REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 3

INQUIRY INTO REGISTERED NURSES IN NSW NURSING HOMES

CORRECTED

At Sydney on Friday 14 August 2015

The Committee met at 9.00 a.m.

PRESENT

Ms J. Barham (Chair)

The Hon. C. Houssos
The Hon. N. Maclaren-Jones
The Hon. S. Mitchell
Reverend the Hon. F. J. Nile
The Hon. W. Secord
The Hon. B. Taylor

CHAIR: Before I commence, I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respect to the elders past and present of the Eora nation and extend that respect to other Aboriginals present. Welcome to the third hearing of the inquiry of General Purpose Standing Committee No. 3 into registered nurses in New South Wales nursing homes. The inquiry is examining the need for registered nurses in nursing homes and other aged-care facilities with residents who require a high level of residential care. Today is the third and final public hearing for this inquiry.

Today's hearing is open to the public. A transcript of the hearing will be placed on the Committee's website. In accordance with the broadcasting guidelines, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that they must take responsibility for what they publish about the Committee's proceedings.

It is important to remember that parliamentary privilege does not apply to what witnesses may say outside their evidence at the hearing. I urge witnesses to be careful about any comments they may make to the media or to others after they complete their evidence, as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation. The guidelines for the broadcast of proceedings are available from the Secretariat. Media representatives who are not accredited to the parliamentary press gallery should approach the Secretariat to sign a copy of the broadcasting guidelines.

There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days following receipt of the transcript. I remind everyone here today that committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. I therefore request that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals or specific nursing homes unnecessarily. Witnesses are advised that any messages to Committee members should be delivered through the Committee staff. Could everyone please turn their mobile phones off or to silent during the hearing.

PHILLIP MICHAEL CARTER, Chief Executive Officer, St Andrews Village Ballina Limited, before the Committee via teleconference, sworn and examined:

CHAIR: Do you have anything to add about the capacity in which you appear today?

Mr CARTER: Yes. I am also appearing as the Chair of Aged and Community Services NSW and ACT in the Far North Coast region.

CHAIR: Would you like to make a short opening statement?

Mr CARTER: The aged-care reforms have put us all in a bit of a position because they have affected the New South Wales legislation, which I believe should be repealed. I will highlight the difficulties that the reforms will cause. I believe that registered nurses [RNs] play an important role in nursing homes in clinical positions. I have nothing against RNs. But I believe that there will be a negative impact on the viability and sustainability of the quality of care services provided if facilities are required to have an RN on duty 24 hours a day, seven days a week. I do not believe that the Federal Government will increase funds to cope with the increased costs, or, if funds are increased they will not be sufficient to cover costs, as is already the case. This will compromise care. Care providers will have to find ways to reduce costs, or close facilities. Facilities will close down and leave the communities in those towns worse off. You have to realise I am a bush boy so I will say the following thing. The bush is always the poor cousin. There will be an influx of residents placed in hospitals so as to meet accreditation standards, which will be a cost to the public health system in New South Wales.

There could be more non-compliance due to not being able to get or afford registered nurses [RN]. There will not be enough RNs registered to fill the positions. Does a facility become non-compliant and close because of that, when it was not the case prior to the stroke of a pen on a reform? Registered nurses will take care staff positions. This is what we believe can happen because people will try to meet the bottom line. Therefore, two or 2½ care staff may be taken to appoint an RN. You are looking at a difference between $20 an hour to probably somewhere around $40 plus an hour. So you have to look at it realistically. The quality of care will not be better because of this move.

Should facilities close in small communities, people will have to find accommodation in larger towns. Being displaced from their loved ones is not what I call quality of care or thinking of your fellow human beings. The extra cost to the Federal Government could be anywhere from—this is what I am led to believe—$100 million to $150 million per year for what gain? Just to meet a stroke of a pen by a bureaucrat on a piece of paper? There needs to continue to be a skills mix provided that meets the needs of those residents with low and high clinical care needs. I am in a high-care facility; I need registered nurses here because there are some with clinical care needs. Up until March 2015, three-year accreditation was achieved, I understand, by 97 per cent of homes, which is the national average. Those that did not achieve accreditation outcomes were compliant within six months. That is my understanding. So what is the problem?

I have worked in lower-care facilities. In the bush we were very stringent with regard to medication and what should happen with medication. There is an assist client with medication under a certificate III course carried out. There is an administration monitoring medication certificate IV carried out. My understanding is that the assessment process for these units is that competency of care workers will be further strengthened, and the new qualification to be released later this year. So I believe it should be repealed. I cannot understand in New South Wales and Australia, where we are short of funds now, there has been no issue whatsoever, why would we be trying to create a problem and spend all this money for no apparent reason?

The Hon. WALT SECORD: How many nursing home aged-care facilities do you represent as the regional chair?

Mr CARTER: I represent up here about 12.

The Hon. WALT SECORD: Twelve aged-care facilities.

Mr CARTER: Yes, 12 aged-care facilities. I only have one myself but you have to realise when I am talking—if it is all right to mention this—I have worked in the Central West, I have worked in the Central North

area and I have worked in the Sydney area. So even though I speak for up here, I am talking about my experience in other areas.

The Hon. WALT SECORD: I understand, but your submission states that you are raising it as the regional chair.

Mr CARTER: That is right.

The Hon. WALT SECORD: How many residents are in those 12 facilities that you represent?

Mr CARTER: I could not answer that. I do not have that specific knowledge. I would have to go to the ACS to Alana Halliday and ask the ACS State board to find out what those figures were.

The Hon. WALT SECORD: I have a couple of questions about your facility. How many residents are in your facility?

Mr CARTER: We have 117 and we are just about to go to 121.

[Redacted by resolution of the committee]

The Hon. WALT SECORD: I will switch to another matter. Are you familiar with an organisation called Aged Care Reviews. It is linked to your aged-care website and it gives reviews from patients and from family members. Are you aware of that?

Mr CARTER: No I am not.

The Hon. WALT SECORD: I suggest that you look at it because there is an interesting one from less than a month ago complaining about a lack of staff in your facility and the person writing about the status of the care of her mother. The reviews into your facility, link to your facility, highlight concerns about a lack of staff at your facility.

Mr CARTER: I am happy to answer that. If you would like, I can give your our compliments book and show you the amount of people who give us compliments for the care we give. So you have one person who has made a comment and she has the right to make that comment and I have no problem with that. Nobody is perfect. I do not think you are, I do not think anybody else is. But I am more than happy for you to come up and do a review of my facility. But you have to realise that my facility has registered nurses in it. My concern is that having a registered nurse does not mean that it can give you any better quality of care than those facilities that have care staff in them.

The Hon. WALT SECORD: I draw you back to a comparison you made when you said you had concerns about the salaries of registered nurses versus care staff. You said it was a comparison of $20 versus $40. The enterprise agreements actually show that the average registered nurse receives $37.37 an hour. Is the bottom line your profits?

Mr CARTER: We just look at it as a surplus, not a profit. The point that you raise is if you look at the difference between the two—$17—that is nearly another care staff member. If you were to take that out into a small place you would need to have two care staff members to be replaced by one registered nurse, if you were going to be hard on your budgeting if you did not get any extra money.

The Hon. PAUL GREEN: Paul Green here, Phil—former registered nurse and particularly in aged care. At the level that you are saying, I think you said 2.5 care staff positions for a registered nurse, how many care positions can you get for a doctor?

Mr CARTER: That's a good point.

The Hon. PAUL GREEN: That was just a cheeky comment.

Mr CARTER: My director of care is close to $55.00 an hour. I have got a deputy that is close to $44.00 now. I have got a community care director that has just gone on to $48.00 an hour. I have registered staff that are between $34.00 and $40.00 an hour. We make sure that we give a 3 per cent increase each year. It is different in every facility and we are trying to just upgrade our collective agreement. I do not have a problem with a registered nurse; we need registered nurses in high clinical care places. All I am saying is that if you have to put an RN in these smaller places or these places that are of lower-care needs—and there are some that have high-care needs in there—and there has not been a problem, why are we trying to push the point?

Nobody is arguing they should not be with high clinical care. What we are saying is: Do we have to go to the extra expense of having to cut care staff to put an RN in? It is not the RN's fault but if we cut the staff to do this it is going to compromise care to the person because now people are struggling with regard to meeting the care needs of people. In relation to the other fellow that was just asking a question, our staffing levels here

are a lot higher than my co-competitors in this area, and we all have single rooms and ensuites. So I would certainly challenge that question before.

The Hon. PAUL GREEN: With due respect, in that matter that is a marketing situation where you have got the edge on your competitors because you provide a higher level of ratios and care. So that is a good thing.

Mr CARTER: It is a good thing.

The Hon. PAUL GREEN: Would you put your parents into a home that did not have a doctor or a registered nurse?

Mr CARTER: Well, I put my grandfather into one, yes—in Barraba.

The Hon. PAUL GREEN: Were you happy that if anything went wrong he would have had the immediate care that he would have needed?

Mr CARTER: Yes, at that stage. If I felt that my grandfather had higher care needs and there had not been the facility or the skills available then I would have looked at trying to transfer him to somewhere else.

The Hon. PAUL GREEN: That is a personal choice obviously.

Mr CARTER: You have got to realise though that I come from the country—

The Hon. PAUL GREEN: So do I, Phil.

Mr CARTER: —and people in the country put up with a lot more than people say. I do not mean this to be disrespectful, do not get this the wrong way—

CHAIR: Mr Carter, half of the Committee are regional members.

Mr CARTER: Sorry, I beg your pardon. All I am saying is that we are used to putting up with things and having to deal with the issues with the skills that are available at the time in facilities. We used to have theatres in little hospitals; we do not have those now, we have to go further.

The Hon. PAUL GREEN: I understand. My point is that while you have your personal view of the situation there, you can appreciate that many families would want that reassurance of having a level of expertise around the place—not that it will ever be called on necessarily but it is there and that reassurance for the quality of life for the patients and the relatives would be a reasonable expectation, would you not think?

The Hon. PAUL GREEN: I am sorry for your loss, Mr Carter.

Mr CARTER: All I am saying is that it does not matter whether you have registered nurses—

The Hon. PAUL GREEN: There was a situation down here where someone was in a toilet for 21 hours in a major hospital.

Mr CARTER: I can understand that that is unacceptable. I think they are putting things into place now to make sure that you check the toilet more regularly.

The Hon. PAUL GREEN: The point is you cannot have a nurse on every corner of the ward and on standby near every toilet but you have got to do your best with the resources you have got. Can I just clarify: If nothing was to change from this day on with the legislation as is, you would be happy with the status quo?

Mr CARTER: I certainly would be. That is a good point. When I say the status quo it is because we have an accreditation system in and we have RNs that come in and check along with people who are not RNs and do accreditation and they are pretty stringent in what they do. They always ask us about our staff levels and our care levels and they interview the clients all the time. We have also got a very strong complaints system in place. So I believe that there are good measures in there to pick things up if there are issues. I am not supportive of people who do the wrong thing—not at all. But I believe that we have been doing the right thing as providers. I think we need to make sure that people are still watching us, and I am happy to have RNs come in and check to see that things are being carried out and that the quality of care is at a high level.

The Hon. NATASHA MACLAREN-JONES: It is Natasha Maclaren-Jones; I am one of the Liberal Party members. Just following on from the question from my colleague in relation to accreditation, there has been alleged in the submissions that there are what has previously been called low-care facilities opting out of providing registered nurses. In your opinion—and I would be very interested in your experience, particularly, as you mentioned, with the ACT as well—what is in place to ensure that there is the correct mix of staff for residents' needs?

Mr CARTER: First of all, I worked in an area that just had basically low-care facilities, as they were known at the time. At that stage you looked at the roster and you looked at the care needs of the people that you had that were in place and there was a mix of people at that stage—and I am talking about the old system where RCS had less than categories four and five. I do not know whether you are familiar with that. Then you actually came down to the two and three getting into higher care—there were a few of those. But a lot of them did not have high clinical needs; they had high-care needs but not clinical-care needs.

So we look at those rosters and we check to see how the care is being delivered. We also do surveys of residents and relatives, as we do with staff, to see how thing are being met, to see if people have concerns. We do that in this facility here, and I am not going to lie to you and say that you get favourable comments all the time; 99 per cent of the time you do, but there are issues that you have got to look at. We are always looking and measuring ourselves and benchmarking ourselves all the time to see that we are delivering the quality and care that we can.

The Hon. NATASHA MACLAREN-JONES: Do you think that the accreditation, particularly the reviews—and obviously this is a Federal matter as opposed to State—should be strengthened or increased in any way?

Mr CARTER: No. To be honest, we normally have two or three people come here, because we have a large facility, but they are very stringent. If you want my honest opinion, I think accreditation should be carried out whereby they call at your door and just turn up. We get to prepare for these people coming, which is great, but you need to see people and take us how we are on the days when we are stressed from patient care and things like that going on around the place. You need to see it how it is, so people get a reality check on what is happening. I think there is enough from what is in place as far as the people who come in are concerned, because they are very stringent with what they look at, but I believe in surprise visits. I think that is a great idea and that is where you learn if you have something wrong and you need to pick it up. It is there and then and on the spot. It is reality.

The Hon. SARAH MITCHELL: I am member of The Nationals. You mentioned you had worked quite extensively across the State. I am based in Gunnedah so I understand when you say that sometimes in regional communities options are limited when it comes to these services. We have had evidence to suggest that

if people can stay in their community or close to their family, it is better for their longevity and their quality of life. Would you agree with that sentiment?

Mr CARTER: One hundred and twenty per cent. My mother has just shifted from her home. We live 20 miles out of Barraba and she had shifted to Barraba. It took a while to get her in—it actually took us eight months to get her out of the place and she is not walking that well. If I were to send her to Tamworth, Gunnedah or some other place I reckon she would be dead in six months.

The Hon. SARAH MITCHELL: One concern I have has been raised by a few witnesses and I have heard anecdotally. It is that facilities in smaller centres have said that if this is brought on them then they will have no alternative but to shut as they will not be able to find the staff. That seems to be a huge issue. Would you agree that it is difficult to attract registered nurses to some regional communities?

Mr CARTER: I have just put on a registered nurse as a director of care—it would be coming up to 12 months ago. He was the only applicant I had. Actually, to be honest I did not have any applicants. I had to go out and hunt him. I had heard about him and I hunted him from another facility. I know that does not sound good, but that is what we had to do. If you go down the chain, yes, it is very hard to get registered nurses in these places. You can advertise and it can take weeks and weeks. What is going to happen if we do have to have registered nurses? Would that mean we are non-compliant and we are going to get fined?

CHAIR: Unfortunately we have run out of time. Perhaps there was a misunderstanding about this inquiry. This was a great opportunity for you to raise some regional concerns, because this Committee has members from regional areas who do not see this as a way of further entrenching some of the disadvantage in rural and regional areas. We see it as an opportunity to hear the voice of regional people and perhaps we will make recommendations about greater support for regional people. Rather than lowering standards, we want to lift them. If you have further issues, you are welcome to raise them with us. Thank you for your time.

Mr CARTER: You have all been very nice and I appreciate the questions. The way it has been conducted has been very professional.

CHAIR: We may send you some supplementary questions and the secretariat staff will be in touch about that.

Mr CARTER: More than happy to do that. Thank you.

CHAIR: Terrific, thank you.

(The witness withdrew)

STEVEN TEULAN, Director, UnitingCare Ageing NSW ACT, and

MARGARET STRAHAN, Residential Operations Manager for Central Coast, Hunter and New England, UnitingCare Ageing NSW ACT, sworn and examined:

CHAIR: I am pleased to welcome representatives from UnitingCare. Would you like to make an opening statement?

Mr TEULAN: Yes.

CHAIR: Please keep it short so we have more time for questions.

Mr TEULAN: It will take about four minutes.

CHAIR: Go right ahead.

Mr TEULAN: Thank you for this opportunity to appear before the Committee. We share with a wide range of stakeholders in this inquiry the desire to ensure a safe environment for every person requiring aged care. We also value the integral role of registered nurses in aged care and acknowledge that UnitingCare is fortunate to have a group of passionate, committed, professional registered nurses. UnitingCare is concerned that there are absolutely inspirational services which must not be lost or compromised through an approach which treats virtually all residential care services as the same. We must not lose the beautiful home-like feel of the 15-bed Caroona aged-care service serving the people of Bonalbo—population 500 in northern New South Wales; or Starrett Lodge at Warnervale, which is nationally and internationally renowned for person-centred care; or Thomas Bowden at Ryde, which provides a wonderful caring environment, particularly in supporting people with mental health conditions.

All of them provide outstanding care with RN input, including access to 24/7 RN support but not 24/7 onsite RN presence. We must also stop creating situations where efforts to comply with the existing 24/7 onsite RN requirement in nursing homes in some rural towns and in other services where there are RN shortages means that RNs are regularly working double shifts, a practice which will almost certainly ultimately cause them to leave their vocation. We can contrast the approaches of the Federal and New South Wales Governments. The Federal Government has responsibility for the operational oversight of aged care, a situation which is clearly understood by other Australian States. The Federal Government undertakes the role comprehensively through the Aged Care Act, the Department of Social Services, the Australian Aged Care Quality Agency and the Aged Care Commissioner. It exercises that responsibility rigorously.

For example, during the year ended 31 July 2015, UnitingCare NSW ACT had 141 visits, each with a minimum of two assessors for a duration of one to five days, including 67 unannounced visits, to our services from the Australian Aged Care Quality Agency. The 44 standards reviewed are comprehensive, including those specifically relating to appropriate skilled and qualified staff. Both clinical outcomes and feedback from residents, families and staff are assessed. The Federal Government places the responsibility and accountability for meeting standards and service outcomes with the service provider. Failure to meet those standards and outcomes can result in penalties, including the appointment of administrators, loss of funding for all services not just the service encountering difficulties, and ultimately loss of the right to operate aged-care services.

New South Wales legislation in relation to aged care is at best piecemeal, relating to a single measure: one person on site 24 hours a day, seven days a week of a single input of registered nurse and with no reference to other factors which contribute to quality or to the outcomes of the service. Compliance is not monitored or enforced and government resources are not invested for the New South Wales regulatory requirement, which is being held up by some contributors to this inquiry as the safeguard for the quality of residential aged care in this State. With the greatest respect of respect to the Committee and NSW Health, if it is true that actions speak louder than words, you do not need a submission from NSW Health on its views. Its actions say that the oversight of operations of aged care is a Federal Government responsibility and the State regulation is redundant. I am not aware of any hard evidence that demonstrates that 24/7 on-site RN cover improves the quality of care or any other aspects of a service's performance and in our experience—and we have a fair amount of experience—there is no correlation between 24/7 RN on-site cover and service performance.

There are other factors which can be demonstrated to affect care outcomes but these cannot be turned into simple legislative measures. Instead, a comprehensive regime of standards, outcomes, monitoring and sanctions is required. The reason that this subject is being discussed in New South Wales and not elsewhere in Australia is that there is a legacy, a New South Wales statute, whose origins preceded the establishment of a comprehensive approach to quality by the Federal Government. That statute is now redundant.

CHAIR: We will start with questions from the Opposition.

The Hon. COURTNEY HOUSSOS: My first question will be on one of your comments from your opening statement. You said that compliance with the existing provision is not monitored or enforced. Can you explain? You have never received any form of monitoring or enforcement from the New South Wales Government?

Mr TEULAN: No. In 15 years in senior roles in aged care, including working with some of the largest aged-care providers in the State, I have not heard of one contact from NSW Health regarding compliance with the 24/7 on-site RN.

The Hon. COURTNEY HOUSSOS: What is the average size of your facilities? You have obviously spoken about a couple of quite small ones.

Mr TEULAN: The average size of facilities overall is about 80 beds. The average size of facilities in this group is about 40 beds. Just to explain, we have 75 residential aged-care services of which 53 have 24/7 RN on site and 22 do not. Of the 22 the average size is about 40 beds.

The Hon. COURTNEY HOUSSOS: And are they what would have formerly been considered low-care facilities?

Mr TEULAN: Yes.

The Hon. COURTNEY HOUSSOS: Do your facilities in regional areas differ in size to your facilities in the metropolitan area?

Mr TEULAN: It varies. Some of them are larger and some of them are smaller. Certainly the smallest ones are in regional and rural areas.

The Hon. WALT SECORD: My name is Walt Secord and I am the shadow Minister for Health. You have 75 aged-care facilities in New South Wales. How many residents are in those facilities in total—just a ballpark figure?

Mr TEULAN: There are 5,000.

The Hon. WALT SECORD: You said in your opening statement that there was no correlation between 24/7 registered nurses and patient care?

Mr TEULAN: Yes.

The Hon. WALT SECORD: Do you still stand by that?

Mr TEULAN: Based on the evidence we have 24/7 on site—let me be really clear, 24/7 on site. All of our services have access to a registered nurse 24 hours a day seven days a week.

The Hon. WALT SECORD: I actually pulled out the Federal Government financial subsidies that UnitingCare receives and all 75 of your facilities are listed. In 2013-2014 you received $280 million from the Federal Government in taxpayer subsidies—

Mr TEULAN: Yes.

The Hon. WALT SECORD: —for your aged-care facilities in New South Wales. Does this not just actually come back to profit margins, that if you are not required to have registered nurses, you will be able to pay lower salaries?

Mr TEULAN: No. There is actually no correlation between that; there is no logic to that argument. The fact that we receive revenue of a certain amount has no bearing on whether we pay our people more or less

The Hon. WALT SECORD: So therefore if revenue or salaries has no bearing on the operation of your facilities, why are you then objecting to registered aged-care nurses?

Mr TEULAN: Because it is a different issue. There are two issues here. One is that we believe we can provide outstanding quality for the people who receive services in those services where it is appropriate not to have 24/7—again I say on-site—RN cover. They all have RN input. They all have 24-hour access.

The Hon. WALT SECORD: But I do not see your point. If it is not profits, if it is not expenditure, that is making you object to having a registered nurse at a facility, is it not better to have a more highly qualified, highly trained person at the facility?

Mr TEULAN: There are two things. If you say to me: Does it have any bearing in terms of the revenue you receive in terms of the number and types of staff that you can afford, the answer is yes. However, in those places where we provide care without 24/7 on-site RNs, we are not going to compromise the quality of care and, to be quite frank, in those places, if we were going to add additional staff, we would not be adding RNs; we would be adding physiotherapists and other people who we believe would have a greater impact on the direct quality of life on the people living there because we believe we have appropriate input of RNs already.

The Hon. WALT SECORD: In situations where you do not have registered nurses and a situation occurs where someone requires S8 drugs and things like that, what is the protocol or practice at UnitingCare? What do you do?

Mr TEULAN: I will ask Ms Strahan to answer that, given that she deals with that every day.

Ms STRAHAN: It will be taken on a case-by-case basis. As Mr Teulan said, we have RNs available 24/7 who are doing assessments of all our residents who are on site. If that situation was to arise, then an RN would be contacted, and discuss what was the best plan of care for that person. But we have people in our services where doctors have ordered an S8 for them. The resident is quite capable of making a statement to say they are clear instructions or indications for use and it has been assessed by the RN as well as to whether that is an appropriate person to be managed in the service.

We have recently had a service that is a 32-bed what was traditionally was a low-care service where the resident was end of life. The family did not want her to move. She was on subcutaneous morphine. We put in place an RN to go in regularly to administer that so that person did not have to be moved from what was her home into a larger service that meant her sharing a room, into the nursing home bed that we had available. She maintained her quality of life in her home and was appropriately cared for. Her family were very happy. We do whatever we can to flex up and down staff where the need arises. I have worked in aged care for 25 years now. I am an RN and I can say that honestly I have never seen care compromised for cost.

The Hon. WALT SECORD: So when situations occur and there is not a registered nurse on duty—

Ms STRAHAN: On site.

The Hon. WALT SECORD: Sorry, can you explain the difference between on duty and on site?

Ms STRAHAN: There is always someone on call. I am on call; I have the service managers on call. I have support staff that are on call; all RNs. We are available to go in, to be phoned, to go into services if needed. We have larger sites that have RNs who are also available that can give advice.

The Hon. WALT SECORD: Does having an RN on duty allow you to comply with the State Government regulation but not actually physically have someone on the site?

Ms STRAHAN: Sorry?

The Hon. WALT SECORD: When you say that someone is on duty but not on site, does that still allow you to comply with the State Government regulation?

Ms STRAHAN: No, the State Government regulation says they must be on site.

The Hon. WALT SECORD: So when someone is on site they on site?

Ms STRAHAN: They absolutely 24/7 cannot step out of that building to even go down to the shops. They are on site 24/7.

Mr TEULAN: Under the current regulations.

Ms STRAHAN: Under the current regulation, that is right, and that is a challenge for us, as previous people have said. I have got a 35-bed nursing home in Singleton, which is a fishpond there. It is servicing the community. It has been there a long time. It is very highly regarded but it is a struggle to get RNs round the clock and it means at times the service manager is working double shifts or night shifts to maintain that requirement.

The Hon. WALT SECORD: Do you concede or recognise that paying a registered nurse $37.37 an hour is one of the reasons that many aged-care facilities have difficulty getting registered nurses when they in fact can get a higher salary just working in the public system because that is what the enterprise agreements we have downloaded show?

Mr TEULAN: Perhaps you could look at ours.

The Hon. WALT SECORD: What do you pay?

Mr TEULAN: I cannot tell you the exact amount. However, I can tell you that where there was previously a disparity between hospital nurses and aged-care nurses, we have largely been able to eliminate that working with the NSW Nurses and Midwives Association. I would be happy for the Committee to look at that. There are two categories of registered nurse [RN] where that is not the case, but generally across our staffing we have been able to do that in recent years.

The Hon. WALT SECORD: What are the two categories? You used a qualifier.

Mr TEULAN: I am happy to provide that to the Committee. The State Government has constrained increases for registered nurses, hospital staff and staff generally in government-run hospitals in recent years, but aged-care providers have been able to provide higher increases in recent years. What was a significant disparity has now been significantly eliminated, certainly in our case.

The Hon. WALT SECORD: Can I get you to take those two categories you qualified on notice and provide that information to the Committee?

Mr TEULAN: That is what I offered to do.

The Hon. COURTNEY HOUSSOS: You say in your submission that the number of residents receiving high care in your 75 facilities is variable, and it could be only one resident. How many of the 75 facilities have only one high-care, complex-needs resident?

Mr TEULAN: I do not know whether there are any. I can say that, overall, 92 per cent of residents in our residential aged-care facilities are classified under the Aged Care Funding Instrument [ACFI] as high care. Members should bear in mind that that instrument records some of that high care at $52 a day and some at $210 a day. It is not a very good instrument to use as the basis for discerning whether someone has particularly high needs or otherwise.

The Hon. COURTNEY HOUSSOS: If an RN is on duty but not on site, what procedures are followed if an ambulance is called?

Ms STRAHAN: The staff would follow an emergency procedure. If it was urgent they would ring. It would depend on the situation. They would all know to ring 000. We have very good, easy flow charts for the staff to follow around escalating a deteriorating resident. Obviously, if it was something critical they would dial 000 as the first resort anyway.

The Hon. COURTNEY HOUSSOS: I am more concerned about when it is not a critical incident.

Ms STRAHAN: They have a process they would work through. They would contact the RN on call to get guidance about what to do next. We spend a lot of time trying to make things skilled for the staff and simplified through education to ensure that they respond very quickly and escalate where needed.

The Hon. COURTNEY HOUSSOS: I might send some supplementary questions on that.

The Hon. PAUL GREEN: Do you have a defibrillator on every ward in your hospital?

Ms STRAHAN: No, and it is not a hospital.

The Hon. PAUL GREEN: Do you have one on every ward in your nursing home?

Ms STRAHAN: No.

The Hon. PAUL GREEN: I was taken by your comment that care is not compromised in any way because of cost. The reason that some people have private health insurance is that they want access to the very latest technology to improve their lives.

Ms STRAHAN: I am saying that I have never faced a situation where I have said, "Okay, we need additional support for that person, but I am not going to do it because we cannot afford it, it is outside our budget."

The Hon. PAUL GREEN: But there is definitely technology that you have not purchased because it is too costly.

Ms STRAHAN: No, I cannot say that either. We have looked defibrillators in the past.

The Hon. PAUL GREEN: That is just one example.

Ms STRAHAN: Any of my service managers would say that any equipment required for the residents that has been assessed as appropriate has been supplied. There has never been a time when I have said no or when my manager has said no to me. If it is needed, we get it. Defibrillators have not—

The Hon. PAUL GREEN: That is just an example. Obviously there are medication costs and other things.

Ms STRAHAN: Yes. We have come a long way in aged care in the 24 years that I have been in it.

The Hon. PAUL GREEN: Yes, and that is fantastic.

Ms STRAHAN: I started as an RN.

The Hon. PAUL GREEN: I asked the question because you have that experience. Any RN would have been frustrated when cost issues compromised the level of care, whether that involved changing bed sheets daily instead of every three days or—

Ms STRAHAN: Certainly not with us.

The Hon. PAUL GREEN: One could argue that that has implications for the level of care. I return to a comment you made, Mr Teulan. In answer to a question from the Hon. Walt Secord you talked about the evidence of having nurses as opposed to straight care.

Mr TEULAN: No, I did not say that. I said 24/7 RN—

The Hon. PAUL GREEN: I want to ask my question so that you can keep it in context. Can you answer that question in terms of the evidence, and then can you give me a breakdown of the evidence that allows you to arrive at that conclusion?

Mr TEULAN: First, I said that 24/7 onsite RNs did not correlate with service performance.

The Hon. PAUL GREEN: That is good. You said you had evidence.

Mr TEULAN: Yes. We look at factors that affect—

The Hon. PAUL GREEN: Can you table that evidence?

Mr TEULAN: I will explain it. For example, we know that the level of engagement of the people who work in the service has a significant impact on the quality of service provided and other service performances. We know that because we use an internationally validated instrument to measure it. We also know what drives that more than any other factor; that is, the quality of the manager on that site. That evidence is there in statistical form. When we look at whether an RN is on site 24/7 or not, that does not vary. There is no correlation.

The Hon. PAUL GREEN: That is fine, but I want to see the evidence.

Mr TEULAN: That is fine.

The Hon. PAUL GREEN: Please provide that on notice. Let us presume that health care is all about holistic care. I hear that you are saying that hands-on, loving and tender care is there 100 per cent. Would you not agree that the psychological wellbeing of a person could benefit from knowing there is an RN on duty 24/7? That might not be an issue for the resident, but it certainly would be for their loved ones.

Mr TEULAN: I will deal with that directly. As you say, that is something people might have a feeling about, regardless of whether there is any evidence to support it. The way to deal with that is to tell people and to be transparent about the staffing. That issue has been raised with the Committee, and we have certainly discussed with the association. We are very much in favour of transparency so that people know exactly where they stand. People who make the choice to stay in a local or rural setting should do that with full knowledge of the staffing and the restrictions on staffing. They will then understand that if something changes and they need to go to another place there is a reason for that. We explain that to people anyway. We are happy to have that transparency to deal with that feeling.

The Hon. PAUL GREEN: That is fair. Let us go back to where most of us are coming from. If you want to age in place in a lovely little rural town and you do not have that choice, what are your options? If you want your parent or a loved one in a facility that has 24/7 RN care, where do you send them if a facility gives you only one option?

Mr TEULAN: You can see the example in our submission, which refers to Bonalbo. There is a choice of either going to the 15 bed facility, which has RN input, but not 24/7 on site. Alternatively, you can go 69 kilometres down the road to a larger facility. Those 15 residents, 13 of whom are high care, and their families are very happy with the situation and they want to stay there. They make those choices.

The Hon. PAUL GREEN: That is my point. There is beautiful little Coolamon just outside Wagga Wagga, where the council has done a great job with aged-care facilities so that people can age in place. However, not everywhere offers the wonderful opportunities that you spoke about. It would be nice if every rural area had its own nursing home or residential high- and low-care facility, but they do not. They do not have a choice. This Committee must consider the situation across the State. If people are to age in place, they should have holistic care.

Mr TEULAN: First, if it is proposed that there be a 24/7 RN on site for every high-care classified resident, you are right, they will not have any choice. Secondly, people in rural areas understand their opportunities, the staffing and their options, and they will exercise them.

Ms STRAHAN: I look after our lodge on the Central Coast, and people come internationally to look at that service. Alzheimers Australia frequently sends people there. It does not have 24/7 RN coverage. The people are very comfortable there. We are transparent around it. Any time I have had dealings with the complaints, the complaints scheme say to me that we are very transparent about what we do. We are not always perfect.

The Hon. PAUL GREEN: In view of the fact that more than two million people will be over the age of 65 between now and 2050 a lot more people will be looking at facilities. It does not mean they like it, it may be the fact that that is all they are left to take. We need to be more mindful of that and this review is to make sure that we have got the right number of places open with the right level of care right across not only New South Wales but also Australia.

Mr TEULAN: I have two points in relation to that. One is those people are visiting because it is renowned around the world for its care: they are not visiting to see whether they might go in there. The second thing is, when you say "we" have to look at the care there is a real question as to whether that is a State Government role.

Ms STRAHAN: I would add that we are not looking at RNs. I absolutely value the role of an RN. As I said, when I started as an RN in aged care I was doing a multitude of things that were not tasks of RNs. The RN role now is that real clinical oversight. It has been able to be more clearly defined by us having more flexibility in how we use other workers. I think we have moved ahead. We have got excellent new grad programs for RNs. We are really trying to upskill the role of the RN we have because it was the poor relation, I think, years ago. It was not seen as the place to work to be in aged care. People come to us—and I do not disrespect public health people—from public health and realise it is an absolute specialty field. It is not the area that it used to be of "I'll pick up some work in an aged-care home on the weekend for some easy money." It is a really good clinical role, and we firmly believe that.

CHAIR: I appreciate that and it is obvious you run a very professional organisation. You have economies of scale by having a big organisation and you structure well. Mr Teulan you said it is not our role: it is our role. We are elected representatives and we are listening to concerns from the community. We are not out to get anyone, our role is to hear from people who work in the field and find out what more can be done. If it were not a factor of money, and you had a fully funded choice to have more registered nurses in your facilities to provide the assurance of greater care, would you want to take that?

Mr TEULAN: If you said to me "Tomorrow here's another $50 million, where would you like to spend it on staffing?"

CHAIR: No, that is not my question.

Mr TEULAN: No, but it is a bit like saying "Would you like to have a policeman outside the front door of every house?

The Hon. WALT SECORD: Yes.

Mr TEULAN: Who wouldn't?

The Hon. WALT SECORD: You wouldn't.

The Hon. PAUL GREEN: Wal would.

Mr TEULAN: I want to respond by saying if you gave me an extra $50 million and I had to choose staff, I would not put on more RNs. I would actually put on more physiotherapists and other people who are missing in the aged-care system today. I take your point about the concern of this Committee. If you are really concerned it is the absence of things like physiotherapists and other allied health people. It is the absence of an effective relationship between the hospital system and the aged-care system—they are the things which I would hope that you would focus on.

The Hon. SARAH MITCHELL: I would to clarify some answers to questions from Opposition members about on-call nurses. I am happy to be corrected, but in your high-care facilities you are required to have a registered nurse 24:7 and for the previously classed low-care facilities there is access to a registered nurse on call. If I were to send a family member to one of your facilities I know there would be access to a registered nurse 24:7 whether that nurse was physically in the building or they had to come in. I would have that piece of mind to know that a registered nurse is available when needed it. Is that right?

Ms STRAHAN: Yes. We would also have a time when we would say to people that we believe they need to move somewhere—potentially we would do that.

The Hon. BRONNIE TAYLOR: I congratulate you on your excellent and very detailed submission and commend you for working with the New South Wales Nurses and Midwives' Association to make sure that your pay rates were at parity with the public health system. You said that Alzheimers Australia had visited your facility and sees it as a benchmark and a high-quality facility. You also noted that there were no registered nurses 24/7 at that site. Is that correct?

Ms STRAHAN: That is correct.

The Hon. BRONNIE TAYLOR: Are you aware that Alzheimers Australia gave the Committee evidence advocating very strongly for 24/7 coverage?

Ms STRAHAN: Yes.

Mr TEULAN: Yes and we find that interesting because they did not realise that that service did not have it. But they actually bring the chair of its board, and other dignitaries to visit that service to demonstrate how aged care should be provided.

The Hon. BRONNIE TAYLOR: I am also a registered nurse and my background is cancer and palliative care. The Committee has heard a lot of evidence in this inquiry about how aged care has changed and has become more complex and you are living it and seeing it every day. No-one else has articulated what you said today relating to the value of allied health which is not represented by an organisation that speaks out on behalf of allied health professionals. Do you say as clients' needs get more complex, therefore, allied health needs are also becoming more complex?

Ms STRAHAN: Yes, I would. We have also got better at that with engaging allied health professionals. We have also got better at training our registered nurses in palliation, as you were saying, to work in with those things to deliver really good, excellent case management and care. Case management is holistic. It is involving all sorts of aspects—pastoral care, allied health.

The Hon. BRONNIE TAYLOR: With extra revenue you alluded to the fact that it is actually physiotherapy, hydrotherapy, speech therapy, occupational therapy?

Mr TEULAN: Exactly.

Ms STRAHAN: Dietitians.

Mr TEULAN: Dietitians, diversional therapists, all of those types of social workers, all of those areas which we see in aged-care services overseas but not present in Australia. Let us face it, most physiotherapists in Australia are spending their time helping the services to get more income because of the rules of the aged-care funding instrument rather than actually providing appropriate allied health support.

Ms STRAHAN: We have had some excellent results with people reducing falls, increasing their mobility, maintaining independence. Psychology is another area we are introducing. Getting people in depression, as you know, is a huge issue in our elderly people and having access to expertise is important. Certainly registered nurses are invaluable but we are part of a team.

The Hon. BRONNIE TAYLOR: Good multidisciplinary care. Do you provide 75 residential aged-care facilities so basically out of every 12 beds in New South Wales one is UnitingCare. Do you have any facilities in the Leichhardt local government area?

Mr TEULAN: Yes, we have several.

The Hon. BRONNIE TAYLOR: Are you aware that Leichhardt council gave evidence to this Committee and stated that Leichhardt council supported 24/7—

Mr TEULAN: Yes, we read that. We noticed also they said they did not operate any of them.

Ms STRAHAN: I read that too.

The Hon. BRONNIE TAYLOR: Did Leichhardt council consult with you about the submission where it stated that they had that support?

Mr TEULAN: No. We get on very well with Leichhardt council and part of the work it is doing with us is around improving opportunities for people on lower incomes to get access to good housing and care support. No, it did not. It has a view, and it is entitled to its view. I just say it is not a view of someone who is intimately involved in the provision of aged care.

The Hon. BRONNIE TAYLOR: Is it unusual for a council to put in a submission and state that people in its area providing aged care supported 24/7 and not consult with them? I find it quite unusual.

The Hon. COURTNEY HOUSSOS: Point of order: Surely it is entirely appropriate for elected representatives to act on behalf of their communities. I would question why this particular organisation would be questioned about whether councillors are entitled to represent their community.

CHAIR: It is not a point of order, but I would say to the member I do not think it is helpful. You have made the point a number of times. It is not necessarily helpful to hear from these representatives about what they think of what other elected representatives do. You have made the point as to whether they were consulted—they were not—

The Hon. BRONNIE TAYLOR: I am just clarifying, if there was consultation when something was put forward, that it represented people.

CHAIR: We have heard the question; we have heard the answer.

The Hon. BRONNIE TAYLOR: Thank you.

CHAIR: Do you have other questions or is there time left?

The Hon. WALT SECORD: We have questions over here.

The Hon. NATASHA MACLAREN-JONES: Excuse me, it is our time and the member has a right to ask whatever questions she likes.

CHAIR: Within order.

The Hon. NATASHA MACLAREN-JONES: Sorry, if there is a problem with the questioning, I would like to know what standing order that is under.

CHAIR: In response to the Deputy-Chair, I am looking for decorum, not necessarily relying on standing orders. Thank you.

The Hon. BRONNIE TAYLOR: Thank you. You spoke about different needs and requirements for different clients. Do you skill up if you have someone who requires more care—do you have that flexibility within your services to do that?

Ms STRAHAN: Yes, we do. Sometimes when we need to move someone on, it could be the building design that requires us to move someone. Flexing staff is something we do on a case-by-case basis and on a daily basis.

Mr TEULAN: Give them the example at Nareen.

Ms STRAHAN: For example, at Nareen, a 32-bed facility, we were able to palliate that person through to end of life by bringing in additional RN hours to come and oversee that person. We do that on a case-by-case basis all the time and we work very well with families.

The Hon. BRONNIE TAYLOR: I commend you on a great outcome for your client.

The Hon. NATASHA MACLAREN-JONES: You represent UnitingCare in New South Wales and the Australian Capital Territory. New South Wales, as you are aware, is the only state that has this requirement.

I am interested to hear of your experience in other jurisdictions such as the ACT where they do not have this legislation. How have they ensured that residents are getting the care that is required and that RNs are available when required?

Mr TEULAN: At the risk of committing the same crime twice, other jurisdictions actually acknowledge the role of the Federal Government in oversighting operational aged care. That is how they do that.

The Hon. BRONNIE TAYLOR: That gets back to my other point. You mentioned in your opening remarks that NSW Health has not done any checks to ensure that the legislation is complied with. Is that because staffing under the accreditation and compliance with the principles is a Federal matter?

Mr TEULAN: You would have to ask NSW Health. I can only assume that they did not pay as much attention to that provision as they might have if the Federal Government had not implemented a comprehensive approach to quality in aged care.

The Hon. BRONNIE TAYLOR: Carrying on further from the Hon. Paul Green's question about care of patients and whether patients would feel better if they knew a registered nurse was on duty, what is your experience? I have worked with many different types of allied health professionals, AINs and ENs. In relation to registered nurses, I have found people actually form the relationship with the nurse regardless of their qualification—with the nurse providing the most care to them that meets their needs. Could you elaborate a bit on that and on those sorts of relationships?

Ms STRAHAN: Certainly in the lower care—the old hostel services—I have. I myself have had my father in a hostel for many years, and I was very comfortable with the service he was receiving. I knew there was not a registered nurse there all the time and I was very happy because the staff responded appropriately to his needs. My biggest battle with families has been when I have suggested to them that they move them out of those services. They really do build a good relationship. Those care workers get to know that person inside out, spending the time with them. And they know when something is not right with this person and they escalate those things. From the family's point of view of reassurance, they know there is someone to be called, but their confidence in that person giving direct care has been overwhelmingly positive. Where they struggle is moving into a more clinical environment, where it is more hierarchical.

The Hon. BRONNIE TAYLOR: Thank you.

The Hon. SARAH MITCHELL: Your submission states:

> It is not the role of State Governments to provide legislation or oversight of the operations of aged care services. That is the role of the Federal Government

In your opinion, should this Committee make a recommendation that these matters be dealt with by the Federal Government and not the State Government?

Mr TEULAN: Yes.

The Hon. SARAH MITCHELL: Thank you.

CHAIR: Mr Teulan and Ms Strahan, you have taken questions on notice. The Committee secretariat will be in touch if there is further follow-up or questions on notice. There are 21 days given for the return of those answers. Thank you very much for your presentation today.

Mr TEULAN: Thank you.

Ms STRAHAN: Thank you.

(The witnesses withdrew)

(Short adjournment)

DR JANICE HEBERT, Gerontologist, NSW Policy Advisory Group, National Seniors Australia, before the Committee via teleconference, sworn and examined:

CHAIR: Thank you for joining us. Would you like to make a short opening statement?

Dr HERBERT: I will make just a very brief statement. National Seniors Australia has submitted a submission to the inquiry. In doing so—and I was heavily involved in preparing it—we do understand that there is a balancing act here. So the statement has been prepared on balance between the requirements of the older people and the needs of the homes that are going to feel some financial pressure if they are required to have registered nurses [RNs] on duty 24 hours a day.

The Hon. WALT SECORD: I am the shadow Minister for Health and a Labor Party member. Thank you for your submission. It is succinct and it gives us a very clear idea of what your organisation would like to see. I would like a comment from you on the growing gulf of evidence between aged-care providers who are resisting registered nurses in aged care versus the advocates, consumer organisations and representatives such as the Council on the Ageing [COTA] and now National Seniors who are all recommending it. What is the advice to you about why the aged-care providers are resisting it so strongly?

Dr HERBERT: There is no question that this will cause financial stress to aged-care providers, particularly to smaller providers who may be in rural areas and who may have trouble with RNs working in the homes in just simply obtaining them and finding enough RNs who are experienced enough. But I think the financial stress will be the major problem, particularly for standalone homes that might have, say, 30 or 40 residents and those residents do not have as higher care needs as perhaps some of the others. That has to be weighed up against the majority of people who provide care in larger facilities and in not quite as geographically demanding areas.

The Hon. WALT SECORD: As you said, it is a balancing act.

Dr HERBERT: It is a terrible balancing act.

The Hon. WALT SECORD: Would you support the State or Federal Government providing financial subsidies or assistance to aged-care providers so long as the aged-care providers did not gobble it up and it did go to the registered nurses in those rural areas?

Dr HERBERT: I certainly would. I am thinking of a number of small homes with 20 or even fewer residents that are providing a wonderful service. Under the current arrangements they would be crippled if they had to provide RN care round the clock. I think we have to acknowledge that.

The Hon. WALT SECORD: We just heard evidence from witnesses from UnitingCare, which runs 75 facilities across New South Wales. They said that rather than having the money for registered nurses they would prefer to put it into providing allied health workers in aged-care facilities. I would like a comment on that because the nature of aged care means that many people are now in high care and so I would not expect a lot of speech pathology or things like that to be taking place. Can you comment on that?

Dr HERBERT: Yes, I would be happy to comment on that. In fact, I was chair of UnitingCare Ageing and a member of the UnitingCare board for a number of years so I know the organisation well. Organisations like UnitingCare have registered nurses round the clock. The residents—I do realise the Commonwealth has changed the name to "care recipients", which I find quite offensive because it makes people sound very dependent rather than calling them residents, which is what they are. The residents in UnitingCare homes, apart from a few smaller homes, are very dependent. They are very frail and the organisation provides round-the-clock care as a general rule. So for an organisation like UnitingCare it would be logical to put that money into allied health and other services. My worry is that we do have some less scrupulous providers who may well see that the money could be used elsewhere and that would not necessarily mean that there would be registered nurses round the clock anyway.

The Hon. WALT SECORD: You believe that unfortunately the unscrupulous ones would find a way to gobble that up.

The Hon. COURTNEY HOUSSOS: Thank you very much for your time and for your concise and succinct submission. I will draw you back to the question of smaller aged-care facilities that are perhaps outside of metropolitan New South Wales. We received some testimony last week that RNs play a more important role in those kinds of facilities than they would in a metropolitan area because of a lack of access to general practitioners and other health professionals. We have heard about flying squads and the like. How would you respond to that testimony? Do you agree that RNs actually are more significant in those facilities rather than less significant?

Dr HERBERT: I would agree with that. If you can afford them and if they can be there RNs in those facilities will enable people to stay where they want to be for longer rather than possibly having to be transferred elsewhere, including to public hospitals. If it was affordable and if the nurses were available I would support that totally.

The Hon. COURTNEY HOUSSOS: I wish to take you back to your submission. On page 2, after a list of treatments, you say, "Such complex treatments can be carried out in an aged-care facility by a registered nurse—a cost saving to the State".

Dr HERBERT: Yes.

The Hon. COURTNEY HOUSSOS: Can you explain how registered nurses in aged-care facilities could alleviate the pressure on public hospitals?

Dr HERBERT: Absolutely. By the way, I better point out that my background is nursing; it is not a medical doctorate so I have a fair bit of experience in this area. There are a number of things. There is end-of-Life care, where people require pain management; people who may have had falls may need to go to hospital briefly but they can be brought back if they have a fractured neck or femur. There are a number of things that require management from a registered nurse. Without that overall support, these people would either have to go to or remain in public hospitals for longer. Particular medications: schedule 8, things like morphine and so on for pain relief management, a number of chemotherapy drugs can be given if there is a registered nurse [RN] available, and most people would prefer to stay in the aged-care facility to have that kind of treatment rather than having to go to acute care.

The Hon. COURTNEY HOUSSOS: That is what we have heard about, ageing in place is so important.

Dr HERBERT: Absolutely. I can think of all sorts of other things. I can think of people who simply go to hospital, say for dialysis for an hour—no, you do not have dialysis in an hour for a day—and then come back in the afternoon. Again, they can be cared for otherwise they would have to be admitted to an acute hospital.

The Hon. COURTNEY HOUSSOS: That is really useful, thank you. I will now go to another part of your submission. You said, "Research by National Seniors has found that: Patients record greater satisfaction and better health outcomes on a number of clinical indicators when there are higher proportions of registered nurses." We have received testimony this morning from UnitingCare that RNs make no difference to the quality of care. Can you explain this research; what are those health outcomes?

Dr HERBERT: That is something I would have to take on notice. That was not one of my inclusions in the submission and I could take that on notice and inquire about where that research came from.

CHAIR: Thank you. I should have advised you that if you do not feel comfortable answering any of the questions that are put to you, you can always take them on notice and check the transcript.

Dr HERBERT: Yes. I will check that with the office. The other thing I might point out, I am a volunteer with National Seniors; I am not a staff member.

CHAIR: Thank you.

The Hon. COURTNEY HOUSSOS: One final question. If the Committee decided that this provision in the Public Health Act should continue to operate, are there any other ways that we could assist what were formerly known as low-care facilities to continue to operate? My colleague Walt Secord has mentioned subsidies.

Dr HERBERT: I have not thought this through but I would think that if there is some State and Commonwealth cooperation between Health and the ageing sector—and we do see that quite a bit—that would be one way. I guess to explore some innovative ways that Health could work with the Commonwealth to assist in covering—quite often these aged-care facilities in country areas are located very close to acute care and there may be some way that something could be tried.

The Hon. PAUL GREEN: Dr Herbert, my name is Paul Green. In regard to your stakeholders, do you get much feedback from seniors and their families about having registered nurses caring for their loved ones as opposed to other staff?

Dr HERBERT: I am going to be absolutely honest.

The Hon. PAUL GREEN: I hope so.

Dr HERBERT: From the residents, probably not a great deal. I think the families are aware of registered nurses and their roles because they are the people they go to to ask questions. A good many of the residents are so frail that they are not always aware of who is caring for them. I am sure you are aware that many of the people have some degree of dementia and that makes it very difficult for them.

The Hon. PAUL GREEN: If I can branch out from that a little bit, would you be of the view, having made your last statement, that many of the residents' loved ones would be reassured by having a nurse present 24/7 in those facilities?

Dr HERBERT: Absolutely. Definitely.

The Hon. PAUL GREEN: Did you say you were a doctor in nursing?

Dr HERBERT: I have a doctorate in gerontology.

The Hon. PAUL GREEN: That is right, but you are a nurse by—

Dr HERBERT: Originally nursing and later on public policy and education.

The Hon. PAUL GREEN: I have a doctor in my office who is—

Dr HERBERT: My speciality is specifically aged care—ageing.

The Hon. PAUL GREEN: Excellent. Most nurses, as you mentioned earlier, are pretty honest in their assumptions. If I could indulge, could you give me your personal view on whether you think it is a good step or a bad step not to have a nurse 24/7 in the appropriate facilities?

Dr HERBERT: This is very personal.

The Hon. PAUL GREEN: Yes.

Dr HERBERT: I think it is a good step. We generally have very caring approved providers in the industry but I can see if the requirement for registered nurses was taken away, or registered nurses 24 hours a day, this could be seen by some providers as a way of saving money or making money, particularly when funding is tight.

The Hon. PAUL GREEN: Would you prefer that a patient have access to a registered nurse, an enrolled nurse or an assistant nurse? And why?

Dr HERBERT: It depends on the need. All care really does need some supervision from a registered nurse or an endorsed enrolled nurse—who may be very competent; often in rural areas they have not done their registered nurse training simply because of the geographic distance from a training hospital or because of other circumstances. I do believe that for oversight, for supervision and for assessment a registered nurse is needed. For day-to-day tasks someone with a certificate III is adequate, and most of the staff are very good. They are doing the basic tasks which do not require background knowledge.

CHAIR: Dr Herbert, I take you back to your submission and your role representing National Seniors Australia. You say in your submission:

> Without registered nurse management, care and supervision of elderly aged care residents, it can be expected that residents will be admitted to hospital for the management and care of avoidable injuries or illnesses …

And you go on to list some of those. Can you give any indication of how often those circumstances might arise?

Dr HERBERT: That is a very difficult question to answer because different homes will have different resident profiles. Things like falls are very frequent in aged care. When I say "very frequent" that does not mean that people are falling all the time; what it means is that it is greater than it would be in the normal population. Without a registered nurse the normal procedure is to call an ambulance and send the person to a hospital emergency department, where they will be examined hopefully by a medical practitioner and a decision will made about whether they need to stay and be admitted—perhaps if there is a fractured neck of femur—or whether they can go back to the aged-care facility.

Likewise with a number of other things, if anything goes astray—and we call "untrained staff" particularly the certificate III staff and some of the enrolled nurses—it is simply a matter of sending people to hospital. Pain management can be very difficult to manage—for example, if you need schedule 8 drugs like morphia or ordine or some of the patches—if you do not have a registered nurse. Chemotherapy can be administered in the home but without a registered nurse a person may have to go to hospital for the day to have the chemotherapy administered.

We are seeing quite a number of online medical consultations, often using Skype, in aged care now. That really does need some backup and support from someone who has assessed and evaluated a resident. So someone with dementia who might previously have had to be taken to a hospital or to a doctor's surgery can be seen using Skype. The consultation can take place without the resident being disturbed. Often it is a much more realistic consultation because the medical practitioner can assess the person in their own environment rather than in the unnatural environment of, say, a doctor's surgery.

Of course for end of life care you need to have people who can manage very specific equipment for the slow administration of drugs like morphia. It has to be done in hospital if you do not have registered nurses to oversight that administration. There are other examples. I guess the other thing I can say is that even for wound care, where you may not need to go to hospital, with some complex wound care you may need a community nurse or to call on someone else to come to home to provide that care because it is a specialised.

CHAIR: It has been suggested that in the current situation where the Commonwealth has control of this area of aged care this is not a role for the New South Wales Parliament. Does your organisation have a position on that—the idea that we should step out of the way and just leave it to the big guys?

Dr HERBERT: No, I do not think there is that view at all.

CHAIR: Do you feel it is working appropriately at the moment—the current circumstance where the Commonwealth has control and management of aged care?

Dr HERBERT: I guess it was ever thus. I can go back to the 1980s, when this State did in fact set the existing standards for numbers. It was not so much the actual category of staffing but the staffing numbers were dictated and legislated by states all around Australia. Every State had a different requirement for staffing, and there were a number of problems with that. That is 30 years ago, and I am old enough to have been involved with it at the time. It is very hard to say whether the existing system is working well, particularly with the changes that have come in. Certainly in 1997 the introduction of the Aged Care Act made a difference.

The most recent changes, over the last year or two, are really only being bedded down now. What I expect to see and what National Seniors is finding already with feedback is that many more people are remaining at home and receiving community care, and the people who are going to residential care are becoming more frail and more dependent. It requires more specialised and a more intensive sort of care than that of the time when people used to say, "I'll go to a hostel because I'm lonely" or "I need someone to cook meals for me". I think in another couple of years we will see a very different profile in aged care.

CHAIR: Do you think—on that distinction between whether or not it is purely residential living; and we heard from the Council on the Ageing and from others during a previous inquiry into housing—that there is a lack of options for residential living in community and that that is a failing of systems to provide?

Dr HERBERT: Yes, there is. In fact, my PhD looked at older people living permanently in caravan parks who were the people who did require this sort of care. There is a serious lack of housing, and we make assumptions that people living in the community live in nice, triple-fronted brick-veneer houses. That is not so at all. There is always going to be a number of people who will never be able to live in their own home comfortably. We are talking about people who choose to be homeless, and there is a number of community packages that provide for them. They are going to need care at some point later on.

CHAIR: And possibly at a point where they are extremely frail.

Dr HERBERT: Absolutely. They will possibly reach that point before people who are at home in a comfortable environment with a family to support them. I might add that, and this is slightly off track, this is where the requirement that a refundable accommodation deposit [RAD] or some sort of a payment be made for high care is causing a great deal of agitation and concern. People are wondering whether they are ever going to be able to afford to go into residential care anyway.

CHAIR: Could you elaborate on that? That is the point I was getting too—we have residential care and then there seems to be a bit of a leap to accommodation for those with high-care needs, which are no longer purely defined.

Dr HERBERT: The number of people who may previously have been able to go to a high-care facility without having to pay a bond would have been greater. Now people are concerned about whether they are going to be able to afford it. They also are left with few options for housing. There is not the supported housing. We have a couple of organisations like Abbeyfield Society and some council homes but at the moment there is a big gap there if someone does not own their own home. We have not discussed the needs of Indigenous and migrant people as well.

CHAIR: You will be pleased to know that we are hearing from an Aboriginal-specific aged-care facility today.

Dr HERBERT: Is that in Kempsey? Can I ask you that?

CHAIR: I can tell you; it is in Kempsey.

Dr HERBERT: Booroongen Djugun Aged Care Facility in Kempsey.

CHAIR: That is who we are speaking with.

Dr HERBERT: They are well worth listening to; I know them well.

The Hon. NATASHA MACLAREN-JONES: I want to touch on section 104, which is what the inquiry is looking at. You may not be aware, but it was introduced over a decade ago. We are the only State in Australia that has this requirement of high care and low care. I am interested to know what happened when this was introduced. Did the National Seniors campaign for the other States and Territories to have the same legislation?

Dr HERBERT: I cannot really comment on that.

The Hon. NATASHA MACLAREN-JONES: I am happy for you to take that on notice and speak to the national president about the history behind it—whether National Seniors were involved and if they campaigned.

Dr HERBERT: I do not know that. I am not aware of that, I am sorry.

The Hon. NATASHA MACLAREN-JONES: That is fine.

The Hon. BRONNIE TAYLOR: Thank you very much for giving evidence today. A doctorate in gerontology is very impressive. I am a registered nurse, so I think that is pretty amazing. You mentioned a few things that I would like to flesh out a bit more. From your opening statement my impression was that you saw that there was a requirement for some places to have flexibility in their staffing. You talked about day-to-day tasks, oversight and assessment. You mentioned using Skype, and how technology is progressing with respect to care. We heard evidence, on our first day of hearings, from the Hunter New England Health Service. They had a model of care where they were looking at exactly that.

Dr HERBERT: That was the one I had in mind.

The Hon. BRONNIE TAYLOR: Are you supportive of those innovative models that are able to facilitate the use of technology if they choose not to have 24/7 registered nursing care?

Dr HERBERT: I am supportive of it but not only for the registered nursing care. I am also supportive of that sort of technology because it is less disruptive for residents, particularly residents who are living with dementia. To take them out of their environment to a doctor's surgery is quite stressful for them and often does not make the assessment by the medico as valid as it could be if they could be assessed or seen in the home where they live all the time.

The Hon. BRONNIE TAYLOR: In their own environment?

Dr HERBERT: Yes. In their own environment you will get a far more satisfactory assessment and, possibly, diagnosis, than you can by taking someone some distance to a hospital, particularly a hospital in the Hunter region, where it is going to be even more confusing. The patient is going to be very confused and the outcome is not going to be nearly as satisfactory.

The Hon. BRONNIE TAYLOR: So it is about the flexibility in models of care.

Dr HERBERT: Absolutely. We have the technology; there are a number of ways we can use it. If we cannot adapt to technology we might as well give up.

The Hon. BRONNIE TAYLOR: You also mentioned wound care. We had a submission from Uniting Care Australia, which cited a case study. I am sorry; I have that in front of me and you do not. They talked about a registered nurse coming in and assessing the wound and educating another nurse—say, an enrolled nurse—to carry out that wound care with regular checks from the registered nurse. That is certainly how I did a lot of my practice in the community. Would you say that that is a practice that would work well?

Dr HERBERT: Absolutely. It is used now. As a bureaucrat, one of my concerns with some of the people who come in—it possibly occurs more in the country—is that quite often they are from community health at the local hospital. So there is a bit of cost-shifting going on there. It is not always a formal relationship. Smaller country areas have a very good relationship with their local hospital; they are often collocated or very close by. One of the nurses from the community health area will pop in and have a look at a wound and provide some instruction, but it is not always a formal or an acceptable thing to be doing. We would say that it is cost-shifting.

The Hon. BRONNIE TAYLOR: In my experience, often the community nurses who are providing that primary care service are the ones who have the high expertise in things like wound care because—

Dr HERBERT: You could not manage without them. They manage the incontinence, the wound care and sometimes palliative care and helping out with some advice about end-of-life care and pain management. They do all those sorts of things, but it is a very informal relationship.

The Hon. NATASHA MACLAREN-JONES: This may be something you need to ask the national president but I am wondering about the other jurisdictions—the other States and Territories—and how aged care is being delivered in the absence of legislation similar to section 104, and whether there are problems.

Dr HERBERT: I am being very cautious. I work in all States. I am still working. I have to be careful because that is in a different role and I feel that I cannot comment on it. I could say that there is not a great deal of difference.

The Hon. NATASHA MACLAREN-JONES: Are you saying that the assurance of having qualified staff to meet the needs of residence—

Dr HERBERT: No, there is not the assurance of having qualified staff, particularly in the evenings, nights and weekends. You hope there will be EN in some of the homes but there certainly are not registered nurses there 24 hours a day in some of the homes, particularly those that were originally low-care homes but are now becoming, more and more, high-care facilities.

The Hon. NATASHA MACLAREN-JONES: Looking at the Federal requirements of ensuring that there is adequate staff to meet residents' needs, what improvements do you think need to be made?

Dr HERBERT: I am thinking now of the accreditation standards which state that there need to be sufficient skilled and qualified staff, which is a very open statement. If there is an accreditation visit, can you really tell, within the period of time, that the staff are adequately skilled and qualified? I think that that needs tightening up.

The Hon. SARAH MITCHELL: In submissions and evidence given to this Committee it has been said that it is difficult to attract registered nurses to these positions?

Dr HERBERT: Very difficult.

The Hon. SARAH MITCHELL: Some of the low-care places have said that they are worried about the viability of being able to stay open because in smaller and more remote communities it is very difficult to attract registered nurses.

Dr HERBERT: That is correct.

The Hon. SARAH MITCHELL: Do you want to make any comment about that issue?

Dr HERBERT: I would support that. As I said in my opening statement it is a balancing act, particularly in small rural communities to obtain registered nurses—even to come in during the day is very difficult. To have registered nurses 24-hours a day could present some problems but I guess you have to look overall. The other thing we are seeing within the industry—and I am talking fairly widely now—is a number of overseas registered nurses coming in to work. Some of the larger organisations do have recruitment programs with registered nurses from various other countries, particularly India, Philippines and Nepal, those sorts of countries.

CHAIR: The Committee has heard from Alzheimer's Australia about the nocturnal behaviour of people with dementia and how that can cause problems which led to falls and so on. In those circumstances do you think for the level of care needed at night supervision by a registered nurse is necessary?

Dr HERBERT: People living with dementia, particularly before they become very frail and dependent, are totally unpredictable in their behaviour. There is something we call "sundowning", which is people late in the afternoon becoming very restless. Funnily enough it is the women who would probably be getting a meal or preparing a meal and putting the children down or something like that. They become very restless late in the afternoon and early evening. There is no real concept of night or day for many people with dementia so they maybe up wandering during the night. If you can manage it, and in my view this is a good way to manage the behaviour, you should let the people—

CHAIR: Wander.

Dr HERBERT: I am trying to be as discreet as I can. You should let the people go with the routine in their mind at the particular time. Trying to put them back to bed, trying to settle them is only going to make them more agitated. The other thing is that you are dealing with a number of challenging behaviours—they can be very challenging behaviours, sometimes leading to the requirement for mandatory reporting. What happens in the homes at the moment is that if you do not have an RN on duty, you have on-call staff. I do not know whether this has been raised, but any home without RNs have senior staff or someone on call. So if you have a fall at night or behaviours that are of concern, anything at all, then somebody has to be rung and possibly have to come into the home in the middle of the night, which is really a pretty awful situation.

The Hon. BRONNIE TAYLOR: My next questions continues on from what you have been saying about people who have become disorientated and want to move around, those who want to feel comfortable because they are unaware of what time it is. I understand you said that you would have to call a registered nurse if the situation came to the point where you were thinking you were unable to control the behaviour so that you were looking at sedation or something. But really we want to be proactive and prevent that.

Dr HERBERT: Absolutely.

The Hon. BRONNIE TAYLOR: That is what you were alluding to. Does it necessarily have to be a registered nurse who assists that restless person to be safe as they move around a facility? Could it be a skilled enrolled nurse in aged care or a skilled assistant?

Dr HERBERT: Yes. If it is just a matter of moving around, making something for them to eat or maybe settling them in some very simple way then it does not have to be a registered nurse.

The Hon. BRONNIE TAYLOR: To keep them safe, to allow them to walk around, to get them a cup of tea if they want or to show them a photo album.

Dr HERBERT: Yes. That is a very simple task; I have made the distinction between task and reviewing behaviours. But if anything should escalate that is when you do need some assistance.

The Hon. PAUL GREEN: Just following on from that, those sons and daughters who look after their parents at home are not registered either. There is room for that love, care and attention in that sort of situation.

Dr HERBERT: Absolutely.

The Hon. PAUL GREEN: Those sorts of people are being embraced in a different form of accommodation to assure their comfort.

Dr HERBERT: Yes, I agree but the degree of frailty that is cared for in residential care can be very high indeed—people who have no ability to do anything for themselves, are incontinent, have to be showered, need to be feed or there is no communication. It would be very difficult for a carer to look after someone at home when they reach that point, nor would any of the community care provide adequate care for a family to support someone at that level of dependency.

The Hon. PAUL GREEN: Some witnesses before this Committee have spoken about online or on-call RNs. That is all well and good until you have an acute situation where you need instant care—for instance, someone who has had a heart attack or a stroke—and put that situation into the rural and regional sector where there is not a fleet of ambulances that can get there in five or even thirty minutes in some cases. How does one justify having that level of 24/7 care, with that instant ability to administer the more acute situations, in those aged-care facilities?

Dr HERBERT: The staff will simply call an ambulance straightaway and keep the person comfortable.

CHAIR: Thank you for your valuable input to the Committee. If you have taken any questions on notice the secretariat will be in touch with you.

Dr HERBERT: I think the main one was the research into the health outcomes that show a number of clinical indicators where there are higher proportions of registered nurses showing greater satisfaction. I will follow that through with the office.

CHAIR: Members may also have some supplementary questions. You are required to answer any questions within 21 days. Thank you.

(The witness withdrew)

ESTHER AILEEN KOK, General Practitioner, Royal Australian College of General Practitioners, before the Committee via teleconference, affirmed and examined:

GUAN YEO, General Practitioner, Chair, New South Wales and Australian Capital Territory Faculty, Royal Australian College of General Practitioners, sworn and examined:

CHAIR: Dr Kok, we are ready to commence the parliamentary hearing when we hear from you by teleconference. Dr Yeo is in the room with us. I welcome you both. You are both from the Royal Australian College of General Practitioners and you are colleagues.

Dr YEO: Yes.

Dr KOK: We are.

CHAIR: I am Jan Barham, the Chair of General Purpose Standing Committee No. 3. Dr Kok, I will set the scene for you. In Parliament House in the Macquarie Room all members of the Committee are present. I will endeavour to familiarise you with members before we commence. In the room are Government members—the Deputy Chair, the Hon. Natasha Maclaren-Jones, the Hon. Sarah Mitchell and the Hon. Bronnie Taylor; Opposition members—the Hon. Walt Secord and the Hon. Courtney Houssos; and a Christian Democratic Party member, the Hon. Paul Green. Also in the room are some members of the public. Some members of the media also may be present. The proceedings are being recorded by Hansard and the secretariat is present.

Dr KOK: I have been in general practice for the last 40 years. During most of that time I have been actively involved in looking after a number of patients in aged-care facilities in my district area. That is my background. I also have been involved in general practitioner [GP] education, both at the undergraduate and postgraduate level.

Dr YEO: I am from Berowra which, with apologies to the Hon. Sarah Mitchell, I consider to be rural Sydney.

The Hon. SARAH MITCHELL: There is no need to apologise.

CHAIR: Would either of you like to make a submission?

Dr YEO: I would like to make an opening statement. First I offer my apologies because we do not have a written submission. We have participated in the New South Wales Health steering committee for aged care. Unfortunately I think the notification of this hearing must have gone to the national office because we only received that quite late.

CHAIR: Okay.

Dr YEO: I offer my apologies for that. I was hoping to make just a short statement. Perhaps, if it pleases you, we could ask Dr Kok to comment. The reason why we would ask Dr Kok is that she has managed a balance between having quite a lot of patients in nursing homes and a busy general practice over many years. She cannot just comment on what she sees but in fact trends. That, I think, is quite useful. The Royal Australian College of General Practitioners [RACGP] is a national organisation. It has faculties in States. In New South Wales and in the Australian Capital Territory [ACT] we have a faculty of more than 7,000 members, which means eight and a half out of 10 general practitioners are members of the RACGP. Out of that, we have more than 2,100 in rural and regional areas.

We have an advisory faculty board that is representative. It has a limited governance role, but representation comes right across the whole State and it roughly ties in with local hospital districts in areas that people represent. Because we have general practitioners who work and live in those areas, that allows us to get perspectives in depth and in breadth. But with 43 people on the board, as you can appreciate, getting from goal to unanimity is a bit of a challenge.

The Hon. BRONNIE TAYLOR: We hear you.

Dr YEO: Last month I had an interstate visitor to the faculty board meeting. After that his polite comment was, "You have a feisty board." Madame Chair, on this issue of the minimum requirements for a registered nurse in places where high care is given, the board was unanimous and the unanimity was very quick. Everybody thought that this was a no-brainer: You have to have qualified staff, particularly at the difficult hours. In fact, for a lot of older patients, the night hours are more difficult. If I recall when I first started working in New South Wales—I moved down from the Northern Territory—my first job was in research of the use of benzodiazepines in general practice. I was speaking to general practitioners about how better to manage anxiety and sleep disorders. Obviously, one issue was nursing homes and it continues to be an issue in a number of nursing homes.

The evidence that has just been given by Dr Herbert confirms some of the things that we were suggesting: That in order not to medicate the patient, it actually need to conduct form to their hours—their day, if you like—and that requires staff. Unfortunately, their day does not quite coincide with our day. That is the situation. When we discussed this, the issue of adequate nursing and the staffing ratio came up as well. It was unanimous that they perceive that there was not an adequate nursing staff ratio. That is not to say that people do not provide care. There are lots of stories of individual, good quality care, but good quality care operating in the system that does not seem to support it is a real problem. We think the problem is that it actually requires qualified and trained people to recognise deterioration. Just having a lot of bodies is actually not enough.

In fact, this week one of the GPs phoned me because they knew that this was happening and said, "I've just had a patient in a nursing home, 78 years old, who had cellulitis for a number of days before it was picked up." This could have been a no-return event for an older person. It was the patient's relatives who picked it up and in fact contacted the doctor, who then spoke to admin. Do you know what I mean? Therefore, you need qualified staff in adequate numbers to actually monitor and prevent. I note the question from Mr Green about emergencies. A lot of emergencies are preventable. You need proper monitoring to prevent them. Obviously, some you cannot prevent. That concludes my opening statement.

CHAIR: Thank you. Dr Kok, do you have an opening presentation?

Dr KOK: Dr Yeo has represented most of my views. I am happy to answer the Committee's questions now.

The Hon. WALT SECORD: Dr Yeo, thank you for your concise opening statement. That was fantastic. In your view, as doctors, would having registered nurses in aged-care facilities reduce the number of unnecessary admissions to hospitals?

Dr KOK: That would certainly be a helpful factor. Assistants in nursing [AINs] and enrolled nurses [ENs] are not qualified enough and do not have enough knowledge to triage a variety of conditions. Immediately there is an incident—for example, a fall or somebody becoming unconscious—my experience is that assistants in nursing and enrolled nurses tend to panic. They either immediately reach for the phone or ignore the issue and do not take steps to examine the patient before making a decision. A registered nurse would assess the patient and do a basic examination to determine whether the issue was major. Furthermore, most of my colleagues and I would be more confident to hear about the incident directly from a registered nurse than from an EN or AIN.

The Hon. WALT SECORD: Dr Yeo, you mentioned in your opening statement that you have spent some time in the Northern Territory.

Dr YEO: That is correct.

The Hon. WALT SECORD: From your experience in the Northern Territory, are there any examples that we could apply to remote and rural areas in New South Wales? The Committee has heard evidence from other experts that it is difficult to employ nurses in rural, regional and remote areas. How do you think we could do that?

Dr YEO: We certainly could not do that if we allowed the perception to continue that they are going to be in a stressful situation, understaffed and overworked. Who would want to work there? That is one of the reasons it is difficult to get general practitioners to work in remote areas. They feel that they are not supported by an adequate number of trained nurses. That means that you end up with a lot more calls and it is difficult to manage. You are out on a limb. There are probably limited comparisons to make between the Northern Territory

and New South Wales, apart from remoteness, because the population profile is quite different with regard to age.

In answer to an earlier question, I am not aware of evidence that proves having registered nurses actually reduces the number of hospital transfers. But in the absence of evidence we have to provide rational thinking. Rational thinking would say yes, because it is about noticing deterioration in a patient and being able to manage it. It is about the general practitioner having confidence that it can be managed. If I, as a general practitioner, do not have confidence, how can I persuade the patient and the relatives that the patient should go hospital because we cannot do our best for them?

The Hon. COURTNEY HOUSSOS: Dr Yeo, thank you for your opening statement. I found it really interesting and very compelling. In your experience, what is the average amount of time that a general practitioner would spend with a patient in an aged-care facility?

Dr YEO: I am hesitant to give a figure because average is sometimes not very meaningful. If you have only a few patients then the average time is a bit longer because of the travel time. When you arrive at a facility it can also take some time to find someone who knows something, in a nursing sense, about the patient. It is quite difficult. If you have a lot of patients, the average time drops, which is why there is a high percentage of transfer of general practitioners soon after a patient goes into a nursing home. That is not a good idea, because it is quite dislocating for the patient. But if the general practitioner has only a small number of patients in the home it is quite difficult for them to manage and to balance that with a busy practice.

The Hon. COURTNEY HOUSSOS: Dr Kok, I am interested to hear about your experience. How often do you visit your patients who are in aged-care facilities? How long, on average, would you spend with each one? I am not asking for specifics. Do you see them, on average, weekly or monthly?

Dr KOK: It depends on the number of patients I have in a facility. In those facilities where I have more than 10 patients, I go in every week as a matter of routine. I have found over the years that if you have a regular visiting day you are not called quite so often for minor issues, such as having to complete paperwork, and you can pre-empt some situations for patients who are not doing well. I think most people would visit their patients once a month, but I can only speak for myself. I find that if I have a regular visiting day I am not called out at inconvenient times or disturbed in the middle of surgery. If I am working at my surgery I cannot get to the nursing home until 8 o'clock at night, which is unsatisfactory for patients and their families, and I am also tired. On a weekend I do get calls, but not often. They tend to be for patients with more complex or unstable conditions. It is hard to generalise.

The Hon. COURTNEY HOUSSOS: If patients have advanced care plans and are transferred from an aged-care facility to a hospital, do you find that those plans are transferred with them?

Dr KOK: The plans are not transferred very often. Staff are so concerned about transferring medication sheets, getting the patient ready and contacting relatives that the care plan sometimes gets lost in the flurry. If there is a written order from the general practitioner that a care plan should be completed and transferred with a patient then it might be done. Currently the practice is patchy, to say the least. Currently, the practice is patchy, to say the least.

Dr YEO: I think there is also the additional problem that even if it is transferred whether in fact the emergency department staff will consider that acceptable for them to apply. There have been many cases that I have heard of where in fact they would not accept it.

Dr KOK: The advance care plan directive is not necessarily set in concrete. When I discuss this with my patients' families I say to them, "This is what you have agreed but it is not set in concrete so when the time comes we would consult you if this is still what you want."

CHAIR: If New South Wales had legislation defining aged-care planning, do you think that would be useful, like other States? Are you aware of other jurisdictions having a better program for dealing with that because of their legislation?

Dr KOK: Not that I am aware of. I just thought it was a kind of individual—

CHAIR: New South Wales is the only State that does not have—

Dr KOK: —without any mandatory rules about it.

CHAIR: We are the only State without legislation.

Dr KOK: Here in New South Wales?

CHAIR: Yes. That is my understanding. If there was that would be useful.

Dr YEO: I think having a legislative framework would assist the clinician because it is your liability, concern about having made a decision complying with what you see is pretty irreversible and that becomes a real issue if there was some protection.

The Hon. PAUL GREEN: It is important to realise that with health care it is not one size fits all. We must legislate sensitively, otherwise we will tie ourselves up and that does not meet the total needs of all patients. Dr Yeo, I would like to clarify a couple of things you said. You were talking about patients and the way that patient care is working, that health care is starting to adapt to patients hours in terms of their needs in a facility. In a patient's hours—we heard this earlier—I think you noted "difficult hours". Can you elucidate for me what could take place in those difficult hours in the shape and form of patients with which you have had some experience? Is it a fall? Is it disorientation? Is it injury? Is it stroke?

Dr YEO: I think all of those things. I think the underlying principle about that is about patient-centred. When we talk about difficult hours, is it difficult for the provider? It is not difficult for the patient, and I think that is the difference. Difficult for provider hours might be that you can have, for example, some amount of occupational therapy or activity being available at those hours. That will help the patients to be occupied and therefore reduce falls and other incidents.

The Hon. PAUL GREEN: You talked about the expertise at different levels, of nurses, care or allied health professionals, and you talked about proper monitoring. In that context, what would "proper monitoring" look like? You used the example of cellulitis. The experience of that nurse knew and had a history of understanding what cellulitis looked like. Can you perhaps put it in a framework what proper monitoring would look like?

Dr YEO: I guess proper monitoring would mean monitoring according to the needs of the situation or to prevent a worse event happening. So it can vary. I gave the example of cellulitis. In fact, I could give the example of my mother when she was in a nursing home, when she progressively became sick over a few days. I discussed with her GP and initially we thought perhaps it was hydration, but we could not properly monitor her fluid intake and output. That is a fairly straightforward sort of thing in that home. Eventually she got admitted to hospital to be hydrated, run a drip in, et cetera. The principle is you actually try not to admit older patients into hospitals. She was in there for two days. Low and behold, in the ward somebody else developed gastroenteritis, so she ended up with a one week stay because the whole ward was quarantined. Those things happen and I think they are preventable, and they are preventable in terms of having adequate people who have the competence to pick up things.

The Hon. PAUL GREEN: If I may speak to your mother's situation, are you suggesting that a simple thing like a fluid balance chart was not implemented or monitored? How was your mother's situation in terms of fluid balance issues not being addressed? Was that a matter of professionalism? Was that a matter of the level of the nurse or was it a matter of the level of the staff? How do you think that may have fallen through?

Dr YEO: My impression is that they probably were not adequately staffed to adequately monitor that. It is funny. We talk about hospital in the home, about doing a number of things to prevent people from going into hospital. But a number of aged-care facilities do not have the capacity to do those things. You would think that with older patients they are more likely to require the equivalent hospital in the home and to be able to do it there, but in fact they do not have the capability.

The Hon. PAUL GREEN: That includes taking someone's temperature?

Dr YEO: No, temperature is pretty basic. I guess anybody could take that nowadays.

The Hon. PAUL GREEN: Blood pressure, which is digitalised?

Dr YEO: Blood pressure is also pretty basic. It could mean replacing fluids. It could be monitoring the input and output. It could mean an infusion pump for analgesia.

The Hon. PAUL GREEN: Diabetes?

Dr YEO: Diabetes or palliation, yes, any number of those things.

The Hon. PAUL GREEN: What I am getting from your evidence—and please help me if I am wrong—is that there seems to be a linking. You are saying it is very important to have someone who is trained and qualified at a high level. From other comments and evidence that you have given I get an inkling, having been a nurse, that GPs as professionals like the idea of coming into a ward where there is a level of medical knowledge and understanding to help prevent and manage someone's care. You like the idea of being able to come in at that level and talk to someone who understands that and have long-term understanding for not just one patient but all the patients in that ward. Am I hearing you right, that you like that idea of going in and probably speaking with someone at the level of a registered nurse, for instance?

Dr YEO: I agree, and it is more than liking the idea. The reason for liking that is that we know that when competent staff at different levels are there and work together it gives better health outcomes for the patients.

The Hon. PAUL GREEN: If there is a gap and there is no registered nurse, one of the bandaid issues is that it is okay, they can ring 000 or they have an online nurse, an online doctor, an on-call doctor or an on-call nurse. What would be your view of that, given the fact that it is obviously okay in a chronic situation, if a patient is chronically ill, as opposed to an acute situation? Do you have a view about the difference that an RN could make in an acute situation in an aged-care facility? I ask Dr Kok to comment on that as well.

Dr YEO: I guess without a doubt in an acute situation, whoever is there counts. That is the most important thing. I guess in practicality, in acute situations it all depends on how often that might occur, whether it could be preventable. When the issues were discussed at the aged-care steering committee about regional and small nursing homes we did discuss whether in fact they could continue to function if there were a lot of requirements. We thought that a compromise might be that to at least have a registered nurse on call might be better than not at all.

The Hon. PAUL GREEN: Dr Kok, do you have a comment on that, given your experience?

Dr KOK: May I say something?

CHAIR: Please do.

Dr KOK: Yes, I agree with Dr Yeo. I think in regional or smaller facilities an on-call nurse would be an option, which is okay. However, I think for most metropolitan aged-care facilities they are quite big and somebody onsite would be preferable because there is always easy access and they can be called upon for advice straightaway. Sometimes there is a culture of not wanting to trouble somebody if they are just on call. The problem with enrolled nurses and AINs is that they do not really know the kind of red-flag situation quite often and they are not adequately trained. I feel that it would be preferable to have an RN.

I am sorry, I did not quite answer completely your previous question to me about how long would I spend at the nursing home seeing these patients. If it is a kind of a routine call there is no problem, it is minimal, perhaps five or 10 minutes. If there is a problem it can be maybe up to half an hour or more, depending on what the situation is, where I have to liaise with families sometimes, and if the families are not there I have to try and contact them so that they are aware of what the situation is and discuss with them what the options for management are. So it is variable. As I said to you, I feel that in my experience it is much better to have the regular once a week or once every fortnight visit than trying to do it in an ad hoc way. That is my opinion.

CHAIR: It is Jan Barham now with a question. I want to follow up on this issue. Being a regional person myself I find it perplexing that we are willing to say that there is a level of care that meets the quality of care guideline, but in the regions it is not possible. My concern is why we are not then advocating for greater support or programs to ensure everyone has equal access to that care whether or not there have been—if both of you can answer—representations made at any time to State or Federal government. Are we lacking in

identifying where there are variables and should we be doing more to facilitate that by way of grants, subsidies, incentives or whatever else is required to not devalue the quality of care? Can you let me know if you have had any input or any suggestions?

Dr KOK: My observation is that aged-care nurses unfortunately are not remunerated enough. It is not a very attractive branch of nursing and a lot of younger nurses rarely want to do it and it is left to the older nurses to carry that burden. A lot of the older nurses, on the other hand, are probably not trained or are unfamiliar with new technology. I think aged-care nurse in nursing training should be a specialised area and be remunerated adequately to attract the right kind of people.

Dr YEO: I agree with that, and that is why I said we toss around this idea about whether a registered nurse on call was good enough. I think the principle, if we did, should apply. However, there are other things to consider in the sense that for older people to be able to age in the community and close to relatives is also important and perhaps, as an interim measure, an on-call thing may be a solution, but I think we should always aim for equity. I agree with that.

CHAIR: We will move to Government questions now.

The Hon. SARAH MITCHELL: Dr Yeo, my first question is to you. You have mentioned a couple of times in your comments so far about the committee that you are involved in, the NSW Health aged-care steering committee that is looking at this issue, and other witnesses have appeared in this inquiry who are involved in that process as well. I am not asking you to go into the specifics, but just in general terms have you found that to be a good process and has that been a good opportunity for the relevant stakeholders to feed into perhaps where the Government might go on this issue?

Dr YEO: Sorry to correct that impression: I have not been personally involved. When I say "we" I meant the royal "we" sort of situation.

The Hon. SARAH MITCHELL: What you know of the process, if you could make some comments around that?

Dr YEO: We have a rural GP on that committee. The difficulty they have is the need to travel up and that none of the meetings are covered in terms of expense or travel expenses et cetera. That is the main difficulty.

The Hon. SARAH MITCHELL: But in terms of any feedback on the discussions that are happening, the process itself in terms of consultation has been generally positive?

Dr YEO: From this doctor it has been positive.

The Hon. SARAH MITCHELL: My next question is to you, Dr Kok. In one of your earlier answers you spoke about how as a GP you have a registered nurse there. I guess you find that a little better because sometimes the AINs and the ENs are not qualified enough to be able to provide the information that you need. One of our terms of reference is to look at whether we need further regulation or minimum standards particularly for assistants in nursing. I just wondered if you wanted to make any comments about that issue.

Dr KOK: That is always useful. I think, again, the level of understanding—there have to be some minimal standards because my current experience is that it is not really consistent; some of them are much more committed and intelligent, for that matter, than others and I am not sure what minimum standards there are and what their ongoing education needs and requirements are for some of these enrolled nurses and AINs. My own observation is that the ENs are much more intelligent and keen and enthusiastic and do themselves then take on further education to become actual registered nurses.

The Hon. SARAH MITCHELL: Dr Yeo, did you want to make any comments on that?

Dr YEO: I think the assistants in nursing cannot be a substitute for an enrolled nurse; the skills are different. Certainly my faculty board and all the GPs I have spoken to believe that there should be a minimum. We know that there are no simple answers and that there are a whole lot of things that we still do not have answers to in aged care. For example, the Federal Government argument for the changes was no optimum staffing levels or mix that meets all circumstances in providing aged care. But that is not a substitute for saying

we do not need a minimum. All we are saying is that we do not know the maximum or the ideal. There is no argument for us not having any minimum; I think people need that to protect the patients.

The Hon. NATASHA MACLAREN-JONES: Dr Kok, I wanted to go back to some comments you made following a question from my colleague, the Hon. Courtney Houssos. In relation to advanced aged-care plans, you made a statement—and correct me if I am wrong—that there are cases where they have not been transferred when the resident has gone to hospital. Is that correct?

Dr KOK: Yes.

The Hon. NATASHA MACLAREN-JONES: Those cases that you are aware of, have they come from facilities where registered nurses were on duty?

Dr KOK: Yes.

The Hon. NATASHA MACLAREN-JONES: Is it fair to say that even through there was a nurse on duty at that time, it made no difference to ensuring the transfer of the information?

Dr KOK: In those cases it did not. There were occasions where it was an overnight incident and the nurse is in charge of more than 70 patients in the one facility. I think what happened was that she did not really check that all the papers should have been transferred. As I say, there is not any hard-and-fast rule or policy or process held by these aged-care facilities about that.

The Hon. NATASHA MACLAREN-JONES: Is it fair to say it is more about ensuring the facilities put in place procedures that all staff are educated about and aware of?

Dr KOK: That would help.

The Hon. BRONNIE TAYLOR: I am one of The Nationals members. Are all the nursing homes you visit in metropolitan areas?

Dr KOK: They are all in metropolitan areas, yes.

The Hon. BRONNIE TAYLOR: Do you visit any aged-care facilities that do not have registered nurses?

Dr KOK: No, all of them have a registered nurse, usually there 24/7. Although, as I say, some of them have only one to service more than 50 people and that is not satisfactory.

The Hon. WALT SECORD: One to 50?

The Hon. BRONNIE TAYLOR: I heard that, thank you very much.

The Hon. WALT SECORD: I am just shocked.

The Hon. BRONNIE TAYLOR: In looking at staffing levels in facilities where you say there is one registered nurse to 50 residents, do you think there needs to be just an increase in registered nurses or in other trained staff in that facility?

Dr KOK: I think all of the above. There needs to be some fair nurse-to-patient ratio and a recognition that a lot of these places do have quite a number of complex care patients including people with Alzheimer's and advanced dementia who also have other physical comorbidities rather than just the kind of behavioural issue. They have to be catered for.

The Hon. BRONNIE TAYLOR: Yes. We have heard evidence from the director of UnitingCare Ageing in response to a question from the Chair about how he would use an increase in funding. He said he would use it to employ a myriad of health professionals, being physiotherapists and others, to increase his multidisciplinary care profile.

The Hon. WALT SECORD: You are misrepresenting the question and the evidence.

CHAIR: Order! Would you like to rephrase the question or elaborate in some way?

The Hon. BRONNIE TAYLOR: Dr Kok, is it an issue that the focus is on an increase in registered nursing hours or would an increase in a general profile of people caring for aged-care residents provide better outcomes?

The Hon. WALT SECORD: Point of order: The question was, if you had—

CHAIR: Order! There is no point of order. The member has rephrased the question. Dr Kok, this was a matter of procedure. The member will put her question again so it is very clear what you are being asked to respond to.

The Hon. BRONNIE TAYLOR: Dr Kok, I appreciate how difficult it is to be on a teleconference and so I will ask the question again. If we looked at an increase in hours in an aged-care facility, in your opinion, would that just be used for registered nurses or would we use it to facilitate an increase in enrolled nurses, AINs, physiotherapists, diversional therapists? Would you see a benefit in that?

Dr KOK: I recognise that perhaps physiotherapists and diversional therapists also have a role, but basically funding to allow for more registered nurses to be available is probably the priority, in my view.

The Hon. BRONNIE TAYLOR: Dr Yeo, you spoke about your mum becoming dehydrated. Were registered nurses on duty when that happened?

Dr YEO: Yes, there were. There were registered nurses in the daytime. She happened to be in the low-care facility, so there were not registered nurses in the evening, I think.

The Hon. BRONNIE TAYLOR: Did that happen over a period of time? I imagine her dehydration did not happen just overnight.

Dr YEO: Yes, over a period of days. That is right. Could I comment on the previous question?

The Hon. BRONNIE TAYLOR: Certainly.

Dr YEO: My concept is that we have to talk about the core care and then the ancillary. The core, in my mind, would be the ability to monitor for deterioration. In my thinking, therefore, quality trained nursing is the backbone of it. You have to be able to do that and then you can add on the other things. In effect, allied health is very important but you do not add it on and then not have a strong core. That would then become a bit of a problem.

The Hon. BRONNIE TAYLOR: Yes, multidisciplinary care. Thank you, Dr Yeo.

CHAIR: Unfortunately, we are out of time. I thank both of you for making yourselves available. Your input into our inquiry has been really valuable.

(The witnesses withdrew)

(Luncheon adjournment)

DEBRA URQUHART, Director of Care, Booroongen Djugun Aged Care Facility, Kempsey, before the Committee via teleconference, sworn and examined:

CHAIR: Would you like to make a short statement?

Ms URQUHART: I will just make a short statement, if that is okay?

CHAIR: Yes, thank you.

Ms URQUHART: Good afternoon and thank you for giving me the opportunity to be part of this important discussion regarding the role of the registered nurse in the aged-care setting. I have listened to most of the evidence given over the last couple of days and I have found it very interesting. I had been at Booroongen Djugun now for close to 17 years—it is quite a long time—and a good part of those years was as a registered nurse delivering clinical and holistic care to residents. Booroongen Djugun was founded in 1997. It was identified that there was a critical shortage of residential accommodation in Kempsey for both Aboriginal and non-Aboriginal people in the area.

We have 60 residents and 20 residents that are in a secure environment—and probably about 90 per cent of those have a dementia—20 residents are in another high-level care area and 20 in a low area, so we do have ageing in place. We have a registered nurse on duty 24 hours a day seven days a week who manages across all areas and we do have enrolled nurses during the day who help provide wound care and medication. The majority of our employees are Aboriginal and we have just recently, over the last three years, ensured that they have all attained their certificate III and some are doing up to their certificate IV in aged care, and the hospitality staff as well are doing other things.

Just a little bit about Booroongen Djugun. It is quite a unique facility and our residents' ages range from 36 to 90. We provide care to people with dementias, brain injuries, a lot of drug and alcohol issues, as well as mental health problems. These people can obviously be challenging and difficult to manage at times but it is becoming more evident that people coming into care do require a higher level of care than ever before. I think families have got a better support system in the community now so they can have their loved ones stay at home longer, and that is a great thing; that is what we want to encourage.

Personally, I believe that for me in this facility without the registered nurse providing that ongoing assessment, monitoring and planning we probably would not be able to provide the appropriate quality care that our residents probably deserve and families expect. I think that is a bit of an expectation that obviously we provide quality care. However, I think every residential facility should be tailored to the needs of the client or the resident and this may mean that the registered nurse's role may have to change to suit that facility. I have been in other Aboriginal facilities that manage very well with the registered nurse on call after hours. However, those residents probably require a lower level of care, but the staff were really well trained. That is a bit about me and it is a little bit of an overview of what my thoughts are.

CHAIR: That is great; thank you. Just one thing; I might have missed it. You said you had 60 residents. Did you say how many staff you have?

Ms URQUHART: I probably have between six and seven in a morning but all up there is probably about 70 staff.

CHAIR: This is a very highly regarded facility. I have heard about it often.

Ms URQUHART: That is good.

CHAIR: I would love to come and visit.

Ms URQUHART: Brilliant. You are welcome.

CHAIR: We will now hear questions from the Opposition.

The Hon. WALT SECORD: I am Walt Secord, shadow Minister for Health and a Labor member of the Committee. I have to declare an interest. In 2008 I had a bit to do with your facility when I was chief of staff

to the Minister for Ageing in Canberra. I know that you guys are one of the cutting edge aged-care facilities specialising in care for Indigenous people, so I am familiar with your work and I want to declare an interest on that. You made reference in your opening statement to the kind of care your facility can provide because you have a registered nurse. Can you give me some tangible examples of things you can do because you have a registered nurse?

Ms URQUHART: Over the years we have had dialysis, we have done peritoneal dialysis, we have had nasal gastric tubes, we have had children even as young as 16- and 17-year-olds, teenagers, that we have been able to provide percutaneous endoscopic gastrostomies [PEG] feeds for and we have had tracheotomies. I guess they sound very medical terms but we would not have been able to accept those people for care—and a lot of that was respite for families—unless we had a registered nurse in place. I was a registered nurse on the floor, and I was providing dialysis to that gentleman. That would be something out of the scope of a care worker.

The Hon. WALT SECORD: Do you think that because you have a registered nurse on staff 24/7 you have avoided having to send people to the emergency department?

Ms URQUHART: Definitely.

The Hon. WALT SECORD: Can you give examples of where you have avoided putting pressure on the emergency department or the health system because a registered nurse is in your facility?

Ms URQUHART: We have really good communication with our local hospital. Sometimes we talk to the doctors at the hospital and tell them what has happened, and they can give us an idea of what is happening after we have done our assessment. They provide some information. We always maintain that the shorter the visit the better. If we need to get a resident to hospital, we want to get them in and out quickly. We are now trialling a model of care to fast track residents through emergency and we provide an appropriate member of staff to accompany them. The resident feels comfortable with that person caring for them in that emergency situation. I believe it will very successful. The resident is already confused, and we do not want to distress them or increase their anxiety.

That does not need to be a registered nurse; it might be a care worker who has good rapport with the resident. That is usually driven by the registered nurse, who will make that decision. We have hospitals in the home as well. We might have a resident who has a cannula and who needs antibiotics. We do not want that resident sitting in a hospital bed; we want them in the home here. We organise for a community nurse to come and give those injections or we can give them as well. That is another way of keeping residents, especially those with dementia, out of the hospital setting.

The Hon. COURTNEY HOUSSOS: You obviously have a unique perspective. I congratulate you on the level of care you provide. It is remarkable.

Ms URQUHART: Thank you.

The Hon. COURTNEY HOUSSOS: I have a couple of questions for you as an aged-care provider operating in regional New South Wales. The Committee has received submissions and testimony from other facilities indicating that it would be financially unsustainable for them to have a registered nurse on duty 24/7. What are your thoughts on that?

Ms URQUHART: I agree. I did a little bit of consulting last year, and I went into two facilities. Admittedly they were Aboriginal facilities. One was in Coober Pedy and one was on the outskirts of Adelaide. They had probably 10 or 12 beds. Obviously, Coober Pedy is very isolated. There was not a registered nurse in place at that facility. It was more or less used for drop-ins. People were living there, but because they are so isolated they would stay for a few days. It was almost like a respite situation. They did not have a registered nurse on call, but they were managing. They would not be able to exist if they had to have a registered nurse on for all shifts for 10 or 12 residents. Sometimes when they go for tests there would be only four or five residents. It certainly would not be viable to have a registered nurse. They did not need that registered nurse because the level of training the care staff had was adequate for those residents.

Before the resident comes into your facility, you need to be very sure that you have the skilled staff to look after them. If you do not, you do not take them. I know that sounds black and white, but if you cannot provide the care that they need you cannot accept them. The people in those Aboriginal facilities still had issues

and some had challenging behaviours, but there was nothing that the care workers were not able to manage. They were well trained and it was very isolated.

The Hon. WALT SECORD: I will take you off track a little. You have 60 residents and I would not imagine that you have a lot of accommodation bonds.

Ms URQUHART: Certainly not.

The Hon. WALT SECORD: You do not have those massive bonds that the commercial for-profit providers are gouging out of people in the community.

Ms URQUHART: Yes.

The Hon. WALT SECORD: How do you fund your activity?

Ms URQUHART: With a lot of tinkering. It is extremely hard sometimes. We are a not-for-profit facility and we live on the edge. We have a lot of Aboriginal people who come in already in debt, and much of the time their families are taking their money. That is just how it is. They are coming in in debt and they require a lot of care and transport, which eats into our budget. It is tricky, believe me. My finance officer is always on my back to curb spending. We are providing care and that is the most important thing. It is tricky at times.

The Hon. PAUL GREEN: In what other ways do you tinker with the budget to make things work?

Ms URQUHART: I will put off what I do not need this month and transfer it to the next month, but the roster stays the same. It goes up and down based on the level of care the residents require. I have a short shift and sometimes that will be reduced if I have empty beds. It is about providing care to the people you have at the time based on their need. When I said "tinkering", I did not mean "tinkering" as such.

The Hon. WALT SECORD: We understood.

Ms URQUHART: You know what I mean.

The Hon. PAUL GREEN: I thought I would draw that terminology to your attention.

Ms URQUHART: It is probably the wrong word.

The Hon. PAUL GREEN: It probably is not; not in this place anyway.

Ms URQUHART: We need new cars at the moment because our cars are not in good condition and we use a lot of transport. We will get a second-hand car or pay one off. We have a community-based service and we will get a second-hand from there. We just make do with what we have.

CHAIR: Do you have community-based transport services that work with your facility?

Ms URQUHART: We do have a community-based service, but we have to pay for it. Most of our transport is absorbed through our own budget. As I said, we have a lot of residents with a lot of co-morbidities. They come in with renal and liver failure and they need specialist appointments. Those appointments are in Port Macquarie, which is 45 minutes away. That involves a staff member being away for a minimum of three hours. That also eats into my budget because I have to support those people to get them to the doctor. We are doing Skype with some of the specialists, including the renal specialist. We have been doing that for about a year. That is helping and relieving the funding. We do not have to take the residents to Port Macquarie every time.

CHAIR: You do not get supplementary funding provided for the transport issues?

Ms URQUHART: There is none. Medicare local assists at times but generally no.

CHAIR: Are the residents who need to be transported to Port Macquarie your older residents?

Ms URQUHART: No, they are generally the younger ones actually that need that complex care.

CHAIR: How important is it for the Aboriginal community to have Aboriginal workers and culturally appropriate services available to them in the way it helps their health and wellbeing?

Ms URQUHART: It is absolutely critical. As I said, I have been here a long time and quite often you will see the reaction and the interaction between resident and nurse. If those nurses were not Aboriginal there would probably be more challenging behaviours because people would not understand their culture and needs. That can be as simple as just a conversation in the way that they communicate, so it is very critical. Like I said, the whole of this corporation was started to provide employment to Aboriginal people as well.

CHAIR: Do you receive any grants, incentives or assistance for that?

Ms URQUHART: No.

CHAIR: Are there any top-ups to the provision of services other than what other residential facilities get or are you on the same level playing field?

Ms URQUHART: We are on exactly the same level—level pegged. There are no exceptions.

CHAIR: I think there would be a lot of assumptions that because you are an Aboriginal service that you would be getting additional money from other pools of funding, but that is not the case.

Ms URQUHART: There certainly is that assumption, I can guarantee that. We have the same budget as everybody else, and we are funded through Aged Care Funding Instrument, the same as everyone else.

CHAIR: Does the accreditation that you have to meet contain enough recognition of the importance of the cultural practices? Are they identified well enough within those accreditation standards?

Ms URQUHART: We have had a few little arguments over the years. We have a goanna pond and there was one incident when I was asked to fence it. No, we can't do that. That might only be something simple to you or anyone else but that pond is very relevant to their cultural needs. I do make it very clear when people come from the agency, I ask them to take that into consideration.

CHAIR: Are they good?

Ms URQUHART: Most of the time they are pretty good. We had the same lady come for quite a few visits. She knew what the facility was like and what to expect. Do not get me wrong, we don't get any privileges, we have to abide by the same rules but, however, I do remind them that it is an Aboriginal; it is not prissy, it is not pretty but it is homely. We are a family. If you talk to any of my staff we are considered to be a family and there are a lot of families, all intertwined.

CHAIR: That is great.

Ms URQUHART: Yes, it is good.

CHAIR: You said the one of the reasons the home was set up was to provide employment. Are there still opportunities for more Aboriginal people to move into that area? Would there need to be additional supports or services provided to ensure that the need is met and the opportunities are available?

Ms URQUHART: No, I think that is going really well. I have about seven trainees at the moment and all the girls are Aboriginal. We have a constant flow of trainees coming through and we also promote, obviously, we are encouraging them to go on to the enrolled nurse. We have been advocating that some of our enrolled nurses then go on to be registered nurses.

CHAIR: The Committee has heard that there is a shortage of people available to fill some of those positions. Do you say there is a real interest from the community to carry out those roles and undertake the training that is involved? Do you say there is no shortage for you?

Ms URQUHART: Of registered staff?

CHAIR: All care staff that is required for your facility.

Ms URQUHART: No, because we also are part of an RTO. We have people coming through all the time doing training so I can kind of pick and choose. I have a big pool. We have a lot of people come through doing work placement and work experience. We have first, second and third university students from Southern Cross University in Coffs Harbour. We have a lot of people come through our facility to do work experience. I guess I have a bit of an avenue where I can, sort of, pick and choose I suppose, which is good, and the people who are really dedicated want to be here. I think it is going along pretty well.

The Hon. BRONNIE TAYLOR: I am one of the members of the Legislative Council from The Nationals. It has been inspirational listening to you about the facility and the service that you provide to your clients. I would actually love to see it one day too.

Ms URQUHART: Yes, you should come.

The Hon. BRONNIE TAYLOR: My background is in nursing. You talked about , and using Skype to consult. Do you have a higher than average number of residents with renal impairment?

Ms URQUHART: We do, we have quite a lot, and, of course, that relates back to your diabetes. We have got a lot of people who are diabetics. They are well managed at the moment. Yes, that is for sure. We have a high level. As I said, we have a lot of people who are drug and alcohol affected—with, of course, the costs and some dreadful challenging behaviour. We are almost known now for being able to manage those people where a lot of other facilities cannot manage them—I am sorry but particularly white facilities have trouble with trying to manage them.

The Hon. BRONNIE TAYLOR: Has using an innovative model of care and your Skype to talk to your renal specialists been useful and helpful for your facility and your clients?

Ms URQUHART: Definitely, not only is it relieving my budget by not having to drive them to Port, but it also obviously makes it easier for residents as well so they do not have to travel 45 minutes, or it is almost an hour now with the roadworks, waiting in the surgery and an hour back. It is definitely a great improvement in the service. We also have our local Durri Aboriginal Medical Service in Kempsey so on Skype we are talking with diabetic practitioners as well. We can talk about insulin over Skype rather than visiting them down there as well. It is really good.

The Hon. BRONNIE TAYLOR: You talked about where you are now and visiting smaller facilities that did not have 24/7 registered nurses. I am not saying to cut out registered nurses where they are required at all, but having flexibility to use your nursing hours in different ways does that help your facility and the ones you have had experience with? I am saying one size does not fit all.

Ms URQUHART: Exactly and I think that is important to remember. As you know, we give individual care to residents. Their home where they live should also be catered to what their needs are.

The Hon. NATASHA MACLAREN-JONES: Thank you very much. I am Natasha Maclaren-Jones and I am also a member of the Liberal Party. First of all I want to congratulate you for the work that you do, not only with the facility but also in delivering care within the community. I have been looking at some of the awards that you have received both at State and Federal levels. You have been receiving awards continually for almost the past decade. I noticed that one of them was in relation to vocational training, particularly Certificate III, I think it was. I want to get a little more information about the training you do through your college but also to ensure that you are providing that right mix of care for your residents.

Ms URQUHART: Yes. You wanted to ask me something?

The Hon. NATASHA MACLAREN-JONES: Yes, sorry—if you could elaborate a little more on the training that you run.

Ms URQUHART: Okay. We have a registered training organisation [RTO]. We have multiple other courses as well through Landcare and other areas, but the cert III girls are signed up in the college and then they are on-the-job trained so that while they are doing their modules they are actually working on the floor. I am training and assessment [TAE] qualified and I have two other staff members who are TAEs. Those people are

actually monitoring and assessing them on the job as they go. We also have a system where they can go up to the college and get assistance from there as well. That seems to be working really well.

The Hon. SARAH MITCHELL: Thanks. I am Sarah Mitchell. I am a Nationals member. One of the terms of reference of the inquiry is looking at assistants in nursing and better regulating their role. You mentioned you have been listening to the evidence. When we heard from Alzheimer's Australia they specifically mentioned they were concerned that there was not enough training in dementia care for AINs. Do you have any comments or suggestions about that?

Ms URQUHART: In relation to dementia training, we have four to five lots of training every month—my staff really get a bit annoyed—so I guess we go over the top. If we have staff that require further training in dementia, we also have good connections with people like the Dementia Behaviour Management Advisory Service [DBMAS] and the Specialist Mental Health Service for Older Persons [SHMOPS]. We have lots of people come into our home to do education as well. That is a great thing. We also have the Aged Care Channel where they are required to watch certain DVDs and complete assessments before they actually start work. That is important to have that ongoing dementia training. I think that is why my staff are so skilled in management of the behaviours, because they are so well trained. I guess I just drive it into them until they are quite sick of it, so eventually they become experts.

The Hon. SARAH MITCHELL: Do you think in general the regulations around assistants in nursing are adequate or do you think there is room for improvement?

Ms URQUHART: I think there is always room for improvement. A lot of the time probably five years ago people would walk off the street into an aged-care facility. I certainly do not advocate that, because you would have a very low standard of care for your residents. I have a minimum requirement now of cert III and preferably cert IV, obviously with the medication component so that they get that education with medications as well. But I think it is important that there is some sort of regulation that they must have cert III or cert IV. It is in our policy now that we cannot employ anyone without it.

The Hon. SARAH MITCHELL: So minimum standards of—

Ms URQUHART: I think so.

The Hon. SARAH MITCHELL: Okay.

Ms URQUHART: Or working towards them, anyway.

The Hon. SARAH MITCHELL: Thank you.

CHAIR: Debra, it was great to get your input. I am not sure that you took any questions on notice—I think you answered them all—but there might be some supplementary questions that members might like to submit if you are happy to take those on notice.

Ms URQUHART: Yes. Sure.

CHAIR: The secretariat staff will be in touch to organise and facilitate that process.

Ms URQUHART: No problem.

CHAIR: Thank you so much for making the time.

Ms URQUHART: You are welcome. Thank you very much for letting me be part of it.

(The witness withdrew)

PROFESSOR COLLEEN CARTWRIGHT, Principal Director, Cartwright Consulting Australia, affirmed and examined:

CHAIR: Good afternoon, Professor Cartwright. Would you like to add anything about your position?

Professor CARTWRIGHT: Until fairly recently I was Professor of Aged Services at Southern Cross University. I am now Emeritus Professor of Southern Cross University and Principal Director of Cartwright Consulting.

CHAIR: Would you like to make a short statement?

Professor CARTWRIGHT: Before I do that, I acknowledge the traditional custodians of the land on which we meet and pay my respect to their elders past and present and emerging. Given my previous role as Professor of Aged Services I would like to pay my respects to the elders of all the cultures that make up this wonderful country of Australia, many of whom we are talking about in this inquiry. Thank you for the opportunity to make a statement about not having legislation that requires residential aged-care facilities to have a registered nurse on duty 24/7, which is of great concern to me. I will acknowledge that in small rural facilities—and I was listening very closely to what Ms Urquhart said—that can be a big challenge. I think for facilities with fewer than 60 residents the cost of that can be enormous, but that does not take away the imperative. It simply means we have to do some lateral thinking to see how we can support those facilities, potentially through things such as subsidies, perhaps, but maybe also through better use of things like telehealth—and I have had quite a bit of experience with that in recent times.

As you would know, I am sure, people in residential care are much more frail overall than they were previously. That is partly because of government policy to keep people at home as long as possible, but also because people are living longer and therefore they are dying at older ages. They are almost all what used to be called high care, with more than 60 per cent in most facilities having dementia, with the associated behaviour problems—although, as we know, the distinction between high and low care is not there anymore. Given that they are older and frailer, the average length of stay in residential aged-care facilities is much shorter than it used to be. The average length of stay used to be several years and now, if my understanding is correct, it is around six months, which means that people are dying sooner after admission.

If we say "average length of stay", some may be there for a year but some for much shorter periods of time. There should be a registered nurse on duty when someone is dying, to provide optimum end-of-life care. That optimum end of life care should be a palliative approach to care. To provide that, you need skills, training and experience. It is also not uncommon for several residents to be in the last days of life at the same time. Thinking about that, if you have several people who are dying, all of them needing someone with skills and experience, and you do not have an RN 24/7, where is that going to leave you? It requires skills and experience to assist both the resident and their families. I think that is something to take into consideration, because if you have a junior person who is trying to deal with not only several people who are dying but with very distressed families as well, that is just not okay. Other crisis events such as heart failure or breathing difficulties also require skills and experience to decide if the resident needs to go to hospital. Ideally they should be kept comfortable where they are, but they are often sent to hospitals because of inadequate staffing levels.

An aged-care facility with a high number of residents with high-care needs cannot provide the care needed without registered nurses. Crisis events by their very nature are unpredictable. If there is no RN on duty the enrolled nurse or assistant in nursing on duty may have no option but to send the person to hospital. As some of you would know, I have been working on the issue of advance care planning for about 22 years. There is a much more increased use of advance care directives now. In fact, on my website there is an advance care directive for New South Wales for use in residential care as well as in community care and for lesbian, gay, bisexual, transgender and intersex [LGBTI] people and a whole range of resources. The one for use in residential care has space for the person to answer questions that if this happens or that happens do you want to be kept comfortable here or do you want to go to hospital. Of course it is linked to consumer directed care.

Many people ask not to be taken to hospital at the end of life. If they are, they often get on to the treadmill because of fears of what if we miss something and we get sued. They often receive both unwanted and/or unwarranted invasive treatments with corresponding costs to the State healthcare system and to the person themselves. I heard a story the other day which really distressed me greatly of someone who had

repeatedly said no to a heart operation and finally was talked into it. They arrested on the trolley on the way to theatre and were resuscitated and the operation went ahead anyway. Excuse me while I breathe.

Sending people to hospital from residential care is also linked to cost shifting. The Commonwealth pays for residential care; the States pay for hospital care. By allowing residential aged-care facilities to not have 24/7 RN cover the New South Wales government will be bearing a higher percentage of the cost for end of life care. For residential aged-care facility management it is also much less expensive to send a resident to hospital than to have an RN on duty 24/7. This is compounded by the fact that the Commonwealth care subsidy is identical whether you operate in a jurisdiction which requires 24/7 RN cover or not.

I will come back just briefly to telehealth and say that we have got to be starting to be a bit more creative as well. I recently evaluated a project on home monitoring for older Aboriginal people in four locations—Coffs Harbour, Armidale, Toowoomba and Brisbane. Of course you have the naysayers who said they would not be able to use the equipment and all of that stuff. Well, of course they could. There was one RN for each of the four locations but this was home care. These were people who were still mobile. Many of them were still reasonably well although some of them did have diabetes and other problems.

Professor Len Grey, who is Professor of Geriatric Medicine at Prince Alexandra [PA] Hospital in Brisbane with whom I used to work, does a lot of his rural and remote consultations now from a studio in PA Hospital. In one residential care facility when they asked the older people how they felt about this I thought you might enjoy the fact that one lady said, "Because he is in a studio and I'm here in the residential aged-care facility with the TV set nobody's knocking on the door or his phone is not ringing." I was thinking it shouldn't be anyway. Another one said, "Because only one person can speak at a time if I start he can't stop me." The third person said, "If I don't like what's happening I just ask the nurse to throw the TV set over the balcony."

I just asked the chief executive officer of what used to be North Coast Medicare Local and is now the Primary Health Network why there is not a lot more of that happening in the region. One person said that a lot of the specialists want to be paid. There are 11 Medical Benefits Schedule [MBS] item numbers for the specialist end of such an interaction and there are 23 MBS numbers for the GP, registered nurse in the facility or even the community nurse so that they can be paid for doing some of it by telehealth. But it does not replace having the human being there to care for our very frailest, oldest people, particularly when they are dying. Finally, emergency departments are no place to die, even with the best intentioned staff. For older people, especially those with dementia, they can be very frightening and distressing places.

The Hon. WALT SECORD: From the evidence we have taken it is clear that there are two camps lining up. One is the medical and academic pool and nurses, researchers, experts who are saying that we should recommend the introduction of registered nurses 24/7 in aged care. In the other camp are the aged-care providers.

The Hon. SARAH MITCHELL: That is your opinion.

The Hon. WALT SECORD: That is my summary of the evidence I have heard so far. On the other side the aged-care providers are saying, "Please don't do this." Why do you think they are saying that?

The Hon. NATASHA MACLAREN-JONES: That is not the evidence.

The Hon. WALT SECORD: I said that was my summary of the evidence.

Professor CARTWRIGHT: I understood that. It is okay. I think there are two things happening. I think those of us who put the wellbeing of the client first—or the resident or the patient or however you want to describe it—want them to have the best care possible. As you know, my work has been particularly focused on medical decisions at the end of life. I know that wrong decisions get made if the people caring for those residents are not very well skilled, highly qualified staff. I do not want to see them being shipped off to hospital because it is convenient. I have heard some terrible stories. Pain relief is one big one. I have a drawer full of cases on inadequate pain relief in terminal illness often because people do not have the skills but also because there are still numbskulls out there who think that giving adequate pain relief which just might risk hastening death is some form of euthanasia when it absolutely is not any under circumstances.

For that to be dealt with effectively you need people who understand that, who understand good palliative care, who understand that even the Catholic Church accepts what is called the doctrine of double

effect where your primary intention is to ease pain and a foreseen but unintended consequence could be the hastening of death by a few hours or days. But you are not going to get generally unskilled staff being aware of such things and knowing such things. But if they are in a facility where they have said in their document or their advance directive, "I do not want to go to hospital and please give me whatever pain relief I need even if it hastens death", that is different to going into an emergency ward and being hooked up. I emphasise I said "I need".

You also asked me about the residential care providers' side. I have been on the board of several of what I consider to be the best residential care providers—UnitingCare Ageing, Feros Care and others. They are not-for-profit, community-based organisations. They still have to make a profit, but we are getting more and more residential care providers seeing that it could be a good business into the future and they do not want to be paying these sorts of wages. I am sorry, but they are going to have to.

The Hon. COURTNEY HOUSSOS: Obviously you have a specific area of expertise. I particularly want to tap into your experience in rural and regional areas. We received testimony earlier in the week that registered nurses are even more significant in rural and regional areas because of the absence of or the difficulty in accessing other health professionals such as GPs. Do you concur with that or do you take a different view?

Professor CARTWRIGHT: No, I concur with it but perhaps from a slightly different perspective. The RN can almost replace the GP, although not entirely, but I come back to advance care planning. I come back to the fact that if you get your planning done well in advance you can pretty much predict what the trajectory is going to be for this person in their last weeks or months of life. You should not need to call a GP in an emergency because you should have had family conferences and planning sessions to say that if this happens then this. You should have had the appropriate medication and other things already prescribed and in the patient's locker or chart to be ready for such an emergency. But if you are not going to have access to the GP then what are you going to do?

Some of the hospitals that would take someone in that condition—some of the small rural and regional areas do not even have them. I am working at the moment with Kyogle Council assessing their aged-care, disability services and respite care needs. The Bonalbo Hospital right up near the Queensland border closed about three years ago. It is going to be eventually a multipurpose service but for now it does not even have any overnight accommodation at all. To get into Lismore or Ballina is about a four hour drive. Is that what we are saying; we are going to put people in ambulances and ship them off for four hours when they are dying? I hope not. Yes, at the very least, you need an RN on call close enough to get there quickly. Even if you cannot afford around-the-shift rosters of three RNs in each rural residential aged-care facility, you have to have one who can get there quickly.

CHAIR: What do you mean by "quickly"?

The Hon. PAUL GREEN: Can we define what "quickly" is? Is that 20 kilometres away in a rural area or 50 kilometres away?

CHAIR: In time.

Professor CARTWRIGHT: Let us hope in Kyogle it is not during a flood because the one RN in Bonalbo at the moment is cut off by seven bridges when it floods. If she had someone who had entered their dying phase, and sometimes it is not anticipated that it is going to happen that quickly, she might not be able to get there. But that would probably mean that if she saw that coming and it was difficult, she would have to stay. It certainly does not mean that you are 50 kilometres away. It would be someone within the community. What I am saying, it is also hard—they told me at the residential aged-care facility there that it is hard to attract RNs. So if you only had one for a very small area, then you cannot have her on duty 24/7. If you have a small number of residents, you are not going to be able to afford to have 24/7 cover, but you have to be a bit creative and find other ways.

The Hon. COURTNEY HOUSSOS: You have outlined a number of the factors that we have heard are difficulties for rural, regional and perhaps remote registered aged-care facilities and one is to provide RNs around the clock. Do you believe that there should be any exemptions for those or do you have suggestions on ways that we can perhaps grandfather the scheme?

Professor CARTWRIGHT: Yes. I think we can also start to be creative with having, perhaps, an RN for a cluster of residential aged-care facilities and community care with a team, which includes assistants in nursing [AINs], enrolled nurses and Allied Health staff, and they can have regular planning meetings, look at their client load, look at their residents and say, "Who is going to be of concern and when and what are we doing about that?" Planning ahead. I know "planning" is the word I use 99 times out of 100 but we should not be reacting in a crisis situation unless there was something totally, truly unpredictable. I do not think you can insist on RN cover 24/7 in a facility that is going to go broke. If you to do that, that would be silly. I do not know that you can afford to subsidise those facilities to have that. There has to be access to RN cover 24/7.

The Hon. COURTNEY HOUSSOS: Do you think that telehealth is a solution?

Professor CARTWRIGHT: Telehealth is one of the solutions. It is one part of the equation. Of course the best telehealth requires more than we have at the moment. Dial-up is fine for home monitoring. With the projects we were doing, people would take their readings several times a week on agreed times. They had up to seven peripheral devices to measure blood pressure, pulse, weight, blood glucose, spirometry, et cetera, and the readings went through to a central data monitoring place so that as soon the RN turned on her computer she would see in red on her dashboard anyone's readings that had gone outside of the parameters set by their GP. She then used her triaging knowledge of her community, because I said they were Aboriginal people, "I am not surprised Aunty Sue's blood pressure is up today because her sister died last week and she is a bit upset. I will give her a call and see she how she is going", or, "Oops, Harry's blood glucose has gone through the roof for the fourth day in a row. I have to get an ambulance out there", or whatever. That is telehealth in the home.

I think telemedicine into residential aged-care facilities can help enormously. It will certainly cut down the travel. I was listening to Ms Urquhart and that is exactly what I have been finding out in Kyogle as well. Families have to take time off work, they have to pay for travel, they have to pay for overnight accommodation. One women had to go to Ballina and back—a 3½ hour journey each way—three days in a row. Yes, I think it is part of the solution. But never, never, never—please—let me see somebody facing a camera and no human being there to hold them as they die. Please.

The Hon. PAUL GREEN: Hear, hear!

The Hon. BRONNIE TAYLOR: I agree. Absolutely.

CHAIR: That is a shocking thought. You mentioned the lack of definition of high and low care. Do you have any opinion on whether or not that has been a problem, that we have lost that definitional character of nurses?

Professor CARTWRIGHT: It is interesting, is it not? I keep hearing everyone saying, "We are not going to have any more low care, it is all going to be delivered in the home." I do not believe that. I believe eventually we will have to go back to having that distinction and part of that staffing. The reason I believe we are going to have to go back to that is we have a reducing number of informal carers available in the community to care for people. Lots of people are now living alone. In the study I have just been doing there are people going into what used to be a low-care facility, called Kyogle Court, not necessarily because they are ready for residential care but they are so lonely and socially isolated, and we know that social isolation is a risk factor for depression, which is a risk factor for dementia.

We absolutely do not have the staff to be going out to people's homes spread all over the whole community. One of the recommendations I have put to council is to talk to providers about what is replacing low-care facilities, and that is an over 55s village with services coming in, or a cluster of independent living units. It is really a replacement of what we had before and it will turn into what we had before.

CHAIR: We have heard from other witnesses that we are seeing a number of people going to residential care facilities because there is not the residential living opportunities that are embedded in the community.

Professor CARTWRIGHT: That is right.

CHAIR: Rather than having staff, there would be a neighbour, a friend, or someone close by. So there is a breakdown in communities and that is sad in rural and regional areas, but sometimes it is because the

physical structures do not exist. Does that mean we are seeing some unusual financial costings and calculations going on because we have lost definition of those things?

Professor CARTWRIGHT: I think there is still a lot of community support in some of those places, but community support when you live alone—having a neighbour or someone—is not the same as having someone there with you. One woman said to me, "Oh, yes, they are very nice and I see people during the day but I am so lonely at night." When her children went away for Christmas she did not see a single soul for two weeks, and she was not well enough to travel. Even if the community is strong and supportive and 49 per cent of that community volunteer that is still not as good as being with other people of similar age.

As I said, we do not have the staff to go out to all of those places. At the moment there is nothing between people living on properties or in big houses and residential care. There is nothing in the middle. My feeling is we will go back to having low-care facilities as well, driven by staffing and other considerations. For now, we do not. For now, most of the people in residential aged-care facilities, to be assessed as needing to go in, by definition, you have to be pretty frail, and there are high numbers with dementia, and you need RN cover.

The Hon. PAUL GREEN: That is a good point. Society is changing. This is more my passion, being a member of the Christian Democratic Party, is that places of public worship perhaps are being sterilised out of future growth areas. At Richmond, for instance, where a church once existed, a community existed and they looked after the aged and the vulnerable. Those things are changing, the ability to cope with what we call the ageing population, which, as I said earlier, will be about two million between now and 2050 over the age of 65. As you say, those gaps have to get smaller. The only way they will get smaller is that we will have different categories. Hospitals in the home is one. It is not the solution, it is a part of the solution, but we are definitely going to have to these low-care facilities.

The other beds are to be stolen away, sadly, by the one million people heading towards Alzheimer's. Where are they going to go? There are not enough facilities ready to accept them. So there is a plethora of things that need to happen here. I guess then we need to work out the appropriate level of care for those people. I come back to the question: Is it appropriate in those areas not to have a registered nurse and what is the appropriate level of care? We keep talking about training up the assistants in nursing or the enrolled nurses to another level, but that means we should be paying them at another level too. Suddenly they are on the same wage as a registered nurse and they are basically a registered nurse. How about we train up the registered nurses a bit more and they can take the GP's position. Do you know what I am saying? Why are we always talking about working back from there when we could really be working forward from somewhere? I may have been a bit cheeky about GPs.

Prof CARTWRIGHT: I know it is slightly off track for this inquiry, but this raises the issue of how much people working in residential care are paid. One of the things that bothered me for a long time was that a registered nurse in residential care was paid something like $387 per week less than a registered nurse in acute care. They are absolutely equally qualified. Some of the staff—for example, assistants in nursing—get paid about the same as the people stacking shelves in Woolworths. What are we doing? These are the people who are caring for our most vulnerable people.

The Hon. Paul Green might be interested to know that when I was doing the telehealth study I found a church in Coffs Harbour prepared to stream their services to old people who could not get to them. And next Thursday night I am going to be watching a church service streamed live from Ireland where my niece is getting married. So in that way people who are confined to home and for whom the church has been a major part of their life can still participate in services. That is slightly off track.

The Hon. PAUL GREEN: It is not off track, and that is the point. Part of a person's holistic being is spiritual, and they need to have that need met as well. So it is good to hear that this transitioning is happening in the home. We look after a couple of aged people, and one is right at the point of going into an aged-care facility. I am sure her world would be a bit more stable if she was able to get to church every Sunday. But she cannot and that really rattles her world—so much so that now she is quite vulnerable. She really feels she needs to move into the next stage, which is aged care—probably not because she needs it physically but because she needs it mentally. She needs the care, the love, the fellowship and the friendship. I think about 52 per cent of Australians live in dual or single households, and we have not even looked at the part of the equation yet. Of course there are implications for the future of aged care and residential care for those people too.

Prof CARTWRIGHT: In fact, your comment reflects something Professor Iain Graham, Professor of Nursing at Southern Cross University, said to me just a couple of days ago that it is not just about the clinical care but also lifestyle, quality of life and what matters to that person. Does that require a registered nurse? Not necessarily. But if the person's health and wellbeing is not maintained then they are not going to be able to do any of those other things anyway—and maintaining that requires a registered nurse. If it is high care, and most of them are, and it is a case of dementia, and most of them are, how can you provide that level of care with someone who does not have the registered nurse skills?

CHAIR: I know you have been working with local government. What do you think their role is in understanding where aged care fits? Do you have anything to offer on that? We have heard a few things said about whether or not local government has a role. We know some are either in full or in part providing services. What can local government do in terms of understanding their local community and what can be done? I should declare here that you inspired me on the positive ageing path about a dozen years ago when I heard you speak.

Prof CARTWRIGHT: And at some future time I would be happy to give the Committee a presentation on the benefits of an ageing population, which the Hon. Walt Secord has already heard. Just as an example, there was an audit done recently of premises in the main street in a town in one of the regions I have been working in recently. Three people in wheelchairs went around all 60 premises on either side of the main street. The fittest and strongest of those people managed to get into 30 of those properties but not the other 30. People on wheelie walkers and wheelchairs cannot get into the local branch of the Commonwealth Bank in this particular community, and the Commonwealth Bank recently announced a 9 billion-dollar profit. So local government can do things there in terms of access and so forth.

I believe that the changes to aged-care funding are going to make a big difference and can help to revive some of the smaller regions which are dying. As Committee members would know, up until now the Commonwealth has allocated home care packages to a region not to a local government area. People put in their applications for packages in the Aged Care Approvals Round [ACAR]. The Commonwealth takes the statistics for the whole region—how many people there are over 70, how many places there are and how many packages there are—and then allocates a certain number of packages. The far North Coast region, for example, includes Kyogle but the providers might be based in Lismore or Casino. So when a person from Kyogle asks for a package, having been deemed to be eligible for a certain level of package, they get a response saying, "Well, we don't have a worker in your area but we will put you on a waiting list". In the next round of applications the waiting lists are used to justify more packages, but there are still no packages in these areas.

From February 2017 the funding will stick with the person who was assessed as needing the services. It will not go to the providers. The person will choose who they purchase services from. I see this as a wonderful opportunity for the regions to start reviving, because a person is not going to pay someone who has to travel three hours out to them when they only have three hours allocation per week. So it should provide more employment opportunities within the local region. The allocation will also travel with the person if they relocate from Sydney or Melbourne to one of our beautiful regional areas. So I think there is a big shift happening and I think local government has a lot to offer here—even in terms of perhaps looking at what subsidies it might be able to offer to service providers to build a facility, independent living units or whatever. There is a lot happening in that space, and I think it is going to be exciting.

The Hon. PAUL GREEN: Once again I come back to Coolamon Shire Council. It is not a big council; it is a rural council. It created an entire aged-care residential facility for its aged so they can age in place in little old Coolamon. So it can be done. It was a great initiative.

Prof CARTWRIGHT: Just quickly, one of my colleagues in Coffs Harbour did say to me after we had done a lot of work there with residential aged-care facilities and advance care planning, "You do realise that Coffs Harbour is now the best place in Australia to die". I said to him, "We're not going to put that on the tourist brochures".

The Hon. BRONNIE TAYLOR: Professor Cartwright, thank you very for your evidence. It is great to have you here. We heard some evidence on our first day from someone speaking on behalf of providers in rural and regional centres. She said that, for the places that do not have registered nurses, when they need to have a registered nurse, because someone has entered a terminal phase and it is complex, then they get a registered nurse in for that period of time. But when they do not need them then they do not have them. So they basically skill up when they need to—to meet the needs of their clients. How do you feel about using those sorts of

innovative models of care in those smaller facilities, which, as you said, have different levels of care? Perhaps there might be an increase in those.

Prof CARTWRIGHT: I guess my concern would be that it is really hard to attract registered nurses into aged care in rural and regional areas. Where are you going to get the person from?

The Hon. BRONNIE TAYLOR: They are actually doing this already.

Prof CARTWRIGHT: They are very fortunate. For how long is the person needed? When do they say they do not require that person? We are talking about high-care facilities with people with dementia.

The Hon. BRONNIE TAYLOR: These were low-care facilities and they were operating very well.

Professor CARTWRIGHT: But we do not have many low-care facilities any more.

The Hon. BRONNIE TAYLOR: We do.

Professor CARTWRIGHT: We do not have many.

The Hon. BRONNIE TAYLOR: We do.

Professor CARTWRIGHT: The distinction has been taken away. It is now just called "ageing in place".

The Hon. BRONNIE TAYLOR: We understand that.

Professor CARTWRIGHT: If there were, say, three or four adjoining regional areas and you had an RN that was willing and prepared to do that, what if she is called to the three places at the one time?

The Hon. BRONNIE TAYLOR: My background is in palliative care. I had eight years as a clinical nurse specialist in palliative care in Cooma. We were achieved very well a situation where someone who did not have 24/7 registered nursing care to have a syringe driver. As you continually mentioned, if the planning was in place we were able to do that extremely successfully. It allowed people to stay where they wanted to stay, to die.

Professor CARTWRIGHT: I would agree with you if the choice is between having to be shipped off to hospital and having good care—perhaps even with someone on Skype, on the phone or whatever, guiding the care at the time that it is needed—in the smaller facilities. But is there really any excuse for the high-care larger facilities—

The Hon. BRONNIE TAYLOR: No. No-one is saying the in high-care facilities or where they are needed that we will not have them.

Professor CARTWRIGHT: I am really pleased to hear that because I thought—

The Hon. BRONNIE TAYLOR: I think that sometimes people do not quite understanding. Uniting Care has 75 residential aged-care services; only two do not have the staff 24/7. So the majority of them have registered nurses 24 hours a day.

CHAIR: Because they have to.

The Hon. WALT SECORD: If the legislation was removed—

The Hon. NATASHA MACLAREN-JONES: I think we need to clarify that this inquiry is not about removing nurses from aged care. Under the law, if a registered nurse is required in an aged-care facility they must be provided. We are looking at the issue of low-care facilities, which no longer exist under the legislation, and whether or not some of those homes or facilities that provide low care, should be forced to have nurses.

CHAIR: That is an interpretation.

Prof CARTWRIGHT: I understand that the New South Wales Department of Health have done away with the monitoring in relation to RNs in high care. Is that correct?

The Hon. NATASHA MACLAREN-JONES: No.

The Hon. WALT SECORD: I have heard that.

The Hon. NATASHA MACLAREN-JONES: For accreditation, the assessments are done at a Federal level. Section 104 relates to having a registered nurse in high-care facilities but not in low-care facilities. In the Federal space, the definition of "high" and "low" does not exist anymore. We are looking at how that impacts on our current legislation.

The Hon. SARAH MITCHELL: The Federal legislation has made it obsolete. New South Wales is the only State that has this. Even though it is mainly federally controlled, as it is supposed to be, about 10 years ago New South Wales brought in a differentiation between high and low, and had requirements for high-care facilities. Now that the Federal legislation which defines high and low care has gone, we are left with something that is obsolete. We have the status quo but in this process all the options are on the table. Potentially, if that legislation is withdrawn or removed in New South Wales our State would then go the way of every other State in Australia. In other States in Australia there are registered nurses in aged care although they do not have what we have. Does that help in terms of where we are?

Prof CARTWRIGHT: Are you saying that there would be nothing that would require them in high-care facilities if the legislation—

The Hon. SARAH MITCHELL: It would be a Federal responsibility, like it is Queensland, Victoria and other places.

Prof CARTWRIGHT: I am sorry; I missed the point then. If you do away with the legislation—

The Hon. BRONNIE TAYLOR: There are no plans, Professor Cartwright, to remove registered nurses completely or to downgrade the services that they are already providing in aged-care facilities across New South Wales. As a registered nurse—

The Hon. WALT SECORD: You ask questions; you do not make statements.

The Hon. BRONNIE TAYLOR: The witness asked me a question.

The Hon. WALT SECORD: You are distorting it again.

The Hon. NATASHA MACLAREN-JONES: You are interrupting our question time.

CHAIR: Order! The time is with the Government. They are engaging in what is, I think, for everyone, a very interesting conversation with the witness. The witness is obviously seeking some clarification which Government members—

Prof CARTWRIGHT: A lot of the people with whom I interact—including the aged-care providers who want to keep the legislation—have said to me that their concern is that if the law goes there will be no law governing how many RNs are required or if RNs are needed 24/7 or whatever, regardless of the level of care. You are saying that that is not the case.

The Hon. SARAH MITCHELL: I will put this as a question. In your experience, in other States around Australia, where they do not have the unique piece of legislation that we have in New South Wales, are there issues with respect to not having any registered nurses in aged-care facilities?

Prof CARTWRIGHT: I do not think there is an issue of not having any. I do think there is an issue of not having adequate nurses, particularly in terms of dementia care. There are places where there are not enough.

The Hon. BRONNIE TAYLOR: In terms of dementia care and Alzheimer's care, the Uniting Care people gave evidence earlier. They run a facility near the Central Coast, I think, that specialises in care for people with Alzheimer's and dementia. It is considered one of the best of its kind, and Alzheimer's Australia

brings groups of people from overseas to look at this facility because it is so fantastic. They have this reputation and this accreditation. They do not provide 24/7 registered nursing care. They have registered nursing and care plans in place. They have invested their money in other facilities that help with dementia. How do you feel about a best-practice facility like that?

Prof CARTWRIGHT: If, as you said earlier, that facility can access an RN quickly when needed, then I am okay with that. If it is a best-practice dementia unit they have probably planned for the behaviours. They have identified them. They have identified that a person is hitting out not because they have dementia and therefore they are acting up but because they have a facture which nobody has noticed because there is no-one with a high enough level of skill. If you say that it is best practice and all the other boxes are ticked I believe you. Yes, with good planning they probably could manage without those staff 24/7. I do not see that level of planning in many places, and I do see poor care in many places.

The Hon. BRONNIE TAYLOR: We all do. Sometimes when the registered nurse is there the care is not—

Prof CARTWRIGHT: There is that, as well, but then that is on their part, rather than the actual role.

The Hon. BRONNIE TAYLOR: Thank you.

Prof CARTWRIGHT: A well trained, well skilled RN should not be providing poor care.

The Hon. BRONNIE TAYLOR: I completely agree.

Prof CARTWRIGHT: You were a palliative care nurse.

The Hon. BRONNIE TAYLOR: I was.

The Hon. NATASHA MACLAREN-JONES: I only have one question. In your opening statement you said something about "not allowing them" in relation to nurses. I just want to ask you to clarify what that meant.

Prof CARTWRIGHT: I do not know—

The Hon. NATASHA MACLAREN-JONES: It was three-quarters of the way through. I am happy for you to take that question on notice. You made a statement about "not allowing them" to have nurses. I was not sure who you were referring to as "them".

Prof CARTWRIGHT: I am sorry. That does not register with anything in my mind.

The Hon. NATASHA MACLAREN-JONES: I am happy for you to take that on notice. Once the *Hansard* transcript—

Prof CARTWRIGHT: I will.

CHAIR: Unfortunately, we have come to the end of our time. Thank you. There may have been some questions on notice. There may be some supplementary questions. The secretariat staff will liaise with you. I will be circulating a question that we will put to Government to get clarification about the last point because there is some concern about what Federal law requires. The accreditation standards, as I understand them, refer to "reasonable or appropriate care". We will get that clarified in writing because for a few people it has been a matter of contention or confusion.

(The witness withdrew)

PAUL SADLER, Chief Executive Officer, Presbyterian Aged Care NSW and ACT, sworn and examined:

CHAIR: Would you like to make a short opening statement?

Mr SADLER: Yes. I should note that I was formerly the chief executive officer of Aged and Community Services, the peak body when the repeal of the Nursing Homes Act went through in New South Wales, so I well remember this debate. Presbyterian Aged Care is the aged-care arm of the Presbyterian Church in New South Wales and the Australian Capital Territory. We run nine residential aged-care services across the State, with more than 600 residents in them, and employ a total of 66 registered nurses. We strongly support the role of registered nurses in aged care and believe they are an absolutely critical part of the provision of aged care.

All of our services have access to registered nurses; four of the nine do not have 24/7 registered nurses as they come from the older group of low-care facilities, as previously defined. As I have heard the Committee debating, the New South Wales legislation in the Public Health Act is outdated and cannot remain as it is currently written. In fact, no-one else has talked about nursing homes, other than this State, since 1997, and high-care places disappeared last year, which is the reason for this review occurring.

We firmly believe that aged care is primarily a Federal Government responsibility. It is the only source of funding for aged-care services. That does not mean that we believe New South Wales has no role to play. We recognise the important role that the New South Wales Government plays, and in particular we commend the work that is already underway in New South Wales—and there needs to be a lot more of it—looking at the interfaces between the health system, the disability services system and aged care. Our position, as the committee will have seen from our submission, is to recommend that the current legislation be repealed on the basis that we believe the staffing requirements are adequately covered by the current Commonwealth legislation, accreditation and other monitoring processes.

The Hon. COURTNEY HOUSSOS: Data published on the federal website shows that your organisation receives well over $27 million in Federal Government subsidies, and I assume that you receive funds additional to that from your residents. On that basis how can you justify your position that registered nurses should not be provided in aged-care facilities when clearly you are a large and well-resourced organisation?

Mr SADLER: Firstly, it is not our position that registered nurses should not be in aged care. In fact, my opening remark was contrary to that.

The Hon. COURTNEY HOUSSOS: Sorry, I should have said why they should not be there 24 hours a day, 7 days per week.

Mr SADLER: We believe the provision in the current New South Wales legislation should be repealed. That is different from saying that we have a view that registered nurses are not required in aged care. Indeed, in the five aged-care services that we currently run where there is 24/7 registered nurse coverage we would not be proposing any change. The reason for our position that the legislation is outdated is very similar to the position that Illana Halliday, on behalf of Aged and Community Services, put to the Committee on the first day of hearings, which is largely that it would be almost impossible to draft legislation now that relates to the current circumstances in aged care. Ever since 1997 there has been a growing gap, and as happened when the Nursing Homes Act was repealed in the mid 2000s, it has been difficult to identify where an Act that refers to nursing homes could possibly continue to apply to the aged-care space in the modern aged-care environment.

We certainly believe that there is a potential financial impact, which is outlined in our submission, for our organisation if there were to be an extension as a result of whatever the Committee's deliberations are and the final decisions of government or the Parliament in terms of any changes. It would be reasonably significant. For us to extend registered nurse coverage 24 hours a day to all of our facilities would add roughly 40 per cent additional registered nurses that we would need to be able to locate and find and, as pointed out in our submission, in at least one case that is in a rural location where it is very difficult to find registered nurses—and that is consistent with the other evidence the Committee has been hearing.

The Hon. COURTNEY HOUSSOS: In your submission I noted that only one facility was in a regional area—other submissions received by the Committee say that it can be difficult to recruit also—and the others are in Gosford, Drummoyne and Haberfield.

Mr SADLER: Correct.

The Hon. WALT SECORD: I would hardly describe those as rural and regional areas?

Mr SADLER: No, and I am not arguing that they are.

The Hon. WALT SECORD: You cite them in your submission.

Mr SADLER: No. Our submission pointed out that there were issues for regional and remote providers. We are one with our service at Walcha—which is in the New England if you did not realise.

The Hon. WALT SECORD: I know where it is.

Mr SADLER: That poses particular challenges for us in that community, and they are very similar to the evidence you have heard from other organisations, including UnitingCare this morning.

The Hon. WALT SECORD: You say in your submission that it takes an average of seven to eight weeks to fill a registered nurse vacancy. Why would it take seven to eight weeks to fill a registered nurse position in Gosford, Drummoyne and Haberfield?

Mr SADLER: Firstly, there has been a shortage of registered nurses across Australia at different times. We find in some of our Sydney sites, with the cost of housing and other factors, that in certain parts of Sydney it is actually quite difficult to find registered nurses who are available living locally. They do not want to travel long distances in the Sydney traffic in order to fill the vacancies that we have. We run a service at Paddington in the Eastern Suburbs and it is not infrequent to find it quite difficult to fill staff positions at Paddington because of some of the transport difficulties and the relatively high cost obviously of housing in the Eastern Suburbs.

The Hon. WALT SECORD: I put it to you that it is not the fact that Paddington, Drummoyne and Gosford are great regional distances for people to travel; the poor salaries you pay registered nurses is the reason that it is hard to attract registered nurses to you and commercial aged-care providers?

Mr SADLER: In our enterprise agreement the registered nurse wage, up to fifth year and after, base rate of pay is $37.95 per hour.

The Hon. WALT SECORD: You pay $37.95, so you are about 20¢ more than other providers?

Mr SADLER: Yes.

The Hon. WALT SECORD: Would you be one of the top-end salaries?

Mr SADLER: We would be slightly higher, as you say, than some organisations.

The Hon. WALT SECORD: So $37.95 would be the top-end, high salary registered nurse provider for aged care. Do you not think—

Mr SADLER: The other thing we can provide as a public benevolent institution is additional—

The Hon. WALT SECORD: So—

CHAIR: The member will allow the witness to complete his answer.

The Hon. WALT SECORD: I am sorry, Madam Chair.

CHAIR: Mr Sadler, please continue with your response.

Mr SADLER: What I was going to say was that the additional benefit that we have as a public benevolent institution is that we can offer some fringe benefit tax concessions to our staff. Certainly our registered nursing staff is probably the group of our staff who are most likely to take that up. When you do the comparisons between what is available in, for example, the public hospital or the private hospital system and the wage rates now in aged care, they have slowly been coming together more. I heard Professor Cartwright's evidence earlier when she was talking about a $300-a-week gap. It is much less than that now between the public sector and certainly the not-for-profit aged-care providers.

The Hon. WALT SECORD: Earlier in response to a question by my colleague the Hon. Courtney Houssos, you revealed that in 2013-14 your nine aged-care facilities received $27 million in Federal Government taxpayer subsidies. You said that that was the only source. I wrote it down as you are saying it. That is incorrect. How much in fact would you have an accommodation bonds from your residents? What sort of value would you have in that?

CHAIR: If—

The Hon. WALT SECORD: I am just getting to the fact that—

The Hon. SARAH MITCHELL: He can take it to that on notice.

The Hon. WALT SECORD: No. He would know this.

CHAIR: Order! Mr Secord, I just want to inform the witness that he has the opportunity to take anything on notice, if he does not have the information with him, at hand, or would like to prepare further. You can take it on notice.

Mr SADLER: Certainly.

The Hon. WALT SECORD: I see some charts!

Mr SADLER: As of June 2015, we have approximately $43 million worth of refundable accommodation deposits or accommodation bonds that we hold. The purpose of that funding is for the purpose of accommodation funding and the rebuilding of the accommodation. All that money is owed back to the residents. It has to be returned when the resident leaves.

The Hon. WALT SECORD: At another point you spoke about the ability of the State to legislate in this area. You said that it would be impossible. Do you envisage that aged-care providers would try to mount some legal challenges to prevent movement in this area?

Mr SADLER: No, not necessarily. My understanding is that if there is a conflict between Federal and State legislation, there is a chance that Federal legislation would override State legislation where there is a conflict. I am a bit of a bush lawyer on this but that is my understanding of it. My point was more about the difficulty of trying to maintain the distinction between high and low care going forward, given the fact that that distinction no longer exists in terms of aged-care places. There is still a distinction that the aged-care funding instrument draws between higher and low-care residents, but that is a movable feast for individual aged-care facilities because it changes. That mix can change over time.

The Hon. WALT SECORD: Can you refresh my memory? What is the roof body organisation for aged-care providers in New South Wales?

Mr SADLER: The peak body, do you mean?

The Hon. WALT SECORD: Yes.

Mr SADLER: For the not-for-profit sector, it is Aged and Community Services NSW and ACT.

The Hon. WALT SECORD: Are you connected to Leading Age Services? There is another body, too.

Mr SADLER: We are not members of them, no. They represent, largely, the for-profit sector but also have some not-for-profit members.

The Hon. WALT SECORD: Why do you not belong to that organisation yet you belong to the other organisation?

Mr SADLER: Because we believe that aligning ourselves with our fellow colleagues in the church charitable sector is very important. We believe that the church and charitable sector has a unique contribution in aged care in that by far we are the majority providers, along with local government, over the Dividing Range. We have only got the one service, but many of my colleagues run services in the rural and remote areas. Ultimately, as mission-driven organisations it is not all about profit for us. Very importantly, from our point of view, it is about quality of service—the spiritual care that we provide as a Christian organisation. We are looking at a reason for being in the space that is what we believe about the dignity of older people created in the image of God. That is why we are actually in the business not solely—although we need to—make money.

The Hon. COURTNEY HOUSSOS: I would like to ask you specifically about some things in your submission. On page four, you state in relation to registered nurses:

> We need the flexibility to have them working during the day while our residents are up and about, and only at night if the residents need them there at night.

Given that you are speaking specifically about the concern that you do not need them in the low-care facilities, I would be interested to hear what proportion of your patients in the low-care facilities have dementia.

Mr SADLER: It varies. One of our services is the service at Haberfield and it is fairly unique for us. There are a couple of other services like it in Sydney. Firstly, we have a majority of males in that residence rather than females, which is quite unusual. Those of you ladies in the room tend to outlive us men into old age. We actually in that service have a substantial proportion of people who have mental health problems. In some cases they are actually homeless and have come to live with us.

The Hon. COURTNEY HOUSSOS: This is your facility in that?

Mr SADLER: Haberfield, yes. It is actually a converted motel, so it is not set up to be an aged-care service where we provide care for patients needing high levels of care. For example, it has significantly lower aged-care funding instrument amounts that we get in that service compared to other services.

The Hon. COURTNEY HOUSSOS: I will stop you there because I am really interested to know what proportion of people have dementia across those low-care facilities.

Mr SADLER: In that facility it would be a relatively low proportion. There would be a proportion—we might be talking about 30 per cent of the residents who would have cognitive impairment, including dementia. In one of our other facilities at Drummoyne we actually have a dementia-specific area. The vast majority of the residents across the whole service there have dementia. Out at Walcha, it is probably 50 per cent maybe who have some form of cognitive impairment.

The Hon. SARAH MITCHELL: I just want to clarify that the four examples you list in here are your four low-care facilities.

Mr SADLER: Correct, yes.

The Hon. SARAH MITCHELL: We have heard some evidence from other witnesses throughout the cause of this inquiry—and obviously as a Nationals member based in Gunnedah I know Walcha very well—about the impact on lower-care facilities, particularly in regional areas, when they close and there is no other option, or if they are forced to close because they cannot meet the staffing requirements and there might not be another option. We heard evidence about the potential ramifications for residents in those facilities if that happens. But it is interesting to read in your submission that three of those about which you speak are in the city. My question is: There is the potential that you may need to look at shutting those services if you cannot meet the 24/7 nursing requirement, if that were to come into effect. Would that be correct?

Mr SADLER: I think, as the previous member's questions went to, we would be in a slightly different position in Sydney. If legislation required us to provide 24/7 registered nurse coverage, we would have more chance of being able to fulfil that criteria from the point of view of a recruitment sense in a metropolitan area or even a large regional town. Once you get out of those large regional communities—Walcha is 3,000 people in

the whole of the shire; it is not a large community—we have difficulty finding the one registered nurse that we employ now. To find another six or seven to fill a 24/7 roster would be either (a) highly expensive—and all we have done there is put the staff costs, not if you had to be flying people in or any additional costs—

The Hon. SARAH MITCHELL: Others have raised that as well.

Mr SADLER: Yes. But (b) I just do not think they are there. You would create an artificial situation where a well-run and well-respected service in that local town, which was set up by the local community in a joint effort between the local community and the Presbyterian Church in the town, would effectively be forced to close because of meeting what we would argue is an artificial regulatory requirement.

The Hon. BRONNIE TAYLOR: If you compare the facility at Walcha to sites in more urban areas, is there greater retention of experienced staff, AINs and ENs, because your organisation is one of the few employers in that community?

Mr SADLER: One small point: Presbyterian Aged Care does not employ assistants in nursing and enrolled nurses except where there is a registered nurse 24 hours a day, seven days a week, simply because an enrolled nurse cannot practise without having a registered nurse available. We employ care service employees under our enterprise agreement in all the sites that do not have nurse coverage 24 hours a day, seven days a week.

Are they more skilled? We put a lot of effort into the training of our staff, across a range of skills. There are some areas where you cannot train a non-registered person to fulfil the obligation. An example of that is delivery of schedule 8 medications. In some instances, facilities work with the local community nurse. The general practice at Walcha, for example, has a nurse. There is a multipurpose service in the town as well. We work closely with other service providers and, wherever possible, look after the needs of residents without them having to move to a different location. But on occasion they do have to be moved.

The Hon. SARAH MITCHELL: On page 3 of your submission you talk about term of reference 2, which ties in with what you said about assistants in nursing. I thought it was interesting that you talked about creating a working with older persons register that would be similar to the Working With Children Check. That point has not been raised in the inquiry so far. Would you elaborate?

Mr SADLER: Certainly. Elder abuse is a significant issue that I have been working to address over the years. Responding to the abuse experienced by people in residential aged care, community aged care—and older people generally—is clearly the remit of the State Government. There are gaps in the system. For example, if one of our staff members is dismissed for abusing a resident, there is no register of that fact unless they are charged and have a criminal conviction against them. The gap in the system is significant when compared to the Working With Children Check process. That matter is a bit of a distraction from the key issues that the Committee is looking at.

The Hon. SARAH MITCHELL: Our terms of reference always include the phrase "and any related matters", so we can explore different issues.

Mr SADLER: That is why I made my opening remarks. The State has a clear and pressing responsibility to look at how it protects older people. That area warrants further examination by all of us.

The Hon. SARAH MITCHELL: You are dealing with a vulnerable group. The Working With Children Check sets a precedent, and it would be a really interesting idea to look at applying it to people who work with the elderly. I imagine that, as an employer, you would find it helpful to go through a process like that when you employ staff.

Mr SADLER: Indeed.

The Hon. NATASHA MACLAREN-JONES: I would like more information about the employment of registered nurses, particularly where a nurse is required because he or she is the best person to provide that service to your residents. We have heard that registered nurses could be taken away from homes that require them. Could you outline what provisions are in place to prevent registered nurses being taken out of homes that clearly need them?

Mr SADLER: Under the Aged Care Act and the residential aged-care standards that apply under that Act, registered nurses are required to provide certain aspects of care. That is monitored by the Australian Aged Care Quality Agency, as part of its monitoring of compliance with the standards in the accreditation process. Assuming you pass the accreditation, there is a three-yearly accreditation audit, which is an announced audit. The Australian Aged Care Quality Agency also makes an unannounced visit every year to every aged-care home in Australia.

The Hon. NATASHA MACLAREN-JONES: One of the issues the Committee is looking at is the application of section 24 of the Public Health Act 2010 to low and high care. Do you have a recommendation on how to bring New South Wales into line with the other States and Territories?

Mr SADLER: Yes. The recommendation is very clear: repeal the provision.

The Hon. NATASHA MACLAREN-JONES: How would you address the issue of definition of homes and their level of care?

Mr SADLER: I would leave it to the Aged Care Act.

The Hon. SARAH MITCHELL: We have heard from other witnesses about the importance of not only nursing staff but allied health professionals. On page 3 of your submission, at point 2 of the summary, you say that an option for aged-care providers trying to meet the requirement to employ a full-time registered nurse would be to remove other types of staff. By "other types of staff" do you mean allied health professionals or do you mean care workers and ENs?

Mr SADLER: If we were ever placed in that invidious position, which I hope we are not, care workers would be the most likely to be replaced. Steve Tuelan gave evidence this morning from UnitingCare's perspective. We, like them, have been trying to employ additional allied health support—diversional therapists and that sort of thing—because we believe that is where there has been a significant gap, historically, in the provision of aged-care services. To a large extent, additional allied health support is being used in the aged-care system now. If we had the magic bucket of money, that is where we, like UnitingCare, would be looking to invest some of it.

The Hon. SARAH MITCHELL: Potentially you could end up with more qualified staff, more registered nurses, but you would have fewer staff available overall.

Mr SADLER: Yes. The qualifications of care staff have increased substantially in the last decade. When I started working in Presbyterian Aged Care, a minority of our staff had formal qualifications at the certificate II or III level. Now a substantial proportion of our staff are trained to a certificate IV level in aged care.

The Hon. PAUL GREEN: How big is your organisation? How many beds do you have?

Mr SADLER: We have just over 600 in New South Wales.

The Hon. PAUL GREEN: Do you provide the best care at any cost?

Mr SADLER: We certainly do not take the approach that others have taken, on occasion, of cutting costs to the bone to maximise profit. That is not what Presbyterian Aged Care or the Presbyterian Church is about.

The Hon. PAUL GREEN: So you provide the best care within your budgetary opportunities.

Mr SADLER: That is correct. I have heard the Combined Pensioners and Superannuants Association, for example, talk about the substantial profit margins in aged care. That is not our experience. We are on track to make a profit for the last financial year of about $60,000 for the whole organisation. That is because we have invested in new services and new information technology. That is over a total income for the whole organisation of $48 million. That is not a substantial profit margin. It is important for all aged-care providers, whether for profit or not-for-profit, to make a surplus to reinvest in the services that they provide.

The Hon. PAUL GREEN: Do you gain interest from bonds? How much interest do you gain?

Mr SADLER: That is correct. I will take on notice the question about interest. I do not know, off the top of my head, the total amount of interest we gain. But what happens is that if you have what are now called refundable accommodation deposits that are paid by an incoming resident, then we have to return the full value of that to the resident when they leave, or their estate if they pass away. But we retain the interest during the period of time that we hold that.

The Hon. PAUL GREEN: Where does that go?

Mr SADLER: That is invested—part of the $48 million income that we have received for the year is the interest part of that.

The Hon. PAUL GREEN: So it is not hypothecated to any particular area—just running costs?

Mr SADLER: No. Within that $48 million budget we have a proportion of the budget that goes towards depreciation, which feeds our capital redevelopment, and that is largely where the interest off the accommodation bonds and so forth are made. It is worth pointing out that our site at Walcha, for example, we are effectively cross-subsidising from our other services. It actually makes a loss at Walcha itself. So we are effectively cross-subsidising that particular small rural service from our other services.

The Hon. PAUL GREEN: You talked about the need for more registered nurses. I am flabbergasted that there are not enough registered nurses to go around, so it is more likely the opportunity of what they are getting to do. Are you of a view that maybe there are some hurdles in the way for former registered nurses who have been out of the system, either parenting or doing some other career thing and they want to jump back in? Are you finding that there are big hurdles?

Mr SADLER: I am not so sure that they are big hurdles.

The Hon. PAUL GREEN: Do they exist?

Mr SADLER: There are hurdles. First, if you are a registered nurse you trained many years ago in the old hospital training system.

The Hon. PAUL GREEN: My kids consider I am no longer a nurse because I have not been in there.

The Hon. BRONNIE TAYLOR: I do.

The Hon. PAUL GREEN: Thank you.

Mr SADLER: I think there are hurdles that happen. If you were trained a long time ago and you want to come back in—you may have been out having your children—you now have to comply with continuing professional development requirements as a registered nurse that were not there a decade or more ago.

The Hon. PAUL GREEN: Do you think they are over-prescriptive if you were to come into the aged-care sector?

Mr SADLER: I think it is important that registered nurses as a profession are highly qualified and have rigorous professional qualifications that attach to them. They are doing a very important job and one that we as an employer organisation value highly.

The Hon. PAUL GREEN: My point is that some of those registered nurses could run rings around general practitioners in their expertise, yet they are sterilised from contributing even in, for instance, a level of aged care, which we have already heard you do not need that level of expertise every five minutes. You just need it available. That depth of knowledge and history and understanding is being sterilised from the aged-care sector for those who want to progress down this track because of the 10-week training course to get you requalified for something for which you are probably overqualified already. They could probably teach some of the lecturers in these cases. At the other end they obviously need to be brought up-to-date with practices and clinical processes.

Mr SADLER: I think there is always a balancing act here. You want the staff—and it is not just registered staff—to be well trained so that when they arrive and begin providing care to vulnerable older people they need to know what they are doing. That is critical. But by the same token you do not want to have hurdles, either for registered nurses returning to work or, indeed, other staff. I make that point in the submission that you do not want to put artificial hurdles that make it difficult for people to enter working in aged care. It is about getting the balance between those.

The Hon. PAUL GREEN: My final question is about elder abuse because we are seeing a bit more of this. I take on board the Hon. Sarah Mitchell's question, which was very good. What processes do you have to work through elder abuse from nurses, assistant nurses and enrolled nurses or any other healthcare professionals? How do you work through such a process if you find that someone is allegedly doing such stuff?

Mr SADLER: The first thing is when we employ staff we obviously look at what we can look at, which is criminal records information, as well as solid reference checking. We then have, as people arrive, training about elder abuse and about respect for older people, about the importance of reporting abuse if you suspect it. It is part of the initial training that all staff have before they commence work. So it is right up front that that is an important component. Then we have every attempt to instil in our staff a culture that if they do see anything happen they let us know about it, they let their supervisor know about it and there is then a policy that Presbyterian Aged Care has in place about how that is responded to and that, where appropriate, includes meeting reporting requirements that we have to the Federal Department of Social Services, the State Police and any other bodies that might require to be advised.

The Hon. PAUL GREEN: Obviously there will be a plethora of recommendations from this inquiry. In your great experience what would be the number one recommendation you would like to see in our report?

Mr SADLER: I personally believe the number one recommendation is to repeal the legislation, as I have said a couple of times now. But I think the other thing that is important for the Committee from the range of evidence you have heard is that none of us want to lose registered nurses from aged care. It is not what our organisation wants. Indeed, we want to encourage them. So out of all the evidence you have heard, if there are ways in which the State in cooperation with aged-care providers, the nurses and midwives association, universities, others can be working to encourage aged-care registered nurses, I am all for that.

CHAIR: Any ideas?

Mr SADLER: If you go to some of the issues that we have talked about in rural areas, if we can be encouraging greater cooperation between the health services, both New South Wales health services but also GPs—they might be employing a practice nurse and so on; cooperating with residential and community aged-care providers in their local communities so that we are sharing what is a scarce resource in the country, good quality registered nurses, that will be a very useful step. I think some of the technology that we have heard about also there are great opportunities for the State, Federal and aged-care systems to be working together to make better use of technology.

CHAIR: We have heard there is a shortage. We have not had many people talk about the need—you have identified that you do some cross-subsidisation between your different facilities. In terms of other opportunities for the State Government to lobby or take on the responsibility of some incentives or subsidies to get more RNs into those regional areas, do you have an insight into why we do not have more RNs? I am surprised that for all the talk about jobs for the future, I do not recall reading or seeing where we have had a government of any flavour that has sought to encourage job creation in the care industry throughout disability, aged, and child care. We talk about it but then we do not do much. We do not do much about the wages to encourage people into caring for our most vulnerable people. It is something that continues to surprise me. I wonder what your angle might be on that, particularly coming from a faith-based organisation.

Mr SADLER: I think it is interesting that when the SACS award debate was happening a couple of years back—indeed, the Gillard Government actually pushed through, and it was endorsed through Fair Work, the increase in the awards—the one section of people covered by the national award that did not get the increase was the home care workers who work in aged care. So the disability section, the social and community services section all got that increase but the home care section of that award did not. The reason it did not was because the Federal Government did not fund that part. It funded the rest of it but it did not fund the aged-care component.

There was an attempt by the previous Labor Government to have some funding that was linked to increases in wages and that was transferred by the incoming Coalition Government at the Federal level to an increase to the base subsidy that we received last financial year. It has been on that basis that our organisation has offered that very modest increase above the average wage increase for the sector. I know some of our colleagues, like UnitingCare, also offered some wage increases above the average that was being offered in the sector. It is a tough one because if we try and address wages without a funding response from government then you are putting it back onto older people to pay more to make up that difference.

CHAIR: That is right, and that is my point. I am interested that it has not been raised. Most of the submissions have been saying, "We can't afford this. We can't afford that". A few submissions have raised the fact that as a society the thing we should be doing is showing the appropriate level of care for people who are the most vulnerable, and that should be way up there and we should be looking at how to meet it. No disrespect intended but I just thought the faith-based organisations might push a bit more about our goals and our values in society and looking at the people that we rely on to do those really important jobs being encouraged.

Mr SADLER: We certainly have. Presbyterian Aged Care is part of the National Aged Care Alliance that has been pushing quite strongly for improved wages and a proper workforce approach. It is multifaceted. The question that I just got around registered nurse and training and so forth—there is no one solution to workforce; it is a very complex intersecting area: you have got international migration issues, you have got issues about are we offering jobs for people here in Australia. They are complex issues to address. But we have certainly been pushing nationally, along with other provider organisations, consumers, unions and professional organisations, that that workforce issue, including wages, has to be there as part of the solution to the future aged-care needs of Australia.

CHAIR: It is probably one of the most important conversations this country should be having rather some of the others.

Mr SADLER: Very definitely.

CHAIR: I think you have taken some questions on notice. You will more than likely receive some supplementary questions from members. Are you happy to take those and respond in 21 days?

Mr SADLER: Very happy.

CHAIR: The secretariat staff will be in touch with you. Thank you very much.

(The witness withdrew)

(The Committee adjourned at 2.52 p.m.)