

**Submission
No 119**

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

Organisation: Health Services Union

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Health Services Union Submission to the Legislative Council General Purpose Standing Committee No. 3 inquiry into registered nurses in New South Wales nursing homes

The Health Services Union welcomes the opportunity to contribute to this review. Our union represents some 31,000 members in both public and private health as well as aged care and the ambulance service, which affords us a uniquely broad perspective on health issues within NSW. In the aged care system we cover all levels of support staff and health professionals.

Medication and medical procedures

The central policy document is the Commonwealth Department of Health and Ageing's [Guiding principles for medication management in residential aged care facilities](#). Guiding principle 14 clearly states that medication cannot be administered in the absence of clinical or nursing staff:

The RACF policy and procedures should specify the circumstances under which registered nurses can delegate medicine administration tasks to appropriately trained and competent staff, where this is permitted by relevant state or territory legislation and regulation. Where medicine administration tasks are delegated to staff by registered nurses, the delegated staff should have formal training in medicine administration, be assessed by the RACF and the registered nurse as competent to administer medicines, accept the delegation, and be appropriately supervised.ⁱ

The issue of supervision is key here, as supervision implies that the delegating nurse is personally present to oversee the procedure.

An exception is made where patients have been assessed as competent to self-administer using dose administration aids (DAAs):

Assistants in nursing/personal care workers (however titled) may be authorised and delegated to assist in administration of medicines from a DAA, where permitted by state or territory legislation and regulation, and RACF policy and procedures.

These principles are broadly followed by all the state and territory policies and regulations. The role of the carer is not to perform the procedure, but to assist the patient. The Queensland [Health \(Drugs and Poisons\) Regulation 1996](#) makes this especially clear by spelling out the circumstances under which such assistance is permitted, including a requirement that the patient must be capable of requesting it:

(1) A person does not need an endorsement under this regulation merely to deliver a restricted drug to a person for whom it has been dispensed, or the person's agent.

(2) Also, a person (a carer) does not need an endorsement under this regulation to help another person (an assisted person) to take a restricted drug that has been supplied for the assisted person as a dispensed medicine, if—

(a) the assisted person asks for the carer's help to take the dispensed medicine; and

(b) the carer helps the assisted person to take the dispensed medicine under the directions on the label attached to the dispensed medicine's container.ⁱⁱ

Tasmanian legislators have taken a different approach. In 2009 the Tasmanian [Poisons Act 1971](#) was amended to expand the scope of certain carers to administer medication. Under [Regulation 95EA](#) an employee of a RACF, providing that person is suitably trained and acting “...under the general supervision or direction of a registered nurse,” may administer some medication. This is, however, strictly controlled. As well as listing procedures that care staff are not qualified to carry out, the [Guidelines for the Administration of Certain Substances by Aged-care Workers in Residential Aged Care Services](#) specify that: “When an aged-care worker has been assigned to administer medication the registered nurse **must be on site** and accessible at all times for the purposes of ensuring safe administration of medication to residents.”ⁱⁱⁱ

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.” These procedures include but are not limited to:

(a) establishment and supervision of a complex pain management or palliative care program, including monitoring and managing any side effects;

(b) insertion, care and maintenance of tubes, including intravenous and naso-gastric tubes;

(c) establishing and reviewing a catheter care program, including the insertion, removal and replacement of catheters;

(d) establishing and reviewing a stoma care program;

(e) complex wound management;

(f) insertion of suppositories;

(g) risk management procedures relating to acute or chronic infectious conditions;

(h) special feeding for care recipients with dysphagia (difficulty with swallowing);

(i) suctioning of airways;

(j) tracheostomy care;

(k) enema administration;

(l) oxygen therapy requiring ongoing supervision because of a care recipient's variable need;

(m) dialysis treatment.^{iv}

Within the private sector, Mederev, which provides training and medications systems management to aged care facilities, draws the same distinction between nursing and care staff. Its training material specifies that the [scope of practice of AINs and care staff](#)

DOES NOT include assisting in the administration of:

- *injections;*
- *as required (PRN) medications, unless under direct supervision of an RN;*
- *suppositories/enemas;*
- *CDs [controlled drugs] which are not a regular order; or*
- *transdermal CDs.^v*

Expanding the role of care staff in Tasmania

Under the 2009 changes to the Tasmanian legislation a review of the effects of the amendments was mandated to be held within three years. The [report of that review](#) was published in October 2013 and the findings were, on the whole, positive. The following outcomes were reported by care providers.

- *The changing focus of resident acuity is that generally residents are entering aged care at a later stage of ill health and disability and require more complex care. Extended Care Assistant (ECAs) being able to deliver medications to health stable residents, has meant that valuable Registered Nurse (RN) and Enrolled Nurse (EN) time has been freed up to give more focus to the assessment and provision of complex care.*
- *ECAs have a greater care knowledge of residents because they are involved with other aspects of care provision for the same group of residents. This leads to a deeper understanding of their personhood.*
- *More effective care practices have been realised as the medication rounds are smaller, meaning that medications are given on time.*
- *Time management is optimised as ECAs administering medications use a 'do not disturb policy' which means that they are subject to much less disruptions than an EN or RN who often get called away when administering medication to attend phone calls, acute care needs, doctor visits, family concerns, resident requests etc.*
- *The new system has allowed for greater skill use in areas of best need.*
- *A longer working life has been created for ECAs as a medication administration role is less demanding. It has taken them away from more physical work such as showering and personal care.*

- *ENs medication load has been reduced allowing more time for other clinical care.*^{vi}

The responses of workers within the sector were more mixed, but still largely in favour of the changes, especially as they were seen to promote patient well-being by leading to reduced stress and a greater feeling of autonomy.

Negative reports of respondents to the review tended to centre on issues of compliance and consistency. The Australian Nursing Federation submitted survey responses that

...training in the workplace was vastly different between employers, some workplaces having in house systems such as buddy or a check list, while other employers have none. The workers in both the aged care and disability sectors consider that there needs to be more consistency to the ongoing training of staff so that they are able to transition from one employer to another without being disadvantaged. Standardised and uniform training across the industries was identified by HACSU as the most important issue. As workers often have more than one employer, differences in training and guidelines between workplaces are confusing and create potentially unsafe work practices.^{vii}

The situation in NSW

NSW Health currently has two sets of policies in place to cover RACFs. The [Guide to the Handling of Medication in Nursing Homes in NSW](#) covers licensed nursing homes, and [Medication Handling in NSW Public Health Facilities](#) which replaced the previous document *Medication Handling in Community-Based Health Services/Residential Facilities in NSW*, applies to non-licensed facilities or “hostels”. Both conform to the standards established in the commonwealth guidelines and make no allowance for care staff to do other than assist.

HSU members working as carers in aged care in NSW are generally classified as Care Service Employees grades 2-4 and hold Aged Care Service Certificates III and IV. Given the shift in the clientele demographic towards older, less self-sufficient patients they report that their duties are moving more and more from assistance and recreational activities to direct care, and the training courses that they undertake are already set up with electives to support these changes.

In general, as found in the Tasmanian review, our members are happy to build up their skills and take a more active care-based role. They do have concerns, however, about being pressured to take on duties beyond the level their training and experience makes them comfortable with. To support them in an expanded care role they need:

- A clear-cut system of position classifications that directly relates duties to levels of training;
- Exactly-defined protocols for delegation and supervision of care roles; and
- That these practices and procedures be officially regulated so as to be consistent across the aged care sector.

The matter of staffing levels also needs to be addressed. The HSU has repeatedly lobbied governments to introduce minimum staffing levels and staff-to-resident ratios as part of the aged care funding model, and this issue will take on more urgency as the sector addresses the increasing demands of an ageing population.

In the union's view, the loss of the distinction between "high care" and "low care" facilities is largely irrelevant as far as it affects the duties undertaken by our members. Their role in the treatment of patients who require a high level of care and professional medical attention will always be by delegation and under the authority of a registered nurse.

We are also concerned that, given these constraints, the effect of the absence of a registered nurse would be to shift residents in need of attention to the ambulance service and public hospitals, causing stress and disruption to patients and further burdening the already overstrained public system.

Conclusion

The presence of a registered nurse is essential if an aged care facility is to provide the most timely and effective health care for its residents. That role can, however, be complemented by care staff who are provided with appropriate training and supervision.

Any changes to the regulations currently in place will only be successful if they are accompanied by clear and consistent requirements for training and supervision. Where guidelines and policy documents refer to "appropriate" management practices and levels of training, what is appropriate needs to be codified and enforced across the aged care industry.

The development of regulations to allow for an expanded role for care staff will require consultation from all stakeholders in the aged care sector, and the Health Services Union will be keen to participate in any such consultation.

Yours sincerely,

Gerard Hayes
Secretary, HSU NSW/ACT.

ⁱ Australian Government, Department of Health *Guiding principles for medication management in residential aged care facilities*, October 2012, p60

ⁱⁱ Queensland Government, Health (Drugs and Poisons) Regulation 1996 - Sect 183

ⁱⁱⁱ Tasmanian Government, *Guidelines for the Administration of Certain Substances by Aged-care Workers in Residential Aged Care Services*, September 2010, p9

^{iv} Australian Government, *Quality of Care Principles 2014*, Part 2.8, Nursing Services

^v Mederev, *Medication Management Manual_V3_September 2012*, p3

^{vi} John Ramsay & Associates, *Review of Authority for Carers to Administer Medication*, October 2013, `pp9-10

^{vii} *Ibid*, p15