Submission No 118

INQUIRY INTO REGISTERED NURSES IN NEW SOUTH WALES NURSING HOMES

Organisation: Palliative Care Service Senior Staff, Calvary Hospital Kogarah

Date received: 23/07/2015

Submission to NSW Legislative Council
General Purpose Standing Committee No 3
Inquiry into Registered Nurses in NSW Nursing Homes

This response has been prepared by members of the Senior Palliative Care Staff (Medical, Nursing and Allied health) at Calvary Health Care Kogarah.

We would like to respond to the key points being addressed by the Parliamentary Inquiry, as outlined in the information on the Parliamentary website.

Patients requiring palliative care are some of the most vulnerable patients cared for within the NSW Health System. Coping with a diagnosis of terminal illness, in combination with requiring ongoing care in a Residential Aged Care Facility (RACF), places tremendous stress on patients and their carers. These patients often require extra doses of medications to manage symptoms, in addition to regular doses of medications in order to alleviate developing deterioration or changes in the patient's condition. It is vital that trained nursing staff are available at all times to assess patient needs and institute appropriate management.

It is difficult to comprehend that consideration is being given to allowing RACFs to function without the essential care provided by Registered Nurses (RNs). We are particularly concerned that this proposed change represents prioritising profits for RACF operators over patient care and deplore this suggestion.

There will also be major implications for the already over-burdened public hospital and ambulance services. Any change in patient condition is likely to provoke a call to ambulance services, requesting transfer to an Emergency Department for assessment and management if RNs are not available – we have experienced this scenario often already. A simple assessment and provision of medication by an RN would often prevent any need for patient transfer into the acute setting. This will lead to unnecessary suffering for patients and carers.

Current arrangements for staffing in RACFs with the goal of allowing elderly residents to "age in place" are only suitable for those with no complex needs – in short, those requiring no specific nursing assessment and assistance.

We are already seeing consequences of this policy in RACFs where there are no RNs available to respond to increasing patient care needs. There is no availability to give extra doses of medications and no understanding of the need for ongoing assessment of patients. Care workers who are not RNs have done Certificate 3 & 4 in healthcare – which provides minimum training (6 weeks to 3 months) in aspects of personal care. There is no knowledge of even the most basic aspects of nursing care and assessment. Furthermore, workers without the required skill-set do not understand what they don't know i.e.: they are not equipped to know when the patients require further assessment. This observation is based on our service's direct involvement with a large number of RACFs.

We have previously provided in-depth education and ongoing support to these carers, via a Commonwealth Government-funded Project. This has shown us that education fails due to high turnover of staff and poor skills of the staff in the English language. An unskilled workforce, unable to adequately communicate with patients and carers is a recipe for disaster and patient suffering. To propose that there be no RN on duty will have a huge impact on patient safety as well, for all the reasons outlined above.

The population is ageing at a rapid rate and this means increasing demand for RACF care. It seems unbelievable that a reduction in skilled nursing staff is being proposed.

Some of the RACFs have employed a dedicated RN to assist staff in assessment and management of patients with palliative care needs – whilst the initiative is to be commended, personnel numbers are completely inadequate. This model should be supported, considered mandatory and receive increased funding.

General Practitioners are also over-worked and often unavailable to provide back-up assessment and management plans for patients in RACFs. They are not adequately remunerated for the task. It would be ideal to consider improving incentives for medical involvement in patient care in RACFs; e.g.: in the Netherlands, there exists a medical speciality of Nursing Home Doctors – doctors who specialise in and work in RACFs.

Patient's relatives and carers simply have no criterion by which they can judge whether a given RACF will be able to provide the level of care (and compassion) which is needed by their loved ones. It will be a further disadvantage for them if they are unaware of the need to know whether a facility has RNs available or less-skilled workers. The net result, again, is likely to be increased burden on the acute health care system when families insist patients are transferred due to inadequate care – a totally preventable situation in many cases if RNs are available. RACF placement is a huge emotional and financial burden for families – it is not fair to them if this additional factor confounds and confuses their decision-making further.

Finally, as a Specialist Palliative Care Unit, we are concerned that poor care in RACFs will place an additional burden upon our service – reluctance for patients to accept RACF placement, resulting in unavailability of beds for other patients who require specialist care with consequent unnecessary transfers of patients to hospital EDs and inability to discharge patients from the acute hospital setting due to "bed block" in the subacute setting.

In summary, we object most strenuously to any suggestion that patients in high level care (and those requiring this, transitioning into the setting or ageing in place) should not have Registered Nurses available to provide basic assessment and care. It is reprehensible to suggest that this vulnerable group of patients do not require the care provided by trained workers or Registered Nurses.

In addition, the issue of RNs in RACFs receiving a lesser wage than in other sectors must be addressed in order to attract and keep vital high-quality staff.

"Just as perinatal mortality is a marker of nutrition and public health, as well as of prenatal services, the care of our dying is an indicator that reflects the overall quality of our care and compassion."
Baroness Ilora Finlay, Clin Med, 2003

Dr Jan Maree Davis FRACP, FAChPM
Area Director, Palliative Care Services, SESLHD, Southern Sector
On behalf of Palliative Care Senior Staff, Calvary Health Care Kogarah