

General Purpose Standing Committee No. 3

Registered nurses in New South Wales nursing homes

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Terms of reference

That General Purpose Standing Committee No. 3 inquire into and report on registered nurses in New South Wales nursing homes, and in particular:

1. The need for registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, in particular:
 - (a) the impact of amendments to the *Aged Care Act 1997* (Cth) by the *Aged Care (Living Longer Living Better) Act 2013* (Cth) on the requirement under s 104 of the *Public Health Act 2010* to have a registered nurse on duty at all times in a nursing home, and in particular:
 - (i) the impact this has on the safety of people in care
 - (ii) the possibility for cost-shifting onto other parts of the public health system as a result of any legislative or regulatory change to the current provisions
 - (b) the requirement for a registered nurse to be on duty in a nursing home at all times, as compared with requirements in aged care hospital wards
 - (c) the administration, procurement, storage and recording of administration of medication by non-registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, as compared with hospital clinical settings
 - (d) the role of registered nurses in responding to critical incidents and preventing unnecessary hospital admissions
2. The need for further regulation and minimum standards for assistants in nursing and other employees or carers with similar classifications
3. The adequacy of nurse to patient ratios in nursing homes and other aged care facilities with residents who require a high level of residential care
4. The report by the NSW Health Aged Care Steering Committee, and
5. Any other related matter.

These terms of reference were referred to the committee by the Legislative Council on 25 June 2015.

Committee membership

Ms Jan Barham MLC	The Greens	<i>Chair</i>
The Hon Natasha Maclaren-Jones MLC	Liberal Party	<i>Deputy Chair</i>
The Hon Courtney Houssos MLC	Australian Labor Party	
The Hon Sarah Mitchell MLC	The Nationals	
Revd the Hon Fred Nile MLC	Christian Democratic Party	
The Hon Walt Secord MLC	Australian Labor Party	
The Hon Bronnie Taylor MLC*	The Nationals	

* Mrs Bronnie Taylor substituted for Mr Ben Franklin as a member of the committee for the duration of the inquiry.

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Chair's foreword

I am pleased to present the committee's report on registered nurses in New South Wales nursing homes.

The inquiry was initiated due to the concerns raised about the possible removal of the requirement in New South Wales for registered nurses to be on duty in nursing homes at all times.

Older Australians living in nursing homes are among the most vulnerable members of our society, needing and deserving of the highest quality of care. This has been at the forefront of the committee's approach to what has proven to be a complex and wide-ranging inquiry. The committee not only examined a number of legislative and policy issues across jurisdictions and service sectors, but also considered the many stories and experiences of registered nurses and other aged care staff and, importantly, the people they care for and their families.

Central to this inquiry is the development of aged care legislation over the last two decades that has reflected a gradual shift in responsibility from the states to the Commonwealth. For New South Wales, however, that shift has never been absolute, resulting in layers of legislation at both the state and Commonwealth level that have become intrinsically linked over time. At the core of this legislative arrangement is section 104(1)(a) of the *Public Health Act 2010* which requires a registered nurse to be on duty in a nursing home at all times. The committee received extensive evidence from a range of stakeholders regarding the retention of this state provision and grappled with numerous issues and concerns raised from all perspectives.

The committee acknowledges that the Commonwealth has jurisdictional responsibility and funds aged care across the country, but ultimately we were not convinced that the regulatory framework at that level adequately ensures that a high standard of care is delivered to residents in aged care facilities through its staffing standards. We therefore support the current legislative requirement for registered nurses to be on duty at all times in New South Wales nursing homes. However, in recognition of the fact that aged care and the needs of our older Australians entering into nursing homes is evolving, the committee believes that this requirement must be framed in new a light.

In this regard, the committee has determined that it is both important and appropriate that the definition of 'nursing home' under the *Public Health Act* be based directly on residents' assessed needs rather than the type of facility. This link between funding and registered nursing coverage allows for the provision of person-centred support.

At the same time, however, the committee acknowledges that the nature of high care needs is broad and that there are different types of high care needs that may not always necessitate the continuous presence of a registered nurse. We also believe that the concerns raised by aged care providers about the financial impact in meeting the requirement, coupled with the availability of registered nurses (particularly on homes in rural, regional and remote areas) warrant some flexibility in the way this state provision is applied. To this end, the committee has endorsed the opportunity for aged care providers to apply for exemptions from the state legislative requirement for consideration on a case-by-case basis and that exemptions may be granted where a home can prove that it is still able to demonstrate the provision of high quality care. The committee hopes that these key recommendations will go some way to addressing the concerns of aged care providers who feared for the viability of their operations, whilst ensuring that the highest standard of care is provided to those who need and deserve the specialised support of registered nurses.

A number of other significant recommendations were made by the committee, including a comprehensive system of enforcement of this state provision, improvements to the wider aged care regulatory framework, better support for and regulation of the aged care workforce and recognition of the wage disparity that exists between government and non-government providers for registered nurses. The recommendations also address the need for government support for improving the training and availability of registered nurses in rural and regional areas.

It is my hope that this inquiry and the suite of measures that have been recommended will provide a positive basis for greater improvement and more innovation in the delivery of aged care services in New South Wales moving forward.

I would like to extend my sincere thanks to all those who participated in the inquiry. I would also like to thank my fellow committee members for their rigorous approach to this inquiry. Finally, I thank Teresa McMichael, Stewart Smith, Rhia Victorino, Kate Mihaljek, Ivana Leo and Erica Vogels of the committee secretariat for their continued hard work and professionalism and as always the work undertaken by Hansard staff to record the proceedings of the inquiry.



Ms Jan Barham MLC
Committee Chair

Summary of recommendations

Recommendation 1

47

That the NSW Government:

- establish a consistent and compatible collection and analysis of data regarding the transfer of residents from aged care facilities to emergency departments, including reasons for admissions, to determine if this represents a cost shifting, and
- that this information be provided in NSW Health annual reports to identify if further action is required.

Recommendation 2

47

That the NSW Government review the requirements for Advance Care Directives to be recognised when residents are transferred from aged care facilities to hospitals, and determine whether a legislative framework is required.

Recommendation 3

63

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to ensure that its new single quality aged care framework includes:

- genuinely unannounced visits that occur at any time of the day on any day of the week,
- assessment of all 44 expected outcomes under the Accreditation Standards during each unannounced visit,
- greater emphasis on resident experience, and
- a requirement to communicate non-compliance with residents and their advocates.

Recommendation 4

64

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to establish minimum staffing ratios in aged care facilities.

Recommendation 5

67

That the NSW Government develop a Working with Older People and/or Vulnerable Adults Check, modelled on the Working with Children Check.

Recommendation 6

67

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to establish a licensing body for aged care workers.

Recommendation 7

78

That the NSW Government:

- retain the requirement in section 104(1)(a) of the *Public Health Act 2010* for registered nurses to be on duty in nursing homes at all times, and
- amend the definition of ‘nursing home’ under the Act to read:

nursing home means a facility at which residential care (within the meaning of the *Aged Care Act 1997* of the Commonwealth) is provided, being:

- (a) a facility at which that care is provided in relation to an allocated place (within the meaning of that Act) to a care recipient whose classification level:
 - (i) includes the following domain categories or combinations of domain categories:
 - (1) a high Activities of Daily Living (ADL) domain category; or
 - (2) a high Complex Health Care (CHC) domain category; or
 - (3) a domain category of medium or high in at least two of the three domain categories; or
 - (4) a high behaviour domain category and either an ADL domain category other than nil or a CHC domain category other than nil; or
 - (ii) is a high level resident respite care.
- (b) a facility that belongs to a class of facilities prescribed by the regulations.

Recommendation 8

79

That the NSW Government allow nursing homes to apply for an exemption from section 104(1)(a) of the *Public Health Act 2010* on a case-by-case basis, and that exemptions only be granted where the facility can demonstrate that it can still provide a high level of quality care.

Recommendation 9

81

That the NSW Government establish a system to monitor, regulate and enforce section 104(1)(a) of the *Public Health Act 2010*.

Recommendation 10

82

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to require aged care facilities to make information about their staffing skill sets publicly available, including for it to be published on the ‘My Aged Care’ website.

Recommendation 11

85

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to disseminate clear information about how to lodge complaints. This should include publicising the information in all aged care facilities and ensuring that residents and/or their advocates receive clear information regarding the complaints process prior to entering into a residency.

- Recommendation 12** **86**
 That the NSW Government establish a clear process for the lodgement and resolution of complaints about section 104(1)(a) of the *Public Health Act 2010* as part of the new system at recommendation 9, and that information about the complaints process be widely publicised throughout aged care facilities in New South Wales.
- Recommendation 13** **89**
 That the NSW Government report on existing programs and incentives and investigate additional programs and incentives to support registered nurses to train and work in regional, rural and remote areas.
- Recommendation 14** **89**
 That the NSW Government, through the Council of Australian Governments, seek Commonwealth support to provide funding assistance for the training and engagement of registered nurses, particularly at rural and regional universities, and graduate placement opportunities in rural, regional and remote areas.
- Recommendation 15** **90**
 That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to take active measures to address the wage disparity between registered nurses in aged care facilities and registered nurses in the public health care system.
- Recommendation 16** **100**
 That the NSW Government consider rolling out the Telehealth model of care provided by the Hunter-New England Medical Local across New South Wales.
- Recommendation 17** **101**
 That the NSW Government:
- review alternative models of housing for older persons other than aged care facilities, including cooperatives and communal living that provide an on-site caretaker, and
 - investigate models in other jurisdictions, including the Netherlands and Scandinavia, that could be trialled in New South Wales.

Chapter 1 Introduction

This chapter provides an overview of the establishment and conduct of the inquiry, as well as an outline of the structure of this report.

Terms of reference

- 1.1 The inquiry terms of reference were referred by the Legislative Council on 25 June 2015 and required the committee to inquire into and report on registered nurses in New South Wales nursing homes.
- 1.2 The full terms of reference can be found on page iv.

Conduct of the inquiry

Submissions

- 1.3 The committee wrote to a number of key stakeholders inviting them to make a submission. A media release announcing the inquiry was also sent to all media outlets in New South Wales. In addition, the inquiry was advertised on Twitter and Storify.
- 1.4 The committee received 165 submissions and three supplementary submissions. A full list of submissions can be found in **appendix 1**.

Hearings

- 1.5 The committee held three public hearings at Parliament House on 5, 10 and 14 August 2015.
- 1.6 A range of witnesses appeared at these hearings, including NSW Ministry of Health, the Commonwealth Department of Social Services and the Australian Aged Care Quality Agency. A number of peak organisations in nursing, aged care and health also gave evidence as well as residential aged care providers and academics.
- 1.7 A full list of witnesses who appeared at the hearings is included in **appendix 2**. A list of documents tabled at these hearings can be found in **appendix 3** and a list of answers provided to questions on notice is at **appendix 4**.
- 1.8 The committee would like to thank inquiry participants for their valuable contributions to this process.

Terminology

- 1.9 The term ‘**nursing home**’ is used throughout this report to refer to facilities that were classed as providing a ‘high level of residential care’ under the former Commonwealth Government’s classification system (see chapter 2 at paragraphs 2.1-2.4 for more information).

- 1.10** The terms ‘aged care worker’ and ‘aged care staff’ are used throughout this report to refer to assistants in nursing, aged care support staff, personal support staff, personal care workers, personal care assistants and personal care attendants.

Structure of the report

- 1.11** **Chapter 2** provides information about how aged care is regulated and delivered in New South Wales within the context of the Commonwealth aged care framework, detailing the relevant legislation and the role of the Australian Aged Care Quality Agency. It also outlines the nature and staffing of residential aged care facilities in New South Wales.
- 1.12** The role and responsibilities of registered nurses in aged care facilities is examined in **chapter 3**. The level of care required by residents in these facilities is also discussed.
- 1.13** **Chapter 4** considers concerns raised about mandating registered nurses in all aged care facilities, including the impact on the viability and operations of aged care facilities, the effect on the public health care system and the issue of the registered nursing shortage in New South Wales.
- 1.14** Jurisdictional responsibility for regulating aspects of aged care is explored in **chapter 5**. In particular, the chapter examines the adequacy and effectiveness of the Commonwealth aged care framework.
- 1.15** **Chapter 6** considers various options in regard to the future of the legislative requirement mandating registered nurses in nursing homes, as expressed in section 104 of the *Public Health Act 2010*. It also explores ways in which the delivery of aged care services can be improved into the future.
- 1.16** Finally, a range of alternative options to requiring the physical presence of a registered nurse within an aged care facility is discussed in **chapter 7**.

Chapter 2 Background

This chapter explains how aged care – and the role of registered nurses as part of this sector – is regulated and delivered in New South Wales within the context of a comprehensive Commonwealth framework. The chapter outlines relevant legislation and the role of the Australian Aged Care Quality Agency, including the accreditation process it administers. It also provides a brief overview of residential aged care facilities in New South Wales.

Public Health Act 2010

2.1 Section 104(1)(a) of the *Public Health Act 2010* dictates that a registered nurse must be on duty in a nursing home at all times. The operation of this provision is dependent upon the definition of a ‘nursing home’ which is defined in the Act as:

... a facility at which residential care (within the meaning of the *Aged Care Act 1997* of the Commonwealth) is provided, being:

(a) a facility at which that care is provided in relation to an allocated place (within the meaning of that Act) that requires a high level of residential care (within the meaning of that Act), or

(b) a facility that belongs to a class of facilities prescribed by the regulations.¹

2.2 This definition is, in turn, reliant upon the definitions of ‘residential care’, ‘allocated place’ and ‘high level residential care’ in the *Aged Care Act 1997* (Cth).

2.3 Currently the *Aged Care Act* defines ‘residential care’ as personal care or nursing care (or both) that:

(a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:

(i) appropriate staffing to meet the nursing and personal care needs of the person; and

(ii) meals and cleaning services; and

(iii) furnishings, furniture and equipment for the provision of that care and accommodation; and

(b) meets any other requirements specified in the Residential Care Subsidy Principles.²

2.4 Prior to 1 July 2014, the *Aged Care Act* defined an ‘allocated place’ as ‘a capacity within an aged care service for provision of residential care ... to an individual,³ and the Classification

¹ *Public Health Act 2010*, Pt 1, s 5.

² *Aged Care Act 1997* (Cth), s 41(3) (this section of the Act also describes what does not constitute residential care, including care in a hospital or a person’s private home).

³ *Aged Care Act 1997*, Sch 1 (repealed).

Principles 1997 (Cth) defined ‘high level of residential care’ as care given to a recipient whose classification level:

- (a) includes the following domain categories or combinations of domain categories:
 - (i) a high ADL [activities on daily living] domain category; or
 - (ii) a high CHC [complex health care] domain category; or
 - (iii) a domain category of medium or high in at least two of the three domain categories; or
 - (iv) a high behaviour domain category and either an ADL domain category other than nil or a CHC domain category other than nil; or
- (b) is high level residential respite care.⁴

2.5 NSW Health is responsible for investigating complaints concerning possible breaches of s 104 of the *Public Health Act*.⁵ However, NSW Health does not govern the aged care sector or the employment requirements, duties, or responsibilities of registered nurses employed in aged care services.⁶ Instead, aged care, including the employment of registered nurses in the industry, is primarily a Commonwealth Government responsibility. The Commonwealth’s compliance and monitoring scheme for aged care is discussed in detail in chapter 5.

Living Longer Living Better reforms

2.6 ‘Living Longer Living Better’ is a package of Commonwealth reforms aimed at building a better and fairer aged care system.⁷ The key reform for this inquiry was the repeal of the distinction between high level residential care (nursing homes) and low level residential care (hostels) in the *Aged Care Act* which came into effect on 1 July 2014.

2.7 The reform stemmed from the Productivity Commission’s 2011 *Caring for Older Australians* report which proposed increasing the flexibility of supply in residential care by removing the alignment between intensity of care and type of accommodation:

To improve the flexibility of supply in residential care, the Commission is proposing to overturn the alignment between intensity of care and type of accommodation (low care in hostel settings and high care in nursing homes), noting that the more recent policy of ‘ageing in place’ has already blurred the boundaries.⁸

⁴ Classification Principles 1997 (Cth), Pt I, s 9(3) (repealed).

⁵ Answers to questions on notice, NSW Ministry of Health, 9 September 2015, p 6.

⁶ Answers to questions on notice, NSW Ministry of Health, p 11.

⁷ Australian Government, *Living Longer. Living Better* (February 2013), p 1, https://www.dss.gov.au/sites/default/files/documents/06_2014/a_-_aged_care_in_australia_is_changing.pdf

⁸ Productivity Commission, *Caring for Older Australians*, Productivity Commission Inquiry, Volume 1, Report No. 53, 28 June 2011, p XXXVIII.

- 2.8** In response to the proposed Living Longer Living Better reforms NSW Health made a submission to the Commonwealth Department of Health and Ageing⁹ in December 2012 raising concerns about the removal of high and low level residential care from the *Aged Care Act 1997*. The submission stated that it was critical to maintain the requirement for a registered nurses in high care facilities to ensure the quality of care:

Under the *Aged Care Act 1997* and the NSW *Public Health Act 2010*, high level care residents currently require care to be provided by a Registered Nurse. NSW Health believes it will be critical to continue these existing regulatory requirements to ensure care quality.¹⁰

- 2.9** The submission also asserted: ‘It should be a priority that legislation to establish the Quality Agency [Australian Aged Care Quality Agency] includes requirements which specify that a registered nurse must be appointed as the Director of Nursing (or similar title) at a residential care facility and a registered nurse must be on duty in a residential aged care facilities.’¹¹
- 2.10** Additionally, the submission sought to ensure that enrolled nurses and assistants in nursing work under the supervision of a registered nurse in all residential aged care facilities to ensure quality care and protection of the public.¹²

Impact on the *Public Health Act*

- 2.11** As a result of the Commonwealth’s repeal of the distinction between high and low care, s 104 of the *Public Health Act* was rendered inoperable given that the definition of ‘nursing home’ was reliant upon the definition of ‘high level of residential care’ in the *Aged Care Act*.
- 2.12** For this reason, the NSW Government implemented the Public Health (Nursing Homes) Regulation 2014, a transitional regulation that ‘grandfathered’ the requirement for a registered nurse to be on duty at all times in facilities that were classified as nursing homes prior to 1 July 2014.¹³ The regulation does not have an expiry date.¹⁴
- 2.13** NSW Health has convened a steering committee to examine the mechanisms to provide an appropriate level of nursing care in residential aged care facilities in the future. The options to be considered by the committee include:

⁹ The Department of Health and Ageing was the commonwealth agency responsible for aged care at the time.

¹⁰ Tabled document, NSW Health, *NSW Health Submission Proposed Amendments to Commonwealth Aged Care Act 1997 and Related Legislation*, December 2012, p 3.

¹¹ Tabled document, *NSW Health Submission Proposed Amendments to Commonwealth Aged Care Act 1997 and Related Legislation*, p 3.

¹² Tabled document, *NSW Health Submission Proposed Amendments to Commonwealth Aged Care Act 1997 and Related Legislation*, p 3.

¹³ Evidence, Ms Leanne O’Shannessy, Director, Legal and Regulatory Services, NSW Ministry of Health, 5 August 2015, p 9.

¹⁴ Answers to questions on notice, NSW Ministry of Health, p 1.

- removing the requirement for a registered nurse to be on duty at all times from the *Public Health Act* and leaving the regulation of aged care facilities to the Commonwealth
- retaining the requirement but redefining ‘nursing home’ in the *Public Health Act*
- introducing a new requirement that better reflects models of care and supports, or is linked to the Commonwealth requirements.¹⁵

2.14 The steering committee expects to report to NSW Health after this inquiry is completed.¹⁶

Aged Care Act 1997 (Cth)

2.15 Aged care services are regulated at the Commonwealth level principally through the *Aged Care Act 1997* (Cth). The Act provides the funding and regulatory regime for all subsidised residential aged care facilities in Australia. In addition to detailing the relevant subsidies, fees and payments, and administration procedures,¹⁷ the Act specifies the responsibilities of approved residential aged care providers, including the provision of quality care as stipulated in the Quality of Care Principles 2014¹⁸ (these principles are outlined in the next section).

2.16 The Commonwealth Department of Social Services controls who can become an aged care provider, imposes a range of responsibilities on approved providers and manages the Aged Care Complaints Scheme.¹⁹ The department also operates a compliance regime, monitored by the Australian Aged Care Quality Agency (the role of which is discussed on the next page), which includes the imposition of sanctions if providers do not meet their obligations under the *Aged Care Act*.²⁰

Quality of Care Principles 2014

2.17 The Quality of Care Principles 2014 set out the responsibilities of approved residential aged care providers.²¹

2.18 The principles specify the care and services that residential aged care providers must provide. For example, the principles state that certain medical procedures such as establishing and supervising complex pain management or palliative care, inserting intravenous and naso-gastric tubes, and establishing and reviewing a catheter care program, can only be carried

¹⁵ Tabled document, NSW Ministry of Health, *NSW Health Aged Care Steering Committee*, 5 August 2015, p 1.

¹⁶ Evidence, Ms O’Shannessy, p 6.

¹⁷ *Aged Care Act 1997*, chs 2, 3, 3A and 6.

¹⁸ *Aged Care Act 1997*, Pt 4.1, Div 54, s 54(1).

¹⁹ Evidence, Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, 5 August 2015, p 16. The Aged Care Complaints Scheme provides a free service for anyone to raise concerns about the quality of care and services being delivered to people receiving aged care services subsidised by the Australian Government, including residential care.

²⁰ Evidence, Mr Culhane, p 16.

²¹ Quality of Care Principles 2014, Explanatory Statement. The Quality Care Principles also set out responsibilities of approved providers in providing care and services for home care.

out by a nurse practitioner, registered nurse, enrolled nurse, or other professional appropriate to the service, acting within their scope of practice.²²

2.19 The principles also set out the following Accreditation Standards that residential aged care providers must comply with in order to receive accreditation from the Australian Aged Care Quality Agency and Commonwealth subsidies:

- Standard one: Management systems, staffing and organisational development
- Standard two: Health and personal care
- Standard three: Care recipient lifestyle
- Standard four: Physical environment and safe systems.²³

2.20 There are 44 expected outcomes listed under these four Accreditation Standards. The key outcome relevant to this inquiry is ‘Standard 1.6 Human resource management’, which requires that ‘[t]here are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives.’²⁴

2.21 The Accreditation Standards do not prescribe the type of staff, qualifications required by staff or the number of staff who work in an aged care facility.²⁵

Australian Aged Care Quality Agency

2.22 The Australian Aged Care Quality Agency (Quality Agency) is an accreditation and monitoring agency established by the *Australian Aged Care Quality Agency Act 2013* (Cth). The agency began operations on 1 January 2014 when it assumed the functions previously performed by the Aged Care Standards and Accreditation Agency.²⁶

2.23 The Quality Agency’s functions include responsibility for accrediting residential aged care facilities by ensuring compliance with the Accreditation Standards.²⁷

2.24 The agency is not responsible for, nor does it have the authority to, determine whether an aged care facility has breached a state regulation or legislation such as s 104 of the New South Wales *Public Health Act*.²⁸

²² Quality of Care Principles 2014, Sch 1, Pt 3, s 3, item 3.8 – Nursing Services.

²³ Quality of Care Principles 2014, Pt 2, Div 2, s 10.

²⁴ Australian Aged Care Quality Agency, *Accreditation Standards*, Standard 1, Expected outcome 1.6.

²⁵ Evidence, Mr Culhane, p 16.

²⁶ Evidence, Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency, 5 August 2015, p 17.

²⁷ Submission 162, Australian Aged Care Quality Agency, p 1.

²⁸ Evidence, Mr Bushrod, p 17.

Accreditation and compliance

- 2.25** An approved residential aged care provider must obtain an initial accreditation when it first commences providing care. The Quality Agency conducts visits to the facility during the first year of operation to monitor and assess the quality of the care and services against the Accreditation Standards, and may provide information and education to the facility's staff to assist with continuous improvement and/or meet the standards.²⁹
- 2.26** Following the initial accreditation, facilities generally apply for re-accreditation every three years. Assessment of re-accreditation applications involve an audit of the facility's performance against the Accreditation Standards by registered assessors.³⁰
- 2.27** Accredited facilities are expected to maintain the Accreditation Standards and undertake continuous improvement. Each facility receives at least one unannounced visit each year to monitor ongoing performance, and additional visits are arranged on a case-by-case basis if there are any failures to meet the standards.³¹
- 2.28** Should a residential aged care facility fail to meet the Accreditation Standards, the Quality Agency imposes a timetable for the service to rectify the problems, monitors the progress of this process, and assesses whether the problems have been resolved.³²
- 2.29** The Commonwealth Department of Social Services also has a role in monitoring and applying sanctions, including the revocation of approved provider status, to facilities that fail to meet the Accreditation Standards.³³
- 2.30** The committee was told that a residential aged care facility that has its accreditation revoked will lose its Commonwealth Government subsidies and most likely close as the service would no longer be viable.³⁴
- 2.31** As part of the Australian Government's 2015 Budget initiatives to develop a single quality framework for aged care, the Accreditation Standards and other aged care standards are being reviewed with a view to consolidating them into a single set of standards.³⁵
- 2.32** The Commonwealth's accreditation and compliance frameworks are considered in more detail in chapter 5.

²⁹ Submission 162, Australian Aged Care Quality Agency, p 2.

³⁰ Submission 162, Australian Aged Care Quality Agency, p 2; Evidence, Mr Bushrod, p 17.

³¹ Submission 162, Australian Aged Care Quality Agency, p 3.

³² Evidence, Mr Bushrod, pp 17-18.

³³ Evidence, Mr Culhane, pp 19-20.

³⁴ Evidence, Mr Bushrod, p 19.

³⁵ Answers to questions on notice, Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, 4 September 2015, p 1; Answers to questions on notice, Mr Ross Bushrod, Director, Quality Standards, Australian Aged Care Quality Agency, 2 September 2015, p 3.

Other relevant legislative instruments

- 2.33** The delivery of aged care services is also dependent on other legislation, including that which governs the management and administration of medication. In New South Wales, that legislation is the *Poisons and Therapeutic Goods Act 1966* and the Poisons and Therapeutic Goods Regulation 2008. This legislation is relevant to this inquiry given the role of registered nurses in managing and administering medicines in the aged care setting, as will be discussed throughout this report.
- 2.34** In New South Wales, an aged care facility that includes at least one high care resident is defined as a ‘hospital’ under the Poisons and Therapeutic Goods Regulation 2008, and must adhere to strict rules concerning the procurement, storage, recording and administration of all medication.³⁶
- 2.35** The committee understands that the *Poisons and Therapeutic Goods Act 1966* and the Poisons and Therapeutic Goods Regulation 2008 are currently under review.³⁷
- 2.36** Medication management and administration in aged care facilities is also guided by the NSW Health’s *Guide to the handling of medication in nursing homes in NSW*,³⁸ the Commonwealth Department of Health and Ageing’s *Guiding principles for medication management in residential aged care facilities*³⁹ and the Australian Nursing and Midwifery Federation’s *Nursing Guidelines: Management of Medicines in Aged Care*.⁴⁰

Aged care facilities in New South Wales

- 2.37** This section briefly outlines the number of aged care facilities in New South Wales, the classification of care needs of residents in these facilities and the application of the Aged Care Funding Instrument. It also includes information about staffing within aged care facilities.

³⁶ NSW Health, *Residential Care Facilities* (10 July 2014), <http://www.health.nsw.gov.au/pharmaceutical/Pages/residential-care-facilities.aspx>.

³⁷ Evidence, Ms O’Shannessy, p 6.

³⁸ NSW Health, *Information Bulletin – Guide to the handling of medication in nursing homes in NSW* (27 May 2003), <http://www0.health.nsw.gov.au/archive/cib/information-bulletins/2003/ib2003-10.pdf>.

³⁹ Commonwealth Department of Health and Ageing, *Guiding principles for medication management in residential aged care facilities* (October 2012), [http://www.health.gov.au/internet/main/publishing.nsf/content/3B17BD9642D56802CA257BF0001AFDA5/\\$File/Guiding%20principles%20for%20medication%20management%20in%20residential%20aged%20care%20facilities.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/3B17BD9642D56802CA257BF0001AFDA5/$File/Guiding%20principles%20for%20medication%20management%20in%20residential%20aged%20care%20facilities.pdf).

⁴⁰ Australian Nursing and Midwifery Federation, *Nursing Guidelines: Management of Medicines in Aged Care* (July 2013), http://anf.org.au/documents/reports/Management_of_Medicines_Guidelines_2013.pdf.

Number of residential aged care facilities

- 2.38** There are approximately 66,000 residents⁴¹ living in 874 aged care facilities in New South Wales.⁴² Of these facilities, 594 must comply with s 104 of the *Public Health Act* as they provide what was formerly classed as a 'high level of residential care'.⁴³ The remaining 345 facilities are not currently required to comply with the legislative requirement.
- 2.39** The committee understands that under the former classification system, facilities could still be classed as low care even if they contained one or more high care recipients.⁴⁴ We note that at present there are no residential aged care facilities with only one high care recipient.⁴⁵

Classification and composition of care needs in an aged care facility

- 2.40** The Aged Care Funding Instrument is the tool used to assess residents' care needs. The funding instrument is a list of questions that collects information about a care recipient's mental and behavioural disorders, medical conditions and other care needs.⁴⁶
- 2.41** The initial appraisal of a resident must either be made by an approved provider that is providing care to the care recipient, a person acting on the approved provider's behalf, or a person that is authorised to make an appraisal.⁴⁷
- 2.42** Following an appraisal a care recipient receives a classification (nil, low, medium or high needs) based on the level of care they require across three domains: activities of daily living, behaviour, and complex health care.⁴⁸ The classification is undertaken primarily to determine the level of care funding payable for that resident.⁴⁹
- 2.43** Reappraisals can occur at any time as care needs change.⁵⁰

⁴¹ Answers to questions on notice, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, 2 September 2015, p 8.

⁴² Answers to questions on notice, Mr Bushrod, p 2.

⁴³ Evidence, Ms O'Shannessy, p 3. The other 345 residential aged care facilities provide low care assistance.

⁴⁴ See for example, Submission 87, NSW Nurses and Midwives' Association, p 9; Submission 152, Combined Pensioners and Superannuants Association of NSW, p 4; Submission 52, Name suppressed, p 1.

⁴⁵ Answers to questions on notice, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association of NSW, 31 August 2015, p 3.

⁴⁶ Australian Government, *Guide to Aged Care Law*, Version 1.07, 21 September 2015, <http://guides.dss.gov.au/guide-aged-care-law/5/2/1>.

⁴⁷ Australian Government, *Guide to Aged Care Law*, Version 1.07, 21 September 2015, <http://guides.dss.gov.au/guide-aged-care-law/5/2/1>.

⁴⁸ Department of Social Services, *Residential Care Manual*, 2014, pp71-75.

⁴⁹ Australian Government, *Guide to Aged Care Law*, Version 1.07, 21 September 2015, <http://guides.dss.gov.au/guide-aged-care-law/5/2/1>.

⁵⁰ Australian Institute of Health and Welfare, *Care needs of permanent aged care residents* (2015), <http://aihw.gov.au/aged-care/residential-and-community-2012-13/permanent-residents/>.

- 2.44** There is declining demand for low care residential places as people are deferring entry into residential aged care facilities until they are older and more frail.⁵¹ A number of stakeholders also gave evidence in support of this to the committee. The committee received evidence that 80 per cent of all residents in residential aged care facilities are currently funded at a high care level, and that of those, most are classed as having high care needs across all three domains.⁵²
- 2.45** It was reported to the committee that the amount of funding received for a high care resident varies widely.⁵³ The current schedule of aged care subsidies and supplements can be found at Appendix 6.

Staff in aged care facilities

- 2.46** Residential aged care facilities employ a range of staff to care for residents, including registered nurses, enrolled nurses and aged care staff. A range of other professionals including general practitioners and allied health professionals also service facilities.
- 2.47** As table 1 demonstrates there has been a significant expansion in the aged care sector over the last ten years. There has also been a significant shift in the composition of the aged care workforce across Australia in recent years as the number of registered nurses and enrolled numbers have declined, while the number of personal care workers (referred to in this report as aged care staff as defined later in this chapter) has increased.⁵⁴
- 2.48** The following sections briefly outline the types of staff, and the qualification and role of each, within an aged care facility.

⁵¹ Productivity Commission, p XXXIII.

⁵² Submission 87, NSW Nurses and Midwives' Association, p 9, quoting Australian Institute of Health and Welfare, *Care needs of permanent aged care residents* (2015), <http://aihw.gov.au/aged-care/residential-and-community-2012-13/permanent-residents/>.

⁵³ Submission 101, Wesley Mission, p 4.

⁵⁴ Debra King, Kostas Mavromaras et al, Commonwealth Department of Health and Ageing, *The Aged Care Workforce, 2012 – Final Report*, Flinders University, p 22.

Table 1 Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007 and 2012 (estimated Full Time Equivalent and per cent)

Occupation	2003#	2007	2012
Nurse Practitioner	n/a	n/a	190 (0.2)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)
Allied Health Professional	5,776* (7.6)	5,204* (6.6)	1,612 (1.7)
Allied Health Assistant	Combined with Allied Health Professional	Combined with Allied Health Professional	3,414 (3.6)
Total number of employees (FTE) (%)	76,006 (100)	78,849 (100)	94,823 (100)

Source: Census of residential aged care facilities. # For consistency, the figures reported in the 2007 report have been replicated here.

Please note that there is a 0.1% rounding difference between the Total and the sum of the numbers for each occupation.

Debra King, Kostas Mavromaras et al, Commonwealth Department of Health and Ageing, *The Aged Care Workforce, 2012 – Final Report*, Flinders University, p 22.

Registered nurses

- 2.49** To become a registered nurse, individuals must complete a three year Bachelor of Nursing degree, and a minimum of 800 hours of clinical placement.⁵⁵
- 2.50** Bachelor of Nursing graduates must apply to the Nursing and Midwifery Board of Australia to practise as a registered nurse. Additionally, nurses must renew their registration annually in order to continue practising and undertake at least 20 hours of professional development per year.⁵⁶
- 2.51** The role of registered nurses in residential aged care facilities is complex, varied and essentially prescribed by the aged care provider. In general, registered nurses lead multi-disciplinary teams to deliver, manage and coordinate person-centred care. They do so by facilitating or providing:

⁵⁵ Correspondence from Ms Tanya Vogt, Executive Officer, Nursing and Midwifery Board of Australia, to Chair, 28 September 2015, Attachment A.

⁵⁶ NSW Health, *Careers Fact Sheet – Becoming a registered nurse*, http://www.health.nsw.gov.au/nursing/employment/Publications/namo_cifs_rn.pdf; Evidence, Ms Linda Kelly, Councillor, Leichhardt Municipal Council, 5 August 2015, p 67.

- clinical assessment, care and support
- medication management and administration
- pain management and wound care
- palliative care
- compliance with clinical practice
- care planning.⁵⁷

2.52 Registered nurses also manage and supervise staff, including enrolled nurses and aged care workers. In addition, registered nurses collaborate with general practitioners and other health professionals and service providers in the coordination and delivery of health care in aged care facilities.⁵⁸

2.53 Other functions of registered nurses in aged care facilities include optimising residents' physical and mental capacity through health promotion, preventing physical or mental illness and disability, providing rehabilitation care, managing the clinical aspects of aged care and supporting residents and their families.⁵⁹

Enrolled nurses

2.54 Enrolled nurses must complete either a Diploma of Nursing or an Advanced Diploma in Nursing. Courses can take between 18 to 24 months to complete. Enrolled nurses must undertake a minimum of 400 hours of clinical placement,⁶⁰ and also apply to the Nursing and Midwifery Board of Australia to practise.⁶¹

2.55 Enrolled nurses work under the direction and supervision of registered nurses and their duties can include providing physical and emotional care to residents.⁶²

2.56 Certain enrolled nurses are also qualified to administer medications, while others have a notation on their registration that states that they do not hold a Board-approved qualification in the administration of medicines.⁶³

⁵⁷ Submission 109, Australian College of Nursing, p 2 and Submission No. 116, Australasian College of Care Leadership and Management, p 2, Submission No. 117, Silver Chain, p 2.

⁵⁸ Submission 109, Australian College of Nursing, p 1.

⁵⁹ Submission 109, Australian College of Nursing, p 3; Submission 116, Australasian College of Care Leadership and Management, p 2.

⁶⁰ Correspondence from Ms Vogt to Chair, 28 September 2015, Attachment A.

⁶¹ NSW Health, *Careers Fact Sheet – Becoming an Enrolled Nurse*, http://www.health.nsw.gov.au/nursing/employment/Publications/namo_cifs_en.pdf.

⁶² Submission 87, NSW Nurses and Midwives Association, p 25 and NSW Health, *Careers Fact sheet, Becoming An Enrolled Nurse*, http://www.health.nsw.gov.au/nursing/employment/Publications/namo_cifs_en.pdf.

⁶³ Correspondence from Ms Vogt to Chair, 28 September 2015, p 1.

Aged care staff

- 2.57** Inquiry participants referred to aged care staff using a variety of terms including assistants in nursing, aged care support staff, personal support staff, aged care workers, personal care workers, personal care assistants and personal care attendants. With the occasional exception to assistants in nursing, this report does not distinguish between these groups, and instead uses the term ‘aged care staff’ throughout this report to encompass all of the various staffing designations mentioned in this paragraph (as noted in chapter 1).
- 2.58** The tasks of aged care staff include:
- assisting residents with their personal care needs such as showering, dressing and eating
 - assisting residents with their mobility and communication needs
 - participating in planning the care of individuals
 - following therapy plans such as interventions to assist those with dementia and behavioural problems
 - observing and reporting changes in residents’ condition, and reporting complaints about care
 - assisting with rehabilitation exercises, basic treatment and delivering medications
 - providing direct support and assistance to therapists.⁶⁴
- 2.59** The committee understands that aged care staff are expected to have a Certificate III or a Certificate IV-level education.⁶⁵ A Certificate III or Certificate IV in Aged Care can be obtained from any registered training organisation accredited to provide aged care training. The education of aged care staff is examined in chapter 5.

⁶⁴ Australian Bureau of Statistics, 1220.0 – ANZSCO – Australian and New Zealand Standard Classification of Occupations, First Edition, *Unit Group 4233 Nursing Support and Personal Care Workers*, Revision 1, 2013, <http://www.abs.gov.au/ausstats/abs@.nsf/0/D57B53FBE61CE0DFCA2575DF002DA72E?open=document>.

⁶⁵ Evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives’ Association, 5 August 2015, p 47.

Chapter 3 Registered nursing and resident need

This chapter examines the role and responsibilities of registered nurses in aged care facilities, in comparison to the role of enrolled nurses or aged care staff. It considers the argument that registered nurses are necessary in aged care facilities to undertake key duties such as administering and managing medication, clinically assessing residents, delivering palliative care and care to residents with dementia, and supervising staff.

The chapter then explores the level of care needed in aged care facilities given that residents are entering with higher needs and requiring more complex care. It looks at the nature of these high care needs and whether, as some inquiry participants suggested, a distinction should be recognised between the various types of high care needs in order to determine the staff required within a facility. Finally, the chapter discusses the need for continuous nursing coverage and considers whether the physical presence of a registered nurse at all times correlates with service performance.

Responsibilities of registered nurses

- 3.1** As outlined in chapter 2, registered nurses in aged care facilities have a wide range of responsibilities. It was argued during the inquiry that many of these responsibilities can and should only be met by registered nurses. On the other hand, it was also suggested that if the legislative requirement for registered nurses to be on duty at all times was expanded to all facilities, the role of registered nurses may be downgraded. These arguments will be considered in the following sections.

Medication administration and management

- 3.2** For many inquiry participants the administration and management of medication in aged care facilities by registered nurses was considered essential to ensure residents' health and safety.
- 3.3** Alzheimer's Australia NSW submitted that should unqualified or inappropriately qualified staff administer certain medications, there could be serious unintended consequences for residents' health and wellbeing:

[While] unqualified or inappropriately qualified care workers can be made aware of correct procedure for medicines delivery, they do not have the necessary education and knowledge required for making clinical judgements on why they are administering a medicine or when not to administer. It is for this reason that medication administration by unqualified or inappropriately qualified staff has the potential for error and possible dire consequences.⁶⁶

- 3.4** Leichhardt Council expressed similar concern about unqualified or inappropriately qualified staff administering medications, particularly Schedule 8 drugs, as it could lead to adverse health outcomes for residents.⁶⁷

⁶⁶ Submission 96, Alzheimer's Australia NSW, p 3.

⁶⁷ Evidence, Ms Linda Kelly, Councillor, Leichhardt Municipal Council, 5 August 2015, p 64; Evidence, The Hon Clr John Jobling OAM, Councillor, Leichhardt Municipal Council, 5 August 2015, p 66.

- 3.5** Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, noted that pain medication can be very difficult for ‘untrained staff’ (which she took to include Certificate III trained staff and some enrolled nurses) to manage, and cautioned that should anything go wrong residents will be sent to hospital:

Likewise with a number of other things, if anything goes astray ... it is simply a matter of sending people to hospital. Pain management can be very difficult to manage – for example, if you need schedule 8 drugs like morphia or testine or some of the patches – if you do not have a registered nurse.⁶⁸

- 3.6** Some stakeholders provided anecdotal evidence of unqualified staff inappropriately administering medication. For example, the Older Women’s Network NSW relayed a story of one woman in an aged care facility who, it was alleged, was inappropriately administered Prednisone for a chest infection:

OWN NSW has heard many stories from older women and their carers about the misuse and abuse of medication administered by unqualified staff, including one from an older woman supporting her elderly severely demented mother who resided in a residential care facility on the North Shore of Sydney. Her mother had been treated with steroids for a chest infection. She was deeply concerned that although the chest infection had cleared up, her mother was becoming increasingly distressed and disoriented. When she checked her mother’s notes, she found that her mother had been on a continuing dose of 70mg of Prednisone without review. Steroids such as Prednisone are known to cause disorientation and mood swings.⁶⁹

- 3.7** The Older Women’s Network stated: ‘Without the daughter’s intervention it is unknown how long this resident may have remained on an inappropriate drug or what long term damage may have resulted.’⁷⁰

- 3.8** The Commonwealth Quality of Care Principles 2014 sets out a range of procedures that can only be carried out by ‘A nurse practitioner, registered nurse or enrolled nurse, or other professional appropriate to the service (for example, medical practitioner, stoma therapist, speech pathologist, physiotherapist or qualified practitioner from a palliative care team), acting within their scope of practice.’ The *Guide to the Handling of Medication in Nursing Homes in NSW* covers licensed nursing homes, and *Medication Handling in NSW Public Health Facilities* applies to non-licensed facilities or ‘hostels’. Both conform to the standards established in the Commonwealth guidelines and make no allowance for unqualified aged care staff to do other than assist.⁷¹

- 3.9** One registered nurse, who consults in the provision of palliative care in aged care facilities, claimed that she is aware of aged care staff who are inappropriately administering Schedule 8 drugs and noted that this was outside their scope of practice:

⁶⁸ Evidence, Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, 14 August 2015, p 21.

⁶⁹ Submission 115, Older Women’s Network, pp 4-5.

⁷⁰ Submission 115, Older Women’s Network, p 5.

⁷¹ Submission 119, Health Services Union, pp 3-5.

I know of AINs [assistants in nursing] in hostels giving liquid form S8 medication that were directed by their manager over the phone to administer this medication. This action is way above AIN scope of practice. AINS need to be guided by the RNs who need to be supported in the important role of caring for the aged.⁷²

3.10 The Health Services Union expressed concern that should the requirement for registered nurses to be on duty in nursing homes at all times be removed, unqualified or inappropriately qualified staff may feel pressured to fulfil duties which are outside their scope of practice.⁷³

3.11 A number of inquiry participants therefore sought to retain s 104 of the *Public Health Act 2010* to ensure that enrolled nurses and aged care staff operate within their scope of practice for the safe management and administration of medication.⁷⁴

Clinical assessment

3.12 The ability of registered nurses to clinically assess the health status of residents was another important role highlighted by stakeholders. For example, one clinical nurse educator submitted that registered nurses have the ‘clinical acumen’ to adequately monitor and care for residents (particularly those with high or complex care needs) in aged care facilities, and that aged care staff – while kind and caring – do not possess the same ability:

Although the PCAs [personal care assistants] and the AINs were overwhelmingly kind and caring to the aged care residents, the reality was that they had no understanding or clinical skill in preventing and assessing changes in condition, understanding pain relief and reducing discomfort or distress.⁷⁵

3.13 Indeed, a registered nurse or nurse practitioner is required to undertake the initial assessment and care planning of a resident’s care needs when they enter a facility.⁷⁶ Further examples of clinical assessment which require the skills of a registered nurse were provided by the Royal Australian College of General Practitioners, including:

- recognising and assessing degrees of dehydration (for example, in scenarios of diarrhoea/vomiting)
- initially assessing signs and symptoms that indicate bowel obstruction
- assessing pulse which is particularly important in the presence of heart symptoms
- assessing level of and changing consciousness in strokes/transient ischaemic attacks/head injuries
- basic auscultation of the lungs and recognising indicators of respiratory distress (for example, speech, breathing rate, intercostal recession)

⁷² Submission 36, Name suppressed, p 1.

⁷³ Submission 119, Health Services Union, p 4.

⁷⁴ Evidence, Ms Kelly, p 64; Answers to questions on notice, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives’ Association, 2 September 2015, pp 4-6. See also Evidence, The Hon Clr Jobling OAM, p 66; Submission 109, Australian College of Nursing, p 7.

⁷⁵ Submission 127, Name suppressed, p 1.

⁷⁶ Quality of Care Principles 2014, Sch 1, Pt 3, s 3, item 3.8 – Nursing Services.

- recognising signs of acute delirium, being alert to infection as a probable cause and checking urine
- managing fluid balance (for example, input/output charts) and being able to implement GP instructions for corrective action (for example, administering intravenous and subcutaneous fluids).⁷⁷

3.14 Ms Nilda Miranda reflected that ‘aged care registered nurses are qualified and educated on assessment techniques which are based on empirical evidence; personal knowledge; [and] aesthetics, which in nursing refers to empathy and intuition.’⁷⁸

3.15 The Combined Pensioners and Superannuants Association asserted that the assessment skills and expertise of registered nurses were particularly critical in aged care facilities, as – unlike hospitals – there is generally no immediate access to a doctor and in situations where a resident’s health deteriorates rapidly, a registered nurse can be at hand to make a clinical judgement about the appropriate course of action.⁷⁹ In support of this argument, the association referenced NSW Health’s *Recognition and Management of Patients who are Clinically Deteriorating* which recommends that a registered nurse undertake a clinical review of a patient who is clinically deteriorating.⁸⁰

3.16 Mrs Linda Langton, a registered nurse who has worked in aged care for 30 years, described the types of situations that registered nurses routinely encounter that require clinical assessment:

RNs spend a lot of their time assessing residents, which may involve taking observations after a dizzy spell, assessing wounds or injuries after a fall, talking to a more confused resident, to figure out why. The skill of the RN is in discovering if medication has caused the dizzy spell and needs adjusting, or the resident may be having a mini stroke or a CVA [cerebrovascular accident] and needs attention, or perhaps they are dehydrated. A hip that feels sore after a fall may be broken, or bruised, or may be a previous hip replacement that has shattered. A wound can be infected, or need suturing or excessively bruised due to blood thinning medication, or just need a dressing. The confused patient may have delirium due to an infection, or be missing a family member who is away, or be needing review by a Specialist Geriatric Team.⁸¹

3.17 Importantly, registered nurses’ clinical assessment skills can help minimise unnecessary transfers to hospital. This is discussed in more detail in chapter 4.

⁷⁷ Answers to questions on notice, Dr Guan Yeo, Chair, New South Wales and Australian Capital Territory Faculty, Royal Australian College of General Practitioners, 1 October 2015, p 1.

⁷⁸ Submission 134, Ms Nilda Miranda, p 1.

⁷⁹ Submission 152, Combined Pensioners and Superannuants Association of NSW, pp 5-6.

⁸⁰ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 6, quoting NSW Health, *Policy Directive – Recognition and management of patients who are clinically deteriorating*, December 2013, p 11.

⁸¹ Submission 38, Mrs Linda Langton, p 1.

Palliative care

3.18 A number of inquiry participants highlighted the fact that registered nurses have the necessary skills training and experience to provide end-of-life care as a reason to mandate their continuous presence in nursing homes.⁸² Ms Bronwyn Heron, Chair, Palliative Aged Care Network NSW, noted that palliative care is a core business for aged care providers.⁸³ This is supported by the Productivity Commission's report on *Caring for Older Australians*, which states that 50,000 Australians die each year in residential facilities.⁸⁴

3.19 Palliative Care NSW described how registered nurses use their clinical judgement to assess and manage the care needs of a person approaching death:

... a resident approaching death may experience a range of symptoms which could include severe and unrelieved pain, restlessness and agitation, nausea, fear, respiratory distress, haemorrhage or distressing secretions – all of which require the trained assessment and management of an RN within the RACF [residential aged care facility].⁸⁵

3.20 Palliative Care NSW emphasised that this skill set is unique to registered nurses:

What is crucial to note here is that the skills of assessment and appropriate management of residents' symptoms and decision making are unique to RNs and it is the RNs who ensure residents' safety. RNs have specific skills and competencies which are not included in EEN [endorsed enrolled nurse] and PCA [personal care assistant] education and training.⁸⁶

3.21 The Palliative Care Service Senior Staff, Calvary Hospital Kogarah, reflected that registered nurses play a pivotal role in administering and managing the medication provided to residents requiring palliative care:

These patients often require extra doses of medications to manage symptoms, in addition to regular doses of medications in order to alleviate developing deterioration or changes in the patient's condition. It is vital that trained nursing staff are available at all times to assess patient needs and institute appropriate management.⁸⁷

⁸² Evidence, Professor Colleen Cartwright, Principal Director and Chief Executive Officer, Cartwright Consulting Australia, 14 August 2015, p 40. Also see Evidence, Dr Lyndal Newton, Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, p 46; Evidence, Ms Margaret Dane, Member, Palliative Aged Care Network NSW, 10 August 2015, p 55; Submission 79, Ms Leonie Gambrill, p 1.

⁸³ Evidence, Ms Bronwyn Heron, Chair, Palliative Aged Care Network NSW, 10 August 2015, p 53.

⁸⁴ Productivity Commission, *Caring for Older Australians*, Productivity Commission Inquiry, Volume 2, Report No. 53, 28 June 2011, p 226.

⁸⁵ Submission 93, Palliative Care NSW, p 2.

⁸⁶ Submission 93, Palliative Care NSW, p 2.

⁸⁷ Submission 118, Palliative Care Service Senior Staff, Calvary Hospital Kogarah, p 1. Also see Submission 87, NSW Nurses and Midwives Association, p 10.

3.22 Another view expressed during the inquiry is that the provision of palliative care by registered nurses in residential aged care facilities is crucial to ensure people have a dignified death in familiar surroundings. This was illustrated by one inquiry participant who shared how her mother was able to receive palliative care in her own facility:

My mother was only able to die a dignified death in a supportive and caring aged care facility due to having a RN available 24/7 who was able to liaise with myself and the GP, and organise and manage pain relieving medication (she was on morphine at the end). If there had been no RN available I am sure she would have been transferred to hospital to die.⁸⁸

3.23 According to the NSW Nurses and Midwives' Association, there is evidence that the majority of older people dying in hospital that were transferred from an aged care facility could have received their end-of-life care in the facility they were admitted from.⁸⁹ Hospital transfers for residents requiring palliative care were argued to increase the pain and suffering of residents, cause distress to families, and place an additional financial burden on hospitals.⁹⁰ Palliative Care NSW suggested that hospital transfers may also result in futile and expensive treatments in the absence of dialogue in emergency departments about palliative care options.⁹¹

3.24 Dr Yvonne McMaster expressed concern that transfers to hospitals for palliative patients would occur more frequently if the legislative requirement for registered nurses to be on duty at all times in nursing homes is repealed.⁹²

3.25 As noted earlier, the role of registered nurses in minimising hospital transfers is further discussed in chapter 4.

Care for residents with dementia

3.26 The provision of care to residents with dementia was another issue raised before the committee. There was general consensus that aged care staff and enrolled nurses can undertake the personal care needs of residents with dementia, however, some inquiry participants pointed out that registered nurses are still required to administer certain medications (as already discussed throughout this chapter) and manage more challenging behaviours.

3.27 According to Professor Peter Gonski, President, Australian and New Zealand Society for Geriatric Medicine, NSW Division, the best way to manage dementia in aged care facilities is around the provision of personal care: '[I]t is about providing all the things that that particular individual will settle with because some of these people can be quite agitated. The best way to treat that is basically to look after the person the way they would like to be looked after.'⁹³

⁸⁸ Submission 77, Name suppressed, p 1.

⁸⁹ Submission 87, NSW Nurses and Midwives' Association, p 10.

⁹⁰ Submission 125, Dr Yvonne McMaster, p 3 and Submission 118, Palliative Care Service Senior Staff, Calvary Hospital Kogarah, p 1.

⁹¹ Submission 93, Palliative Care NSW, p 2.

⁹² Submission 125, Dr Yvonne McMaster, p 3.

⁹³ Evidence, Professor Peter Gonski, President, Australian and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, p 45.

- 3.28** Professor Gonski acknowledged that such care does not necessarily require a registered nurse, however, he and Dr Lyndal Newton, Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division, cautioned that registered nurses still play an important role in administering medication should a patient's behaviour escalate.⁹⁴
- 3.29** This was reflected by Alzheimer's Australia NSW, which expressed concern about how such situations are being addressed. The organisation explained that critical incidents relating to the symptoms of dementia often occur during non-business hours when less qualified or unqualified aged care staff instead of registered nurses are rostered on.⁹⁵
- 3.30** Alzheimer's Australia NSW contended that removing the requirement for registered nurses to be on duty at all times in nursing homes would result in more people with dementia presenting to emergency departments as less qualified staff would be more inclined to call an ambulance if a resident was displaying challenging behaviours.⁹⁶ This was elaborated upon by Mr Brendan Moore, General Manager of Policy, Research and Information at Alzheimer's Australia NSW, who commented that 'a personal care assistant ... with a Certificate III that has undergone one hour of training about what is dementia is ill-equipped to deal with those [challenging behaviours]'.⁹⁷
- 3.31** Alzheimer's Australia considered this issue especially problematic as the condition of people with dementia often deteriorates in hospital, which reduces the chances of them returning to an aged care facility:
- For people with dementia, the longer the stay [in hospital] the less likely they are to be able to be accommodated in a facility due to increased agitation, more frequent and severe behavioural and psychological symptoms of dementia (wandering, verbal and physical aggression, vocalisation,), increased risk of falls and malnutrition/dehydration.⁹⁸
- 3.32** Mr Moore further contended that the care needs of people with dementia may not be adequately met in hospitals as staff are often not well trained and resourced to manage the dementia, whereas qualified staff in aged care facilities are better equipped to meet these needs.⁹⁹

Supervision

- 3.33** Numerous stakeholders noted that the supervision of enrolled nurses and aged care staff is a key accountability for registered nurses in residential aged care facilities.

⁹⁴ Evidence, Professor Gonski, p 45; Evidence, Dr Newton, p 45.

⁹⁵ Evidence, Mr Brendan Moore, General Manager, Policy, Research and Information, Alzheimer's Australia, NSW, 10 August 2015, p 12.

⁹⁶ Submission 96, Alzheimer's Australia NSW, p 3.

⁹⁷ Evidence, Mr Moore, p 12.

⁹⁸ Submission 96, Alzheimer's Australia NSW, p 2.

⁹⁹ Evidence, Mr Moore, p 8.

- 3.34** In regards to enrolled nurses, the Australian Nursing and Midwifery Council's *National Competency Standards for the Enrolled Nurse* stipulate that enrolled nurses must work under the direction and supervision of registered nurses.¹⁰⁰ The NSW Nurses and Midwives' Association reflected on this responsibility:

The provision of registered nurses at all times in RACF's is essential to enrolled nurse practice. Enrolled nursing practice requires the enrolled nurse to work under the direction and supervision of the registered nurse as stipulated by the Australian Nursing and Midwifery Council. At all times, the enrolled nurse retains responsibility for his/her actions and remains accountable in providing delegated nursing care ...¹⁰¹

- 3.35** The NSW Nurses and Midwives' Association added that, '[i]f the requirement for registered nurses is removed then there are important considerations for our enrolled nurse workforce in aged care.'¹⁰²

- 3.36** Dr Herbert acknowledged that enrolled nurses may be very competent, however, pointed out that a registered nurse is nevertheless needed for oversight, supervision and assessment:

All care really does need some supervision from a registered nurse or an endorsed enrolled nurse – who may be very competent; often in rural areas they have not done their registered nurse training simply because of the geographic distance from a training hospital or because of other circumstances. I do believe that for oversight, for supervision and for assessment a registered nurse is needed.¹⁰³

- 3.37** Registered nurses also supervise aged care workers. NSW Health's *Employment of Assistants in Nursing (AIN) in NSW Health Acute Care* dictates that 'an AIN will work within a plan of care under the supervision and direction of a registered nurse when providing aspects of nursing care'.¹⁰⁴ Inquiry participants raised concerns about the impact on aged care facilities if registered nurses are not there to supervise aged care staff. For example, the Palliative Care Service Senior Staff, Calvary Hospital Kogarah, stated:

We are already seeing consequences of ... RACFs where there are no RNs available to respond to increasing patient care needs. There is no availability to give extra doses of medications and no understanding of the need for ongoing assessment of patients. Care workers who are not RNs have done Certificate 3 & 4 in healthcare – which

¹⁰⁰ Australian Nursing and Midwifery Council, *National Competency Standards for the Enrolled Nurse*, October 2002, p 2.

¹⁰¹ Submission 87, NSW Nurses and Midwives' Association, p 25.

¹⁰² Submission 87, NSW Nurses and Midwives' Association, p 25.

¹⁰³ Evidence, Dr Herbert, p 20.

¹⁰⁴ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 6, quoting NSW Health, *Policy Directive – Employment of Assistants in Nursing (AIN) in NSW Health Acute Care*, September 2010, p 1. The NSW Health *Policy Directive - Care Type Policy for Acute, Sub-Acute and Non-Acute Patient Care* defines acute care as care where the primary clinical purpose or treatment goal includes curing illness or providing definitive treatment of injury, relieving symptoms of illness or injury (excluding palliative care), reducing severity of an illness or injury, performing diagnostic or therapeutic procedures, and/or protecting against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function.

provides minimum training (6 weeks to 3 months) in aspects of personal care. There is no knowledge of even the most basic aspects of nursing care and assessment.¹⁰⁵

- 3.38** The Combined Pensioners and Superannuants Association expressed concern about relying on less qualified or unqualified staff to work without direct supervision from a registered nurse:

... residential aged care facilities are primarily staffed by low-skilled workers and assistants in nursing who should not be providing care to high needs residents without the direct supervision of a registered nurse. Not only is this unsafe for residents, it places totally unreasonable expectations and responsibilities on these workers.¹⁰⁶

- 3.39** Several aged care workers themselves also expressed concern about the potential repeal of s 104 of the *Public Health Act*. For example, Ms Amanda Thackeray, who has worked in the aged care industry for nearly 20 years, said she is more confident working in an environment with a registered nurse and would not want to work in a facility without one on duty at all times.¹⁰⁷ Similarly, Ms Linda Hardman, an assistant in nursing, submitted that ‘it is imperative that we keep registered nurses in aged care 24/7’.¹⁰⁸

- 3.40** Mrs Rebecca Mercer, an aged care worker, was uncertain as to how aged care staff would perform their duties if a registered nurse was not able to supervise their work:

RN’s are also there to ‘supervise us’ during out shift, can you imagine how much neglect there would be with some people knowing they aren’t being watched by an RN so they don’t successfully fulfil their duties and take corners with their work, I know some people like that now let alone WITHOUT an RN present. RN’S ARE our most valuable asset within the aged care sector as well as the public health section. DO NOT TAKE OUR RN’S away!!!!¹⁰⁹

- 3.41** Mrs Alison Williams, an assistant in nursing, told the committee that she relies on having a registered nurse on duty to ensure the safety of staff and residents, and that she may leave the industry if the legislative requirement was removed.¹¹⁰

Potential downgrading of the role of registered nurses

- 3.42** On the other hand, a number of aged care providers contended that if continuous registered nursing coverage was mandated in all aged care facilities, including those formerly considered low care, there would not be enough clinical work for them to do and as a result their role would change significantly and would no longer reflect their skills and qualifications. Concerns about the potential extension of the legislative requirement are discussed in more detail in chapter 4.

¹⁰⁵ Submission 118, Palliative Care Service Senior Staff, Calvary Hospital Kogarah, p 1.

¹⁰⁶ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 7.

¹⁰⁷ Submission 85, Ms Amanda Thackeray, p 1.

¹⁰⁸ Submission 16, Ms Linda Hardman, p 1.

¹⁰⁹ Submission 74, Mrs Rebecca Mercer, p 1 [emphasis as per original].

¹¹⁰ Submission 72, Mrs Alison Williams, p 1.

- 3.43** For example, according to Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, ‘there would not be the workload for an RN 24/7’.¹¹¹ Sunhaven Hostel suggested that an expansion of legislation would result in registered nurses having to take on more menial tasks: ‘They would be expected to assist with the washing, ironing, providing personal care to residents, assist in the kitchen, assist with cleaning and take on some of the administrative duties’.¹¹²
- 3.44** The same point was echoed by another aged care provider who stated that ‘residents in low care facilities may require very little medical care and trained staff may be required to provide nursing and personal care including feeds, toileting and showering’.¹¹³ Because of this, the provider expressed concerns about the ‘professional downgrade’ that may occur by placing registered nurses in situations where their skills are underutilised.¹¹⁴
- 3.45** McLean Care suggested that because the skill set required to meet these basic care needs are different to the clinical skill set of a registered nurse, registered nurses would require additional training:
- RNs role will need to change to a role that includes RN undertaking, for example, personal care, toileting and behaviour management – the traditional domains of the care worker. A significant training and development program would need to be implemented as these activities are not the skill set of clinicians and to avert a potential negative impact on residents with dementia and challenging behaviours.¹¹⁵
- 3.46** Presbyterian Aged Care NSW & ACT questioned the ability of aged care providers to attract registered nurses to aged care if their duties were to change to include basic care duties: ‘If we have to employ RNs who then end up doing basic care duties (replacing care workers) to meet artificial legislative requirements, are we really going to be able to find an RN who wants to do more menial duties and not use their skills and qualifications to the full?’¹¹⁶
- 3.47** Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, drew the conclusion that registered nurses whose role would be expanded to include care duties would be bored without the work or challenges to meet their skill level: ‘There is a role for [registered nurses], but you would not necessarily want one in a low-care facility. They would get bored witless’.¹¹⁷

Committee comment

- 3.48** The committee commends registered nurses for the valuable role they undertake in aged care facilities. The committee acknowledges that registered nurses are qualified to undertake a range of key duties that enrolled nurses or aged care staff are not, including clinical assessment and supervision of staff, in the delivery of quality care to residents.

¹¹¹ Evidence, Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, 10 August 2015, p 4.

¹¹² Submission 20, Sunhaven Hostel, p 2.

¹¹³ Submission 100, Name suppressed, p 2.

¹¹⁴ Submission 100, Name suppressed, p 2.

¹¹⁵ Submission 67, McLean Care, p 7.

¹¹⁶ Submission 82, Presbyterian Aged Care NSW & ACT, p 2.

¹¹⁷ Evidence, Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, 5 August 2015, p 41.

- 3.49** The committee recognises that registered nurses also play a pivotal role in the administration and management of medication, particularly Schedule 8 drugs, in aged care facilities. We note the concerns that should unqualified or inappropriately qualified staff take on these responsibilities there may be adverse health outcomes for residents and an increase in unnecessary transfers to hospital. The committee notes anecdotal reports of aged care staff acting outside of their scope of practice to administer medication. The Committee notes there are clear guidelines for the handling and administration of medication in NSW and unqualified aged care staff can only assist.
- 3.50** We acknowledge that care for residents with dementia can, for the most part, be undertaken by enrolled nurses and aged care staff. However, we note that registered nurses are required when residents display more challenging behaviours or require certain medications, and that critical incidents relating to the symptoms of dementia often occur during non-business hours when registered nurses may not be rostered on.
- 3.51** The committee notes the concerns that if s 104 of the *Public Health Act* was expanded to encompass all aged care facilities, registered nurses in what were previously classified as 'low care' facilities may be required to undertake a role that does not adequately reflect their skills and qualifications.
- 3.52** These matters form part of the overarching policy question of whether or not there should be registered nurses on duty at all times in aged care facilities, which the committee will address in chapter 6.

The level of care required by residents in aged care facilities

- 3.53** During the inquiry, numerous stakeholders discussed the level of care required by the range of residents within aged care facilities. Many drew attention to the trend that residents are entering facilities later in life, and typically with higher, more complex care needs. These participants thus argued that registered nurses in aged care facilities are more critical now than ever before to cater to these needs.
- 3.54** Some participants expressed the need for a multidisciplinary approach to aged care as residents' needs become more complex:
- We have had some excellent results with people reducing falls, increasing their mobility, maintaining independence. Psychology is another area we are introducing. Getting people in depression, as you know, is a huge issue in our elderly people and having access to expertise is important. Certainly registered nurses are invaluable but we are part of a team.¹¹⁸
- 3.55** Others pointed out, however, the importance of distinguishing between different high care needs, arguing that not all residents with high care needs require the ongoing presence of a registered nurse. These inquiry participants did not support a legislative requirement for registered nurses, asserting that other care staff may be more appropriate in meeting the needs of certain high care residents.

¹¹⁸ Evidence, Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, 14 August 2015, p 15.

- 3.56 Some stakeholders further asserted that there is no correlation between continuous nursing cover and service performance. All of these arguments will be examined in the following sections.

Residents have higher, more complex needs

- 3.57 The committee was informed that residents are presenting to aged care facilities later in life (with the average age of residents entering into facilities being 84 years old)¹¹⁹ and with higher, more complex needs, including chronic diseases and dementia.¹²⁰ This pattern was attributed to higher life expectancies and the Commonwealth Government's 'ageing in place' policy which encourages people to stay at home for as long as possible.¹²¹
- 3.58 For example, Mr Moore advised that '[p]eople are living at home longer and when they do arrive in residential aged care often they are very complex, high levels of acuity, often with co-morbidities and from our perspective very often with dementia'.¹²²
- 3.59 According to the NSW Nurses and Midwives' Association, this trend shows no signs of abating and it is increasingly rare to find facilities where the majority of residents have low care needs.¹²³ Indeed, as advised by the Combined Pensioners and Superannuants Association, a recent report on the operation of the *Aged Care Act 1997* (Cth) indicated that the increasing acuity of residents has resulted in approximately 75 per cent of residential aged care beds in New South Wales being used for individuals with high care needs.¹²⁴
- 3.60 The Health Services Union reported that their members' duties were 'moving more and more from assistance and recreational activities to direct care'. The training courses their members undertook were designed to support the changes in residential care and they indicated their members were 'happy to build up their skills and take a more active care-based role'.¹²⁵

¹¹⁹ For example, Evidence, Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW-ACT, 5 August 2015, p 32; Evidence, Ms Lisa Langley, Policy Manager, Council on the Ageing NSW, 5 August 2015, p 57;

¹²⁰ For example, Submission 83, Australian and New Zealand Society for Geriatric Medicine, NSW Division, p 1; Submission 109, Australian College of Nursing, p 10; Submission 152, Combined Pensioners and Superannuants Association of NSW, p 7; Submission 107, National Senior Australia, p 2; Evidence, Ms Helen Macukewicz, Professional Officer—Aged Care, NSW Nurses and Midwives' Association, 5 August 2015, p 48; Submission 117, Silver Chain Group, p 2; Evidence, Ms Langley, p 56; Evidence, Ms Dane, p 57.

¹²¹ Submission 87, NSW Nurses and Midwives' Association, p 3 and Submission 152, Combined Pensioners and Superannuants Association of NSW, p 7.

¹²² Evidence, Mr Moore, p 9.

¹²³ Answers to questions on notice, Mr Holmes, p 8. Also see Evidence, Ms Charmaine Crowe, Senior Adviser, Research and Advocacy, Combined Pensioners and Superannuants Association of NSW, 10 August 2015, p 32.

¹²⁴ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 7, quoting Department of Social Services, *Report on the Operation of the Aged Care Act 1997*, 2014, p 31.

¹²⁵ Submission 119, Health Services Union, p 6.

- 3.61** Evidence was also received noting that as residents are entering into aged care facilities older and with higher, more complex needs, they are spending less time in these facilities than in the past.¹²⁶ For example, Professor Colleen Cartwright, Principal Director and Chief Executive Officer, Cartwright Consulting Australia, stated that the average length of stay at a facility is now six months:

Given that they are older and frailer, the average length of stay in residential aged-care facilities is much shorter than it used to be. The average length of stay used to be several years and now, if my understanding is correct, it is around six months, which means that people are dying sooner after admission.¹²⁷

- 3.62** In relation to the medical conditions held by high care residents, Dr Con Costa, a doctor in general practice, explained the nature and complexity of some of these conditions, which often include multiple pathologies, co-morbidities and pharmacotherapy. In particular, he drew attention to the integral role experienced staff play in monitoring multiple conditions and medications:

High care residents inevitably have:

Multiple pathologies including heart disease, high blood pressure, diabetes, chronic pain, arthritis, depression, dementia etc and often multiple co-morbidities. They are on multiple pharmacotherapy including multiple anti-hypertensives, hypoglycemics, statins, antidepressants, dementia medications, diuretics, digoxin, heart medications etc – usually a minimum of 5 or 6 different medications in combination. These medications are often toxic individually requiring regular monitoring especially in patients with poor liver and renal function – but in combination can be even more toxic and unpredictable side effects, if not monitored carefully by experienced staff in the aged care facility – especially as most of these patients have poor kidney and liver function.¹²⁸

- 3.63** The need for appropriate staff to manage these higher, more complex needs was also raised by several other inquiry participants, who ultimately drew the conclusion that the complexities of these conditions require the expertise of a registered nurse. For example, the Australian and New Zealand Society for Geriatric Medicine, NSW Division, stated:

These complexities of conditions and management require registered nurse expertise and cannot be managed by more junior nurses. The care of an acutely deteriorating resident needs urgent recognition, urgent assessment and urgent management.¹²⁹

- 3.64** Likewise, Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, insisted that registered nurses in aged care facilities have the necessary skills and knowledge to provide ‘patient-centred care to frail, older people with complex care needs’.¹³⁰ She stated:

¹²⁶ Submission No. 117, Silver Chain, p 2.

¹²⁷ Evidence, Professor Cartwright, p 40.

¹²⁸ Submission 137, Dr Con Costa, p 4.

¹²⁹ Evidence, Professor Gonski, p 38.

¹³⁰ Submission 132, Dr Maree Bernoth, p 1.

Older people being admitted to residential aged care are increasingly more frail. If they can be managed at home, they would remain there but their needs are such that it is no longer possible and they require complex care. This level of care necessitates a registered nurse skilled in aged care.¹³¹

3.65 Many inquiry participants therefore argued in favour of retaining the legislative requirement for registered nurses to be on duty at all times in nursing homes on the basis that it would ensure that the increasingly complex needs of residents will be appropriately met by the most suitably qualified staff.¹³²

3.66 The Council on the Ageing NSW indicated its support for the legislative requirement as a means to ensure a consistently high standard of care for residents with complex needs who may find themselves moving across the health care system, noting that aged care residents often become hospital patients and vice versa:

COTA NSW supports the requirement for a registered nurse to be on duty in a residential aged care facility 24 hours a day, seven days a week ... COTA NSW believes that the NSW Government has a responsibility to its residents to ensure that those people who require care in a residential aged care facility in NSW receive the best care possible. The responsibility to provide 'care' to older people with complex care needs and dementia, or palliative care for example often traverse the boundaries between aged care and hospital care. Very often a nursing home 'resident' can quickly become a NSW hospital 'patient' and vice versa. The NSW Government has a continuing responsibility to ensure standards of nursing care are maintained across both hospital and aged care settings for the benefit of NSW residents in need of care.¹³³

Distinguishing between different high care needs

3.67 On the other side of the argument, some stakeholders insisted that it is critical to distinguish between the varying care needs of residents, particularly those with high care needs, and to apply the most appropriate staff to meet those needs. They were supportive of residents with high complex health care needs having a registered nurse in their facility at all times, but challenged the need for the same coverage at facilities with residents of other high care needs. As put by Ms Halliday: 'Just be careful. High care does not necessarily mean nursing care'.¹³⁴

3.68 As outlined in chapter 2, high care residents are assessed under the Aged Care Funding Instrument (ACFI) across three domains – complex health care (CHC), activities of daily living (ADL) and behaviour. The Residential Care Manual explains these categories in greater detail, identifying the areas rated within each domain:

¹³¹ Submission 132, Dr Maree Bernoth, p 5.

¹³² See for example, Submission 114, Central Sydney GP Network, p 1; Submission 115, Older Women's Network, p 6; Submission 131, Dr Charles Ovidia, p 1; Submission 132, Dr Maree Bernoth, p 5; Evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, 5 August 2015, p 47; Submission 87, NSW Nurses and Midwives' Association, p 3.

¹³³ Submission 110, Council on the Ageing NSW, p 2.

¹³⁴ Evidence, Ms Halliday, p 42.

- CHC – medication and complex health care procedures
- ADL – nutrition, mobility, personal hygiene, toileting and continence
- Behaviour – cognitive skills, wandering, verbal behaviour, physical behaviour and depression (areas relevant to the diagnosis of dementia, for example).¹³⁵

3.69 McLean Care emphasised the difference between residents of varying high care needs:

It needs to be stressed that the ACFI tool assess 3 domains of care: ADLS, Behaviours and CHC. A resident may be classified as high care by having significant dependencies in ADLS and behaviours but does not require clinical or complex care interventions.¹³⁶

3.70 HammondCare also commented on the distinction and asserted that residents with high care needs have diverse care requirements which may best be met by registered nurses for some but not others:

It is important to recognise that aged care residents with ‘high care’ needs can have vastly different care requirements that will be best met through a range of different staffing models. While some facilities with ‘high care’ residents will require an RN on duty at all times, others will not. HammondCare believes that it is appropriate to have an RN on duty at all times in aged care homes with high proportions of residents who have complex health care needs that require technical clinical interventions, such as complex pain management, wound care and the administration of catheters.¹³⁷

3.71 Ms Halliday expressed a similar view, stating that a number of high care residents ‘typically do not need nursing care’, rather they require assistance in areas of living:

They may be listed as needing high care and they may need allied care — physiotherapists, diversional therapy. They need help to get dressed, to eat, and to play. They are there to live their lives, not to wait to die. We need to provide them with the right activities, and we must have flexibility so that we can ensure we provide the right person ... People are in aged-care facilities because they are old and they need help.¹³⁸

3.72 Indeed, Wesley Mission gave evidence that many of their residents require high level support but not always complex health care support: ‘Like many providers, four of our facilities carry a large proportion of residents needing high levels of support with activities of daily living or behaviour management, rather than nursing support’.¹³⁹

3.73 Mission Australia advised the committee that in their experience many of their residents have had high ADL and behaviour needs, with much fewer having high complex health care needs:

¹³⁵ Commonwealth Department of Social Services, *Residential Care Manual*, 2014, pp 73-74.

¹³⁶ Submission 67, McLean Care, p 4

¹³⁷ Submission 112, HammondCare, p 3.

¹³⁸ Evidence, Ms Halliday, p 38.

¹³⁹ Submission 101, Wesley Mission, p 4.

... residents needs vary enormously – even for those with high needs ... Not all residents who require high levels of care require high levels of medical care ... Owing to their histories of homelessness and experiences in poverty, our residents tend to obtain high ACFI scores due to their inability to complete their ADL's, showering, toileting etc., along with their various behavioural diagnoses which can related to acquired brain injuries or a mental illness. But the main role of the RNs in our facilities is to oversee any/all complex care needs, which are much fewer.¹⁴⁰

- 3.74** Mission Australia concluded that requiring all aged care facilities with residents who have been assessed as having high needs to have a registered nurse on site at all times would be 'counterproductive' without acknowledgment of the differences between these needs, and argued that 'services should be tailored accordingly rather than prescribing a particular kind of care'.¹⁴¹

The need for registered nurses 'at all times'

- 3.75** Some stakeholders argued that the legislative requirement for registered nurses to be on duty at all times should be preserved given the unpredictable nature of an ageing resident's health. For example, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, commented:

... care needs [of people with high and complex care needs] cannot always be predicted or confined to an eight-hour roster or 16-hour roster coverage. Anyone who has dealt with aged-care people or family members who are ageing knows that things happen at unexpected times. People do not become sick when the nurse is available. Accidents, injuries, falls do not occur just because someone is rostered on duty, so the importance of 24-hour coverage is to try to provide the best quality of care and the best capacity to respond to the sometimes unexpected needs of residents in aged-care facilities.¹⁴²

- 3.76** Likewise, the Australian College of Nursing noted that the health state of residents with high and complex levels of care need may quickly become unstable and incidents requiring clinical nursing interventions cannot always be foreseen or planned for.¹⁴³

- 3.77** Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association, concurred, stating that the need for continuous nursing cover was particularly relevant in rural and remote areas:

An earlier witness explained very well anything can happen at any time. A resident can deteriorate very rapidly at night or on the weekend. It is particularly important in regional areas because there is limited access to GPs particularly at night and on weekends.¹⁴⁴

¹⁴⁰ Submission 91, Mission Australia, p 2.

¹⁴¹ Submission 91, Mission Australia, p 2.

¹⁴² Evidence, Mr Holmes, p 47.

¹⁴³ Submission 109, Australian College of Nursing, p 3.

¹⁴⁴ Evidence, Ms Crowe, p 32.

- 3.78** The issue of nursing and GP coverage in rural and remote areas is discussed further in chapter 4.
- 3.79** The Council on the Ageing NSW also advocated the need for registered nurses to ‘be available around the clock to monitor the increasingly complex needs of residents’, but moreover, to help avoid unnecessary and inappropriate hospital admissions.¹⁴⁵ The role of registered nurses in reducing hospital transfers is also examined further in chapter 4.
- 3.80** On the other hand, some aged care providers, such as Aged & Community Services NSW & ACT, asserted that registered nursing coverage does not necessarily equate to better service performance and quality care, stating: ‘There is no evidence to suggest that higher levels of RNs in aged care increase quality outcomes for residents ...’.¹⁴⁶
- 3.81** This point was reiterated by Mr Steven Teulan, UnitingCare Ageing NSW ACT, who told the committee:

I am not aware of any hard evidence that demonstrates that 24/7 on-site RN cover improves the quality of care or any other aspects of a service’s performance and in our experience — and we have a fair amount of experience — there is no correlation between 24/7 RN on-site cover and service performance.¹⁴⁷

- 3.82** Mr Teulan explained that there are other factors that impact on service quality, such as the engagement of staff and the quality of the manager:

For example, we know that the level of engagement of the people who work in the service has a significant impact on the quality of service provided and other service performances. We know that because we use an internationally validated instrument to measure it. We also know what drives that more than any other factor; that is, the quality of the manager on that site. That evidence is there in statistical form. When we look at whether an RN is on site 24/7 or not, that does not vary. There is no correlation.¹⁴⁸

- 3.83** UnitingCare NSW ACT declared that the legislative requirement for registered nurses to be on duty at all times in an aged care facility is ‘ill considered’ on the basis that: ‘The onsite presence of a single RN in a RACF does not guarantee safe, quality care’.¹⁴⁹

Committee comment

- 3.84** The committee notes that people are delaying entry into aged care facilities until they are older, frailer and have more complex care needs. Residents with complex care needs often have multiple pathologies, co-morbidities and pharmacotherapy which require the skills and capabilities of appropriately qualified staff, which – in aged care facilities – are usually registered nurses.

¹⁴⁵ Submission 110, Council on the Ageing NSW, p 2.

¹⁴⁶ Submission 113, Aged & Community Services NSW & ACT, p 2.

¹⁴⁷ Evidence, Mr Teulan, p 8.

¹⁴⁸ Evidence, Mr Teulan, p 13.

¹⁴⁹ Submission 148, UnitingCare Ageing NSW ACT, p 5 and p14.

- 3.85** The committee acknowledges the argument raised by stakeholders about distinguishing between high care needs to determine the most appropriate care for residents, and also acknowledges the evidence that continuous registered nursing coverage may not necessarily equate to better service performance or quality of care.
- 3.86** As per the committee's earlier comment, all of these matters form part of the broader policy question of whether there should be a mandated requirement for registered nurses to be on duty at all times, will be considered in chapter 6.

Chapter 4 Concerns about mandating registered nurses in all aged care facilities

During the inquiry, aged care providers expressed concern that the removal of the distinction between high and low level residential care from the *Aged Care Act 1997* (Cth) may have the effect of extending s 104 of the *Public Health Act 2010* to all aged care facilities, regardless of residents' care needs.

This chapter examines the impact on the viability and operations of aged care facilities, particularly in rural, regional and remote areas, if s 104 is not only retained, but extended, as per the concern of these stakeholders. It also considers the potential impact on the public health care system and the issue of the shortage of registered nurses in New South Wales.

Financial impact and viability

- 4.1** One of the most significant impacts raised by many aged care providers is the financial burden and threat to the viability of their operations if the legislative requirement for registered nurses under s 104 was extended to all aged care facilities. As put by one aged care provider in regard to their own facility: 'The cost to implement the amendments is substantial and would see the viability of the facility in question ...'.¹⁵⁰
- 4.2** Wesley Mission told the committee that if there was a requirement to provide permanent registered nursing coverage in all of their facilities, it would 'add an extra financial burden of \$1.1 million per annum'.¹⁵¹ Similarly, another aged care provider commented that if there was such an extension, 'we would be forced to carry a huge and potentially crippling financial burden. If enacted, we would be looking at additional costs into the millions across our 30 facilities'.¹⁵²
- 4.3** In discussing the views of the NSW Health Steering Committee, Ms Leanne O'Shannessy, Director, Legal and Regulatory Services, NSW Ministry of Health, acknowledged the economic impact if the legislative requirement were to be extended, stating: '... I think there may be some financial issues, particularly if there was a view to extend them to low-care facilities. That would become a big cost issue.'¹⁵³
- 4.4** Mission Australia highlighted the challenge for not-for-profit aged care providers in particular, questioning how costs could possibly be met by such facilities without impacting on the quality of care provided to residents:

... in the event that the Government seeks to move ahead with a mandated level of nursing care, we would also respectfully ask what measure the Government will put in place to fund the new positions in not-for-profit aged care services working to support the most vulnerable groups? There is no means to recover this cost from our

¹⁵⁰ Submission 100, Name suppressed, p 2.

¹⁵¹ Submission 101, Wesley Mission, p 4.

¹⁵² Submission 151, Name suppressed, p 2.

¹⁵³ Evidence, Ms Leanne O'Shannessy, Director, Legal and Regulatory Services, NSW Ministry of Health, 5 August 2015, p 10.

residents without impacting on their standard of living and wellbeing, which would defeat the purpose of putting RNs in services in the first place.¹⁵⁴

- 4.5** Other aged care providers argued that the only outcome of extending s 104 to all aged care facilities would be a financial burden, rather than an improvement in the standard of care for residents. For example, Presbyterian Aged Care NSW & ACT stated:

Should the legislative burden to have RNs in every facility 24/7 be extended to cover all residential aged care services, PAC [Presbyterian Aged Care] will face being non-compliant with legislation and have huge financial burdens with no improvements in the quality of care.¹⁵⁵

- 4.6** Mission Australia expressed a similar view, arguing that ‘mandating that aged care services have an RN on site 24 hours a day would not improve the outcomes for our residents, but it would add a cost of around \$350,000, per service, per year.’¹⁵⁶

- 4.7** The question of whether continuous registered nursing coverage improves the standard of care for aged care residents was considered in chapter 3.

- 4.8** Some inquiry participants cautioned about the potential closure of facilities as a result of extending the legislative provision. For example, Aged & Community Services NSW & ACT told the committee:

It is feared that if this requirement is expanded to include all services that have any residents assessed under the funding instrument as requiring a higher level of care that many of the formerly low care services would not be able to remain financially viable and would subsequently close.¹⁵⁷

- 4.9** This point was reiterated by Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, who asserted that the number of residential aged care places would potentially be in jeopardy:

If we attempt to extend a 24/7 RN requirement into a low-care facility there will be problems. We have crunched some of those numbers and we are looking at losing 10 per cent or 6,000 of our beds. Already 60 facilities are saying that they will have to close because they cannot cope.¹⁵⁸

- 4.10** Christophorus House Retirement Village remarked: ‘To impose a 24/7 RN, regardless of needs, would be to see valuable resources to the community close’.¹⁵⁹ The organisation applied this statement to itself:

¹⁵⁴ Submission 91, Mission Australia, p 1.

¹⁵⁵ Submission 82, Presbyterian Aged Care NSW & ACT, p 2.

¹⁵⁶ Submission 91, Mission Australia, p 1.

¹⁵⁷ Submission 113, Aged & Community Services NSW & ACT, p 8.

¹⁵⁸ Evidence, Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, 5 August 2015, p 38.

¹⁵⁹ Submission 76, Christophorus House Retirement Village, p 3.

To require a facility such as CHRV (a small bed facility) to change its operational model to a 24/7 RN situation is cost prohibitive. Additional cost import would be in the order of over \$300,000. For a facility that currently loses \$250,000 per annum this additional cost import would be unsustainable and force the closure of the facility.¹⁶⁰

- 4.11** McLean Care stated that if providers could not find the means to cover costs, through subsidies or otherwise, ‘the financial viability and sustainability of aged care providers will be eroded, facilities will close and hospitals will become the new residential aged care providers’.¹⁶¹

Rural, regional and remote facilities

- 4.12** Inquiry participants were particularly concerned about the sustainability and viability of rural, regional and remote aged care facilities if s 104 of the *Public Health Act* was extended. Wesley Mission told the committee:

The introduction of such a requirement at the present time would threaten the operational viability of many providers, particularly facilities in rural and regional areas, where the resident needs were not sufficient to attract higher ACFI [aged care funding instrument], or the built environment was not suitable for complex clinical needs.¹⁶²

- 4.13** Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW-ACT, similarly drew attention to the impact of extending the legislative requirement to smaller rural, regional and remote aged care facilities that were classified as low care under the former system:

... that would call service delivery significantly into question for a range of facilities in that historical low-care group ... a couple of hundred services are not subject to this regulation and a blunt instrument may change that ... If there were a requirement to have registered nurses in services where they are not now required that would disturb the viability of a range of service providers. They would be predominantly the smaller rural and regional and more remote services.¹⁶³

- 4.14** Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, while calling for the legislative requirement to be retained, acknowledged that smaller facilities in rural and remote areas would be ‘crippled’ if they had to provide a registered nurse at all times:

There is no question that this will cause financial stress to aged-care providers, particularly to smaller providers who may be in rural areas ... I think the financial stress will be the major problem, particularly for standalone homes that might have, say, 30 or 40 residents and those residents do not have as higher care needs as perhaps some of the others ... I am thinking of a number of small homes with 20 or even fewer residents that are providing a wonderful service. Under the current

¹⁶⁰ Submission 76, Christophorus House Retirement Village, p 2.

¹⁶¹ Submission 67, McLean Care, p 10.

¹⁶² Submission 101, Wesley Mission, p 4.

¹⁶³ Evidence, Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW-ACT, 5 August 2015, pp 36-37.

arrangements they would be crippled if they had to provide RN care round the clock¹⁶⁴

4.15 Aged care providers gave specific examples of their own facilities in discussing the impact of an extension of the legislative requirement to all facilities. For example, Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, a small facility in the Northern Tablelands that was classified as low care under the former system, stated: ‘Sunhaven does not require a permanent 24-hour RN. If this becomes a requirement then Sunhaven and all other small, rural and remote facilities will close their doors’.¹⁶⁵

4.16 McLean Care said that its Beresford Coward and Arrawatta Centres in the north-west of the state that would also have to close, amongst other impacts, as a result of an extension to s 104:

McLean Care will be unable to financially sustain RN 24/7 in Beresford Coward and Arrawatta Centres. This will mean:

1. Closure of the Beresford Coward and Arrawatta areas and relocate 63 residents to other facilities around the region or to hospital environments
2. The creation of a chasm between supply and demand for residential aged care with local hospitals having to provide additional aged care services where supply cannot meet the demand
3. Potential financial impact on McLean Care and its future viability and sustainability...¹⁶⁶

4.17 In contrast, a number of inquiry participants acknowledged the challenges for rural and remote facilities in meeting the legislative requirement if extended, but maintained that their geographical location was all the more reason to mandate a minimum standard of care. For example, Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, contended that the need for registered nurses is greater in rural and remote New South Wales because residents already have limited access to doctors and other health care professionals:

Older people are older people in rural or metropolitan areas. I have worked in both metropolitan and rural areas. Usually it is in the rural areas where we need the registered nurses ... From working in the rural areas, we need the registered nurses in the aged-care facilities because often there is not a doctor. It is difficult to get a doctor; they are not there. The registered nurse is integral to providing that quality care in those facilities.¹⁶⁷

¹⁶⁴ Evidence, Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, 14 August 2015, p 18.

¹⁶⁵ Evidence, Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, 10 August 2015, p 2.

¹⁶⁶ Submission 67, McLean Care, p 8.

¹⁶⁷ Evidence, Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, 10 August 2015, p 20.

- 4.18** The same point was echoed by Professor Peter Gonski, President, Australian and New Zealand Society for Geriatric Medicine, NSW Division, who noted that residents in rural areas often find it difficult to get a quick response from other medical services, including general practitioners.¹⁶⁸
- 4.19** Similarly, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association, commented that mandating registered nursing coverage ‘is particularly important in regional areas because there is limited access to GPs particularly at night and on weekends ... So, if anything, there is a greater need to have a registered nurse in those facilities at all times in the interests of the health and safety of their residents.’¹⁶⁹
- 4.20** Mr Brett Holmes, General Secretary, NSW Nurses and Midwives Association argued that aged care residents should have access to the same standard of care, through a registered nurse, across all areas of the state:
- ... there needs to be a reasoned decision making process as to how you can make those services deliver quality care and ensure that people who live in regional New South Wales are entitled to the same standard and quality of care as those people who have the benefit of living in larger centres.¹⁷⁰
- 4.21** Some inquiry participants pointed out that there are already a number of rural and remote facilities complying with the legislative requirement for residents both with high as well as low care needs. For instance, evidence was provided by Ms Crowe of small aged care facilities in regional New South Wales that house low and/or high care residents that have a registered nurse on duty at all times, such as one in Singleton with only low care residents.¹⁷¹ Ms Crowe cited further examples of small facilities in townships in Victoria, Western Australia and South Australia that have a 24 hour registered nurse, most with high care residents but one with predominantly low care residents.¹⁷²

Potential displacement from local community

- 4.22** A related issue to the viability of rural and remote facilities if the legislation was extended is the importance of residents staying in their communities and the adverse impacts on their health and wellbeing if they are forced to move away to receive the care they need. For example, Dr Bernoth said that older people, particularly in rural areas, often pass away when they are moved from familiar surrounds:

¹⁶⁸ Evidence, Professor Peter Gonski, President, Australian and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, p 41.

¹⁶⁹ Evidence, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association of NSW, 10 August 2015, p 32.

¹⁷⁰ Evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives’ Association, 5 August 2015, p 50.

¹⁷¹ Answers to questions on notice, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association of NSW, 31 August 2015, p 2, quoting information from the Aged Care Guide website, accessed August 2015.

¹⁷² Answers to questions on notice, Ms Crowe, pp 2-3, quoting information from the Aged Care Guide website, accessed August 2015.

... when you move older people from their areas they die, we actually found that. We spoke to rural communities around New South Wales and we found ... that older people find place important, especially rural older people ... Older people want to age where they have lived, especially farmers who have a real affinity with the land. So we certainly need to provide aged care appropriate to what rural people prefer, want and need and we certainly need to keep them in those rural areas.¹⁷³

- 4.23** Ms Halliday similarly reflected on the devastating dislocation that residents feel if they are forced to move away from their community, using Sunhaven Hostel as an example:

[Sunhaven] is part of the community and those people would otherwise have to go to Toowoomba. You would never see them again; you would be sending them off to die. It would be horrible to cause that kind of dislocation from their community and their loved ones. That is the real nub of this problem. For the rural and remote communities those are the only facilities for aged care.¹⁷⁴

- 4.24** Ms Thompson echoed this view, describing the close-knit community of Ashford and what it means for its older people to age in place. She insisted that if her residents were to be moved, there would be a drastic deterioration in their condition:

... out where we are the community is very close and people have their families, their friends ... all within this area. Now you take them 60, 80, 100, 200 kilometres away and I can assure you that their overall holistic care will deteriorate drastically, not because of the physical care that they are given but by the emotional upheaval that they will experience.¹⁷⁵

- 4.25** Mr Phillip Carter, Chief Executive Officer, St Andrew's Village Ballina, questioned the pursuit of registered nurses if it meant that residents would be displaced because of facility closures, arguing: 'Should facilities close in small communities, people will have to find accommodation in larger towns. Being displaced from their loved ones is not what I call quality of care or thinking of your fellow human beings.'¹⁷⁶

- 4.26** A number of inquiry participants noted that, at present, residents and their families have a choice to stay in their communities because there are local facilities available to provide the care they need, which may not always include continuous onsite registered nursing care.

- 4.27** Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, gave the example of Bonalbo to demonstrate that people would rather stay locally, even if there is not a registered nurse on duty at all times:

You can see the example in our submission, which refers to Bonalbo. There is a choice of either going to the 15 bed facility, which has RN input, but not 24/7 on site. Alternatively, you can go 69 kilometres down the road to a larger facility. Those 15 residents, 13 of whom are high care, and their families are very happy with the situation and they want to stay there. They make those choices.¹⁷⁷

¹⁷³ Evidence, Dr Bernoth, p 20.

¹⁷⁴ Evidence, Ms Halliday, 5 August 2015, p 44.

¹⁷⁵ Evidence, Ms Thompson, p 5.

¹⁷⁶ Evidence, Mr Phillip Carter, Chief Executive Officer, St Andrew's Village Ballina, 14 August 2015, p 2.

¹⁷⁷ Evidence, Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, 14 August 2015, p 13.

- 4.28** Mr Teulan emphasised that people in rural and remote communities understand the circumstances they are in and make measured decisions with these in mind. He acknowledged that there is often little choice in aged care within regional communities but pointed out that if some of the few facilities are forced to close, there will be no choice at all for the residents of that community: ‘First, if it is proposed that there be a 24/7 RN on site for every high-care classified resident, you are right, they will not have any choice. Secondly, people in rural areas understand their opportunities, the staffing and their options, and they will exercise them’.¹⁷⁸
- 4.29** Christophorous House Retirement Village expressed a similar view, declaring that ‘the closure of small facilities ... is an anathema against the ‘right of individual choice’ as outlined in the Act’.¹⁷⁹

Cost of providing continuous registered nursing care

- 4.30** Many aged care providers attributed the threat of closure to simply being unable to afford staff if registered nurses were to be required on all shifts, with Ms Halliday calling it ‘an impossible situation’.¹⁸⁰
- 4.31** One aged care provider estimated that an extension of the legislative requirement to all facilities would see an annual increase in its staff of 6,650 hours ‘or an annual expense of \$380,000’.¹⁸¹
- 4.32** Another not-for-profit provider indicated similar increases in staffing and costs, advising that for its facility in the Southern Highlands, which services the needs of an entire shire of approximately 366 people over the age of 70 years, an extension of the legislative requirement would mean an increase of 138 registered nursing hours per week which would amount to a \$426,000 increase per annum. The provider commented on the difficulty in finding both the staff and the funds to meet this increase:
- The difficulty in securing RNs in this location together with the cost would challenge [the provider] to reconsider the viability of operating this facility. Our withdrawal would not only leave this regional town with inadequate beds, but it would also mean the loss of 27 jobs.¹⁸²
- 4.33** The issue of the shortage of registered nurses is considered in more detail at the end of this chapter.
- 4.34** The provider further stated that its central west facility, a major employer in the town, would need to increase registered nursing hours by 138 hours per week, equating to a \$426,000 increase in costs. It informed the committee that it would be forced to consider also closing this facility and other smaller facilities like it would not be able to comply with the legislation.¹⁸³

¹⁷⁸ Evidence, Mr Teulan, p 13.

¹⁷⁹ Submission 76, Christophorous House Retirement Village, p 2.

¹⁸⁰ Evidence, Ms Halliday, p 38.

¹⁸¹ Submission 100, Name suppressed, p 2.

¹⁸² Submission 151, Name suppressed, p 3.

¹⁸³ Submission 151, Name suppressed, p 3.

- 4.35** St Andrew’s Village Ballina discussed the significant financial impact on a similarly small facility if it were required to provide constant registered nursing care: ‘[For a] ‘small 47 bed facility such as Timbreebongie House Aged Care Narromine, this could be as much as \$400,000 per year. Small facilities in the Far North Coast will be affected financially in the same way.’¹⁸⁴
- 4.36** Other stakeholders discussed the costs of flying agency staff in if there were not enough registered nurses to cover all shifts. For example, Ms Halliday advised this practice was already being undertaken by some providers but at a substantial cost:
- ... even when they want an RN – or some of them have got a high-care end so they would have an RN on duty if they could get one – they fly agency staff in. McLean at Inverell, for instance, has got the figures there showing you how it has cost them nearly \$500,000 a year to try to get the agency coverage when they cannot cover the shifts because they have not got the numbers of staff.¹⁸⁵
- 4.37** Ms Thompson said that her facility, along with many smaller rural and remote facilities, simply could not afford the option of flying nursing staff in: ‘We are too far to access agency nurses and even so it would be an expense that Sunhaven could not afford ... The costs of sourcing agency nurses would be well beyond the facility’s financial capability.’¹⁸⁶
- 4.38** Ms Thompson explained what an extension of the legislative requirement would mean in practical and financial terms for her facility if they were to access agency staff from other locations:
- ... taking costings into account, you have to understand that if we have to access RNs 24/7, they are going to have to be brought in from agencies. We cannot get them locally. We have one local RN. That would mean they would have to fly to Armidale, Tamworth or Toowoomba from Sydney, which is more than three to four hours away from us. We would have to supply them with vehicles to get here. They would come here and work. We would have to offer them overnight accommodation, which we do not have – we do not have a local pub anymore – and then we would have to fly them to their return.¹⁸⁷
- 4.39** However, some other inquiry participants challenged the financial concerns expressed by smaller facilities, stating that there is substantial Government funding available to eligible facilities. Mr Holmes, for instance, contended that smaller isolated facilities would get considerable government funding because of their circumstances: ‘... we know on average an aged-care resident in those facilities can get government funding of up to \$50,000-\$60,000 a year. There is a considerable amount of Commonwealth funding going into those facilities and they get extra support because they are isolated facilities working in difficult circumstances.’¹⁸⁸

¹⁸⁴ Submission 39, St Andrew’s Village Ballina, p 1.

¹⁸⁵ Evidence, Ms Halliday, p 39.

¹⁸⁶ Evidence, Ms Thompson, p 2.

¹⁸⁷ Evidence, Ms Thompson, p 4.

¹⁸⁸ Evidence, Mr Holmes, p 50.

- 4.40 Dr Bernoth also questioned the figures and presumption of closures being suggested by some aged care providers, stating: ‘... I would say that the assessment that they would need to close is subjective; we have not got figures ... All we have got is their word about that.’¹⁸⁹

Committee comment

- 4.41 The committee acknowledges that there would be significant financial implications for aged care facilities that were classified as low care under the former system, particularly those in rural and remote areas, if s 104 of the *Public Health Act* was expanded to all facilities. The committee notes the concerns about the viability of these facilities, including the fears that many of them may be forced to close, and acknowledges the impact this would have on residents who may then be displaced from their community.
- 4.42 We agree that residents in all aged care facilities deserve access to quality care, regardless of location, and note that certain small facilities in rural and regional areas already provide around-the-clock registered nursing care to low care residents. However, the committee believes that patients and their families should be provided with a clear outline of the staffing allocations, including if registered nurses are provided 24/7, both before they enter the facility and while they are residing there. This is discussed in further detail with a recommendation in chapter 6.
- 4.43 As will be seen in chapter 6, the committee does not intend for s 104 to be expanded to all aged care facilities. However, the committee’s recommendations in that chapter do involve some extension of the legislative requirement to more facilities than are currently captured by the provision. The committee has therefore also recommended in that chapter that there be limited exemptions, which can be applied for on a case-by-case basis, for aged care facilities that can demonstrate that they can still provide a high level of quality care (see recommendation 8).

Cost shifting to public health system

- 4.44 Another point argued during the inquiry is that it is crucial to have a registered nurse on duty to respond to critical incidents and reduce unnecessary admissions to hospital. As discussed in chapter 3, numerous inquiry participants asserted that registered nurses are the most suitable staff within aged care facilities to clinically assess a resident’s health status and make informed decisions regarding whether the resident should be transferred to hospital.¹⁹⁰
- 4.45 Inquiry participants, such as Dr Bernoth acknowledged that ‘[a]nyone who is ill has a right to an acute care bed and if there is nowhere else for them to be cared for, then they have a right to that bed.’¹⁹¹ However, there was concern that there are residents of aged care facilities unnecessarily occupying hospital beds, or ‘bed blocking’, and that this is placing increasing

¹⁸⁹ Evidence, Dr Bernoth, p 25.

¹⁹⁰ See also Submission 52, Name suppressed, p 2; Submission 59, Name suppressed, p 1; Submission 61, Name suppressed, p 1; Evidence, Ms Joanne Russell, Nurse Practitioner, Aged Care, NSW Nurses and Midwives’ Association, 5 August 2015, p 48; Submission 124, Name suppressed, p 4.

¹⁹¹ Evidence, Dr Bernoth, p 18.

financial pressure on the public health care system. It was also argued that unnecessary admissions can unduly impact on the health of a frail older person.¹⁹²

- 4.46** The ability of registered nurses to prevent unnecessary hospital transfers was raised by Professor Colleen Cartwright, Principal Director and Chief Executive Officer, Cartwright Consulting Australia, who noted that: ‘Crisis events by their very nature are unpredictable. If there is no RN on duty the enrolled nurse or assistant in nursing on duty may have no option but to send the person to hospital.’¹⁹³
- 4.47** This was reflected by Dr Esther Kok, Member, Royal Australian College of General Practitioners, who commented that registered nurses are qualified to assess residents’ health status in an emergency, whereas an enrolled nurse or care worker may be more inclined to ‘panic’ and call for an ambulance.¹⁹⁴
- 4.48** This argument was supported by information presented by the NSW Nurses and Midwives’ Association, referencing studies which found that between 8 to 44 per cent of presentations to emergency departments from residential aged care facilities are unnecessary and could be managed by a registered nurse.¹⁹⁵
- 4.49** Dr Marie Healy, a general practitioner and former registered nurse, contended that repealing the requirement for a registered nurse to be on duty at all times in nursing homes would be a ‘short-sighted’ economic decision that would result in increased hospital transfers:

The push to reduce registered nurse (RN) cover is an economic one, but is short-sighted. Transfers to hospital are more likely when staff are not qualified to assess or treat unwell residents, or to arrange timely review by a GP or other specialised service.¹⁹⁶

- 4.50** Furthermore, chapter 4 outlined how the transfer of patients to hospitals should be prevented, where possible, as transferring patients, particularly with dementia, can accelerate their decline.
- 4.51** One registered nurse who has worked in aged care for 13 years similarly argued that the consequences of removing registered nurses from aged care facilities could include ‘... an increased burden on ambulance service, significantly higher presentation rates to local hospital emergency departments, [and] increases in hospital admissions...’.¹⁹⁷ Alzheimer’s Australia NSW expressed concern that this issue would be exacerbated by the increasing acuity and complex care needs of residents:

¹⁹² See for example, Evidence, Ms Linda Kelly, Councillor, Leichhardt Municipal Council, 5 August 2015, p 64; Submission 37, Ms Marie Scholes, p 1; Submission 62, Name suppressed, p 1.

¹⁹³ Evidence, Professor Colleen Cartwright, Principal Director and Chief Executive Officer, Cartwright Consulting Australia, 14 August 2015, p 40.

¹⁹⁴ Evidence, Dr Esther Kok, Member, Royal Australian College of General Practitioners, 14 August 2015, p 27.

¹⁹⁵ Submission 87, NSW Nurses and Midwives Association, p 10.

¹⁹⁶ Submission 58, Dr Marie Healy, p 1.

¹⁹⁷ Submission 69, Name suppressed, p 2. Also see Submission 140, Name suppressed, p 1; Submission 35, Name suppressed, p 1; Submission 131, Dr Charles Ovadia, p 1; Submission 137, Dr Con Costa, p 3 and p 5; Submission 107, National Seniors Australia, p 1.

Combining the increasing acuity and complex care needs with decreased registered nursing staff on duty in aged care facilities is likely to have an impact on the health and hospital system in NSW. A pattern of missed clinical issues that if picked up earlier could have been managed in the facility with primary care support, will likely result in increased ambulance call outs and admissions to Emergency Departments and wards in NSW hospitals.¹⁹⁸

4.52 Inquiry participants also suggested that having registered nurses in aged care facilities minimises cost shifting to the public health care system outside of crisis situations. For example, as registered nurses liaise with other medical professionals (particularly general practitioners) it was suggested that they minimise the demand for these doctors to attend the facilities.¹⁹⁹

4.53 In addition, the committee received evidence that having a registered nurse on duty provides greater opportunity for residents to return to their aged care facility from the hospital.²⁰⁰ National Seniors Australia expressed concern that removing the legislative requirement would result in people having to stay in hospital for longer:

There will also be prolonged acute hospital stays as elderly patients are not able to be discharged back to an aged care facility if registered nurses are not available to provide skilled, clinical care and management to aged care residents with complex high care needs.²⁰¹

4.54 On the other hand, some stakeholders pointed out that inappropriate hospital admissions occur now, even with registered nurses being required under current legislation. For example, Ms Halliday acknowledged this particularly in the context of broader systemic issues within the public health system:

We must avoid inappropriate admissions to hospital. We agree with that; in fact, it is happening now with or without nurses being on duty 24 hours a day. We know that happens sometimes, just as sometimes people are referred to hospital and are sent back without having received the care they need. There are some problems in the system that we must fix, and we want to work with NSW Health to do that.²⁰²

4.55 Another argument, raised by Mr Carter was that if s 104 is expanded to all facilities and providers are required to employ additional registered nurses, many facilities may be forced to close (as discussed earlier) which will result in an increased number of older people presenting to public hospitals, especially in rural and regional areas:

¹⁹⁸ Submission 96, Alzheimer's Australia NSW, p 2.

¹⁹⁹ Submission 69, Name suppressed, p 1. Also see Submission 87, NSW Nurses and Midwives Association, p 10.

²⁰⁰ See for example, Submission 109, Australian College of Nursing, p 6; Evidence, Dr Lyndal Newton, Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, p 39; Evidence, Ms Imelda Gilmore, Carer and Dementia Advocate, Alzheimer's Australia, 10 August 2015, pp 8-9.

²⁰¹ Submission 107, National Seniors Australia, p 2. Also see Submission 110, Council on the Ageing NSW, p 5.

²⁰² Evidence, Ms Halliday, p 38.

Care providers will have to find ways to reduce costs, or close facilities. Facilities will close down and leave the communities in those towns worse off ... There will be an influx of residents placed in hospitals so as to meet accreditation standards, which will be a cost to the public health system in New South Wales.²⁰³

- 4.56** This was supported by McLean Care which argued that ‘... if all residential services were required to have RN 24/7, there would be a disproportionate increase in the rate of unnecessary hospital admissions due to residential care closures and RN 24/7 non-compliance.’²⁰⁴ The committee also heard from at least two aged care providers that they would consider transferring high care residents in their low care facilities to hospitals to avoid not complying with the requirement if it was introduced.²⁰⁵

Data collection

- 4.57** The committee was informed that there is no detailed data to determine the extent of cost shifting from residential aged care facilities to New South Wales public hospitals. Mr Luke Worth, Director, System Relationships, NSW Ministry of Health, stated that while NSW Health has raw data on the number of ambulance transfers from a residential aged-care facility to an emergency department, the data is not analysed to determine the reasons for each transfer.²⁰⁶ NSW Health told the committee:

Data on the transfer of patients is collected and categorised for the purposes of clinical care and patient need. It does not ... categorise or retain information on whether the transfer was for an aged care facilities, another hospital, hostel, residence or other care setting.²⁰⁷

- 4.58** Mr Worth advised that the only way to determine the level of cost shifting would be to ‘to go through the individual clinical notes for each person who comes through.’²⁰⁸ He noted that there are currently different data systems for integrated care and state-funded health services, and acknowledged this as an issue that NSW Health is trying to resolve:

... one of the issues we are trying to overcome and one of the barriers we are working very hard on overcoming, and when we talk about integrated care - there is information within the system for residential aged care, the general practitioners and the type of systems they use, and then there are the systems we use in the State-funded health services through our admitted patients and our ED [Emergency Department] data and all of that. One thing we are working on very hard at the moment is how to bring those two systems, which are completely funded differently, completely monitored differently and have completely different data sets, so that we can look at how you can seamlessly start to flow those patients from one to the other.²⁰⁹

²⁰³ Evidence, Mr Carter, p 2.

²⁰⁴ Submission 67, McLean Care, p 10.

²⁰⁵ Submission 82, Presbyterian Aged Care NSW & ACT, p 3; Submission 151, Name suppressed, p 3.

²⁰⁶ Evidence, Mr Luke Worth, Director, System Relationships, NSW Ministry of Health, 5 August 2015, p 11.

²⁰⁷ Answers to questions on notice, NSW Health, 8 September 2015, p 10.

²⁰⁸ Evidence, Mr Worth, p 11.

²⁰⁹ Evidence, Mr Worth, p 12.

- 4.59** Mr Wurf expressed the view that ‘it would be instructive’ to have data to monitor cost shifting between residential aged care facilities and hospitals, but cautioned that the analysis of such data was critical in order to distinguish between necessary and unnecessary transfers:

The decision for transfer to hospital can be for a whole range of legitimate causes. It can be assessed by registered nurse or doctor; it can be in response to a critical event – as I said earlier, a fall or an increase in acuities in some persons.²¹⁰

Advance care directives

- 4.60** Another issue related to the transfer of residents from nursing homes to hospitals concerns advance care directives. Some inquiry participants highlighted the value of advance care directives but raised concerns that such directives are not being transferred with residents or complied with by hospital staff upon their transfer.

- 4.61** For example, Professor Cartwright highlighted the importance of advance care plans in allowing greater ability to determine how best to meet the resident’s needs during their end of life stage:

I come back to advance care planning. I come back to the fact that if you get your planning done well in advance you can pretty much predict what the trajectory is going to be for this person in their last weeks or months of life. You should not need to call a GP in an emergency because you should have had family conferences and planning sessions to say that if this happens then this. You should have had the appropriate medication and other things already prescribed and in the patient’s locker or chart to be ready for such an emergency.²¹¹

- 4.62** Alzheimer’s Australia also acknowledged the importance of advance care directives in relation to providing good palliative care in residential aged care facilities and reducing unnecessary hospital transfers, particularly for residents with dementia for whom ‘hospitals are not good places ... to go’ (as discussed in chapter 3 at 3.29 - 3.30).²¹²

- 4.63** According to an Australian Institute of Health and Welfare report, end of life care of residents with dementia in residential aged care settings has been ‘inadequate’ over the last decade, however, advance care planning has significantly improved the quality of care for these residents in recent years. The report referred to an Australian study across two hospitals and 21 residential aged care facilities which showed that advance care directives had significantly decreased the rate of hospital admissions.²¹³

- 4.64** The committee heard that unfortunately advance care plans are often not being transferred with residents when they are moved from an aged care facility into a hospital. For example, Dr Kok argued that the practice of transferring plans with residents from facilities to hospitals is ‘patchy’ as plans are often lost:

²¹⁰ Evidence, Mr Wurf, p 34.

²¹¹ Evidence, Professor Cartwright, p 42.

²¹² Submission 96, Alzheimer’s Australia, p 1.

²¹³ Submission 97, Alzheimer’s Australia, p 2, quoting the Australian Institute of Health and Welfare, *Dementia care in hospitals: costs and strategies*, 2013, pp 67-68.

The plans are not transferred very often. Staff are so concerned about transferring medication sheets, getting the patient ready and contacting relatives that the care plan sometimes gets lost in the flurry. If there is a written order from the general practitioner that a care plan should be completed and transferred with a patient then it might be done. Currently the practice is patchy, to say the least.²¹⁴

- 4.65** Alzheimer's Australia agreed that aged care directives often do not follow residents from aged care facilities into hospitals. The organisation contended that numerous people are subsequently subjected to unwanted and unnecessary interventions as a result:

Often the ACP [Advanced Care Plan] does not go with the resident should they be admitted to hospital and costly and unwanted interventions are provided unnecessarily, sometimes without consent thereby constituting assault of people with dementia by NSW Health staff.²¹⁵

- 4.66** Others argued that even when a plan is taken with a resident to a hospital, hospital staff may not accept or comply with the resident's directive. Dr Guan Yeo, Chair, New South Wales and Australian Capital Territory Faculty, Royal Australian College of General Practitioners, for example, told the committee that in many cases emergency department staff do not accept the plans:

I think there is also the additional problem that even if it is transferred whether in fact the emergency department staff will consider that acceptable for them to apply. There have been many cases that I have heard of where in fact they would not accept it.²¹⁶

- 4.67** Professor Cartwright shared a similar view, claiming that residents often receive 'unwanted invasive treatments' that result in corresponding costs being shifted to the public health system, despite their care plans stating otherwise:

Many people ask not to be taken to hospital at the end of life. If they are, they often get on to the treadmill because of fears of what if we miss something and we get sued. They often receive both unwanted and/or unwarranted invasive treatments with corresponding costs to the State healthcare system and to the person themselves.²¹⁷

- 4.68** To address these concerns, Dr Kok suggested that a legislative framework for advance care directives would be helpful in protecting and assisting clinicians to make judgements about a resident's care at the end stage of their life.²¹⁸

Committee comment

- 4.69** The committee acknowledges that registered nurses in aged care facilities play a key role in minimising unnecessary transfers to hospital as they are able to clinically assess a deteriorating resident to determine the most appropriate course of action. The committee understands that unnecessary hospital transfers from aged care facilities already have significant cost

²¹⁴ Evidence, Dr Kok, 14 August 2015, p 28.

²¹⁵ Submission 96, Alzheimer's Australia, pp 3-4.

²¹⁶ Evidence, Dr Guan Yeo, Chair, New South Wales and Australian Capital Territory Faculty, Royal Australian College of General Practitioners, 14 August 2015, p 28.

²¹⁷ Evidence, Professor Cartwright, p 42.

²¹⁸ Evidence, Dr Kok, 14 August 2015, p 29.

implications for the New South Wales public health care system, and as residents' care needs become increasingly complex, any action that may increase this burden is undesirable.

- 4.70** The committee notes the concerns that requiring a registered nurse in all aged care facilities would increase pressure on the public health care system as facilities may close or refuse to accept high care residents. However, the committee hopes that the recommendations in chapter 6 will go some way toward addressing this issue and alleviating these concerns.
- 4.71** The committee is concerned about the lack of available data regarding the transfer of residents from aged care facilities to emergency departments. The committee acknowledges that NSW Health is trying to resolve this issue, and urges the government to make this a priority. The committee further recommends that this information be provided in NSW Health annual reports in order to identify if further assistance or action is required.

Recommendation 1

That the NSW Government:

- establish a consistent and compatible collection and analysis of data regarding the transfer of residents from aged care facilities to emergency departments, including reasons for admissions, to determine if this represents a cost shifting, and
- that this information be provided in NSW Health annual reports to identify if further action is required.

-
- 4.72** The committee also acknowledges the value of advance care directives in ensuring that residents are cared for and treated according to their wishes at the end stage of their life. The committee is therefore concerned by the evidence that these directives are not being moved with residents, and in some cases not being complied with, when they are transferred from a residential aged care facility to a hospital. The committee believes that stringent processes are needed to ensure that advance care directives are acknowledged and respected by both aged care providers and hospitals, and therefore recommends that the NSW Government review its requirements for aged care directives when residents are transferred from aged care facilities to hospitals.

Recommendation 2

That the NSW Government review the requirements for Advance Care Directives to be recognised when residents are transferred from aged care facilities to hospitals, and determine whether a legislative framework is required.

Misallocation of resources

- 4.73** A number of aged care providers contended that there would be a gross misallocation of resources in aged care facilities across New South Wales if s 104 was to be retained and expanded to apply to all facilities regardless of the resident mix.

4.74 Mr Wurf, for example, stated that the current state legislative requirement is ‘an incredibly blunt instrument’ that will misallocate resources within a Commonwealth system that was designed to be flexible and non-prescriptive:

... it would be a misallocation of scarce critical clinical resources when the system is designed increasingly to assess the care needs of an individual and make sure that the proper mix of skilled staff are devoted to ensuring the best care for an individual.²¹⁹

4.75 Concerns were raised that mandating the employment of registered nurses would come at the cost of other aged care staff with different but important skills, to the detriment of residents. For example, one aged care provider stated: ‘To fund required RNs we would consider removing other staff including Lifestyle Co-ordinators and Pastoral Care workers that will impact on the overall quality of life care our residents enjoy today.’²²⁰

4.76 Similarly, Mission Australia submitted that should it need to replace its ‘personal care assistants’ with registered nurses there may not be any benefits to residents’ wellbeing:

In our assessment, it is difficult to see the benefits of having an RN on staff 24 hours a day if that funding had to be diverted from a Personal Care Assistant (PCA) who has been trained to assist with daily living activities, for example, or in some cases a physiotherapist or occupational therapist. When assessing the value of different services with limited funding, it is our strong view that we should favour those services that will have greatest impact on resident’s wellbeing.²²¹

4.77 Mr Carter insisted that extending the requirement would in fact compromise care rather than ensure it as new registered nurse positions would come at the cost of other aged care staff:

Registered nurses will take care staff positions. This is what we believe can happen because people will try to meet the bottom line. Therefore, two or 2½ care staff may be taken to appoint an RN. You are looking at a difference between \$20 an hour to probably somewhere around \$40 plus an hour. So you have to look at it realistically. The quality of care will not be better because of this move ... Do we have to go to the extra expense of having to cut care staff to put an RN in? It is not the RN’s fault but if we cut the staff to do this it is going to compromise care to the person because now people are struggling with regard to meeting the care needs of people.²²²

Committee comment

4.78 The committee is deeply concerned by the submissions received stating that existing aged care staff may be cut as a result of extending the application of s 104 of the *Public Health Act* to all aged care facilities.

4.79 The committee acknowledges the concerns regarding a misallocation of resources – that is, that registered nurses would replace aged care staff to the detriment of residents – if s 104 of the *Public Health Act* was expanded to apply to all aged care facilities.

²¹⁹ Evidence, Mr Wurf, p 36.

²²⁰ Submission 151 Name suppressed, p 3.

²²¹ Submission 91, Mission Australia, p 2.

²²² Evidence, Mr Carter, p 2 and p 4.

- 4.80** As previously discussed, the committee does not intend for the legislative requirement to encompass all facilities. The committee's proposed amendments to the provision are discussed in more detail in chapter 6.

Shortage of registered nurses

- 4.81** A number of inquiry participants noted that even if cost was not an issue, there is a critical shortage of registered nurses, particularly in rural and remote areas.

- 4.82** One aged care provider contended that an extension of the legislative requirement would be 'impossible to achieve as there are not enough RNs to sustain this'.²²³ The provider commented on the difficulties in recruiting registered nurses under the current system, let alone under a system that required significantly more nurses:

We, like all aged care providers, struggle to secure the RNs we need to operate our business today. In NSW, it takes on average 7-8 weeks to fill an RN vacancy. Given the shortage of RNs, finding a further 2,000 to work in aged care is not going to be possible. Furthermore, competition between for-profit and not-for-profit will intensify as we find over this limited resource.²²⁴

- 4.83** McLean Care also drew attention to the shortage of registered nurses in New South Wales, arguing that if the legislative requirement was expanded to all aged care facilities it 'will necessitate the utilisation of agency staffing which is also not an infinite resource'.²²⁵

- 4.84** Another aged care provider said that its facility is in 'a small rural town of approximately 8,500 people, and while not considered remote would struggle to provide 5 professional staff to fill this void created'.²²⁶

- 4.85** Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW & ACT, said that even in Sydney it is difficult to find registered nurses who are available living locally.²²⁷

- 4.86** Moreover, inquiry participants raised concerns that if the legislative provision were extended to all aged care facilities, many facilities in these communities would be forced to close as they would be unable to comply with the legislation. As put by Ms Halliday: 'When you look at the rural and remote areas, I do not know that we can find them. That is why we are talking about closures. The RNs [registered nurses] are not there. We have people overseas trying to recruit RNs. They are just not available in those locations'.²²⁸

²²³ Submission 151, Name suppressed, p 2.

²²⁴ Submission 151, Name suppressed, p 2.

²²⁵ Submission 67, McLean Care, p 7.

²²⁶ Submission 100, Name suppressed, p 2.

²²⁷ Evidence, Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW & ACT, 14 August 2015, p 50.

²²⁸ Evidence, Ms Halliday, p 39.

4.87 Another factor impacting on the ability of rural and remote aged care facilities to recruit nurses is competition with local hospitals. Ms Halliday stated that registered nurses are ‘getting harder and harder to find ... It can take us months to fill a vacancy in a rural facility. We are competing with the rural hospital for that nurse, so there must be better ways for us to use those resources rather than saying that they are needed 24/7 somewhere where they are not needed now’.²²⁹

4.88 Similarly, Mr Carter described his experience recruiting a Director of Care for his facility:

I have just put on a registered nurse as a director of care – it would be coming up to 12 months ago. He was the only applicant I had. Actually, to be honest I did not have any applicants. I had to go out and hunt him. I had heard about him and I hunted him from another facility. I know that does not sound good, but that is what we had to do. If you go down the chain, yes, it is very hard to get registered nurses in these places. You can advertise and it can take weeks and weeks. What is going to happen if we do have to have registered nurses?²³⁰

4.89 Ms Margaret Strahan, Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT, shared her struggle recruiting a registered nurse for a facility in Singleton, and pointed out that the shortage of registered nurses means that those that are employed are often asked to work additional shifts to provide the cover required:

I have got a 35-bed nursing home in Singleton ... It is very highly regarded but it is a struggle to get RNs round the clock and it means at times the service manager is working double shifts or night shifts to maintain that requirement.²³¹

4.90 Dr Yeo expressed a similar view, cautioning that registered nurses are often discouraged from working in rural and remote areas because of the perception that ‘they are going to be in a stressful situation, understaffed and overworked’.²³² Dr Yeo likened it to the struggle to get doctors to work in remote areas because they felt that they would not be supported by an adequate number of trained nurses.²³³

4.91 Mr Sadler also spoke of the challenges faced by rural and remote aged care facilities in finding registered nurses to cover all shifts, citing the example of a facility in Walcha:

If legislation required us to provide 24/7 registered nurse coverage, we would have more chance of being able to fulfil that criteria from the point of view of a recruitment sense in a metropolitan area or even a large regional town. Once you get out of those large regional communities – Walcha is 3,000 people in the whole of the shire; it is not a large community – we have difficulty finding the one registered nurse that we employ now. To find another six or seven to fill a 24/7 roster would be either (a) highly expensive – and all we have done there is put the staff costs, not if you had

²²⁹ Evidence, Ms Halliday, p 38.

²³⁰ Evidence, Mr Carter, p 7.

²³¹ Evidence, Ms Margaret Strahan, Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT, 14 August 2015, p 11.

²³² Evidence, Dr Yeo, p 27.

²³³ Evidence, Dr Yeo, p 27.

to be flying people in or any additional costs – But (b) I just do not think they are there.²³⁴

- 4.92** A different view was suggested by Dr Bernoth who said that there is a significant supply of nursing graduates available in rural and regional areas, however, there is just no support for them to stay:

I know that I have a large number of graduate nurses who are having trouble getting jobs – positions as registered nurses. I teach rural nurses. CSU promotes professionals staying in rural areas ... I would suggest that if we had support for our graduate nurses to work in those facilities they would go there. Our rural students, again some of them go to the metropolitan areas to get experience but there is an awful lot of them who come back again.²³⁵

Committee comment

- 4.93** The committee notes that there is a shortage of registered nurses practising in aged care, especially in rural and regional areas, and that extending the provision of s 104 of the *Public Health Act* to encompass all aged care facilities may be unworkable as there would not be enough workforce capacity to fill the required new positions.
- 4.94** As discussed in previous comments, the committee does not intend for the legislation to be extended to all aged care facilities, and it has also recommended that facilities be able to apply for exemptions from the legislation on a case-by-case basis (see recommendation 8 in chapter 6).
- 4.95** Further, in order to address the issue of the skills shortage, the committee has also made recommendations in chapter 6 regarding programs and incentives to encourage registered nurses to practise in aged care facilities.

²³⁴ Evidence, Mr Sadler, pp 52-53.

²³⁵ Evidence, Dr Bernoth, 10 August 2015, p 21.

Chapter 5 Jurisdictional responsibility and the regulation of aged care

This chapter considers the role of both the Commonwealth and the state in regulating aspects of aged care delivery in New South Wales. In particular, this chapter considers the adequacy of the Commonwealth aged care framework in ensuring that quality care is provided to residents in aged care facilities, as a precursor to discussions about the need for a state legislative requirement prescribing registered nurses in nursing homes in chapter 6. Issues regarding the education and licencing of aged care workers are also examined.

The responsibility for aged care

- 5.1** As outlined in chapter 2, aged care and the regulation of its services is primarily a Commonwealth responsibility centred on the *Aged Care Act 1997* (Cth). In New South Wales, however, s 104 of the *Public Health Act 2010* provides an additional regulatory measure pertaining to registered nurses as a staffing requirement.
- 5.2** The role of both jurisdictions in regulating aged care was highlighted by a number of inquiry participants who argued for the repeal of s 104 of the *Public Health Act* in favour of the Commonwealth regulatory framework, which includes standards for staffing. These stakeholders emphasised that, while the state has some role to play in aged care, regulation of the sector is ultimately a Commonwealth responsibility.
- 5.3** UnitingCare Ageing NSW ACT, for example, stated: ‘It is not the role of State Governments to provide legislation or oversight of the operations of aged care services. This is the role of the Federal Government’.²³⁶ Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW & ACT, concurred, pointing out that ‘aged care is primarily a Federal Government responsibility. It is the only source of funding for aged-care services’.²³⁷
- 5.4** Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, reflected that it is a responsibility understood and accepted by all other states and territories in Australia who, unlike New South Wales, have relinquished their own regulatory functions in favour of the Commonwealth system.²³⁸ This was reiterated by Aged & Community Services NSW & ACT which noted that ‘no other state has this legislative imperative’ to require certain staff in an aged care facility.²³⁹

²³⁶ Submission 148, UnitingCare Ageing NSW ACT, p 3.

²³⁷ Evidence, Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW & ACT, 14 August 2015, p 49.

²³⁸ Evidence, Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, 14 August 2015, p 8 and p 17.

²³⁹ Submission 113, Aged & Community Services NSW & ACT, p 2.

- 5.5** Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW-ACT, asserted that the role of New South Wales in regulating aged care is redundant, stating that ‘Australia now has a very comprehensive national system of aged-care services’ which regulates all aspects of aged care and must be recognised as such.²⁴⁰
- 5.6** Other stakeholders, however, contended that a state legislative requirement for registered nurses in nursing homes is necessary due to inadequacies with the Commonwealth regulatory framework. These arguments will be considered in the following sections and in chapter 6.

The Commonwealth aged care framework

- 5.7** There was deep division amongst inquiry participants over the strength and effectiveness of the current Commonwealth regulatory framework for aged care.
- 5.8** On the one hand, several stakeholders opposed a mandated requirement for registered nurses in nursing homes on the basis that the Commonwealth framework provides a comprehensive system of standards, outcomes, monitoring and sanctions which ensure the protection of older Australians in residential aged care facilities.
- 5.9** On the other hand, as will be explored below, numerous other inquiry participants argued that there are inadequacies with the Commonwealth system in regard to the accreditation, compliance and monitoring of aged care facilities, and the staffing standards prescribed within the framework.

Accreditation, compliance and monitoring

- 5.10** As noted in chapter 2, all residential aged care facilities in Australia seeking a Commonwealth Government subsidy are subject to an accreditation, compliance and monitoring process carried out by the Australian Aged Care Quality Agency.
- 5.11** Several inquiry participants supported the current mechanisms in place for these processes, arguing that high standards of care can and are being met under the Commonwealth aged care framework.
- 5.12** Mr Teulan, for example, expressed the view that the Commonwealth’s responsibility for aged care regulation is being exercised ‘rigorously’ through the Department of Social Services and the Australian Aged Care Quality Agency, and that the standards assessed by the agency are ‘comprehensive’.²⁴¹
- 5.13** Likewise, Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, referred to the ‘stringent’ processes currently in place to ensure that older Australians are protected and cared for, and questioned why there was a need to look beyond the Commonwealth framework to regulate aged care in New South Wales:

²⁴⁰ Evidence, Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW-ACT, 5 August 2015, p 28.

²⁴¹ Evidence, Mr Teulan, p 8 and p 8.

Why not leave aged care and its requirements to Federal Government and the Aged Care Quality Agency? They have stringent assessments and legislation in place for the aged-care training and principles to ensure that our aged are taken care of to the best possible standard, that our aged live in a home and safe life environment and that our staff are trained to a required standard – in our case, an exceptionally high standard.²⁴²

5.14 This sentiment was also expressed by Mr Phillip Carter, Chief Executive Officer, St Andrew’s Village Ballina, who drew particular attention to the high compliance rate of residential aged care facilities under the Accreditation Standards, stating: ‘Up until March 2015, three-year accreditation was achieved, I understand, by 97 per cent of homes, which is the national average. Those that did not achieve accreditation outcomes were compliant within six months. That is my understanding. So what is the problem?’²⁴³

5.15 Indeed, Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency, informed the committee that since the accreditation process commenced in 1999, ‘there has been improvement in the performance of residential aged care through Australia based on the assessments of each service against the Accreditation Standards over that time’.²⁴⁴

5.16 Mr Bushrod advised that at the end of December 2012, 95 per cent of residential aged care facilities complied with the Accreditation Standards. He compared this with the first round of assessments completed in December 2000:

In the first round of accreditation assessments that ended in December 2000, 64 per cent of facilities were found to meet the Accreditation Standards. In the last completed round of comprehensive assessments, ending in December 2012, 95 per cent of services then met all of the Accreditation Standards.²⁴⁵

5.17 However, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association, challenged the validity of this compliance rate, contending that it is ‘unrealistic’ when compared with the failure rates of aged care facilities in other countries:

It is an unrealistic pass rate. If you look at the United Kingdom [UK], the failure rate is around 25 per cent on the latest data I have seen and if you look at the United States [US] the failure rate is around 90 per cent, so it is the inverse, and when I say failure rate, they may have failed one or two standards.²⁴⁶

5.18 Ms Crowe, along with numerous other inquiry participants, was highly critical not only of the rigour of the assessment processes in place to produce such high compliance rates, but other aspects of the accreditation system and its standards under the Commonwealth aged care

²⁴² Evidence, Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, 10 August 2015, p 2.

²⁴³ Evidence, Mr Phillip Carter, Chief Executive Officer, St Andrew’s Village Ballina, 14 August 2015, p 2.

²⁴⁴ Evidence, Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency, 5 August 2015, p 17.

²⁴⁵ Evidence, Mr Bushrod, p 17.

²⁴⁶ Evidence, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association of NSW, 10 August 2015, p 29.

framework.²⁴⁷ As one inquiry participant declared: '[T]he system currently in place requires an overhaul'.²⁴⁸

5.19 Reflecting on the experiences of his organisation's members, Mr Brendan Moore, General Manager – Policy, Research and Information, Alzheimer's Australia NSW, asserted that there is 'a litany of evidence' to suggest that the current regulatory framework is falling short of providing the care residents need, despite accreditation rates suggesting otherwise.²⁴⁹

5.20 Ms Crowe expressed a similar view, arguing that more often than not, nursing homes that have been found to mistreat residents are fully accredited. She therefore questioned the effectiveness of the accreditation system in protecting residents and ensuring a high standard of care:

I do not believe that the current system of regulation is picking up on those bad homes and is ensuring that those residents are as safe and are receiving the care that they need. Time and time again whenever a facility which is found to be doing the wrong thing and to be providing appalling care is shown in the media nine times out of 10 it is fully accredited. The question is why. If we have such a great system of accreditation why are these facilities falling through the cracks?²⁵⁰

5.21 Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, provided an example of a facility that was fully accredited, only to be later found to have contravened over 20 of the expected outcomes under the Accreditation Standards. She commented on the assessment process to suggest that assessors should focus more on working with the staff and residents of a facility, rather than paperwork, to determine compliance:

[I]n the Hunter in about 2004 an aged-care facility was fully accredited but the families protested and the accreditors went into the home and worked with the staff. They turned up at 6 o'clock in the morning and worked with the staff. So, two or three months after being accredited, that facility was shown to be contravening 25 of the standards. That was reduced to 22 when the accreditors looked at the care that was being given and not at the paperwork that was presented to the accreditors.²⁵¹

5.22 Ms Crowe agreed that greater focus should be placed on assessing the health and wellbeing of residents rather than the paperwork, which does not reflect the quality of care being given:

The process of accreditation is very paper based and it does not give really any idea of what the quality of care is like. That is a key issue. We would say that if they changed accreditation to look at the health and wellbeing outcomes of the residents it would

²⁴⁷ For example, Evidence, Ms Crowe, p 29; Evidence, Ms Lisa Langley, Policy Manager, Council on the Ageing NSW, 5 August 2015, p 58; Evidence, Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, 10 August 2015, p 18.

²⁴⁸ Submission 69, Name suppressed, p 4.

²⁴⁹ Evidence, Mr Brendan Moore, General Manager – Policy, Research and Information, Alzheimer's Australia NSW, 10 August 2015, p 10.

²⁵⁰ Evidence, Ms Crowe, p 34.

²⁵¹ Evidence, Dr Bernoth, p 26.

probably reduce the paperwork. It would probably reduce the time that providers spent on preparing for accreditation, and that would be a good thing.²⁵²

- 5.23** Ms Crowe informed the committee about the model of aged care regulation in the Netherlands which considers the experiences of every individual resident at an aged care facility to determine the quality of care being provided. She reflected that by comparison, only a small proportion of the quality of care is considered under the Commonwealth system:

In the Netherlands they actually look at each resident. They survey every resident. Here we are only required to interview 10 per cent of residents. It gives a far better idea of what life is like in the facility and what care is like in the facility. Here you are really only getting a very small snapshot of the quality of care.²⁵³

- 5.24** Ms Crowe further suggested that the residents and their families may filter any negative feedback in fear of negative repercussions by the provider:

Speaking to family members and residents, they often say to us that even when they are interviewed by the accreditation agency they do not want to express their concerns to the agency. Even though they can do so in a private way they still have a huge concern that it will somehow get back to the provider and there will be retribution. That is a problem.²⁵⁴

- 5.25** The Combined Pensioners and Superannuants Association told the committee that '[t]he Aged Care Quality Agency by law only visits facilities during business hours (unless directed otherwise by the Minister), so it does not directly observe staffing outside these times'.²⁵⁵

- 5.26** Concerns about the program of visits to aged care facilities as part of the accreditation process were also raised during the inquiry – particularly the effectiveness of 'unannounced' visits by the Australian Aged Care Quality Agency, which a number of stakeholders said are actually pre-announced.

- 5.27** For example, one inquiry participant remarked: 'I have completely lost faith in a system that constantly appears to ignore the reality', claiming that in her experience aged care providers are often forewarned of visits and therefore pursue temporary measures to improve compliance outcomes. She urged for unannounced visits to truly be so if an accurate assessment is being sought by the agency:

Residential aged care facilities are given numerous months warning if they are to have an agency visit and even warned if they are going to have an 'unannounced' agency visit? So of course facilities will do all they are able to in this pre-warned timeframe, to improve the outcomes. I've been in facilities that employ many more staff to work on the floor the day of any accreditation visits, as soon as the visit's over, staffing returns to its normal minimal standard. I've witnessed organisations give in-services or have meetings prior to agency visits, educating staff on what they should say or not say, and educating staff on aspects of care delivery and documentation that should be regularly reinforced not only when an agency visit is due ... If the Standards and Accreditation Agency wants to accurately assess what is truly occurring in residential aged care

²⁵² Evidence, Ms Crowe, p 35.

²⁵³ Evidence, Ms Crowe, p 35.

²⁵⁴ Evidence, Ms Crowe, p 35.

²⁵⁵ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 5.

facilities then perform ‘unannounced visits’ but ensure these visits are ‘unannounced’.²⁵⁶

5.28 A related concern, raised by Ms Crowe, Combined Pensioners and Superannuants Association, is the effectiveness of the monitoring mechanisms if unannounced visits are taking place during business hours. Ms Crowe pointed to the United Kingdom model for the monitoring of aged care facilities where all visits are unannounced and can occur at night or on weekends, espousing it as a model that ‘Australia should emulate’.²⁵⁷

5.29 Similarly, Mr Carter expressed the view that while the current system is ‘very stringent’, visits should be unannounced to reveal the reality of how an aged care facility operates:

To be honest, we normally have two or three people come here, because we have a large facility, but they are very stringent. If you want my honest opinion, I think accreditation should be carried out whereby they call at your door and just turn up. We get to prepare for these people coming, which is great, but you need to see people and take us how we are on the days when we are stressed from patient care and things like that going on around the place. You need to see it how it is, so people get a reality check on what is happening ... I believe in surprise visits. I think that is a great idea and that is where you learn if you have something wrong and you need to pick it up. It is there and then and on the spot. It is reality.²⁵⁸

5.30 The inconsistency with which the standards are assessed across aged care facilities was also raised as a concern. For instance, Dr Lyndal Newton, Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division, indicated that she would have more confidence in the system if all standards were assessed across all facilities:

The standards obviously are there. I think the problem from my experience going around to different nursing homes or residential aged-care facilities recently is that within a small area one nursing home or facility had some 44 issues looked at and one had two issues looked at, yet they are the same type of facility. I would say that if all of the standards were being examined all the time I could feel more comfortable that the quality was very good.²⁵⁹

5.31 This point was reiterated by Ms Crowe who also commented on the number of standards being assessed by the Australian Aged Care Quality Agency, and advised the committee of one facility that had only two expected outcomes under the standards assessed at an unannounced visit:

... facilities receive one unannounced visit each year. Now I was under the impression that during those visits around 10 or 12 standards were looked at. I have recently come across some evidence that suggests that in fact in some places it is far fewer. There was a case was brought before the Administrative Appeals Tribunal recently which discussed the unannounced visits that the facility has had because they are not

²⁵⁶ Submission 69, Name suppressed, pp 3-4.

²⁵⁷ Evidence, Ms Crowe, p 29.

²⁵⁸ Evidence, Mr Carter, p 6.

²⁵⁹ Evidence, Dr Lyndal Newton, Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, pp 44.

made public and it said that on one visit only two standards were assessed out of 44, one of which was lifestyle.²⁶⁰

Staffing standards

5.32 As part of the Commonwealth aged care framework, the Accreditation Standards require that residential aged care facilities provide a sufficient number of ‘appropriately skilled and qualified staff’ to ensure that services are delivered in accordance with the standards and ‘the residential care service’s philosophy and objectives’.²⁶¹ As noted in chapter 2, the Commonwealth does not prescribe the qualifications required by staff or the number of staff in any given facility.²⁶²

5.33 Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, explained the rationale behind this standard and the view that ‘it is inappropriate to mandate the staff skills and mix in residential aged care’.²⁶³

The relationship between staffing in aged-care facilities and quality of care is complex. There is considerable diversity across accredited homes in Australia. This is expected given the considerable variation in the size of aged-care facilities, the nature of the care provided by individual facilities, the key needs of individual care recipients within those facilities, and the facility design. Residents’ needs also change over time. Therefore, a static staff ratio will not necessarily meet residents’ needs.²⁶⁴

5.34 A number of inquiry participants supported this position, arguing that s 104 of the *Public Health Act* should be repealed because the Commonwealth standards ensure that residents receive the quality care appropriate to their needs.²⁶⁵ Mr Sadler, for example, stated that ‘the staffing requirements are adequately covered by the current Commonwealth legislation, accreditation and other monitoring processes’.²⁶⁶ Likewise, Mr Teulan discussed how comprehensive he considered the Accreditation Standards to be, highlighting in particular those relating to appropriately skilled and qualified staff.²⁶⁷

5.35 In particular, stakeholders highlighted how the staffing standards under the Commonwealth regulatory system allow for the flexibility needed within the aged care sector to employ staff with the right skills mix to appropriately cater to what Mr Bushrod from the Australian Aged

²⁶⁰ Evidence, Ms Crowe, p 29.

²⁶¹ Australian Aged Care Quality Agency, *Accreditation Standards*, Standard 1, Expected outcome 1.6.

²⁶² Evidence, Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, 5 August 2015, p 16.

²⁶³ Answers to questions on notice, Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, 4 September 2015, p 5

²⁶⁴ Evidence, Mr Culhane, p 16.

²⁶⁵ For example, Submission 113, Aged & Community Services NSW & ACT, pp 2-3; Evidence, Mr Wurf, p 29; Evidence, Ms Thompson, p 2.

²⁶⁶ Evidence, Mr Sadler, p 49.

²⁶⁷ Evidence, Mr Teulan, p 8.

Care Quality Agency described as ‘the diversity of circumstances that exist across aged care facilities’.²⁶⁸

- 5.36** For example, Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, stated that flexible staffing enables facilities to engage staff ‘in the right place at the right time so we can give the right care to someone based on their care needs’.²⁶⁹ She emphasised that registered nurses are not always the most appropriate care givers in every situation:

RNs are invaluable ... They are vital, precious and rare ... [T]here must be better ways for us to use those resources rather than saying that they are needed 24/7 somewhere where they are not needed now ... [W]e may get better value out of a couple of diversional therapists than an RN. That is the flexibility we seek, particularly for the lower and mixed areas.²⁷⁰

- 5.37** Ms Halliday commented on the ever-changing needs of residents to further illustrate her point:

[P]eople’s needs change, their ratings change, they get short-term needs, they get longer term needs. They may come in with high-care needs and we do all the right things to enable them and they become low care. The individual’s needs let alone the individual facility can change quite quickly in respect of the mix of people they have got there and the mix of staffing that they need. That is why we need the flexibility ...²⁷¹

- 5.38** A number of aged care providers supported the staffing standards under the Commonwealth system because they allow facilities to ‘flex up’ staff when needed by providing additional, more qualified staff to meet higher, more complex needs as they arise (and vice versa).

- 5.39** For example, Ms Margaret Strahan, Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT, informed the committee that ‘flexing staff is something we do on a case-by-case basis and on a daily basis’.²⁷² She used the example of a small facility in Nareen which took a person in for palliative care through to their end of life by providing additional registered nursing cover.²⁷³

- 5.40** Ms Strahan also provided a further example of a similar situation involving a palliative care resident whose family did not want the person moved from the facility. She advised that Sunhaven was able to bring in a registered nurse to provide the necessary care and medication and avoid the physical and emotional upheaval of moving a resident from their home to a different facility:

²⁶⁸ Answers to questions on notice, Mr Ross Bushrod, Director of Quality and Standards, Australian Aged Care Quality Agency, 2 September, p 5.

²⁶⁹ Evidence, Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, 5 August 2015, p 38.

²⁷⁰ Evidence, Ms Halliday, p 38.

²⁷¹ Evidence, Ms Halliday, p 40.

²⁷² Evidence, Ms Margaret Strahan, Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT, 14 August 2015, p 16.

²⁷³ Evidence, Ms Strahan, p 16.

We have recently had a service that is a 32-bed what was traditionally was a low-care service where the resident was end of life. The family did not want her to move. She was on subcutaneous morphine. We put in place an RN to go in regularly to administer that so that person did not have to be moved from what was her home into a larger service that meant her sharing a room, into the nursing home bed that we had available. She maintained her quality of life in her home and was appropriately cared for. Her family were very happy. We do whatever we can to flex up and down staff where the need arises.²⁷⁴

- 5.41** Ms Halliday told the committee about a facility in the far South Coast which also occasionally takes in a resident for palliative care. She explained that the facility does not have a registered nurse on duty at all times because it was classed as a low care facility under the former system, however, it knows that when it has a palliative care resident it will need and subsequently provide registered nursing coverage through an agency until that resident has a peaceful death. Ms Halliday stated: ‘That is what they do because that is what that person needs, so they have a got a system in place to cope with the needs of the person regardless of the rating of what that organisation may be. Flexibility is what is needed’.²⁷⁵
- 5.42** While these stakeholders argued that the flexibility of the staffing standards under the current Commonwealth framework allows for an appropriate staff mix to meet the varying needs of residents, numerous other inquiry participants argued that the standards are grossly inadequate and do not ensure that residents are being treated by the appropriately qualified staff. As such, this latter group of participants contended that a state legislative requirement for registered nurses in nursing homes is necessary.²⁷⁶
- 5.43** For example, Dr Guan Yeo, Chair, NSW ACT Faculty, Royal Australian College of General Practitioners, told the committee that the college board was unanimous in its perception that ‘there was not an adequate nursing staff ratio’ in places where high care is given, stating that ‘... on this issue of the minimum requirement for a registered nurse in places where high care is given, the board was unanimous and the unanimity was very quick. Everybody thought that this was a no brainer’.²⁷⁷ In his evidence, Dr Yeo outlined such a consensus is rare.²⁷⁸
- 5.44** Furthermore, Ms Crowe asserted that s 104 of the *Public Health Act* was critical given the void in Commonwealth standards pertaining to staffing ratios:

... there is no Federal minimum staffing ratio or skill requirement in residential aged care. The New South Wales requirement is therefore not a doubling up of regulation – it is in my view and that of the people I represent, an absolute necessity. It is a necessity in the interests of health and safety of care recipients in New South Wales.²⁷⁹

²⁷⁴ Evidence, Ms Strahan, p 10.

²⁷⁵ Evidence, Ms Halliday, p 41.

²⁷⁶ For example, see Evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives’ Association, 5 August 2015, p 47; Evidence, Ms Crowe, p 28; Evidence, Ms Langley, p 58; Answers to questions on notice, National Seniors Australia, 15 September 2015, p 3

²⁷⁷ Evidence, Dr Guan Yeo, General Practitioner, Chair, New South Wales and Australian Capital Territory Faculty, Royal Australian College of General Practitioners, 14 August 2015, p 27.

²⁷⁸ Evidence, Dr Yeo, pp 26-27.

²⁷⁹ Evidence, Ms Crowe, p 29.

- 5.45** Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, noted that the requirement for ‘sufficient skilled and qualified staff’ to provide care is ‘a very open statement’.²⁸⁰ She discussed the assessment of this standard during accreditation visits, asking ‘If there is an accreditation visit, can you really tell, within the period of time, that the staff are adequately skilled and qualified? I think that that needs tightening up’.²⁸¹
- 5.46** Ms Crowe from the Combined Pensioners and Superannuants Association shared this view, asserting that the expected outcomes relevant to staffing under the Accreditation Standards are ‘vague’, which allows for wide latitude in its interpretation and therefore opportunity for aged care providers to understaff facilities:
- ... the accreditation agency is not prescriptive when it comes to staffing: the standard is very vague and it is left wide open to interpretation. That is why you have such a wide variation in aged-care facilities’ staffing profiles because there is nothing to prevent them from putting on one care worker for 40 people when they might need three or four, for example.²⁸²
- 5.47** The Combined Pensioners and Superannuants Association further submitted that the ‘lack of robust staffing regulation by the Federal Government exposes residents to unsafe staffing practices by nursing home operators’,²⁸³ using the example of a Queensland nursing home to demonstrate this point:
- ... in 2012 a Queensland nursing home in was found to have no staff rostered on for 10.5 hours at night, presumably because it did not think that residents needed to have a carer present overnight. Residents were found absconding, falling, and wandering. It is unclear how long this home had been run without staff at night. It remains fully accredited.²⁸⁴
- 5.48** Mr Sadler conceded that there are ‘gaps in the system’ regarding staffing standards.²⁸⁵ He highlighted the need to address issues such as elder abuse through better measures for screening all employees in aged care facilities.²⁸⁶
- 5.49** Mr Sadler asserted that responding to abuses experienced by older people, regardless of the setting, is ‘clearly the remit of the State Government’, and noted that there is currently no register to record if a staff member is dismissed for abusing a resident unless they are charged and have a criminal conviction.²⁸⁷ Mr Sadler therefore suggested that a Working with Older People and/or Vulnerable Adults Check modelled on the Working with Children Check process should be developed to provide additional protection for older people.²⁸⁸

²⁸⁰ Evidence, Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, 14 August 2015, p 24.

²⁸¹ Evidence, Dr Herbert, p 24.

²⁸² Evidence, Ms Crowe, p 29.

²⁸³ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 4.

²⁸⁴ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 4.

²⁸⁵ Evidence, Mr Sadler, p 53.

²⁸⁶ Evidence, Mr Sadler, p 53.

²⁸⁷ Evidence, Mr Sadler, p 53.

²⁸⁸ Answers to questions on notice, Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW and ACT, 24 August 2015, p 1.

Committee comment

- 5.50** The committee acknowledges that jurisdictional responsibility for aged care lies with the Commonwealth and recognises that a legislative framework is in place at this level to regulate residential aged care facilities. The committee also notes that, as mentioned in paragraph 2.31 in chapter 2, moves are underway to develop a single quality framework for aged care, which includes a review of the Accreditation Standards. As such, the committee understands that its scope to recommend action in this area is limited.
- 5.51** However, the committee acknowledges the concerns raised by inquiry participants regarding the adequacy and effectiveness of the Commonwealth regulatory framework in ensuring that a high standard of care is provided to residents in aged care facilities.
- 5.52** In particular, the committee considers the way in which residential aged care facilities were described by inquiry participants as being monitored and assessed against the Accreditation Standards to be troublesome. The value placed on providing paperwork to demonstrate compliance with the standards needs to be addressed and the focus re-shifted to a dialogue with residents and their families to determine quality of care. The committee believes that the monitoring of facilities should include a program comprised of genuinely unannounced visits, at any time of the day across any day of the week, in order to capture a true account of a facility's day-to-day operations. Facilities should be consistently measured against all four standards and their 44 expected outcomes, rather than a random number, and furthermore, we believe that residents and/or their advocates should be notified if a facility fails to meet any of the standards.
- 5.53** The committee also notes the various issues raised in regard to staffing standards under the Commonwealth framework. While the committee acknowledges the flexibility of the current system in allowing aged care facilities to determine and provide the staffing skills and mix to meet the varying needs of residents, the committee shares the concerns of inquiry participants who feel that the staffing standard requiring 'appropriately skilled and qualified staff' is too vague and allows for wide latitude in its interpretation.
- 5.54** As such, the committee recommends that, as part of the Commonwealth initiative to develop and improve the aged care framework, consideration should be given to all of these issues.

Recommendation 3

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to ensure that its new single quality aged care framework includes:

- genuinely unannounced visits that occur at any time of the day on any day of the week,
- assessment of all 44 expected outcomes under the Accreditation Standards during each unannounced visit,
- greater emphasis on resident experience, and
- a requirement to communicate non-compliance with residents and their advocates.

- 5.55** The committee is also significantly concerned with the evidence regarding unsafe practices in nursing homes which do not provide adequate numbers of staff on their premises at all times. We are disappointed that the Commonwealth Government does not prescribe a minimum staffing ratio in aged care facilities. The committee notes that the Commonwealth Government rightly acknowledges the need to prescribe minimum staffing ratios in child care centres, however, has failed to acknowledge the same need in aged care facilities, where some of the most vulnerable members of our society live. We therefore recommend that staffing ratios be established to ensure the safety of residents.

Recommendation 4

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to establish minimum staffing ratios in aged care facilities.

Education and licencing of aged care workers

- 5.56** At present, while registered nurses and enrolled nurses are regulated by the Nursing and Midwifery Board of Australia (whose function is to ‘register nurses and midwives who are safe and competent to practice’),²⁸⁹ no authority exists to regulate other aged care workers in residential aged care facilities, including assistants in nursing and personal care staff. This issue was highlighted by a number of stakeholders who raised concerns about the lack of regulation surrounding the education and licencing of aged care workers.

- 5.57** In regard to the education of aged care workers, the Combined Pensioners and Superannuants Association gave evidence that a large number of registered training organisations (RTOs) delivering certificate courses in aged care are non-compliant with training standards and, moreover, that some of these organisations are granting qualifications in an inadequate period of time:

... a 2013 audit of registered training organisations (RTOs) offering vocational aged and community care qualifications found that 87.7% did not comply with at least one of the national training standards required of programs to meet to attain qualifications under the Australian Qualifications Framework. Some of these RTOs were offering Certificate III in Aged Care course qualifications in just 11 weeks. Of a randomly selected sample, only 20% of RTOs provided the required minimum 1,200 hours of training.²⁹⁰

- 5.58** Ms Diane Lang, a TAFE teacher of Certificate III in Aged Care, also discussed the variability in aged care courses, giving evidence that some training providers are offering a ‘Certificate of Attainment in Aged Care’ in six units over one month, while some online courses ‘are advertising that the student can achieve a Cert III in 5 weeks’.²⁹¹ Ms Lang compared this with the requirements of the course she teaches at TAFE:

²⁸⁹ Correspondence from Ms Tanya Vogt, Executive Officer, Nursing and Midwifery Board of Australia, to Chair, 28 September 2015, p 1.

²⁹⁰ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 7.

²⁹¹ Submission 31, Ms Diane Lang, p 1.

The TAFE Cert III course I teach was 12 hours a week over 12 teaching weeks, with a minimum of two-week placement. In that 12 weeks we deliver 14 units such as legal and ethical framework, First Aid, how the body functions, delivery of personal care, WHS, dementia and palliative care.²⁹²

- 5.59** The Australian Skills Quality Authority (ASQA) informed the committee that there is in fact no minimum duration for courses in aged care, but that the Australian Qualifications Framework (AQF) provides some guidance in course durations in general:

Typically, the qualifications contained in training packages do not currently mandate minimum durations for courses, rather, RTOs develop their training and assessment strategies based on the number and type of units of competency that make up the qualification.

The AQF, being the national policy for regulated qualifications in Australian education and training, does provide guidance in respect of volume of learning ... [that being: Certificate III – 1-2 years – 1200-1400 hours].²⁹³

- 5.60** The authority further advised that ‘while ASQA does not develop courses (and, as such, does not mandate minimum requirements), it is keenly interested in ensuring that the VET sector graduates possess the skills and knowledge required by industry’²⁹⁴ and is therefore ‘currently working to strengthen regulation of course duration to ensure that the amount of training provided to a learner is sufficient to ensure the learner does acquire the specified skills and knowledge’.²⁹⁵
- 5.61** In regard to the licensing of aged care workers, the Combined Pensioners and Superannuants Association informed the committee that there is no minimum qualification requirement for personal care workers to work in aged care facilities (although around two thirds of personal care workers nonetheless have a Certificate III in Aged Care).²⁹⁶ This lack of a minimum qualification requirement was of concern to some inquiry participants.²⁹⁷
- 5.62** A related concern, pointed out by Ms Diane Lang, is that unlicensed care workers are not accountable to any regulatory board.²⁹⁸ Similarly, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives’ Association, stated that the fact that aged care workers are ‘not required to respond professionally to anyone’ has long been a concern of the association. He explained that while aged care workers are accountable to their employer and that the Commonwealth

²⁹² Submission 31, Ms Diane Lang, p 1.

²⁹³ Correspondence from Mr Christopher Robinson, Chief Commissioner and Chief Executive Officer, Australian Skills Quality Authority, to Chair, 1 October 2015, p 4.

²⁹⁴ Correspondence from Mr Robinson, to Chair, 1 October 2015, p 4.

²⁹⁵ Correspondence from Mr Robinson, to Chair, 1 October 2015, p 4.

²⁹⁶ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 7.

²⁹⁷ For example, Dr Esther Kok, Member, Royal Australian College of General Practitioners, 14 August 2015, p 31, Evidence, Ms Debra Urquhart, Director of Care, Booroongen Djugun Aged Care Facility, 14 August 2015, p 39, Submission 89, Name suppressed, p 1, Submission 97, Bridgette Mexted, p 1, Submission 109, Australian College of Nursing, p 9, Submission 87, NSW Nurses and Midwives’ Association, p 16.

²⁹⁸ Submission 31, Ms Diane Lang, p 2.

provides some oversight of adverse actions against residents, aged care workers ‘do not have a professional body’.²⁹⁹

- 5.63** Mr Holmes remarked: ‘These people [aged care workers] are given a high level of responsibility to do the most intimate of care and yet they are not required to be licensed in any way in order to deliver that care, and there is no absolute requirement for them to have a standard of education’.³⁰⁰
- 5.64** Some inquiry participants expressed the view that there should be a mandated minimum qualification for aged care workers. For example, Ms Debra Urquhart, Director of Care, Booroongen Djugun Aged Care Facility, asserted that ‘it is important that there is some sort of regulation that they must have Cert III or Cert IV’.³⁰¹ Likewise, National Seniors Australia recommended that a minimum standard, such as a Certificate III, should be required for nursing assistants and other carers.³⁰²
- 5.65** In contrast, other inquiry participants, such as Ms Halliday, strongly opposed mandating a minimum qualification for aged care workers. Ms Halliday asserted that ‘aged care is one of the few career paths left in Australia where if someone has the right attitude’ they are able to enter the workforce and work towards a qualification within it.³⁰³
- 5.66** Ms Halliday stated that ‘if you mandate it and block people from coming in when they really care about aged care, then we may block out people who would be wonderful in the role’.³⁰⁴ She explained that providers are more than willing to support aged care workers attaining qualifications but emphasised the importance of having someone ‘keen, enthusiastic and caring’ first:

... if they come in and they want to work there, which is a lovely thing to do – that is our prime thing: Can we get someone who cares about old people first, please? – we bend over backwards to give them free education and time off to do their study and submissions. We will put them through Cert III, Cert IV, EN, RN. That is a really common pattern of giving people a career path they cannot get anywhere else, because we are paying for it. We are giving them the time. We want them to have these things. If they come to us keen, enthusiastic and caring, we bend over backwards to give them all of that. Nearly everyone does Cert III ...³⁰⁵

- 5.67** Moreover, Mr Sadler pointed out that the qualifications of aged care staff have ‘increased substantially in the last decade’ anyway, advising that a substantial proportion of the staff in his organisation are trained to a Certificate IV level in aged care.³⁰⁶

²⁹⁹ Evidence, Mr Holmes, p 51.

³⁰⁰ Evidence, Mr Holmes, p 51.

³⁰¹ Evidence, Ms Urquhart, p 39.

³⁰² Answers to questions on notice, National Seniors Australia, 15 September 2015, p 3.

³⁰³ Evidence, Ms Halliday, p 40.

³⁰⁴ Evidence, Ms Halliday, p 40.

³⁰⁵ Evidence, Ms Halliday, p 40.

³⁰⁶ Evidence, Mr Sadler, p 54.

Committee comment

- 5.68** The committee notes the evidence proposing additional measures to ensure that residents are cared for by the right staff and protected from issues such as elder abuse. The committee is mindful that an inquiry is currently being undertaken by our colleagues in General Purpose Standing Committee No. 2 into elder abuse and expects that such issues will be considered further by that committee.
- 5.69** In the context of this inquiry, the committee agrees that there should be a check to screen aged care workers who do not have a criminal record but may, for example, have had their employment terminated on the basis of mistreatment or abuse, or have had any other relevant issues of concern. The committee therefore recommends that a Working with Older People and/or Vulnerable Adults Check be developed and modelled on the Working with Children Check.

Recommendation 5

That the NSW Government develop a Working with Older People and/or Vulnerable Adults Check, modelled on the Working with Children Check.

- 5.70** Further improvements to staffing standards are also needed with respect to the education and licencing of aged care workers. The committee notes that there is a lack of regulation in the education being provided to aged care workers, with registered training organisations determining course content and duration at their discretion. The resulting variability in the quality of aged care qualifications is of concern to the committee.
- 5.71** Also of concern is the fact that aged care workers are not regulated in any way and are therefore not accountable to any professional or licencing body for safe and competent practice. The committee believes that further consideration of this issue is warranted and therefore recommends that a licencing body be investigated at the Commonwealth level to regulate all aged care workers.

Recommendation 6

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to establish a licensing body for aged care workers.

Chapter 6 The way forward

The previous chapters of this report detailed the arguments for and against retaining, and potentially expanding, the legislative requirement to have registered nurses on duty at all times in nursing homes, as expressed in s 104 of the *Public Health Act 2010*.

This chapter now considers various options in regard to the future of that legislative requirement. It also explores ways in which the approach to the delivery of aged care services can be improved, including increasing transparency in the system, improving access to information about complaints processes, and providing incentives to attract and support registered nurses to work in aged care.

Legislative options

6.1 The following sections consider four potential options in regard to the future of the mandated requirement for continuous registered nursing coverage in nursing homes. These options are:

- retaining the current requirement and defining the distinction between low and high levels of residential care
- extending the requirement to all residential aged care facilities regardless of the level of care
- extending the requirement to all residential aged care facilities regardless of the level of care, but allowing for exceptions
- repealing the legislative requirement and defaulting to the Commonwealth regulatory framework.

Retaining the legislative requirement

6.2 The numerous arguments for retaining the legislative requirement have already been canvassed throughout this report. In addition to those arguments, which related to specific matters such as the role and responsibilities of registered nurses in comparison to enrolled nurses or aged care workers, inquiry participants argued that s 104 should be preserved as a minimum safeguard for aged care residents. As put by Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association: '... the State legislation should continue to protect the residents of New South Wales aged-care facilities and protect those people with high and complex care needs'.³⁰⁷

6.3 The importance of s 104 was espoused by Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association, who asserted that retaining the legislative requirement is 'a necessity in the interests of the health and safety of care recipients in New South Wales'.³⁰⁸

³⁰⁷ Evidence, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, 5 August 2015, p 47.

³⁰⁸ Evidence, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association of NSW, 10 August 2015, p 28.

6.4 Several inquiry participants insisted that retaining the provision is particularly necessary given the various weaknesses of the Commonwealth regulatory framework (examined in the previous chapter). For example, Mr Holmes argued that the state requirement is ‘forward-looking, protective legislation’.³⁰⁹ He added that a commitment of this kind ensures ‘the best standard of care for older people in aged care homes in NSW, through the *Public Health Act*’.³¹⁰

6.5 The Combined Pensioners and Superannuants Association also supported retaining the state legislation to protect aged care residents, stating:

This is to provide a safeguard in terms of staffing for all residents; one which is currently not mandated by federal legislation governing standards and staffing in residential aged care. The NSW Government’s decision regarding the requirement under section 104 of the *Public Health Act 2010* should be based on the safety and care needs of residents.³¹¹

6.6 Dr Guan Yeo, Chair, NSW ACT Faculty, Royal Australian College of General Practitioners, acknowledged that ‘there are no simple answers’ to determining the ideal staffing requirements in aged care facilities, but argued that there should at least be a *minimum* requirement:

Certainly my faculty board and all the GPs I have spoken to believe that there should be a minimum. We know that there are no simple answers and that there are a whole lot of things that we still do not have answers to in aged care. For example, the Federal Government argument for the changes was no optimum staffing levels or mix that meets all circumstances in providing aged care. But that is not a substitute for saying we do not need a minimum. All we are saying is that we do not know the maximum or the ideal. There is no argument for us not having any minimum; I think people need that to protect the patients.³¹²

6.7 A similar view was expressed by Mr Holmes who remarked: ‘One registered nurse on duty is a minimum requirement. It protects the public by ensuring clinical oversight at all times by a registered nurses, and allows a baseline for the provider to staff flexibly in response to resident needs’.³¹³

Suggested amendments to the Public Health Act

6.8 In regard to how s 104 can operate into the future, given the impact of the Commonwealth reforms on the state provision, several stakeholders suggested certain amendments to the *Public Health Act*.³¹⁴

³⁰⁹ Answers to questions on notice, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives’ Association, 2 September 2015, p 8.

³¹⁰ Answers to questions on notice, Mr Holmes, p 8.

³¹¹ Answers to questions on notice, Ms Charmaine Crowe, Senior Advisor, Research & Advocacy, Combined Pensioners and Superannuants Association of NSW, 31 August 2015, p 1.

³¹² Evidence, Dr Guan Yeo, Chair, NSW ACT Faculty, Royal Australian College of General Practitioners, 14 August 2015, pp 31-32.

³¹³ Answers to questions on notice, Mr Holmes, p 8.

³¹⁴ See for example, Submission 87, NSW Nurses and Midwives’ Association, p 15; Evidence, Ms Linda Kelly, Councillor, Leichhardt Municipal Council, 5 August 2015, p 68; Submission 164, National Tertiary Education Union - NSW Division, p 2.

6.9 For example, the NSW Nurses and Midwives' Association recommended amending the Act by replacing the definition of 'nursing home' with the former definition of 'high level of residential care' from the 'pre-1 July 2014' *Aged Care Act 1997* (Cth) (that is, prior to recent reforms that removed the distinction between high and low levels of care).³¹⁵ Under this proposal the term 'nursing home' under the *Public Health Act* would read:

nursing home means a facility at which residential care (within the meaning of the Aged Care Act 1997 of the Commonwealth) is provided, being:

(a) a facility at which that care is provided in relation to an allocated place (within the meaning of that Act) to a care recipient whose classification level:

(i) includes the following domain categories or combinations of domain categories:

- (1) a high Activities of Daily Living (ADL) domain category; or
- (2) a high Complex Health Care (CHC) domain category; or
- (3) a domain category of medium or high in at least two of the three domain categories; or
- (4) a high behaviour domain category and either an ADL domain category other than nil or a CHC domain category other than nil; or

(ii) is a high level resident respite care

(b) a facility that belongs to a class of facilities prescribed by the regulations.³¹⁶

6.10 The Nurses and Midwives' Association argued that linking the requirement for a registered nurse to residents' assessed levels of care is a way to avoid reliance on Commonwealth legislation and would be '... an opportunity to put in place a legislative system that no longer associates the provision of registered nurses with the type of care facility'.³¹⁷

6.11 Ms Helen Macukewicz, Professional Officer, Aged Care for the NSW Nurses and Midwives' Association, elaborated on the association's position, commenting that funding and registered nurse coverage should be linked to the assessed needs of residents:

I think there is opportunity for us to look at the way we are wording the State legislation and to try to frame something around the assessment of need within that so that the funding is following where people need the nurses, so that there is no discrepancy between what we are paying for and what we are receiving. If we clearly link the three – the funding to the assessment to the need for registered nurses – then there can be no lack of clarity about what we are funding for and what we are saying people's needs are ... At the moment there is a lack of clarity for all parties concerned.³¹⁸

6.12 The Combined Pensioners and Superannuants Association also recommended that the *Public Health Act* be amended, proposing that it reflect a minimum requirement of at least one

³¹⁵ Answers to questions on notice, Mr Holmes, p 3.

³¹⁶ Answers to questions on notice, Mr Holmes, p 3.

³¹⁷ Submission 87, NSW Nurses and Midwives' Association, p 14.

³¹⁸ Evidence, Ms Helen Macukewicz, Professional Officer – Aged Care, NSW Nurses and Midwives' Association, 5 August 2015, p 51.

registered nurse on duty at all times in all aged care facilities which look after high care or high needs residents.³¹⁹

6.13 The association suggested that a definition of ‘high care’ could be inserted into the *Public Health Act* and defined in the same way that ‘high care’ is currently defined in s 7(6) of Part 2, Division 1 of the Quality of Care Principles 2014.³²⁰ The result would be to define ‘high care’ under the *Public Health Act* as:

(a) a care recipient whose classification level includes any of the following:

(i) high Activities of Daily Living (ADL) domain category;

(ii) high Complex Health Care (CHC) domain category;

(iii) high behaviour domain category;

(iv) a medium domain category in at least 2 domains;

(b) a care recipient whose classification level is high level residential respite care.

Extending the legislative requirement to all aged care facilities

6.14 As noted in chapter 4, some inquiry participants considered that a consequence of removing the distinction between high and low care facilities may be that s 104 of the *Public Health Act* could now potentially extend to *all* aged care facilities, including facilities previously considered as low care. This was the key concern raised by aged care providers, who strongly opposed requiring registered nurses to be on duty at all times in all facilities because of the significant impact it would have on the viability of the facilities, which could have subsequent repercussions on residents, their communities and registered nurses themselves. As one aged care provider stated: ‘The legislation was never intended to cover low care facilities and if enacted will have a dire impact on aged care services’.³²¹

6.15 St Andrew’s Village Ballina described any move to require all aged care facilities to employ registered nurses at all times as ‘ludicrous’, drawing attention to the number of facilities that would be affected by the legislative requirement if it were to be retained and extended:

... the NSW legislation which covers 580 facilities could be covering over 1200 facilities, meaning that every facility would need to have an RN on duty 24 hours a day (whether they need one or not). This is absolutely ludicrous ... A registered nurse would be required 24 hours a day in facilities that previously did not require or need them. This is absolute bureaucracy gone mad.³²²

³¹⁹ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 10.

³²⁰ Submission 152, Combined Pensioners and Superannuants Association of NSW, p 10. As noted in chapter 2, the Quality of Care Principles set out the responsibilities of approved residential aged care providers.

³²¹ Submission 151, Name suppressed, p 1.

³²² Submission 39, St Andrews Village Ballina, p 1 and p 2.

- 6.16** Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, said that it would be a ‘disaster’ for smaller facilities if such a ‘blunt’ measure was used to determine staffing, especially as many facilities do not need such coverage:

Now and in the future there will be many facilities and residents who have no need for a nurse to be on duty 24 hours a day. I am not saying that they do not need nurses, but having them on duty 24 hours a day becomes a problem, and that is particularly true in low-care facilities and hostels.³²³

- 6.17** The arguments against extending the provision to all aged care facilities were examined at length in chapter 4.

Extending the legislative requirement to all aged care facilities with exceptions

- 6.18** Some inquiry participants suggested that if the legislative requirement were to be extended to all aged care facilities, there could be exceptions to permit alternative options to requiring the physical presence of a registered nurse at all times in each facility. The exceptions canvassed during the inquiry include: allowing registered nurses to be on call rather than on duty; utilising technological initiatives, such as Telehealth; or offering access to a clinical resource team rather than a single registered nurse on site. These alternative options are examined in chapter 7.

- 6.19** Another exception canvassed by stakeholders was the provision of an exemption from the legislative requirement for rural and remote aged care facilities, due to the various challenges faced by residential aged care facilities in these areas (discussed in chapter 4). However, while a number of stakeholders highlighted the critical need for registered nurses in these areas, in general inquiry participants across the spectrum of opinion did not support the idea of an exemption.

- 6.20** For example, Dr Lyndal Newton, Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division, strongly opposed exemptions for rural and remote aged care facilities, asserting that an exemption implies a double standard for people in these communities. She maintained that the challenges for these facilities can and must be overcome:

I think that regardless of where you are in this country you are entitled to good care. Giving someone an exemption says that, “Well, we can’t meet the need so we shouldn’t have to”, and I think that we should have to try and meet the need; we should provide quality care whether you live in the country or not. If that proves a little more difficult this is why there are rural incentive schemes in other professions, not necessarily just in medicine, nursing and allied health, and there should be some incentive to have people work in the country if that is proving to be difficult. But we should not just say “You live in the country therefore we should make the standard less for you”.³²⁴

³²³ Evidence, Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, 5 August 2015, p 38 and p 44.

³²⁴ Evidence, Dr Lyndal Newton, Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, p 41.

- 6.21** Ms Halliday also did not support the idea of exemptions for rural and remote aged care facilities, but expressed her argument from the perspective of providing care tailored to a person's needs. Ms Halliday insisted that all residents are entitled to appropriate care, which she acknowledged may or may not entail registered nursing care, regardless of their location:

I think the residents in an aged-care facility have to get the appropriate care regardless. The system has to be designed around the person's care needs when they are in that facility. For many people the high care does not actually refer to nursing care, so it is being clear that the care plan says what they need. If it is that they need nursing care and it is a complex clinical thing, we may be able to get them to a hospital, get them treated and get them back without that complexity – if it is acute, treat it and let the person come back. I am very nervous about exemptions, because we have to think about the person that is actually in the facility.³²⁵

- 6.22** Another argument raised during the inquiry against exemptions for facilities in rural and remote areas is that there is a greater need for registered nurses in these areas as access to doctors is limited (see chapter 4 at paragraphs 4.18-4.20).

- 6.23** As a variant to the suggestion for exemptions for rural and remote aged care facilities, Alzheimer's Australia were asked their views about exemptions for smaller aged care facilities in general, whether they be in rural and remote or metropolitan areas. Mr Brendan Moore, General Manager, Policy Research and Information, Alzheimer's Australia, disapproved of exemptions for smaller facilities, arguing that the needs of residents do not change whether they are in a smaller or larger facility. He declared:

I do not think that it is reasonable to say that just because you are a small facility you should be exempt from the requirements. The needs of the residents do not change. The needs of people in residential aged care are increasing ... You cannot say that a facility with 30 people is a different scenario to a facility with 150 people. The needs are effectively going to be the same; they are just greater in volume. The 150-bed facility obviously has a greater capacity to afford to pay. That is the issue.³²⁶

Repealing the legislative requirement

- 6.24** The final option considered is a repeal of the state legislative requirement altogether. This option was supported by a number of aged care providers and their peak organisations who reflected on the way in which aged care legislation has evolved over time to argue that the current New South Wales requirement for registered nurses is a historical remnant and redundant within today's context of a national regulatory system.

- 6.25** For example, peak organisation Aged & Community Services NSW & ACT described the legislation specifying the registered nursing requirement as 'unnecessary and unhelpful' and asserted that 'the legislation is out of date and must be repealed'.³²⁷

³²⁵ Evidence, Ms Halliday, 5 August 2015, p 40.

³²⁶ Evidence, Mr Brendan Moore, General Manager – Policy Research and Information, Alzheimer's Australia, 10 August 2015, p 9.

³²⁷ Submission 113, Aged & Community Services NSW & ACT, pp 3 and 7.

- 6.26** Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW-ACT, suggested that the New South Wales provision is a ‘miscellaneous omnibus piece of legislation’ that is ‘quite narrow’ in its scope.³²⁸ Moreover, he asserted that the term ‘nursing home’ is a ‘creature of history’ that no longer exists.³²⁹
- 6.27** Likewise, Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW and ACT, argued that the state provision is ‘outdated and cannot remain as it is currently written’ given that ‘no-one else has talked about nursing homes, other than this State, since 1997, and high-care places disappeared last year’.³³⁰ Furthermore, in its submission, Presbyterian Aged Care suggested that the impact of the Commonwealth amendments ‘highlight the archaic state of affairs in NSW by attempting to retain provisions of this nature in State legislation’.³³¹
- 6.28** Mr Sadler discussed the ‘growing gap’ that has existed between the New South Wales requirement and the evolving aged care environment, concluding that it would be difficult to consider legislation with such prescriptive terms moving forward:
- ... it would be almost impossible to draft legislation now that relates to the current circumstances in aged care. Ever since 1997 there has been a growing gap, and as happened when the Nursing Homes Act was repealed in the mid-2000s, it has been difficult to identify where an Act that refers to nursing homes could possibly continue to apply to the aged-care space in the modern aged-care environment.³³²
- 6.29** Aged & Community Services NSW & ACT thus described s 104 as ‘unwarranted’,³³³ while Mr Wurf argued it was superfluous and insisted that there is no evidence to suggest that the provision ‘makes any material difference in the face of the national system’.³³⁴
- 6.30** Nevertheless, a number of written submissions from family members of residents, registered nurses and other aged care workers expressed grave concerns about any potential removal of the requirement, and argued strongly about the integral role registered nurses play in the delivery of aged care services.
- 6.31** For example, Mr Robert Harris declared that repealing the legislative requirement would be ‘unthinkable and appalling’,³³⁵ while Ms Bridgette Mexted claimed that it would put lives at ‘extreme risk’.³³⁶ One individual whose mother had spent the last years of her life in an aged care facility implored the committee not to ‘degrade the quality of care in residential aged care’ by removing the requirement for registered nurses to be on duty at all times.³³⁷

³²⁸ Evidence, Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW-ACT, 5 August 2015, p 29.

³²⁹ Evidence, Mr Wurf, 5 August 2015, p 29.

³³⁰ Evidence, Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW and ACT, 14 August 2015, p 49.

³³¹ Submission 82, Presbyterian Aged Care NSW and ACT, p 2.

³³² Evidence, Mr Sadler, 14 August 2015, p 49.

³³³ Submission 113, Aged & Community Services NSW & ACT, p 2.

³³⁴ Evidence, Mr Wurf, 5 August 2015, p 35.

³³⁵ Submission 15, Mr Robert Harris, p 1.

³³⁶ Submission 97, Ms Bridgette Mexted, p 1.

³³⁷ Submission 77, Name suppressed, p 1.

6.32 Indeed, several inquiry participants discussed the impact on the quality of care residents would receive if the legislative requirement was repealed. Mrs Jessica Prochazkova, for instance, contended that to do so would be ‘a blight on our duty of care to nursing home patients’.³³⁸ Ms Margaret Zanghi commented that it would ‘seriously compromise’ the services provided in aged care facilities.³³⁹

6.33 Ms Crowe from the Combined Pensioners and Superannuants Association drew particular attention to a ‘dire’ situation being made worse if the current legislative requirement was removed:

Older people with high needs have a right to high-quality care; they have a right to feel safe in their nursing home. I do not think we have achieved that universally, even with this regulation, and if it was to disappear then I would say that we risk worsening an already dire situation.³⁴⁰

Concerns about profit maximisation goals

6.34 A number of inquiry participants expressed concern that proponents of removing the legislative requirement for registered nurses are driven by a desire to maximise profits rather than wanting to provide more flexible care to residents in aged care facilities.

6.35 For example, Ms Crowe commented that ‘staffing comprises around 70 per cent of a provider’s budget; so if there is anywhere that they are going to make savings or cost cuts it is typically reducing staffing and highly skilled staff.’³⁴¹

6.36 Ms Crowe contended that some aged care providers are already choosing to employ care workers and assistants in nursing over registered and enrolled nurses:

I think financial considerations are the chief concern that providers have, and that is demonstrated in the evidence. We have seen, as I mentioned, a huge shift to employing care workers and assistants in nursing over registered nurses and enrolled nurses.³⁴²

6.37 Ms Crowe was critical of facilities employing cheaper, unqualified staff on the basis of profit maximisation, noting the increasing frailty of residents in need of quality care:

... much of what is happening in residential aged care is ethically and morally wrong. There has been a substantial shift to replace registered nurses with assistants in nursing and care workers, despite record high acuity levels of residents in care. Many facilities struggle to feed residents let alone provide clinical care or recognise when a resident is deteriorating, and yet profits in the industry are on the rise.³⁴³

6.38 The Palliative Care Service Senior Staff, Calvary Hospital Kogarah also condemned any possible prioritisation of profits over patient care:

³³⁸ Submission 55, Mrs Jessica Prochazkova, p 1.

³³⁹ Submission 32, Ms Margaret Zanghi, p 1.

³⁴⁰ Evidence, Ms Crowe, 10 August 2015, p 28.

³⁴¹ Evidence, Ms Crowe, 10 August 2015, p 29.

³⁴² Evidence, Ms Crowe, 10 August 2015, p 29.

³⁴³ Evidence, Ms Crowe, 10 August 2015, p 28.

It is difficult to comprehend that consideration is being given to allowing RACFs [residential aged care facilities] to function without the essential care provided by Registered Nurses (RNs). We are particularly concerned that this proposed change represents prioritising profits for RACF operators over patient care and deplore this suggestion.³⁴⁴

- 6.39** Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, acknowledged ‘we generally have very caring approved providers’ however commented: ‘I can see if the requirement for registered nurses was taken away, or registered nurses 24 hours a day, this could be seen by some providers as a way of saving money or making money, particularly when funding is tight.’³⁴⁵ The same fear was echoed by another inquiry participant – a registered nurse who has worked in aged care for the past 13 years – who said:

I fear if legislation isn’t in place ensuring RN’s are required to be on duty in nursing homes 24/7, some unscrupulous aged care providers will move to cut costs and no longer employ RN’s to oversee care, instead utilise enrolled nurses and care staff in our place, or solely have RN’s on-call, not immediately accessible.³⁴⁶

- 6.40** Dr Newton, Australian and New Zealand Society for Geriatric Medicine, expressed the view that while some residential aged care providers would reinvest their profits into patient care, others would not.³⁴⁷

- 6.41** Professor Peter Gonski, President, Australian and New Zealand Society for Geriatric Medicine, NSW Division, agreed that the drive for profit was a significant factor for aged care providers, but also acknowledged the genuine desire for flexibility:

I do not think it is totally profit; I just think that they would be much more flexible if their only RN rings up in the evening and says they cannot be there tonight; they can still run a nursing home, an aged-care facility, whereas if there is jurisdiction obviously they are going to have to run around and find someone. So I think for them it is money and it is flexibility.³⁴⁸

Committee comment

- 6.42** The committee acknowledges the many arguments presented throughout this report in support of retaining the legislative requirement for registered nurses in nursing homes, and strongly agrees with the basic principle underlying these arguments – that registered nurses play an incredibly valuable role in the provision of high quality care to older Australians in residential aged care facilities.

³⁴⁴ Submission 118, Palliative Care Service Senior Staff, Calvary Hospital Kogarah, p 1.

³⁴⁵ Evidence, Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, 14 August 2015, p 20.

³⁴⁶ Submission 69, Name suppressed, p 1.

³⁴⁷ Evidence, Dr Newton, 10 August 2015, p 40.

³⁴⁸ Evidence, Professor Peter Gonski, President, Australian and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, pp 40-41.

- 6.43** The committee is particularly swayed by the arguments that a provision mandating registered nurses is still needed at the state level, despite the Commonwealth regulatory framework for aged care. As noted in chapter 5, the committee considers the Commonwealth framework to have some weaknesses that need to be addressed.
- 6.44** The committee therefore believes that s 104(1)(a) of the *Public Health Act* should be retained and that the definition of ‘nursing home’ under the Act be amended to insert a stand-alone definition based on – but not tied to – the now-repealed definition of ‘high level of residential care’ in the pre-1 July 2014 *Aged Care Act 1997* (Cth). The committee believes that linking funding and registered nursing coverage to the assessed needs of residents in this way is both important and desirable, and is consistent with the person-centred principles that are being implemented around the country in other sectors, such as the disability sector under the National Disability Insurance Scheme.
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Recommendation 7

That the NSW Government:

- retain the requirement in section 104(1)(a) of the *Public Health Act 2010* for registered nurses to be on duty in nursing homes at all times, and
- amend the definition of ‘nursing home’ under the Act to read:
 - nursing home** means a facility at which residential care (within the meaning of the *Aged Care Act 1997* of the Commonwealth) is provided, being:
 - (a) a facility at which that care is provided in relation to an allocated place (within the meaning of that Act) to a care recipient whose classification level:
 - (i) includes the following domain categories or combinations of domain categories:
 - (1) a high Activities of Daily Living (ADL) domain category; or
 - (2) a high Complex Health Care (CHC) domain category; or
 - (3) a domain category of medium or high in at least two of the three domain categories; or
 - (4) a high behaviour domain category and either an ADL domain category other than nil or a CHC domain category other than nil; or
 - (ii) is a high level resident respite care.
 - (b) a facility that belongs to a class of facilities prescribed by the regulations.

- 6.45 The above recommendation should go some way in alleviating the concerns of aged care providers that feared the legislative requirement would be extended to all aged care facilities. However, the committee notes that the recommendation, if implemented, will still have the effect of extending the requirement to a number of facilities that were not previously captured under the previous provision.
- 6.46 In this regard, the committee notes the evidence of the need to distinguish between different types of high care needs and acknowledges that not all high care needs may necessitate the care of a registered nurse (as discussed in chapter 3). In particular, the committee notes that, for example, residents with dementia typically rate highly under the behaviour domain category, but not necessarily under the Complex Health Care domain category (as noted in paragraph 3.68).
- 6.47 Moreover, the committee recognises the challenges that may be faced by rural and remote nursing homes in meeting this mandated requirement (as discussed in chapter 4).
- 6.48 In light of these factors, the committee considers that some flexibility in the approach to staffing is warranted. The committee therefore believes nursing homes should be able to apply for exemptions from this legislative requirement on a case-by-case basis. For example, a provider may seek an exemption if they have residents that rate medium or high in activities of daily living and behaviour, and not in complex health care.
- 6.49 In addition, the committee believes that such exemptions should only be granted where the facility can demonstrate that it can still provide a high level of quality care. This could be achieved through a number of alternative avenues which we set out in chapter 7, such as providing on-call access to a registered nurse or general practitioner within a reasonable time period, or through the use of Telehealth systems or other appropriate technologies.
- 6.50 While the committee notes some evidence disapproving of an exemption for rural and remote aged care facilities, the committee emphasises that our recommendation for exemptions is on a case-by-case basis, rather than being a blanket exemption. It is not the committee's intention to promote a 'double standard' of any kind for rural and remote facilities, and agrees with inquiry participants that registered nurses are particularly important in these areas where access to doctors and other health practitioners is limited. The committee believes that our recommendations will ensure a high standard of quality of care without threatening the viability of aged care facilities.

Recommendation 8

That the NSW Government allow nursing homes to apply for an exemption from section 104(1)(a) of the *Public Health Act 2010* on a case-by-case basis, and that exemptions only be granted where the facility can demonstrate that it can still provide a high level of quality care.

Enforcement of the state legislative requirement

- 6.51** While it was clear to numerous inquiry participants that a state requirement for registered nurses in nursing homes is both necessary and desirable, it was not so clear how such a requirement is enforced at present and whether the mechanisms in place for its enforcement are adequate and effective.
- 6.52** Ms Leanne O’Shannessy, Director of Legal and Regulatory Services, NSW Ministry of Health, explained that the regulation of s 104 of the *Public Health Act*, which she noted is a ‘single offence provision’, is enforced through a complaints-based system by NSW Health:
- ... when we have a stand-alone legislative provision requiring something, we would usually have a complaints-based system. If there is a complaint, we would investigate it ... If you have a whole regulatory regime then of course you have a lot more checks and balances such as compliance audits and reviews. What we have in New South Wales is a single provision.³⁴⁹
- ... when you have a single offence provision that is quite narrow on what it requires – it does not deal with the quality of care in nursing homes; it is simply whether there is a registered nurse in attendance – it is appropriate that we do it on a complaints-based process ...³⁵⁰
- 6.53** In regard to the number of complaints received, Ms O’Shannessy informed the committee that NSW Health has had three complaints about breaches of the legislation since 2005. When asked if she was confident that, given the small number of complaints, all relevant nursing homes were complying with s 104, Ms O’Shannessy replied that NSW Health ‘have had no information provided to us that they are not’.³⁵¹
- 6.54** Ms O’Shannessy advised that there are no procedures in place for making complaints about a breach of the provision, noting that in regard to the three complaints received by NSW Health: ‘I think at least two of those matters were either initiated or referred to us through the accreditation processes of DoHA [Department of Health and Ageing]’.³⁵²
- 6.55** There appeared to be some confusion amongst inquiry participants as to whose role it is to enforce the presence of registered nurses in nursing homes under s 104. For example, Professor Colleen Cartwright, Principal Director, Cartwright Consulting Australia, said: ‘I understand that the New South Wales Department of Health have done away with the monitoring in relation to RNs in high care. Is that correct?’,³⁵³ while Ms Halliday was surprised that NSW Health had even taken complaints about breaches of the registered nursing requirement because she assumed all complaints would go to the Commonwealth Government, given that aged care falls within their jurisdiction.³⁵⁴

³⁴⁹ Evidence, Ms Leanne O’Shannessy, Director, Legal and Regulatory Services, NSW Ministry of Health, 5 August 2015, pp 3-4.

³⁵⁰ Evidence, Ms O’Shannessy, 5 August 2015, p 4.

³⁵¹ Evidence, Ms O’Shannessy, 5 August 2015, p 3.

³⁵² Evidence, Ms O’Shannessy, 5 August 2015, p 7.

³⁵³ Evidence, Professor Colleen Cartwright, Principal Director and Chief Executive Officer, Cartwright Consulting Australia, 14 August 2015, p 47.

³⁵⁴ Evidence, Ms Halliday, 5 August 2015, p 41.

- 6.56** Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, told the committee that the monitoring and enforcement of s 104 is ‘at best piecemeal’,³⁵⁵ stating that in his 15 years in aged care, NSW Health has not once contacted any of his organisations regarding compliance with the state legislation.³⁵⁶
- 6.57** Mr Holmes from the NSW Nurses and Midwives’ Association argued that it is ‘in the interest of the State to continue to have a role in high-level oversight’ of the state provision.³⁵⁷

Committee comment

- 6.58** The committee notes that NSW Health is currently responsible for enforcing s 104(1)(a) of the *Public Health Act*, and does so through a complaints-based system. The committee feels that this system is grossly inadequate and fails to ensure that the legislative requirement is being complied with.
- 6.59** Given that the committee supports the retention of this provision, we believe that it is essential that the provision be adequately monitored, regulated and enforced. We therefore recommend that the NSW Government establish a system to ensure this occurs. This could be implemented through NSW Health, or potentially even through a new statutory authority, which could also consider applications for the exemptions recommended at recommendation 2.

Recommendation 9

That the NSW Government establish a system to monitor, regulate and enforce section 104(1)(a) of the *Public Health Act 2010*.

Transparency

- 6.60** Some inquiry participants stressed the need for greater transparency in the industry, particularly in regard to the staffing profiles in nursing homes and whether or not homes have a registered nurse on duty at all times.
- 6.61** Ms Crowe, Combined Pensioners and Superannuants Association, told the committee that she often advises her members to ask about the staffing profile of a nursing home before entering a residency because there is currently no transparency about this information:

My first question I tell them to ask is what the staffing profile is like because that information is not made public generally. They need to know whether there is a registered nurse available at night times and on weekends, what the staffing is like at night times and on the weekend. They are the key things.³⁵⁸

³⁵⁵ Evidence, Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, 14 August 2015, p 8 and p 8.

³⁵⁶ Evidence, Mr Teulan, 14 August 2015, p 8 and p 9.

³⁵⁷ Evidence, Mr Holmes, 5 August 2015, p 47.

³⁵⁸ Evidence, Ms Crowe, 10 August 2015, pp 32-33.

- 6.62** Some aged care providers, such as Mr Teulan from UnitingCare, welcomed greater transparency in the sector, stating:

We are very much in favour of transparency so that people know exactly where they stand. People who make the choice to stay in a local or rural setting should do that with full knowledge of the staffing and the restrictions on staffing. They will then understand that if something changes and they need to go to another place there is a reason for that. We explain that to people anyway. We are happy to have that transparency to deal with that feeling.³⁵⁹

- 6.63** Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator from the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University, supported the staffing flexibility available under the Commonwealth system, but stated that such flexibility must come with ‘a recognition that there needs to be an openness. There needs to be transparency. There needs to be recognition of the level of skill required by these people’.³⁶⁰

Committee comment

- 6.64** The committee strongly supports greater transparency in the aged care system and believes residents and their families should be enabled to make fully informed decisions about the level of care they expect to receive from nursing homes. The committee believes that prospective residents and their families should be able to easily access information about staffing profiles, including the level of registered nursing coverage in a facility.
- 6.65** The committee therefore recommends that all aged care facilities make publicly available their staffing profiles and that such information should be given to prospective residents. In addition, the committee believes that such information should be provided online through the Commonwealth Government’s My Aged Care website.

Recommendation 10

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to require aged care facilities to make information about their staffing skill sets publicly available, including for it to be published on the ‘My Aged Care’ website.

Complaints

- 6.66** A number of inquiry participants also raised concerns and expressed confusion over the aged care complaints system. Stakeholders submitted that it is not clear who residents and their families should approach to lodge a complaint, and that some residents and their families are hesitant to make a complaint for fear of reprisal.

³⁵⁹ Evidence, Mr Teulan, 14 August 2015, p 8 and p 13.

³⁶⁰ Evidence, Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, 10 August 2015, p 27.

- 6.67** In regard to the lodgement of complaints, evidence was received during the inquiry illustrating a fragmented complaints system that some users found difficult to navigate.
- 6.68** The committee was informed that the Commonwealth Department of Social Services manages the Aged Care Complaints Scheme, which receives complaints and other feedback from the public and users of the age care system. Mr Michael Culhane, Branch Manager of Aged Care Quality and Regulatory Policy, from the department explained the nature and activities of the scheme, including free services to resolve concerns, and announced and unannounced visits separate to those conducted by the Australian Aged Care Quality Agency.³⁶¹ The committee was also advised about further measures that can be pursued if a complainant or provider is dissatisfied with the outcome of the complaints process, such as seeking internal reconsideration of the decision or an independent review by the Aged Care Commissioner. Notably, the Aged Care Commissioner will take over responsibility for managing the Complaints Scheme from the Department of Social Services on 1 January 2016.³⁶²
- 6.69** Additionally, Mr Culhane said that if concerns are raised in relation to the conduct of health practitioners, including nurses, these should be directed to the Australian Health Practitioner Regulation Agency in the first instance;³⁶³ while Ms Lisa Langley, Policy Officer, Council on the Ageing NSW, said that her organisation refers people to the My Aged Care website, ‘which is supposed to be the central gateway – the seer and doer of all things’.³⁶⁴
- 6.70** Ms O’Shannessy advised that the Health Care Complaints Commission also has a role in the complaints system, which she understood involves some ‘considerable’ overlap.³⁶⁵
- 6.71** Further, as noted earlier, NSW Health receives complaints about the enforcement of the registered nursing requirement under s 104 of the *Public Health Act*.
- 6.72** According to Aged Care Crisis, there are moves to promote self-regulation of complaints, whereby ‘[c]omplaints by residents or family members to the Aged Care Complaints Scheme will be referred back to the home in question for resolution, including those that identify serious risk to resident health and safety ...’.³⁶⁶ Aged Care Crisis asserted that this will result in ‘weakening of the involvement of the aged care complaints system in complaints handling’.³⁶⁷
- 6.73** To overcome these issues, Dr Bernoth suggested that there should be an external complaints body, as well as improvements in the way in which complaints are handled:

³⁶¹ Evidence, Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, 5 August 2015, p 16.

³⁶² Answers to questions on notice, Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, 4 September 2015, p 4.

³⁶³ Answers to questions on notice, Mr Culhane, 4 September 2015, p 4.

³⁶⁴ Evidence, Ms Lisa Langley, Policy Manager, Council on the Ageing NSW, 5 August 2015, p 58.

³⁶⁵ Evidence, Ms O’Shannessy, 5 August 2015, p 12.

³⁶⁶ Submission 147, Aged Care Crisis, p 4.

³⁶⁷ Submission 147, Aged Care Crisis, p 4.

I certainly think that we do need an external body to look at complaints but I think it needs to be more effective than the one we have at the moment. The bureaucratic speak that people get back in response to their complaints is not helpful.³⁶⁸

- 6.74** In regard to users navigating their way around the system, Mr Clive Watson shared his experiences trying to lodge a complaint after his wife had died following respite care at a nursing home. After contacting the nursing home for information and resolution, Mr Watson said that ‘he was no further advanced and looked for alternatives’.³⁶⁹ In doing so he found the Aged Care Complaints Scheme website but considered it to be confusing and ineffective in meeting his needs:

I found www.agedcarecomplaints.govspace.gov.au however; it was very bureaucratic, off-putting and self-serving, completing the complaint would be difficult for even the above average person. Besides it only has the ability to comment and advise i.e. no teeth. The committee should take care with any statistics provided by them as I am quite sure they turned away more complaints than they handled.³⁷⁰

- 6.75** When asked how information is made available to residents and their families about the complaints system, including their rights and how complaints can be made, Ms O’Shannessy advised that NSW Health does not play an active role in providing information to residents ‘because we are not the regulator of aged-care facilities’.³⁷¹

- 6.76** Ms O’Shannessy said that she expected that the Commonwealth agencies responsible for regulating aged care would have processes ‘for ensuring that residents know their rights and can make complaints’.³⁷² However, Mr Moore from Alzheimer’s Australia advised that in his experience, information about complaints is often just passed through carer support groups:

Further to your point around where people find out about these things, often it is carer support groups. We run a number of those across New South Wales and it is that word of mouth for referral from others – people come into the carer support group and the other carers are very helpful.³⁷³

- 6.77** Another issue raised by some inquiry participants is a reluctance to make a complaint for fear of reprisal. Dr Bernoth discussed what she described as an ‘attack and denial’ approach to complaints in aged care, contending that residents are often afraid to make complaints due to concerns that they may be subsequently targeted:

... people have told me that when they complain the abuse becomes worse. They are targeted. So they are very reticent to make complaints in the future. Our complaints scheme is flawed; we need to do better with that ... We need to welcome complaints as a way to look at systems and improve them, and we are not doing that now. From what I have seen, especially from Aged and Community Services, they seem to attack. When people complain it is attack and denial ...³⁷⁴

³⁶⁸ Evidence, Dr Bernoth, 10 August 2015, p 24.

³⁶⁹ Submission 163, Mr Clive Watson, p 1.

³⁷⁰ Submission 163, Mr Clive Watson, p 1.

³⁷¹ Evidence, Ms O’Shannessy, 5 August 2015, p 13.

³⁷² Evidence, Ms O’Shannessy, 5 August 2015, p 7.

³⁷³ Evidence, Mr Moore, 10 August 2015, p 15.

³⁷⁴ Evidence, Dr Bernoth, 10 August 2015, p 24.

- 6.78** Mr Moore agreed that there is a sense of fear in some residents and their families in regard to lodging a complaint:

[W]e direct the people to make those complaints known to the agency appropriate for dealing with that. In some cases they do not want to do that; people have a real fear of raising complaints about a facility that is looking after their relative 24/7. It is difficult.³⁷⁵

- 6.79** On the other hand, Mrs Imelda Gilmore, Carer and Dementia Advocate, Alzheimer's Australia, shared her positive experiences in dealing with her husband's aged care facility when making a complaint. She stated that on the occasions when she has had to advocate and complain on her husband's behalf, the response from management has been forthcoming and positive,³⁷⁶ thus highlighting the variability in the way complaints can be investigated and treated.

Committee comment

- 6.80** The committee notes the evidence received about the current complaints mechanisms in place for residents and their families to engage and notes the concerns of inquiry participants who are confused by the process. It is evident that the complaints handling system is fragmented and difficult to navigate, and that users have had difficulties determining who to approach if there is a complaint about a residential aged care facility. It is essential that information about the complaints system be made clearer and more accessible to residents and their families.
- 6.81** Complaints about aged care facilities fall within the jurisdiction of the Commonwealth, therefore we recommend that the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to disseminate clear information about how to lodge complaints. At a minimum, this information should be publicised in all aged care facilities and should be provided to residents and/or their advocates prior to entering into a residency.

Recommendation 11

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to disseminate clear information about how to lodge complaints. This should include publicising the information in all aged care facilities and ensuring that residents and/or their advocates receive clear information regarding the complaints process prior to entering into a residency.

- 6.82** The committee notes that complaints about registered nursing coverage under s 104 of the *Public Health Act*, on the other hand, are the responsibility of NSW Health (as discussed earlier in this chapter). The committee refers to its earlier recommendation (recommendation 9) that the NSW Government establish a system to monitor, regulate and enforce this state legislative provision. This system should include the handling of complaints about s 104, and have a

³⁷⁵ Evidence, Mr Moore, 10 August 2015, p 10.

³⁷⁶ Evidence, Mrs Imelda Gilmore, Carer and Dementia Advocate, Alzheimer's Australia, 10 August 2015, p 15.

clear process for the lodgement of complaints. We suggest that this include a user-friendly website and a phone hotline, and that information about the process be widely publicised throughout aged care facilities.

Recommendation 12

That the NSW Government establish a clear process for the lodgement and resolution of complaints about section 104(1)(a) of the *Public Health Act 2010* as part of the new system at recommendation 9, and that information about the complaints process be widely publicised throughout aged care facilities in New South Wales.

- 6.83** The committee is concerned by the evidence that some stakeholders are hesitant to lodge a complaint for fear of reprisal from the aged care facility. The committee did not receive enough evidence regarding this matter to make a recommendation, however, the committee notes that its colleagues in the Legislative Council's General Purpose Standing Committee No. 2 is currently conducting an inquiry into elder abuse in New South Wales, and consider that it may be a matter raised further by stakeholders in that inquiry.

Programs and incentives for registered nurses

- 6.84** Inquiry participants proposed a range of programs and incentives to encourage registered nurses to practise in aged care facilities, and particularly to increase the uptake of registered nurses in rural and remote areas.

Programs for registered nursing students and graduates

- 6.85** Dr Bernoth from Charles Sturt University canvassed a range of potential programs to address the recruitment problem by improving education and training programs offered to registered nursing students and graduates.³⁷⁷ One such program involves providing support for new nursing graduates wishing to work in regional New South Wales. Dr Bernoth discussed the need for strong partnerships to be forged between universities and aged care facilities in order to facilitate this type of program.³⁷⁸
- 6.86** Dr Bernoth advised that distance education courses are already being provided to enrolled nurses wanting to become registered nurses, and suggested scholarships as a means to encourage more aged care staff to progress their careers and become registered nurses.³⁷⁹
- 6.87** Dr Bernoth also spoke of mentoring and preceptor programs in aged care facilities that team new graduates with established registered nurses to support them in their first year of practice. She recommended that a program be established to provide incentives for aged care facilities to build capacity – by enhancing the skills and capabilities of their staff – and participate in such programs.³⁸⁰

³⁷⁷ Evidence, Dr Bernoth, 10 August 2015, p 21.

³⁷⁸ Evidence, Dr Bernoth, 10 August 2015, p 21.

³⁷⁹ Evidence, Dr Bernoth, 10 August 2015, p 21.

³⁸⁰ Evidence, Dr Bernoth, 10 August 2015, p 21.

- 6.88 Other inquiry participants noted that the onus is generally on aged care facilities to provide incentives to entice and keep staff, often at their own expense. For example, a number of aged care providers gave evidence about the training programs offered by their facilities to upskill their aged care workers, including registered nurses.³⁸¹
- 6.89 Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, informed the committee about the formal training provided to her staff:

The responsibility is taken on by the individual facilities. There used to be some [financial support], but once staff have done Certificate III there is not a lot funding for Certificate IV and upwards. That is such a shame. However, we have just enrolled 13 girls in Certificate IV at a cost of about \$2,000 for each staff member. We will meet that expense ourselves because we feel it is very important that they have that level of training.³⁸²

- 6.90 Ms Thompson indicated that this is an area that could be improved as she believes there are opportunities for people in rural and remote areas in particular to extend their training.³⁸³

Adequately remunerate registered nurses in aged care

- 6.91 A number of inquiry participants noted that registered nurses in aged care are paid less than registered nurses in public hospitals, and expressed significant concern with this pay disparity. For example, in regard to the difference in pay between the aged and acute care sectors, Professor Cartwright from Cartwright Consulting Australia declared:

One of the things that bothered me for a long time was that a registered nurse in residential care was paid something like \$387 per week less than a registered nurse in acute care. They are absolutely equally qualified. Some of the staff – for example, assistants in nursing – get paid about the same as the people stacking shelves in Woolworths. What are we doing? These are the people who are caring for our most vulnerable people.³⁸⁴

- 6.92 Dr Esther Kok, member of the Royal Australian College of General Practitioners, noted the difficulty in attracting staff to the sector to argue that registered nurses should receive more remuneration:

My observation is that aged-care nurses unfortunately are not remunerated enough. It is not a very attractive branch of nursing and a lot of younger nurses rarely want to do it and it is left to the older nurses to carry that burden ... I think aged-care nurse in nursing training should be a specialised area and be remunerated adequately to attract the right kind of people.³⁸⁵

³⁸¹ For example, Evidence, Ms Gwen Cleeve, Director of Nursing and Facility Manager, Opal Aged Care Mudgee, 10 August 2015, p 48; Ms Debra Urquhart, Director of Care, Booroongen Djugun Aged Care Facility Kempsey, 14 August 2015, pp 38-39; See also Evidence, Ms Halliday, 5 August 2015, p 45; Evidence, Mr Moore, 10 August 2015, p 16.

³⁸² Evidence, Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, 10 August 2015, p 6.

³⁸³ Evidence, Ms Thompson, 10 August 2015, p 6.

³⁸⁴ Evidence, Professor Cartwright, 14 August 2015, p 44.

³⁸⁵ Evidence, Dr Esther Kok, Member, Royal Australian College of General Practitioners, 14 August 2015, p 31.

6.93 Some aged care providers advised that they have worked towards bridging the pay gap between registered nurses in aged care and their equivalents in the hospital setting. For example, Mr Teulan from UnitingCare explained how UnitingCare has reduced the pay disparity significantly in recognition of the valuable work registered nurses do in their facilities:

... where there was previously a disparity between hospital nurses and aged-care nurses, we have largely been able to eliminate that working with the NSW Nurses and Midwives Association ...

The State Government has constrained increases for registered nurses, hospital staff and staff generally in government-run hospitals in recent years, but aged-care providers have been able to provide higher increases in recent years. What was a significant disparity has now been significantly eliminated, certainly in our case.³⁸⁶

6.94 In addition to wage increases, UnitingCare told the committee that it has taken a number of other steps to improve the wages and conditions in its enterprise agreements for registered nurses:

UnitingCare NSW.ACT has negotiated significant improvements in wages and conditions its NSW and ACT enterprise agreements since 2009. These have included the awarding of wage increases in excess of general increases in the aged care sector in NSW and the ACT; accelerated progression for nursing staff with the removal of incremental levels at years 6-8; the introduction of paid parental leave of 14 weeks, compared to the aged care standard of 9 weeks; higher on-call allowances for nursing staff; paid trade union conference leave for ANMF [Australian Nurses and Midwives Federation]/NSWNMA [NSW Nurses and Midwives' Association] delegates; paid natural disaster leave; and recognition of paid E-learning and other modes of external education and development to assist in maintenance of CPD [Continuing Professional Development] points for nursing registration.³⁸⁷

6.95 Some contended that the Commonwealth Government should play a more active role in settling the wage disparity by providing additional funding to the sector. Mr Sadler, Presbyterian Aged Care, for example, asserted that it is difficult for aged care providers to address wage issues without additional funding from the Government because ultimately, 'you are putting it back onto older people to pay more to make up that difference'.³⁸⁸

6.96 Mr Sadler said that Presbyterian Aged Care has been strongly pushing for improved wages as part of a broader approach to addressing concerns about supporting and strengthening the aged care workforce, but recognised that it was a complex multifaceted area that needed to be considered in its entirety as part of the future of aged care in Australia:

... there is no one solution to workforce; it is a very complex intersecting area: you have got international migration issues, you have got issues about are we offering jobs for people here in Australia. They are complex issues to address. But we have certainly been pushing nationally, along with other provider organisations, consumers, unions

³⁸⁶ Evidence, Mr Teulan, 14 August 2015, p 8 and p 11.

³⁸⁷ Answers to questions on notice, UnitingCare Ageing NSW ACT, 9 September 2015, Attachment, p 1.

³⁸⁸ Evidence, Mr Sadler, 14 August 2015, p 57.

and professional organisations, that that workforce issue, including wages, has to be there as part of the solution to the future aged-care needs of Australia.³⁸⁹

Committee comment

- 6.97** The committee agrees that there should be more incentives to encourage registered nurses to work in aged care facilities, particularly in rural, regional and remote areas.
- 6.98** The committee supports the suggestion from Dr Bernoth for programs to support nursing graduates, especially those from regional universities, to practise in aged care and undertake their training in local aged care facilities. The committee agrees that it is important to build strong relationships between universities and aged care facilities to facilitate this, and believe that greater financial support in establishing these partnerships is essential.
- 6.99** The committee also encourages the development and implementation of mentoring and preceptor programs to ensure registered nurses continue practising in this field, and considers incentives and subsidies for aged care providers to promote such programs among their staff will encourage this. Further, the committee believes that the NSW Government should seek Commonwealth support to provide funding assistance for the training and engagement of registered nurses and graduate placement opportunities in rural, regional and remote areas.

Recommendation 13

That the NSW Government report on existing programs and incentives and investigate additional programs and incentives to support registered nurses to train and work in regional, rural and remote areas.

Recommendation 14

That the NSW Government, through the Council of Australian Governments, seek Commonwealth support to provide funding assistance for the training and engagement of registered nurses, particularly at rural and regional universities, and graduate placement opportunities in rural, regional and remote areas.

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- 6.100** The committee also acknowledges the concerns raised by inquiry participants that registered nurses in aged care facilities are not adequately remunerated. Evidence was received that the pay gap persists between registered nurses practicing in aged care facilities and their counterparts in the public health care system, however as government is only able to influence public salaries and award wages this issue must be addressed by the private providers.

³⁸⁹ Evidence, Mr Sadler, 14 August 2015, p 57.

- 6.101** The committee notes those aged care providers, such as UnitingCare and Presbyterian Aged Care, for reducing the pay disparity between registered nurses in its facilities and registered nurses in the public health system.
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Recommendation 15

That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to take active measures to address the wage disparity between registered nurses in aged care facilities and registered nurses in the public health care system.

Chapter 7 Alternative options

As noted in chapter 6, some inquiry participants suggested a range of alternative options to the legislative requirement for the continuous presence of registered nurses in nursing homes. This chapter examines these alternative options, which include allowing registered nurses to be on-call rather than physically within a facility, innovative methods of care provision such as the use of technology, and access to clinical or allied health resources. This chapter also discusses the wider issue of housing options for the aged.

On-call registered nurses

- 7.1** A number of inquiry participants were supportive of an option to have access to on-call registered nurses, particularly in rural and remote communities, as an alternative to having a registered nurse physically present within an aged care facility at all times. While for many the preference is still to provide a registered nurse on-site, there was acknowledgement that an on-call option is better than none at all.
- 7.2** For example, in discussing the views of the steering committee convened by NSW Health to consider the state legislative requirement for registered nurses, Dr Guan Yeo, Chair of the NSW ACT Faculty of the Royal Australian College of General Practitioners, said there was recognition of the concerns of smaller, regional facilities (as set out in chapter 4) and support for on-call nurses in these areas as a compromise.³⁹⁰
- 7.3** Dr Esther Kok, Member of the Royal Australian College of General Practitioners, also supported an on-call option, however cautioned that this should only apply to rural and remote facilities as the expectation is that metropolitan facilities have greater access to registered nurses and should therefore have a registered nurse on-site at all times.³⁹¹
- 7.4** In regard to the operation of an on-call option, Professor Colleen Cartwright, Principal Director and Chief Executive Officer, Cartwright Consulting Australia, stated that ‘at the very least, you need an RN on-call close enough to get there quickly’.³⁹² She acknowledged that determining what is ‘quickly’ is subjective, however asserted: ‘[I]t certainly does not mean that you are 50 kilometres away. It would be someone within the community’.³⁹³
- 7.5** Indeed, the committee received evidence that on-call arrangements have worked successfully for a number of aged care facilities. UnitingCare NSW ACT, for example, advised that it currently provides two types of staffing models within its facilities: ‘24/7 Registered Nurse support on-site’ and ‘Scheduled and Planned Registered Nurse support on-site with on-call Registered Nurse’.³⁹⁴

³⁹⁰ Evidence, Dr Guan Yeo, Chair, NSW ACT Faculty, Royal Australian College of General Practitioners, 14 August 2015, p 30.

³⁹¹ Evidence, Dr Esther Kok, Member, Royal Australian College of General Practitioners, 14 August 2015, p 30.

³⁹² Evidence, Professor Colleen Cartwright, Principal Director and Chief Executive Officer, Cartwright Consulting Australia, 14 August 2015, p 42.

³⁹³ Evidence, Professor Cartwright, 14 August 2015, p 42.

³⁹⁴ Submission 148, UnitingCare Ageing NSW ACT, p 7.

7.6 UnitingCare explained the nature of the ‘on-site with on-call’ model:

These facilities allocate set times and hours for RNs onsite to provide residents with initial and ongoing assessment, planning, management of care and interventions. These services also have an allocated on-call system to an RN to provide support for unforeseen resident needs and healthcare support.³⁹⁵

7.7 UnitingCare also drew attention to the fact that under the Commonwealth aged care framework, older people with high care needs living in their own home are provided with on-call support:

The Commonwealth has not imposed a 24/7 onsite RN requirement for people classified as high care. There are thousands of people living in their own homes classified as requiring high care (level 3 & 4) home packages that are not receiving 24/7 RN onsite support in their home services. These programs provide 24/7 offsite on-call support.³⁹⁶

7.8 However, some inquiry participants questioned whether such arrangements are acceptable. For example, Ms Deborah Lang expressed the view that having registered nurses on-call rather than in the facility at all times is ‘irresponsible and unworkable’,³⁹⁷ particularly in regards to attending to residents in need of Schedule 8 pain medication. She stated: ‘I can’t imagine the extra time wasted if the Registered nurse wasn’t on site for S8 as required medication provision. The needless suffering that would be caused with delay in administering pain medication is unthinkable’.³⁹⁸**7.9** Likewise, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association, highlighted the need for immediate attention for residents with high care needs, asserting: ‘... we as an organisation would not be comfortable with [on-call registered nurses]. Often time is of the essence when you are dealing with people at this level of acuity. We really do not see that as being a solution, particularly for those high-needs people’.³⁹⁹**Innovative methods of providing care****7.10** Several inquiry participants supported exploring and pursuing innovative methods of providing care as an alternative to providing a registered nurse on duty at all times. They looked to technology and clinical resources to potentially achieve this.

³⁹⁵ Submission 148, UnitingCare Ageing NSW ACT, p 7.

³⁹⁶ Submission 148, UnitingCare Ageing NSW ACT, p 12.

³⁹⁷ Submission 19, Ms Deborah Lang, p 1.

³⁹⁸ Submission 19, Ms Deborah Lang, p 1.

³⁹⁹ Evidence, Ms Charmaine Crowe, Senior Advisor, Research and Advocacy, Combined Pensioners and Superannuants Association of NSW, 10 August 2015, p 36.

Technology – Telehealth and Skype

- 7.11** Given the challenge of resourcing clinical care and advice in rural and remote aged care facilities, some stakeholders canvassed the use of technology to provide high quality care to older people in these facilities.
- 7.12** For instance, Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, recommended that, if access to registered nursing care is required 24 hours a day for all aged care facilities, the Government ‘should allow such access to be available via telephone or other electronic means, rather than requiring on-site presence’.⁴⁰⁰
- 7.13** Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, expressed strong support for the opportunities available to use technology and improve and build upon existing systems, giving evidence about the work done by the Hunter-New England Medicare Local in rolling out the Telehealth model to surrounding aged care facilities. She advised that the model involves a facility calling the hospital, which then uses the full scope of Telehealth technology available to conduct an assessment of the resident. If an ambulance is needed, one is dispatched. If not, measures to treat a resident in place are used. Ms Halliday explained the model in detail:

If someone is unwell of an evening, for example, they ring the hospital. The hospital does a telehealth communication about what is happening. They have the ability to Skype. They take the iPad to the person. They talk about what is happening. If they need an admission then an ambulance is dispatched to get them. Otherwise, if there are other things that can be done to make sure that person is comfortable and not unnecessarily transferred, then that is put in place. They come out, they train the staff in the facility about what to do if such and such happens so that they do not need to call again. There is an outreach program – we love it. In the jargon I think they refer to it as an asset program, where they come out and they will do some training of our staff to say, “When these things happen, you do this, and if that doesn’t work then call us and we will work through what needs to happen”.⁴⁰¹

- 7.14** Professor Cartwright also supported the use of Telehealth to provide some sort of solution – or form ‘part of the equation’⁴⁰² – for residential aged care facilities to provide quality care in rural and remote areas. She informed the committee about a Telehealth project ‘in the home’ that she was involved with that included comprehensive health assessments that were monitored by a local registered nurse who knew her community well and could make clinical judgements based on the information collected:

... people would take their readings several times a week on agreed times. They had up to seven peripheral devices to measure blood pressure, pulse, weight, blood glucose, spirometry, et cetera, and the readings went through to a central data monitoring place so that as soon the RN turned on her computer she would see in red on her dashboard anyone’s readings that had gone outside of the parameters set by their GP. She then used her triaging knowledge of her community, because I said they

⁴⁰⁰ Answers to questions on notice, Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, 9 September 2015, p 2.

⁴⁰¹ Evidence, Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, 5 August 2015, p 39.

⁴⁰² Evidence, Professor Cartwright, 14 August 2015, p 43.

were Aboriginal people, “I am not surprised Auntie Sue’s blood pressure is up today because her sister died last week and she is a bit upset. I will give her a call and see she how she is going”, or, “Oops, Harry’s blood glucose has gone through the roof for the fourth day in a row. I have to get an ambulance out there”, or whatever. That is telehealth in the home.⁴⁰³

7.15 Professor Cartwright acknowledged there is a lot of work to be done in this area, particularly if it were to be applied to residential aged care facilities. She referred to factors such as the payment of specialists providing services over Telehealth, and the dial up technology still currently being used, stating that ‘the best Telehealth requires more than we have at the moment’.⁴⁰⁴ Nevertheless, Professor Cartwright emphasised the strengths of such a model in providing specialised care with the least disruption to residents who would otherwise be distressed or uncomfortable being moved and transported to be treated.⁴⁰⁵

7.16 Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, expressed similar support for the use of technology due to it being sensitive to the needs and wellbeing of residents, particularly residents with dementia, by keeping them in place amongst familiar surrounds. She commented:

To take them out of their environment to a doctor’s surgery is quite stressful for them and often does not make the assessment by the medico as valid as it could be if they could be assessed or seen in the home where they live all the time ...

In their own environment you will get a far more satisfactory assessment and, possibly, diagnosis, than you can by taking someone some distance to a hospital, particularly a hospital in the Hunter region, where it is going to be even more confusing. The patient is going to be very confused and the outcome is not going to be nearly as satisfactory.⁴⁰⁶

7.17 Dr Con Costa suggested that high care residents in aged care facilities could also access specialist consultants or geriatricians, who may assist GPs in complex care management through video conferencing.⁴⁰⁷

7.18 Indeed, Ms Debra Urquhart, Director of Care, Booroongen Djugun Aged Care Facility, talked about her facility’s use of technology to connect residents with specialists they would otherwise spend significant time and funds to access. She explained the needs of the residents in her facility which have necessitated the use of Skype to ‘attend’ renal and diabetes specialist appointments, and reflected on how it has relieved her budget and transport concerns considerably.⁴⁰⁸

7.19 Ms Halliday told the committee about another effective innovation using technology, a ‘state of the art’ wound management system in place in Concord Hospital, but highlighted a

⁴⁰³ Evidence, Professor Cartwright, 14 August 2015, p 43.

⁴⁰⁴ Evidence, Professor Cartwright, 14 August 2015, p 43.

⁴⁰⁵ Evidence, Professor Cartwright, 14 August 2015, p 43.

⁴⁰⁶ Evidence, Dr Janice Herbert, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, 14 August 2015, p 23.

⁴⁰⁷ Submission 137, Dr Con Costa, p 5.

⁴⁰⁸ Evidence, Ms Debra Urquhart, Director of Care, Booroongen Djugun Aged Care Facility, 14 August 2015, p 38.

problem with such programs in that they are often fragmented and run in isolation, rather than being shared.⁴⁰⁹ She observed that a number of these models are ‘run by local health districts or by particularly good Medicare Locals in a partnership, and they are not getting expanded out’.⁴¹⁰ Ms Halliday advocated for a state-wide system of models rather than ‘letting it happen at the level of an individual facility or local health district’, insisting that developing such a system is ‘critical’.⁴¹¹

7.20 Some inquiry participants discussed technology as a means to potentially avoid unnecessary hospital admissions. Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, gave evidence about successful examples of steps taken by local hospitals, including the John Hunter Hospital as part of the Hunter-New England model discussed earlier, to address unnecessary ambulance call outs:

There was a paper presented at a qualitative research conference last year in Newcastle and the emergency staff at John Hunter Hospital presented their concerns about the numbers of older people from residential aged care who are being admitted to their emergency department. They took some steps to address that. They put in place a program that consisted of a multidisciplinary team, they made representations to the aged-care facilities and did some education and set up a phone line so that the staff of the aged-care facility could contact the emergency department and get some advice over the phone before they had to put a frail older person in an ambulance and go through the trauma of being admitted to emergency and lay on a gurney for a number of hours.

Recently I was speaking to the director of nursing at Wagga Base Hospital who was telling me the same sort of thing. He is fairly new to the area but he was bringing together all the directors of nursing of the aged-care facilities in the Riverina to talk to them about the issue and see how they can support the staff with older frail people in residential aged care instead of taking them to the emergency department.⁴¹²

7.21 While Dr Bernoth encouraged the use of technology to provide quality care to residents in aged care facilities, she maintained the position that appropriately qualified people need to operate it. She related it back to the argument about the clinical assessment skills of registered nurses compared to aged care workers (as discussed in chapter 3), stating:

Telehealth is a great way to go. We have to embrace technology. There is a lot to offer ...

The thing is who is there to say that this person needs to be seen on the Telehealth? Who is there to say that this person’s condition has deteriorated, we need to get them on the Telehealth and connect them with the hospital? I am concerned about the assessment skills of our staff in aged care.⁴¹³

⁴⁰⁹ Evidence, Ms Halliday, 5 August 2015, p 44.

⁴¹⁰ Evidence, Ms Halliday, 5 August 2015, p 44.

⁴¹¹ Evidence, Ms Halliday, 5 August 2015, p 44.

⁴¹² Evidence, Dr Maree Bernoth, Senior Lecturer and Postgraduate Course Coordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University, 10 August 2015, p 18.

⁴¹³ Evidence, Dr Bernoth, 10 August 2015, p 23.

- 7.22** Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, also raised concerns about the use of technology, such as the Telehealth model, citing material from the 2013 Nursing and Midwifery Telehealth Consortia which cautioned that 'technology is a means to care, not a replacement for care or the information provided by nurses and midwives'.⁴¹⁴ Like Dr Bernoth, Mr Holmes asserted that the effectiveness of telehealth services in aged care is dependent upon sound clinical judgement at all stages, from assessment to designing treatment to evaluating care outcomes.⁴¹⁵

Access to clinical and allied health resources

- 7.23** A number of inquiry participants proposed some sort of mechanism to provide residential aged care facilities with regular access to clinical and allied health resources, including registered nurses, to meet resident care needs. Flying squads, Medicare Locals and teams of allied health professionals were all discussed.

- 7.24** For example, Professor Peter Gonski, President, Australia and New Zealand Society for Geriatric Medicine, NSW Division, gave evidence about 'flying squads' that are currently available in metropolitan areas which visit residential aged care facilities on-call and assess whether hospitalisation is necessary for a resident. Professor Gonski explained the dynamics of the flying squads and their success rate in keeping residents out of hospitals where appropriate:

Basically what happens is that our team gets called. Within two to four hours a doctor and a nurse practitioner or a clinical nurse consultant will go out and assess the patient and make a decision whether the patient requires hospitalisation or not. If they do not, they will talk to the general practitioner, they will talk to the family and carers and obviously the staff of the facility and they will instigate treatment. In the three-year period we saw 3,000 referrals. We kept 90 per cent of those out of an emergency department and out of hospital.⁴¹⁶

- 7.25** Presbyterian Aged Care expressed support for the use of flying squads as an alternative to continuous registered nursing coverage:

We also note the potential for enhanced information communications technology to alleviate some of the need for RNs to be physically present all the time – some of our colleagues in the aged care industry have models of RN flying squads already in use in lower care residential settings as well as in community aged care.⁴¹⁷

⁴¹⁴ Australian Nursing Federation 2013, *Guidelines for Telehealth Online Video Consultation Funded Through Medicare* cited in Answers to questions on notice, Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association, 2 September 2015, p 7.

⁴¹⁵ Answers to questions on notice, Mr Holmes, p 8.

⁴¹⁶ Evidence, Professor Peter Gonski, President, Australia and New Zealand Society for Geriatric Medicine, NSW Division, 10 August 2015, p 44.

⁴¹⁷ Submission 82, Presbyterian Aged Care NSW & ACT, p 4.

7.26 Another option, suggested by Dr Bernoth from Charles Sturt University, is to do away with the accreditation system under the Australian Aged Care Quality Agency and instead provide aged care facilities with access to specialist groups, similar to Medicare Locals⁴¹⁸:

I suggest something like disbanding the accreditation scheme and setting up regional specialist groups like the Medicare Locals but for aged-care facilities, where we have nurse practitioners, a physiotherapist, an occupational therapist or something like that who can be drawn on by a number of aged-care facilities in those smaller communities. That might be worth exploring.⁴¹⁹

7.27 Dr Bernoth acknowledged that it was not feasible to permanently have such specialist groups in all areas, but argued that at least having access to them and having them visit aged care facilities would be more effective than the current accreditation scheme: ‘To be working there with the staff would be more effective than people who come now every three years, and they are now saying every five years, and look at paperwork.’⁴²⁰

7.28 The value of just being able to access specialist medical staff was reiterated by Mission Australia, which informed the committee that ‘in fact we offer higher levels of care, with a psycho-geriatrician providing a regular clinic onsite to cater for the specific needs of the residents, but it doesn’t require a permanent presence’.⁴²¹

7.29 Other inquiry participants emphasised the importance of allied health professionals. For instance, Mr Steven Teulan, Director of UnitingCare Ageing NSW ACT, said that if he had the choice, he would invest additional funds in allied health staff that he considered to be currently lacking in the delivery of aged care services, such as ‘physiotherapists and other allied health people ... [d]ietitians, diversional therapists, all of those types of social workers, all of those areas which we see in aged-care services overseas but not present in Australia’.⁴²²

7.30 Ms Margaret Strahan, Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT, also supported this view, noting that allied health staff have ‘had some excellent results with people reducing falls, increasing their mobility, maintaining independence. Psychology is another area we are introducing. Getting people in depression, as you know, is a huge issue in our elderly people and having access to expertise is important’.⁴²³ She stressed the importance of providing a varied team of people to meet care needs, declaring: ‘Certainly registered nurses are invaluable but we are part of a team’.⁴²⁴

⁴¹⁸ Note: Medicare Locals are primary health care organisations established as part of the Commonwealth Government’s National Health Reform to coordinate primary health care delivery, address local health care priorities, support health care professionals and improve access to primary care. From 1 July 2015, Medicare Locals were replaced by Primary Health Networks. Primary Health Care Research and Information Services (28 September 2015), http://www.phcris.org.au/guides/medicare_locals.php.

⁴¹⁹ Evidence, Dr Bernoth, 10 August 2015, p 25.

⁴²⁰ Evidence, Dr Bernoth, 10 August 2015, p 25.

⁴²¹ Submission 91, Mission Australia, p 2.

⁴²² Evidence, Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT, 14 August 2015, p 8 and p 15.

⁴²³ Evidence, Ms Margaret Strahan, Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT, 14 August 2015, p 15.

⁴²⁴ Evidence, Ms Strahan, 14 August 2015, p 15.

- 7.31** Mr Paul Sadler, Chief Executive Officer of Presbyterian Aged Care NSW & ACT, shared a similar perspective with UnitingCare, stating that his organisation has also been seeking to employ additional allied health staff to provide a more holistic approach to aged care delivery:

[We] have been trying to employ additional allied health support – diversional therapists and that sort of thing – because we believe that is where there has been a significant gap, historically, in the provision of aged-care services. To a large extent, additional allied health support is being used in the aged-care system now. If we had the magic bucket of money, that is where we, like UnitingCare, would be looking to invest some of it.⁴²⁵

- 7.32** Professor Cartwright explored the idea of an allied health care team that could cater to a cluster of residential aged care facilities, in order to provide access to allied health resources that would not otherwise be available in each facility. She suggested this flexible approach as a way of providing residents with access to such resources when needed:

I think we can also start to be creative with having, perhaps, an RN for a cluster of residential aged-care facilities and community care with a team, which includes assistants in nursing [AINs], enrolled nurses and Allied Health staff, and they can have regular planning meetings, look at their client load, look at their residents and say, “Who is going to be of concern and when and what are we doing about that?”⁴²⁶

- 7.33** However, other inquiry participants warned against the danger of valuing allied health staff over registered nurses. For example, Dr Yeo, Royal Australian College of General Practitioners, advocated the need for strong core care (which would include registered nurses) that is then supported by an ancillary team, which would include allied health professionals. He explained:

My concept is that we have to talk about the core care and then the ancillary. The core, in my mind, would be the ability to monitor for deterioration. In my thinking, therefore, quality trained nursing is the backbone of it. You have to be able to do that and then you can add on the other things. In effect, allied health is very important but you do not add it on and then not have a strong core. That would then become a bit of a problem.⁴²⁷

- 7.34** Mr Holmes, NSW Nurses and Midwives Association, cited information from the Allied Health Professions Australia which highlighted that while there is some overlap in the scope of practice with nurses, allied health professionals have their own unique skill set which enables them to provide highly specialised services. Mr Holmes emphasised that allied health professionals and registered nurses have ‘separate core functions which are complimentary, but not interchangeable due to the very different knowledge and skills base each profession holds’.⁴²⁸

⁴²⁵ Evidence, Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW & ACT, 14 August 2015, p 54.

⁴²⁶ Evidence, Professor Cartwright, 14 August 2015, p 43.

⁴²⁷ Evidence, Dr Yeo, 14 August 2015, p 33.

⁴²⁸ Answers to questions on notice, Mr Holmes, p 7.

Housing options for the aged

7.35 During the course of the inquiry, several participants expressed the view that there is a significant lack of housing options for the aged population in Australia, particularly in rural and remote communities. They discussed how this void in housing options has impacted on the resident mix within aged care facilities and complicates the application of the legislative requirement for registered nurses, should it be retained.

7.36 For example, Ms Crowe, Combined Pensioners and Superannuants Association, reflected on the limited choice older Australians have in residential living, commenting: ‘We do seniors living very poorly in Australia ... older people really do not have much choice in that respect and often end up in a nursing home as a result.’⁴²⁹

7.37 Ms Lisa Langley, Policy Manager, Council on the Ageing NSW, also acknowledged the problem of housing options for older people and suggested that alternative housing arrangements need to be offered given the trend that residents are entering aged care facilities older and with higher, more complex needs. She discussed the home care packages currently available to older Australians but, like Ms Crowe, was concerned for those who, for example, have entered hospital but cannot return home and can only to be transferred to an aged care facility because there is no other choice:

I see the problem as sitting within a wider problem of housing options for older people. I think the reason why a person in this newly reformed system, which no longer has low care and high care distinctions, ends up in a situation like that is because there is a lack of other alternatives in the community for them. There are not enough packages because, as you know, packages are still rationed from region to region, which is unfortunate ...

In my opinion the need is for other housing arrangements. It is quite sad for an older person who has been in hospital and must be transferred somewhere; the only alternative for them is to go into a residential care facility.⁴³⁰

7.38 Similarly, Professor Cartwright observed that ‘at the moment there is nothing between people living on properties or in big houses and residential care. There is nothing in the middle’.⁴³¹ She did acknowledge, however, that according to aged care providers, formerly low care facilities are being replaced by ‘over 55s villages with services ... or a cluster of independent living units’.⁴³²

7.39 Ms Crowe suggested looking to the models used in the Netherlands and Scandinavia which include purpose-built housing for the aged which facilitates home care provision:

If you look at the Netherlands or Scandinavia, they do seniors living really well. You have small clusters of appropriate housing, university-designed housing, which allows the older person to remain in their home and if they have to access home care then that is also available. That kind of model is very limited in Australia. We would love to see more of it. It would be cheaper to provide and it would better facilitate home care

⁴²⁹ Evidence, Ms Crowe, 10 August 2015, p 36.

⁴³⁰ Evidence, Ms Lisa Langley, Policy Manager, Council on the Ageing NSW, 5 August 2015, p 56.

⁴³¹ Evidence, Professor Cartwright, 14 August 2015, p 44.

⁴³² Evidence, Professor Cartwright, 14 August 2015, p 43.

provision. Simple things like stairs can prevent someone from remaining in their home.⁴³³

Committee comment

- 7.40** The committee acknowledges the range of alternative options raised by inquiry participants as a means to maintain a high standard of care for residents in nursing homes without requiring the physical presence of a registered nurse within the home at all times.
- 7.41** In particular, the committee notes the option of on-call access to registered nurses, particularly for rural and remote facilities. While the committee acknowledges the concerns surrounding on-call registered nurses, the committee is supportive of this option in so far as it allows access to a registered nurse in areas where this resource is limited. The committee agrees with inquiry participants that, even though the preference is for a registered nurse on-site, an on-call option is better than none at all.
- 7.42** Likewise, the committee supports the innovative methods of providing care discussed by inquiry participants. In particular, the committee sees merit in investigating technologies that allow nursing homes and other aged care facilities to access hospitals and specialised clinicians, and believes that there is a need for greater knowledge sharing between local health districts and the respective nursing homes within their locale. The committee believes that successful models, such as the Hunter-New England Medical Local model, should be explored for potential roll out to other local area health services.

Recommendation 16

That the NSW Government consider rolling out the Telehealth model of care provided by the Hunter-New England Medical Local across New South Wales.

- 7.43** The committee also appreciates nursing homes having regular access to a clinical or allied health team who can provide care and services in the home. The committee notes the evidence that such health care professionals are currently lacking in aged care and therefore supports moves to provide greater access to them.
- 7.44** However, while the committee sees the value in all of these alternatives, the committee supports the use of these options only under certain circumstances and does not believe they can or should be mutually exclusive to the presence of a registered nurse in a nursing home.
- 7.45** The committee recommended in chapter 6 that nursing homes be permitted to apply for an exemption from s 104 of the *Public Health Act* on a case-by-case basis, and that exemptions only be granted where the facility can demonstrate that it can still provide a high level of quality care (see recommendation 2). The committee is of the view that the alternative options canvassed in this chapter could be used to assist nursing homes applying for such an exemption to attain the necessary high level of quality care.
- 7.46** Finally, the committee notes that the concerns raised by inquiry participants about the increasing care needs of residents within nursing homes has highlighted a broader problem of

⁴³³ Evidence, Ms Crowe, 10 August 2015, pp 36-37.

housing options for the aged. The committee acknowledges that there is limited choice for older Australians who may require minimal assistance or care, or who seek communal living, given the trend for nursing homes to be increasingly occupied with residents of higher, more complex needs. The committee therefore recommends that there be a review of alternative models of housing for older persons, including cooperatives and communal living that may provide an on-site caretaker, and that consideration be given to trialling models that exist in other jurisdictions, such as the Netherlands or Scandinavia, in New South Wales.

Recommendation 17

That the NSW Government:

- review alternative models of housing for older persons other than aged care facilities, including cooperatives and communal living that provide an on-site caretaker, and
 - investigate models in other jurisdictions, including the Netherlands and Scandinavia, that could be trialled in New South Wales.
-

Appendix 1 Submission list

No	Author
1	Name suppressed
2	Ms Jill Wright (Partially confidential)
3	Mrs Pamela Johnston
4	Confidential
5	Country Women's Association of NSW
6	Ms Susan Ardill (Partially confidential)
7	Mrs Katherine Crapp
8	Miss Debbie Hardy
9	Mr Richard Stein (Partially confidential)
10	Name suppressed
11	Ms Kerrelyn Carey
12	Name suppressed
13	Confidential
14	Confidential
15	Mr Robert Harris
16	Ms Linda Hardman
17	Confidential
18	Name suppressed
19	Mrs Deborah Lang
20	Sunhaven Hostel
21	Mr Des Hartree
21a	Mr Des Hartree
22	Mr Gerard Ryan
23	Name suppressed
24	Mrs Nada Carroll
25	Name suppressed
26	Name suppressed
27	Ms Anne Robinson (Partially confidential)
28	Mrs Anne McDonald
29	Ms Janet Langridge
30	Mrs Cecilia O'Meara
31	Mrs Diane Lang

No	Author
32	Mrs Margaret Zanghi
33	Name suppressed
34	Mrs Bevlyn Grant
35	Name suppressed
36	Name suppressed
37	Ms Marie Scholes
38	Mrs Linda Langton
39	St Andrew's Village Ballina Ltd
40	Mrs Reylani Manabat
41	Ms Saniya Sabu
42	Mrs Mary Anne Yeldham
43	Ms Julie Williams
44	Leichhardt Municipal Council
45	Mr Harpreet Singh
46	Mr John Nadjarian
47	Name suppressed
48	Name suppressed
49	Name suppressed
50	National Seniors Australia Randwick-Botany Branch Inc.
51	Name suppressed
52	Name suppressed
53	Name suppressed
54	Name suppressed
55	Mrs Jessica Prochazkova
56	Mrs Penelope Callaghan
57	Ms Robyn Harman
58	Dr Marie Healy
59	Name suppressed
60	Mr Li Hui Tan (Partially confidential)
61	Name suppressed
62	Name suppressed
63	Name suppressed
64	Ms Cheryl Firth
65	Name suppressed
66	Mrs Maree Wiseman

No	Author
67	McLean Care Ltd
68	Confidential
69	Name suppressed
70	Name suppressed
71	Name suppressed
72	Mrs Alison Williams
73	Mrs Kerrie Scotcher
74	Mrs Rebecca Mercer
75	Name suppressed
76	Christophorus House Retirement Village
77	Name suppressed
78	Professor Lynn Chenoweth
79	Ms Leonie Gambrill
80	Mrs Margaret Dungan
81	Name suppressed
82	Presbyterian Aged Care NSW & ACT
83	Australian and New Zealand Society for Geriatric Medicine, NSW Division
84	Mrs Emmarentia Collins
85	Ms Amanda Thackeray
86	Name suppressed
87	NSW Nurses and Midwives' Association
88	Mrs Janice de Jager (Partially confidential)
89	Name suppressed
90	Cancer Council NSW
91	Mission Australia
92	Name suppressed
93	Palliative Care New South Wales
94	Mrs E Leclere (Partially confidential)
95	Ms Lynette Cochran
96	Alzheimer's Australia NSW
97	Ms Bridgette Mexted
98	Mrs Rita Martin
99	Name suppressed
100	Name suppressed
101	Wesley Mission

No	Author
102	Palliative Aged Care Network - NSW
103	Mrs Kate Mannix
104	Mrs Janet Ma
105	Name suppressed
106	Mrs Susan Knight (Partially confidential)
107	National Seniors Australia
108	Leading Age Services Australia NSW-ACT
108a	Leading Age Services Australia NSW-ACT
109	Australian College of Nursing
110	Council on the Ageing NSW
111	Australian Nurse Teachers' Society
112	HammondCare
113	Aged & Community Services NSW & ACT
114	Central Sydney GP Network Ltd
115	Older Women's Network of NSW
116	Australasian College of Care Leadership & Management
117	Silver Chain
118	Palliative Care Service Senior Staff, Calvary Hospital Kogarah
119	Health Services Union
120	Name suppressed
121	Mr Walter de Ruyter
122	Ms Eleanor McDonald
123	Name suppressed
124	Name suppressed
125	Dr Yvonne McMaster
126	Ms Alison Rahn
127	Name suppressed
128	Mrs Suzanne Bouliopoulos
129	Name suppressed
130	Mrs Cheryl Barnard
131	Dr Charles Ovadia (Partially confidential)
132	Dr Maree Bernoth (Partially confidential)
133	Name suppressed
134	Ms Nilda Miranda
135	Ms Ruth Hatch

No	Author
136	Ms Jennifer Blennerhassett
137	Dr Con Costa (Partially confidential)
138	Name suppressed
139	Mrs Cheryl Christie
140	Name suppressed
141	Ms Gwenneth van Duuren (Partially confidential)
142	Name suppressed
143	Name suppressed
144	Name suppressed
145	Dr Arthur Chesterfield-Evans
146	National Tertiary Education Union – NSW Division
147	Aged Care Crisis
148	UnitingCare Ageing NSW ACT
149	Name suppressed
150	Confidential
151	Name suppressed
152	Combined Pensioners & Superannuants Association of NSW
153	Ms Hannah Barclay
154	Ms Jo-Anne McKeough
154a	Ms Jo-Anne McKeough
155	Confidential
156	Confidential
157	Name suppressed
158	Miss Jenny McDonald
159	Bupa Care Services Australia
160	The University of Notre Dame Australia - Sydney School of Nursing
161	Name suppressed
162	Australian Aged Care Quality Agency
163	Mr Clive Watson (Partially confidential)
164	Country Women's Association of NSW - Grattai
165	National LGBTI Health Alliance

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Wednesday 5 August 2015 Parliament House Sydney	Ms Leanne O'Shannessy	Director, Legal and Regulatory Services, NSW Ministry of Health
	Mr Luke Worth	Director, System Relationships, NSW Ministry of Health
	Mr Michael Culhane	Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services
	Mr Ross Bushrod	Director, Quality and Standards, Australian Aged Care Quality Agency
	Mr Charles Wurf	Chief Executive Officer, Leading Age Services Australia NSW-ACT
	Ms Illana Halliday	Chief Executive Officer, Aged & Community Services NSW & ACT
	Mr Brett Holmes	General Secretary, NSW Nurses and Midwives' Association
	Ms Helen Macukewicz	Professional Officer – Aged Care, NSW Nurses and Midwives' Association
	Ms Joanne Russell	Nurse Practitioner – Aged Care, NSW Nurses and Midwives' Association
	Ms Lisa Langley	Policy Manager, Council on the Ageing NSW
Ms Linda Kelly	Councillor, Leichhardt Municipal Council	

Date	Name	Position and Organisation
	Hon John Jobling OAM	Councillor, Leichhardt Municipal Council
	Ms Erla Ronan	Group Manager Community and Cultural Services, Leichhardt Municipal Council
Monday 10 August 2015 Parliament House Sydney	Ms Roberta Thompson	Assistant Manager, Sunhaven Hostel
	Mr Brendan Moore	General Manager - Policy, Research and Information, Alzheimer's Australia
	Ms Imelda Gilmore	Carer and Dementia Advocate, Alzheimer's Australia
	Dr Maree Bernoth	Senior Lecturer and Postgraduate Courses Co-Ordinator, School of Nursing, Midwifery & Indigenous Health, Charles Sturt University
	Ms Charmaine Crowe	Senior Advisor, Research & Advocacy, Combined Pensioners & Superannuants Association of NSW
	Professor Peter Gonski	President, Australian and New Zealand Society for Geriatric Medicine, NSW Division.
	Dr Lyndal Newton	Treasurer, Australian and New Zealand Society for Geriatric Medicine, NSW Division.
	Ms Gwen Cleeve	Facility Manager, Opal Aged Care, Mudgee
	Mrs Bronwyn Heron	Chair, Palliative Aged Care Network

Date	Name	Position and Organisation
	Ms Linda Hansen	Member, Palliative Aged Care Network
	Ms Margaret Dane	Member, Palliative Aged Care Network
Friday 14 August 2015 Parliament House Sydney	Mr Phillip Carter	Chief Executive Officer, St Andrew's Village Ballina
	Mr Steven Teulan	Director, UnitingCare Ageing NSW ACT
	Ms Margaret Strahan	Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT
	Dr Janice Herbert	Gerontologist, NSW Policy Advisory Group, National Seniors Australia
	Dr Guan Yeo	Chair, NSW ACT Faculty, Royal Australian College of General Practitioners
	Dr Ester Kok	Member, Royal Australian College of General Practitioners
	Ms Debra Urquhart	Director of Care, Booroongen Djugun Aged Care Facility, Kempsey
	Professor Colleen Cartwright	Principal Director and Chief Executive Officer, Cartwright Consulting Australia
	Mr Paul Sadler	Chief Executive Officer, Presbyterian Aged Care NSW & ACT

Appendix 3 Tabled documents

Wednesday 5 August 2015

Public hearing, Macquarie Room, Parliament House, Sydney

1. NSW Steering Committee for Aged Care and Membership, *tendered by Ms Leanne O'Shannessy Director, Legal and Regulatory Services, NSW Ministry of Health*
2. Correspondence from Mr John Roach, NSW Health, to Ms Kerrie Westcott, Director, Legislation Section, Transition Branch, Ageing and Aged Care Division, Department of Health And Ageing, NSW Health Submission Proposed Amendments to Commonwealth *Aged Care Act 1997* and Related Legislation, December 2012, *tabled by Ms Jan Barham MLC*
3. Community Strategic Plan 2025, *tendered by Ms Linda Kelly, Councillor, Leichhardt Municipal Council*
4. Leichhardt Healthy Ageing Plan 2015-2024, Plus 4 Year Service Delivery Plan 2015-19, July 2015, *tendered by Ms Linda Kelly, Councillor, Leichhardt Municipal Council*
5. Quality of Care Principles 2013, December 2013, *tendered by Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency*
6. Quality of Care Principles 2014, January 2015, *tendered by Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency*
7. Accreditation Standards, *tendered by Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency*
8. Results and processes guide, October 2014, *tendered by Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency*
9. Assessor handbook, October 2014, *tendered by Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency.*

Appendix 4 Answers to questions on notice

The committee received answers to questions on notice from:

- Aged & Community Services NSW & ACT
- Alzheimer's Australia
- Australian Aged Care Quality Agency
- Booroongen Djugun Aged Care Facility, Kempsey
- Cartwright Consulting Australia
- Combined Pensioners & Superannuants Association of NSW
- Commonwealth Department of Social Services
- Council on the Ageing NSW
- Leading Age Services Australia NSW-ACT
- Leichhardt Municipal Council
- National Seniors Australia
- Australian and New Zealand Society for Geriatric Medicine, NSW Division
- NSW Ministry of Health
- NSW Nurses and Midwives' Association
- Opal Aged Care, Mudgee
- Palliative Aged Care Network - NSW
- Presbyterian Aged Care NSW & ACT
- Royal Australian College of General Practitioners
- School of Nursing, Midwifery & Indigenous Health, Charles Sturt University
- St Andrew's Village Ballina
- Sunhaven Hostel
- UnitingCare Ageing NSW ACT.

Appendix 5 Minutes

Minutes no. 2

Thursday 25 June 2015

General Purpose Standing Committee No. 3

Parkes Room, Parliament House, Sydney, at 2.15 pm

1. Members present

Ms Barham, *Chair*

Mrs Maclaren-Jones, *Deputy Chair*

Mr Franklin

Mrs Houssos

Mrs Mitchell

Revd Nile

Mr Secord

2. Draft minutes

Resolved, on the motion of Mrs Mitchell: That draft minutes no. 1 be confirmed.

3. Consideration of terms of reference

The Chair tabled a letter proposing the following self-reference:

That General Purpose Standing Committee No. 3 inquire into and report on registered nurses in New South Wales nursing homes, and in particular:

1. The need for registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, in particular:
 - a. the impact of amendments to the *Aged Care Act 1997* (Cth) by the *Aged Care (Living Longer Living Better) Act 2013* (Cth) on the requirement under s 104 of the *Public Health Act 2010* to have a registered nurse on duty at all times in a nursing home, and in particular:
 - i. the impact this has on the safety of people in care
 - ii. the possibility for cost-shifting onto other parts of the public health system as a result of any legislative or regulatory change to the current provisions
 - b. the requirement for a registered nurse to be on duty in a nursing home at all times, as compared with requirements in aged care hospital wards
 - c. the administration, procurement, storage and recording of administration of medication by non-registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, as compared with hospital clinical settings
 - d. the role of registered nurses in responding to critical incidents and preventing unnecessary hospital admissions
2. The need for further regulation and minimum standards for assistants in nursing and other employees or carers with similar classifications
3. The adequacy of nurse to patient ratios in nursing homes and other aged care facilities with residents who require a high level of residential care
4. Any other related matter.

Resolved, on the motion of Revd Nile: That the terms of reference be amended by inserting a new paragraph 'The report by the NSW Health Aged Care Steering Committee' before paragraph 4 'Any other related matter'.

Resolved, on the motion of Revd Nile: That the committee adopt the terms of reference, as amended.

4. ***

5. Conduct of the inquiry into registered nurses in New South Wales nursing homes

5.1 Closing date for submissions

Resolved, on the motion of Revd Nile: That the closing date for submissions be 23 July 2015.

5.2 Stakeholder list

Resolved, on the motion of Mrs Mitchell: That the secretariat circulate to members the Chairs' proposed list of stakeholders to provide them with the opportunity to amend the list or nominate additional stakeholders, and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.

5.3 Advertising

The committee noted that the inquiry will be advertised via twitter, stakeholder letters and a media release distributed to all media outlets in New South Wales.

5.4 Timeline

Resolved, on the motion of Revd Nile: That the secretariat circulate proposed dates for hearings and/or site visits and a reporting date, and that the dates be determined by the Chair after consultation with members regarding their availability.

6. Next meeting

The committee adjourned at 2.29 pm, *sine die*.

Madeleine Foley
Committee Clerk

Minutes no. 3

Wednesday 5 August 2015

General Purpose Standing Committee No. 3

Macquarie Room, Parliament House, Sydney, at 8.45 am

1. Members present

Ms Barham, *Chair*

Mrs Maclaren-Jones, *Deputy Chair*

Mrs Houssos

Mrs Mitchell

Revd Nile (Mr Green from 8.50 am – 9.05 am)

Mr Secord

Mrs Taylor

2. Draft minutes

Resolved, on the motion of Mrs Mitchell: That draft minutes no. 2 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received:

- 20 July 2015 – Mr Igor Grabovsky to the committee advising that he would like to provide documents to the inquiry.
- 21 July 2015 – Mr Igor Grabovsky to the committee advising that he would like to provide documents to the inquiry.
- 22 July 2015 – Mr Igor Grabovsky to the committee advising that he would like to provide documents to the inquiry and appear before the committee.

- 23 July 2015 – Mr Igor Grabovsky to the committee providing documents to the inquiry and requesting to appear before the committee.
- 27 July 2015 – Mr Brett Holmes, General Secretary, NSW Nurses and Midwives Association, to Senior Council Officer, accepting the invitation to appear at the public hearing and providing witness details.
- 28 July 2015 – Mr Peter Goslett, Director Policy and Practice, Clinical Innovation and Governance Directorate, Ageing, Disability and Home Care, NSW Department of Family and Community Services, to Principal Council Officer, confirming that the agency has no response to the inquiry.
- 28 July 2015 – Mr Igor Grabovsky to the committee providing documents to the inquiry to support his request to appear before the committee.

Resolved, on the motion of Mrs Taylor: That the committee keep all correspondence and attachments from Mr Igor Grabovsky confidential as they refer to current or proposed legal proceedings and include documents addressed to other entities.

4. Inquiry into registered nurses in NSW nursing homes

4.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of an earlier resolution: submission nos. 3, 5, 7-9, 11, 15, 16, 19-22, 24, 28-32, 34, 37-46, 50, 55-58, 64, 66, 67, 72-74, 76, 78-80, 82-85, 87, 90, 91, 93, 95-98, 101-104, 107-119, 121, 122, 125, 126, 128, 130, 134-136, 139, 145-148, 152-154a, 158.

4.2 Partially confidential submissions

Resolved, on the motion of Mrs Maclaren-Jones: That the names of all aged care facilities and/or their location identified by individuals be omitted.

Resolved, on the motion of Mr Secord: That any graphic photos of individuals contained within submissions be omitted before publication.

The committee noted that the following submissions were partially published by the committee clerk under the authorisation of an earlier resolution: submission nos. 1, 2, 6, 10, 12, 18, 23, 25, 26, 27, 33, 35, 36, 47-49, 51, 52, 53, 54, 59-63, 65, 69-71, 75, 77, 81, 86, 88, 89, 92, 94, 99, 100, 105, 106, 120, 123, 124, 127, 129, 131-133, 137, 138, 140-144, 149, 151, 157.

4.3 Confidential submissions

Resolved, on the motion of Mrs Mitchell: That the committee keep submission nos 4, 13, 14, 17, 68, 150, 155, 156 confidential, as per the request of the authors.

Mr Green left the meeting.

Revd Nile joined the meeting.

4.4 Submission from Mr Clive Watson

Resolved, on the motion of Mrs Maclaren-Jones: That the secretariat redact the name and location of the nursing home, the photo and the web links in Mr Clive Watson's submission.

4.5 Site visits to aged care facilities in Sydney/Ballina

The committee agreed not to undertake any site visits to nursing homes either in Sydney or Ballina.

4.6 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Leanne O'Shannessy, Director, Legal and Regulatory Services, NSW Ministry of Health
- Mr Luke Worth, Director, System Relationships, NSW Ministry of Health

Ms O'Shannessy tendered a document outlining the NSW Steering Committee for Aged Care and its membership.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Michael Culhane, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services
- Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency

Mr Bushrod tendered the following documents:

- Submission by the Australian Aged Care Quality Agency
- Australian Aged Care Quality Agency Accreditation Standards
- Australian Aged Care Quality Agency Assessor Handbook
- Australian Aged Care Quality Agency Results and Processes Guide
- Quality Agency Principles 2013
- Quality Agency Principles 2014

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW – ACT

Mr Wurf tendered a supplementary submission from Leading Age Services Australia

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Brett Holmes, General Secretary, NSW Nurses and Midwives' Association
- Ms Helen Macukewicz, Professional Officer – Aged Care, NSW Nurses and Midwives' Association
- Ms Joanne Russell, Nurse Practitioner – Aged Care, NSW Nurses and Midwives' Association

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Lisa Langley, Policy Manager, Council on the Ageing NSW

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Linda Kelly, Councillor, Leichhardt Municipal Council
- Hon John Jobling OAM, Councillor, Leichhardt Municipal Council
- Ms Erla Ronan, Group Manager, Community and Cultural Services, Leichhardt Municipal Council

Ms Kelly tendered the following documents:

- Leichhardt Council, Community Strategic Plan
- Leichhardt Council, Leichhardt Healthy Ageing Plan 2015-2024

The evidence concluded and the witnesses withdrew.

4.7 Deliberative meeting

Resolved, on the motion of Mrs Houssos: That the committee:

- conduct a public hearing in Sydney instead of Ballina on Friday 14 August 2015
- invite Professor Colleen Cartwright and representatives from National Seniors Australia as witnesses and to arrange for them to appear in person
- invite the following witnesses via teleconference:

- St Andrew's Village
- Yarrabee Aboriginal Community Aged Care Centre or another Aboriginal aged care facility
- Cobar Shire Council
- Royal Australian College of General Practitioners

Resolved, on the motion of Revd Nile: That the committee accept and publish the following documents tendered during the public hearing:

- NSW Steering Committee for Aged Care and its membership
- Submission from the Australian Aged Care Quality Agency
- Australian Aged Care Quality Agency Accreditation Standards
- Australian Aged Care Quality Agency Assessor Handbook
- Australian Aged Care Quality Agency Results and Processes Guide
- Quality Agency Principles 2013
- Quality Agency Principles 2014
- Supplementary submission from Leading Age Services Australia
- Leichhardt Council, Community Strategic Plan
- Leichhardt Council, Leichhardt Healthy Ageing Plan 2015-2024

5. Next meeting

The committee adjourned at 4.29pm until Monday 10 August 2015, 9.00am, Room 814/815, Parliament House (public hearing).

Madeleine Foley
Committee Clerk

Minutes no. 4

Monday 10 August 2015
 General Purpose Standing Committee No. 3
 Room 814/815, Parliament House, Sydney, at 9.03 am

1. Members present

Ms Barham, *Chair*
 Mrs Maclaren-Jones, *Deputy Chair*
 Mrs Houssos
 Mrs Mitchell
 Mr Secord
 Mrs Taylor

2. Apologies

Revd Nile

3. Draft minutes

Resolved, on the motion of Mrs Mitchell: That draft minutes no. 3 be confirmed.

4. ***

5. Inquiry into registered nurses in NSW nursing homes

5.1 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters. The following witness was sworn and examined by teleconference:

- Mrs Roberta Thompson, Assistant Manager, Sunhaven Hostel

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Brendan Moore, General Manager – Policy, Research and Information, Alzheimer’s Australia
- Ms Imelda Gilmore, Carer and Dementia Advocate, Alzheimer’s Australia

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Dr Maree Bernoth, Senior Lecturer and Postgraduate Courses Co-ordinator, School of Nursing, Midwifery and Indigenous Health, Charles Sturt University

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Professor Peter Gonski, President, NSW Division, Australian and New Zealand Society for Geriatric Medicine
- Dr Lyndal Newton, Treasurer, NSW Division, Australian and New Zealand Society for Geriatric Medicine

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined by teleconference:

- Ms Gwen Cleeve, Manager, Opal Aged Care, Mudgee

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mrs Bronwyn Heron, Member, Palliative Aged Care Network
- Ms Linda Hansen, Member, Palliative Aged Care Network
- Ms Margaret Dane, Member, Palliative Aged Care Network

The evidence concluded and the witnesses withdrew.

6. Next meeting

The committee adjourned at 3.20 pm until Friday 14 August 2015, 9.00am, Macquarie Room, Parliament House (public hearing).

Stewart Smith
Committee Clerk

Minutes no. 5

Monday 14 August 2015

General Purpose Standing Committee No. 3

Macquarie Room, Parliament House, Sydney, at 9.00 am

1. Members present

Ms Barham, *Chair*

Mrs Maclaren-Jones, *Deputy Chair*

Mr Green (substituting for Revd Nile)

Mrs Houssos

Mrs Mitchell

Mr Secord

Mrs Taylor

2. Draft minutes

Resolved, on the motion of Mrs Maclaren-Jones: That draft minutes no. 4 be confirmed.

3. Correspondence

The Committee noted the following correspondence

Received:

- 5 August 2015 – Hon Paul Green to Director advising that he will be substituting for the Hon Revd Fred Nile on Friday 14 August 2015.
- 7 August 2015 – Ms Donna Austin, Research Officer, Health Services Union, to Council Officer Assistant, explaining that Mr Gerard Hayes and Ms Lindy Twyford from the Health Services Union will not be attending the hearing on 10 August 2015.
- 10 August 2015 – Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency to Director clarifying evidence provided at the hearing on Wednesday 5 August 2015 (D15/24056) (*attached*).

Resolved, on the motion of Mrs Maclaren-Jones: That the correspondence from Mr Ross Bushrod, Australian Aged Care Quality Agency, clarifying evidence provided at the hearing on Wednesday 5 August 2015 be published.

4. Inquiry into registered nurses in NSW nursing homes**4.1 Public hearing**

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined by teleconference:

- Mr Phillip Carter, St Andrew's Village Ballina

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Steven Teulan, Director, UnitingCare Ageing NSW ACT
- Ms Margaret Strahan, Residential Operating Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined by teleconference:

- Dr Janice Herbert, NSW Policy Advisory Group, National Seniors Australia

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Dr Guan Yeo, Royal Australian College of Practitioners
- Dr Ester Kok, Royal Australian College of Practitioners, by teleconference

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined by teleconference:

- Ms Debra Urquhart, Director of Care, Booroongen Djugun Aged Care Facility, Kempsey

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Professor Colleen Cartwright, Chief Executive Officer, Cartwright Consulting Australia

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW & ACT

The evidence concluded and the witnesses withdrew.

4.2 Deliberative meeting – report tabling date

Resolved, on the motion of Mrs Mitchell: That the committee table its final report on Friday 30 October 2015, and that the committee meet for its report deliberative on Monday, 26 October 2015 at 10 am.

5. Other business

Resolved, on the motion of Mrs Maclaren-Jones: That the committee invite Allied Health Professions Australia to make a written submission to the inquiry.

Resolved, on the motion of Mr Green: That additional supplementary questions be drafted by the secretariat and sent to Mr Michael Culhane, Commonwealth Department of Social Services, regarding whether there is a Commonwealth legislative requirement regarding staffing qualifications, clarification about the role of registered nurses in nursing home, and a definition of the respective roles of the Commonwealth and the State in aged care.

6. Next meeting

The committee adjourned at 3.03pm until *sine die*.

Rhia Victorino
Committee Clerk

Minutes no. 6

Tuesday 25 August 2015

General Purpose Standing Committee No. 3

Room 1136, Parliament House, Sydney, at 1.32 pm

1. Members present

Ms Barham, *Chair*

Mrs Maclaren-Jones, *Deputy Chair*

Mr Colless (substituting for Mrs Taylor)

Mrs Houssos

Mrs Mitchell

Revd Nile

Mr Secord

2. Correspondence

The Committee noted the following correspondence:

Received:

- 25 August 2015 – Government Whip to the secretariat advising that Mr Colless will be substituting for Mrs Taylor for the meeting on 25 August 2015.

3. Inquiry into registered nurses in NSW nursing homes

3.1 Publication of evidence given by Mr Phillip Carter, St Andrew's Village Ballina

Mr Secord moved: That three paragraphs on page 3 of the transcript of evidence given by Mr Phillip Carter, St Andrew's Village Ballina, on Friday 14 August 2015 be redacted.

Mrs Maclaren-Jones moved: That the motion of Mr Secord be amended by omitting all words and inserting instead:

That all words after 'we are just about to go to 121' on page 3 and before 'I will switch to another matter' on page 4 of the transcript of evidence given by Mr Phillip Carter, St Andrew's Village Ballina, on Friday 14 August 2015 be redacted.

Amendment put.

The committee divided.

Ayes: Ms Barham, Mr Colless, Mrs Maclaren-Jones, Mrs Mitchell, Revd Nile.

Noes: Mrs Houssos, Mr Secord.

Amendment resolved in the affirmative.

Original question lapses.

3.2 Comments made to the media by the Hon Walt Secord

Revd Nile moved: That the committee notes that the unauthorised disclosure of confidential committee proceedings in *The Sydney Morning Herald* on 21 August 2015 by the Hon Walt Secord constitutes an interference with the work of the committee under standing order 224.

Mrs Maclaren-Jones moved: That the motion of Revd Nile be amended by omitting all words and inserting instead:

The committee notes that:

- the unauthorised disclosure of confidential committee proceedings in *The Sydney Morning Herald* on 21 August 2015 by the Hon Walt Secord constitutes a substantial interference with the work of the committee and the Legislative Council committee system
- the committee make a special report to the House, describing the circumstances of the unauthorised disclosure and recommending that the matter be referred to the Legislative Council Privileges Committee for inquiry and report.

Amendment put.

The committee divided.

Ayes: Mr Colless, Mrs Maclaren-Jones, Mrs Mitchell.

Noes: Ms Barham, Mrs Houssos, Revd Nile, Mr Secord.

Amendment resolved in the negative.

Original question put and passed.

4. Next meeting

The committee adjourned at 2.01 pm until Monday 31 August 2015, 9.00am, Jubilee Room (Budget Estimates).

Rhia Victorino
Committee Clerk

Draft minutes no. 13

Monday 26 October 2015
General Purpose Standing Committee No. 3
Room 1254 Parliament House, Sydney at 10:05am

1. Members present

Ms Barham, *Chair*
Mrs Maclaren-Jones, *Deputy Chair*
Mr Green (substituting for Revd Nile) from 10.09 am
Mrs Houssos
Mrs Mitchell
Mr Secord
Mrs Taylor

2. Previous minutes

Resolved, on the motion of Mrs Mitchell: That draft minutes nos. 5, 6 and 12 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 10 August 2015 – Mr Michael Culhane, Branch Manager, Quality and Regulatory Policy Branch - Access Quality and Compliance Group, Department of Social Services to Director clarifying evidence provided at the hearing on Wednesday 5 August 2015
- 24 August 2015 – Mr Michael Culhane, Branch Manager, Quality and Regulatory Policy Branch - Access Quality and Compliance Group, Department of Social Services to the secretariat advising that he is unable to provide responses to certain supplementary questions as they are outside the jurisdiction of the Department of Social Services
- 7 September 2015 – Dr Lyndal Groom, Branch Manager - International Strategy Branch, Department of Education and Training, to the secretariat advising that any questions regarding educational qualifications, training and licencing requirements for aged care workers should more appropriately be addressed to other agencies
- 11 September 2015 – Ms Jessica Ellis, Director, Office of the Secretary, NSW Education, to the secretariat advising that they are unable to answer the questions regarding educational qualifications, training and licencing requirements for aged care workers
- 15 September 2015 – Mr Phillip Carter, Chief Executive Officer, St Andrew's Village Ballina, to the secretariat requesting that two portions of his transcript of evidence taken on 14 August 2015 be redacted
- 24 September 2015 – Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia, to committee, advising that Loula Koutrodimos has been appointed Acting Chief Executive Officer of Leading Age Services Australia
- 25 September 2015 – Mr Michael Bopf, Acting Manager, Australian Skills Quality Authority, to Senior Council Officer, advising that responses to the questions regarding the vocational education and training sector and registered training organisations will not be ready by specified date and requesting an extension
- 28 September 2015 – Ms Tanya Vogt, Executive Officer, Nursing and Midwifery Board of Australia, to Chair, providing responses to letter to Dr Cusack seeking information about the education and practice of registered nurses and enrolled nurses
- 2 October 2015 – Mr Christopher Robinson, Chief Commissioner and Chief Executive Officer, Australian Skills Quality Authority, to the Chair, providing responses to the questions regarding the vocational education and training sector and registered training organisations
- 20 October 2015 – Revd the Hon Fred Nile to the secretariat advising that Mr Green will be substituting him for the report deliberative meeting on Monday 26 October 2015

Resolved, on the motion of Mrs Mitchell: That the correspondence from Mr Phillip Carter, Chief Executive Officer, St Andrew's Village Ballina, requesting transcript redactions be kept confidential as it refers to text that was redacted by a previous resolution of the committee.

Sent

- 17 August 2015 – A/Principal Council Officer to Mr Michael Culhane, forwarding further supplementary questions following his evidence on Wednesday 5 August 2015
- 17 August 2015 – A/Principal Council Officer to Ms Peta Lucas, A/Deputy Director, Strategic Relations, Strategic Relations and Communications, NSW Ministry of Health forwarding further supplementary questions to Ms Leanne O'Shannessy and Mr Luke Worth following their evidence on Wednesday 5 August 2015
- 18 August 2015 – A/Principal Council Officer to Mr Igor Grabovsky advising him of the status of his correspondence

- 19 August 2015 – A/Principal Council Officer to Ms Lin Oke, Executive Officer, Allied Health Professions Australia, inviting them to make a written submission to the inquiry
- 7 September 2015 – Chair to Ms Michele Brugine, Secretary, NSW Department of Education, attaching questions regarding educational qualifications for nurses and other aged care workers
- 7 September 2015 – A/Principal Council Officer to Dr Lyndal Groom, Executive Director, Australian Qualifications Framework Council, regarding questions about educational qualifications for nurses and other aged care workers
- 8 September 2015 – Chair to Mr Rod Cooke, Chief Executive Officer, Community Services and Health Industry Skills Council, regarding questions about educational qualifications for nurses and other aged care workers
- 8 September 2015 – Chair to Mr Chris Robinson, Chief Commissioner and Chief Executive Officer, Australian Skills Quality Authority, regarding questions about educational qualifications for nurses and other aged care workers
- 8 September 2015 – Chair to Dr Lynette Cusack, Chair, Nursing and Midwifery Board of Australia, regarding questions about educational qualifications for nurses and other aged care workers.

4. **Inquiry into registered nurses in NSW nursing homes**

Redaction of excerpts from the transcript of evidence from 14 August 2015

Resolved, on the motion of Mrs Taylor: That:

- all words after ‘would you not think?’ and before the words ‘I am sorry for your loss’ on page 5 of the transcript of evidence given by Mr Phillip Carter, St Andrew’s Village Ballina, on Friday 14 August 2015 be redacted.
- all the words after ‘the quality and care that we can’ and before the words ‘Do you think that the accreditation’ on page 6 of the transcript of evidence given by Mr Phillip Carter, St Andrew’s Village Ballina, on Friday 14 August 2015 be redacted.

5. **Public submissions**

The committee noted that the following submissions were published by the committee clerk under the authorisation of an earlier resolution: submission nos. 21a, 164, 165.

Mr Green joined the meeting.

Attachments to submissions

Resolved, on the motion of Mrs Maclaren-Jones: That all attachments to submissions received during the inquiry remain confidential, unless otherwise published by the committee.

6. **Answers to questions on notice**

The committee noted that the following answers to questions on notice and supplementary questions were published by the committee clerk under the authorisation of an earlier resolution:

- Answers to questions on notice and supplementary questions from Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, received 8 August 2015
- Answers to questions on notice and supplementary questions from Dr Maree Bernoth, Senior Lecturer, Postgraduate Courses Co-Ordinator, School of Nursing, Midwifery & Indigenous Health, Charles Sturt University, received 16 August 2015
- Answers to questions on notice and supplementary questions from Ms Illana Halliday, Chief Executive Officer, Aged & Community Services NSW & ACT, received 20 August 2015
- Answers to questions on notice and supplementary questions from Ms Gwen Cleeve, Director of Nursing/Facility Manager, Opal Aged Care, Mudgee, received 20 August 2015
- Answers to questions on notice and supplementary questions from Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW & ACT, received 24 August 2015
- Answers to questions on notice and supplementary questions from Ms Charmaine Crowe, Senior Advisor, Research & Advocacy, Combined Pensioners and Superannuants Association, received 31 August 2015

- Answers to questions on notice and supplementary questions from Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, received 31 August 2015
- Answers to questions on notice and supplementary questions from Ms Danielle Missos, PA to General Manager, Leichhardt Municipal Council, received 31 August 2015
- Answers to questions on notice and supplementary questions from Professor Peter Gonski, President, Australian and New Zealand Society for Geriatric Medicine (NSW Division), received 31 August 2015
- Answers to questions on notice and supplementary questions from Ms Roberta Thompson, Assistant Manager, Sunhaven Hostel, received 1 September 2015
- Answers to questions on notice and supplementary questions from Ms Stella Topaz, Professional Officer - Aged Care, Secretary, QACAG Inc. NSW Nurses and Midwives' Association, received 2 September 2015
- Answers to questions on notice and supplementary questions from Mr Brendan Moore, General Manager, Policy, Research and Information, Alzheimer's Australia NSW, received 2 September 2015
- Answers to questions on notice and supplementary questions from Mr Ross Bushrod, Director, Quality and Standards, Australian Aged Care Quality Agency, received 2 September 2015
- Answers to questions on notice and supplementary questions from Mr Charles Wurf, Chief Executive Officer, Leading Age Services Australia NSW ACT, received 2 September 2015
- Answers to questions on notice and supplementary questions from Professor Colleen Cartwright, Principal, Director, Cartwright Consulting Australia, received 2 September 2015
- Answers to questions on notice and supplementary questions from Dr Maree Bernoth, Senior Lecturer, Postgraduate Courses Co-Ordinator, School of Nursing, Midwifery & Indigenous Health, Charles Sturt University, received 3 September 2015
- Answers to questions on notice and supplementary questions from Mr Michael Culhane, Branch Manager, Quality and Regulatory Policy Branch. Department of Social Services, received 4 September 2015
- Answers to questions on notice and supplementary questions from Ms Bron Heron, Chair, Palliative Aged Care Network (NSW), received 4 September 2015
- Answers to questions on notice and supplementary questions from Dr Tim Jap, Senior External Relations Officer, Strategic Relations & Communications, NSW Ministry of Health, received 9 September 2015
- Answers to questions on notice and supplementary questions from Ms Linda Seaman, Executive Assistant to Director, UnitingCare Ageing NSW ACT, received 9 September 2015
- Answers to questions on notice and supplementary questions from Mr Phillip Carter, Chief Executive Officer, St Andrew's Village Ballina, 15 September, 2015
- Answers to questions on notice and supplementary questions from Ms Naomi Moy, Policy Support Officer, National Seniors Australia, received 15 September 2015
- Answers to questions on notice and supplementary questions from Ms Lisa Langley, Policy Manager, Council on the Ageing NSW, received 17 September 2015
- Answers to questions on notice and supplementary questions from Ms Debra Urquhart, Director of Care, Booroongen Djugun Aged Care Facility, received 22 September 2015
- Answers to questions on notice and supplementary questions from Ms Roslyn Irons, Royal Australian College of General Practitioners, to Council Officer Assistant, received 1 October 2015.

Resolved, on the motion of Mrs Mitchell: That the committee keep confidential Appendix 3 of the NSW Nurses and Midwives' Association's answers to questions on notice as it names and provides a case study of an individual nursing home.

7. Additional documents

The committee noted that a document titled 'NSW Health Submission – Proposed Amendments to Commonwealth Aged Care Act 1997 and Related Legislation' was tabled by the Chair on 5 August 2015.

The following documents that were referred to in the draft report were also tabled by the Chair:
'Dementia care in hospitals: costs and strategies', Australian Institute of Health and Welfare, 2013
'Residential Care Manual', Department of Social Services, 2014.

8. Consideration of the Chair's draft report

The Chair submitted her draft report entitled *Registered nurses in New South Wales nursing homes*, which, having been previously circulated, was taken as being read.

Chapter 1

Resolved, on the motion of Mrs Houssos: That paragraph 1.10 be amended by inserting '**and aged care staff**' after 'The term '**aged care worker**'.

Chapter 2

Mrs Houssos moved: That paragraph 2.35 be amended by omitting 'currently under review' and inserting instead 'currently under discussion'.

Question put.

The committee divided.

Ayes: Mrs Houssos, Mr Secord.

Noes: Ms Barham, Mr Green, Mrs Maclaren-Jones, Mrs Mitchell, Mrs Taylor.

Question resolved in the negative.

Resolved, on the motion of Mrs Houssos: That paragraph 2.44 be amended by inserting 'A number of stakeholders also gave evidence in support of this to the committee' after 'people are deferring entry into residential aged care facilities until they are older and more frail'.

Resolved, on the motion of Mrs Maclaren-Jones: That Table 1 be amended by:

a) omitting:

Occupation	2003#	2007	2012
Nurse Practitioner	n/a	n/a	190 (0.2)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)

b) inserting instead:

Occupation	2003#	2007	2012
Nurse Practitioner	n/a	n/a	190 (0.2)
Registered Nurse	16,265 (21.4)	13,247 (16.8)	13,939 (14.7)
Enrolled Nurse	10,945 (14.4)	9,856 (12.5)	10,999 (11.6)
Personal Care Attendant	42,943 (56.5)	50,542 (64.1)	64,669 (68.2)

Allied Health Professional	5,776* (7.6)	5,204* (6.6)	1,612 (1.7)
Allied Health Assistant	Combined with Allied Health Professional	Combined with Allied Health Professional	3,414 (3.6)
Total number of employees (FTE) (%)	76,006 (100)	78,849 (100)	94,823 (100)

Resolved, on the motion of Mrs Houssos: That paragraph 2.47 be amended by inserting ‘referred to in this report as aged care staff’ before ‘as defined later in this chapter’.

Resolved, on the motion of Mrs Houssos: That paragraph 2.47 be amended by inserting ‘there has been a significant expansion in the aged care sector over the last ten years.’ after ‘As table 1 demonstrates’ and by omitting ‘there has been a significant shift’ and inserting instead ‘There has also been a significant shift’

Chapter 3

Resolved, on the motion of Mrs Houssos: That paragraph 3.5 be amended by inserting ‘trained’ after ‘Certificate III’.

Resolved, on the motion of Mrs Maclaren-Jones: That the following new paragraph be inserted after paragraph 3.8:

‘The Commonwealth Quality of Care Principles 2014 sets out a range of procedures that can only be carried out by ‘A nurse practitioner, registered nurse or enrolled nurse, or other professional appropriate to the service (for example, medical practitioner, stoma therapist, speech pathologist, physiotherapist or qualified practitioner from a palliative care team), acting within their scope of practice.’ The *Guide to the Handling of Medication in Nursing Homes in NSW* covers licensed nursing homes, and *Medication Handling in NSW Public Health Facilities* applies to non-licensed facilities or “hostels”. Both conform to the standards established in the Commonwealth guidelines and make no allowance for unqualified aged care staff to do other than assist’.

[FOOTNOTE: Submission 119, Health Services Union, p 3-5]

Resolved, on the motion of Mrs Maclaren-Jones: That paragraph 3.48 be amended by:

- a) omitting ‘is concerned about’ after ‘The committee’ and inserting instead ‘notes’
- b) inserting ‘The committee notes there are clear guidelines for the handling and administration of medication in NSW and unqualified aged care staff can only assist’ after ‘administer medication.’

Resolved, on the motion of Mrs Maclaren-Jones: That the following new paragraph be inserted after paragraph 3.52:

‘Some participants expressed the need for a multidisciplinary approach to aged care as residents’ needs become more complex.

‘We have had some excellent results with people reducing falls, increasing their mobility, maintaining independence. Psychology is another area we are introducing. Getting people in depression, as you know, is a huge issue in our elderly people and having access to expertise is important. Certainly registered nurses are invaluable but we are part of a team.’

[FOOTNOTE: Evidence Mr Teulan, Director, UnitingCare Ageing NSW ACT, 14 August 2015, p 15.]

Resolved, on the motion of Mrs Maclaren-Jones: That the following new paragraph be inserted before paragraph 3.58:

‘The Health Services Union reported that their members’ duties were ‘moving more and more from assistance and recreational activities to direct care’. The training courses their members undertook were designed to support the changes in residential care and they indicated their members were ‘happy to build up their skills and take a more active care-based role.’

[FOOTNOTE: Submission 119, Health Services Union, p 6.]

Mrs Mitchell moved: That paragraph 3.62 be amended by omitting ‘Many inquiry participants’ and inserting instead ‘A number of inquiry participants’.

Question put and negatived.

Chapter 4

Resolved, on the motion of Mrs Houssos: That paragraph 4.42 be amended by inserting at the end:

‘However, the committee believes that patients and their families should be provided with a clear outline of the staffing allocations, including if registered nurses are provided 24/7, both before they enter the facility and while they are residing there. This is discussed in further detail with a recommendation in chapter 6.’

Resolved, on the motion of Mrs Houssos: That the following new paragraph be inserted after paragraph 4.50:

‘Furthermore, chapter 3 outlined how the transfer of patients to hospitals should be prevented, where possible, as transferring patients, particularly with dementia, can accelerate their decline.’

Resolved, on the motion of Mrs Houssos: That recommendation 1 be amended by splitting the paragraph into two bullet points.

Resolved, on the motion of Mrs Houssos: That the following new paragraph be inserted before paragraph 4.77:

‘The committee is deeply concerned by the submissions received stating that existing aged care staff may be cut as a result of extending the application of s 104 of the Public Health Act 2010 to all aged care facilities.’

Resolved, on the motion of Mrs Houssos: That paragraph 4.91 be amended by omitting ‘capacity in the market’ and inserting instead ‘workforce capacity’.

Chapter 5

Resolved, on the motion of Mrs Houssos: That the following new paragraph be inserted after paragraph 5.25:

‘The Combined Pensioners and Superannuants Association told the committee that “[t]he Aged Care Quality Agency by law only visits facilities during business hours (unless directed otherwise by the Minister), so it does not directly observe staffing outside these times”.

[FOOTNOTE: Submission 152, Combined Pensioners and Superannuants Association of NSW, p 5.]

Resolved, on the motion of Mrs Maclaren-Jones: That paragraph 5.42 be amended by:

- a) omitting ‘in residential aged care facilities in New South Wales’ and inserting instead ‘in places where high care is given,’
- b) inserting at the end: ‘stating that “... on this issue of the minimum requirements for a registered nurse in places where high care is given, the board was unanimous and the unanimity was very quick. Everybody thought that this was a no-brainer”.’

Resolved, on the motion of Mrs Houssos: That paragraph 5.42 be amended by inserting at the end: ‘In his evidence, Dr Yeo outlined such a consensus is rare’.

Resolved, on the motion of Mrs Mitchell: That paragraph 5.50 be amended by omitting ‘is keen to acknowledge’ and inserting instead ‘acknowledges’.

Mrs Maclaren-Jones moved: That the following paragraph 5.54 be omitted:

‘The committee is also significantly concerned with the evidence regarding unsafe practices in nursing homes which do not provide adequate numbers of staff on their premises at all times. We are

disappointed that the Commonwealth Government does not prescribe a minimum staffing ratio in aged care facilities. The committee notes that the government rightly acknowledges the need to prescribe minimum staffing ratios in child care centres, however, has failed to acknowledge the same need in aged care facilities, where some of the most vulnerable members of our society live. We therefore recommend that ratios be established to ensure the safety of residents.'

Question put.

The committee divided.

Ayes: Mrs Maclaren-Jones, Mrs Mitchell, Mrs Taylor.

Noes: Ms Barham, Mr Green, Mrs Houssos, Mr Secord.

Question resolved in the negative.

Resolved, on the motion of Mrs Houssos: That paragraph 5.54 be amended by omitting 'that the government' and inserting instead 'that the Commonwealth Government'.

Ms Houssos moved: That paragraph 5.54 be amended by omitting 'that ratios be established' and inserting instead 'that staffing ratios be established'.

Question put.

The committee divided.

Ayes: Ms Barham, Mr Green, Mrs Houssos, Mr Secord.

Noes: Mrs Maclaren-Jones, Mrs Mitchell, Mrs Taylor.

Question resolved in the affirmative.

Mrs Maclaren-Jones moved: That the following recommendation 4 be omitted: 'That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to establish minimum staffing ratios in aged care facilities'.

Question put.

The committee divided.

Ayes: Mrs Maclaren-Jones, Mrs Mitchell, Mrs Taylor.

Noes: Ms Barham, Mr Green, Mrs Houssos, Mr Secord.

Question resolved in the negative.

Chapter 6

Resolved, on the motion of Mrs Houssos: That paragraph 6.24 be amended by omitting 'several stakeholders' and inserting instead 'a number of aged care providers and their peak organisations'.

Resolved, on the motion of Mrs Houssos: That paragraph 6.30 be amended by omitting 'numerous other inquiry participants, including family members of' and inserting instead 'a number of written submissions from family members of'.

Resolved, on the motion of Mrs Mitchell: That paragraph 6.43 be amended by omitting 'some significant weaknesses' and inserting instead 'some weaknesses'.

Resolved, on the motion of Mr Green: That Recommendation 7 be amended by omitting 'retain section 104(1)(a) of the *Public Health Act 2010* and inserting 'retain the requirement in section 104(1)(a) of the Public Health Act 2010 for registered nurses to be on duty in nursing homes at all times'.

Resolved, on the motion of Mrs Mitchell: That paragraph 6.48 be amended by omitting 'limited flexibility' and inserting instead 'flexibility'.

Resolved, on the motion of Mrs Mitchell: That paragraph 6.50 be amended by omitting 'we note the evidence' and inserting instead 'we note some evidence'.

Resolved, on the motion of Mrs Maclaren-Jones: That Recommendation 8 be amended by omitting 'permit nursing homes' and inserting instead 'allow nursing homes'.

Resolved, on the motion of Mrs Maclaren-Jones: That Recommendation 10 be amended by omitting 'staffing profiles publicly available' and inserting instead 'skill sets publicly available'.

Resolved, on the motion of Mrs Taylor: That Recommendation 13 be omitted: 'That the NSW Government provide incentives and subsidies for registered nurses to train and work in rural, regional and remote aged care facilities', and the following new recommendation be inserted instead:

'That the NSW Government report on existing programs and incentives and investigate additional programs and incentives to support registered nurses to train and work in regional, rural and remote areas.'

Resolved, on the motion of Mrs Taylor: That Recommendation 14 be amended by omitting 'registered nurses' and inserting instead 'registered nurses, particularly at rural and regional universities,'.

Resolved, on the motion of Mrs Houssos: That Recommendation 14 be amended by inserting 'through the Council of Australian Governments' after 'NSW Government'.

Resolved, on the motion of Mrs Mitchell: That paragraph 6.100 be amended by omitting 'It is disappointing to receive evidence that the pay gap persists between registered nurses practising in aged care facilities and their counterparts in the public health care system' and inserting instead:

'Evidence was received that the pay gap persists between registered nurses practising in aged care facilities and their counterparts in the public health care system, however as government is only able to influence public salaries and award wages this issue must be addressed by the private providers.'

Resolved, on the motion of Mrs Mitchell: That paragraph 6.101 be amended by omitting 'however, believes that it should not be the responsibility of providers to address this gap' after 'public health system.'

Mrs Mitchell moved: That paragraph 6.101 be amended by omitting 'Instead, we believe that the Commonwealth Government should address the wage disparity by providing additional funding to the sector'.

Question put.

The committee divided.

Ayes: Mr Green, Mrs Maclaren-Jones, Mrs Mitchell, Mrs Taylor.

Noes: Ms Barham, Mrs Houssos, Mr Secord.

Question resolved in the affirmative.

Resolved, on the motion of Mr Secord: That paragraph 6.101 be amended by omitting 'the committee commends' and inserting instead 'the committee notes'.

Mrs Maclaren-Jones moved: That the following Recommendation 15 be omitted: 'That the NSW Government, through the Council of Australian Governments, urge the Commonwealth Government to take active measures to eliminate the wage disparity between registered nurses in aged care facilities and registered nurses in the public health care system.'

Question put.

The committee divided.

Ayes: Mrs Maclaren-Jones, Mrs Mitchell, Mrs Taylor.

Noes: Ms Barham, Mr Green, Mrs Houssos, Mr Secord.

Question resolved in the negative.

Mr Green moved: That Recommendation 15 be amended by omitting 'active measures to eliminate' and inserting instead 'active measures to address'.

Question put.

The committee divided.

Ayes: Ms Barham, Mr Green, Mrs Houssos, Mr Secord.

Noes: Mrs Maclaren-Jones, Mrs Mitchell, Mrs Taylor.

Question resolved in the affirmative.

Chapter 7

Mrs Houssos moves: That paragraph 7.41 be amended by omitting 'the committee is supportive of this option' and inserting instead 'the committee acknowledges this option'.

Question put.

The committee divided.

Ayes: Mrs Houssos, Mr Second, Ms Barham.

Noes: Mr Green, Mrs Mitchell, Mrs Taylor, Mrs Maclaren-Jones.

Question resolved in the negative.

Resolved, on the motion of Mrs Mitchell: That paragraph 7.42 be amended by omitting 'area' and inserting 'local health districts'.

Mrs Taylor moved: That Recommendation 16 be amended by omitting 'That the NSW Government consider' and inserting instead 'That the NSW Government strongly consider'.

Question put and negatived.

Resolved, on the motion of Mrs Mitchell: That:

- the draft report, as amended, be the report of the committee and that the committee present the report to the House;
- the transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, minutes of proceedings and correspondence relating to the inquiry be tabled in the House with the report;
- upon tabling, all transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, minutes of proceedings and correspondence relating to the inquiry not already made public, be made public by the committee, except for those documents kept confidential by resolution of the committee;
- the committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- the committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;
- the report be tabled on Thursday 29 October 2015.

Resolved, on the motion of Mr Green: That the committee thank the committee secretariat, all stakeholders and the Chair for their efforts.

9. Adjournment

The committee adjourned at 12:41 until Wednesday 28 October 2015 at 1pm (briefing by Link-Up for the Stolen Generations inquiry).

Teresa McMichael
Clerk to the Committee

Appendix 6 Aged care subsidies and supplements



Australian Government

Department of Social Services

Aged Care Subsidies and Supplements New Rates of Payment from 20 September 2015

Home Care Subsidies and Supplements

These rates are applicable from 1 July 2015 to 30 June 2016.

Home Care Subsidy Rates

Home Care Package Level	Subsidy Rate
Level 1	\$21.71
Level 2	\$39.50
Level 3	\$86.84
Level 4	\$132.01

Home Care Supplements

1. Dementia and Cognition and Veterans' Supplement

Home Care Package Level	Amount of Supplement
Level 1	\$2.17
Level 2	\$3.95
Level 3	\$8.68
Level 4	\$13.20

2. EACHD Top Up Supplement

Eligibility	Amount of Supplement
For consumers who were in receipt of an EACHD package on 31 July 2013	\$2.62

3. Oxygen and Enteral Feeding Supplements

Supplement	Amount of Supplement
Oxygen Supplement	\$10.98
Enteral Feeding Supplement – Bolus	\$17.39
Enteral Feeding Supplement – Non-bolus	\$19.54

4. Home Care Viability Supplement

ARIA Score	Amount of Supplement
ARIA Score 0 to 3.51 inclusive	\$0.00
ARIA Score 3.52 to 4.66 inclusive	\$5.22
ARIA Score 4.67 to 5.80 inclusive	\$6.27
ARIA Score 5.81 to 7.44 inclusive	\$8.77
ARIA Score 7.45 to 9.08 inclusive	\$10.53
ARIA Score 9.09 to 10.54 inclusive	\$14.73
ARIA Score 10.55 to 12.00 inclusive	\$17.68

5. Hardship Supplement * – As determined by the Secretary.

* Payable where consumers meet the requirements under the *Aged Care Act 1997*.

Residential Aged Care Subsidies and Supplements

These rates are applicable from 1 July 2015 to 30 June 2016.

Basic Subsidy Rates

1. Daily ACFI subsidy rates*

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	\$0.00	\$0.00	\$0.00
Low	\$36.11	\$8.25	\$16.25
Medium	\$78.62	\$17.10	\$46.27
High	\$108.92	\$35.66	\$66.82

* Where an appraisal or reappraisal is received within 3 months after the end of the appraisal or reappraisal period, if the daily amount for a resident is at least \$25 the basic subsidy for the period up until the appraisal or reappraisal is received (the late claim period) is that amount less \$25. If the daily amount for a resident is less than \$25 the basic subsidy for the late claim period is \$0.

Where an appraisal or reappraisal is received more than 3 months after the end of the appraisal or reappraisal period, the basic subsidy is \$0 for the late claim period.

2. Interim rate for new residents with an ACAT approval awaiting submission of an Application for Classification – \$55.39

3. Daily RCS Rates for Grandparented Residents

RCS classification level	Full amount	Reduced amount for late applications
Classification level 1	\$160.76	\$125.76
Classification level 2	\$145.77	\$110.77
Classification level 3	\$125.58	\$90.58
Classification level 4	\$88.77	\$53.77
Classification level 5	\$54.08	\$34.08
Classification level 6	\$44.78	\$24.78
Classification level 7	\$34.40	\$14.40
Classification level 8	\$0.00	\$0.00

4. Daily Residential Respite Subsidy Rates

Level	Amount of Supplement
Low	\$44.78
High	\$125.58

Residential Aged Care Supplements

These rates are applicable from 1 July 2015 to 30 June 2016.

Supplement	Amount of Supplement
Oxygen Supplement	\$10.98
Enteral Feeding Supplement – Bolus	\$17.39
Enteral Feeding Supplement – Non-bolus	\$19.54
Adjusted Subsidy Reduction	\$12.66
Conditional Adjustment Payment	Rolled into subsidy rates
Veterans' Supplement	\$6.78
Homeless Supplement	\$15.49

Residential Aged Care Viability Supplement

These rates are applicable from 1 July 2015 to 30 June 2016.

2005 Scheme Services*

Score	Amount of Supplement
Eligibility score of 100	\$49.94
Eligibility score of 95	\$44.26
Eligibility score of 90	\$39.73
Eligibility score of 85	\$34.07
Eligibility score of 80	\$28.35
Eligibility score of 75	\$22.69
Eligibility score of 70	\$18.21
Eligibility score of 65	\$12.47
Eligibility score of 60	\$10.21
Eligibility score of 55	\$6.82
Eligibility score of 50	\$4.55
Eligibility score of 45 #	\$0.00
Eligibility score of 40 #	\$0.00
Less than a score of 40	\$0.00

Safety net – former 1997 or 2001 scheme services: viability supplement is \$1.87.

2001 Scheme Services*

Score	Amount of Supplement
Eligibility score of 100	\$30.34
Eligibility score of 90	\$18.66
Eligibility score of 80	\$14.48
Eligibility score of 70	\$10.29

Eligibility score of 60	\$6.10
Eligibility score of 50	\$2.11
Eligibility score of 40	\$1.87

1997 Scheme Services*

Degree of Isolation [^]	Number of Places	Amount of Supplement
Isolated Remote Area	1-15	\$30.34
Isolated Remote Area	16-29	\$18.66
Isolated Remote Area	30 or more	\$1.87
Remote Centre	1-15	\$14.48
Remote Centre	16-29	\$10.29
Remote Centre	30 or more	\$1.87
Rural Outside Large Centre	1-15	\$6.10
Rural Outside Large Centre	16-29	\$1.87
Rural Outside Large Centre	30 or more	\$1.87
All Other Areas	Any	\$1.87

[^] The degree of isolation refers to the classification given to Statistical Local Areas in the "Rural Remote and Metropolitan Area Classification, 1991 Census Edition." AGPS 1994.

* "2005 scheme services", "2001 scheme services" and "1997 scheme services" have the meanings given to them in the *Aged Care Act 1997*.

Residential Aged Care Supplements (Accommodation and Hotel Related)

These rates are applicable from 20 September 2015 to 19 March 2016.

1. Concessional Supplement

Eligibility	Amount of Supplement
Concessional or Assisted if a service is significantly refurbished or newly built	\$53.84
More than 40% low means, supported, concessional and assisted residents	\$40.38
	\$21.45
40% or fewer low means, supported, concessional and assisted residents	\$14.02
	\$8.83
If a service is not significantly refurbished or newly built	
Concessional - more than 40% low means, supported, concessional and assisted residents	
Concessional - 40% or fewer low means, supported, concessional and assisted residents	
Assisted residents	

2. Pensioner Supplement – \$8.04**3. Accommodation Supplement (maximum)**

Eligibility	Amount of Supplement
If a service is significantly refurbished or newly built	
More than 40% low means, supported, concessional and assisted residents	\$53.84
	\$40.38
40% or fewer low means, supported, concessional and assisted residents	\$35.08
	\$26.31
If on the day the service meets building requirements in Schedule 1 of Aged Care (Transitional Provisions) Principles 2014	
More than 40% low means, supported, concessional and assisted residents	\$29.49
	\$22.12
40% or fewer low means, supported, concessional and assisted residents	
If on the day of service does not meet those requirements	
More than 40% low means, supported, concessional and assisted residents	
40% or fewer low means, supported, concessional and assisted residents	

4. Transitional Accommodation Supplement

Eligibility	Amount of Supplement
For the day when the care recipient entered residential care less the amount of accommodation supplement payable for the care recipient	\$8.04
	\$5.36
After 19 March 2008 and before 20 September 2010	\$2.68
After 19 September 2010 and before 20 March 2011	
After 19 March 2011 and before 20 September 2011	

5. Transitional Supplement

Eligibility	Amount of Supplement
Aged care services where residents meet the requirements under the <i>Aged Care (Transitional Provisions) Act 1997</i>	\$21.45

6. Basic Daily Fee Supplement

Eligibility	Amount of Supplement
Where residents meet the requirements under the <i>Aged Care (Transitional Provisions) Act 1997</i>	\$0.56

7. Accommodation Charge Top Up Supplement

Eligibility	Amount of Supplement
Where residents meet the requirements under the <i>Aged Care (Transitional Provisions) Act 2014</i>	As per <i>Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014</i>

8. Charge Exempt Resident Supplement

Eligibility	Amount of Supplement
Where residents meet the requirements under the <i>Aged Care (Transitional Provisions) Act 2014</i>	As per <i>Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014</i>

9. Hardship / Hardship Accommodation

Eligibility	Amount of Supplement
As per the <i>Aged Care Act 1997</i> or <i>Aged Care (Transitional Provisions) Act 1997</i> as appropriate	As determined by the Secretary

10. Respite Supplement

Eligibility	Amount of Supplement
Respite Care – High Level is equal to or greater than 70% of the specified proportion of respite care for the approved provider.	\$87.97
	\$51.70
	\$36.88
Respite Care – High Level is less than 70% of the specified proportion of respite care for the approved provider.	
Respite Care – Low Level	

Further Information on aged care subsidies and supplements can be found at www.dss.gov.au or the Guide to Aged Care Law dss.gov.au/guide-aged-care-law

Appendix 7 Dissenting statement

Dissenting Statement

The Hon Natasha Maclaren-Jones MLC, Liberal Party
The Hon Sarah Mitchell MLC and the Hon Bronnie Taylor MLC, The Nationals

The Government members support the majority of the report as published. However we disagree with paragraphs 5.54 and 6.101 and Recommendations 4 and 15, as adopted.

Recommendation 4

The Government members dissent from the recommendation to 'urge the Commonwealth Government to establish minimum staffing ratios in aged care facilities'. In addition, we do not support the position that the Committee is 'disappointed' the Commonwealth Government does not prescribe a minimum staffing ratio in aged care facilities, as outlined in paragraph 5.54.

According to evidence received by the inquiry, Commonwealth legislation requires aged-care facilities to have sufficient numbers of appropriately skilled and qualified staff, including instances where a registered nurse is required, and this is monitored by the Australian Aged Care Quality Agency.

The Productivity Commission's report released in 2011, "Caring for Older Australians", noted staffing ratios would not be a positive reform because of the diversity of care needed across aged care facilities.

We support the position that it is the responsibility of individual aged care facilities to determine the number and staff skill set they require to ensure that individuals receive quality care. Each individual facility should retain the flexibility to adjust their staffing profile to best suit the needs of their residents. For example, particular residents with greater needs might require more of a staff member's time. In this way, the number of staff in relation to the number of residents will vary between facilities.

Recommendation 15

The Government member's dissent from the recommendation to 'urge the Commonwealth Government to take active measures to eliminate the wage disparity between registered nurses in aged care facilities and registered nurses in the public health care system.'

Aged care is the responsibility of the Commonwealth Government and the Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia. It is not responsible for wage equalisation between the public sector and private organisations.

In every aged care facility across NSW nursing and health service management makes an assessment of staffing requirements, using professional judgement based on a range of factors including specific patient safety, patient needs, previous experience and safe systems of work.

The Commonwealth Government has legislated to achieve a comprehensive national framework for aged care incorporating regulation, funding, accreditation and compliance. Since 1 January 2005 when the NSW Nursing Homes Act 1988 was repealed, NSW has been progressively removing itself from regulation of aged care facilities.

Under the Aged Care Act 1997, the Commonwealth Government is responsible for residential aged care in Australia. Accreditation of residential aged care facilities under the Act is the responsibility of the Australian Aged Care Quality Agency.

The Australian Aged Care Quality Agency is responsible for monitoring residential aged care facilities in meeting the Accreditation Standards. In NSW, residential aged care services are delivered by a range of providers including not-for-profit, private organisations.



The Hon Natasha Macaren-Jones MLC



The Hon Sarah Mitchell MLC



The Hon Bronnie Taylor MLC

