departments are consulting as to who will take the prime responsibility. As some People with DisAbilities present with poor living skills and comorbidity, there is a skills gap that will need to be addressed to cater for so that this group can age with respect.

5.3 Summary

The results of this survey show that there is a crisis in the industry which will be exacerbated within in the next 5 years due to the current staff turnover, lack of adequately trained staff and the retiring ages of the current workers. Factors also affecting the staffing needs of the industry are shortage of staff due to funding constraints, and lack of career path and structure for mentoring of existing staff. There appears to be a critical shortage of nursing staff on the mid north coast willing to work in the industry, however, this is an area that needs further research.

The proposed influx of 2,500 new retirees within 2 years, coupled with the mass exodus of young people (potential carers) compounds the dilemma of providing caring staff to cater for the needs of the third and fourth age on the Mid North Coast. Provision of an Aged Care training centre on this campus will assist in ameliorating this need.

# 6 RECOMMENDATIONS

* 1. General

It is recommended that the Aged Care Industry alters its focus from a biomedical model to a community model. The incorporation of social value components, will aid the image of the industry. This may change workplace culture to fit the community model, and make the industry more appealing to younger staff.

It is further recommended that the profile and image of nursing be raised to reflect the professional status of nursing in the aged care industry. A review changing pay & conditions may assist to address this issue and alleviate high turnover rate of employees.

Career paths need to be reviewed and altered so that nurses may continue with their career.

Collaboration between different cultural groups and minorities, to focus the existing curricula towards incorporating their specific needs, may attract consumers from these cohorts.

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Specifically, there need to be formal management training for managers of aged care facilities, so ameliorate the high turnover of the managerial staff. All staff will require skills in managing challenging behaviours and conflict resolutions skills. Knowledge of computer skills could be a requirement for all staff undertaking future courses.

Nursing staff will require additional skills in dealing with HIV positive patients and AIDs related illnesses, as well as attitudinal changes dealing with same sex partners.

Unlicensed nursing staff need career structures to entice them staying in the industry. This could be achieved by providing pathways for conversion to nursing degrees. As well a regulatory body is required to monitor the movement of these workers between organisations.

Educational bodies need to consider the skills preferred by employers but, conversely, employers need to recognise that they have failed to value some skills.

A universal client based databank for the region could lessen the overlap of resources to each client requiring multiple services. This would fast track each application and ensures non duplication of services.

Domestic workers also require ongoing training in safe handling of chemicals and food handling, as well as personal hygiene as it relates to the elderly.

6.2 Future Research Areas

There appears to be a need to research the reasons the assistants in nursing are leaving their positions so quickly. Some regulation of the workforce may be able to answer this question. Curricula of courses need to be reviewed to deal with the requirements of community work and the lack of conflict resolution skills for this workforce.

Research into the treatments offered to address qualitative not quantitative outcomes, may assist in improving the image of care for the elderly. Social demands are transforming elderly from ‘inmates’ to ‘consumers’. Already ‘consumer choice’ policy drives the proliferation of overlapping aged care services in the HACC program. The baby boomer generation will drive this choice further. Yet, funding is at a premium as services vie with each other to win tenders. There needs to be a standardisation of services so that the funding dollar is spent in the best possible way and consumers and workers alike can access these services.

The possibility of a “one stop” shop approach to service delivery needs serious condideration.

An area not covered by this research is the needs of the lay carer. 80% of the aged population live at home and a large percentage have informal care. Currently, there is no training requirement to satisfy any regulations for such informal care. Anecdotally, there are reports of elder abuse and mismanagement of finances and medication. Further research into the training needs of this group of carers is paramount as more aged choose to reside in the community for longer periods of time.

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**APPENDIX 1 QUESTIONNAIRE 1**

Categories of Staffing in the Aged Care Industry

1. Actual Number of full-time employees.
2. Preferred Number of full-time employees, within existing funding restraints.
3. Actual Number of permanent part-time employees.
4. Actual Number of casual part-time employees.
5. Preferred Number of permanent part-time employees, within existing funding restraints.
6. Preferred Number of casual part-time employees, within existing funding restraints.
7. Actual Number of contracted workers.
8. Preferred Number of contracted workers, within existing funding restraints.
9. Number of staff entitled to take long-service leave within 5 years.
10. Number of staff planning retirement within 5 years.
11. Number of relief staff required due to maternity/paternity leave within 5 years.
12. Number of person-hours lost due to work-place injuries over last 5 years per job type.
13. Number of staff who have held each position over last 5 years.

**APPENDIX 2 QUESTIONNAIRE 2 (Sample)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year of Birth** |  |  |  |  |  |  |  | **Job Title** |  |  |  |  |  |  |  |  |
|  | Manager | DoNurse/Care | DD of Nurse/care | Receptionist | CU Educator | RN | EN | Specialist | AIN | Recreational Officer | Maintenance Staff | Kitchen Staff | Cleaning Staff | Laundry Staff | Drivers | Others |
| <1948 |  |  |  |  |  |  |  |  | 1 |  |  | 2 | 1 |  |  |  |
| 1949 |  | 1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1950 |  |  |  |  |  |  |  |  |  |  | 1 |  |  |  |  |  |
| 1951 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1952 |  |  |  | 1 |  |  |  |  |  |  |  | 1 |  |  |  |  |
| 1953 |  |  |  |  |  |  |  |  |  | 1 |  |  |  |  |  |  |
| 1954 |  |  | 1 |  |  |  |  |  |  |  |  |  | 1 |  |  |  |
| 1955 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1956 |  |  |  |  |  |  |  |  | 1 |  |  |  |  |  |  |  |
| 1957 |  |  |  |  |  |  |  |  |  |  | 1 | 2 |  |  |  |  |
| 1958 |  |  |  |  |  |  | 1 |  | 1 |  |  |  |  |  |  |  |
| 1959 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1960 |  |  |  |  |  |  |  |  |  |  |  |  | 1 |  |  |  |
| 1961 |  |  |  | 1 |  |  |  |  |  |  |  |  |  |  |  |  |
| 1962 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year of Birth** |  |  |  |  |  |  |  | **Job Title** |  |  |  |  |  |  |  |  |
|  | Manager | DoNurse/Care | DD of Nurse/care | Receptionist | CU Educator | RN | EN | Specialist | AIN | Recreational Officer | Maintenance Staff | Kitchen Staff | Cleaning Staff | Laundry Staff | Drivers | Others |
| 1963 |  |  |  |  |  | 1 | 1 |  | 1 |  |  |  |  |  |  |  |
| 1964 |  |  |  |  |  |  |  |  | 1 |  |  |  |  |  |  |  |
| 1965 |  |  |  |  |  |  |  |  |  |  |  |  | 1 |  |  |  |
| 1966 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1967 |  |  |  |  |  |  |  |  | 1 |  |  |  |  |  |  |  |
| 1968 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1969 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1970 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1971 |  |  |  |  |  |  |  |  | 1 |  |  |  |  |  |  |  |
| 1972 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1973 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1974 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1975 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1976 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1977 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1978 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year of Birth** |  |  |  |  |  |  |  | **Job Title** |  |  |  |  |  |  |  |  |
|  | Manager | DoNurse/Care | DD of Nurse/care | Receptionist | CU Educator | RN | EN | Specialist | AIN | Recreational Officer | Maintenance Staff | Kitchen Staff | Cleaning Staff | Laundry Staff | Drivers | Others |
| 1979 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1980 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1981 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1982 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1983 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1984 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1985 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1986 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1987 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

# APPENDIX 3 QUESTIONNAIRE 3

# Preferred Skills for Aged Care Nursing

# Scale of Preference

1. strongly agree
2. agree
3. uncertain
4. disagree
5. strongly disagree

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SKILL** | **1** | **2** | **3** | **4** | **5** |
| Provide personal care to patients, e.g. showering, washing, toileting etc. | 16 | 1 |  |  |  |
| Prioritize customer service to users of facility and their relatives | 11 | 3 | 2 |  |  |
| Follow OH&S policies | 17 |  |  |  |  |
| Follow safe manual handling practices | 17 |  |  |  |  |
| Follow safe practices when operating and moving equipment | 17 |  |  |  |  |
| Work effectively with culturally diverse patients, clients and co-workers | 14 | 3 |  |  |  |
| Demonstrate environmental awareness and responsibility | 14 | 3 |  |  |  |
| Respond effectively to difficult or challenging behaviour | 14 | 3 |  |  |  |
| Comply with infection control policies and procedures | 16 | 1 |  |  |  |
| Apply basic first aid | 11 | 6 |  |  |  |
| Demonstrate knowledge of basic care requirements, e.g. nutrition, dental, | 12 | 5 |  |  |  |
| Demonstrate chemical safety | 3 | 4 |  | 1 | 1 |
| Prepare and maintain beds | 5 | 8 | 1 | 2 | 1 |
| Assist with client/patient movement – without equipment | 10 | 6 | 1 |  |  |
| Assist with client/patient movement –using equipment, e.g.lifters | 10 | 6 |  |  |  |
| Plan and conduct group activities | 7 | 9 |  |  | 1 |
| Interpret and provide occupational & physiotherapy programme | 8 | 2 | 1 |  | 1 |
| Handle medical gases safely | 6 | 3 | 1 |  |  |
| Handle waste in a health care environment | 9 | 8 |  |  | 1 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SKILL** | **1** | **2** | **3** | **4** | **5** |
| Dispose of body fluids according to appropriate health standards | 10 | 4 |  |  |  |
| Prevent, manage and treat pressure sores | 14 | 3 |  |  |  |
| Prevent, manage and treat urinary tract infections | 13 | 4 |  |  |  |
| Demonstrate awareness of protocols for prevention of falls e.g. monitoring patients with tendency to faint; awareness of situations where fainting may occur | 14 | 3 |  |  |  |
| Demonstrate knowledge of relevant legislation, policies and procedures | 8 | 8 |  |  | 1 |
| Apply problem-solving and conflict resolution strategies | 12 | 5 |  |  |  |
| Contribute to the formulation of care plans | 14 | 3 |  |  |  |
| Contribute to the promotion of safety, security and personal integrity of individuals and groups | 14 | 3 |  |  |  |
| Evaluate progress and expected outcomes of clients/patients | 14 | 2 | 1 |  |  |
| Demonstrate an awareness of anatomy and physiology of all body systems. | 11 | 6 |  |  |  |
| Respiratory/cardiovascular systems | 6 | 4 |  |  |  |
| Nervous/endocrine systems | 6 | 4 |  |  |  |
| Gastrointestinal/Urinary systems | 7 | 3 |  |  |  |
| Musculoskeletal/integumentary systems | 6 | 1 |  |  |  |
| Demonstrate a knowledge of physical, cognitive, social and emotional changes in the ageing process | 14 | 3 |  |  |  |
| Demonstrate a knowledge of palliative and terminal care procedures | 14 | 3 |  |  |  |
| Demonstrate a knowledge of mental health nursing | 8 | 7 | 2 |  |  |
| Demonstrate awareness of personal safety issues | 9 | 1 |  |  |  |
| Manage challenging behaviours | 8 | 2 | 1 |  |  |
| Demonstrate awareness of environmental security | 6 | 2 |  |  |  |
| Maintain and co-ordinate information systems | 7 | 8 | 1 | 1 |  |
| Maintain daily documentation according to legal requirements. | 15 | 2 |  |  |  |
| Demonstrate critical thinking | 11 | 5 | 1 |  |  |
| Organise relief staff | 4 | 8 | 2 | 3 | 1 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SKILL** | **1** | **2** | **3** | **4** | **5** |
| Recognise and report changes in the health status of individuals and groups | 13 | 4 |  |  |  |
| Plan and manage nursing care of individuals and groups | 10 | 5 | 2 |  |  |
| Plan, conduct and review assessment of student staff | 6 | 6 | 2 | 1 |  |
| Collect and organise information | 5 | 9 | 1 | 2 |  |
| Manage/contribute to research activities | 6 | 7 | 2 | 2 |  |
| Provide administrative support | 4 | 9 | 1 | 3 |  |
| Plan and promote training sessions | 6 | 7 | 1 | 2 | 1 |
| Manage finances, accounts and resources | 5 | 5 | 4 | 3 |  |
| Provide community education programmes | 4 | 7 | 3 | 2 | 1 |
| Develop and implement community programmes | 4 | 7 | 2 | 2 | 1 |
| Risk management procedures relating to infectious conditions | 10 | 6 | 1 |  |  |
| Special feeding; e.g. patients with dysphagia | 12 | 2 | 1 | 1 |  |
| Enema administration | 5 | 4 | 1 | 3 |  |
| Establish and review a stoma care programme | 6 | 5 | 2 |  |  |
| Wound management e.g. burns | 9 | 3 | 1 |  |  |
| Initial and ongoing assessment of student nurses | 5 | 5 |  | 1 | 2 |
| Monitoring and managing side effects e.g. sedating medications | 8 | 4 | 1 |  |  |
| Perform Venipuncture | 4 |  | 3 | 5 |  |
| Insertion of naso-gastric tubes | 4 | 3 | 1 | 5 |  |
| Insertion of intravenous tubes | 4 |  | 1 | 6 | 1 |
| Establish and review a catheter care programme | 10 | 2 | 1 |  | 1 |
| Monitor oxygen therapy | 9 | 2 | 1 | 1 |  |
| Demonstrate an awareness of skin complaints | 6 | 4 | 1 | 2 |  |
| Refer patient to specialist | 10 | 1 | 1 |  | 1 |
| Administer correct medication after checking pulse and blood pressure | 10 | 2 | 1 |  |  |
| Order renewal scripts and/or contact GP | 8 | 5 |  |  |  |
| Supervise nursing and/or other staff | 10 | 1 | 1 | 1 |  |
| Monitor stores of S8 drugs | 9 | 1 |  | 1 | 1 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SKILL** | **1** | **2** | **3** | **4** | **5** |
| Demonstrate computer skills in word processing, record keeping, databases and statistics | 7 | 3 |  |  |  |
| Supervise issue of special meals e.g. for diabetics | 6 | 3 |  | 2 |  |
| Demonstrate management skills | 7 | 4 |  | 2 |  |
| Carry out performance management/quality assurance audits | 5 | 5 |  |  |  |
| Carry out office management procedures | 4 | 4 |  | 1 |  |
| Organize rosters | 5 | 2 | 1 | 1 | 1 |
| Manage complaints | 7 | 2 | 1 |  |  |
| Demonstrate pro-active leadership | 5 | 4 |  | 1 |  |
| Demonstrate ability to carry out budgeting | 6 | 2 | 1 | 1 |  |
| Interpret statistics and audit requirements | 3 | 6 |  | 1 |  |

**APPENDIX 4 SKILLS IN ORDER OF PREFERENCE**

Follow OH&S policies

Follow safe manual handling practices

Follow safe practices when operating and moving equipment

Comply with infection control policies and procedures

Provide personal care to patients, e.g. showering, washing, toileting etc

Demonstrate an awareness of anatomy and physiology of all body systems; Musculoskeletal/integumentary systems

Maintain daily documentation according to legal requirements

Work effectively with culturally diverse patients, clients and co-workers

Demonstrate environmental awareness and responsibility

Respond effectively to difficult or challenging behaviour

Prevent, manage and treat pressure sores

Demonstrate awareness of protocols for prevention of falls e.g. monitoring patients with tendency to faint; awareness of situations where fainting may occur

Contribute to the formulation of care plans

Evaluate progress and expected outcomes of clients/patients

emotional changes in the ageing process

Demonstrate a knowledge of palliative and terminal care procedures

Demonstrate a knowledge of physical, cognitive, social and emotional changes in the ageing process

Recognise and report changes in the health status of individuals and groups

Prevent, manage and treat urinary tract infections

Recognise and report changes in the health status of individuals and groups

Demonstrate knowledge of basic care requirements, e.g. nutrition, dental

Apply problem-solving and conflict resolution strategies

Special feeding; e.g. patients with dysphagia

Demonstrate critical thinking

Demonstrate an awareness of anatomy and physiology of all body systems: Gastrointestinal/Urinary systems; Nervous/endocrine systems; Respiratory/cardiovascular systems

Apply basic first aid

Prioritize customer service to users of facility and their relatives

Assist with client/patient movement – without equipment

Assist with client/patient movement –using equipment, e.g.lifters

Dispose of body fluids according to appropriate health standards

Plan and manage nursing care of individuals and groups

Risk management procedures relating to infectious conditions

Establish and review a catheter care programme

Refer patient to specialist

Administer correct medication after checking pulse and blood pressure

Supervise nursing and/or other staff

Monitor stores of S8 drugs

Order renewal scripts and/or contact GP

Demonstrate computer skills in word processing, record keeping, databases and statistics

Demonstrate management skills

Demonstrate ability to carry out budgeting

Handle medical gases safely

Handle waste in a health care environment

Demonstrate awareness of personal safety issues

Monitor oxygen therapy

Demonstrate knowledge of relevant legislation, policies and procedures

Wound management e.g. burns

Monitoring and managing side effects e.g. sedating medications

Interpret and provide occupational & physiotherapy programme

Demonstrate a knowledge of mental health nursing

Demonstrate awareness of environmental security

Plan, conduct and review assessment of student staff

Manage complaints

Manage/contribute to research activities

Plan and conduct group activities

Maintain and co-ordinate information systems

Demonstrate management skills

Plan and promote training sessions

Establish and review a stoma care programme

Demonstrate an awareness of skin complaints

Demonstrate pro-active leadership

Prepare and maintain beds

Collect and organise information

Manage finances, accounts and resources

Enema administration

Initial and ongoing assessment of student nurses

Carry out performance management/quality assurance audits

Organize rosters

Demonstrate chemical safety

Organise relief staff

Provide administrative support

Provide community education programmes

Develop and implement community programmes

Perform Venipuncture

Insertion of naso-gastric tubes

Insertion of intravenous tubes

# APPENDIX 5 RAW DATA

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Beyond CH-Res. | Admin. | | Recep. | | Clinical | | N/L carers | | paramed. | | dom. | |
| f/t |  | 24 | | 18 | | 92 | | 39 | | 7 | | 53 |
| f/t preferred |  | 26 | | 19 | | 117 | | 48 | | 7 | | 55 |
| perm. P/t |  | 3 | | 16 | | 183 | | 270 | | 11 | | 135 |
| perm. P/t pref. | 5 | | 23 | | 221 | | 316 | | 11 | | 144 | |
| Casual p/t |  |  | | 1 | | 102 | | 88 | | 11 | | 27 |
| Casual p/t pref. |  | | 1 | | 111 | | 152 | | 11 | | 33 | |
| Contract |  |  | |  | | 15 | |  | | 2 | | 1 |
| Contract pref. |  |  | |  | | 17 | |  | | 2 | | 1 |
| leave |  | 10 | | 12 | | 132 | | 156 | | 2 | | 61 |
| w/place inj. |  | 1 | |  | | 10 | | 24 | |  | | 4 |
| turnover |  | 48 | | 49 | | 468 | | 544 | | 33 | | 255 |
|  |  |  | |  | |  | |  | |  | |  |
| total staff |  | 27 | | 35 | | 392 | | 386 | | 31 | | 214 |
| turnover |  | 48 | | 49 | | 468 | | 542 | | 33 | | 253 |
| % |  | 78 | | 40 | | 20 | | 40 | | 6 | | 18 |
|  |  |  | |  | |  | |  | |  | |  |
| preferred staff | 30 | | 42 | | 463 | | 495 | | 31 | | 231 | |
| % |  | 10 | | 20 | | 19 | | 28 | | 0 | | 8 |
|  |  |  | |  | |  | |  | |  | |  |
| leave |  | 10 | | 12 | | 132 | | 156 | | 2 | | 61 |
| % |  | 27 | | 35 | | 33 | | 40 | | 6 | | 29 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Beyond CH-Com.prog. | | Admin. | | Recep. | | Clinical | | N/L carers | | paramed. | | dom. | |
| f/t |  | | 6 | | 9 | | 33 | |  | | 8 | | 2 |
| f/t preferred |  | | 8 | | 10 | | 37 | | 1 | | 9 | | 6 |
| perm. P/t |  | | 3 | | 10 | | 31 | | 5 | | 2 | | 4 |
| perm. P/t pref. | | 4 | | 12 | | 36 | | 5 | | 2 | | 4 | |
| Casual p/t |  | |  | | 3 | | 5 | |  | | 1 | | 4 |
| Casual p/t pref. | |  | | 4 | | 8 | |  | | 3 | | 6 | |
| Contract |  | |  | |  | |  | |  | |  | | 4 |
| Contract pref. |  | |  | |  | |  | |  | |  | | 4 |
| leave |  | | 3 | | 6 | | 47 | |  | | 7 | |  |
| w/place inj. |  | | 1 | | 1 | | 3 | |  | |  | | 1 |
| turnover |  | | 16 | | 25 | | 84 | | 5 | | 14 | | 15 |
|  |  | |  | |  | |  | |  | |  | |  |
| total staff |  | | 9 | | 22 | | 69 | | 5 | | 11 | | 14 |
| staff turnover |  | | 16 | | 25 | | 84 | | 5 | | 14 | | 15 |
| % |  | | 78 | | 14 | | 22 | | 0 | | 27 | | 7 |
|  |  | |  | |  | |  | |  | |  | |  |
| preferred staff | | 12 | | 26 | | 81 | | 6 | | 14 | | 20 | |
| % |  | | 33 | | 18 | | 17 | | 20 | | 27 | | 43 |
|  |  | |  | |  | |  | |  | |  | |  |
| leave |  | | 3 | | 6 | | 47 | |  | | 7 | |  |
| % |  | | 33 | | 27 | | 68 | |  | | 64 | |  |
|  |  | |  | |  | |  | |  | |  | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Coffs-Res. |  | | Admin. | | Recept. | | Clinical | | u/l carers | | paramedic | | domestic |
| f/t |  | | 15 | | 2 | | 18 | | 5 | |  | | 32 |
| f.t preferred |  | | 18 | | 3 | | 25 | | 10 | | 1 | | 34 |
| perm p/t |  | | 5 | | 7 | | 121 | | 150 | | 3 | | 77 |
| perm p/t preferred | | 7 | | 8 | | 131 | | 189 | | 5 | | 84 | |
| cas. P/t |  | | 2 | | 2 | | 77 | | 67 | |  | | 33 |
| cas. P/t preferred | | 2 | | 2 | | 80 | | 71 | | 1 | | 35 | |
| contract |  | |  | |  | | 6 | | 15 | | 7 | | 7 |
| contract preferred | |  | |  | | 6 | | 15 | | 8 | | 7 | |
| leave |  | | 7 | | 1 | | 48 | | 58 | |  | | 39 |
| w/place inj. |  | | 2 | | 1 | |  | | 18 | |  | | 2 |
| turnover |  | | 37 | | 13 | | 265 | | 327 | | 12 | | 159 |
|  |  | |  | |  | |  | |  | |  | |  |
| staff total |  | | 22 | | 11 | | 222 | | 237 | | 10 | | 149 |
| turnover |  | | 37 | | 13 | | 265 | | 327 | | 12 | | 159 |
| % |  | | 68 | | 18 | | 19 | | 38 | | 20 | | 7 |
|  |  | |  | |  | |  | |  | |  | |  |
| staff preferred | | 27 | | 13 | | 242 | | 285 | | 14 | | 160 | |
| % |  | | 23 | | 18 | | 11 | | 12 | | 40 | | 7 |
|  |  | |  | |  | |  | |  | |  | |  |
| leave |  | | 7 | | 1 | | 48 | | 58 | |  | | 39 |
| % |  | | 32 | | 10 | | 22 | | 24 | |  | | 26 |
|  |  | |  | |  | |  | |  | |  | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Coffs-Com.prog. | | Admin. | | Recept. | | Clinical | | u/l carers | | paramedic | | domestic | |
| f/t |  | | 31 | | 12 | | 16 | |  | |  | | 3 |
| f.t preferred |  | | 31 | | 13 | | 20 | | 1 | |  | | 4 |
| perm p/t |  | | 1 | | 3 | | 30 | | 67 | |  | | 4 |
| perm p/t preferred | | 1 | | 5 | | 35 | | 87 | |  | | 11 | |
| cas. P/t |  | | 1 | | 1 | | 1 | | 39 | |  | | 3 |
| cas. P/t preferred | | 1 | | 1 | | 1 | | 41 | |  | | 3 | |
| contract |  | |  | | 1 | | 6 | | 13 | |  | | 7 |
| contract preferred | |  | | 1 | | 6 | | 13 | |  | | 7 | |
| leave |  | | 7 | | 7 | | 18 | | 16 | |  | |  |
| w/place inj. |  | |  | | 1 | | 1 | | 6 | |  | |  |
| turnover |  | | 42 | | 28 | | 66 | | 166 | |  | | 17 |
|  |  | |  | |  | |  | |  | |  | |  |
| total staff |  | | 33 | | 17 | | 53 | | 119 | |  | | 17 |
| staff turnover |  | | 42 | | 28 | | 66 | | 166 | |  | | 17 |
| % |  | | 27 | | 65 | | 25 | | 38 | |  | | 0 |
|  |  | |  | |  | |  | |  | |  | |  |
| staff preferred | | 33 | | 20 | | 62 | | 142 | |  | | 25 | |
| % |  | | 0 | | 18 | | 17 | | 19 | |  | | 47 |
|  |  | |  | |  | |  | |  | |  | |  |
| leave |  | | 7 | | 7 | | 18 | | 16 | |  | |  |
| % |  | | 21 | | 41 | | 34 | | 13 | |  | |  |