

**Submission
No 21**

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

Name: Mr Des Hartree

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LEGISLATIVE
COUNCIL

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GENERAL PURPOSE STANDING COMMITTEE NO3

Inquiry into registered nurses in New South Wales nursing homes

Dear Sir

My wife of 55 years has dementia and has been in a High Care facility for the past 18 months. I spend 4 to 5 hours each day at the facility and it has been an eye opener.

I support totally the need for there to be a minimum standard for Registered Nurses (RNs) in nursing homes and other similar aged care facilities. Although the current minimum standard predates s52 of the *Public Health Act 1991 (NSW)* – the predecessor to the 2010 law – I would argue that the need for fully qualified RNs in nursing homes is greater today than ever before. Due to the prevalence of at-home care programs (including TACP: the Transitional Aged Care Program - funding) residents in nursing homes and other residential care facilities are now older, frailer, have more complex/combinations of ailments and subsequent complex sometimes conflicting medications. Essentially – people are only turning to nursing homes or other aged care facilities as a last resort when their conditions and disabilities have deteriorated to the level where they are unable to be managed at home.

The need for highly qualified RNs is amplified by increased communication difficulties these days between the resident and staff, and the need to fully understand the meaning of vital signs and external indicators not obvious or possible detectable by the novice or untrained well-meaning amateur. I believe the intervention by a Registered Nurse has saved my wife on at least two occasions:

1. One lunch time, while my wife was still in "Respite Care" I noted that my wife had significantly and sudden reduced cognitive function, she was having balance problems as she stood or walked, and she was leaning to the right. My initial fear was that she had suffered a stroke. I contacted the Registered Nurse on duty whose comment was that staff who had showered and dressed her that morning had not noticed anything unusual. She then checked my wife and within seconds realised that she appeared to have a urinary tract infection and that she was dehydrated. Within an hour my wife was in hospital on a drip and medication. Although it could be said that my wife did recover, she did not return to the same cognitive function nor did her balance return and she lost the ability to feed herself and had to be put on a pureed diet and thickened fluids.
2. My wife who is on warfarin had a fall with trauma to the back of her head. The Registered Nurse called an ambulance, but was told that all available ambulances were attending a pub brawl in a nearby suburb. As an actual Registered Nurse, she was trained to handle the situation until paramedics arrived some three hours later. This seemed to be out of the realm of normal first aid because there was blood everywhere and in the end my wife required seven stitches.

Discussions with other citizens with loved ones in Nursing homes, particularly as I collected signatures for the RN's 24/7 petition, have hi-lighted countless occasions when the registered nurse on duty has intervened and minimised trauma or suffering for their loved ones or even the counselling they received from the RN with regard their loved ones condition and ongoing care. The Registered Nurses at my wife's facility are the primary staff managing her eating difficulties, her constipation, and, more recently, preventing and managing pressure injuries ("bed sores"). I am also aware of RNs handling of a food choking incident and another resident having a fit and I have been told of numerous other incidents from palliative care to handling distressed relatives after a passing.

The RN's are the primary contact between my wife and her weekly attending doctor providing feed back re her vital signs and staff observations allowing the doctor to adjust treatment regimes, medications or further required testing or specialised referrals.

Besides maintaining a minimum number of Registered Nurses in nursing homes and residential aged care facilities, I believe that because of their unpredictability and the potential sudden changes in their demeanour, with potential to hurt themselves or their frail fellow residents, that residents with dementia in speciality dementia wards, must have a carer, or Assistant in Nursing, on duty and in the common room from the time the first resident rises until the last resident is in bed and in worse case scenario with extremely violent or potential self harm residence, individual management plans. This is also essential to manage shift changeovers and for when staff are assisting with other patients. Dementia residence beds should be fitted with pressure warning devices so staff are warned if a dementia resident gets out of bed. Dementia residents must not be left unsupervised at any time, unless they are in bed and have a pressure warning device.

Authorities should publish recommended staffing levels based on the number of residents and the number of residents of specific classifications based on their condition, as well as their care plan for which the facility is claiming Federal funding. If these are currently in place, then this information must be made available in a form that is easy for a person of my age and income level to access. If I am unable to find these, then how are the many other families of those in nursing homes – or even people looking to place themselves in care – supposed to make an informed decision?

Authorities should also mandate **minimum** staffing levels and there needs to be greater financial penalties than the 100 penalty units (\$11,000 as of 2015) in s.104 of the *Public Health Act (NSW) 2010*. Considering that since the commencement of the *Aged Care (Living Longer Living Better) Act 2013 (Cwlth)* on 1 July 2014, two of the three listed corporate aged care providers, Estia Health Ltd (ASX:EHE) and Regis Healthcare Ltd (ASX:REG), floated on the Australian Stock Exchange. The third, Japara healthcare Ltd (ASX:JHC) floated in April 2014. From the outset it does appear that these laws may have improved the profitability of the aged care sector for these providers – especially when you consider how these laws have potentially nullified the requirement for a minimum number of Registered Nurses on staff in New South Wales. However, back to the matter of compliance, for large private companies such as these, \$11,000 for a single infringement is a small price to pay considering the lists the annual minimum salary (without penalty rates) for a first-year graduate Registered Nurse as being \$56,529.12 from 1 July 2014. That for an 8 year Registered Nurse is \$79,383.20. These represent the potential for large annualised savings providers would be making from not meeting these requirements, all for the price of \$11,000 (100 penalty units). Given these large major players represent the corporatisation of aged care services in Australia; it is of great concern to me that there are not greater penalties for non-compliance with their legal obligations, especially with the amounts of money involved.

Such options for redress when minimum standards are not met could be the threat of possible deregistration of the facility itself, particularly as facilities are now doing their own resident assessments to claim the Government subsidies. Registered Nurses alone should be part of the head-count with respect to minimum staffing levels, with requirements for lesser-trained staff, such as Enrolled Nurses, carers and Assistants in Nursing, also set out. However, I cannot stress enough the importance of having a Registered Nurse constantly on-site. There also needs to be a comprehensive compliance regime that picks up non-compliance that is not just the duty roster with 9:00am to 5:00pm checks and advance warning of these, so that the facility can whitewash any factors that would make them otherwise non-compliant with regulations.

Hospitals have very strict protocols for handling medications such as Schedule 4 and Schedule 8 drugs – and the clinical setting of a nursing home or other residential aged care facility should be no

different. There is the same probability of medication errors occurring, and the need to know **which drug** is more important and possible side affects, considering the complex and competing array of conditions that you find in the elderly. If we reduce the constraints we are creating a recipe for disaster. Moreover, the possibility for unscrupulous individuals to procure "drugs of addiction" (Schedule 8 medications) through a system with lacklustre controls will not benefit the community in the slightest. There have already been instances where people have been caught stealing these drugs under the current system. I am concerned about how many of these would not be caught if the system was relaxed in aged care just to improve the bottom line of the budgets of private operators.

Australia is a great multicultural society with millions of new citizens migrating to Australia since World War II from non-English speaking countries, generally they have willingly learned to speak English and adapted to the Australian way of life and made significant positive benefit to our society, however as they have aged and particularly those with even early signs of dementia have lost or have reduced verbal communication or have exaggerated accents which makes communication difficult. Of the 12 residents in the special needs ward where my wife is resident, the mix is six Italian, two Australian, and one each Egypt, Assyrian, Chilli, and Sri Lanka. Particularly when you consider that many of the staff come from non-English speaking backgrounds at odds with the residents. Any way that current nursing graduates could be enticed to work in aged care would go a long way to improving this – especially when we're conflictingly told that there is a nursing shortage in aged care, but many graduate Registered Nurses go without jobs. The fact that we are having to bring workers into these facilities from overseas is not the sign of a "skills shortage" but a failure at the Government level to ensure that graduate nurses are able to see aged care as a viable option for a career – in terms of working conditions but also standards of care. I am sure that it would not be enticing for a 20-something graduate to work in a poorly fitted-out nursing home when compared with a comparably better-funded public or private hospital (though these are still behind in funding themselves).

Finally, I would recommend that all members of the inquiry should watch a copy of a Lateline story "Assaults in nursing homes go unreported" on the ABC by Margot O'Neil on Lateline 11/04/2013 or read the attached transcript as it appears that nothing has changed. I would also suggest that the committee review the complaints which I understand the authorities receive on abuse and negligent care issues in nursing homes plus the comments and recommendations from coroners across Australia when a loved one is lost. The Committee should also visit a variety of these facilities to see what is going on first-hand, though I fear that any areas of concern would be hidden from the view of Committee Members.

I hope that the Committee considers my submission and recommends that Registered Nurses remain a permanent fixture in nursing homes and residential aged care facilities. Otherwise we run the risk that there will no longer be any real "nursing" going on in "nursing homes".

Des Hartree