Submission No 258

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: New South Wales Nurses and Midwives' Association

Date Received: 16 December 2020

NSW NURSES & MIDWIVES' ASSOCIATION

Submission to Health outcomes and access to health and hospital services in rural, regional and remote NSW

DECEMBER 2020

NSW NURSES & MIDWIVES' ASSOCIATION

Recommendations

1. First Nations people in regional, rural and remote parts of NSW should have access to Aboriginal Community Controlled Health Services.

2. Aboriginal health liaison staff should be available to all First Nations peoples who are admitted to inpatient care.

3. That NSW Health adopts the NSWNMA 2018 Ratios claim as the minimum nursing numbers required on each shift. See Appendix C for details of this claim.

4. That every aged care facility has a minimum of one registered nurse on duty 24/7.

5. That staffing and funding for aged care facilities be re-considered with reference to the findings of the Aged Care Royal Commission and the ANMF National Aged Care Staffing and Skills Mix Project Report.

6. That all rural and regional hospitals currently covered by the NHPPD (or equivalent ratios) convert NHPPD wards to six NHPPD in order to be equal to metropolitan hospitals in terms of staffing and skill mix.

7. That NSW Health recognise minimum staffing ratios are necessary to provide safe patient care but may not be sufficient to ensure the safety of staff, especially in smaller facilities with very limited staffing numbers. In this case, staffing numbers should be determined by ratios plus a risk assessment of numbers required to provide an effective duress response.

8. Wherever there is an emergency department open 24/7, regardless of its delineation or classification (however named), that facility requires minimum staffing of three nursing staff rostered on duty, two of whom are suitably qualified to attend to an acute emergency presentation.

9. That the Nurse Practitioner (Generalist) model of care and role in regional and rural areas is properly implemented. This will require funding to be directed towards recruitment and development of additional Nurse Practitioners to work in rural and regional areas, particularly in sites without 24/7 medical officers reliant on virtual medical officer coverage.

10. **Where rural and regional sites do not have access to medical officers 24/7 and are reliant on virtual medical officer coverage, there must be a minimum of one registered nurse rostered on-call and within 15 minutes to the site, to be present and provide physical in person support to respond to emergency events in addition to two Registered Nurses on duty.**

11. **That nurses and midwives are paid all their Award entitlements.**

12. **Any service relying on staff to be available during their time off work to respond emergencies should formalise this on-call roster and pay appropriate on-call allowances.**

13. **Review nursing and midwifery incentives with reference to Queensland Health's Remote Area Nursing Incentive Package.**

14. **Every site must have the capacity to provide a timely and effective duress response, regardless of the size or location of the facility.**

15. **NSW Health should undertake a review of existing duress arrangements in place across regional/rural facilities. This should consider at a minimum, the staffing numbers across each shift, the availability of security staff by shift and the availability of external resources, including external security companies and police.**

16. **The Association recommends that visible, uniformed, unarmed security staff be positioned in close proximity to emergency departments, psychiatric units and other areas of the hospital where violent incidents may occur.**

17. **Increased funding for mental health services in regional, rural and remote areas to ensure suitable services are available at all levels of care provision, from community-based care through to Mental Health Intensive Care Units (MHICU).**

18. **That more specialist mental health beds be made available for older persons who require MHICU.**

19. **That NSW Health develop plans to address shortages in mental health nursing staff, training, recruitment, and retention of mental health nurses. This should also include increased opportunities for Nurse Practitioners (Mental Health).**

20. **NSW Health to review EDs currently gazetted as mental health assessment facilities. Where these facilities are unable to undertake this work in a way that ensures the safety of nurses (whether due to physical limitations of the facility, the staffing levels, lack of access to security staff and police to enable a suitable duress response), they should be removed from the "declared mental health assessment" list.**

21. **Work with local police and other relevant groups to decrease inappropriate drop offs of intoxicated persons. This should include a clear agreement on when it is appropriate to bring a person to a declared facility for assessment, as well as training to improve understanding of when a person may need a mental health assessment.**

22. **If intoxicated persons with acute severe behavioural disturbances are to be managed in hospital environments, this must occur in secure facilities with suitable staffing arrangements to ensure risk can be managed effectively.**

23. **Review the availability of mental health and drug & alcohol resources including the use of telehealth options for rural and regional areas for patients presenting to EDs under the influence of psychostimulants such as "ice", both for immediate management and longer term referral and treatment.**

24. **Revise systems in place for community nurses and midwives in keeping with chapters 16 & 17 of Protecting People and Property – NSW Health policy and standards for security risk management in NSW Health agencies.**

Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the industrial and professional body for nurses and midwives in New South Wales, representing over 70,000 members across the full spectrum of health care services in NSW in facilities including public and private hospitals, corrective services, aged care, disability and community settings. Approximately half our members work in Local Health Districts that cover regional, rural and remote parts of NSW.

NSWNMA strives to be innovative in our advocacy to promote a world class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving standards of patient care and the quality of services of all health and aged care services whilst protecting and advancing the interests of nurses and midwives and their professions.

This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.

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NSW NURSES & MIDWIVES' ASSOCIATION

"I am Clinical Nurse Specialist / RN working in a rural ED. I'd like to share a story about a recent shift, and the challenges faced as a rural hospital with less resources than our metro counterparts.

Recently I was in charge of the Emergency Dept. on an evening shift, 1300-2130. Our 12 bed ED is staffed with 3 nurses on the evening shift and a triage nurse that goes home at 1830.

The dept. was heaving when we arrived, every bed was occupied and we hit the ground running. It's often like this for the handover period, but mostly we have it back under control by the time the morning shift leave. This shift however, just got busier and busier. Patients kept coming, and they had serious and complicated conditions that required lots of nursing attention.

After 1600 there is no clerk, so the triage nurse does the clerical registration of the patients as well as the clinical triage. After 1830 there were just 3 of us to care for a full department of acutely unwell patients. As coordinator I clerked, triaged and treated patients, liaised with the hospital supervisor, booked beds, arranged transfers, booked ambulances and coordinated patient flow with the doctors.

At about 7pm, we were still flat out and had patients in every bed, when we called by a wardsman (the only one in the hospital) to an "unconscious woman in the carpark". Two of us nurses went out to perform a car extraction (getting an unconscious patient safely from a car is no easy feat). Luckily for us the patient was able to get herself from the car to stretcher bed, which we wheeled into the ED, moving patients like deck chairs on the Titanic to fit her into a bed bay with cardiac monitoring.

Not so lucky for us, our patient was experiencing a mental health crisis and her behaviour very quickly escalated to very loud and aggressive. While 2 of us tried to calm her, our remaining nurse and doctor tried to reassure the other patients that they were safe.

Behind the flimsiest of curtains was an unstable and extremely angry young woman. Sharing the ED, and in beds beside her, were a 3yr old with a fractured leg and her mum, a 6yr old girl needing stitches in her face and her mum, 10yr and 16yr old brothers who'd crashed their skateboards at speed and needed extensive dressings, an

elderly woman with a hip fracture and dementia, who needed constant supervision not to climb over the bed rails, a man in his 70's with chest pain, a young woman with severe abdominal pain who was sobbing and vomiting, a man in his early 20s with a fracture dislocation of his elbow, a young man waiting for burns dressing to both of his legs, and a 4yr old with a cough and fever, which despite being asthma, required full covid infection control precautions, and all of the family members who were with them.

With no security on site on weekends, only 1 wardsman and clinical staff already stretched beyond capacity we were unable to restrain the patient with a mental health disturbance, something that was needed to keep her, our patients and ourselves safe. Without the ability to restrain her safely, our patient left the ED and started roaming the hospital. She smashed a glass cabinet and was brandishing a large piece of glass as a knife, threatening to kill herself and others.

Our rural town has a police station that is often unstaffed, police are dispatched from 30 mins away. So, no security, minimal staffing and unreliable police presence. We are vulnerable. Thankfully, on this occasion police responded quickly and were able to safely get our patient to comply with handcuffs, which allowed us to safely assist in transferring her to the specialist care she needed.

Rural sites so often run on minimal staffing, there aren't the extra people that can be called upon to help in a crisis. We had no clerk, so I made the call to the police, taking valuable time when I needed to be assisting. We had no security, perhaps the situation might have been averted if we could have restrained her appropriately earlier. We were already at capacity and when forced to prioritise the treatment of our other patients was compromised.

I'm proud to say all our patients, including the distressed young woman, had good outcomes - because we worked hard to make it so. But the system did not support us. Even after this, our senior LHD management want to cut the staffing in our ED. We are determined to fight any reduction in staffing, but how much effort can we keep directing to keeping safe staffing when we are using all our energy keeping our patients safe?"

The Association welcomes this renewed interest into health outcomes and access to health and hospital services in rural, regional and remote parts of NSW. As illustrated by the testimony above, the situation is dire for people outside of Sydney, with health outcomes substantially poorer than their Sydney counterparts. This needs to change. It is not acceptable that residents in the rest of NSW are provided with an inadequately resourced, substandard system of healthcare while metropolitan Sydney residents enjoy far superior access and outcomes. Regional, rural and remote citizens of NSW are entitled to the same standard of healthcare as every other member of the NSW community.

This interest in healthcare delivery is also good news for the nurses and midwives who are the backbone of healthcare in rural, regional and remote parts of NSW. While the supply of nurses and midwives varies across remote areas, the nursing profession stands out as the best distributed health workforce in comparison to other professions[1]. The Association represents 35,000 nurses and midwives employed in Local Health Districts (LHDs) outside Sydney. The members we consulted in preparation for this submission universally expressed their concerns about poor healthcare, not only from a professional perspective, but also in terms of their deep commitment to their community and the reality that they and their families are also reliant on a system they know is under-resourced.

People living in regional, rural and remote parts of NSW have greater and more complex needs for health services but less access. They have higher rates of coronary heart disease, stroke, chronic kidney disease, mental ill-health and diabetes. The burden of chronic disease is increasing in Australia and there is a strong gradient in burden across remoteness areas.[2] However, in response to this increased demand we see poor staffing and skill mix, nurses and midwives routinely working in isolation, limited access to continuing education, reliance on colleagues to provide unpaid on-call support, skill shortages, inadequate security and transport services and lack of medical cover.

[1] National Rural Health Alliance, 2019, https://www.ruralhealth.org.au/sites/default/files/publications/fact-sheet-nurses.pdf, accessed 11/11/2020

[2] Australian Institute of Health and Welfare 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. https://www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death-2015/, accessed 11/11/2020

We are not an Indigenous organisation so we defer to the expertise of the many First Nations organisations that are the experts in healthcare and health outcomes of Aboriginal and Torres Strait Islander peoples. In more general terms, we know that the health of Aboriginal and Torres Strait Islander people is poorer than other people in NSW and that First Nations people frequently do not have access to culturally sensitive healthcare, appropriate drug and alcohol support, education, housing services, mental health interventions or support for cognitive disabilities. The interests of First Nations people must be addressed in the final recommendations of this Inquiry.

The NSWNMA is committed to working to address the inequalities experienced by many Aboriginal and Torres Strait Islander peoples and achieve health equality for First Nations peoples. NSWNMA is also committed to supporting the principle of self-determination for First Nations people. Self-determination must be a key characteristic of measures aimed at improving the health of Aboriginal and Torres Strait Islander peoples and therefore we support Aboriginal and Torres Strait Islander community controlled health services in regional, rural and remote areas as a key means of reducing health inequalities. Aboriginal Community Controlled Health Organisations are well known to enhance equitable access to healthcare and effectively manage chronic diseases. First Nations people in regional, rural and remote parts of NSW should have access to their services.

Every member of the NSW community regardless of where they live, should have access to comprehensive, high quality healthcare. However, we know that people in rural, regional and remote communities are dying prematurely because of inequitable access to healthcare and a lack of investment in rural, regional and remote communities. There have been multiple well publicised failures of care that have had devastating impacts, not just on the patients and their families, but also the nurses and midwives who are doing their best.

It is true that most of the time, largely due to the good will, hard work and sacrifice of staff, services are being delivered. However there is growing awareness among people outside Sydney that their healthcare needs are being neglected. We see growing media interest in the catastrophic failures of care that once went unnoticed. Certainly this organisation is working hard to ensure affected communities understand that their limited access and subsequent poor health outcomes are attributable to choices that are made by the NSW Government.

We believe that the current situation in many parts of regional, rural and remote NSW contravenes NSW Health's statutory obligations to provide a safe work environment for nurses and midwives and to ensure so far as reasonably practical the safety of staff and patients in terms of the way work is carried out.

To accurately capture the views and perspectives of our members, we invited them to provide us with reports of their experiences and these are included in this submission. We have also included submissions from members that were collected for an earlier project that looked specifically at violence in the workplace. Their testimony is compelling and paints a stark picture of the range of issues that sooner or later cascade into the terrible tragedies and catastrophic failures of care that precipitated this Inquiry.

It should be noted that many contributors were concerned about potential repercussions if they raised their concerns in this context. This was despite our assurances that advocacy is included in both the nursing and midwifery codes of conduct[3]. Many expressed fears that raising their concerns would result in a punitive response from their management. For this reason, individuals, services and localities are not identified in this submission.

> *"Nurses cannot speak up about the issues due to the potential for reprisals. This is the only employer in the town for nurses. The fear is that if they are targeted there is nowhere else to go for work."*

This is a matter that should be of great concern. It is a fundamental principle of safety and quality in healthcare that individuals feel empowered to raise concerns about issues that impact on patient safety.

These firsthand reports from our members move beyond the official government statements and statistics by capturing the experiences of the people on the ground. Their testimony is deeply concerning although frankly, not unexpected considering the well-documented poor health outcomes in regional, rural and remote NSW.

Staffing is the number one issue raised by our members trying to deliver care in regional, rural and remote parts of NSW. On a routine shift they are expected to care for more patients than they have capacity to attend to safely, and when emergencies arise, they are woefully unsupported. There is also limited access to a casual workforce which means that it is difficult to replace nurses and midwives who require short term leave.

[3] Nursing and Midwifery Board of Australia, https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx, accessed 23/11/2020

"Night shift 1 – on COSOP (remote medical consultation process, Critical Operations Standard Operating Procedures). We have 1 midwife (MW), 1 registered nurse (who is allocated to ED on nightshift even though they are the ward RN) and 1 enrolled nurse. This is a district hospital with 3 bay emergency dept (ED) and 28 bed acute med/surg ward that includes maternity, high dependency unit, paediatrics and palliative care. Our ED is located over 60m from the acute ward. The hospital is in a town approximately 1 hr away from a base hospital. We are generally on COSOPs at least 70% of the time (sometimes a Dr available for triage 1-2).

Elderly gentleman brought in by ambulance with sepsis, decreased GCS (5), very sick – family wanting no CPR but full treatment otherwise. History of CVA a few months prior. Unstable – hypotension, tachycardia, hypoxia. MW & RN go to ED as it is unsafe for 1 staff to attend ED alone. This left the EN alone on the ward with 12 acute patients.

Rural and Remote Dr (RaRMs) was contacted by the MW whist the RN was treating the patient - IVC, ECG, point of care (PoCT) pathology as per sepsis pathway. Inotropes were given to maintain BP even with no Dr on site. Dr wasn't happy to arrange retrieval but was insistent that MW should discuss the intervention and management plan with the family. Dr would not talk to the family himself as he didn't think that would be 'fair' as he hadn't physically seen the patient. It was a very difficult situation to be in as a nurse. I felt I was practicing above my scope of practice as it's not my role to arrange NFR orders.

Night shift 2 – on COSOPs (again!!) I had expressed concerns with management a week prior to my shift about staffing for night shift. The RN who was rostered on x4 night shifts is a new graduate RN with no ED or triage experience at all. A few staff raised their concerns, including the RN herself (she was very stressed about the upcoming shifts) with management highlighting that the RN was allocated to ED despite holding no qualifications or experience. The recent incidents at Tenterfield and Gulgong were highlighted but management decided they would have the new CNE on-call (this CNE had been working for 4 weeks at the site and has no rural/remote experience including triage and adults (paediatrics background only) and lives over 20mins away).

I arrive on shift and receive handover – 14 in patients (including a palliative care patient and 3 with dementia). During handover a patient presented to ED and the evening staff call the Dr in as they were on call until 2200hrs – 2 more ED patiens arrive during this

time. The Dr sees the 3 pts and I and the junior RN finish off their care. The EN has been alone on the ward looking after 14 pts since evening staff left. We are now on COSOPs until 0800hrs.

Shortly after another patient presents as a triage 3 (acute, severe abdominal pain) – while I was assessing this patient another patient arrived by ambulance and at this time the fire alarm is activated. As I am in-charge I have to go to the fire panel to assess the situation (hoping to god that it is a false alarm) leaving the junior RN to take handover from the ambulance and triage patient even though she is not qualified to do so. The EN is still on the ward working in isolation trying to calm a dementia patient who is wandering and stressing over the fire alarm. I call the on-call CNE in but I know it will be realistically at least 30mins before she arrives.

So myself, the RN, and the CNE are doing what we can to assess the 2 pts and contact the RaRMs Dr and patient flow unit back and forth to work out a plan and treatment for both pts – including IVC, PoCT path, ECG, analgesia, ect. Multiple times one of us had to go down to the ward to get equipment (IV pump) and stores as evening staff had had a very busy shift and had no time to restock ED. Both the patients had morphine, but the 2nd patient then developed hives and shortness of breath – so was treated as per the anaphylaxis protocol due to the morphine reaction. As I was drawing up the adrenaline the fire alarm reactivated so I had to leave the other 2 inexperienced staff members to check the fire panel again. The night continued in much the same way.

The ward patients did not receive their IV antibiotics on time as the EN could not check/give them alone – she was alone most of the night working in isolation managing 16 acute patients – including dementia, palliative patients who required meds/settling/toileting/pressure area care.

I'm grateful no maternity patients arrived overnight as I would have been in labour ward which is 40 metres away from the ward and 100 metres away from the ED.

IIMS completed – to go off into the never never!!"

"Staffing is by far the biggest (but not the only) barrier to delivering quality health care. Two nurses looking after a general ward and a

four-bed emergency ward is in no way a satisfactory situation. Frequently both nurses are required in the ED, this leaves the general ward unattended. If only one nurse is required in the ED, then both nurses are working in isolation. This is unfair on the staff, it is unfair on the patients, but more than that, it is unsafe. Too often we rely on kitchen staff to "keep an eye on the patients." There are no wardsmen, there are no security staff, there are no clerical staff after hours and frequently there is only a doctor on the end of the phone who is working in another busy emergency department in another hospital. This puts a huge responsibility on two nurses, especially the nurse in charge."

"Nurses are frequently asked to stay back or called in at short notice to cover sick leave because there are no casual staff available to cover these situations. We are being snowed under with paperwork which leaves even less time to deliver hands on care to our patients, and not surprisingly an increase in falls and pressure area injuries is the result."

"We are also expected to teach our student nurses while working in this environment, but often it is not possible to give them the direct supervision that we are obliged to give. These students are the future nurses that we will rely on. They need and deserve good training."

Understaffing has very serious consequences for the quality and safety of healthcare. Of all the members of the interdisciplinary healthcare team, the nurse is the only one who provides a continuous (24 hours/day, seven days/week) presence at the patient's bedside. Thus, the nurse is the member of the healthcare team most likely to pick up deterioration in a patient's condition and initiate interventions that minimise the impact of adverse events and prevent negative outcomes for the patient.

"I work in charge of an emergency department out of hours which is generally fine however on night shifts when there is only one registered nurse, the acuity of the department quickly exceeds the capacity of one nurse and it doesn't matter how senior or

experienced you are it is not safe. Recently in the ED by myself at night I have had a cardiac arrest, a STEMI[4], and an intubation/retrieval. I am looking at employment options outside NSW Health because I worry about being caught in a situation that causes serious harm to a patient."

"We need more nursing staff working on the ground. When I start work I hit the floor running, trying to keep up with my workload, and anticipating any new problems I may encounter during my shift. This often means missing my breaks due to lack of staffing to replace you on the floor. If you are lucky enough for a manager to relieve you for a break, you can guarantee the work during that period is there waiting for you on your return. I get home exhausted. It's extremely hard to give patients what they deserve in the way of personal care, and frequently medication is either missed or late. Management are just not listening to staff. Nurses are being blamed and performance managed when patients miss medications and there is no acknowledgement of the role of the excessive workload as a factor in such incidents. Staff are totally exhausted, sick leave is very high due to burn out, and high overtime rates as shifts are not filled. Our patients deserve more as do our nursing staff."

The evidence is clear that there is a link between staffing and outcomes in healthcare settings[5]. There is a limit to how many patients one nurse or midwife can care for safely and in a way that maintains the patient's comfort. When the patient load exceeds that number, patients are more likely to have poor outcomes.

An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% and every 10% increase

[4] ST-Elevation Myocardial Infarction (STEMI) is a very serious type of heart attack during which one of the heart's major arteries is blocked.
[5] https://www.nswnma.asn.au/wp-content/uploads/2019/02/Ratios-and-safe-patient-care-FINAL.pdf

in bachelor's degree nurses was associated with a decrease in this likelihood by 7%.[6,7]

All members of the interdisciplinary healthcare team have a role to play in prevention of adverse outcomes; however the depth and breadth of evidence – both domestic and international – describing the significant link between nurse-to-patient ratios/nursing hours per patient day and patient outcomes, provides a compelling case for mandated minimum staffing in inpatient settings. The growing body of evidence clearly demonstrates that inadequate nurse staffing leads to an increase in negative outcomes for patients and ultimately a greater burden of cost to both the healthcare budget and society.

"I have 25 years' experience in rural nursing. My concern is staffing levels in the facility I currently work in. There is one RN and one EN/EEN/AIN per shift, to care for 10 high care aged residents, possible 4 acute patients, and manage the emergency department which can be very busy. We don't have the support of the NSW government to provide adequate care to all our patients. My experience is that the care is always compromised, with toileting, feeding, showering not attended on time, and always rushed. Sometimes some of these things are missed.
This contributes to staff burnout, and risk of deteriorating mental health amongst staff is a real issue.
Our VMO is the town GP, but she has limited availability, frequently only 4 days per week, sometimes only 3. We then rely on Virtual Rural Generalist Program GPs who attend via telehealth. As mentioned before, one RN and EN in emergency situations means the other patients and residents (10 to 14 in number) will be left on their own devices - domestic staff try to be of assistance but after 6pm there is no one else. I feel that all the above is a safety concern; both for staff and patients who are entitled to the same level of care as people in the city."

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[6] Based on discharge data for 422,730 patients aged 50 years or older who underwent common surgeries in 300 hospitals in nine European countries.
[7] Aiken et al. (2014) Nurse staffing and education and hospital mortality in nine European countries: a retrospective study, The Lancet Vol 383, 9931: 1824-1830.

Understaffing is rife across NSW hospitals, but more so in regional, rural and remote areas. This compromises the quality and timeliness of patient care and increases the risks to nurses and midwives. In addition to issues with the numbers of staff, there are also significant concerns about inappropriate skill mix, e.g. for large numbers of new graduates working in high risk areas with insufficient supervision and support, or Assistants In Nursing (AINs) being used to replace RNs.

"Working a night shift in an MPS, where I was the RN in the 3-bed ED, with an attached 6-bed acute ward. The only other staff member in the entire hospital was an RN in the 21-bed attached aged care facility. A very ill patient arrived at the emergency in the early morning and was treated as per protocol by me and the other nurse. As a result, there was no one left to attend any of the 21 aged care residents, some were wanderers, some had dementia, some required regular care from nurses."

"I have worked in regional LHD for the last 30 years and we have virtually hit rock bottom in our efforts to provide safe, high quality healthcare to patients and their families. We keep asking for staff enhancements for our service to cope with the fact that activity has increased threefold. They firmly state there is no additional funding and instead, despite our workload statistics tripling, our budget seems to be cut each year by 5% regardless. Whenever a staff member leaves, we are told that staff member won't be replaced. When benchmarked against Sydney LHDs, we have similar casemix and statistics, but they have double and triple the number of staff and a far greater budget to purchase and maintain equipment."

Aside from patient safety, adequate staffing levels are also vital in:

- the prevention of violence, e.g. reducing levels of patient frustration and aggression due to excessive waiting times or being able to engage with and redirect mental health patients who may become agitated.
- the de-escalation of violence e.g. early observation of escalating behaviour provides the best opportunity to respond and de-escalate.

- the capacity to manage violent incidents that occur e.g. training provided by NSW Health in restraint requires a minimum of five responders. This means that the facility requires at least this many trained people to be available to respond to an incident.

"I did my new graduate remote rural -both hospitals have no doctor on site. There is usually only one RN and one EN on night shifts for the whole hospital. Day shifts there is one RN and one EN for the ward/ED and then two other nurses for the aged care site attached as they are multipurpose sites. You are expected to treat and triage patients whilst also looking after any patients on the wards and coordinating possible RFDS retrievals. Every so often there would be a critical emergency and with two-three nurses and the doctor being called in. The care delivered to patients is obviously nowhere near what a metro hospital would be, as is their chances of survival.

I am now working at a C1 hospital but still think that there is a HUGE difference between this and the referral hospital. I quite often have 6 patients and can have 10 with an Ain, no educator or in charge without patient load. Whereas when I work at the referral hospital I don't usually have more than 4 patients and there is an in-charge without a patient load and an educator. The nature of the work in remote/rural and the workload in the C1 hospital is very similar so I am moving to the referral hospital.

I think a lot of nurses feel this way. They are moving to the bigger hospitals with better nurse to patient ratios because why should we work harder and watch patients suffer?"

The Association is concerned that the Royal Commission into Aged Care Quality and Safety has recommended that Approved Aged Care Providers operating out of a MPS should be able to apply to the Aged Care Quality and Safety Commission for an exemption from the Quality and Safety Standard relating to staffing. It has long been a concern to our members that the residential aged care provision within an MPS has been regarded as requiring a lower skill level than the main hospital. This results in removal of registered and enrolled nurses from the residential care section to provide back-up staffing to the main hospital, or circumstances whereby a

registered nurse is unable to attend the residential side throughout their entire span of duty.

Having dedicated staffing ratios within the residential care section will guarantee there is no transfer of staff between areas, and ensure residents receive the quality care they deserve.

"I have worked in an MPS for 30yrs. We are often without doctors and nurse staffing is atrocious. For example, only 2 staff overnight to manage care for 24 aged care residents, 6 acute inpatients and 2 emergency beds.

Even though we have no security and police are usually 50 minutes away, we are required to manage scheduled mental health patients due to lack of beds or transport to the nearest gazetted unit.

There is no on-call person to escalate to in emergencies."

Many of the violent incidents that come to the attention of the Association occur at times when staffing levels are unsuitable. The safety of nurses and midwives in regional, rural and remote settings will be discussed in more detail later in this submission.

"I have worked as a community nurse in a small rural community for the last 16 years. In the last 2 years we have lost 1.4 RNs, leaving 1 FTE to run an ambulatory care clinic and attend home visits.

We do a lot of wound care, some complex, IV Baxter exchanges, catheter care, Palliative care and aged care. Recently some days have seen 16 clients in an 8-hour day. Plus answering the door, phone, ordering stock, attending to referrals, entering new registrations and dealing with problems as they arise with clients being seen. Our data proves increased activity, but we're still told we had to lose the only day that overlapped with 2 staff. This day was paramount to a good handover of clients and problem solving.

I often go home feeling emotional and stressed wondering if I can continue."

Population numbers are subject to proportionately substantial variations. There are a range of temporary groups that drive spikes of demand for care in regional, rural and remote health services. There are a number of settings in NSW that deal with transient employment models such as FIFO workers in the mining industry. For example, Parkes Hospital has been significantly impacted by mining workers as well as workers associated with the inland rail project. Similarly, large tourist events, festivals and grey nomads all rely on regional, rural and remote healthcare services. These spikes in demand have implications for workload, staffing and patient safety.

"With the growing lack of experienced nurses there is less & less support & mentoring for our new nurses. There is just so much work with not enough staff to do it. COVID has amplified this, we have no back up. Our small LHDs can't handle an influx of tourists or pandemics. We just don't have enough skilled people."

It can be an exciting environment but also a very stressful one as there is so much more responsibility for the nurse with very little support and limited resources. There are no permanent educators on most of these sites and not all the nurses working there have critical care experience or advanced life support. The "grey nomad" trend is a major issue as so many elderly people with multiple comorbidities and complex needs travelling out that way."

The geographical isolation of many services in NSW presents particular practice challenges to nurses and midwives. They often work without access to clinical supports and assistance. Their scope of practice is often extremely broad because they are frequently the only professional available to respond to a wide range of needs. They also experience pressure to work outside their scope of practice which can have disciplinary implications. Nurses and midwives frequently take on non-nursing/midwifery roles that would otherwise be staffed in metropolitan settings, such as pharmacy, pathology, x-ray, mortuary and domestic services. There is very

limited access to allied health, primary healthcare (including early intervention and prevention) and specialist services. Where specialist services are available, they are frequently limited to a few days per month or on an ad hoc basis.

"I am paediatric nurse working in a local rural hospital. If our ward is closed due to no children in the hospital, we are deployed to other wards to assist, and often take a patient load dealing with adults in surgical or medical situations. This practice can undermine safety. Recently, as senior nurse I was placed in charge of an adult surgical ward with a junior RN from paediatrics, a new graduate from another ward with 3 months experience and two ENs. Of the 3 RNs and 2 ENs covering the shift, only one was familiar with the ward. I expressed my concerns about this to the after-hours manager and placed 2 IIMS into the system. This is dangerous for patient care and safety as well as a risk to nursing staff who are being forced to work outside our scope of practice. This particular incident led to me going on stress leave for a month."

"Our facility does not have an on-site pharmacist - we have a remote clinical pharmacist that covers our health service. With the increasing complexity of medications, I worry about patient safety in this situation."

"More specialist services need to be based in regional Australia and stop de-skilling rural doctors by requiring them to send everything on to a referral hospital. Smaller hospitals need greater scope of care."

The lack of on-site doctors and limited service capabilities of many facilities in regional, rural and remote areas means that there is a high level of frequency of patient transfers and retrievals which can be very time consuming to arrange.

"We are a small rural ED operating without on-call medical officer services (telehealth phone only Monday to Friday and locum doctors on the weekends) as a fully functioning emergency department. There is poor governance, poor safety and increased risk to patients and staff alike. ***APPENDIX A*** *is an example of the complicated transfers resulting from lack of onsite medical officer coverage. In this scenario you had 4 different doctors, 7 different nurses (including nurse managers) and 8 different transfer co-ordination conversations. A total of 25 DIFFERENT PHONE CALLS to arrange transfer of one patient to receive medical assessment more than 12 hours after initial presentation to a supposedly fully functioning ED. There is push back from all facilities that we try to transfer their patients to because everyone is sick of dealing with the fact that we do not have a doctor for medical assessments!"*

"I work at a Base hospital in a regional area. In our hospital we often have patients waiting 3 days for transport for urology and orthopaedic care at another hospital. We need a 24 hour patient transport service or orthopaedics and urology based at our facility. These patients stay in the emergency department. A crowded and noisy environment. This is not safe for the patient, nor other patients waiting for treatment."

"Lack of support for the facility to keep certain patients within their role delineation. Facilities can look after patients but are constantly asked by larger facilities to send them for review. This review may take <24 hrs. These unnecessary transfers contribute to an immense budgetary burden for smaller rural health services."

"Working a night shift in an MPS, where I was the RN in the 3-bed ED, with an attached 6-bed acute ward. The only other staff member in the entire hospital was an RN in the 21-bed attached aged care facility. A sick very child arrived in ED and we were lucky to have

called the on-call doctor for a previous patient, so that he was present at the arrival of the child. The child required urgent transfer to the local regional hospital as there were no facilities or staff at the MPS to continue care, especially if there was a deterioration. The NSW Ambulance Service was called for an urgent 'lights and sirens' transfer, within the hour. After 2.5 hours and more phone calls the ambulance still had not arrived. When the ambulance arrived, the paramedics asked when I had called for them, as they were stationed 5 minutes away in a caravan park. It was difficult to continue observations, reassure patient and family, modify treatment, and at the same time be on the telephone via and understaffed and incompetent system. Again, the potential for a severe adverse outcome was high."

Several of our members raised the impact of ageing built environments and equipment on workflow efficiency and work health safety and security. The physical work environment plays an important role in decreasing risks associated with occupational violence and aggression. Physical changes to the workplace that eliminate or minimise the risks associated with violence are high order controls under the WHS Regulation 2017 and should be employed wherever possible.

"This health service building is >45 years old. Services keep increasing but the footprint of the facility stays the same. We keep cramming in more people to the same building. We now have much more equipment and larger items such as lifters, beds etc. The environment in which patients reside whilst hospitalised provides many hazards due to the size of the rooms and the amount of equipment such as walkers, lifters etc."

"I work in a small MPS with the main hospital 1.5 hrs away. For years now, we have been asking for an I-Stat machine which our nurses consider critical for our POC service. We were denied it even though we pointed out how many of the pathways it could be used for: chest pain, sepsis, stroke. We also have 2 residents on warfarin that would benefit. We have chest pains come through our

emergency department, but we are told we don't have the numbers to justify the expense. To me, this seems to degrade both our staff and our community. Please help."

"We also don't have necessary equipment maintained and when it breaks, we don't have the budget to get it fixed. My service is so backlogged it is unsafe for staff, patients and the community."

"I work in an MPS with 24 aged care beds. Predominately I work night shift and there are only 2 staff. The police station is not 24/7. Our next one is 60kms away. The hospital is old, we have doors out on to the veranda. Only some of these are alarmed and old-style sash windows that can be easily accessed."

Rural, regional and remote practice places a significant burden on nurses and midwives in terms of the need to manage higher complexity interventions such as chemotherapy and dialysis whilst maintaining generalist nursing and midwifery skills, including low frequency high risk clinical capability such as trauma response. Access to continuing education is a crucial mechanism by which nurses and midwives maintain their skills and knowledge but is difficult to access outside of metropolitan settings. Most significantly, the extent of understaffing means that nurses and midwives cannot be relieved to attend professional development opportunities.

"Rural nurses are not provided the access and training that our metro colleagues are given. Education is at our own expenses and being released to attend is not supported as there is no staff to replace on the floor clinical care."

While there is consensus in the literature about the link, unfortunately there is not clear consensus regarding a precise staffing ratio that maximises quality, safety and

efficiency. A nurse hours per patient day (NHPPD) formula has been implemented in parts of the system with good effect. There are a range of contextual factors that must be taken into consideration as we seek further implementation of minimum staffing standards, but it is also crucial that the process is guided by the available evidence.

Further, we are aware that many rural and remote services can only operate because staff provide on-call coverage in the event of emergencies. According to our members, this is almost always unpaid. This is a flagrant breach of the Award entitlements of nurses and midwives and it disrespects these people and their families. If a service cannot operate without a reliable on-call roster then this needs to be formalised and the cost of paying these allowances must be factored into operating costs.

Recommendations

- **That NSW Health adopts the NSWNMA 2018 Ratios claim as the minimum nursing numbers required on each shift. See Appendix C for details of this claim.**
- **That every aged care facility has a minimum of one registered nurse on duty 24/7.**
- **That staffing and funding for aged care facilities be re-considered with reference to the findings of the Aged Care Royal Commission and the ANMF National Aged Care Staffing and Skills Mix Project Report.[8]**
- **That NSW Health recognise minimum staffing ratios are necessary to provide safe patient care but may not be sufficient to ensure the safety of staff, especially in smaller facilities with very limited staffing numbers. In this case staffing numbers should be determined by ratios plus a risk assessment of numbers required to provide an effective duress response.**
- **That nurses and midwives are paid all their Award entitlements including on call entitlements wherever they are currently expected to be available to attend work outside their standard roster.**

The lack of onsite medical coverage poses many challenges for our members. Not only do they shoulder a huge burden of responsibility, they also describe widespread problems associated with accessing on-call and telehealth medical officers.

[8] National Aged Care Staffing and Skills Mix Project Report 2016 -- Meeting residents' care needs: A study of the requirement for nursing and personal care staff, Aust Nurs Midwifery J. 2017 Apr;24(9):28-33

It is acknowledged that whilst the Virtual Model of care is a necessity in circumstances where no medical coverage is available, the lack of physical presence of a medical officer on site in emergency situations presents huge challenges for the nurse who is responding to such situations. Rural and regional sites that are reliant on virtual medical officer coverage must have the option of calling in an on-call registered nurse, who is within 15 minutes of the site, for support.

Our members report that while, in theory, nurse managers/HSMs are on-call, they often live substantial distances away or are out of town on their time off which means they are not physically available to the nurses on duty in the emergency department. An expectation that nurse managers/HSM are on call 24/7 is unsafe and untenable.

"I live in an isolated town of nearly 5,000 people and we are 300km from the nearest facility with higher level services. In our town we operate on sporadic locums, usually a different doctor each time, and otherwise the virtual doctor service. This means almost no continuity of care for any patient, many of whom have significant chronic health conditions and co morbidities. We have GPs in town; however this service is also being propped up by locums, which again significantly impacts continuity of care.

As nurses, my colleagues and I are stressed, anxious and at times fearful going to work. Not having a doctor on site means we feel solely responsible for the journey and outcome of every patient that comes through the door. We are responsible for the head to toe assessment of the patient for the virtual doctor to use to decide the course of treatment. The doctor does not collect this information. We are told this is simply working to the top of our scope of practice, however we feel we are being used to replace the physical doctor.

I have no issue with working to the top of my scope, however I feel unsupported in doing so. There has been no training to suture wounds or apply plaster casts. We have very limited access to professional development. Why is it ok for people living in the country to have nurse-only treatment? Why is it ok for people living in the country to be denied access to a doctor when their condition requires it?

Patients who present to our facility with a wound that requires sutures must drive 600km round trip to the next doctor. Patients who require an ultrasound often have to do the same. Patients with a dislocation of a joint (eg shoulder) also must be transported to the

facility 300km away. Some people cannot be transported by private car so hospital transport is arranged but due to the increased demands on the service, the transport can be delayed. For non-urgent transfers, the delay can be days. The demands for air transfers for patients whose care needs are urgent, or whose health condition means it is not safe or appropriate to go by car, has also increased, as have delays. Some of the increase in demand is a direct result of not having onsite doctors. Resources have not been increased to meet this demand. Patients can wait overnight for a transfer for significant conditions, such as minor heart attacks, sepsis, or fractures.

What can be done to address this? State and federal governments can work collaboratively to redesign the health system to educate, attract and retain skilled health practitioners- Rural Generalist Doctors, Rural Generalist Nurses and Nurse Practitioners, supported by a combination of virtual and hands on specialist care. Better access to radiology services and allied health is also needed. Creating and supporting these positions will pay for itself in terms of savings on patient transfers, and more importantly- healthy communities into the future.

People living in rural areas contribute to the economy just as people in urban areas do, yet we do not have access to the basics which that economy claims to offer. Why? This issue requires urgent senior political attention and leadership across state and federal government, from all parties. Access to health care is a basic right of all Australians. Why are residents of rural postcodes being denied this?

"Frequently there is only a doctor on the end of the phone who is already working in another busy emergency department in another hospital."

"The 'on-call' doctor was called but did not answer the phone on several occasions. This doctor was billeted in a 'hospital-owned' house about 1/4 km away, so we asked two family members of the patient to drive there and wake the doctor. We had only two staff in the hospital, so none were able to leave. The family members returned as were unable to rouse anyone at the house. I woke the

CEO in the early hours of the morning, explained the issue, and she drove to the house, to also bang on the door, eventually waking everyone but the doctor on call. The others then woke him. The delay in time could have been catastrophic for the patient."

"People don't want to work in a hospital that doesn't have a doctor on shift all the time. It makes them feel unsafe. We have had agency nurses come and when they realise there is no doctor, they leave the next day."

"Having no doctor on-site or on-call most afternoons and after hours makes it very difficult to coordinate care. We must liaise with ED doctors at our referral hospital who are already busy physically seeing their own patients in their busy emergency department. The registered nurse has to spend a lot of time on the phone liaising with the doctor making sure you are not missing anything. This can place a lot of pressure and responsibility that would not be asked of a registered nurse who works in a tertiary hospital. Having a doctor on-site or at least on-call specifically for our small rural hospital would improve patient safety and outcomes."

"The model of relying on privately run GPs providing on call VMO services to public hospitals is OUTDATED and not functional and not how young doctors coming through medical school want to live their lives so it will become an increasing issue.

Doctors need to be employed by small hospitals as both on call for the hospital and to operate a GP practice out of the hospital - look to QLD Health for this model!"

Recommendations:

- **That the Nurse Practitioner (Generalist) model of care and role in regional and rural areas is properly implemented. This will require funding to be directed towards recruitment and development of additional Nurse Practitioners to work in rural and regional areas, particularly in sites without 24/7 medical officers reliant on virtual medical officer coverage.**
- **Where rural and regional sites do not have access to medical officers 24/7 and are reliant on virtual medical officer coverage, there must be a minimum of one registered nurse rostered on-call, and within 15 minutes to the site, to be present and provide physical in person support to respond to emergency events.**
- **Wherever there is an emergency department open 24/7, regardless of its delineation or classification however named, that facility requires minimum staffing of three nursing staff rostered on duty, two of whom are suitably qualified to attend to an acute emergency presentation.**

Inadequate technological infrastructure, especially unreliable internet coverage, impedes access to clinical information systems, telehealth consultations and the delivery of safe, high quality healthcare.

"I think the main problem for us in terms of Medchart is that it is heavily reliant on an internet connection that is not wholly reliable at a high standard all the time. The fact that this issue is intermittent is part of the problem. If it didn't work all the time it would be easier to know how to fix it or what exactly is wrong.

Sometimes it is very slow to load each page. This means that when you are waiting for each page to load 30 - 45 seconds per page and your patient may have 10 medications, it significantly impacts on how long it takes to actually perform the task of administering medication. If you are giving out 16 - 20 peoples' medication it can take an exceedingly long time to complete the task. It can take up to 60 seconds to save that each medication has been given. This also impacts negatively on the time required. It is very frustrating when you know how busy you are and know how much you need to do and you have no choice but to stand and wait for a page to load. I have resorted to breathing slow and deep and trying to be mindful of

the adrenaline like responses occurring in my body and deliberately try to calm them.

Reliability is an intermittent problem. You can follow the appropriate steps and believe Medchart has saved what you have just administered and then at the next pill round find that it has not been saved and is indicating the medication is late and still requiring administration. I think this is quite dangerous because it is possible that the next shift may readminister the medication because it looks as though it has not been given. We are aware and wary of doing that and generally try and check with the previous staff first.

It feels like the RN does nothing but give out the pills some days and there is so much more required of the job.

When first introduced, Medchart provided a problems sheet for us to fill in if any concerns. It was quite detailed and onerous to complete in an already time poor environment. We did complete pages of it and received no feedback. I acknowledge there may have been a breakdown in communication, I don't really know. We have designed a simpler version and intend to monitor intensely for 2 weeks using the speedy form to try and capture the issues I have raised here."

The Association also has concerns about excessive reliance on telehealth. While telehealth options exist for mental health and drug and alcohol resources in rural and regional areas, these are not always a suitable option, particularly in relation to immediate management.

Several of our members quite rightly raised the issue of incentives and the role these could play in improving staffing. There needs to be an honest acknowledgement that staffing in regional, rural and remote areas will necessarily rely on attracting a temporary workforce to some degree. If the current incentives are not enough to attract people in the competitive market for nurses and midwives, then they should be improved.

"I am a Registered Nurse and work mostly for an agency but sometimes do short term contracts for NSW Health. The reason I do short term contracts is that NSW Health only provide

accommodation for agency nurses and short-term contracts. When I started nursing, I couldn't get a graduate program, so I started working for QLD Health as a rural and remote nurse. With this job came RANIP (rural and remote incentive package) which included 2 flights per year to the nearest capital city and generous cash bonuses after each year of service. As well as this incentive came free furnished housing inclusive of electricity.

Often now I am tempted to remain in some of the many places I work in country NSW but I would need to buy furniture and very often the rentals in small country towns are either non-existent or very expensive. It's not an incentive to stay in one place in NSW. If I decide to settle in one town I will go back to QLD where there are incentives to accept the challenges of rural work.

You asked for my story, I hope this makes some of the pollies understand why health care professionals are in short supply in country areas and maybe think about some incentives for those of us who choose to help in the country areas."

The Association continues to have grave concerns about the safety of our members in many regional, rural and remote locations. The issue of occupational violence and aggression is a priority concern for the membership of the Association. Current arrangements for preventing and controlling violence in NSW hospitals are not effective, evidenced by the continuing number of violent incidents across the state.

Our members report increasing levels of exposure to violence as well as an increase in the severity of the incidents that are experienced. Member requests for assistance from the Association to deal with issues of violence and aggression across all areas of nursing & midwifery have increased markedly over the last few years.

While we know violence towards nurses and midwives is a very serious issue that is well documented, well researched and widely accepted to be a significant problem, quantifying the true extent of the issue is hampered by the lack of transparency and very poor incident reporting.

In order to better understand the nature and prevalence of violence and aggression currently experienced by nurses and midwives in NSW, the Association collaborated with researchers from the University of Technology Sydney on a project that looked at the experiences of NSW nurses and midwives with violence at work, involving over 3500 nurses and midwives, making it one of the largest studies undertaken on this topic worldwide. While this not specifically about regional, rural and remote health services, the research provides valuable insights into the issue of violence against nurses and midwives in NSW Health facilities and a copy of the report provided to the Association on this study is attached at Appendix B.

Key findings from the study include:

- 47% of nurses & midwives had experienced violence at work in the week prior to completing the survey.
- 80% of nurses & midwives had experienced violence at work in the 6 months prior to completing the survey.
- 76% perceived that the frequency of violent episodes was increasing.

The other thing that became very clear from the study is that exposure to violence is not restricted to nurses working in emergency departments or in mental health, with workers in a wide range of clinical and specialty areas reporting exposure to violence in the last six months.

The research by Dr Pich indicates that rural and remote nurses experience higher rates of violence and aggression than those in metropolitan areas. Common characteristics of these facilities include:

- Small numbers of staff, particularly overnight mean that there are insufficient numbers of staff to provide an internal duress response.
- Often do not have security staff, or if they do, they do not cover all shifts.
- May not have ready access to police.

The Association surveyed members working for NSW Health in the development of a previous submission in relation to workplace aggression and violence. The largest number of responses were from members working in smaller rural and regional facilities, with concerns primarily related to staffing numbers and the lack of security staff or police.

"My town is situated 2 hours north of the nearest regional centre. We have a local police station, but it is not open 24/7, and the nearest on-call police attend from 2 hours' drive away with no towns

in between. Our MPS consists of aged care beds (18 high care, 10 low care and 8 dementia specific in a separate secure wing), 6 acute/sub-acute beds and an emergency department with 2 beds.

Overnight staffing consists of 1 RN, 1 EN and 2 residential care assistants (one working in low care and one in the dementia unit).

Walk-ins to the ED often present out of hours due to escalating mental health issues and drug and alcohol consumption. At 9pm, an intoxicated person & a friend presented to the ED. As there was no one available immediately to open ED doors and assess as all staff were providing care to aged care residents at the other end of the facility, the male friend proceeded to smash through the glass doors into the ED.

The nurses confronted by aggressive intoxicated persons smashing the ED doors felt very unsafe, they had no internal duress capacity, no on-call police available and no alternative localised procedures in place to manage duress situations. In the absence of any localised procedure, the nurses set off fire alarms which got a response from the rural fire brigade and along with ambulance personnel assisted in resolving the immediate issue.

Following this incident nurses were subjected to social media harassment as well as verbal abuse and intimidation within the local community."

"I work in a small rural hospital. 25 acute beds,4 bed ED, 9 bed maternity. We only have security Friday, Saturday and Sunday night shift. All other times we have a duress alarm that if activated the security company rings approximately 5 mins later to see if we are ok. Not good enough! Our security man can only observe due to no training to intervene. We do not have a 24hr police service, so they must recall or travel 80kms from the next town. We are expected to hold mental health and sometimes violent patients overnight with one nurse in ED, and two nurses in the acute wards."

"I work in a rural hospital, with a 6 bed ICU -3 nurses. We admit mental health patients including acute psychosis from street drugs, alcohol, other reasons; even though none of us have mental health training. Scheduled or confused ward patients are admitted to HDU, just because they can have 1:2 nurse: patient ratio."

"We do not have security, only 2 nursing staff on duty and no police in our small town after hours, meaning the closest police would be 45 mins away. We also have 9 exits that the nurses must lock down every night. I would like to express my concerns about the lack of ANY security in our community health centre. We currently do not have working duress alarms."

"I work in a small rural MPS facility which have 29 beds (20 aged care and 9 acute, an emergency department (nurse led service). We don't have 24hr police in town. After hours all calls go to the nearest town, which is 30 minutes away. The hospital does not have 24hr hospital security assistants on duty which is a major concern for us. Duress alarms - have never worked properly since the system was installed and don't go anywhere - only internal to staff on duty."

"Most small hospitals and MPSs do not have security at all in this LHD. Minimum staffing in MPS-only 2 nurses on night duty, 3 on an AM and PM, all female nursing staff on this site. Police Station in the town but often covering neighbouring towns 30 minutes away."

Security staff have a very important role to play in the prevention and management of violence and aggression in NSW Health facilities, as has been found to be the case in reviews in other Australian jurisdictions. The Association supports the finding of the Victorian Public Health Service Security Model Review that highly trained security personnel are an essential component in the prevention,

management and response to workplace violence[9].

Unfortunately, it appears that the deployment and use of security across NSW Health facilities lacks consistency or any clear rationale, with rural and regional facilities often afforded limited or no access to on-site security, despite staff working in these facilities having very similar levels of exposure to violence. Our recent examination of violence experienced by nurses and midwives in NSW based on geographical location and found that people working in rural locations were actually more likely to have experienced violence and aggression at work in the previous six months than those in a major city.

Geographical area	Violence experienced in last six months
Major city	79%
Inner regional	82%
Outer regional	82%
Remote	81%

Hospital X is a small rural hospital consisting of a maternity unit, a 22 bed ward and an emergency department. At night there is one nurse working in isolation in the ED, one midwife in the maternity unit and 3 nurses in the ward. A security assistant was employed to work 4 nights per week, but the position was not replaced if he was sick or on leave. Nurses had made a number of requests for security to be provided 24/7, and for an increase in nursing numbers to ensure their safety.

On 21 November 2018 an aggressive incident occurred overnight. This was a night that there was no security on site and there were insufficient nursing staff to provide a duress response. The private security service took 45 minutes to arrive."

All nurses and midwives, regardless of where they are working, must have access to suitable duress arrangements in the event of an emergency. It is appreciated that

[9] Loss Prevention Group of Australia, Public Health Services Security Model review (C5965)

these arrangements will look different according to the type of workplace and its location, however staff must have the capacity to call for support when required and to receive a timely and effective duress response.

It must be recognised that people will not always be able to make a telephone call in the event of a violent episode and so this method cannot be relied on to call for assistance, particularly when nurses are working in isolation in the community.

Recommendations:

- **NSW Health should undertake a review of existing duress arrangements in place across regional/rural facilities. This should consider at a minimum, the staffing numbers across each shift, the availability of security staff by shift and the availability of external resources, including external security companies and police.**
- **The Association recommends visible, uniformed, unarmed security staff be positioned in close proximity to emergency departments, psychiatric units and other areas of the hospital where violent incidents may occur.**

We are also deeply concerned about the safety of community nurses and midwives working in community health who have a different set of risks than other nurses, with community centres rarely purpose built, and unlikely to have access to security or sufficient staffing numbers for a duress response.

Nurses visiting patients and mental health consumers and midwives visiting new mothers and babies in their homes are often working in isolation in environments not controlled by NSW Health, where risk can vary markedly from one visit to the next and where often the risk of violence relates to the presence of friends and family members.

We receive reports of incredibly unsafe practices including:

- Poor/no initial risk assessment prior to home visits
- Poor communication of emerging risk
- No access to duress beyond a mobile phone (which cannot always be accessed in an emergency and does not always have signal coverage)
- Nurses working in isolation in high risk environments
- No system to ensure nurses and midwives have safely exited the home at the conclusion of the home visit.

Recommendation:

- **Revise systems in place for community nurses and midwifery in keeping with chapters 16 & 17 of *Protecting People and Property – NSW Health policy and standards for security risk management in NSW Health agencies*.[10]**

NSW Health recognises that around 40% of violent episodes occur in mental health units, making mental health an important area of focus in violence prevention. Prevention and early intervention of mental health disorders is an important element of reducing exposure to violence. From there, providing treatment early and preventing relapses is also critical.

Poor resourcing of mental health along with a limited specialised workforce in regional, rural and remote areas is reaching a critically unsafe level for both staff and clients. Our members identified insufficient numbers of mental health intensive care (MHICU) beds generally to manage those who are most acutely unwell and insufficient numbers of beds available for older persons requiring MHICU. Currently older persons requiring an MHICU admission are being inappropriately accommodated in the limited MHICU beds or worse, in general aged care facilities.

In community mental health we are seeing an increase in non-nursing mental health professionals managing clients on complex medication regimes leading to relapse and readmission that could have been avoided, as well as staff not backfilled when on leave.

Small rural/regional hospitals with Emergency Departments gazetted as declared mental health assessment centres are another area of concern for the Association.

There appear to be around 14 small rural hospitals that have been gazetted as "mental health emergency assessment centres" in what appears to be an attempt to restrict the transport of patients by ambulance and/or police to larger facilities.

It is hard to see how being taken to the emergency department of a small rural hospital with minimal staffing and generally no staff with mental health training beyond a 30 minute on-line training session only to wait for hours for a telehealth mental health assessment before waiting many more hours for patient transport to be transferred to a larger facility with mental health beds is in the interests of an extremely unwell behaviourally disturbed patient.

[10] https://www.health.nsw.gov.au/policies/manuals/Pages/protecting-people-property.aspx

It is certainly unsafe for the staff who are trying to manage highly volatile patients despite having:

- no mental health training
- inadequate staffing to be able to implement a restraint if required
- no seclusion room
- no security staff
- no local police presence.

Another significant issue for our members in more isolated areas is an increase in inappropriate drop offs of intoxicated persons for mental health assessments.

The Association is regularly receiving reports from members that behaviourally disturbed intoxicated people are being taken to an ED or mental health unit by police for mental health assessment even though they are unable to be assessed until they are no longer intoxicated. This leaves an aggressive person in a hospital setting while they sober up rather than a police setting. While we appreciate the competing priorities for the police and the potential for serious health issues to be overlooked within a police environment, police environments are generally more suitable for the management of acute behavioural disturbances linked to drug or alcohol intoxication. If intoxicated persons are to be managed in a hospital setting, this needs to be a secure environment with suitable staffing arrangements in place to manage the risk.

"A behaviourally disturbed person is detained by a police officer who believes they are in need of an involuntary mental health assessment. It is 11pm. They are taken to the nearest declared mental health emergency assessment centre at a small rural hospital. There are 3 staff members rostered on, a single nurse working in the emergency department and 2 on the ward. There are no security staff at this time and the nearest police station is 90kms away.

There is no one with any mental health experience or qualifications and the assessment is to be done by video-link. If the patient is intoxicated, they cannot be assessed and are to remain in the ED until the assessment can be undertaken. Even if they are sober it could be 5 hours until the video-link conference occurs. Once the assessment occurs, if the patient is scheduled they will need to be

transferred to a hospital with mental health beds. It can take many hours to organise for the patient transfer, particularly overnight. All of this time you have nurses and other patients in a very high-risk situation."

"Community mental health nurses requested police assistance in working with consumer X. Police said consumer X was 'mouthy' but not a risk and the nurses were overreacting. Consumer X entered the community mental health centre and doused 2 nurses and the premises with petrol and threatened to set them on fire."

Nurses and midwives in regional, rural and remote parts of NSW are facing increased levels of violence arising from patient use of methamphetamines. While alcohol use is still responsible for greater numbers of aggressive and violent incidents, it is the nature of violence associated with 'ice' that makes it such a serious concern.

It is important to note that emergency departments are not the only places that nurses are facing ice related violence and aggression. In addition to the traditional areas of concern – emergency departments, drug and alcohol services and mental health units, the Association is also receiving reports of increasing ice related aggression across all areas of nursing, but most notably in cardiology. Methamphetamine is cardio-toxic and causes damage to heart muscles and arteries, it can also cause heart arrhythmias and endocarditis. Ice users are a very different patient cohort than traditional cardiology patients and wards are less likely to be designed with the management of violence as a key consideration, provision of duress alarms are not routine and nurses working in cardiology are unlikely to have appropriate training in the management of violence and aggression.

Methamphetamine is notorious for its association with violence characterised by its capricious and often bizarre nature and is a significant public health concern.[11] Based on data collected from wastewater analysis, methamphetamine use appears to disproportionately affect some regional areas in NSW and yet these are the areas least likely to have access to training, security or sufficient staff to allow for a

[11] McKetin, R., Lubman, D., Najman, J., Dawe, S., Butterworth, P., & Baker, A., (2014), Does Methamphetamine Use Increase Violent Behaviour? Evidence from a prospective longitudinal study. Addiction, 109, p798-806

duress response in an emergency.

> *The rate of methamphetamine-related hospitalisations increased rapidly from 12.2 per 100,000 population in 2010-11 to 137.9 per 100,000 population in 2018-19. The rate has stabilised slightly from 2015-16 onwards. Methamphetamine-related hospitalisation rates were higher in males, Aboriginal people, people aged 25-44 and people living outside of major cities.*[12]

Recommendations:

- **Increased funding for mental health services in regional, rural and remote areas to ensure suitable services are available at all levels of care provision, from community-based care through to Mental Health Intensive Care Unit (MHICU).**
- **That NSW Health develop plans to address shortages in mental health nursing staff, training, recruitment, and retention of mental health nurses. This should also include increased opportunities for Nurse Practitioners (Mental Health).**
- **Work with local police and other relevant groups to decrease inappropriate drop offs of intoxicated persons. This should include a clear agreement on when it is appropriate to bring a person to a declared facility for assessment, as well as training to improve understanding of when a person may be in need of a mental health assessment.**
- **If intoxicated persons with acute severe behavioural disturbances are to be managed in hospital environments, this must occur in secure facilities with suitable staffing arrangements to ensure risk can be managed effectively.**
- **Review the availability of mental health and drug & alcohol resources, including the use of telehealth options for rural and regional areas for patients presenting to EDs under the influence of psychostimulants such as "ice", both for immediate management and longer term referral and treatment.**

[12] HealthStats NSW, Methamphetamine-related hospitalisations, http://www.healthstats.nsw.gov.au/Indicator/beh_illimethhos/beh_illimethhos_aria_snap, accessed 01/12/2020