

**Submission
No 93**

**INQUIRY INTO REGISTERED NURSES IN NEW SOUTH
WALES NURSING HOMES**

Organisation: Palliative Care New South Wales

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Inquiry into registered nurses in NSW nursing homes

Submission by Palliative Care NSW

Thank you for the opportunity to contribute to this very important inquiry into 24/7 RNs in NSW nursing homes. Palliative Care NSW is the peak body for palliative care in NSW and we are most concerned about the effect of this potential change on the capacity of facilities to provide quality end of life and palliative care to those residents who are approaching and reaching the end of their lives.

The NSW Government has stated its very welcome intention to increase access to palliative care services in their 'Plan to Increase Access to Palliative Care 2012-2016'. This plan in part aims to "develop new models of care, foster new partnerships and establish linkages across services and sectors to develop an integrated network of primary care, specialist palliative care, aged care and community services".

Significantly, the NSW Government Plan addresses the need to increase access to palliative care within aged care facilities

The key strategic Objectives of the NSW Plan are a four point approach to the future, the first two objectives specifically targeting aged care:

1. Expanded community based palliative care services, especially in rural areas and for the special needs populations
2. Integration of primary care, aged care services and specialist palliative care services across the state
3. Expanded support for families and carers and
4. Extended capacity of palliative care services in NSW

PCNSW believes that removing the requirement for RNs 24/7 in RACFs has the potential to undermine this NSW Government Plan.

Palliative Care New South Wales addresses each of the Terms as Reference of the Inquiry.

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*

With one RN currently often required to care for more than 100 residents, the capacity of that RN to meet the needs of all residents is already compromised. Not requiring an RN to be available 24/7 will significantly minimise the palliative care nursing capacity of RACFs and therefore jeopardise residents' opportunity to receive appropriate symptom management that would allow for a 'good' death. For example, 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. 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 and PCA education and training.

Hypothetically, even if an EEN was competent and permitted to administer a medication, there would not be the skills to assess when a specific medication was required, when it was effective and when further medication and advice/intervention was required.

This is the professional domain of the RN. Resident safety would be severely under threat if symptom assessment and medication management was undertaken by untrained staff.

About 10% of all deaths in NSW occur in RACFs. The RACF population is expected to increase by 70% over the next 3 decades. (NSW Government Plan to increase access to palliative care 2012-2016, p9)

It is clear that without 24/7 RNs in RACFs, there will be a default increase in ambulance transfers to Emergency Departments (EDs) at NSW Public Hospitals, placing extreme pressure on EDs and the NSW Ambulance Service as facilities will have no option but to transfer to hospital.

Not only will there be a sharp increase in costs for this unnecessary event to the LHDs but there is also the risk that 'futile' and expensive treatments would be initiated in the absence of dialogue in ED about palliative care options. Palliative care staff are not employed in EDs.

As highlighted in the NSW Plan, a seven fold increase in the RACF population over the next 3 decades would produce major cost increases for the NSW public hospital system if a corresponding pattern of transfer from RACF to ED developed. Without RNs 24/7 in RACFs there is reason to believe that this would occur.

In addition, there is a clear moral and ethical issue in transferring residents with acute symptoms to EDs which are not intended, designed or equipped to neither respond immediately to palliative care needs nor initiate the palliative care discussion.

For example, a frail aged resident presenting in ED with an obstructing bowel could be faced with bowel surgery, transfer to Intensive Care and inevitable subsequent death when a palliative approach in ED would have been the most appropriate and morally correct course for this person.

In the words of Prof Ken Hillman:

Once death was treated as a relatively normal and inevitable experience. It is now a highly medicalised ritual. Now, when someone who is old and near the end of their life suddenly or even gradually deteriorates, the ambulance is called. The paramedics cannot be discretionary, even when it is against the wishes of the patient. The role of emergency rooms is to resuscitate and save lives, and package the patient for admission to hospital, whether active treatment is appropriate or not.

from Prof Ken Hillman, *When the end is nigh, it's best to avoid hospital*, from Vital Signs, 2009

<http://www.smh.com.au/it-pro/when-the-end-is-nigh-its-best-to-avoid-hospital-20091030-hppj.html#ixzz3gOz7i41W>

- 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*

Many facilities only have RNs working 9- 5 pm Mon – Fri, so in evenings, night-duty and weekends, there are none. However, this practice erroneously suggests that the skills of RNs to assess residents' changes in condition and symptom development are only required in business hours. The availability of RNs is therefore a huge issue for clinical decision making and provision of symptom relieving medications. The larger facilities that are deemed villages, ie they have independent living, hostel and nursing homes satisfy requirements by saying they have someone available within the huge facility. While we use those 3 terms there is now supposedly no difference between hostel/nursing home staff ratios but in reality, there is. Hostels primarily have personal care assistants whereas aged care hospital wards do have RNs on duty every shift.

The greater need for RN in RACF can be illustrated thus:

- medical advice is not as accessible as it would be in aged care hospital where at the very least there would be medical officer (MO) on call 24/7 to assist with difficult situations and to support the RN. In addition, the MO would see and assess patients regularly, meaning that the RN and MO worked collaboratively on a regular basis.
- in hospital, a wider range of drugs is available to treat new symptoms than would generally be available in the RACF. The implications of this are that the RN is required in the RACF to closely assess residents at the end of life and seek the advice of GP or consult service when indicated. This is further evidence of the 24/7 need for RN skills.

The elephant in the room with this issue is that frail aged people living in residential care have less access to end of life care appropriate to their needs than their counterparts in hospitals. How can this be allowed to occur in our society?

- 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

Quality and informed palliative care nursing can only be led by an RN: legally only and RN can administer Schedule 8 drugs and if residents are unable to receive regular and PRN (as required) opioid and other scheduled medication 24/7 within a timely, safe and legal framework, they will receive sub-optimal care and often will be transferred to ED by ambulance. The lack of a 24/7 on site RN threatens the nationally accepted practice of a palliative approach with the RACF setting.

For an RN, the key to safe medication administration is professional nursing assessment of the presenting symptoms followed by clinical decision making and appropriate medication administration over time. Understanding the nuances of end of life symptoms is fundamental to this role. A 'floating' RN in a RACF is required to rely on the assessment of untrained staff to alert re the resident's needs in the first instance and then to monitor what happens next if medication is administered. This is without doubt unsafe practice and leaves the resident vulnerable to poor symptom relief and inappropriate care.

CASE STUDY:

Joan Black is an 82 year old widow admitted to an acute hospital with exacerbation of her Chronic Obstructive Pulmonary Disease (COPD) for the third time within a six-month period. Joan's functional status has significantly deteriorated and she is no longer able to return to home and with her frequent symptoms of severe shortness of breath and panic attacks she now requires 24.7 care. Joan is assessed by the Aged Care Assessment Team (ACAT) who approves residential high-level care (Level 3-4). Joan realizes this is her best option as she has no idea how she can afford the cost of continuous home oxygen and how she would manage with frequent episodes of shortness of breath which can escalate to panic attacks.

The treating medical team refers Joan to the local Palliative Care team to consult with the RACF RN and GP to assist with symptom assessment and management. A care plan is devised which includes regular review of Joan's symptoms, a combination of a regular opioid and an as required short-acting oral opioid to help with her breathlessness and an anti-anxiety medication (benzodiazepine sublingually) as required for panic attacks.

This care plan requires a 24/7 RN to legally and professionally enact this management plan. Without an RN on site 24/7 the professional limitations and scope of practice of a care worker at the RACF would mean that the only option would be to call an ambulance and transfer Joan to the local Emergency Department.

- d. the role of registered nurses in responding to critical incidents and preventing unnecessary hospital admissions.*

RNs have particular skills around assessments of incidents such as falls, managing symptoms such as restlessness or agitation that can escalate and become difficult to manage, as well as management of confused residents at the end of life, eg prevention of wandering. An RN is able to contribute significantly to the prevention of medication errors and is able to

undertake assessment and early intervention for treatable end of life symptoms, eg delirium, excess calcium

An RN is able to anticipate haemorrhage and manage early signs as well as undertake early detection of pathological fractures

- 2. The need for further regulation and minimum standards for assistants in nursing and other employees or carers with similar classifications*

PCNSW notes that role of AINs and similarly qualified employees are task oriented and can't by definition simply be extended to a professional one. This requires considerably more consideration and discussion.

- 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*

Unlike within acute hospitals, there are no fixed registered nurses-to-patient staffing ratios that apply in Australian RACFs. In these facilities, management alone determines the staffing levels for the provision of nursing care for residents, based on the principle of a duty of care.

- 4. The report by the NSW Health Aged Care Steering Committee, and*

We are unable to comment on this.

- 5. Any other related matter.*

The difficult decision that many families make to place their family member in a RACF is predicated by the recognition that more professional care 24/7 is required to provide the appropriate palliative and end of life care to their family member. If an RN is not available 24/7 in the RACF, the professional and appropriate care that was assumed by the family to be provided at the RACF cannot be guaranteed to be provided. Paid carers within RACFs do not have the appropriate training and education to make informed assessments of dying residents and without timely RN availability have no other option to transfer the dying, symptomatic resident to the closest ED which is of course inappropriate and burdensome to the dying resident.

Linda Hansen
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