Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales

HEARING
SUPPLEMENTARY QUESTIONS

MAY 2021

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NEW SOUTH WALES BRANCH

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Portfolio Committee No. 2 – Health
Legislative Council
NSW Parliament
Email: portfoliocommittee2@parliament.nsw.gov.au

Dear Chair

Re: Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Please find attached our responses to the supplementary questions provided by the Committee.

Yours sincerely

BRETT HOLMES
General Secretary
NSW Nurses and Midwives' Association

1 Many rural, regional and remote services say they have difficulty attracting the staff they need. Are you aware of any recruitment and retention incentives used in other states to address this?

When we sought feedback from our members in relation to the terms of reference to this Inquiry, the recruitment and retention incentives frequently cited were those offered by Qld Health as detailed in our submission. A review of arrangements in the other Australian states and territories indicates that the package offered by Qld Health is indeed the most competitive, with other states offering a less comprehensive range of benefits, often focussed on scholarships for professional development.

Our view is that if NSW Health wishes to compete effectively for nurses and midwives in rural, regional and remote areas, then the Qld package should be considered the benchmark.

When I started nursing, I couldn't get a graduate program, so I started working for QLD Health as a rural and remote nurse. With this job came RANIP (rural and remote incentive package) which included 2 flights per year to the nearest capital city and generous cash bonuses after each year of service. As well as this incentive came free furnished housing inclusive of electricity. Often now I am tempted to remain in some of the many places I work in country NSW but I would need to buy furniture and very often the rentals in small country towns are either non-existent or very expensive. It's not an incentive to stay in one place in NSW. If I decide to settle in one town I will go back to QLD where there are incentives to accept the challenges of rural work.

However, as effective as these incentives are, it needs to be understood that standard pay and conditions for nurses and midwives in NSW have fallen behind those in other states. NSW nurses and midwives are well aware that they can earn more working in the other states and that legislated minimum staffing levels in Queensland and Victoria provide a superior professional practice environment.

Safe workloads have been the highest priority issue for our members for at least the last 2 decades. As detailed in our submission, our rural, regional and remote members tell us the stress of not having capacity to provide a decent standard of care to their communities is physically and emotionally corrosive. The ongoing failure to address poor skill mix and excessive workloads in rural, regional and remote NSW has led to burn-out and rising attrition rates.

Nurses and midwives are not attracted to services that do not provide safe care and they describe a growing unwillingness to subject themselves to the risk of being involved in an adverse incident by working in an understaffed service. They know that adequate staffing and skill mix delivers better patient care and limits adverse incidents.

Adverse events are often deeply traumatising for nurses and midwives. To be involved in the delivery of substandard care that results in serious injury to or the death of someone's parent or child is personally devastating. Frankly, it is disappointing that we need to explain that and we

encourage the Committee to think carefully about this aspect of the nursing and midwifery role when considering how staff can be attracted to rural, regional and remote service. During our recent testimony, the Hon Wes Fang dismissed the sincere pleas of our members for service enhancements as "melodramatic". This attitude is deeply offensive to nurses and midwives and we believe it indicates a very concerning lack of appreciation for the gravity of the issues at hand. We encourage the Hon Wes Fang to educate himself on the devastating impacts of adverse events and recommend the NSW Coroner's website as a good place to start.

We believe that as long as rural, regional and remote services in NSW are unable to provide an appropriate professional practice environment, the issues associated with recruitment and retention will be ongoing.

2 Mr Holmes, your submission made reference to the safety of nurses and staff in some of these small rural hospitals and how there needs to be adequate security measures in place. Can you outline examples that you may have been given by nurses to highlight how significant this issue is in rural hospitals?

Mental health presentations are the source of very significant safety concerns for our members in rural, regional and remote areas is mental health in rural.

There are rural and regional hospitals in NSW that are "declared facilities" under the Mental Health Act for the purpose of mental health assessments, but do not have an appropriate physical environment nor adequate staffing arrangements in place to safely fulfil this role.

The Mental Health Act 2007 allows the Secretary of NSW Health, by order published in the NSW Government Gazette, to declare any facility to be a declared mental health facility. In a number of instances, it appears that the decision to gazette the facility has more to do with police/ambulance resources for transporting patients than it does the health needs of the individual or the safety of nursing staff.

The Mental Health Act 2007 allows a range of authorised persons, including police officers, ambulance officers, clinicians and accredited persons to detain a person they believe may be mentally ill or mentally disordered and take them to a declared mental health facility for the purpose of undergoing a mental health assessment.

If they are found to be mentally ill or mentally disordered as a result of this assessment, they can be further detained and given involuntary mental health treatment in a declared mental health facility.

The problem arises as follows: a person is detained by police as they are displaying erratic and aggressive behaviour. They are transported to a declared facility for a mental health assessment and the police depart.

There is no one on site capable of conducting a mental health assessment, and the assessment is to be conducted via telehealth. The person is unable to participate in an assessment as they are intoxicated and need to remain on site until they are no longer intoxicated, and the assessment is able to be conducted. There may be only 2-3 nurses working overnight in the hospital (and no other staff onsite). Once the telehealth assessment is conducted, if the person is to be admitted then patient transport must be arranged, which can take a considerable time (sometimes days).

If there is an aggressive incident there are not enough people on site to physically restrain the patient. If nurses press their duress it may be answered by a security firm as far away as Brisbane, who will call the police. The nearest 24-hour police station may be over an hour away.

Narrandera Hospital consists of a 20-bed ward and an emergency department (ED). At night there are 3 nurses on shift working across the ED and the ward. This means there is often one nurse working in isolation in the emergency department (or if 2 nurses are in the ED it leaves one in isolation with up to 20 patients on the ward).

In the event of a violent incident, the facility design limits access to rapid egress and safe havens and does not provide for a purpose-built safe assessment room. The staffing levels, particularly at night, do not allow for a duress response, utilisation of restraint practices or utilisation of sedation practices and there is no local police presence, with the nearest 24 house police service at Griffith 90kms away.

Other hospital Emergency departments that are declared facilities under the Mental Health Act, that do not have mental health beds or the capacity to effectively manage acute severe behavioural disturbances include:

- Moree
- Corowa
- Deniliquin
- Leeton
- Young
- Lithgow
- Bateman's Bay
- Cooma
- Bowral
- Mudgee

Nyngan

Nyngan is a multipurpose service (MPS) with approximately 20 aged care beds, 8 dementia specific beds, 6 acute beds and an ED. The night shift staffing consists of 1 Registered Nurse (RN) and 2 Enrolled Nurses (EN). In one incident, 2 people presented to the doors of the ED and found that the doors were shut. The people presenting were demonstrably intoxicated and tried to smash in the doors. Nursing staff were terrified and knowing there was no security or police they were forced to set off the fire alarm in the hope that the local RFS would respond.

Cobar

A mental health patient had been there for 4-5 days with an AIN special as an ambulance wouldn't come and retrieve.

Wellington

Wellington has a large transient population associated with the prison, and a lot of social disadvantage. Nursing staff report antisocial activity including incidents where their car windows have all been smashed.

Cooma

Cooma Hospital consists of an ED, a 20-bed ward and a maternity unit (located on a different floor of the building to the ED and the ward). At night there is 1 nurse working in isolation in the ED, 3 nurses in the ward and a midwife working alone in the maternity unit. Security on 4 nights per week.

In one incident 2 of 3 nurses on the ward were threatened and injured by a patient. Outsourced security took 45 minutes to arrive.

Leeton

Leeton District Hospital consists of a ward and an emergency department. Current nursing staffing numbers at night are inadequate leaving a single nurse working in isolation in the ED in contravention of the requirements of Protecting People and Property which clearly states that "no nurse will be working alone in isolation" and which describes working in isolation as including a nurse working alone in a unit separated from other units by closed doors.

It has one full time Heath & Security Assistant (HASA) and is otherwise without a localised security response across all other shifts.

Nursing numbers do not allow for the provision of continuous visual observation or 1:1 special observation for patients triaged as a 1 or a 2 as outlined in the "Mental Health for Emergency Departments – reference guide" and are insufficient to provide for a patient restraint in the event of a violent incident or if required to provide for intramuscular medication.

Cowra

Security Audit identified risks including:

- no control measures have been put in place due to poor facility design
- no air lock
- no CCTV for facial recognition on exit
- waiting room in disused corridor
- no safe room
- no fixed duress.

Incidents have occurred in the ED associated with management of violent patients. Aggressive patients are managed within the ED placing staff and other patients at risk. There is insufficient

staff to perform a restraint. A decision was made not to train staff in restraint due to low numbers. The facility is reluctant to make change as anticipating a new hospital build by 2025

Rylestone

ED location is in isolation from other wards separated by office space that is unoccupied after hours. Low staff numbers after hours are insufficient to perform a restraint. When unpredictable patients come to ED requiring a staff member from ward to attend to maintain 2 staff, one staff member is left alone with up to 30 patients.

Mudgee

Declared Mental health facility 130k from Dubbo or Bathurst. There is limited support after hours by police. At midnight an aggressive patient of known risk appeared at entry to ED. The intercom and CCTV were not operational. The HASA was upstairs cleaning theatres. There was 1 nurse in isolation in ED with rest of staff upstairs on the wards. The nurse treating a mother and child evacuated patients from ED via rear Ambulance bay into darkness. The nurse called staff upstairs as if they attended the ED from the designated route they would walk into the incident. Staff attended via external fire escape and entered via Ambulance bay. The patient damaged the waiting room and the nurse suffered injury from aggression and PTSD. The SafeWork NSW Improvement Notice required 2 staff to be in ED at all times. This was achieved with employing an extra HASA for all shifts

Dungog

2 staff only after hours to provide care to ~30 residents and operate an ED. If assistance required in ED patients are left unattended. Control measure is to request Ambulance assistance or on call doctor. An incident occurred with aggressive wandering patient accessing ED after hours who damaged ward and equipment. Patient was secured in isolation in ED due to aggression until assistance provided. Police attended to restrain patient. The Facility Manager and DoN unable to progress any improvements in staffing despite their support for doing so when escalated to senior LHD management.

Condobolin patient “JW”

This patient required wound care three times per week, requiring nurse to administer care in close quarters during which time the patient hurled abuse at nursing staff without any provocation. The abuse was highly personalized and targeted and often escalated to the patient hitting nursing staff with his “pick up stick”. Despite the existence of a conditional treatment agreement since November 2018, which set conditions of behaviour that the patient must satisfy to continue to receive treatment from Western NSW Local Health District (“the LHD”), the patient continued verbal and physical abuse of staff unabated. The continual breaches of the conditional treatment agreement were brought to the attention of the LHD by NSWNMA on numerous occasions, however the LHD did not act due to the unavailability of any treatment alternatives in the area.

Albury – Nolan House Mental Health

Nolan House is a mental health facility consisting of a 20-bed general adult acute unit, and a 3-bed high dependency unit for patients that cannot be safely treated in the general adult acute setting. Provision of care on these wards requires highly trained specialist mental health nurses to safely manage the acute behavioural disturbances and frequent aggression present in these patient populations. That is particularly so in the High dependency unit, where patient violence and aggression against staff is common.

Specialist mental health nurses are very difficult to recruit in the regional setting, often resulting in casuals and junior nurses with no mental health experience being rostered to work in mental health, and with the most acutely unwell patients in the High Dependency Unit. The rate of violent incidents and serious assaults upon staff appears to be increasing in recent times as the shortage of trained mental health clinicians worsens.

Manning Hospital - Taree

Similar to Nolan House, incidents involving violence and aggression directed at staff are becoming more frequent as appropriate skill mix and staffing levels grow more difficult to achieve. In addition, closure of the ward dedicated to safe management of delirious patients has caused immense problems with patients suffering delirium and dementia now having to be managed in a physical environment that is unsafe and inappropriate for their care.

3 We received a large number of submissions from nurses, obviously with their names withheld to protect them, they have raised many concerns, but a common theme is the pressure particularly those working in Emergency Departments without doctors. Some have said they don't feel like they take leave as there is no one to replace them. Mr Holmes, your members must be under an enormous amount of pressure, what is the number one thing they seek the help of their union for? How does this differ from those in the major cities?

As detailed in our submission, the priority issues for our members are safety and workloads. Over the last 20 years, our research with our members has consistently identified workloads as a top issue for our members. Excessive workload drives stress and burnout for nurses and midwives who simply cannot meet all the needs of the patients who are relying on them in the time available to them. Outside of the major centres this stress in exacerbated by factors such as the absence of clinical support, inability to take leave because they know they won't be replaced, the stress of being responsible for clinical issues that are beyond their scope of practice, and delivering a standard of care to their community that they know is substandard due to lack of resources.

Of growing priority within our membership is the issue of violence and safety at work. Once again, for rural, regional and remote nurses and midwives, the stress associated with violence and safety at work is exacerbated by isolation, lack of security, inappropriate infrastructure and a wide range of issues that we have raised repeatedly with the relevant authorities. The lack of serious action in response is unconscionable in our view.

4 Have your members raised concerns about Telehealth? If so, can you please outline some of the most common issues nurses have in relation to telehealth?

The feedback we received from our members for this Inquiry is included in our submission. Our members value telehealth as an extremely useful tool in many situations but it is not a panacea. Reliance on telehealth has a number of challenges that need to be addressed. Connectivity is a problem in some areas. Our members report that there are occasions when it doesn't work or there is a delay so difficult for the medical officer at the other end of camera to make an accurate assessment. Our members have raised concerns about its utility for mental health assessments.

In general there is a concern that use of telehealth for medical consultation places an increased burden of responsibility on the nurse who is present with the patient who is responsible for the nursing role but then is also responsible for performing aspects of the medical role. It exposes nurses to working outside their scope of practice and increased expectations to deal with emergencies. It further reinforces the need to increase staffing by Registered Nurses in smaller facilities operating Emergency Departments.

It provides a good example of how nurses and midwives in rural, regional and remote areas often work at the top of their scope of practice and beyond. They should have enhanced access to relevant professional development education, both in terms of leave and scholarship support, in order to meet the demands placed on them by the use of telehealth.

5 In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding ways to improve both the access and availability of palliative medicine, nursing and care in rural, regional and remote New South Wales?

From our perspective there are 2 key areas which require action in rural and regional areas. The first is the need to ensure that enough staff with adequate skill mix are available to deliver end of life care and the second is for these staff to be supported effectively by specialised palliative care services.

In terms of the latter, we believe there is enormous potential for Nurse Practitioners (NPs) to provide leadership in the delivery of palliative care in rural, regional and remote parts of NSW and to support nursing staff who are providing end of life care. The ability of NPs to provide advanced clinical care while working independently and collaboratively makes them an ideal option for improved access to palliative care in underserved areas. There is a very substantial body of evidence supporting the effectiveness of this role and there must be a commitment from the NSW Government to ensure that rural, regional and remote communities have access to their affordable, high quality services.

The MPS Program in NSW is comprised of 64 services with a total of 1,193 aged care places, 90% of which are designated high care places[1]. Those entering these services typically have multiple co-morbidities, disabilities, dementia, and complex care needs. The average length of stay is below three years suggesting many residents use residential aged care at the end of their lives and enter requiring palliative care[2] or subsequently need 'as required' pain relief to ensure a dignified and comfortable end of life.

As detailed in our submission, the widespread poor staffing levels in these MPS services mean that people requiring palliative care are being cared for in a system that denies them access to a minimum safe level of nursing care.

The provision of guaranteed minimum staffing ratios not only benefits residents but creates a professionally safe and attractive workplace for aged care workers. RNs and ENs frequently cite burnout and untenable workloads when explaining why this sector is not appealing to work in. Unsafe staffing and skills mix put considerable pressure on their ability to maintain and work within the scope of their professional responsibilities. Good clinical governance and safe and secure working environments supported by ongoing education and professional development opportunities will make aged care a clinical specialty that can appeal to current and future generations of nurses and other health professionals.

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[1] Department of Health (2020) 2019-20 Report on the Operation of the Aged Care Act 1997. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf

[2] Department of Health (2020) Op. cit.

50 O'Dea Avenue
Waterloo NSW 2017

EMAIL
gensec@nswnma.asn.au

PHONE
8595 1234 (METRO)
1300 367 962 (NON-METRO)

FAX
(02) 9662 1414

www.nswnma.asn.au