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Ms Rhia Victorina
Principal Council Officer
General Purpose Standing Committee No 3
Legislative Council
Parliament House, Macquarie St
SYDNEY NSW 2000

Dear Ms Victorina

Re: Inquiry into the registered nurses in New South Wales nursing homes

Thank you for the opportunity to check the transcript of my evidence to the Enquiry, to respond to the question on notice and to answer the supplementary questions.

Transcript: As requested, I have carefully checked the transcript and made minor corrections in the left-hand margin, as directed.

Question on Notice: The Hon. Natasha Maclaren-Jones (p48 of the transcript) said that, in my opening statement I said something about "not allowing them" in relation to nurses. She asked who I was referring to as "them".

A: I have read the transcript thoroughly and I cannot find those words. The only place in my opening statement where the word "allowing" appears is where I said (Line 4, p41). "By allowing aged-care facilities to not have 24/7 RN cover …". In this sentence I was referring to my concern that, if the current NSW legislation is repealed, as proposed, facilities would have no legal imperative to have 24/7 cover, even large facilities with high numbers of residents with high-care needs.

Supplementary Questions:

1. In your evidence at the hearing you discussed the importance of access to a registered nurse and their role in people's care. Could you please elaborate about the circumstances or conditions where a registered nurse's presence and the role they can perform would be crucial?

I believe that a registered nurse is needed, in person,

(a) to undertake care planning with residents (if they have capacity), their families, the resident's GP if available and other staff involved in the resident's care; issues that should be discussed at such a time include:

   a. why no CPR would be used if the resident's heart stopped (and that requires knowledge about the very, very limited chance that the resident would survive the CPR attempt, and that, even if they survived they would almost certainly be in a much worse condition than they were previously, possibly with fractured ribs which would make breathing painful, and that they would be likely to die a worse death than they would otherwise have done); and

   b. that withdrawing/withholding artificial nutrition/hydration (ANH) when a person has entered their dying phase does not cause the usual suffering associated with starvation or dehydration and that, to continue ANH when a person has entered their dying phase can not only increase their suffering but can also deprive them of a peaceful death, because the human organism is designed to recognise when death is approaching and to release endorphins that act like a natural analgesic and give the person a natural "high" or "euphoric" experience; if ANH is continued the body does not get the signal, does not release the endorphins and so deprives the person of a peaceful death. Not only would this level of knowledge rarely be found below the level of RN but explaining that to family members requires both the skills and the standing of a senior staff member, i.e., an RN.

(b) To make a decision about whether or not a resident needs to be taken to hospital, or if they can be adequately and safely cared for in the facility. This also includes having the ability to deal with very stressed families who are demanding that the person be taken to hospital and demanding that hospital staff should be told to "do everything" to keep them alive. Prolonging someone's dying – and potentially their suffering – should never be done to placate their family, even if a member of that family is threatening legal action if staff do not do what the family member is insisting on. Asking a junior member of staff to deal with such a situation is totally unacceptable. Not only must the person dealing with the situation know the law and their obligation to the resident but they must have the skills (and required terminology) to respectfully explain the situation to family members and to ensure that their resident dies peacefully in the appropriate place, i.e., their current home.

(c) To ensure that adequate pain relief medication is provided to the resident "as required" (and not 4-hourly as is still, unfortunately, sometimes prescribed). This may require interaction and negotiation with a GP, but it may also mean having a staff meeting and explaining to more junior staff that providing the right combination of drugs, in the right doses, at the right time intervals will seldom hasten a patient's death by even a few hours but, if junior staff are concerned that it has done so, to explain to them why that is not euthanasia. It may also require hour-by-hour assessment of pain levels in an unconscious patient – a high level skill that more junior staff often do not possess.

A registered nurse is also needed, either in person or by telehealth or Skype, when a resident is dying, in case there are unexpected complications, such as fitting or sudden onset of severe breathing difficulties or other complications. This situation would, of course, be compounded if more than one resident was in the terminal phase of their illness, or if other residents experience a crisis or unexpected deterioration. In such a situation, junior staff on duty may not have the capacity to care for everyone who needs their care.

2. What recommendations to the NSW Government would you like to see come out of this inquiry?

I would like to see the following recommendation to the NSW Government: that NSW Health retains a monitoring role of the number of people who are admitted to NSW Hospitals from RACFs, the reasons for admission, the interventions they receive in hospital and the number of those residents who die in hospital, and that these statistics are assessed regularly to see if there is an increase in such admissions once the current legislation is repealed.

Yours sincerely

Professor Colleen Cartwright
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