IN-CAMERA **PROCEEDINGS BEFORE**

SELECT COMMITTEE ON THE PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

CORRECTED

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At Macquarie Room, Parliament House, Sydney, on Monday 22 February 2021

The Committee met in camera at 10:00.

PRESENT

The Hon. Courtney Houssos (Chair)

The Hon. Mark Banasiak (Deputy Chair)
The Hon. Greg Donnelly
The Hon. Wes Fang
The Hon. Daniel Mookhey
The Hon. Mark Pearson

PRESENT VIA VIDEOCONFERENCE

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Natasha Maclaren-Jones

The CHAIR: Welcome to the in-camera session of today's hearing of the Select Committee on the Provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020. Before I commence, I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respect to the Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginal people present. I will make some brief comments about the hearing today. Please note that, as this is an in-camera hearing, you are bound by the confidentiality of today's hearing. Depending on the matters raised today, including the confidentiality and sensitivity of issues discussed, the Committee may choose to publish today's evidence. If the Committee wishes to publish some or all of the transcript, the secretariat will consult with you about what is to be published, taking into account your privacy. However, the decision as to what is or is not published ultimately rests with the Committee.

Before we get started, I will cover a few key procedural points. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have the right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If you are unable to answer a question today and want more time to respond, you can take a question on notice. Written answers to questions taken on notice are to be provided within seven days. If you wish to hand up any documents, you should do so through the Committee's staff.

Evidence in camera by **WITNESS A**, Aged-care worker, Newmarch House, Anglicare, affirmed

Evidence in camera by **WITNESS B**, Homemaker, [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]], sworn

Evidence in camera by **WITNESS C**, Aged-care assistant, [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]], before the Committee via videoconference, affirmed

The CHAIR: Would you like to make a brief opening statement of a couple of minutes? WITNESS A?

WITNESS A: Good morning. I have been an aged-care worker, starting at [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]]. Then in May of last year, in the middle of COVID, I was signed up on the surge team for Newmarch House. I have been appointed at Newmarch House and working there since then.

The CHAIR: Thanks, WITNESS A. I think we will have plenty of questions for you this morning. WITNESS B?

WITNESS B: I am a homemaker for [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] at [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]]. I work 10-hour shifts. I have 23 residents in my section. All but two do not have personal care, but we still have basic chores that they need help with. Out of those 21 residents who do have care, there may be nine who are doubles. We have behaviour problems. We have a whole range of different things. When we are short-staffed, it impacts—it is unbelievable. Looking after the aged is not just about changing a pad. There is a whole heap of things, and sometimes we just cannot do it. We have got 10 minutes to answer a buzzer. The next person will be buzzing. If we do not get those buzzers answered within 10 minutes, then I will get an email: "Why was that buzzer not answered?" You can see people needing lifters to be able to get up have fear in their eyes as people rush as there is so much work to be done and just don't communicate with them or from poor training don't know how to communicate and are task focused.

We get agency staff. They do not communicate so good. They are not trained really good or they are doing their training whilst they are doing their agency shifts. We are having to train people as we go. We do not have the time. We are burning out. It is awful to see the fear in the eyes of 90-year-olds because they just want you to slow down and take the time, talk to them, and it is not always possible. People need help with feeding. I would love you all to come out and work with us for a day and experience it firsthand, because I can sit here and tell you—I could tell you lots of good things and lots of bad things, but if you just see it firsthand, it would be really, really good. I am 55 this year. We are all getting older. We probably have loved ones who need to go into aged care. God help us. If I had to go into aged care, how it is now, it would not be good.

The CHAIR: Thank you very much, WITNESS B. We are going to have lots of questions for you. We really appreciate those insights. Thank you. WITNESS C, did you want to make a brief opening statement as well?

WITNESS C: Yes, please, if I could. I am a 50-year-old assistant in nursing [AIN]. I am currently studying for my diploma of nursing. I have worked in regional aged care for approximately five years. We often work while short-staffed. On one occasion recently, we had four staff plus one registered nurse [RN] to 70-plus residents, all with varying degrees of impairment. These residents had to be fed, assisted to eat, assisted into pyjamas and assisting into bed. They did not receive showers, nor did we do any skincare. Although this degree of being short-staffed is rare, we more often than not just have to get the job done. None of the people I have worked with went into the industry, looking at it as just a job. If it were only a job, we would all leave and get jobs at supermarkets or Macca's and get paid more. We do what we do because we care.

Recently while on night duty, we had a 99-year-old resident fall. She was going to the toilet by herself because we did not get to her quickly enough after she had buzzed for assistance. She broke her clavicle and pelvis. Six weeks later she is still bedridden with a catheter. Her quality of life is zero, and she often expresses her wish to die. We did not have an RN on duty that night, so we did what we could for her, checked to make sure all the obvious injuries, head trauma or broken hips, were not there, before putting her back into bed to wait for the RN to come in a couple of hours later. It would have been beneficial to all involved if there was an RN on duty, but that would not have stopped the resident from falling. Having more than three care staff looking after 70-plus residents over two levels of a facility would have had one of us getting to her quicker, mitigating the need for an RN. Being proactive and stopping most incidents, wounds and falls relies on care staff having the time and the skills. It would be nice to be able to put cream to their skin before the RN is required to dress a skin tear or pressure wound.

Getting quality staff is hard, as the pay for the job that we do under immense time constraints and pressure is very poor. Adding to the difficulty in regional areas is that people often stop us in the street to inquire about a family member. We rarely get a break. Our personal lives are impacted, all for $24 an hour. We then have other problems, which are trying to be fixed. I think we are getting the medical restraint for dementia residents wrong. We have a secure dementia unit housing 20 residents. We recently had one resident spend three months in Wagga being assessed and having her medications changed. When she came home, she was happy. She was able to participate in her own daily living activities. Now her medications have been changed, as she is not allowed to stay at the same level of prescribed medications for an extended period of time. She is now back to the same depression and anxiety she suffered before she went. On Saturday she asked me to help her to die. Not only is it heartbreaking for the staff and family; it is heartbreaking for her. Thank you.

The CHAIR: WITNESS C, thank you very much for that very insightful and very moving opening statement. I will open up to the Committee.

The Hon. DANIEL MOOKHEY: First I also thank you for taking the time to appear before us today. I understand that these are some sensitive matters. WITNESS A, for how long have you been working in the industry?

WITNESS A: I have been there for three years with Anglicare. I was doing home care before that.

The Hon. DANIEL MOOKHEY: Right, so three years attached to Anglicare. Does Anglicare get to decide which facility you work in or do you have a input in that?

WITNESS A: When I applied for the job, they assigned me to [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] because they just opened a new facility. I did not have a choice on where to work. When I came to Newmarch, I requested a transfer because I wanted to stay on.

The Hon. DANIEL MOOKHEY: How did you end up being attached to Newmarch?

WITNESS A: I signed up for the surge team with Anglicare when COVID happened and then I was placed into the Newmarch House.

The Hon. DANIEL MOOKHEY: I presume the surge team is extra people who are required to be able to deal with the additional requirements.

WITNESS A: Yes. They wanted me specifically because I was with Anglicare and I know the routine. I basically know—because the agency case staff did not know anything about the residents or the routine to care for them so they wanted me to come on. I felt honoured to come and care for the residents there because I knew how to basically give the care for the residents and could give the agency staff an insight of what care is like for Anglicare.

The Hon. DANIEL MOOKHEY: When you say "agency staff", are you referring to people who have been sourced through a labour hire agency?

WITNESS A: Yes.

The Hon. DANIEL MOOKHEY: Do they have a direct employment relationship with Anglicare, to the best of your knowledge?

WITNESS A: No, they do not.

The Hon. DANIEL MOOKHEY: Are you still at Newmarch?

WITNESS A: Yes, I am.

The Hon. DANIEL MOOKHEY: You have been there for close to a year. Is that right?

WITNESS A: Yes.

The Hon. DANIEL MOOKHEY: Were you there at the time when the issues at Newmarch surfaced in the public domain?

WITNESS A: I was. I came in May, so it was in the middle of COVID. I believe the start or the end of March was when COVID came into Newmarch.

The Hon. DANIEL MOOKHEY: Can you give us a bit of an insight into what you observed at the time when there were all those issues occurring that impacted on you and the other staff?

WITNESS A: At that time during COVID, we did notice that the residents were not properly cared for because the agency staff came in. As I said, they did not know the routine of the residents. It was very hard to train up the agency staff as well as look after the residents at the same time.

The Hon. DANIEL MOOKHEY: I was going to ask you that. How many agency staff were present at the time?

WITNESS A: We work 12-hour shifts so there were about—we were assigned one care worker to three residents.

The Hon. DANIEL MOOKHEY: When you say that you were required to train them, am I right to infer that that is because they were not qualified or they did not have the same level of training that was required?

WITNESS A: They were quite undertrained. They basically did a test on how to be a care staff worker. They did not do anything physically to be trained. I did not have to train them, but I wanted to give them the knowledge and the know-how from a care staff worker—

The Hon. DANIEL MOOKHEY: So you just took responsibility for it.

WITNESS A: Yes, I did.

The Hon. MARK PEARSON: When the agency staff came, was it presumed that they were trained and ready do the work?

WITNESS A: Yes.

The Hon. MARK PEARSON: So was it more of an orientation and getting them to know how to care for specific needs of each resident?

WITNESS A: Yes.

The Hon. MARK PEARSON: That was the difficulty—and doing the work at the same time.

WITNESS A: Yes, that is right.

The Hon. MARK PEARSON: So nobody was actually appointed to train them on site in relation to the new residents or these residents that they were going to look after.

WITNESS A: No, I think the only training they got was from the agencies and it was just an oral training.

The Hon. MARK PEARSON: Did the training involve hands-on work?

WITNESS A: No, it did not involve hands-on work.

The Hon. DANIEL MOOKHEY: To the best of your knowledge, did any of them have experience in aged care prior to joining you?

WITNESS A: Some of them came from hospitals. That was the RNs. Mostly the RNs came from hospitals but not the care staff.

The Hon. DANIEL MOOKHEY: Is it wrong for us to infer that basically the agency sent whoever they could find?

WITNESS A: Yes.

The Hon. DANIEL MOOKHEY: So that is correct?

WITNESS A: That is correct.

The Hon. DANIEL MOOKHEY: So it is not much different to just finding a person off the street and putting them into an aged-care facility in terms of the care staff that the agency provided. Is that an accurate summation?

WITNESS A: Yes, because the management came from all of the country. A lot were from Victoria. But the care staff were mainly from the Sydney area. To me they were not qualified.

The Hon. DANIEL MOOKHEY: Did they have any TAFE qualification or any form of qualification to the best of your knowledge?

WITNESS A: I was chatting to quite a few of them and some did not even have certificate III.

The Hon. MARK PEARSON: I would like to talk about restraint with residents. I am aware that there is chemical restraint and other kinds of restraint which are now called restraint which may not have been before, when a resident is not actually able to get up from the bed or from their seating when they otherwise could. Is that kind of restraint occurring in the nursing homes in which you work?

WITNESS B: No, [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] has a no-restraint policy: no bed rails, no tables over chairs, nothing like that.

The Hon. MARK PEARSON: What about chemical restraint? Would you be of the view that chemical restraint is used to address difficult behaviours in residents that could have otherwise been dealt with if the staffing level were higher and there was more quality time with residents rather than basic needs and care? Do you think chemical restraints are used to deal with behaviour which is distressing as a consequence of some things you were talking about? How you cannot talk to someone—you are in a rush. There is fear in their eyes because they just want more contact.

WITNESS B: Definitely. There was a 90-year-old who had terrible fear when staff were getting her up in a stand-up lifter. Because she was short, she had fear of the short toilet commode. Staff were going in and rushing. Then I would go in with medication later and she would tell me all these fears. Then I would report that and say to the staff, "You have to slow down. You have to explain everything to her." I understand both sides. She ended up going onto an anti-anxiety medication and then just refused to get out of bed. Well, she is at end-of-life now. She gave up. She does not want to live.

The Hon. MARK PEARSON: Who prescribes it? Was it her specific doctor who prescribed the medication?

WITNESS B: Yes. It was her doctor.

The Hon. MARK PEARSON: This question could be for WITNESS C as well. Have you ever seen a specialist psychogeriatrician come to the units?

WITNESS B: Yes.

The Hon. MARK PEARSON: Do they mainly prescribe the medications and treatments? Or is it the GP?

WITNESS B: I could not answer that. We see the doctor come in. Then he would liaise with the family and the RN, I would imagine.

The Hon. MARK PEARSON: I will go to you, WITNESS C. You spoke about the incident where you thought that, if a registered nurse had been on duty that night, the lady who fell when staff could not get to her in time after she rung the buzzer—how would having a registered nurse make the outcome different for that resident?

WITNESS C: I actually do not think it would have made the outcome different. What we probably needed was more care staff. An RN there would have been better medical knowledge so that we would know whether to ship her out to hospital or not. But we really needed care staff to stop the fall.

The Hon. MARK PEARSON: I understand—correct me if I am wrong—that the critical need of a registered nurse, for example, in that situation where an elderly person has fallen is that there is a proper assessment. That needs to be done to make sure that the lifting of the resident and putting them back into bed or wherever does not aggravate any injury that has occurred. Is a registered nurse skilled to be able to assess that?

WITNESS C: That is correct. All we could do is know that she had not hit her head. We checked to make sure her legs were pretty much the same length, because that would show that she had done something to her hip if they were different lengths. What we really needed was an RN to go from top to bottom to double check.

The Hon. MARK PEARSON: Would that RN make your judgements more supported and certain and would you feel more confident in the way you were managing the resident? If the registered nurse is saying, "Look, I think there isn't an issue with the fracture of the femur", or something like that, "I think we can carry her in a certain way"—

WITNESS C: Definitely. We are not trained as RNs. It is a lot of responsibility on night staff, especially in my facility. We only have an RN by phone and we have to think pretty hard before we actually ring them. We cannot just ring them for any old thing.

The Hon. MARK PEARSON: What happens if you do ring them? What is the consequence when it is presumed that you have rung without necessity? What is the outcome? You seem to put the position that assistants in nursing are reluctant to ring the registered nurse. Why?

WITNESS C: It has to be for a serious incident that we ring them; otherwise we are expected to deal with it ourselves.

WITNESS B: We would also have to take observations, which would take care staff off the floor. We would have to take obs every 15 minutes, I think, for the first hour and every half an hour for the second and third hour until eventually the RN would say that is okay.

The Hon. MARK PEARSON: You are saying if a resident has a fall of that nature—

WITNESS B: Especially an unwitnessed fall, yes.

The Hon. MARK PEARSON: —then they have to have their observations taken every 15 minutes for an hour?

WITNESS B: Yes.

The Hon. MARK PEARSON: Then every half an hour for—

WITNESS B: I think it is two hours.

The Hon. MARK PEARSON: Okay.

WITNESS B: And then it goes on to three hours.

The Hon. MARK PEARSON: No other staff are brought in to cover that?

WITNESS B: No. Sometimes we will just leave a blood pressure cuff on them and keep coming back because we have got to continue. Then we will have to do a QUASAR and then all the paperwork that goes along with notifying family and so on.

The Hon. MARK PEARSON: How much time do you think you would spend on the paperwork as a consequence of that, let alone the extra observations? Can you give us a rough ballpark figure?

WITNESS B: The QUASAR would probably take at least 20 minutes to do.

WITNESS A: Can I just elaborate? Our restraints—as WITNESS B said they have taken off the bedrails. The residents who are bed-bound go to a Lo-Lo bed, which is on the floor, and they have crash mats next to them. A lot of that time the residents do fall out of bed and they do injure themselves. The policy at Anglicare is no bedrails because they would prefer a resident to fall out of bed and that is when care staff see them. As I say, they do have injuries even falling out of—because they are quite frail and they can break something. But it is always the care staff that have to put them back into beds, and if the RNs are not around we have to assess them and put them back. We are not RNs; we do not know what fractures they have got or what injuries they have got.

WITNESS B: Then, once again, if somebody gets a bruise then we have to do a wound chart—

The Hon. MARK PEARSON: Sorry, would you mind just bringing the microphone a little closer to you?

WITNESS B: We have the same kind of set-up; they go onto the crash mat. If somebody gets a bruise then it is photos, wound charts and skin assessments. Then we have to get two staff in to get a lifter to get them back up into bed.

The Hon. WES FANG: WITNESS C, you probably cannot see me on the camera angle you have. I am Wes Fang from The Nationals. I live in Wagga so I have got quite an interest in rural and regional aged care facilities, particularly because my grandmother was in West Wyalong for a very long time in the aged care facility there before she passed. I have seen rural and regional aged care facilities firsthand. I guess my [audio malfunction]—Is the audio working now?

The CHAIR: Yes.

The Hon. WES FANG: My apologies. WITNESS C, did you catch most of that?

WITNESS C: I did.

The Hon. WES FANG: Thank you. We thought we might have had some microphone issues. The bill itself is looking to put registered nurses in nursing homes effectively 24/7. But WITNESS B, I think from your

opening statement and some of the evidence you have given so far it is your contention that what would be of more assistance to you in your role would be more staff there immediately—

WITNESS B: More hands on.

The Hon. WES FANG: More hands-on staff would be of more benefit to the residents and the nursing care homes than having, for example, a registered nurse being on a higher pay at a more expensive cost to the facility.

WITNESS B: In the lodge where I work we have 58 residents and we have one RN. We have two homemakers—we are split into two levels. But if my section could have four hours extra of a morning that would make a huge difference. That would free me up to actually concentrate more on my job and therefore help the RN.

The Hon. WES FANG: In your opinion, WITNESS B, do you think having a registered nurse there full-time or having another on-the-ground support staff member like yourself to assist residents—what would provide more quality of care to the resident?

WITNESS B: Floor staff.

The Hon. DANIEL MOOKHEY: Surely we should also put the proposition that you could have both?

The Hon. WES FANG: No, I am just asking because I am now about to pivot to WITNESS C, if that is okay, with a similar question.

The CHAIR: Before you do, Mr Fang, I am just going to ask WITNESS B: Obviously Mr Fang posed it to you as an either/or. Would you prefer to have both?

WITNESS B: I would rather have two floor staff.

The CHAIR: Two floor staff and an RN as well?

WITNESS B: No, I would be happy with two floor staff.

The CHAIR: Okay.

The Hon. WES FANG: WITNESS C, I note again your opening statement, in which you talked about the incident with the fall of the resident. I think you indicated that if you had more floor staff assisting it is likely that you would have been able to get to her earlier when she buzzed to help her to the toilet, and that would have actually ameliorated the whole issue. Is that your opinion of what would have been of benefit to the residents?

WITNESS C: Definitely. If we had more floor staff we would not need an RN 24/7. I mean, it would be nice to have one there, but if we had the floor staff on the ground doing the work she would have never had a fall. A lot of the skin tears—we would not be rushed if we had more floor staff. All the little things that happen would not happen if we were not so pushed for time.

The Hon. WES FANG: In your opinion, if you had—I will just use some arbitrary numbers—if you could have the 12 hours of a registered nurse or you could have 24 hours of a care worker on the ground at a similar cost, would you have more hours of a care worker assisting you or would you rather have—for example, the value of a registered nurse would be X; I imagine that with those qualifications they would be required to be paid more than somebody who works on the floor. Would you prefer to have more hours of somebody working on the floor with residents or less hours with a registered nurse?

WITNESS C: Definitely more hours on the floor. We could have two care workers to one RN, as far as costs go, and we would not have anywhere near as many incidents.

The Hon. WES FANG: My last question: If the cost of a registered nurse was imposed on smaller communities such as West Wyalong or Young do you think that would either be absorbed be the organisation or do you think it would potentially be passed on to residents, in your opinion?

WITNESS C: In my opinion and in my experience I would say it would get passed on to the residents.

The Hon. WES FANG: Do you think that an increased cost of aged care would be a factor in people seeking that aged care, if it was more expensive to them?

WITNESS C: Definitely. We have some families already that—the partner, wife or husband that is left at home is devastated. They do not have enough money because pretty much one half of the pension goes to the nursing home. They are left living on absolute basics. They are still having to come into the nursing home and they assist us so much. It is incredible. We could not do without some of the family members coming in and

helping doing feeds. We have one staff member to 20 residents most of the time and that is including trying to feed them and trying to do all their basic daily living activities. We rely on the families to help us a lot of the time. So, they are paying a lot of money and still having to help.

The Hon. WES FANG: The people in rural and regional communities are often quite stretched in order to be able to provide the fees required for aged care facilities, are they not? It is not like there is a lot of fat in those rural and regional communities to be able to provide extra registered nurses if that was mandated.

WITNESS C: I think it would be a real struggle, yes.

The Hon. MARK BANASIAK: I have a couple of questions for you, WITNESS C. You mentioned that there is a reluctance to call the RNs and you only do it for serious incidents. Are there any parameters set within your facility about what is a serious enough incident to call an RN or is that just a line call from whoever the care worker is on duty?

WITNESS C: There are definitely parameters. If a resident has a fall and they hit their head, then we would definitely ring the RN. A lot of the problem with calling an RN is that, of a night time, we have three staff looking after 76 residents. They might be wandering the corridors. They go into other people's rooms because we are not allowed to lock the doors due to restraint. Ringing an RN is another set of paperwork that we have to do. They do not appreciate us ringing them during the night if it is not a serious issue. If it is something that they think could wait until they come in at seven o'clock or 6.30 a.m. the next morning, they get quite upset about us ringing them.

The Hon. MARK BANASIAK: What I am trying to gauge is if there is a written policy that sets out—I know you mentioned head injuries. Is there anything else where it would be an automatic call for an RN and it does not matter whether they are going to be cranky because they have been woken up?

WITNESS C: No.

The Hon. MARK BANASIAK: Is there a written policy that you could provide on notice?

WITNESS C: I do not believe so, no. If we think that we need to call an ambulance for somebody then we have to ring the RN and it is their decision. It is normally their call whether we get an ambulance or not.

WITNESS B: One of our clients was in a bit of a mess in the bathroom. I went in to say to his wife, "Come on down for dinner." I went in to help him. His wife has dementia and is aggressive—a few grabs and a few hits. I called for help to look after this man. He has an indwelling catheter. I noticed around his pubic area was really swollen, hard and very sore. He was in a lot of pain. I finished dressing him up, rang the RN at maybe a quarter to five and told her. I report everything because they are people. If they are hurt or in pain, they need attention. My job is to help them, so I rang the RN and reported it. She said, "Okay. I'm down at [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]]." There is one RN for [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] and [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]], so 58 becomes 78 or 80 residents. "I will do it when I come back." I finished at six, so I left. The next morning, I came into work. This little woman came down and said to me, "There is a man on the floor. Can you come up?" I said, "Okay."

I grabbed another staff member. I said, "Is it your husband?" She said, "There's a man on the floor." Up we went. As soon as I went to go into the room to help her husband—bang, bang, on your back. I tried to get the RN. We had to wait a little while. We were trying to reassure him and do a bit of a head to toe, to save the RN a bit of time. The wife was upset—her behaviours. He still had that problem. I said to the RN, "What was done about that?" She said, "Nothing. It was handed over to me to attend to it today." There were two staff in there with him, trying to keep his wife calm until an ambulance came. When I left at six o'clock that night, he was still in hospital. We had a lot of behaviours with his wife during the day because she could not go to be with him and staff could not go with her. They had been together for 66 years. That takes a lot of effort and a lot of time from everybody. So, we do report things, but they are not necessarily always followed up promptly.

The Hon. MARK BANASIAK: In an incident like that, do you think having an RN in both those two facilities would have assisted and that man would have potentially got treatment a little bit earlier?

WITNESS B: One would assume so, but I cannot be guaranteed that.

The Hon. MARK BANASIAK: WITNESS C, going back to something that you raised in your opening statement, you said that you think we are getting the medical restraint for dementia wrong. Can you just elaborate on that and where you think the system is getting it wrong?

WITNESS C: I understand that restraints get used inappropriately at times and that is due to a lack of staffing. Sometimes, instead of spending a bit of one on one time, pro re nata [PRN] chemical restraint is given because staffing is so low that they do not have the time to do the one on one and alleviate the behaviour. We do have residents who we have sent to Wagga for specialised treatment and appraisal. This lady in particular spent three months down there. They changed all of her medications to make sure she was right. She came home and she would sit on the veranda and she would read a book. She would come out all of her meals.

Now, because the restraint rules are that they cannot stay on chemical restraints for any lengthy period of time, they are now changing her medications without taking into consideration how happy she was. She is now back to crying. She is shaking. She is scared. She is scared to have a shower. She is having her meals in her room and we cannot get her to come out because she is scared. The other day she asked me to help her die. That is just a heartbreaking thing for somebody who cares for these people day in and day out. Her family cannot do anything about changing her medications back because the rules are there and the rules are being followed—but the rules are wrong.

The Hon. MARK PEARSON: Who set those rules?

WITNESS C: I believe it is a Federal rule, as far as I am aware.

The Hon. MARK PEARSON: Is it the nursing home policy?

WITNESS C: No. I believe it is more of a blanket policy on all facilities when it comes to restraint rules.

Ms CATE FAEHRMANN: Can I just ask a question of clarification on this issue? Basically you are saying that the three-month rule does not necessarily mean, "Get off all medications in those three months." It is a change of medications to something else. Is that what the rule is, or is it the fact that she is no longer on any medication and you are suggesting she needs to be on some?

WITNESS C: She still takes medication but they have reduced some, changed some, and now they have got it wrong. If she had have been allowed to stay on what she was on after the dementia experts had spent three months working it out, she would still be having a happy life where her daily life was nice for her. It has nothing to do with us. If she cries, I am there to comfort her, but it is her quality of life that has been affected by having her medications changed.

Ms CATE FAEHRMANN: I just wanted to explore this concept of not having RNs there, particularly at night. Does it seem like there is a barrier for nurses? You are suggesting that the AINs do not want to disturb RNs at night. Therefore, for example, if there were RNs on duty they would be going to attend probably quite a few more incidents during the evening than is the case now because of the reluctance of calling the RN—who, as you said, would prefer not to be disturbed in the middle of the night. Is that a cultural thing that is happening at the moment?

WITNESS C: I do not know that it is a cultural thing; it is just that we are expected to deal with everything that we can deal with. So we try to deal with an issue right up to the point where we realise that we cannot, and that is when we ring the RN. Like I said, it then becomes a time-consuming exercise. We have to do all the paperwork to justify phoning the RN, so that just takes more time off the floor.

Ms CATE FAEHRMANN: Would you quickly describe for the Committee what that paperwork looks like?

WITNESS C: We have to do a paper-based call-out form. We write in the reasons that we have called. We obviously have to get all the vital obs from a resident before we do it, which we would do anyway if they have had a fall. We do not do 15-minute checks; we do hourly checks for the first four hours, unless we are overly concerned and then we do them more regularly. Our rules are hourly for the first four hours and then shift obs—

Ms CATE FAEHRMANN: Is that the first four hours after the incident?

WITNESS C: Yes, so if you had a fall now we would take your obs now and then we would take them hourly for four hours. Then they would go to shift obs, so that is two times a day—three times a day after that for four days.

The Hon. MARK BANASIAK: WITNESS C, if an RN is already present in the facility is there less paperwork or no paperwork that is needed to be filled out, or is it that the RN would fill out that paperwork?

WITNESS C: If the RN is on duty and there, they fill out—well, there is no real paperwork. There is the incident paperwork so that if there has been an incident—somebody has fallen—we still have to do the incident report for that, but we do not have to do any paperwork for getting the RN.

Ms CATE FAEHRMANN: Can you outline what AINs can do in terms of care and what RNs can do in terms of care? Where is the distinction drawn? I am sure you can provide us with some documents in relation to this. When RNs are on duty, what do they do that you cannot do, legally?

WITNESS C: There is really not a great deal that we cannot do. The company that I work for—we have all the training for medications. We do the medications. If we need to give PRN pain relief to somebody, then we go through the RN. We get permission from them. We have to try everything else we can first, whether it be a heat pack or a massage. Whatever we can do, we have to try that first. Then we contact the RN to get permission to give PRN medication, which is when-required medication. Apart from that, we pretty much do the rest of it. Our RNs now are doing wound care, which saves us a massive amount of time. In that instance, they take that part of the work away, but all the rest of the hands-on care—we do everything. The RNs do not do any of it.

The Hon. GREG DONNELLY: Thank you all for participating today. I will go through each of the facilities one at the time in the order that you have given evidence to establish the current RN resource at the facility, on average, per day or per week—you can define it how you like, but in terms of the RN resources currently available at the facility. WITNESS A, does your facility employ an RN on an average day?

The CHAIR: I will ask you to tell me about the level of care workers as well.

WITNESS A: Basically, Newmarch is down to 67 residents from 102. Residents have passed away from COVID and other health issues as well. At the moment the RNs for each shift—morning shift is one RN, afternoon shift is one and on the night shift there is one.

The Hon. GREG DONNELLY: So in your particular facility is there an RN always on site? I think from your earlier evidence the RN is shared across two sites. Is that the case?

WITNESS A: No, just on one site.

The Hon. GREG DONNELLY: So there is an RN present 24 hours a day, seven days a week?

WITNESS A: Yes.

The Hon. GREG DONNELLY: WITNESS B, with respect to the facility where you work, what is the average allocation of RNs on a typical day?

WITNESS B: In my section, [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]]?

The Hon. GREG DONNELLY: Yes, the complete facility.

WITNESS B: Three, plus the deputy director of nursing [DON] is an RN and our manager is also an RN—so, three working.

The Hon. GREG DONNELLY: Are there times when there is no RN?

WITNESS B: Yes. In our facility, we have come in and there has been no RN. They could not get agency so we have had to call on the deputy DON to come over. She will come over and do the schedule 8s or S8s.

The Hon. WES FANG: An S8 is a drug that requires a prescription?

WITNESS B: In our facility—an RN and a homemaker to administer.

The Hon. GREG DONNELLY: If you take an average day where everything is running according to plan, what hours would there not be an RN?

WITNESS B: They have an RN 24/7. If they were short in [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]]—no RN—there would still be one in the nursing home. But they are busy of a morning. I have come in and there has been no RN, so I have just rang our director of nursing—"We need these S8s done."

The Hon. GREG DONNELLY: But that is giving you access to a registered nurse—a person with that qualification.

WITNESS B: Yes.

The Hon. GREG DONNELLY: Your evidence, then, WITNESS B, is that if things are working according to roster plans and there is no failure of the plan to be properly working, there is always an RN on site at your facility?

WITNESS B: Yes.

The Hon. MARK PEARSON: Can I just clarify something? If you are relying on the director of nursing to fill in for a registered nurse who is not there that day, that director of nursing would only do the absolute minimum requirement legally, such as signing off on the schedule 8 drugs.

WITNESS B: Absolutely. Yes.

The Hon. MARK PEARSON: That would be it, except for anything else absolutely pertinent. Then the director of nursing would go away and you would be left without a registered nurse in the facility.

WITNESS B: That is it.

The Hon. GREG DONNELLY: WITNESS C, in regards to the facility that you work at, what is the resource of RNs on an average day? In other words, what part of the day is covered and what part of the day is not covered by RNs?

WITNESS C: We have an RN there from 6.30 to 10 o'clock at night. From 10 o'clock until 6.30 the next morning we have one on call. So we can phone them, but we do not have one on site.

The Hon. GREG DONNELLY: When you say you call them, they are readily available, you ring them up and you direct your question to them? Or are there issues in calling them? And I think you alluded to that a bit earlier about a degree of reluctance, if I could use that phrase, to contact them outside those rostered hours.

WITNESS C: Yes, we stop and think quite seriously about whether we are going to ring them or not. They are not happy with us at all if we ring them and it is not something critically important. Sometimes we might have to try to ring them half a dozen times before they actually pick up the phone.

The Hon. GREG DONNELLY: I presume that there are advantages and you find there are advantages to be able to deal with an RN during the course of the rostered day hours, they are on site and you can deal with them, and that is an advantage to you as a carer to be able to deal with RNs and speak to them about matters, is that correct?

WITNESS C: Oh definitely, yes.

The Hon. GREG DONNELLY: What do you say? Do you think it is problematic that you are having to almost wonder whether or not you should even put the call through at night? Do you find that?

WITNESS C: Oh definitely. A lot of the times it is really out of our scope of experience or training, really. We have to make the decision on whether something is serious enough that we need to ring them. That is a responsibility on an AIN, we are only cert III, and there are only three of us. We do ring them if somebody is in pain and we need to give a schedule 8. We have got the authority to do it if we get the permission over the phone and we will ring them for that. Nobody likes to see anybody in pain, but, you know, it would be better if we did have an RN on duty 24 hours a day, seven days a week. It would also be better if there were more than care staff. Even just to ring them, that takes one care staff away from the floor to spend the time to ring an RN and get permission to do whatever we need or to get advice. So that leaves just two of us, and our facility is an 86-bed facility over two levels. Most of the time we do not even have time to catch the lift from one level to the other, we use the fire stairs.

The CHAIR: WITNESS A, you wanted to add to that?

WITNESS A: I do, yes. Anglicare are restructuring, we have been told in the past two weeks. They are going to be making care staff redundant, as well as RNs. As far as I know from Newmarch House, 21 care staff are being made redundant, as well as 17 RNs.

The CHAIR: That is at Newmarch House, 21 care staff and seven RNs.

WITNESS A: Yes, 17.

The CHAIR: Seventeen RNs and 21 care staff. Can I ask you about that, WITNESS A. You have obviously been told by the facility that is going to—

WITNESS A: No, not by the facility, through an RN.

The CHAIR: Through an RN?

WITNESS A: Yes. We do not get communication from management. We get told these things by word of mouth.

The CHAIR: Which is hardly an optimum situation to be in. WITNESS A, can you explain, you went into Newmarch House at the peak of the COVID outbreak there, there were obviously some pretty serious issues. You said at the time that there was one carer to three residents?

WITNESS A: Yes.

The CHAIR: Did you find that was about optimum for you to be able to provide that day-to-day care?

WITNESS A: In the section where I am still working there are two care staff for one resident. So, it was impossible for you to care to three residents on your own. You would always need someone to help you.

The CHAIR: Across the facility you said you have 67 residents, how many care staff do you generally have on?

WITNESS A: In the section where I am working there are 17 residents and all requiring double assist, and there are two on the floor.

The CHAIR: So you have the two care staff for the 17 residents?

WITNESS A: Yes.

The CHAIR: And you care together for the staff?

WITNESS A: Yes, and one care staff to do medications and there are five female residents that only require a female worker, and we do have male workers as well, so you will be required to assist with residents on your own.

The CHAIR: There are different complications amongst that?

WITNESS A: Yes.

The CHAIR: WITNESS B, you said that there are 23 residents in your section, but that is one part of the facility. How many residents in the total facility?

WITNESS B: In [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] there are 58.

The CHAIR: You reference the lodge then a nursing home?

WITNESS B: We have a locked dementia ward. There will be 20 residents in there. Then there is the nursing home. I think there is 30-something, I am not a hundred per cent sure. Then there is [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]], which is 26.

The CHAIR: We are looking at in excess of 100 people?

WITNESS B: One hundred and thirty-four residents, I think.

The CHAIR: The requirement currently is just that there needs to be one RN for those 134?

WITNESS B: I think it is 10.30 until 6.30, there is one RN.

The CHAIR: How about the care workers, would you be able to give us some idea?

WITNESS B: Overnight there are two in [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] for the 58 residents. So, there would have to be 20-something doubles. Then there would be one–I think there is one care staff in [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]], that is the dementia ward. Then I think there is one in the nursing home with the RN. Then that staff goes over to [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] and helps out. I think that is the way it is. Then one from [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] will go down and relieve one staff member in [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]], for them to have their break. So in fact that leaves one then in [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] by themselves.

The CHAIR: We are talking about a very, very low number of both care staff and RNs, particularly overnight and that has certain issues when you think about sundowning for dementia residents and the reason why a lot of these residents are in the aged care facilities in the first place is because families cannot do that overnight care. Is that accurate?

WITNESS B: And then when staff come in at 6.30 the next morning, a lot of people are lying wet, incontinent in beds. They could have opened their bowels, all wanting to get up. And that is not good for skin integrity.

The CHAIR: Absolutely.

WITNESS B: I helped a lady go to bed the other night before I went home. I helped her down with her pants and she saw all this snowflake, "Oh, what's that?" I said, "You know, I'm sorry to say but that's dry, dead skin cells." So, she has not been getting that skin integrity. I know it is only a couple of minutes, and I have said this to our manager. A couple of minutes here, a couple of minutes there, it goes on. We just do not have it.

The CHAIR: And that has profound effects on their health and quality of life.

WITNESS B: Yes. Skin gets itchy. That becomes a behaviour. Then it becomes C11, skin integrity charts, wound charts, because they might bruise themselves and it just goes on, and goes on, goes on, goes on.

The CHAIR: I have one more question then I will pass to Mr Mookhey. I wanted to ask you and perhaps start with you WITNESS B and if the others want to add to it, the increasing burdens on your time. Have you seen things like working in the kitchens, staff decreasing there and cuts to that or the quality of food? Can you explain a little bit to me about what are the challenges for you as a care worker in that space?

WITNESS B: A lot of the residents do not enjoy [EVIDENCE OMITTED BY RESOLUTION OF THE COMMITTEE [29 MARCH 2021]] food, who they employ to cook. Most of the time it looks pretty appalling. So then they will come to you, "I don't want that. What can you cook me?" I am limited to what I can cook them. I can cook omelettes and toasted sandwiches, because we just do not have—I just cannot get the eggs or whatever, to make sure that they eat. Because if they lose weight, then they become a weekly weigh. Then food charts, it is an ongoing process. But lately the kitchen staff, being nearly all agency and short staffed, then they are asking us to help them serve people in the dining room and to get the meal trolleys upstairs and all that. So, it does impact us a lot.

The CHAIR: In addition to your usual duties you are now being asked to provide additional assistance in the kitchens?

WITNESS B: Yes. I was asked to clean the downstairs kitchen oven yesterday, because they have a food audit on the twenty-third. I said, "Sure, we'll just add that to my list, no problem." I did, and then they asked me to do the pancake machine and I said, "No, I'm not doing that." I do not know how to do it, but you know. I do not understand why they know about these audits though. They rush around, clean everything. Even when accreditation, I have not seen accreditation come through our facility for quite some time, but when they do, we always have really good extra staff on, everything is spotless, everything is all hunky dory. I have been given my lecture on how to answer accreditation, maybe a couple of months ago, this is what is expected of you to say. But I have not seen them. I have seen no spot checks.

The CHAIR: Does accreditation come through about every three years?

WITNESS B: Yes, I think so.

The CHAIR: Mr Mookhey, unfortunately we are running out of time.

The Hon. DANIEL MOOKHEY: I will get straight to the point. Is the right summary of your evidence today that the entire system is under-resourced and under-staffed? In your view do you think the entire aged-care facilities that you are operating are under-staffed?

WITNESS B: Yes.

The Hon. DANIEL MOOKHEY: Do you think you are underpaid for the work that you do?

WITNESS A: Yes.

The Hon. DANIEL MOOKHEY: Do you think that the system profits from the fact that it does not pay you properly?

WITNESS A: Aged care is a non-profit organisation; that is how they are run.

The Hon. DANIEL MOOKHEY: I mean the way in which they maintain the cost control is to depress your wages. Do you agree with that?

WITNESS A: I agree.

The Hon. DANIEL MOOKHEY: Do you think that, if you were to have more staff who were better paid, we would have better care for aged-care residents?

WITNESS A: Absolutely.

WITNESS B: Yes.

The Hon. DANIEL MOOKHEY: What I am understanding is that, when there is not enough staff, be it care or registered nurses, the moment anything goes wrong, the entire system collapses. Is that basically what you are describing?

WITNESS B: Can you say that again?

The Hon. DANIEL MOOKHEY: Yes. In the absence of proper staff levels, the moment that there is any incident, be it a fall, be it a collapse, be it a person soiling themselves, the entire system delays and falls apart: Is that correct?

WITNESS B: Yes. It is a snowball effect.

The Hon. DANIEL MOOKHEY: And there is no shock absorber in the system because there is not enough care staff in the system. Is that correct?

WITNESS B: Yes.

The Hon. DANIEL MOOKHEY: Is it your view that, in addition to us considering registered nurses and mandating registered nurses, we should also be thinking about mandating certain staff levels for care staff?

WITNESS B: Hundred and fifty per cent.

The Hon. DANIEL MOOKHEY: Is it your view that there is an actually a dependence between care staff and registered nurses [audio malfunction] care staff? And for care staff to do their job properly they need enough registered nurses.

WITNESS B: Yes.

The Hon. DANIEL MOOKHEY: In your view are we lacking the proper number of care staff and the proper number of nurses?

WITNESS B: Yes.

The CHAIR: We will, just for the benefits of Hansard, say that that was agreement from all of the witnesses, particularly on those last three questions. I am very sorry, but our time has come to an end. We have actually gone a little bit over time. I sincerely thank you for coming to share your stories. We are very keen to get as much of this on the public record as we can, but the secretariat will work closely with you in determining what you feel comfortable with. I wholeheartedly on behalf of the Committee thank you for the incredibly important work that you do. I think WITNESS C said it is not just a job. We know that you could be paid better, working elsewhere, stacking shelves. But the work that you do is so important, especially in maintaining dignity in those final years of life. Thank you very much for your time today and for the work that you do.

(The witnesses withdrew.)

(Evidence in camera concluded.)

REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON THE PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Monday 22 February 2021

The Committee met at 11:15.

PRESENT

The Hon. Courtney Houssos (Chair)

The Hon. Mark Banasiak (Deputy Chair)
The Hon. Greg Donnelly
The Hon. Wes Fang
The Hon. Daniel Mookhey
The Hon. Mark Pearson

PRESENT VIA VIDEOCONFERENCE

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Natasha Maclaren-Jones

The CHAIR: Good morning, everyone. Welcome to the first hearing of the Select Committee on the Provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020. The inquiry is examining whether there is a need to have a registered nurse [RN] on duty at all times in nursing homes and aged-care facilities with residents who have a high level of care. In examining the bill, we will look more broadly at the need for further regulation, minimum standards of care and appropriate staffing levels in aged-care facilities, the potential for cost shifting onto other parts of the public health system and lessons from the COVID-19 pandemic.

Before I commence, I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respect to the Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginal people present today. Today we will be hearing from a number of stakeholders, including registered nurses working in the aged-care sector and NSW Health. While we may have some witnesses later on in person, our session now will be by videoconference. I thank everyone for making the time to give evidence to our inquiry. Before we commence, I will make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available.

In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments they may make to the media or others after they complete their evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2019.

I also remind witnesses that, if they are unable to answer a question today or they want more time to respond, they can take a moment or you can take a question on notice. We ask that written answers to questions taken on notice are provided within seven days. If you wish to provide any documents, then the Committee's secretariat will liaise with you to do that. I remind both Committee members and witnesses to speak into their microphones. As we have a number of witnesses via videoconference, identifying to whom questions are directed or that they are directed to the panel entirely is helpful. Those with hearing difficulties who are present in the room today, please note that the room is fitting with induction loops compatible with hearing aid systems and have telecoil receivers. Finally, everyone present should turn their mobile phones to silent for the duration of the hearing.

CATHERINE SHARP, Registered Nurse, CEO, The Wound Centre, Expert Witness, Expert Witness Nurse Consultants Australia, before the Committee via videoconference, sworn and examined

MAREE BERNOTH, Registered Nurse, Community Engagement Lead, Charles Sturt University, before the Committee via videoconference, sworn and examined

MARY GIBBS, Registered Nurse, NSW Nurses and Midwives' Association, before the Committee via videoconference, sworn and examined

Ms SHARP: I have been in self-employed roles since 1997 as well as working in numerous hospitals.

Associate Professor BERNOTH: I have been in the industry for 35 years.

The CHAIR: Thank you very much. Would you like to make a short opening statement, Ms Gibbs?

Ms GIBBS: As I said, I am here today as a registered nurse [RN] representing the industry of aged care. I have been nursing in both the private and public hospital system and in for-profit and non-profit aged care over my years. I have had senior leadership roles in the last 20 years. My last experience was recently during COVID, when our home actually experienced COVID and I had to implement a plan. Today I am representing the NSW Nurses And Midwives' Association. I had also participated in the skill-meets-workforce survey that was done a few years ago. The aim of today for me is, as a passionate RN who has been in the industry for a very long time and who has seen very many commissions, inquiries and outcomes promised but not delivered in respect to the safety and governance of the residents that we look after—I think it is very important that today's submissions are reviewed and any evidence that I can give from a first-hand experience be used to support recommendations of a proper skill mix in the workforce and mandated ratios at least to start the ball rolling. Because there are no regulations to help us provide the fundamental care that we need in aged care.

We have an unskilled workforce. Whilst it has some minor education, it does not have the skills required today to manage and work within an aged-care facility. The aged-care facilities are now all sub-acute units—extensions of sub-acute units from the hospitals with the complexity of the residents that are coming out of those facilities. We are getting early discharges and complex care. We are getting residents with behavioural and mental health issues. The junior workforce is not skilled to manage that. It is solely reliant on a registered nurse's ability to do clinical assessments and work with the general practitioners in the community. Today I really want to focus on and provide evidence in relation to the leadership and clinical supervision and also the need for a qualified and skilled workforce, because fundamentally, if we do not improve those, the industry will continue to not survive. The royal commission at the moment—we have already seen the interim report but hasten to see the final report. The fundamentals behind that are about skill mix and a lack of education.

We need to be treated as a part of and similar to the health system. My colleagues and I have always felt that aged care here is the second cousin to the health industry. We deserve the opportunity to be treated and provided with the resources that they have in the hospital system, particularly if we are expected to take sub-acute residents. Sub-acute residents are those that are on slow stream rehab. We have to put physiotherapists in place and do a multidisciplinary team. We have clinical pathways and polypharmacy reports. We are now mandated to have a registered nurse because of the infection control policies that have been put in place. They are directed to the registered nurses, not enrolled nurses or aged-care workers. I want the committee to be aware that it does not matter what position I have held on the front line as a registered nurse. I still provide care to the residents that they deserve, whether they are public, private, profit or non-profit. At the end of the day we need to do the right thing by the residents at all times. Thank you.

Associate Professor BERNOTH: Good morning. This is my fiftieth year as a nurse. Since 1985 I have worked predominantly with older people. I have worked in residential aged care, palliative care and acute care. I have been a senior nurse educator at a number of large aged-care facilities. I am also very much involved in research. I have worked in regional and rural aged-care facilities—in the facilities and the services. I have a PhD, a Master of Education by research and a Bachelor of Health Science in nursing. I was also a registered psychiatric nurse and a gerontic nurse under the older systems of level A and B nurses. I chair the Murrumbidgee Primary Health Network Aged Care Consortium. I am a member of the Australian Association of Gerontology and a member of the NSW Nurses And Midwives' Association. I have been at Charles Sturt University [CSU] for 10 years, focusing on trying to ensure that the nurses who graduate as registered nurses have a sound knowledge of ageing wherever the person is. To that end, we have written and edited a book to make learning about ageing more attractive.

We have an aged-care or an ageing well research group at CSU. We also have gerontic postgraduate courses for registered nurses. I have also submitted to a number of inquiries. My research career started with looking at abuse and neglect in aged care and, when I reported that to management, became the target of the abuse. I am very well aware of deteriorating standards. Unfortunately I have watched aged care go from a fabulous place to work to something that is challenging us all in Australia. What else do I need to say? Now that I am working at Charles Sturt University I am particularly interested in our rural and remote aged-care facilities and services. To that end we have been trying to support them through a transition-to-practice program and at two o'clock this afternoon we will submit a tender to the Federal Government initiative to provide a transition-to-practice program for newly registered nurses. I think that is enough from me.

The CHAIR: There is plenty of experience. I have no doubt we will have plenty of questions for you. Ms Sharp, would you provide us with a short opening statement?

Ms SHARP: I am a registered nurse, founder and CEO of both the Wound Centre in Sydney and Expert Witness Nurse Consultants Australia. I have been in that self-employed role since 1997, as well as working in numerous hospitals. I qualified in general and paediatric nursing in Sheffield in the UK in the 1970s. So I have been at it for longer than you, Associate Professor Bernoth. I hold several other qualifications including a Master of Clinical Nursing, Master of Public Health and a Master of Health Law from the University of Sydney. I am a PhD candidate at the University of New South Wales studying residents who died in residential aged-care facilities with pressure ulcers and who died at home as well. I was really honoured to be asked to speak at the aged-care royal commission at the Darwin Supreme Court in 2019 specifically on pressure ulcers in aged care.

Now I have a sizeable and ever-increasing workload through my business Expert Witness Nurse Consultants Australia because people sue healthcare facilities unfortunately. I have written many expert nursing reports for law firms in every State and Territory in the country. Many of the cases have involved the aged of developed pressure ulcers—but not just the aged as some are as young as 40—a foreseeable and preventable condition in aged-care facilities and in hospitals. The sad tragedy of this is that people who develop heel pressure ulcers often end up having an above knee amputation or both legs chopped off, which I cannot imagine at the age of 40 nor can I imagine it at 80. I cannot even see how an elderly person can manage with one leg or no legs. Why do I think it is important to have a registered nurse on site for visiting professionals?

Well, imagine that you have to have open heart surgery and your hospital tells you that they cannot afford to pay heart surgeons but there are a couple of very clever med students: "They will have a go. They will do your surgery for you. You'll be okay. Just sign here on this charter of rights." It is no different in aged care when we do not have trained, qualified registered nurses on duty [audio malfunction]. Firstly, registered nurses in aged care are educated about the Charter Of Aged Care Rights; the Aged Care Quality and Safety Commission's book entitled *Guidance and Resources for Providers to support the Aged Care Quality Standards*, in particular standard 8; the Aged Care Act 1997, section 3; and item 3.2 of the Australian Quality of Care Principles 2014 that ensures an air mattress is provided to those at risk of pressure ulcers. The talk about air mattresses is a whole other section, and I will not go into that now unless there is time later. Care staff will not be aware of any of these documents and it is not their responsibility to know about them. All those documents are huge; there is no time even for registered nurses to read them.

The CHAIR: Ms Sharp, I might just stop you there because I am mindful our time is going to run out very quickly this morning. I will pose a quick question to Associate Professor Bernoth to get us started. The inquiry has received submissions—and I know certainly in our previous inquiry we heard particularly from rural and regional aged-care facilities that stated they would go out of business if it they were to be required to have a RN on site 24/7. Can you provide us with any insight on that over your 50 years as a nurse but particularly in your role now at the CSU.

Associate Professor BERNOTH: Thank you for that question. Please be aware that I am not an accountant or a financial expert, and my husband will attest to that. About the issue of going out of business, I find that a little bit curious on a number of levels. Firstly, how do we know that when there is no transparency required of aged-care facilities? Except for those in Queensland, I believe, these facilities do not have to share with us their financials. We do not know how much they are spending on staff. We do not know how much they are spending on equipment. We do not know where our taxpayer money is being used. That lack of transparency does not enable—it means that the aged-care facilities cannot claim that they are going out of business. We need to see where their money is being spent and then maybe we can make some comment, but until then we cannot. That is the first thing.

Secondly, if that is so, why do we have so many aged-care facilities in rural areas that are doing very well? There are a number of aged-care facilities that I have worked with; I will not name them because I am not sure of the legal requirements but I am happy to provide those names to the Committee. But there are quite a few

aged-care facilities that have registered nurses and are doing very well. Recently I spoke to ABC Statewide Drive. They were interested in the aged-care facilities that are closing down. I was contacted by an accountant from northern New South Wales—I am also happy to provide his name in confidence—who told me that he had been able to work with a number of smaller facilities in northern New South Wales to take them from the brink of going broke to making them very financially viable. It is possible.

My question is: If the claim is I am going out of business because I have to have a registered nurse then why do so many other facilities work really well? A number of rural aged-care facilities have contacted us now they have found out we are applying for this tender for the transition-to-practice program because they want their registered nurses enrolled in the transition to practice program. They want to keep them in the facility and they want to provide them with a career pathway. Working with us, we can do that. If we have some that can, why can't all?

The Hon. MARK BANASIAK: I have two questions. I think one of the witnesses touched on people in the middle-aged bracket, around the 40s, being in aged-care facilities as well because of some difficulties they are experiencing. What is the percentage of people in aged care who would not necessarily traditionally fit in that "aged" bracket but are highly dependent?

Associate Professor BERNOTH: The audio is very, very difficult. It is not clear at all. Can I just ask who that question was directed to, please?

The Hon. MARK BANASIAK: Sorry, Associate Professor Bernoth. I will direct that to you to start off with and then see whether anyone else has any comments.

Associate Professor BERNOTH: Could you then repeat the question? I am really sorry.

The Hon. MARK BANASIAK: That is alright. The question is around people in aged care who are not necessarily in that aged bracket but have highly dependent medical needs that mean the only facility they can go in is an aged-care facility. I was wondering what is the percentage of residents that would fit into that category. Are we adequately catering for the needs of those people?

Associate Professor BERNOTH: Ms Gibbs, do you think that is a question that you could answer more appropriately?

Ms GIBBS: Currently in my experience we have probably 10 per cent of our residents who are under the age of 65 and we have some under the age of 50. Those residents really fall a lot under the NDIS scheme, which has now changed a lot to meet the requirements such as the aged-care provisions. We provide the same level of care to those residents at the time. The issue for them is the socialisation and the difference in the ages between the residents and those young people in nursing homes. The youngest ones we have seen are 40. We have nursed them because they have had very serious comorbidities and are not suitable for home placements.

The Hon. MARK BANASIAK: You talked about how we have not got the staff mix right. Would it be your submission that we not only need to look at increasing the number of registered nurses in aged care but also increasing the care workers as well, as we have heard from other submissions?

Ms GIBBS: I think, yes, basically you definitely need a registered nurse on shift. The care does not change 24/7. It is not a nine to five. The registered nurses provide that clinical governance and that strength and direction, and the ability to identify actions that need to be delivered promptly. With the skill mix that we have currently got—and because it is not mandated—we have got aged-care workers that have only had three to six months' experience. That experience is basically ticking the boxes and doing 120 hours of clinical practice wherever they have been sent. They do not understand the concept of aged care and gerontology. They do not understand the dementia reasons. They do not understand the behaviour management strategies that they have got to put in place.

The workforce that we have sees us as a stepping stone to other career paths. The junior aged-care workforce overall are seeing us as a stepping stone as they go on to another career. People such as registered nurses who have already qualified and done their postgraduate training before they come to us are dedicated to do the assessments and work for that. Enrolled nursing is another area that I have been debating about this morning. It is a model of care that I think would strongly support the requirements within aged care at the moment. The model of care has to be looked at to strengthen it for the care that we need to provide.

The Hon. WES FANG: Thank you to the witnesses for appearing today. My first question is for Associate Professor Bernoth. In relation to the testimony that you just gave from the Chair's initial questioning around rural and regional facilities, and the discussion around whether a 24-hour registered nurse would create

financial difficulties, you indicated that you require more financial disclosure from facilities. Let us assume for a minute that what they are saying is correct and that the provision of 24/7 nurses would have a financial impact on rural and regional facilities. Would you expect that cost to be borne by the organisations themselves, or do you think that cost could potentially be passed on to the residents? Secondly, as you are involved with CSU—and just for declaration, I live in Wagga Wagga, so I am regional myself—you would be well aware that the ability to recruit and retain medical staff, not so much in regional but certainly in rural and remote areas, is difficult. How would you imagine the requirements would affect those communities that are not readily able to have a registered nurse 24/7 because of staffing requirements?

Associate Professor BERNOTH: Great questions, thank you, and hello to a fellow Wagga Wagga person. To the first question about costing: I think of aged care and providing services to older people as a community thing and as a collaboration. I like the concept of working with rather than caring for. In all structures, we need to be working with—seeing aged care not as a competition but as a collaboration. If an aged-care facility in a rural or regional area feels that it is not managing—that it is not working things out—then how can we as a teaching organisation, you as a Government or other aged-care organisations work with that facility to help them, to support them and to try to provide them with some guidance or input? Rather than looking at where costing has to go, let us have this collaboration. People in the bush do that really well. Let us work together to support those smaller facilities. How can we do that? I am throwing the university in there as well. We all need to be in there. The primary health networks, the acute facilities—we all need to be in there helping.

As far as attracting registered nurses to smaller areas, we are trying to do that through the work that we do here at CSU, but it is a fabulous initiative that the Hon. Sarah Mitchell is doing with teachers. She is looking at valuing the teaching professional. Would that not be a fabulous opportunity to again work together and look at valuing registered nurses in smaller facilities? To get teachers to the bush, they get rental subsidies between 50 per cent and 90 per cent, $5,000 retention bonuses, $10,000 bonuses and 10 weeks' trial in the facility to see how they go. We can do that and we can provide them with a career pathway. Currently once nurses finish our Transition to Practice Program we then enable them to roll into our graduate certificates in nursing, management, teaching and research. Together we can do great things. I really am glad of this inquiry and of the ability to push my barrow about collaboration. People in the bush do that really well and we can teach metropolitan people a lot about it.

The Hon. WES FANG: I am very much liking what you have to say, Associate Professor Bernoth. My concern, though, is that—I certainly think that you paying credit to Minister Mitchell is appropriate, but I guess in that instance we are talking about teachers being employed in schools that in effect are run by government. What we would see in this policy would be aged-care facilities competing with other hospitals and medical facilities for nurses to be on staff. We have submissions here that nursing care for smaller facilities may be able to be provided by an on-call service, which reduces the burden of having somebody on staff and the impact on rosters et cetera that that provides. For those smaller facilities, do you think that having the same impost as larger facilities by having to have a nurse 24/7 is worth the flow-on effects that they may face by doing this—particularly for rural and regional communities? Would that potentially have an impact on people looking to open facilities into the future, given that they may struggle to find appropriate staff for a small town of a couple of hundred people?

Associate Professor BERNOTH: I will give you the example of Deniliquin, which has an aged-care facility on one side of the road and a hospital on the other. The hospital has nursing staff, palliative care staff, all of the specialties and education but the aged-care facility is not allowed to engage with that at all. That is a really good example of how we could be working together. Why does a road prevent older people from having services that they deserve and need? Why can we not collaborate? I know that the Federal Government funds aged care and the State Government funds acute care, but surely working together is a great way to prevent old people being admitted to acute care. If a registered nurse from the acute facility could walk across the road and provide some advice about pain relief, swallowing problems or whatever then that would be a great way to work together to ensure the older person gets the care that they need. Can we not have consideration about that sort of cooperation in our smaller areas? Do we dismiss that out of hand, or can we think about it?

The Hon. WES FANG: So we should possibly be looking more at how we can better utilise and connect existing services than mandating that smaller rural and regional communities have a 24-hour nurse.

Associate Professor BERNOTH: Yes. The Murrumbidgee has the Primary Health Network Aged Care Consortium. We have a community of practice where all of the aged-care facilities and managers get together and share. They share what is going on, they share initiatives and the Primary Health Network supports them in various ways.

Ms GIBBS: In the metropolitan area, we network exactly the same way. We work closely with the Geriatric Flying Squad. We use them as our ports of consultation and education. We work with Calvary Hospital. We with the palliative care clinicians. It is collaborative. When we had the COVID experience the networking that we had to put into place here was conducive—it was so well done between the collaboration of a primary health nurse, the aged-care flying squad, the home itself and the Government as well. We all worked as a team to contain the outbreak that I had in my home. That required a lot of work effort and planning from a registered nurse and a lot of dedication to the point where our staff actually slept here overnight to ensure that the services were provided 24/7 because of the impact of COVID.

But I think what the professor is saying is correct: The relationship should be able to happen in the rural area just as it happens in some of our Sydney local area health services. I can say that South Eastern Sydney has a tremendous model that works extremely well with the aged-care facilities. We virtually reduced our planned admissions to other hospitals because we bring the hospital to here. So, we try and do our best but I do support the idea of a collaborative approach for the rural area if the decision was made not to have registered nurses 24/7 onsite. There needs to be that partnership for 24/7 from the hospital.

The Hon. MARK PEARSON: Thank you very much for attending. I will move closer to the microphone. Can you hear me, Professor Sharp? Can you hear me, Catherine Sharp?

Ms SHARP: I am sorry. I still cannot hear. I think I heard my name but I do not know what the question was.

The Hon. MARK PEARSON: Okay. This question is to all of you: Would you agree that the monitoring of medications given to elderly residents is a complex area and needs supervision of a registered nurse?

Ms SHARP: Absolutely. I would like to make a short comment on that. I was in a facility doing a Wound Care consult. This is not just one time, but this has happened several times. I saw a careworker—no registered nurse in sight—had popped all the pills out of everybody's Webster-paks into little pill pots. You cannot do that. The Webster-paks have the residents' names on and the morning, lunch-time, evening medications. Why would anyone think that it was faster or better to pop them all out? This careworker went around to a bunch of demented residents in a locked up dementia ward and just handed out pill pots. I said to her, "You know I am a registered nurse. I have to report you."

I do not believe this would have ever happened if a registered nurse had been in that ward, in that part of the building at the time, but we do not know who got whose meds and, you know, who might have died overnight and it was considered an expected death. So I reported that careworker to the Director of Nursing but the same thing happened in the same ward just a couple of days later and I said again to the girl—because they all knew I am a registered nurse—"I have to report you. This is so dangerous." But I was saying I do not believe that that would happen if a registered nurse was overseeing. Nobody would be popping out all the Webster-pak pills into pots.

The Hon. MARK PEARSON: Would you say that a lot of these medications, because the person, the resident, often already has brain damage of some kind, whether it be dementia, Alzheimer's disease or any other sort of trauma to the brain, therefore the way the brain responds to typical medications like antidepressants, anxiolytics, et cetera, can be very confusing or very complicated? For example, to see a resident who might be exhibiting different symptoms to the usual, and that could be a delirium from an anticholinergic reaction to some of the medication, would it be the case that a registered nurse would know when to withhold medication—

Ms GIBBS: Correct.

The Hon. MARK PEARSON: —where an assistant in nursing would not? I am not saying anything negative about assistants in nursing. I am just talking about the skill of training.

Ms GIBBS: You are right. May I answer that from a registered nurse's point of view? At the end of the day the responsibility for any medication under my shift is mine. It does not matter what—if it is an enrolled nurse or an aged-care worker. The way that the medication is administered within aged-care facilities is generally through a Webster-pak or a sachet. The principle behind those is so that the person administering it, if it is an aged-care worker, does not necessarily need to know what the drugs are but they have just got to give the drugs there. But for a registered nurse, we understand. We tick the medication charts. We are familiar with all the drugs. We know to take their blood pressure before they take their blood pressure tablets in case they are hypotensive. We know that if they have got heart arrhythmias to take their pulse for the digoxin. We know to do the blood sugar levels for insulin.

As I was saying earlier when I started about the complexity of the residents that are coming through, there are on multiple medications. Some are oral and we have to crush them. Some are given through an infusion and we have the palliative care crisis medication. So we are dealing with S8 and S4 drugs—scheduled drugs—through a syringe driver and we are aware of the side effects and the monitoring that is required. For example, you raised the issue about a resident with dementia being commenced on a new psychotropic drug. Currently the standards that we have through the Aged Care Quality require us to monitor these, put in a monthly report and look at the indications. We had to watch them for 28 days once they commence the new medication, looking for changes in their behaviour: Is it effective? If it is not effective, what have we done about it? How are we recording it? The escalation process with the GP and the consultation with the family. The residents, if they have some form of capacity, we invite them to have the feedback, but we are responsible at the end of the day for all that monitoring of the medications that they receive.

So it does not really matter who gives the medication. At the end of the day I go home worried that I—making sure that I signed off that every resident has received medication. Now the argument has been that errors happen even if the registered nurses give them. That is correct. I am not downing that, you know. But what I am saying is that we have the ability to identify if we have made an error quickly. We have got the ability to assess and the ability to escalate straightaway and not wait for the adverse outcome of the resident to be escalated. So, again behaviour management—this is a key focus of our standards and requirements, and also with antimicrobial stewardship. This is part of the clinical governance again. It comes back to a registered nurse to coordinate the antibiotics, make sure that residents are not given antibiotics unnecessarily, that we record these documents and we look at the sensitivity. All of this has to be done before we actually administer the medication. We do not just rely on the prescription. To give out medications, it is a really big component and it is within our scope practice whereas this might be a level of a Certificate IV or a Certificate III giving the meds and just giving the prepping, there is a lot more to just handling the medication. What they technically do is assist with medication.

The Hon. MARK PEARSON: That is very helpful, thank you. I have just one quick question to Ms Sharp, if you can hear me? In your study that you did in relation to pressure sore or pressure care of heels which related to the removal of half a leg—can you hear me?

Ms SHARP: Yes, sort of. Which paper are you talking about?

The Hon. MARK PEARSON: You referred to a study that you did, which was looking at pressure care of heels of residents which led to amputations of legs or halves of legs. Correct?

Ms SHARP: Yes.

The Hon. MARK PEARSON: You indicated that some of those amputations could have been prevented. Would you say that if a registered nurse was in the facility 24/7, the nurse's supervision would help to prevent the pressure sore from occurring to the extent leading to amputation?

Ms SHARP: I have no doubt. This happens in hospitals as well, where patients are left with their heels on a bed. They may have no feeling in the heels because they have diabetes and peripheral neuropathy. Tissue death can start as soon as after half an hour of unrelieved pressure. The cases I have done that I was referring to are those medico-legal reports that I have written, which I have been asked to write because pressure ulcers are foreseeable and preventable. A registered nurse would or should know that they can access a really good alternating-pressure air mattress the minute the patient is admitted or even before the patient is admitted so they have got this mattress on the bed. It has to be a specific alternating-pressure air mattress with side formers. I will tell you about those in a while.

If they are on one of these, then they have complete pressure relief to the heels and all parts of the body every few minutes throughout the 24 hours. One study I did with another aged-care consultant a few years ago we presented at the aged-care royal commission in Darwin. We were able to, over a period of weeks, have no pressure ulcers whatsoever in this facility, and they were all at high risk. I know it can be done. I have done it in several facilities over the years. I have been in 200 or 300 aged-care facilities since 1997, trying to bring in good alternating-pressure air mattresses to prevent pressure ulcers. They will prevent them. I do not want to be 80 and have an above-knee amputation.

The Hon. GREG DONNELLY: Thank you all for making yourselves available to participate in this inquiry. My question is a general question in its nature. I will direct the same question to each of you, because you bring high levels of experience to this area, and allow you to answer it as generally as you can. What are the key disadvantages faced by aged-care residents who do not have access to onsite RNs compared with those who do? We have a situation of a facility that has 24/7 availability of registered nurses working in conjunction with the carers, and then we have other facilities, which do not have that 24/7 RN access. What are the key

disadvantages for the residents in those facilities that do not have that 24/7 RN availability that you apprehend? Perhaps we will start with Associate Professor Bernoth.

Associate Professor BERNOTH: Thank you for your question. In the research that I have done where I have spoken to people where there is not—it is not just not having RNs but also not having sufficient RNs. Having RNs tied up in an office or an RN who is responsible for 160 residents is going to have the same impact as not having an RN there at all. We have already talked about medications. Medications are packed in a chemist's shop but not by a chemist, so there are huge errors before the medications even get to the older person. There are issues there.

The other thing is that aging brings about a number of physiological changes and those physiological changes mean that pathophysiologies or illnesses do not present in the same way as they would to a younger person. So it takes a skilled registered nurse to be able to assess an older person and see if they has a delirium, which is treatable, or dementia. The issue there is that failing to identify and address a delirium can lead to serious illness—sepsis, for example—and death. An untrained person will have difficulty with differentiating between delirium and dementia. The other really sad thing is that not having registered nurses there and overseeing what is happening—we hear so much about dehydration and malnutrition in aged care. We know that, whatever food is provided, a lot of residents, if they need assistance, often do not get their food.

Another issue for me is that people who have dementia are trying to communicate in ways that are foreign to an unskilled person. We need to be really skilled in being able to identify that. Challenging behaviour or an angry outburst could be caused by pain or distress or an inability to communicate a need rather than a need to be restrained physically or chemically. Being able to communicate effectively with a person with dementia, who cannot communicate effectively, is something that a skilled registered nurse can do. Other staff may not have the skills to intervene. Hence we have more risperidone and more angry and sedated people with dementia. I will stop there and let the others have a go.

Ms GIBBS: I support everything that Associate Professor Bernoth has said. I think it is really important that we also look at what is happening in our industry now. We have a regulated body in respect to the aged-care quality commission. They have changed their recent standards to look at the clinical infrastructure, focus on risk management, focus on complexity of residents, how we work with those residents. A registered nurse is ultimately the prescriber of all of that, the coordinator, the collaborator with all the other disciplines to ensure that we provide the care that needs to happen. We also look at the risk management point of view. The expectations of the quality agency for the infection control program now—we have all been mandated to have a registered nurse as our infection control leads. One nurse per home is dedicated to that role on top of everything else that they have got to do. We do a lot of admin duties. We do a lot of work planning. We look at the skill mix. The RN on site compared with an aged-care worker—when we come on, we look at what is happening across all our levels to ensure that we have the appropriate skill mix across all floors.

The reliance on unregulated staff creates a lot of issues. And we have seen—and I think it will come out on the twenty-sixth of this month, when we publish with the royal commission report—the amount of neglect, isolation, the poor care outcomes. Even if there was a registered nurse in, there was not the sufficient support in the back for these teams on the floor to understand, as we said, the dementia behaviours. I have recently undertaken training for one year with Dementia Australia to look at that complexity and how we can change the model for care, because I need to educate my workforce to understand simple behaviour management strategies. So I think it is very important that we do not substitute the aged-care workforce for a registered nurse.

A registered nurse is essential. They are the ones that are called upon all the time, even doing it remotely, giving that consultation. The families expect to be given that care. That is a part of their expectation. When they come into a home, they are extremely disappointed if there is not a registered nurse able to address them. I take the calls after hours. I am up at midnight or 2 o'clock, taking all these calls, because I need to provide that sound clinical judgement and support the teams that are on the floor. So there is a lot of pressure on the registered nurses. I think not having a registered nurse on the floor will mean that we will continue to see what we have seen come out of the royal commission's interim report. So I do not think substituting or replacing—aged-care workers definitely have a value to the industry; I am not saying they do not. But they do not have the skill set to be able to manage a clinically deteriorating resident or redirect resources to manage a situation that is occurring.

The Hon. GREG DONNELLY: Thank you. Ms Sharp, did you have anything to add about disadvantages for facilities that do not have an RN 24 hours a day, seven days a week?

Ms SHARP: Our registered nurses in aged-care facilities know all about the Aged Care Act 1997. They can actually do something about this. For decades aged-care facility residents at risk of pressure ulcers have been

repositioned every two hours throughout the 24 hours, sometimes for months and years on end. The downsides of being repositioned are that it will not necessarily prevent pressure ulcers and that it keeps residents awake. They are so sleep-deprived that I have seen them asleep at the breakfast table; they are asleep on bus trips. They become angry. There are challenging behaviours. A registered nurse will be able to order an alternating-pressure air mattress to be delivered quick as, whereas the care worker will not. They do not have that authority. One particular mattress, which is outstanding in aged care, costs $1.40 a day to rent. That's all: $1.40 a day. We are not looking at thousands of dollars. But they will prevent pressure ulcers.

There is a chap in Queensland called Nicholas Graves, who showed the cost of pressure ulcers in hospitals and aged-care facilities to total $1.65 billion. Even though I am not here talking about costs, that is a huge amount. That is not even looking at the surgical care that is required when somebody does develop a huge sacral or heel pressure ulcer. Even in 2019 the Clinical Excellence Commission reported on pressure ulcers in aged care, mainly on the sacrum and heels, yet they are foreseeable and preventable. This makes up a huge amount of my expert witness nurse business, which is very, very sad.

The CHAIR: Thank you very much, Ms Sharp. I apologise. We are rapidly running out of time. We only have a few minutes left. So I am going to pass to my colleague Mr Mookhey.

The Hon. DANIEL MOOKHEY: Thank you for all of your appearances and for sharing your sesquicentury of experience in nursing with us. I know very little about it and certainly could not match your expertise whatsoever, so I am going to ask really basic questions here. I presume that the basis of your argument is that everybody is entitled to first-class aged care. Would you agree with that?

Ms GIBBS: Yes.

The Hon. DANIEL MOOKHEY: Some people have been making fleeting references to the interim report of the royal commission, which has found that we are not currently providing people with first-rate aged care. Would you agree that that is an accurate summation of the interim report?

Ms GIBBS: Yes.

The Hon. DANIEL MOOKHEY: Is part of that because the system is understaffed and under-resourced in general?

Ms GIBBS: The aged-care industry is not a well-resourced structure. It lacks a mandated structure of the minimum required. If you compared us with a hospital, you would see that we do not have the requirements of mandatory training to the extent that the public sector does. We do not have the guidelines that say that you must have a minimum of X amount of staff. I do not always agree that having an exact number of staff per floor is the right answer; it is about the quality and the skill mix of your staff. We have an unregulated workforce that holds no accountability. We as registered nurses come in and take on that extra level of burden because the staff who work underneath us do not take any accountability. They have a scope of practice that they have to abide by, whereas we have our Australian Health Practitioner Regulation Agency registration, which has a lot of complex domains in it. I think it is really important that we start being looked at. Like I said early in the piece, we are a subacute unit. And I can guarantee you—

The Hon. DANIEL MOOKHEY: I understand that and the point that you are making. Just in the interest of time I am going to try to go through this relatively quickly just to see if we can get the evidence in. Your basic argument is that, to turn around the systemic underperformance of the system, we have to invest more in the quality of both care staff and registered nurses and enrolled nurses. Is that correct?

Ms GIBBS: Yes.

Associate Professor BERNOTH: We also have to look at the way standards are monitored. I think the Aged Care Quality and Safety Commission has let us down badly. They are one of the reasons that we are where we are at. We need to have a whole other look at how we maintain standards. That is supporting our aged-care workers, not hitting them with a big stick.

The Hon. DANIEL MOOKHEY: I want to now open up and return to this issue that my colleague Mr Fang was raising, which was about the cost of turning around systemic underperformance to be able to increase investment in both care staff and registered nurses. One of the propositions that Mr Fang put was that that would have a price impact. But listening to the rest of your evidence, I could not but help notice that you are effectively arguing that earlier investment at this level saves the system money at the acute level. Is that a correct summation of your view?

Ms GIBBS: That is correct.

The Hon. WES FANG: Point of order—

The Hon. DANIEL MOOKHEY: I am just putting the proposition.

The CHAIR: No, Mr Fang. I gave you wide-ranging latitude to ask a lot of questions. I am going to allow Mr—

The Hon. WES FANG: I am just raising a point of order, though.

The Hon. DANIEL MOOKHEY: What is your point of order?

The Hon. WES FANG: I think the Hon. Daniel Mookhey has put words into my mouth. I think that he is certainly entitled to put a question—

The CHAIR: What is your point of order?

The Hon. WES FANG: I do not believe Mr Mookhey has correctly represented what I asked of the witness originally.

The CHAIR: That is not a point of order. I am going to allow Mr Mookhey to continue. I am also going to say, Mr Fang, we do not need to head down this path.

The Hon. DANIEL MOOKHEY: Basically your argument is that, if we were effectively reallocating resources towards the actual aged-care facilities and not the hospitals, we would actually be in a position where we would be providing better care and care which was more cost-effective. Is that the correct argument? Am I understanding that correctly?

Associate Professor BERNOTH: That is a question to us, I assume.

The Hon. DANIEL MOOKHEY: Yes.

Associate Professor BERNOTH: It is again very hard to hear. None of us are making any comments about the acute system. Again this competition—we are not saying deprive one to feed the other. We need to have a look at the whole system and have a look at this transparency with finances: Where is the money going? Is it being spent in the most effective way? It may not be that we need more money; we need to do things differently, perhaps. But until we see where money is going, we cannot make comment about what extra financial support these facilities need. Let us get some transparency happening, please.

The CHAIR: Associate Professor Bernoth, I am just going to stop you there. I am going to give Mr Mookhey one last question, because we are quite over time.

The Hon. DANIEL MOOKHEY: My final question picks up this point. To turn around the system at a systemic level requires collaboration between aged-care management, the registered and enrolled nursing components, as well as the care staff, and the system needs to be reorganised to reflect that collaboration. Is that the take-home of your evidence that you are giving us?

Associate Professor BERNOTH: I would also say that we need to be collaborating with the wider acute systems, the primary health networks, the other community services, with Government, the university system, the VET system. We need to be working together to make sure we are enhancing this system. Also we need to hear what the royal commission's recommendations are.

The Hon. DANIEL MOOKHEY: Basically we have to stop thinking of aged care like an afterthought.

Associate Professor BERNOTH: I didn't hear that.

The Hon. DANIEL MOOKHEY: That we have to stop thinking about aged care as an afterthought to the health system. That is your argument.

Associate Professor BERNOTH: As a—sorry—to the acute system?

Ms GIBBS: I suppose I have always said that aged care is the poor cousin to the healthcare industry. That is what you will sense from a majority of registered nurses who have been in the industry for a very long time. We have been overlooked so many times. This is the outcome that you are going to see and will continue to see.

The CHAIR: I am mindful of time. We have gone over because your testimony has been so valuable. I am going to put a series of quick questions to you. I think some of the other members might have some questions on notice. Can I just ask you for a yes or a no. A lack of a registered nurse leads to poorer health outcomes and unnecessary hospital admissions. Would you agree with that?

Ms SHARP: Yes.

Ms GIBBS: Yes.

Associate Professor BERNOTH: Yes.

The CHAIR: We have yeses from all witnesses. Do you agree that there is a need for more care staff to undertake work such as preventing falls and that that would then allow registered nurses to utilise their clinical skills and their expertise?

Ms SHARP: I really cannot hear anything that you are saying.

Ms GIBBS: It is hard to understand what you are asking.

Associate Professor BERNOTH: Are you asking—

The CHAIR: Would you agree that there is a need for more care staff to do work, including preventing falls, that would then—

Ms GIBBS: No, I am saying we need more skilled workforce to do it. You can have as many staff as you want, but that does not necessarily mean the outcome is going to be better. It is about the skill mix.

The CHAIR: We need a skill mix. I understand that.

Associate Professor BERNOTH: It is the registered nurse's assessment skills of the patient that will prevent the falls.

The CHAIR: That requirement for a registered nurse does not end at 6.30 p.m. In fact, it is actually exacerbated by things like sundowning in dementia patients. Is that correct?

Associate Professor BERNOTH: That is correct.

Ms GIBBS: That is right, yes.

The CHAIR: Do you think a single RN for an entire facility, which can number up to hundreds of residents, is enough to provide appropriate clinical care?

Associate Professor BERNOTH: No.

Ms SHARP: No.

The CHAIR: Unfortunately, we have gone well over time. Thank you so much for sharing your expertise with us today. We may have some follow-up questions for you as a result of your testimony today. I also thank you for the incredibly important work that you do in a sector that is, unfortunately, undervalued by our society. You are certainly at the cutting edge of it and your incredible expertise has been well utilised by the Committee this morning. Thank you so much for your time.

(The witnesses withdrew.)

(Short adjournment)

NIGEL LYONS, Deputy Secretary, Health System Strategy and Planning Division, NSW Health, sworn and examined

The CHAIR: Would you like to start by making a brief opening statement?

Dr LYONS: I do have a brief opening statement. Thank you very much for inviting me to discuss NSW Health's position on the bill. Firstly, I would like to acknowledge the traditional owners of the land we are meeting on today and pay my respects to Elders past, present and emerging. It is critical that people living in residential aged-care facilities in New South Wales and across Australia have their clinical care needs met by skilled and appropriately trained staff. Under the Aged Care Act 1997, responsibility for the regulation of residential aged care rests with the Commonwealth. Despite significant reforms in aged care and the introduction of the new aged care quality standards, the regulatory instruments do not currently adequately address the need for appropriately trained staff to deliver clinical care.

NSW Health has consistently advocated to the Commonwealth, through appropriate forums and relevant submissions, that clinical care should be delivered by appropriately qualified clinical staff. We have also retained legacy legislation, as you know, which imposes the requirement for facilities that provided high level care prior to July 2014 to have at least one registered nurse on duty at all times. We have done this because we have recognised that the Commonwealth regulatory framework still requires strengthening. We have seen the impact of this during the recent hearings of the Royal Commission into Aged Care Quality and Safety. On behalf of the New South Wales Government, NSW Health has responded to numerous requests from the Royal Commission into Aged Care Quality and Safety through formal submissions and providing direct evidence at a number of hearings.

We have advocated, in particular, around the need for improvements in the interface between the health and aged-care systems, as well as the criticality of enhancing primary care access for aged care residents and also the interface with the disability care system—particularly relevant for younger people living in aged-care facilities at the moment. As part of those interactions, we recognise that access to registered nurses in residential aged-care facilities is currently inadequate and needs improving. For the reasons outlined in NSW Health's submissions to this select Committee, we are of the view that it is the Commonwealth's responsibility to implement a nationally consistent approach. New South Wales notes that the counsel assisting the royal commission has provided measures to introduce mandatory 24-hour, seven-days-a-week registered nurses in residential aged-care facilities across Australia.

With the final report due by 26 February 2021, we believe this Committee should await the opportunity to review the report and the Australian Government's response to it as part of its consideration of this bill. I would add that NSW Health has a responsibility to care for all of our citizens, regardless of which sector they may receive care from. We see that through our response to the COVID-19 pandemic, which has devastated populations across the globe. Here in New South Wales, we are very proud of the work we have done with our frontline healthcare workers and in concert with our residential aged care providers in partnership to provide that support to ensure that residents are kept safe. If there is one positive that we can take from this pandemic, it is that our collective efforts and hard work—particularly at the local level—have strengthened the relationships between residential aged-care providers and our local health districts. The two systems are working very closely together and I believe that will carry on well beyond the current COVID response. I now look forward to answering any questions from the Committee.

The CHAIR: Thank you very much, Dr Lyons. I have a couple of questions that I will start off with. I want to ask you specifically about the *NSW Health response to final report of the independent review into the Newmarch House COVID-19 outbreak*. On the bottom of page two, after outlining the series of days and what happened on each day at Newmarch House, it says:

> NSW Health put in a team of highly-skilled specialists in infectious diseases, geriatrics, palliative care and intensive care from NBMLHD.

Can you tell us what date that was put into place?

Dr LYONS: I have not got the details around the Newmarch response in front of me, but I was actively involved. It was very early on in the response that the district provided that in-reach model to Newmarch House. From my recollection, it was within the first few days of the announcement of the outbreak. I was involved from NSW Health along with the aged-care group and the Commonwealth, the local health district and the local operator, in coordinating our response. We very quickly mobilised those teams of specialists to provide that support into Newmarch.

The CHAIR: You said "within the first few days". At Dorothy Henderson Lodge that crisis team was in place on the same day. Can you explain the reason for the delay?

Dr LYONS: I do not think there was a delay is what I am saying. It happened quite quickly. As soon as there was acknowledgement that there was a COVID case in the facility, the district mobilised those supports in infectious diseases, infection control and all of those speciality groups that you outlined there. I do not believe there was a delay. In fact, there was a very close focus on making sure that as much support was provided into the home as we possibly could.

The CHAIR: I understand that there was quite a lot of support that was provided eventually. My question goes to how quickly it was put in place, because the log of events that is recorded in the independent review says on 11 April this happened, on 12 April this happened, on 13 April and 14 April this happened, and then it says that then NSW Health stepped in. In reviewing the response to the Dorothy Henderson Lodge, which has been written up in medical journals and other places, a crucial part of the success and keeping the numbers of fatalities lower than those at Newmarch House has been credited with the fact that that crisis team was put into place so early. Can you explain why it was not put into place on that first day?

Dr LYONS: I will take the specific question on notice around the timing. I have not got that detail in front of me now. But from my recollection, having been directly involved in it myself, there was no delay. That is the first thing I want to say. The second thing I want to say is that comparisons between Dorothy Henderson Lodge and Newmarch House—it would be very important to be cautious about drawing conclusions about the two situations because they were very different, from what I understand. At Newmarch House there was quite an extensive period of exposure by a staff member who did not realise that they were COVID positive. By the time it became known that there was an issue there were many issues to deal with in terms of the potential for staff and residents to be COVID affected. I think the Dorothy Henderson situation and Newmarch House were two very different circumstances.

The CHAIR: But Dorothy Henderson Lodge also involved a staff member having attended the site on multiple occasions.

Dr LYONS: My understanding was it was about the length of exposure of the person before they became aware that they were COVID positive, the number of days on duty, where they worked and the number of staff and residents they were exposed to. I think it is no doubt that both of those were challenging responses and we worked very hard to work with the aged-care providers in both situations to ensure that we provided every support we possibly could.

The CHAIR: Yes, but why then did it take four days to test all Newmarch House residents when Dorothy Henderson Lodge residents were all tested on day one?

Dr LYONS: I do not believe all were tested on the first day because the assessment was made about where the most likely exposures were. I have to say that in the situation of both Dorothy Henderson Lodge and Newmarch House we were evolving our response. They were the first two aged-care facilities that had COVID in them in New South Wales. How we responded was guided by the public health advice and infectious disease specialist advice at the time about what we should do, who we should test and the sequence of testing. I note that that evolved over the course of the Newmarch House response, because at that stage we were not routinely testing staff. That was introduced at Newmarch House during the course of the response to the COVID exposure.

Those things were changing as people became aware of what they should do and were experiencing what was required for an appropriate response. It was not hard and fast. We were working through—as everyone around the world was—how we should respond, what action to take and what the appropriate things to do were. There was no guidebook to tell us what to do. In hindsight, if you look at what has happened in other places, we could say we have learnt a lot from those early exposures. Certainly, if we were to respond now to an outbreak in an aged-care facility, we have had a huge amount of experience about what we should do and we have detailed outbreak management plans, which have been worked out well in advance with not only the aged-care providers but also local health districts. What would happen now compared to what happened at Newmarch House, for example, would be very different.

The CHAIR: Yes, but Dr Lyons, Newmarch House happened only a month after Dorothy Henderson Lodge. There were clear lessons that could have been learnt from Dorothy Henderson Lodge that were not applied at Newmarch House, including having a crisis team in early and testing all the residents. When the Dorothy Henderson Lodge residents were all tested, they discovered that some were asymptomatic and that the spread was further. But yet at Newmarch House it took four days to test residents. What was the reason for that slower response at Newmarch House as opposed to at Dorothy Henderson Lodge?

Dr LYONS: Let me take the detail on notice. As I have said to you, I was directly involved. I do not believe there was an inadequate response or delays. Let me take the detail of the question around timings on notice.

The CHAIR: Yes. Can you take on notice specifically when the crisis team went into operation and also when all residents were tested? The information that was provided to me was that Dorothy Henderson Lodge was tested on the first day but Newmarch House was four days later.

Dr LYONS: I will provide the detail of those two issues to you on notice.

The CHAIR: That is important, Dr Lyons, because we saw a much worse outcome—four times the amount of cases and almost three times the number of deaths—at Newmarch House as opposed to Dorothy Henderson Lodge.

Dr LYONS: But as I said to you, Chair, you need to be very careful about drawing conclusions between the two because the context and what happened can be very different. In fact, if you wanted to draw further conclusions, as we know, in aged care there is a highly vulnerable population and that is why when outbreaks occurred in other jurisdictions the outcomes were even worse in residential aged care. Those are the reasons why we have worked hard to work with our local health districts and our aged-care operators to put outbreak management plans in place and enhance infection prevention and control activities in advance to make sure that people are prepared. We have done many things since those two outbreaks where we have learnt from the responses. To say that our response was inadequate—at this point I would need to get the detail around the questions you have asked because I believe the response was an appropriate response informed by experts on the basis of the knowledge we had at the time.

The CHAIR: I am not saying that it was an adequate but that it was delayed and that those delays had serious consequences. Even your own report states that the reality was that neither the Commonwealth nor Anglican Care executive had an operational plan for how the residents should be managed. When did you come to that conclusion?

Dr LYONS: Quite early on because we got directly involved in providing those health supports in.

The CHAIR: Can you take on notice when you formed that view?

Dr LYONS: Certainly.

The CHAIR: I also put to you that this inquiry has received a submission from the Australian Health Services Research Institute [AHSRI], which states that Australia had one of the highest rates of worldwide deaths as a percentage of total deaths.

Dr LYONS: I am not familiar with who AHSRI are or the report, I am sorry.

The CHAIR: It is the Australian Health Services Research Institute at the University of Wollongong. They have worked closely with the royal commission and have been commissioned to do work for the royal commission. They are now saying that by worldwide standards our response in aged care was not adequate.

Dr LYONS: We have 880-odd residential aged-care facilities in New South Wales; we had outbreaks in two of them during the course of the pandemic. So I believe the work we have done to do as much as we can to keep those residents as safe as possible through our public health measures and work with residential aged-care operators—when you look at the total fatality rate for COVID in our New South Wales community, I find it difficult to reconcile that report and its assertions of the fatality rate with our experience in New South Wales in totality.

The CHAIR: Yes, but they are saying that if you actually look at what is going on in aged-care facilities—we are not looking at what is going on across New South Wales compared to what is happening across the rest of the world. We are looking specifically at what is going on in our aged-care facilities and that is a real issue.

Dr LYONS: We have had two outbreaks in 880 residential aged-care facilities to date.

The CHAIR: Yes, but there was a significant amount of deaths. I will move on.

The Hon. MARK PEARSON: If it was to be shown that any delay—whether it be 12 hours, 24 hours or three or four days—of the appropriate intervention into an aged-care facility and if it was shown that people died because of that, that is a very serious matter, is it not?

Dr LYONS: With respect, I am not sure how that could be shown. How would we know at what point the infection was introduced, how would we know when it was transmitted—

The Hon. MARK PEARSON: But we do know that rapid, quick intervention prevents deaths in COVID.

Dr LYONS: What we know is that taking infection prevention control activities and strong public health measures have shown to keep our community safe over the past 12 months.

The Hon. MARK PEARSON: Correct. So if any person died in an aged-care facility because we delayed an intervention, that is unacceptable, is it not?

Dr LYONS: When you say "delayed"—

The Hon. MARK PEARSON: We did not act when we should have. If there was a delay in the intervention of going to the facility with the crisis intervention team—whatever it is—of 12 hours, 24 hours or two or three days, it is likely that has resulted in the death of people. Is that correct?

Dr LYONS: No. There are a few things in your question that I think need to be teased out in terms of the suggestion of delays and the "we". Defining the "we" is really important because it goes to part of our issue around residential aged care. The State has a responsibility to every citizen to provide health care, which we take very seriously, and the Commonwealth has the responsibility for oversight policy regulation of the aged-care sector.

The Hon. MARK PEARSON: Sorry, Dr Lyons, can you just actually answer my question? It is very clear and I am not pointing fingers at anybody in particular. If it is shown that the intervention was delayed for 12 hours up to three days, when it should have occurred earlier than that and if people died as a consequence, would you not consider that to be a very serious matter?

Dr LYONS: If there were circumstances that were known and there was a delay in responding to those particular circumstances, yes.

The Hon. MARK PEARSON: Thank you.

Dr LYONS: Can I just add, in answering your question, in every situation where I have been involved, as soon as information was provided, the system has responded by providing support to endeavour to minimise any risks to residents and to maintain their safety and health as much as possible.

The Hon. DANIEL MOOKHEY: Thank you for your appearance and sharing your time today, Dr Lyons. I have a few follow-up questions to the line of questioning initiated by the Chair as well as a new line. The Chair read to you a statement that said that NSW Health determined that Newmarch House did not have an infection control plan in place and that New South Wales became aware of that when you stepped in to help them. Am I right in saying that that was your evidence?

Dr LYONS: That is not my evidence. The Chair provided a summary of a document, which I do not have in front of me—

The CHAIR: I read directly from the New South Wales—

The Hon. DANIEL MOOKHEY: So long as I understood the interchange appropriately.

Dr LYONS: Sorry, I thought you had read from the independent report.

The CHAIR: No, I read from the NSW Health response to the independent report.

Dr LYONS: Okay, thank you.

The Hon. DANIEL MOOKHEY: You said that there are 880 aged-care facilities in New South Wales. Do they all have plans in them?

Dr LYONS: They do now, because we have been working with all the aged-care providers locally and with the peaks, meeting with them on a regular basis to ensure that we had an appropriate response to these incidents based on our experience at both Dorothy Henderson and Newmarch.

The Hon. DANIEL MOOKHEY: You say that they do have them now, prior to you initiating those actions did they have plans in place?

Dr LYONS: This evidence came out in relation to the special hearings of the Royal Commission into Aged Care Quality and Safety and there were surveys done by the regulator, the aged-care regulator, and many of

the aged-care operators felt they did have plans in place. The issue was that when there was an outbreak it was found that those plans were somewhat wanting in terms of their ability to deliver effectively.

The Hon. DANIEL MOOKHEY: Am I right in inferring from your answer that to the extent to which they had plans, their plans did not meet the standards that NSW Health would have expected?

Dr LYONS: We do not have expectations about the plans in advance of a pandemic. What we experienced was the response to the circumstances when there was COVID in the aged-care facilities, and at that stage we identified that there were things that could be strengthened, including the health care provided into those aged-care facilities, including the knowledge and awareness of staff around infection prevention control activities. So, there were a range of things where it became evident that a greater level of skill and capability would be of benefit. In fact, that is consistent with the evidence we have consistently given right through the royal commission into aged care, prior even to the COVID outbreaks.

The Hon. DANIEL MOOKHEY: I accept that. When you say therefore that as of now they do, when in time in your view did the 880 update their plans to be in accordance with the lessons and learnings of Newmarch and Dorothy Henderson?

Dr LYONS: We initiated activities with the aged-care providers through the peaks initially, and then through the operators at the local level with their local health districts within the weeks after those outbreaks, and that work has continued on over the months since then. It is an ongoing piece of work where those plans and the relationships at the local level, the interactions between key staff are ongoing to ensure that if we were—and let us hope that we do not have any further outbreaks in aged-care facilities—that the people at the local level are aware of how they should respond, what they should do, who they should speak with, how the response would be coordinated between the operator, the Commonwealth and the local health district health services.

The Hon. DANIEL MOOKHEY: On notice is it possible that you could provide us a sample of what one of those plans looks like?

Dr LYONS: Certainly.

The CHAIR: And the exact date when they were completed?

The Hon. DANIEL MOOKHEY: Yes, and the exact date when they were completed, or at least when you had enough time to audit them to the point where you had at least some insight into whether or not they existed and what their quality was?

Dr LYONS: I am not sure we would be able to provide you evidence about the date of every plan in all 880 facilities across the State.

The Hon. DANIEL MOOKHEY: Whatever information you can provide that gives us an indication as to when you think that the 880 reached systemic compliance with best practice procedure as currently understood by NSW Health, that would be useful.

Dr LYONS: We will do our best.

The Hon. DANIEL MOOKHEY: Thank you very much. Can I follow up on two things that you also said in answer to the Chair? You said that NSW Health has learnt the lessons and effectively revised its procedures to take account of the learnings of Newmarch and Dorothy Henderson. What changed in the procedures?

Dr LYONS: We highlighted the need for more aggressive infection prevention control support right from the outset, so those have been provided in terms of baseline training and support, but there would be an immediate ramping up of that support into a facility if there were to be a COVID-positive case. There would also be, in terms of the response from the district and with the operator, a risk assessment about the environment in which the care was provided; the ability to cohort appropriately and effectively to maintain appropriate measures to keep potentially infected residents and staff separate; the way staff would be rostered and the impact of potentially impact to the staff on the ability of the aged-care facility to continue to operate and the supports that the district might provide in, in terms of staffing; the level of specialist involvement, both aged care, infection prevention control, infectious diseases, all of the things that I outlined, all of that that would go in in terms of these outreach programs. All of those things were worked through in terms of the context of the aged-care operator, their circumstances and the district's ability to respond to those in relation to where the district services were provided from.

The Hon. DANIEL MOOKHEY: Are these written procedures?

Dr LYONS: Some of them are detailed, but a lot of them have been worked through in terms of the response. Much of it will be documented, yes.

The Hon. DANIEL MOOKHEY: On notice can you provide us with the documentation that would show us the current standard operating procedure for an outbreak as of today?

Dr LYONS: That would be an outbreak management plan, which I think you requested earlier, so I certainly could.

The Hon. DANIEL MOOKHEY: Great. I think we requested separately the 880, or at least a sample of what the actual facility level is. I guess the second follow up is what is NSW Health's current? Do you understand the distinction?

Dr LYONS: We have an incident outbreak management plan, which is the higher level which guides, so that is all documented quite clearly.

The Hon. DANIEL MOOKHEY: Can we get that on notice as of today's date?

Dr LYONS: Certainly.

The Hon. DANIEL MOOKHEY: Is it standard practice now to move an infected person or personnel or residents from an aged-care facility to a hospital?

Dr LYONS: No, it is not standard practice.

The Hon. DANIEL MOOKHEY: Is that a discretion that you retain?

Dr LYONS: It is certainly open based on the assessment of the clinicians to the risk to the individual and their safety and their wishes as well, as well as the assessment of the environment in which their care is being provided.

The Hon. DANIEL MOOKHEY: How many residents are in the 880 homes as of today?

Dr LYONS: I have not got those figures off the top of my head but it is many tens of thousands.

The CHAIR: Plus 61,000?

The Hon. DANIEL MOOKHEY: And we have more than any other State do we not?

Dr LYONS: We are a third of the population of the country, so by that measure, yes.

The Hon. DANIEL MOOKHEY: When you said in your opening statement that the position of NSW Health is to wait for the Commonwealth to regulate, why? Why is that our position?

Dr LYONS: For a number of reasons. My understanding was that I was here to speak to particularly the issue around regulation or legislation in relation to nurses.

The Hon. DANIEL MOOKHEY: Yes, that is precisely my question. Why do we have to wait for the Commonwealth to decide what the requirements are for nurses in NSW Health facilities? Why is that the position of NSW Health?

Dr LYONS: That is because of a couple of things: The first is that aged care is a policy and a Commonwealth legislation responsibility, so it sits with the Commonwealth; because we would want consistency in terms of national standards wherever possible; because in relation to the definitions that currently exist around nursing homes, they do not actually apply to current residential aged-care facilities, and the definition of low-care and high-care places do no longer apply. How these things are actually supported does need to be informed by, when you have got a royal commission under way, and where counsel assisting has provided a series of recommendations, one of which relates to this very issue, and that response is only due within a matter of weeks, we felt it was an appropriate response that we consider the findings before making any decisions around legislation in New South Wales.

The Hon. DANIEL MOOKHEY: I accept the Commonwealth is the lead regulator; it is not disputed. But New South Wales has not ceded its power, has it?

Dr LYONS: We currently have regulations, but there are some legislations that are covered in the Public Health Act 2010, but we do not specifically legislate around aged care, as I understand it.

The Hon. DANIEL MOOKHEY: But we have not constitutionally transferred our power, have we?

Dr LYONS: Not that I am aware of.

The Hon. DANIEL MOOKHEY: We retain it, so effectively, you made reference to the fact that the health legislation currently requires that there be a registered nurse available at a health facility, so it is quite clear that New South Wales is still exercising its independent regulatory power, aside from the Commonwealth. Is that correct?

Dr LYONS: It has retained a provision which was in the previous Act by regulation, which is difficult to enforce because it relates to high-care places, nursing homes with high-care places, which that definition no longer applies under the current—

The Hon. DANIEL MOOKHEY: My point is that the power exists, not how it is being used, the power still exists in New South Wales, that is correct?

Dr LYONS: Yes, there is still a regulation that stands.

The Hon. DANIEL MOOKHEY: In fact is the reason why New South Wales would prefer the Commonwealth to act because the Commonwealth funds? Is that the actual reason, it is to do with the money?

The Hon. WES FANG: Point of order—

Dr LYONS: It is not the primary reason, but I think there is an important issue here which we need to acknowledge, and this is one that in NSW Health we are very conscious of in relation to the interface between, not just the aged-care system but the disability care system, primary care and some of the other things that the Commonwealth has primary responsibility for. If there are failings in any of those sectors—we have a responsibility to our citizens. We take that very seriously. Invariably what happens is that the services that NSW Health provides and the New South Wales Government, therefore, provides to those citizens steps in to take the place where there are any failings in any of those other areas.

It is an issue of concern when the NSW Health expenditure is continuing to grow at the rate it is growing that we do ensure that where there is a responsibility of the Commonwealth to provide components, we are defining those responsibilities very clearly and holding each other to account to ensure that we are delivering those effectively. In relation to the implications of some of these interfaces, we think it is really important to be explicit about what each arm of Government does—what the State is responsible for and what the Commonwealth is responsible for—and to define those in a way that allows us to ensure that we are delivering effectively to ensure that our residents are getting access to the appropriate care and supports that they should.

The Hon. DANIEL MOOKHEY: Dr Lyons, we are in furious agreement here. But what I take from that is that a failure from the Commonwealth to fund their responsibilities transfers the responsibilities to the New South Wales taxpayers to be met through our health system. Would you agree?

Dr LYONS: Unfortunately, that is often the case.

The Hon. DANIEL MOOKHEY: Is it the case right now that part of the reluctance of NSW Health to embrace a proposition around immediate introduction of minimum nursing standards and care standards is because the risk is that that funding cannot be provided by the New South Wales taxpayer without the Commonwealth?

Dr LYONS: It is not our position in relation to the response and our submission to this inquiry, but it has been a position we have provided to the Royal Commission into Aged Care Quality and Safety on a number of occasions, about the criticality of ensuring that where primary care, which is a Commonwealth responsibility, is failing into residential aged care, we address the primary care issues, not that we then respond by providing specialist models, which are very expensive, provided by the State into those aged-care facilities as a proxy. So it is not the primary driver, but what we are concerned about is continuing to see where there are failings in responsibilities and services that should be provided by one arm of Government being by necessity taken up by another. It is about trying to get those boundaries really clear and ensuring that the access to the appropriate care and service is provided.

The Hon. DANIEL MOOKHEY: I will finish on this. You said that you have been taking these issues up with the Commonwealth. In which forums have you been taking this up with the Commonwealth?

Dr LYONS: Our Minister took up with COAG Health Council as a result of, I think, the 2015 inquiry here, the issues around the staffing in residential aged-care facilities. I think that was in October 2016. But I might check my memory of which COAG Health Council meeting it was. Again at the Australian Health Ministers' Advisory Council [AHMAC] our secretary at the time took those matters forward to the chief executives of all the other State and Territory health departments to gain support for the position to ensure that we improved the level of staffing and the clinical care provided. Now—

The Hon. DANIEL MOOKHEY: Since 2016 has there been a substantial response by the Commonwealth?

The Hon. WES FANG: Point of order: The witness was continuing to answer and Mr Mookhey—

The Hon. DANIEL MOOKHEY: I was just bringing the witness to the question in the ordinary bounds of witness interactions, and this witness is doing very well and capable of answering.

The Hon. WES FANG: I know, but I was interested to hear—

The CHAIR: For the benefits of Hansard we are going to have one speaker at a time. I understand your point of order, Mr Fang. I think Mr Mookhey has been clear. I think this witness is well capable of responding to the question and also pointing out if he needs more time answer the question.

Dr LYONS: I have a little bit more to add, Chair. In addition to those two occurrences, there have been hearings at the Royal Commission into Aged Care Quality and Safety, where I have been a witness on three occasions now, providing that very same evidence to the royal commission: that there is a need to enhance access to health care for residents in aged care, that there are significant failings in the current circumstances, that the State feels that there needs to be enhancement of primary care and also the clinical care provided by the operators, that there is a need to enhance the resources provided to aged care to enable that to occur, and that models that exist where the State steps through specialist outreach and in-reach models are not necessarily the solution. While they provide great access to services where they are able to be provided, they are not able to be provided across every part of our State, particularly in regional and rural areas, where those services are stretched. So there is a whole range of opportunities where we have provided that evidence and submitted that position.

The Hon. DANIEL MOOKHEY: I do not dispute that, but I guess the proposition I put to you is: Despite the advocacy in this respect, there has been no substantive increase by the Commonwealth in their investment in primary care so far as it relates to aged care. Do you agree?

Dr LYONS: Let us see what the outcome of the royal commission is.

The Hon. DANIEL MOOKHEY: But it is not a question. My question is, in your opinion, since your Minister first started raising this in 2015 to 2016, there has been no substantial increase in Commonwealth investment in primary care and aged care.

Dr LYONS: There are just a couple of things that I would say there. There have been enhancements in certain things into aged care. I will give you an example. Something that has been enhanced just recently as a result of our advocacy is palliative care. The Commonwealth announced a program where they would invest funds into end-of-life and palliative care, which, you would be aware, was a major item of interest in this inquiry in 2015. We have been doing a whole lot of work in advanced care planning and end of life. The Commonwealth have announced that they would provide matched funding: where the State was providing additional resources in, they would provide matched funding. So we were the beneficiary of $10 million of extra funding into palliative care and aged care as a result of advocacy. Palliative care is a primary care service.

The Hon. DANIEL MOOKHEY: But the logical follow-up to that is: Therefore are you suggesting that no further Commonwealth investment is needed?

Dr LYONS: That has not ever been our position. As I said, I provided ample evidence of a need for more.

The Hon. DANIEL MOOKHEY: I think we are in agreement.

The Hon. GREG DONNELLY: The Government's submission to the inquiry, in the fourth-last paragraph, provides:

> The Australian Government has full policy, funding and regulatory responsibility for the aged care system. The NSW Government has a longstanding position that it is the Commonwealth's role to regulate the standards, staffing and quality of care in this sector.

That is a very explicit statement by the New South Wales Government. Is this reference to the longstanding position to be read that that is the current position of the New South Wales Government as well? I am just trying to be very clear. Is what is being said the position of the New South Wales Government presently, that it is the Commonwealth's role to regulate the standards, staffing and the quality of care in this sector?

Dr LYONS: It is my understanding.

The Hon. GREG DONNELLY: Your understanding. Are you aware of any discussions that have taken place within NSW Health to alter that position?

The Hon. NATASHA MACLAREN-JONES: Point of order: I just wanted to clarify if Mr Donnelly is actually asking the witness for a policy position, which I believe would be out of order.

The Hon. GREG DONNELLY: To the point of order: I am not asking for a declaration of a policy position or to articulate an explanation of a policy position but rather an explanation of, in fact, the policy as it currently is and an awareness of any discussion that may be taking place in terms of changing that policy.

The CHAIR: I note the point of order. I think at the moment Mr Donnelly is well within his rights to be asking questions in relation to that, but I will be mindful going forward.

The Hon. GREG DONNELLY: In terms of comments made in answer to questions, I think, from the Hon. Daniel Mookhey about representations to AHMAC by the New South Wales health Minister, have there been propositions put that you are aware of that would seek to alter this longstanding position that is outlined in this paragraph?

Dr LYONS: Not that I am aware of, no.

The Hon. GREG DONNELLY: To the best of your knowledge, the current position and looking into the future as far as one practically can do so is that the New South Wales Government's position is as it is: The regulation of standards, staffing and the quality of care in the sector is the remit of the Commonwealth and the Commonwealth only.

Dr LYONS: That is my understanding, yes, that it is not—you said "the Commonwealth only". We have current regulations, which apply, as you know. So it is not the Commonwealth only currently.

The Hon. GREG DONNELLY: With respect then to those elements that are not part of the Commonwealth and are in fact regulations or other arrangements in this State, what would they be? Can you provide a description of what those New South Wales—

Dr LYONS: I think the specific one that we were talking about is the requirement for a registered nurse to be on duty in nursing homes that at a point in time in 2014 were designated as high care places. In nursing homes they have a requirement to maintain registered nurses 24/7. There is a regulation that requires that.

The Hon. GREG DONNELLY: I am aware of that. What other regulation from the State of New South Wales operates inside nursing homes?

Dr LYONS: There would be legislation that covers pharmaceuticals, medications, and schedule 4 and schedule 8 drugs and the requirements for those to be administered in certain ways. Those will be in place. There will be certain other provisions under the Public Health Act 2010, which would come generally to the fact that health care is being provided in the settings.

The Hon. GREG DONNELLY: It would be normal for a State or Territory to have legislative or regulatory arrangements on those matters.

Dr LYONS: Correct.

The Hon. GREG DONNELLY: That would be typically divided between Commonwealth and State responsibility.

Dr LYONS: That is correct.

The Hon. GREG DONNELLY: In terms of altering what I will call the status quo arrangement between the New South Wales Government or the State of New South Wales and the Commonwealth with respect to the regulation of standards, staffing and the quality of care in the sector, there is nothing stopping the State of New South Wales becoming more proactive in that area. Is there?

Dr LYONS: There is not, no.

The Hon. GREG DONNELLY: Effectively we have a situation where New South Wales is adopting a position that these significant areas—which are the regulation of standards, staffing and the quality of care—fall to the Commonwealth. The State of New South Wales, as far as we can gather, is happy to retain that arrangement of having the Commonwealth being primarily responsible.

Dr LYONS: Yes, because the Commonwealth has primary responsibility for a range of other components of support for that sector. For us to not have all of those levers in our control means it would be difficult for us. For instance, if we were to define the certain things that need to change that require resources and

we are not responsible for funding those aged-care providers, it makes it very difficult to know how the things that we want to put in place can be delivered unless we have all of those levers and we do not.

The Hon. GREG DONNELLY: But that is essentially a decision of government. If the Government, at the end of the day, discerns that there is a serious problem inside the residences which house our elderly and infirm in New South Wales—the New South Wales Government is clearly capable of doing more. It is essentially a decision to not do more and retain that position. That is the current position. I do understand the issue about the forthcoming royal commission report, but that is essentially a decision of the Government. The Government could do more in this area if it wished to do so, couldn't it?

Dr LYONS: It could, yes.

The Hon. GREG DONNELLY: The penultimate paragraph talks about—once again, it is a straight out statement:

> The implementation of changes at this time, which are consistent with the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020, would compromise the financial viability of small providers …

It is a very definitive statement. On what basis does NSW Health make that statement?

Dr LYONS: I think there was a recent quarterly report by StewartBrown Advisory that looked at the financial viability of operators in the aged-care sector. That provided quite concerning information around the level of operators that were financially in deficit for that quarter and were operating in a situation where they were not able to meet the budget for the revenue they were receiving and expenditure that was going out. That is a concern in that that is a financial audit of activity currently. I think that advisory and quarterly report came out in September 2020. We are also aware that many of the operators, particularly in rural and regional areas, are often small, not-for-profit community groups or local councils that have established services in the towns to ensure that their citizens and residents are able to have access to aged care in the town. Many of those are struggling. Even this year we have had advice that one of the operators could no longer make ends meet and would need to stop providing that service. It has been seeking support from NSW Health as to what it might do with its 40 residents in that town.

These are ongoing issues that have been evolving and emerging. In part we have had a policy response in New South Wales which has been around the establishment of multipurpose services, which I think—and we gave some evidence at the Royal Commission into Aged Care Quality and Safety—has been a very good model for smaller rural communities, where the Commonwealth and the State come together and pool the fund for that town and provide the services out of one facility. So there is an after-hours access to primary care through an emergency department model, there are rooms for community health people to provide outpatient services and perhaps for a GP to provide primary care, and there are also a number of aged-care places in that facility. Together, that operates in a way which provides economies of scale and pools the resources from the State and Commonwealth to have a viable model of healthcare delivery.

We operate those in many of our rural towns. They are very successful models and there was a lot of advocacy from community members about what they saw as the positives of that model in the towns where they exist. It is an example of where a response can—but it is quite clearly, as I said, delineating the responsibilities of the Commonwealth and the State and looking at ways that, together, we can actually provide those services into citizens in those circumstances. But there are issues around economies of scale and the financials for many of the aged-care operators, particularly where they operate small numbers of places and where they are in rural communities where there are the costs of doing that and staffing can be difficult to attract.

The Hon. GREG DONNELLY: I have a final question. You may be able to answer this question or take it on notice. One thing that appears to be the case is that there are some operators of aged-care facilities that do actually have registered nurses on basically 24 hours a day, seven days a week. It is part of their built-in rostering arrangements. There are others that have them effectively only during—and I will use this phrase—daylight hours or broadly daylight hours but not overnight. If there is a need to deal with an RN overnight, a phone call is put through to talk through the issue that might need to be dealt with. In terms of looking the provision of registered nurses, one could make the statement that the facility that is not providing the registered nurse overnight is essentially trying to save on costs.

That is its model of operating. It wants to cut things as thin as it can to maximise profit or minimise exposure to cost, that is, a registered nurse. But we do know that some facilities have registered nurses there all the time. How does one make that judgement, if one can, that one has got genuine—if this is the argument—cost imperative issues facing it and that is why it is not providing the registered nurse versus, well, they essentially

made a management decision to get by without one and deal with it remotely over the telephone? How does one make that distinction?

Dr LYONS: I am not an aged-care operator so it is not my area of expertise. I think some of the factors that you would consider that might play a part are things like the scale and size of the facility and the staffing profile of the facility for the number of residents, but it should always come back to the needs of residents. That should be driving the level of care that is provided. We also need to be conscious that, if we are providing aged care in rural and regional communities where there are issues around expertise and availability of staff and skills, on occasions different models might be looked at. I think it comes back to the assessment of the care that is provided to those residents and whether it is backed up by that expertise, whether people can access that knowledge and capability when they need it, and whether the staff who actually provide the care feel like they are backed up and supported and know where they can access knowledge if they need it. We are very conscious that there might be different models that might work. It is a question of whether the outcomes are met. The outcomes are what we should be measuring, which is that residents have access to safe high-quality care and that their health and wellbeing is maintained as much as possible.

The CHAIR: Does NSW Health collect any information around admissions to hospital and where they are coming from or potential cost-shifting onto NSW Health from a lack of an RN in place?

Dr LYONS: Certainly we look at patterns of care and where transfers to hospital occur from nursing homes. There has been a lot of analysis of that data at the local level. In fact, that is what has driven a lot of our local health districts to put in place models where they provide support into the homes to provide that additional expertise and back-up for the staff and to, wherever possible, ensure that we are providing care to residents in situ if that can be appropriately provided in situ. Transferring somebody to a hospital emergency department when the care could actually be delivered effectively in the home we feel is a significant inconvenience for the resident and should be avoided wherever possible.

These are the sorts of reasons why we are advocating very strongly in the evidence we have provided to the royal commission so far about the need for enhancing primary care, access to health care—particularly after hours, and the need for specialist input into the care of these residents. As you know, when they are elderly and have lots of potential illnesses and comorbidities having access to specialist advice and input is important as well. We are very conscious of all of those things being important but, as with any citizen in the community, it should not be that the only place a resident can access those supports is through what the State provides; it is actually what the Commonwealth provides as well through its responsibilities in healthcare delivery.

The Hon. DANIEL MOOKHEY: Could I just tease that out a little? You said that you maintain data about admission to hospitals. Is that correct?

Dr LYONS: Yes.

The Hon. DANIEL MOOKHEY: Does that data encompass admissions to hospitals that came from an aged-care facility?

Dr LYONS: Yes, it does.

The Hon. DANIEL MOOKHEY: How many transfers per year were happening between an aged-care facility and—

Dr LYONS: I have not got those exact numbers in front of me.

The Hon. DANIEL MOOKHEY: What is the cost?

Dr LYONS: I have not got the details of the cost either. It is very difficult to say what is an inappropriate transfer.

The Hon. DANIEL MOOKHEY: Sure.

Dr LYONS: It could be that it is a very appropriate transfer to hospital.

The Hon. DANIEL MOOKHEY: Yes, and that is very complicated; I am the first to accept that. But do you analyse that?

Dr LYONS: We look at the transfers but we do not look at costs so much as issues around how care could be better provided. It is an issue around transferring people by ambulance to an emergency department, which ties up ambulance resources and the emergency department activity. If that can be avoided then we look at models that actually might prevent that happening.

The Hon. DANIEL MOOKHEY: I do not dispute that, Dr Lyons, and it is of course welcome that you do. But we are trying to get to the bottom of whether or not there are some resources in the system that could be better spent, just as you do.

The Hon. WES FANG: Is that what we are doing?

The Hon. DANIEL MOOKHEY: I hope we are, Mr Fang.

The Hon. WES FANG: I thought we were looking at a bill.

The Hon. DANIEL MOOKHEY: Dr Lyons, what analysis is available about cost-shifting from the Commonwealth to New South Wales in aged care?

Dr LYONS: I would not determine it as "cost-shifting" as you have outlined. Certainly we look at patterns where transfer of care is occurring to emergency departments or to hospitals, and look at what people are being transferred for and whether or not there is an assessment that perhaps that care could be provided within the aged care environment. If it is possible to put in models of care that support that happening then we look at how we do that.

The Hon. DANIEL MOOKHEY: Do you analyse it at an LHD level?

Dr LYONS: It is often done at a level even lower than that. It is often done by hospitals and surrounding aged-care facilities.

The Hon. DANIEL MOOKHEY: So you would have these data available to the Committee—these patterns, as you have put it?

Dr LYONS: We do not collate them centrally because these are issues that the districts put in place with their own aged care operators under our devolved governance arrangements. That is appropriate because they need to analyse the care they are delivering for their local communities.

The Hon. DANIEL MOOKHEY: I am not disputing that, but what I am asking is what evidence base is available to the community that can shed some insight into this? I understand the point that you are making. It is really not more complicated than that: What is the evidence base that we can rely upon to quantify these numbers?

Dr LYONS: We will endeavour to find what we have got in terms of that activity and data. It is another part of the ministry that I am not directly responsible for that looks at these issues.

The Hon. DANIEL MOOKHEY: Do you mind taking that on notice?

Dr LYONS: Certainly.

The Hon. DANIEL MOOKHEY: Are there any regions that stand out more than others? Any hospitals that stand out more than others?

Dr LYONS: Not to my knowledge.

The Hon. DANIEL MOOKHEY: It is universally distributed as a problem or a solution, depending on your perspective? You are saying that there are no imbalances whatsoever at the levels that you—or you are not aware of where they are?

Dr LYONS: I am not aware of where they are. That is not to say they are universally distributed. It may be that there are patterns.

The CHAIR: But you can take that on notice for us, Dr Lyons?

Dr LYONS: If that information is available we will make it available to the Committee. I am not sure that it is available—that is my only point.

The CHAIR: I understand.

The Hon. MARK PEARSON: Just relying on your knowledge and skills, having been a registered doctor for some time—and obviously you are now aware of the aged care issues and what this inquiry is about—in your view would it be likely that if a registered nurse is working at an aged-care facility from five o'clock on Friday afternoon—one or two or three different rosters—until 9.00 a.m. on Monday that there are less likely to be admissions from an aged-care facility into an emergency department or hospital if a registered nurse is there and able to assess a situation that might warrant that?

Dr LYONS: Not necessarily.

The Hon. MARK PEARSON: Why do you answer that way?

Dr LYONS: Because care that is provided in any team situation is multidisciplinary. The nurse will usually have a general practitioner who is actually the on-call general practitioner for the residential aged-care facility. Decisions that are made around the care that is provided to the resident will be based on the assessment of the health professionals who are actually on duty, but they would usually consult with others about what their findings are—whether there is a need to have a further assessment; whether or not they believe that what the person has is something that can be dealt with locally. It depends on all of those factors as to what might happen and what occurs.

The Hon. MARK PEARSON: But if there is no registered nurse on site the assistant in nursing would rely on speaking to a registered nurse or doctor over the phone? Would that usually be the case over a weekend period?

Dr LYONS: That may be the case. I am not an aged care operator so I am not completely au fait with all the models that operate in aged care.

The Hon. MARK PEARSON: What about the other way around? If a resident started to suddenly develop a state of confusion from medication or anything else, do you think it is more likely something new like that is going to be much more quickly assessed, dealt with and treated if there is actually a registered nurse with the knowledge that they have compared to an assistant in nursing who obviously—and this is no criticism—is not trained as much as a registered nurse, who has three-plus years of training as opposed to six months to one year?

Dr LYONS: I do not want to offer a view about the skills and capability of various health professionals. It is not just around the level of training that is provided and what their qualifications are. It is about their skills and experience in that environment and what back-up is provided to them. It could be that somebody in that situation—an enrolled nurse or an assistant in nursing—does recognise the confusion, contacts a GP and the care is provided and resolved. I think there are too many assumptions—

The Hon. MARK PEARSON: The difference there is, though, that a phone conversation is quite different from an experienced registered nurse in aged care looking at and assessing a person when the initial symptoms and difficulties arise as opposed to somebody with less experience going, "What's this?" and maybe giving them medication they should have withheld, which is going to make the condition worse, because of their lack of knowledge—picking up the phone and talking to a registered nurse and talking to a doctor.

Dr LYONS: Rather than deal with the specifics about your hypothetical, might I just restate the fact that we have given evidence on many occasions now, including to the Royal Commission into Aged Care Quality and Safety, that we believe there need to be improvements in the level of clinical care provided to aged care residents.

The Hon. MARK PEARSON: But how can we have the improvement of clinical care—and I mean clinical care as opposed to the general care that assistants in nursing and enrolled nurses provide—how can we be certain of that clinical assessment and care if there is not an experienced registered nurse working? Assistants in nursing and enrolled nurses are trained to a certain degree of clinical expertise, but it is clear that a registered nurse has a much higher level of capacity to be able to assess and implement a treatment or intervention.

Dr LYONS: I did not want to get into a debate about the classification of individual nurses and whether or not one has specific advantages over another.

The Hon. MARK PEARSON: That is what the inquiry is about.

Dr LYONS: We always work as a team in health care delivery. Our expectation even in an aged care environment is that there would be a team involved in providing care. What level of experience, training, capabilities and qualifications are required to ensure that the care is high quality and safe needs to be worked through. Of course there is an assumption that registered nurses have greater skill and capability by the nature of their training and there is a desire to increase the level of clinical input and care. We have expressed a desire for that. We feel it is important that there is flexibility around how that is delivered and what action is taken to address that issue. I will use the regional and rural example again. In a smaller aged-care facility in a smaller town, the ability to attract and retain staff is sometimes an issue. If a model needs to be put in place to support the staff that are there and can provide the same outcomes then we need to explore those models.

The Hon. MARK PEARSON: We were given evidence that there was a situation in Deniliquin with an aged-care facility on one side of the road and the hospital on the other. This aged-care facility does not always have registered nurses but because of the different allotting of funds—one is Federal and one is State—they cannot

come together and provide a service. The aged-care facility cannot go across the road and ask a registered nurse to come over and assess a situation for them because of this division in funding. Would you recommend that that division in funding and that mechanism should be overhauled and addressed?

Dr LYONS: I think you might have been absent when I gave some evidence around the multipurpose service model that exists in many of our towns already. It is actually addressing the very issue you have raised, which is where the aged-care facility and the hospital services are co-located in the one building. The Commonwealth provides resources for the aged care component, we provide resources for the outpatients, community health and emergency side of things and together that service is provided. There is the benefit of the economies of scale and when you have a workforce that is somewhat constrained, there is also the benefit of people with skills like those registered nurses being on duty. They are on duty but they are there for everybody, including the aged-care facility. Those models are seen as very positive by our communities in many of the rural towns where they exist.

The Hon. WES FANG: Thank you, Dr Lyons, for coming along today. Speaking of absences, it is disappointing that the Deputy Chair is not here to hear the evidence that you were just giving from rural and regional communities about his bill. I think that would have been very beneficial for him.

The CHAIR: Order!

The Hon. DANIEL MOOKHEY: Point of order: Mr Fang, you were not here for much of this. We can both play that game. We have a practice in the House and in the Committees not to make those observations because we are not aware of whatever reasons there might be. If you wish us to point out every time you are not present to hear evidence from expert witnesses, including from government witnesses, then we are more than happy to.

The CHAIR: I uphold the point of order. If you do wish to pose a question then you can do that, but I will also ask you to withdraw your comments about the Deputy Chair.

The Hon. WES FANG: I withdraw. Dr Lyons, I wanted to seek your guidance. I know you have been given a very wide variety of questions today but turning to the bill itself, do you think it is possibly a bit premature to be looking at something like this when there has been a royal commission at the Commonwealth level with findings due to be released soon?

Dr LYONS: Absolutely, that is our position. I think we are in furious agreement about the fact that we need to look at how we continue to provide better care for citizens who are residents of aged care and we have advocated very strongly for that. But given that the royal commission's findings will very imminently be handed down and we will see what the Commonwealth Government's response is, it was only an issue of timing more than anything that guided our advice to Government about holding off to see what that response was. It could very well be that it is addressed through recommendations that are being made and the Government's response. That was our only point. It is not that we do not agree that there is a need to do more. We do agree and we are very strongly advocating for that.

As I said, we are also very strongly advocating for clarity around roles and responsibilities. In the National Health Reform Agreement for the next five years, which we have been involved in negotiating, we have highlighted to the Commonwealth that those issues around the interfaces with health are absolutely critical. As we have seen the rollout of improvements in disability care through the National Disability Insurance Scheme, we need to be clear about what the scheme covers in terms of disability care for our citizens and what the expectations are for mainstream health services. There is a need to get that clarity because otherwise there can be confusion and duplication, but there can also be gaps. The same things apply in aged care. We need to be much clearer around what the Commonwealth is saying it is doing to provide health and support for residents in aged care.

Let us be honest and face the fact that since the Commonwealth took responsibility, we have had increasing pressures on the aged care sector because our community is getting older. We are ageing. Our people are living longer but living with chronic conditions, so the likelihood of somebody who goes into residential aged care having significant health problems is very high. It is not just about aged care and providing a residence and a home for them; it is about ensuring they have access to all of those healthcare services. The need has never been greater. We need to respond appropriately, through appropriate models that are supported. We need to do that in a way that tries to keep them well as much as possible and maintains their health status through primary and secondary care, with specialists in those community settings providing services into the residents' homes rather than having to transfer them by ambulance to a public hospital to access that care.

We are certainly not keen to see those models continue. We are keen to see those other issues addressed to make sure that we have better primary care, GPs who care for residents in their homes and 24/7 cover to ensure as much as possible that if someone gets ill in the night then someone comes to see them in their home. Those are the sorts of things that we have been advocating for and we are very strongly supporting that through everything we do, recognising that as the State health system we are always there as the safety net. At the end of the day, if someone cannot access care then it is always open to them to call an ambulance and be transferred to the local hospital. That often happens.

The Hon. WES FANG: You spoke before about the risks to smaller facilities in rural and regional communities, where a bill like this could have a potential negative impact on the operation of the facility due to a difficulty in attracting and retaining registered nurses. The question is, acknowledging that part of it, what would the competition be like for a registered nurse in a smaller community between a hospital and an aged-care facility? What would their workload be like if they were required to have staff in there 24/7?

Dr LYONS: I think looking for opportunities as we have done with the multipurpose service model of bringing those services together under one umbrella is actually a very positive thing. It allows for scarce resources to be better utilised, for people who have skills to be retained and maintained in their communities and for people to have access to services that might not otherwise be there. I do think there is often market failure in those smaller rural and regional communities. We know the issues around getting health professionals to work in those environments and the challenges that we face in continuing to deliver health care. Looking at ways that we can do that through governments working together is very desirable. We do not want to go down a path of creating the unintended consequence of competing for scarce resources by requiring certain things to be done, which actually drives us further apart rather than bringing things together.

The Hon. WES FANG: So there is the potential that in those smaller communities, where resources are scarce, a bill like this could actually have a negative impact on aged-care provision in those communities.

Dr LYONS: Or to the local health services, if the registered nursing staff were attracted to the aged-care facility. So I think we have got to look at all these issues. There are unintended consequences often from taking a position.

The Hon. DANIEL MOOKHEY: This might be a stupid question but what exactly is the harm of there being competition for registered nurses?

Dr LYONS: In an environment where there is workforce shortage?

The Hon. DANIEL MOOKHEY: Yes. In a scenario in which registered nurses and other careworkers make the point that they are underpaid, what is the problem with competition?

Dr LYONS: So, are you assuming there that competition means that wages increase, I assume, by the line of your question?

The Hon. DANIEL MOOKHEY: Well, no. I am not assuming that. You made the point that one of the unintended consequences might be that because the workforce skills are scarce there would be greater competition for them. From the perspective of a highly qualified professional like a registered nurse or a care staff member, what is the harm for them? Why should we consider that to be a concern for the purposes of our inquiry?

Dr LYONS: It is not a harm for the registered nurse or the healthcare professional but it is a potential harm for delivering services to the community if that person is not then available to provide care in another setting.

The Hon. DANIEL MOOKHEY: So, is not the solution to that to therefore create a greater supply of trained professionals who are capable of doing this work?

Dr LYONS: If it were that easy, we would not have the shortages we have and the distribution issues. I mean, there have been increasing numbers of health graduates through our universities for many years. It does not mean that we have got the problem solved across the—in a State the size of New South Wales.

The Hon. DANIEL MOOKHEY: So can you take us through NSW Health's contemporary measures to increase around workplace planning around aged care? Is this an area in which you are developing policy or thinking of more strategy?

Dr LYONS: We have been very active even just as recently as the COVID response indicating that we would provide support to the aged-care operators by having a stand-by workforce available to deploy, if required, so we are very conscious of the need. But workforce is not my area of expertise. So if there are particular actions that are underway, I can certainly take that on notice and provide the Committee with advice.

The Hon. DANIEL MOOKHEY: Well, it is a core question, is it not? I mean, NSW Health is the operator of Australia's biggest health system. It is relevant for how exactly are you planning for your workforce planning requirements for NSW Health. You are the market leader. You are the biggest buyer of healthcare services in the country. We would like to know what exactly initiatives have you got in place around workforce planning for the registered nurse, the enrolled nurse and care staff level. Is that not core to your function, or is that not core to your personal function?

Dr LYONS: It is not core to my personal function but I am struggling a little bit to understand the relevance to the particular issues that we are—

The Hon. DANIEL MOOKHEY: Well, the relevance is that an obstacle that has been identified for us being able to mandate registered nurses and additional care staff and that obstacle is that they do not exist. Therefore the obvious solution to that particular problem is to train more of them. As NSW Health is the market leader, the biggest buyer of labour services and health care, I would like to know what exactly is NSW Health doing to expand workforce planning over the next decade. Because if it is going to continue to be nominated by NSW Health as an obstacle for us being able to endorse a bill like this, it is open to us to want to ask: What exactly are you doing to solve the shortage of registered nurses and care staff? That is the context.

Dr LYONS: I made a simple observation that in an environment where there are shortages of workforce it may be an issue. I am not sure that I went as far as—

The Hon. DANIEL MOOKHEY: Well, is NSW Health involved in aged-care workplace planning whatsoever?

Dr LYONS: For the aged-care facilities that we are responsible for and in relation to the specialist aged-care services that we operate, but in relation to residential aged care, I will take that on notice. But it is not an area that is our core responsibility.

The Hon. DANIEL MOOKHEY: Whose core responsibility is it?

Dr LYONS: As I said, it is provided through the Commonwealth and through policy funding and regulation of the Commonwealth.

The Hon. DANIEL MOOKHEY: Dr Lyons, I am not identifying you as being the obstacle or responsible solely for these problems but do you understand the frustration that many people who are campaigning for this change have that no-one seems to be taking any responsibility for workforce planning.

The Hon. WES FANG: Point of order: That is not a question that Mr Lyons should or is able to, really, answer.

The CHAIR: Well, no.

The Hon. GREG DONNELLY: To the point of order: I think Dr Lyons is capable of expressing a position.

The Hon. WES FANG: I understand that but Dr Lyons is here to provide evidence and the perspective from the Government standpoint.

The Hon. DANIEL MOOKHEY: Maybe I will rephrase.

The Hon. WES FANG: As to people's frustrations about workforce shortages, I am not sure that—

The CHAIR: Okay. I have the gist of it. Time is running out. I appreciate that. I am going to pass it back to Mr Mookhey to rephrase, but I do think this question of workforce planning is an important one and the role of whether NSW Health is actually doing it is important for the Committee to ascertain.

The Hon. DANIEL MOOKHEY: Previously, Dr Lyons, you have nominated examples of advocacy that NSW Health has been doing to the Commonwealth. We discussed it around the responsibilities around primary care. Has NSW Health been advocating to the Commonwealth around workforce planning issues?

Dr LYONS: We certainly advocate for the need for workforce planning across all of the health services that are provided, not just by NSW Health, but we have a core responsibility to plan for the services that we are directly responsible for. So, we do extensive workforce planning in relation to those. The issue I suppose I am highlighting is that, given aged care is predominantly provided by services that are outside of NSW Health, I am not aware to what extent Health workforce planning is being done for aged care. It could be that it is being done in places that I am not aware of, that's all.

The Hon. DANIEL MOOKHEY: Look, I accept that it is not your responsibility to know everything that your department is doing.

Dr LYONS: Or that the Commonwealth might be doing, or that aged-care operators might be doing.

The Hon. DANIEL MOOKHEY: Well, I am certainly not suggesting for a second, Dr Lyons, that you are all-seeing when it comes to Australia's health system but let me therefore be specific about NSW Health. Can you take on notice and come back to us with any information about specific advocacy that NSW Health has been making to the Commonwealth or for that matter anybody else around workforce planning issues to do with aged care?

Dr LYONS: Certainly.

The CHAIR: In the absence of any other questions, I have quite a few, Dr Lyons.

The Hon. WES FANG: I have just got a few more but that is all right.

The CHAIR: I just ask you: Have you done any modelling around the role of registered nurses in aged-care facilities and the impact that could have on reducing the workload on public hospitals?

Dr LYONS: Not that I am aware of.

The CHAIR: Okay. Can you take that on notice and see if anything has been prepared by the department?

Dr LYONS: Certainly.

The CHAIR: Thanks. I just need you to say yes so we can register it.

Dr LYONS: That is all right. That is fine.

The CHAIR: Can I just ask as well: Would you agree—I mean, I understand what you said earlier about the New South Wales Government's position: That there is a need for trained healthcare professionals within our aged-care sector. Would you agree that this has been shown even more so through the COVID pandemic with the need for trained staff within our aged-care facilities, including registered nurses?

Dr LYONS: I think it has highlighted that, certainly in things like infection prevention and control, the knowledge and experience and capability can be enhanced, and certainly there is a need. There has been just recently a decision by the Commonwealth to provide to the States and Territories under the COVID national partnership agreements and the funding to enhance infection prevention and control activities into the aged-care sector. So, we welcome that investment and we are looking at how we can provide that extra expertise in.

The CHAIR: It shows that there is a need for a stable and a trained workforce to be able to carry out these measures, particularly in a global pandemic. That is correct, is it not?

Dr LYONS: Certainly stability of the workforce is important and having a workforce that is aware of the operating models staff and teamwork arrangements, particular needs of the residents—all those things are hugely beneficial, yes, through stability.

The CHAIR: Can you tell me when the review of the Poisons and Therapeutic Goods Act will be completed?

Dr LYONS: I cannot tell you, but I can take that on notice.

The CHAIR: Okay. Can you tell me when it commenced?

Dr LYONS: I cannot tell you that either because it is not actually my area of responsibility. That is something that falls under another part of the department, so I am not directly aware of all of those particular components, but I will take them on notice.

The CHAIR: Okay. Can you tell me if NSW Health does any mapping of young people who are currently in aged-care facilities?

Dr LYONS: So there is continuing to be advocacy around this. We do map and look at some young people who are—particularly in the aged-care facilities that we have responsibility for and we have seven aged-care facilities that we operate across the State.

The CHAIR: Okay. Can you provide the list of those on notice?

Dr LYONS: Certainly.

The CHAIR: And the numbers of young people—

Dr LYONS: And numbers of young people in those facilities, we can.

The CHAIR: —in each facility. But if you can also provide us with any details of mapping of young people across the broader system?

Dr LYONS: Sure.

The CHAIR: At the outset of the COVID pandemic, when the first case was first detected at Dorothy Henderson Lodge, NSW Health played a role in getting what we call a surge workforce into the lodge. Is that correct?

Dr LYONS: There was an involvement of providing staffing from the Northern Sydney LHD, yes.

The CHAIR: Is that something that you have looked at more broadly across the system?

Dr LYONS: It is. That was what I was alluding to in response to the question that was previously put to me: That we looked at providing a surge workforce, if required. Our first—in terms of these outbreak management responses and the discussions that we had with the local aged-care providers, our first preference was for the aged-care operator to look at what ability they had to surge their workforce. But we were very conscious that the findings at Dorothy Henderson and Newmarch showed that there was significant impact on the workforce of the operator. So there was a need to look elsewhere. The Commonwealth provided access to workforce agencies that provided the staff in, but sometimes there were issues around the timeliness of being able to access those staff. So we were looking at what we could do in terms of having a response from the local health district.

But in addition to their own staff—because we were very conscious that we did not know what the context might be in which these were occurring. And if there was a pandemic to the point where there were infections in an aged-care facility, our services were probably going to be impacted as well. So then we looked at whether or not we could actually employ some additional staff that might go in on a surge basis. We explored that concept and established a pool to be deployed if required. Fortunately, we have not required that, but we were certainly very conscious of this issue and the need for solutions.

The CHAIR: When were those staff hired?

Dr LYONS: They were given some basic training and put on a retainer, but I do not think we ever deployed them into a facility, so they have never actually been working in an aged-care facility at this point.

The CHAIR: I am happy if you want to take this on notice, but can you tell us a date at which that surge workforce was trained and when the retainers began to be paid?

Dr LYONS: Will do.

The CHAIR: Thanks. Why did it take until day 22 at Newmarch House to separate the positive and negative cases?

Dr LYONS: I cannot remember the specifics of exactly what happened and why and on what days. As you can imagine, a lot has transpired since Newmarch. I do know that there were difficulties in actually knowing who was positive and who wasn't because it was considered that there was significant exposure because the staff member had worked for a long period, and it was unclear to what extent residents had been infected or not. So it took a couple of weeks before it was really clear about who was actually infected from that situation. Then there was the concern that there might have been potential for further infection through interactions between staff while the pandemic response was underway. So it did take some while for it to be clear exactly which of the residents was affected and which were not.

The CHAIR: I come back to my earlier question when I said that at Dorothy Henderson they were not tested on day one. It took several days for that to occur. This was reported by *Four Corners*: On day 22 they finally separated the positive and negative cases.

Dr LYONS: Just to reflect on that: Just because you are tested and have a negative test result does not mean that you have not been infected.

The CHAIR: I do not dispute that, Dr Lyons.

Dr LYONS: So you could still be in the incubation period. I am conscious that there are assertions being made here that I think we need to—I am not a public health expert or an infectious diseases expert. I think there

has been independent reviews of both Dorothy Henderson Lodge and Newmarch House that have provided advice about what can be done better as a result. In that context, I am being cautious about how I respond to the questions.

The CHAIR: I am happy if you take that on notice.

Dr LYONS: It may be that it has already been covered by a report, given there has been a number of reports into—

The CHAIR: Yes, and I have read a number of them, so I would appreciate if you could take the question of why they took until day 22 to separate residents into positive and negative cases on notice.

Dr LYONS: I am just trying to understand what is behind the question.

The CHAIR: *Four Corners* reported that on day 22, after 14 deaths occurred in Newmarch House, Anglicare finally told families that it was going to separate positive and negative cases—I assume that means known positive cases—from each other in the facility over the coming days. I was wondering if you could explain on notice why that was the case.

Dr LYONS: It might actually be better to put it to the operator, if Anglicare were the people who were providing that response to *Four Corners*. It is maybe not something that I have knowledge of, that is all I am saying.

The CHAIR: I am comfortable that if we do hear from Newmarch House, I may put this question to them as well. But I am asking whether you will take this question on notice and perhaps consult with some other people in NSW Health about why that decision was taken.

Dr LYONS: If we are able to provide a response, I will.

The CHAIR: Thank you very much. How many resources are currently in place to enforce the regulation of this weird duality system we have in the Public Health Act, where if you had a system in place before 2014, you are required to have a registered nurse on deck 24/7, but if it was established after 2014, it is not. Does NSW Health have any enforcement provisions or any resources to put into enforcing this regulation?

Dr LYONS: I will take that on notice.

The CHAIR: In terms of your mapping, you said at a local health district level that there might be mapping of specific local hospitals. I am not sure whether you took on notice whether you would provide that information for us.

Dr LYONS: We might be able to provide an example of that. All I am saying is I am not sure we would be able to provide that across the whole State because we do not have visibility necessarily of all of it across the State. But I will do my best to provide you an example of how that is being done.

The CHAIR: That would be helpful. I wanted to come to the question of accessing personal protective equipment [PPE]. That was something that was raised in both the NSW Health response to the independent review of Newmarch House but also more generally has been raised in this inquiry. What is the New South Wales Government currently doing to allow aged-care facilities to access PPE?

Dr LYONS: Our position is that we recognise that there are arrangements for aged-care providers to gain access to PPE if they require it. Certainly they have got to have their own operating processes. They should have business practices where they ensure they have appropriate PPE available to provide care as part of their responsibilities. If they have difficulties accessing PPE, they can access the National Medical Stockpile. If there are situations where there is time criticality and they are short, then certainly we are very keen to make sure they have got no barriers to having access to PPE and we will provide it in that situation through the local health district arrangements to the aged-care operators to ensure they have got access to it.

The CHAIR: Are you aware of how many instances the national stockpile has been accessed by New South Wales aged-care facilities?

Dr LYONS: I do not have those figures. They are a Commonwealth responsibility. I do not have access to the National Medical Stockpile.

The CHAIR: But according to the NSW Health response to the independent review, it says that NSW Health was advised on the Friday evening—six days after the outbreak had begun at Newmarch House—that they were having potential PPE shortage. Are you aware of whether they accessed the national stockpile?

Dr LYONS: I believe they endeavoured to access the National Medical Stockpile, but it is a question about how quickly those supplies can be delivered. So in the circumstances, my understanding is that the Nepean Blue Mountains Local Health District were very happy to make sure there was PPE available to Newmarch so that they were not short.

The CHAIR: But this shows that it was actually the State hospital sector that was stepping in despite the fact there is this national stockpile. Is that correct?

Dr LYONS: Correct.

The CHAIR: Are you able to take on notice whether there were any instances of accessing the national stockpile by aged care?

Dr LYONS: At Newmarch?

The CHAIR: By New South Wales aged-care facilities.

Dr LYONS: By New South Wales aged-care facilities—do you mean the ones that we are responsible for or the 880 that are in the State?

The CHAIR: If you are aware of any of the 880 that work with your local health districts accessing the national stockpile.

Dr LYONS: Certainly.

The Hon. DANIEL MOOKHEY: By the way, how many are you responsible for?

Dr LYONS: Seven.

The Hon. DANIEL MOOKHEY: And where are they?

Dr LYONS: I have not got all of them off the top of my head, but I know there is Garrawarra in South Eastern Sydney Local Health District. There is Wallsend in Hunter New England. I think there is one in Lithgow in the Blue Mountains. They are spread across the State.

The Hon. DANIEL MOOKHEY: On notice, can you provide us with the location, the number of residents, and the number of staffs in them as well so we can get a basic snapshot of what NSW Health directly operates?

Dr LYONS: Certainly.

The Hon. DANIEL MOOKHEY: Can you also provide us some information about registered nurses at those facilities—I presume they are 24 hours—and equally the number of care staff as well so we can start to see what the ratio is between patients, staffs and registered nurses?

Dr LYONS: Yes. Can I just try and get behind that question? I think this is one of the issues for the State in providing these services—that we have historically provided the services with a profile of staffing depending on what type of residents are actually in those facilities.

The Hon. DANIEL MOOKHEY: Perhaps on notice you can provide whatever explanatory detail you like in respect to each facility. I accept that they are different and they have been consigned for different purposes and the decisions that they would make would reflect the different circumstances. It is really just a case of getting the information and I welcome any explanatory detail you would like to attach to it.

Dr LYONS: Certainly.

The CHAIR: Just to be clear, we want the total number of residents; if there is a registered nurse on duty; if it is 24/7; and any other care staff.

The Hon. DANIEL MOOKHEY: And the number of care staff by 24 hours. That would be useful.

Dr LYONS: And the type of residents?

The Hon. DANIEL MOOKHEY: Yes.

The CHAIR: That is perfectly fine.

Dr LYONS: Because some of those have got highly specialised responsibilities which might put them apart from a direct comparison with other operators.

The Hon. DANIEL MOOKHEY: Yes, of course, and we would like to be able to tease out the differences, as well, as to what each facility does. If you are going to be generous, I will equally take how a resident gets admitted to those facilities. That would be really useful, too.

The CHAIR: I think that would be very helpful.

The Hon. DANIEL MOOKHEY: And how much people have to pay.

The CHAIR: Excellent.

The Hon. WES FANG: And the colour of the bed sheets.

The Hon. DANIEL MOOKHEY: Yes, I will take that too.

The CHAIR: Excluding the last question from Mr Fang, I think we will assume that Dr Lyons has taken those questions on notice.

Dr LYONS: We will do our best to provide that information.

The CHAIR: I appreciate that.

The Hon. WES FANG: What do they serve on a Wednesday lunch?

The Hon. DANIEL MOOKHEY: If you want to provide that, we will take it.

The CHAIR: Thank you for your time this afternoon and for the information that you have provided to the Committee, Dr Lyons. I understand you have taken a number of questions on notice; the secretariat will be in contact about those. We are asking that those answers are provided within seven days. That concludes the hearing for today. Thank you very much.

Dr LYONS: Thank you.

(The witness withdrew.)

The Committee adjourned at 14:00.