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 29 March 2021

The Committee met at 10:00

PRESENT

The Hon. Courtney Houssos (Chair)
The Hon. Greg Donnelly
Ms Cate Faehrmann
The Hon. Wes Fang
The Hon. Taylor Martin
The Hon. Daniel Mookhey
The Hon. Mark Pearson

PRESENT VIA TELECONFERENCE

The Hon. Mark Banasiak (Deputy Chair)

CORRECTED

The CHAIR: Good morning and welcome to the second 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 require 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 who are present or who might be watching on the broadcast today. Today we will be hearing from a number of key stakeholders, including the Chief Executive Officer of Anglicare Sydney, the Nurses and Midwives Association, the Health Services Union, the Australian Health Services Research Institute, and a number of industry bodies and community groups. I thank everyone for making the time to give evidence to this important 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.

If witnesses are unable to answer a question today and want more time to respond, they can take a question on notice. Written answers to questions taken on notice must be provided within 14 days. If witnesses wish to hand up documents, they should do so through the Committee secretariat staff. For audibility of the hearing today I remind both Committee members and witnesses to speak into their microphones. As we have a number of witnesses in person and via videoconference, it might be helpful to identify to whom questions are directed and who is speaking. Those with hearing difficulties who are present today, please note that the room is fitted with induction loops compatible with hearing aid systems that have telecoil receivers. Finally, everyone present should turn their mobile phones to silent for the duration of the hearing.

CORRECTED

GRANT MILLARD, Chief Executive Officer, Anglicare Sydney, sworn and examined

The CHAIR: I welcome our first witness, Mr Grant Millard. Before we commence, let me acknowledge that Anglicare has raised concerns in relation to potential prejudice to its interests in the coronial inquest into the deaths of the 19 residents at Newmarch House. I wish to observe for the benefit of the witness that these proceedings are covered by parliamentary privilege and the evidence given by Mr Millard today may not be used in court proceedings against him or Anglicare Sydney. I note that Mr Millard is appearing under summons today. Under paragraph 12 (b) of the procedural fairness resolution to the House, witnesses appearing under summons may be required to answer questions if the Committee so decides and failure to do so may constitute contempt of Parliament punishable under section 11 of the *Parliamentary Evidence Act 1901*. Mr Millard, let us get underway. Did you want to start by making an opening statement?

Mr MILLARD: Yes, thank you, Chair. I have a brief opening statement. I will just read it.

The CHAIR: Please keep it to a couple of minutes if you can.

Mr MILLARD: Good morning. I am pleased to be with you. I wish to acknowledge the very important work of this Committee regarding the role and presence of registered nurses [RNs] in the operation of residential aged-care homes. I am the CEO of Anglican Community Services and we operate under the name Anglicare Sydney. We are a not-for-profit public benevolent institution and a large residential aged-care provider with 23 residential aged-care facilities located in New South Wales. I welcome the opportunity to discuss and share our experience and learnings with this Committee. While I have received a summons to attend, this should not reflect any slight by me towards the very important work of this Committee. However, the context of the pending coronial inquest into the tragic deaths suffered last year in Newmarch House means we did not want to be seen to be traversing the work of the NSW State Coroner so I sought the issue of a summons.

The Royal Commission into Aged Care Quality and Safety has recently issued its final report. Among the many recommendations, there are key findings and recommendations in relation to the issue of staffing, including in relation to nursing staff. The terms of reference for the royal commission required an inquiry into the critical role of the aged-care workforce in delivering high quality, safe and person-centred care. The commissioners have now concluded that "there is now a clear and pressing need for a substantial development of the workforce in the aged-care sector." The royal commission also held hearings in August 2020 concerning the early experience of residential aged-care homes, including Newmarch House, in dealing with COVID-19. The report was issued on 30 September last year and, amongst a number of findings, included important information about lessons for residential aged-care facilities in managing an outbreak during a pandemic. I welcome the opportunity to answer your questions this morning.

The CHAIR: At the outset, I will perhaps ask you to just briefly talk us through the events that occurred and specifically the dates that they occurred after the first case of COVID was discovered at Newmarch House, which I believe was on 11 March.

Mr MILLARD: Yes, that is correct. I will try to keep this brief. I must refer to my notes.

The CHAIR: Of course.

Mr MILLARD: You are quite right. The first case of COVID was identified on Saturday evening. It was Easter Saturday on 11 April.[1] On 12 April on the following day we were notified about a second staff member who tested positive and the first resident also tested positive on 12 April.

The CHAIR: When did testing begin of all of the patients?

Mr MILLARD: Polymerase chain reaction [PCR] testing actually commenced on 12 April on Sunday, so Nepean Blue Mountains Health were in there testing on the first day really.

The CHAIR: Did they test all of the residents? When were all of the residents tested?

Mr MILLARD: To my knowledge, all residents were tested and the program was to test all residents and all staff—everyone who was potentially listed as a close contact. It occurred over a number of days. There

[1] In his evidence, Mr Grant Millard, Chief Executive Officer, Anglicare Sydney referred to a number of dates in March. Mr Millard subsequently clarified that any references to dates in March should be corrected to April.

were challenges with actually testing people, particularly residents with cognitive difficulties. It was quite confronting to have people who had cognitive impairment be approached by someone in full personal protective equipment [PPE] wanting to put something up their nose. You can understand that. So was a bit of a challenge. But it did occur over a few days. Certainly where there is

The CHAIR: Okay. Perhaps you can take on notice exactly when that first round of testing occurred. I understand that later on—

Mr MILLARD: 12 April.

The CHAIR: When was it completed?

Mr MILLARD: Yes, that is really a matter for State Health. They have the detailed records on that. But I will seek to provide that to you.

The CHAIR: Yes, we have asked specifically that question of NSW Health, which has previously appeared at the inquiry, and it did not give us a conclusive answer. I would be interested if you have got records of when that first round of testing was completed and then how the subsequent rounds of testing were conducted. Mr Millard, did you make any requests for additional personal protective equipment from NSW Health?

Mr MILLARD: Yes, indeed, we did. We first went to the Commonwealth Government as they are the regulator for aged care and we sought to access the national stockpile. There were volumes of evidence in the information given to the royal commission about this. I think it is a matter of record that we faced significant difficulties in accessing PPE and initially received rejections of our requests. In fact, statements were made that PPE was only for use for those residents who were actually COVID-positive or suspected as being COVID-positive and one of the key learnings about an outbreak of COVID in a residential aged-care facility is that you need to regard everyone as if they are positive until it is proven otherwise by a series of testing over an extended period.

The CHAIR: That was a significant impost. I think I read somewhere that it was about $21,000 every day. Was that right?

Mr MILLARD: There were about 21,000 items of PPE that we went through every single day.

The CHAIR: Sorry.

Mr MILLARD: It was millions and millions of dollars, some of which was incurred by Anglicare and some of which was incurred by the Commonwealth. I believe the State also supplied gowns and aprons.

The CHAIR: Was that as a result of a request from yourselves or did that go through the Commonwealth?

Mr MILLARD: We made direct requests to New South Wales State Health and we also made direct requests to the Commonwealth. As was our evidence during the royal commission hearings, there was substantial confusion about who was responsible for what and who was taking a lead in these matters and everyone was trying their very hardest to get PPE. At that time it was scarce and people were very concerned about community transmission so it was a challenge.

The CHAIR: You said that there was some confusion between Commonwealth and State. Can you talk us through the specific days or what exactly happened, what specific requests you made and what that process was?

Mr MILLARD: Regarding PPE?

The CHAIR: Yes.

Mr MILLARD: Right. Anglicare had sought to secure its own supplies of PPE and we had actually been obtaining masks, foot coverings, gowns, hairnets and goggles, but when we learned—we were in discussions with Dorothy Henderson Lodge about their experience of the outback. It became clear that the volume of PPE that we had accumulated even to deal with an outbreak in one home was just not going to be adequate. So before we actually heard about the index case or the first notified positive case in Newmarch House we had been seeking to contact the national stockpile to establish protocols about how, if we did have an outbreak, we could access that stockpile and that was challenging.

The CHAIR: Could you explain that a little more, Mr Millard?

Mr MILLARD: The position that we received was that we would only be able to access the national stockpile in the event that we did actually have an outbreak. Within a number of days we did actually have an

outbreak and regrettably our outbreak occurred in the middle of Easter on Saturday evening. We faced significant challenges with accessing responsible persons to deal with requests over that period.

The CHAIR: I will come to this question about requests for PPE because this was specifically addressed by the New South Wales Government in their response to the final report of the independent review, where they said that no additional—they confirmed on 13 April that PPE was confirmed to be in place for staff and no requests of further assistance were made. That is not correct, then, is it, Mr Millard?

Mr MILLARD: I do not believe it is. I think the email documentation that has been supplied already to the royal commission is also going to be part of a document package going to the coroner. It would point to a different conclusion.

The CHAIR: I am happy if you want to take that on notice, but could you provide us with a breakdown of how many requests for PPE you made to NSW Health? That would also be helpful. I want to go to the question of what specifically happened. You talked about Dorothy Henderson Lodge and they obviously have their crisis team. Different terminology is used but they had their crisis team in place right from the very first day that a case was identified. When was that crisis team in place for you in Newmarch House? When did those NSW Health representatives come in?

Mr MILLARD: Dr James Branley from Nepean Blue Mountains hospital was certainly on site from the thirteenth. It may well have been on the twelfth—I would need to check that—but very early on.

The CHAIR: When was the crisis team actually put together? When was that team of people who were supposed to be overseeing the response established—those key NSW Health representatives who were supposed to work with your existing management structure?

Mr MILLARD: The agreement for leadership and different roles between the Commonwealth, Anglicare as the approved provider and NSW Health was only finally agreed on 21 April, some time after the initial outbreak. Everyone was trying their very hardest to be present and be there. But in terms of physical presence by State health, I am only aware of the presence of James Branley and perhaps also Dr Anita Sharma from the Virtual Aged Care Service at that stage. I would need to check what other personnel were there.

The CHAIR: There was obviously Dr Branley, who I think is the head of infection control at Nepean Blue Mountains.

Mr MILLARD: Yes, that is my understanding.

The CHAIR: So he was incoming, providing that. But you are saying the team was put together on 21 April?

Mr MILLARD: At Newmarch House itself, after the outbreak was declared, my understanding is there was very little physical presence evident from NSW Health and the Commonwealth Government. In fact, my recollection is that no-one from the Commonwealth Government actually attended the site until weeks and weeks into the outbreak. I attended with them when they came. From State health, I am not aware of large numbers of people. Certainly many people were operating behind the scenes. We were having daily telephone calls and conferences multiple times a day with the public health unit, so there were many people involved in this. But physically in the home, I think you could count them on your hand.

The Hon. MARK PEARSON: I will ask questions that relate to the same theme. What constitutes the crisis team?

Mr MILLARD: To be frank, that is not a term that I am really familiar with. Our experience at Newmarch House was that very early on through the PCR testing we had a list of staff who were identified and known to be close contacts of COVID-positive patients, who were immediately required to be removed from site. That meant that within a week we had lost almost 90 per cent of our workforce. We had a dire problem in seeking to obtain staff, in particular registered nurses [RNs] and personal care workers to attend on site. Anglicare had already pre-prepared. In the event of an outbreak we had, on roster and available, a workforce consisting of personal care workers and registered nurses that would have dealt with an outbreak of about 40 per cent of the workforce of a home. That workforce was activated; that was called the surge team. But when they went into the home, because of the evolving nature of the PCR testing identifying who was actually positive, they themselves were then substantially all listed as close contacts and had to be removed. If you like, we were sending our troops into the battle and unknown to them they were actually being potentially contaminated and had to be removed from the site.

The Hon. MARK PEARSON: So the crisis team is the intervention that replaces all the staff who had to leave because of infection.

Mr MILLARD: We referred to it as the surge team, yes, the surge workforce.

The Hon. MARK PEARSON: Okay, so that happened on 21 April.

Mr MILLARD: No, sorry, the surge workforce was actually present within the first few days of the outbreak.

The Hon. MARK PEARSON: Okay. But by the time this crisis team was established, so to speak, how many residents had died?

Mr MILLARD: The first death of a resident due to COVID-19 was on 19 April. Two residents had passed away.

The Hon. MARK PEARSON: Okay. I have a quick question about the testing. You have said that it is very difficult for a person who is demented or confused or who has cognitive or mental health issues to be able to relax or whatever when this test is being done. Has Anglicare looked at the possibility that there were factors that could have caused an incorrect diagnosis because of the difficulty of doing the swab correctly?

Mr MILLARD: I think that is a matter for those responsible for PCR testing. It was not just one or two swabs taken; there were multiple rounds of testing. Residents were tested every couple of days. The frequency of testing decreased the further we went on, but the last three COVID-positive residents were identified on 30 April. That is day 20 of the outbreak. The outbreak was designated as a period of 66 days in total—that is when it finally cleared—but the last resident was identified on day 20. Through this process of rigorous testing, isolating residents and cohorting residents, they were able to identify who were true negatives and who were actually positive.

The Hon. MARK PEARSON: Would you say that you were seriously understaffed because of so many staff having to leave because of being positive or a risk? Were you seriously understaffed for a period of two to three weeks because of that?

Mr MILLARD: There was a critical period, I believe, of no more than a week. But we were seriously understaffed, yes. We were reaching out to everyone through the Commonwealth surge workforce, which was originally through Mable and then through Aspen. I think Dr James Branley referred to what was probably the darkest day on 20 April, when he himself had to roll his sleeves up and get involved in personal care for some residents. Everyone was pulling out stops but despite everyone's effort, there just were not staff anywhere.

The CHAIR: That is pretty remarkable testimony, Mr Millard. You would be aware that the Committee has now received evidence that the surge workforce that the New South Wales Government was seeking to employ was not actually in place until October or November last year. That was a key challenge for you in the midst of the pandemic, is that correct?

Mr MILLARD: Yes, it was. It was our experience and it was the experience of Dorothy Henderson Lodge, even though their outbreak was not as significant in numbers. I did receive a call personally during the Dorothy Henderson Lodge outbreak—"Can we please provide staff?" That was their experience, it was our experience and tragically in Victoria, shortage of staff and lack of surge workforce was a huge issue there as well.

The CHAIR: So along with accessing the appropriate PPE, finding the staff to then staff the centres was crucial and should have been crucial to the Government's response. Is that not correct?

Mr MILLARD: Indeed. I might just mention the types of staff that you need and the impact on residents of being isolated in their own rooms and being tended to by new staff in full PPE. They do not know the residents. The residents are in their home and it is very invasive and traumatic for them. Many of the staff they were presented with—some RNs had never worked a shift. It was their first job in residential aged care. Many had no aged care experience.

The CHAIR: Mr Millard, I want to ask you about that in terms of the actual training that staff undertook before they started. I appreciate the shortages and the context of that. What kind of training did RNs and personal care workers receive before they started working in Newmarch House?

Mr MILLARD: There was, if you like, a cut-down induction program. I will need to take the question on notice to give you the details of that because the training materials are available. But it was intended to familiarise the people with the home and with the environment and drill them in the use of PPE, because that is a skill that needs to be practised and practised and practised. When you are tending to residents, you could be taking PPE on and off up to 70 times a day and you need to be rigorous about that—no mistakes.

The CHAIR: Did the Commonwealth or the New South Wales Government provide you with support to provide that training to your staff who were coming in?

Mr MILLARD: My understanding is that the Commonwealth certainly had put together infection control training and some PPE videos. However, we were relying on our own resources because we were there in the home and we knew what actually worked. We were also under the guidance and assistance of the Clinical Excellence Commission and Kathy Dempsey, who did an outstanding job.

The Hon. DANIEL MOOKHEY: Forgive me for some really preliminary questions, Mr Millard. How many aged care facilities does Anglicare operate in New South Wales?

Mr MILLARD: Twenty-three.

The Hon. DANIEL MOOKHEY: Are you one of the major providers of aged care services in New South Wales?

Mr MILLARD: Within New South Wales, yes, we would be.

The Hon. DANIEL MOOKHEY: And how many staff do you have working there?

Mr MILLARD: For the organisation?

The Hon. DANIEL MOOKHEY: Yes.

Mr MILLARD: We have a bit over 4,000 staff, but we are a large organisation that operates lots of activities.

The Hon. DANIEL MOOKHEY: Okay, but is that 4,000 staff directed towards the primary purpose of aged care?

Mr MILLARD: No.

The Hon. DANIEL MOOKHEY: How many staff do you have which are directed to that purpose, at this stage?

Mr MILLARD: To give you an accurate number I will need to come back with that number, but it would be the vast majority of the 4,000 staff.

The Hon. DANIEL MOOKHEY: Okay. How many registered nurses do you have on staff?

Mr MILLARD: The actual number would be difficult to quantify. We do actually have registered nurses on duty 24 hours a day in all of our homes. The number at a given point in time—I would need to confirm that with you. The number of RNs in a home depends on the care needs of individual residents. It really depends on the skill mix.

The Hon. DANIEL MOOKHEY: Do you retain them as full-time employees in your organisation?

Mr MILLARD: Our preference is to employ people on a permanent basis, whether that is full-time or part-time. Often it is the worker's choice for flexibility to work on a part-time basis.

The Hon. DANIEL MOOKHEY: Okay. I was just after the headcount.

Mr MILLARD: We do not agree with casualisation, if that is what you are getting to.

The Hon. DANIEL MOOKHEY: All I am really after is the headcount of how many permanent RNs you have on staff, exclusively working for Anglicare. That was it; there was nothing more loaded than that. Also, how many personal care workers of each form do you have? I am happy for you to take that on notice, if you can. We are just trying to get a bit of a footprint.

Mr MILLARD: I will provide that to you.

The Hon. DANIEL MOOKHEY: Do you accept the general point that you are a major employer of aged care workers in New South Wales?

Mr MILLARD: Yes.

The Hon. DANIEL MOOKHEY: Aside from the Newmarch context, which is of course valid, as of today what are the training requirements that you require for a person to work as a personal care worker?

Mr MILLARD: My understanding is that the minimum standard is for someone to have Certificate III training. I think there has been a fair amount of evidence before the royal commission about the adequacy of that

training. Our experience is that it needs to be significantly augmented by on the job training and skilling up—but, yes, Certificate III.

The Hon. DANIEL MOOKHEY: Can you tell us, therefore, what on the job training and skilling up you provide?

Mr MILLARD: We provide a comprehensive induction program—some of which is in person and a lot of which is online through modules, which are followed up by testing for competency—and on the job mentoring, support and oversight. We use an online learning platform called Cornerstone, which has significant volumes of training to be undertaken, and completion of those modules is monitored and reported.

The Hon. DANIEL MOOKHEY: If that is what you offer, do you require your staff to complete the training?

Mr MILLARD: Yes, we do.

The Hon. DANIEL MOOKHEY: How many hours does it involve to get to the requisite standard that you apply?

Mr MILLARD: I am happy to provide you with that information about the hours and the composition of that training.

The Hon. DANIEL MOOKHEY: I presume they are remunerated while they are doing that training?

Mr MILLARD: They are.

The Hon. DANIEL MOOKHEY: Yes. Do you use labour hire in your facilities?

Mr MILLARD: Where we cannot fill shifts, we will provide agency staff. We have a policy of seeking to minimise the use of agency staff. But, of necessity, you have to rely on them at times.

The Hon. DANIEL MOOKHEY: Yes, sure. How many labour agency staff do you have, say, on staff today as a proportion of your total staffing needs?

Mr MILLARD: If we are talking about residential aged care—

The Hon. DANIEL MOOKHEY: Yes.

Mr MILLARD: —it would be a very low percentage. I would need to give you that precise information and over what period of time, but it is a very low proportion. It does tend to be a bit higher in community aged care. I think the Committee will be aware of the significant challenges in employing and sourcing an aged care workforce.

The Hon. DANIEL MOOKHEY: Yes. If you do not mind taking that on notice, that would be helpful. Are you currently embarking upon a process of reducing hours across your business in terms of your staff, by any chance?

Mr MILLARD: We have a matter before the Fair Work Commission at the moment where we have looked to change the roster structure. When we look at the performance of Anglican Community Services homes versus the latest StewartBrown benchmark data, our staffing costs are higher. It is somewhat anomalous with the 50 per cent band which we seek to be at. So, yes, we have been looking to reduce hours.

The Hon. DANIEL MOOKHEY: And that is across all 23 facilities?

Mr MILLARD: It will vary between homes. Some homes have more of an issue than others. But, as a general proposition, yes.

The Hon. DANIEL MOOKHEY: If I am right—and correct me if I have misinterpreted you in any way—according to a benchmark, you have concluded that your facilities are overstaffed by a number of hours. Is that fair?

Mr MILLARD: I would never want to say that our services are overstaffed. The issue is—

The Hon. DANIEL MOOKHEY: Well, you have surplus hours being performed by your workforce.

Mr MILLARD: It is an issue of financial sustainability and viability. Our organisation last year—currently we are operating at a loss of circa $20 million per annum for residential aged care. That is not sustainable.

The Hon. DANIEL MOOKHEY: That is in the New South Wales operations?

Mr MILLARD: That is for our organisation. This position is multiplied across the sector. It is dire.

The Hon. DANIEL MOOKHEY: Sure. Look, to be fair, the royal commission has made it very clear about the financial distress that the industry is under. I am not suggesting for a second that it is specific to you, certainly not at this point. What I am wanting to appreciate is, therefore, how the industry and the sector is responding to that. How much do you expect to save through the reduction of hours in your facilities?

Mr MILLARD: We are looking to adjust our wage costs to approximately 85 per cent of government subsidy income.

The Hon. DANIEL MOOKHEY: Okay. In quantum terms, how much would that reduce in terms of costs?

Mr MILLARD: I am sorry, I do not have that knowledge to hand. I can provide that to you.

The Hon. DANIEL MOOKHEY: Okay. Do you think that the reduction in hours is going to have an impact on service levels to residents?

Mr MILLARD: The cost reductions that we have been seeking to make are not really focused on direct care delivery. They are more in operational matters—so, for example, a reduction in servery staff and operational administrative roles. The focus through this reduction in hours has been to not compromise care hours at all, but what we have seen is that we have some fairly rigid rosters and some inflexible work practices. We are trying to get more hours for those who actually work for us, and minimise casualisation. As a consequence of that, there is some inflexibility. I understand that for personal reasons people are not wanting to vary their hours.

The Hon. DANIEL MOOKHEY: But are you reducing catering hours, for example?

Mr MILLARD: We are reducing the costs of catering staff. Currently our food delivery cost—which includes central production and kitchen meal preparation, both of which are central and on site—is circa $37 a day, which is very high by industry standards, as an example.

The Hon. DANIEL MOOKHEY: Just to be very clear about your motive, is this because the current financing structure is unsustainable for Anglicare in your catchment?

Mr MILLARD: It is unsustainable, yes.

The Hon. DANIEL MOOKHEY: Have you advocated or raised this with the Federal Government or the State Government, aside from the sector's broader campaign?

Mr MILLARD: I think the sector has been very clear about this. On these matters we think a consolidated peak body approach is most impactful and that certainly has been done by our peak, Aged and Community Services Australia, and also by Leading Age Services Australia.

The Hon. DANIEL MOOKHEY: In terms of the independent review as well as the royal commission, how is it possible that—to be fair, the independent review has made clear that additional training is an absolute requirement, as well as additional staff. How is it possible that you could try to meet your recommendations to both increase training and increase staff when right now you are cutting it?

Mr MILLARD: The increased training is for staff on an individual basis. What we are seeking to reduce is the number of staff, so it is a mix involved there if you like.

The Hon. DANIEL MOOKHEY: Sure, but you agree already that the sector has been criticised for understaffing?

Mr MILLARD: I do not think it is just the sector that has been criticised. I think it is the Australian population as a whole in terms of, "Do we really care about the dignity and choice of people in aged care?" It is not what it should be, clearly. I think the Government is on notice and they need to respond with significant funding.

The Hon. DANIEL MOOKHEY: But sitting here a year after the height of the COVID crisis in, at least, Newmarch, it would appear that we are going backwards in terms of staffing levels, security, training, precautions, or am I inferring incorrectly?

Mr MILLARD: I think the royal commission report on workforce is very, very clear. They have heard, we have heard, and if you ask whether I am comfortable with reducing the number of hours, no, I am not. That is not the way we want to go, but if we want to stay viable—able to operate—there is very little else. We are a price taker from government. There is very little that you can do when we are already subsidising residential aged care to the tune of $20 million a year. We cannot do that.

The Hon. DANIEL MOOKHEY: Can you spell out, in terms of both pandemic readiness in general at Newmarch, how are we better off today than we were a year ago? What steps have you taken to improve both your pandemic readiness and to give comfort to the residents that if this was to appear again in one of your facilities it would not happen again?

Mr MILLARD: That is an excellent question, and infection control practices, competency in the use of PPE, is a clear identifying issue. It was a major issue at Dorothy Henderson Lodge, which benefited, actually, from the very early presence of Kathy Dempsey. We were not so fortunate initially. The Commonwealth Government has moved to require to have at least one infection control practitioner in every residential aged care home. That was a requirement that I think at the beginning of February had to be in place. We have that and have sought not just to have one present but to deal with succession planning to increase the level of infection prevention and control training and accreditation for our workforce.

The Hon. DANIEL MOOKHEY: So the core of the answer is there is an infection control expert in each facility?

Mr MILLARD: There is, on a daily basis. That is correct.

The Hon. DANIEL MOOKHEY: Is that in all 23 facilities?

Mr MILLARD: That is correct.

The Hon. DANIEL MOOKHEY: How are you affording that?

Mr MILLARD: There was some more funding given by the Federal Government towards the end of last year, but this is a number of regulatory imposts, if you like, which providers have really just had to take on board. There has been an element of funding in the first half of this year, which is helping to support some of these matters, but it is a challenge to do all these things on top of what you are doing already.

The Hon. DANIEL MOOKHEY: Are you saying that the Federal Government is cost-shifting to you?

Mr MILLARD: I think the royal commission has sought to examine the relationship between providers, which are not just not-for-profits, but for-profits and the Government, and providers are a price taker. We do not set prices. One of the recommendations from the commission is there needs to be a detailed cost review into what the appropriate cost is of providing safe and high-quality care. We would absolutely support that. It needs to be independently determined and regularly updated with inflationary indexation linked to real cost increases. We would fully support that.

The CHAIR: Thanks very much, Mr Mookhey. Mr Donnelly?

The Hon. GREG DONNELLY: Thanks, Mr Millard, for coming along today. In an answer to another question you explained that with respect to Anglicare Sydney it is policy to have registered nurses working at facilities 24 hours a day, seven days a week. Can I ask you a broader question because, obviously, as a large organisation working in this area—through, I guess, affiliation with Aged & Community Services Australia and other peak bodies—you talk about, discuss, examine the arrangements that they have with respect to the position of registered nurses. I am trying to establish from your general discussions with other operators—you do not have to reveal specifics if you do not wish to do so, but if you do you can—why are they saying, if they do say, that they do not believe that having registered nurses is necessary for running an aged care facility? In other words, "We can effectively run an aged care facility without registered nurses being there effectively 24 hours a day, seven days a week" Bearing in mind that is not the policy of your organisation, what is the argument that they are putting forward if they do discuss such matters?

Mr MILLARD: I cannot refer to any discussions that I have had with any senior leader who has argued that you do not need registered nurses in a nursing home. I think that the issue was more about sustainability, where you do not actually have a registered nurse 24/7 in a small home, of putting a registered nurse on to provide night coverage. That will be the difference between a minimal surplus and a loss. That was our experience in a couple of homes. When we made that change to 40-odd-bed homes—putting on a night RN which was not previously the case—but when we did that it made those homes a negative financial result. I think it is not just the right thing to do. I think there is a community expectation of that, and I believe that because of this no longer is there a distinction between high and low care in residential aged care. By far and away the population of a residential aged care home is comprised of people who either have memory support issues—there may be up to 70 per cent of people experiencing dementia—and high care needs. Our experience is that people do not come to residential aged care as a form of retirement living—not at all. They are complex healthcare needs, and you need registered nurses.

The Hon. GREG DONNELLY: With respect to the employment of registered nurses in aged care facilities, is a particular type of registered nurse sought to work inside such facilities? We are trying to understand, looking ahead, because this Committee will produce its report and some recommendations that, hopefully, the State Government will give some consideration to. Are we looking at a particular cohort of registered nurses who you are looking for to work in aged care facilities?

Mr MILLARD: As a general rule, what we look for when we look to recruit registered nurses is—I think we say, "We employ for compassion and train for skill". So we are looking for people who have the right mindset about aged care, that they are passionate about meeting with people. Aged care nursing is complex health care.

The Hon. GREG DONNELLY: Yes.

Mr MILLARD: It is very, very challenging. They often think, "Oh you're just helping give a Panadol." It is not the case; it is complex health care, and I think to have people in there who need to—often they will be trained with dementia care training, and we do provide that training for RNs and personal care workers for dementia-specific training. In instances we actually subsidise that training with external accreditation by this particular University of Tasmania. We employ our own clinical nurse consultants in dementia care, palliative care and we provide on-the-job training for that as well. So you are looking for people who have a passion for the work, first and foremost, and who are able to learn about what it means to tend to complex healthcare needs with people who are experiencing dementia.

The Hon. GREG DONNELLY: I ask this question not to reflect on the organisation you represent here, but this general question about the need to have registered nurses in nursing homes, which is clearly a policy of your organisation. First of all, do you have an explicit policy around that that actually mandates the position? So, for example, at one of your facilities it is understood that this is done because this is in a formal policy or does it take a different form?

Mr MILLARD: That is a good question. I am not aware of a particular policy, but it is a decision that we made under my leadership probably two years ago, I think, that we need to have RNs on 24/7. That is our policy with rostering. At a time you might have an RN who is sick or until we have an unfilled shift, but our approach is to have them.

The Hon. GREG DONNELLY: Yes, of course, but as a general proposition?

Mr MILLARD: Yes.

The Hon. DANIEL MOOKHEY: When you say "on duty", do you mean physically in the facility?

Mr MILLARD: Physically present, yes.

The Hon. DANIEL MOOKHEY: So that is the case for all of your facilities at all times—every day someone is physically present?

Mr MILLARD: That is our approach and policy. In fact, I just tried to test that recently looking at two weeks of rostered shifts. There were a couple of homes where that was not the case, but that was someone who was sick or a missed shift in the evening. But they are listed, if you like, as anomalous because there is a big red dot on the chart where they should be. That is our policy.

The Hon. DANIEL MOOKHEY: We have had other people who have come before us and said that at times when there has been a fall or an accident or a trip of some form they have had to fill out a form and call an RN because they are not at the facility. That was at one of your facilities; in fact, it was at Newmarch House.

Mr MILLARD: When was that, sorry?

The Hon. DANIEL MOOKHEY: That was given to us in an earlier hearing when we had a witness come before us, a personal care worker, who said that it was in fact almost routine that they would have to find—registered nurses were not physically present. It might be that they were factually incorrect or perhaps you were, but you are sure that at all times, with the exception of obvious illness or injury, you have a 24-hour nurse on site at all your facilities?

Mr MILLARD: I am just going through the data in terms of RNs on duty. It is the case because—as I mentioned, these dire staffing problems during the outbreak—night RNs, if they were the only RN on duty they were listed as close contacts. We had great difficulties in staffing. There were no RN at night on duty on 7 April, and on 12 April, which was the first full day of an outbreak, the Newmarch House went to 12-hour shifts—so we did not have three shifts a day, it was 12-hour shifts. We then started increasing the number of RNs per day—it

went up. The lowest day was 15 April, when there were just three RNs in total for the day. We were terribly scrabbling. The average number of RNs during the outbreak period was 26.5.

The Hon. GREG DONNELLY: Just changing tack slightly to the matter of the tragedy that took place and the matter of an "operational plan" for dealing with such an incident—we will call it an incident. As a large and professionally run aged-care operator that is well familiar with the Commonwealth's interface with aged care and Commonwealth regulation over aged care regarding all matters to do with aged care, did the Commonwealth have in place at that time—and when I say at that time, leading up to the outbreak—a specific operational plan or plans to deal with an incident like this that was clearly understood by yourself and other aged-care operators?

Mr MILLARD: I believe the conclusion of the royal commission concerning COVID was that the Commonwealth did not have an operational plan for aged care. It was relying on a healthcare plan but it did not have an aged care-specific plan. Anglicare had been relying on the Communicable Diseases Network Australia [CDNA] guidelines.

The Hon. GREG DONNELLY: So the Commonwealth did not have a specific operational plan for aged care, it was in the broader health domain of dealing with an outbreak of a viral incident like this. But with respect to yourself, if you could elucidate further, your operational plan was framed around what was a particular framework or architecture for dealing with something?

Mr MILLARD: That is correct. We had an operational plan in place, which had been revised for all our homes shortly before the outbreak at Newmarch took place. That outbreak management plan was based on the CDNA guidelines and the evidence we gave at the royal commission with the benefit of hindsight—hindsight is a wonderful thing—was that that plan was not adequate. It was based on an understanding of outbreak that COVID-19 was something like influenza, but it is not.

The Hon. WES FANG: I was just noting your testimony earlier when you were discussing much smaller aged-care facilities. Turning to the bill, you spoke of the difficulties with smaller aged-care communities being able to fund the impost of what would be a 24/7 nurse. Could you just talk about that experience and expand perhaps a little bit? Because being from a regional area, that is my greatest concern—that while a large organisation like Anglicare would be able to shoulder the burden, we know that some of the smaller homes may struggle, and you sort of spoke to that. I would just like a bit more expansion, if you would not mind?

Mr MILLARD: Yes, certainly. The only regional home we operate would be classified as Nowra, which is a considerable town where the workforce population—we do not particularly struggle with this issue. However, the royal commission has made it clear that many providers in regional or remote areas will struggle to staff at an appropriate level to have the skills necessary to operate residential aged care and certainly to seek an appropriate skilled and qualified workforce, including registered nurses. They would struggle with viability. The recommendations have been made in order to supplement or support the delivery of residential aged care in those locations because they would struggle at a small-home level with access to workforce to get the right skills mix necessary and access to RNs.

The Hon. WES FANG: Do you have a thought or position on how the New South Wales proposal would cross over with the findings of the royal commission with regard to nursing? If New South Wales was to go down this path prior to the Federal Government implementing changes, would that create difficulties for your organisation and would it be more harmonious to try to adopt a strategy across the nation?

Mr MILLARD: My personal and organisational perspective is that it would be better for us if we had one regulator and one source of regulation. The challenge of working with health authorities, both State and Commonwealth, was particularly acute during COVID outbreak. I note that the royal commission does have recommendations for 24/7 RNs to be provided, but that is only effective, I believe, from 1 July 2024, whereas they are recommending from 1 July 2022 to 16 hours per day. But, as I mentioned, we already have 24-hour RNs in our organisation.

The CHAIR: Just to be clear, Mr Millard, you made that decision two years ago as a policy change not because of Government regulation but because you think that is in line with community expectations. Is that correct?

Mr MILLARD: That is correct, yes.

The Hon. WES FANG: With what is proposed in front of our Parliament now, likely crossing over with Federal regulation, would you see it as a difficulty for your organisation to implement it now or would you prefer to wait for a single plan from the Federal Government and then just dealing with the one organisation?

Mr MILLARD: It would be simpler at face value to just see this matter implemented from a Commonwealth perspective, but I understand community expectations might be that this needs to happen sooner. However, there is a cost involved in that and it is not an insignificant cost, particularly for rural, remote and smaller providers.

The Hon. WES FANG: So, if you were operating a small aged-care facility in a regional setting with 30 to 40 residents and you were facing either a loss at the moment or a small profit, then a situation where without funding from either Federal or State governments to support this, you might question the viability of that location?

Mr MILLARD: It may have to go further than a question of viability. You may not be financially sustainable and you might fail. There have been registered nursing homes that have been failing and have had to close their doors.

The Hon. WES FANG: My final question is: What do you believe, in your experience, would be worse for the community? Would it be to have a nursing home or aged care facility leave a country town, being unviable, or to have a continued model that it potentially adopts already?

The CHAIR: Mr Millard, that is quite a hypothetical situation, I think.

The Hon. WES FANG: In your experience?

The CHAIR: We have let Mr Fang ask quite a lot. I will give you the option of declining to answer that one.

The Hon. WES FANG: In your experience?

Mr MILLARD: I would comment that it is a terrible choice that you would have to make and it ought not to be so.

The CHAIR: Mr Millard, I wanted to ask you this: You said that Kathy Dempsey, from the Clinical Excellence Commission, I believe, provided you with great support.

Mr MILLARD: Correct.

The CHAIR: What date did she come into Newmarch House?

Mr MILLARD: I will have to come back to you with the precise date.

The CHAIR: That is fine.

Mr MILLARD: But it was not as early as it was the case with Dorothy Henderson Lodge, but certainly within the first two weeks. But I will give you the precise date.

The CHAIR: That would be helpful. I have just got some really quick questions because we are running out of time and I know that my colleagues have a few questions. Did you refuse any offers of help from NSW Health?

Mr MILLARD: I am not aware of any such. In fact, we sought help.

The CHAIR: Okay. That is very helpful. If you want to provide us on notice with those request dates for assistance, that would be very helpful. Were all of your requests agreed to for testing staff, additional PPE and the like? Any others?

Mr MILLARD: We had sought support for the provision of registered nurses and we did not receive any. We relied on Commonwealth support largely and volunteer nurses from St Vincent's Hospital, which we were very, very grateful for. PPE requests initially, as I mentioned, was extremely challenging to access. We had pushback for the requests that we had made but, within days, those requests were being met. But it was a constant struggle to get. The delivery was managed very tightly.

The CHAIR: The sense of all hands being on deck that you would be provided with the resources that you needed, whether it was PPE or staff, that was not forthcoming from NSW Health. Is that right?

Mr MILLARD: Our experience was—and I understand that this was a public health emergency. There was huge concern about community transmission at the time. I understand all that. But our experience was it was frustrating and difficult to get access, yes.

The CHAIR: "Frustrating and difficult". You just said that there was pushback from—

Mr MILLARD: Initially, there was.

The CHAIR: Was that from the Commonwealth or from the State?

Mr MILLARD: State.

The CHAIR: From the State Government. Okay.

The Hon. WES FANG: Can I just clarify that? Sorry, Mr Millard. The PPE stockpile that you are seeking to access, that is the Commonwealth stockpile? Is that correct?

Mr MILLARD: It was that the national stockpile, Commonwealth. That is right.

The Hon. WES FANG: Yes.

Mr MILLARD: But some items are actually obtained and held by State.

The Hon. WES FANG: Okay. And the State Government was proactive in providing you PPE?

Mr MILLARD: No. We had to request it.

The Hon. WES FANG: But those requests that were likely satisfied. Is that correct?

The CHAIR: No. That is not what Mr Millard's earlier evidence was.

The Hon. WES FANG: Because that is different to my understanding. It is that the State Government—

Mr MILLARD: They were not met initially, no.

The Hon. MARK PEARSON: Can I ask a question?

The CHAIR: Of course.

The Hon. MARK PEARSON: Were you suspicious that there might be an attitude of other priorities above aged care by the State Government?

Mr MILLARD: Yes, I was.

The Hon. DANIEL MOOKHEY: On what basis did you have that suspicion?

Mr MILLARD: As I have said, I understand that the State Health bore a tremendous responsibility to cover the interests of the entire community. I do not believe there was any evidence of ageism—certainly not from Dr Branley—but I believe at the time there was great concern to keep COVID positive cases in Newmarch House and not risk a contamination beyond that place.

The Hon. DANIEL MOOKHEY: Is that the reason why you think NSW Health did not transfer them to any hospitals or any other facilities?

Mr MILLARD: Residents and families were told that under the Hospital in the Home Program, at their choice and should the need arise, they would be able to be transferred to hospital. I believe the experience of COVID is that from someone being stable to dying can happen very, very quickly in the elderly and there were a number of hospital transfers, but that was exceptional.

The Hon. DANIEL MOOKHEY: Did you seek to transfer a broader class of persons?

Mr MILLARD: The residents were under the clinical care, supervision and medical guidance of Nepean Blue Mountains health. That was not our call and there was always—and that is where the Hospital in the Home Program works. Those decisions are made because they are admitted as patients of State Health.

The Hon. DANIEL MOOKHEY: Did you seek to physically relocate, or did you ever express an opinion that they should be?

Mr MILLARD: The whole question about relocation of residents, both either positive or transferring negative residents out, was from the earliest days of the outbreak was a subject of considerable debate between Commonwealth, State and us as the provider. There was not a clear or consensus view.

The Hon. DANIEL MOOKHEY: Yes, but that was not my question. My question was: Did you seek to—

Mr MILLARD: We asked those questions but I did not force the point at that time.

The Hon. DANIEL MOOKHEY: I want to ask two other questions, unrelated.

The CHAIR: Yes, of course.

The Hon. DANIEL MOOKHEY: Mr Millard, what is the average salary or earnings of a personal care worker at an Anglicare facility who has a certificate or a degree qualification?

Mr MILLARD: I will take that on notice and provide it to you.

The Hon. DANIEL MOOKHEY: Do you have any range by any chance?

Mr MILLARD: I am sorry?

The Hon. DANIEL MOOKHEY: A range or estimate?

Mr MILLARD: There is a range and that is why I will provide you with specific information because it depends on training level, years of work, et cetera.

The Hon. DANIEL MOOKHEY: Do you agree with the proposition that in general they are low-paid workers?

Mr MILLARD: Yes.

The Hon. DANIEL MOOKHEY: Yes. What about RNs? Do you have a view as to what an average salary would be for a registered nurse?

Mr MILLARD: Again, it depends on what classification they have within our enterprise bargaining agreement, and I will provide that information to you.

The Hon. DANIEL MOOKHEY: Are they paid more or less then they would be paid at a hospital?

Mr MILLARD: We have sought to match salaries in the acute sector. I am just not sure where that is at the moment because it is a marketplace and it is contested.

The Hon. DANIEL MOOKHEY: How many hours in general would a personal care worker work per week when you factor in overtime and other charges?

Mr MILLARD: Again, I will take that on notice and provide that to you as an average.

The CHAIR: Okay. Mr Donnelly?

The Hon. GREG DONNELLY: Time, I think, is about to beat me, but I will proceed anyway and perhaps, if you wish to do so or elucidate, you could take it as a question on notice. Do you have any particular comments regarding the current provision of palliative medicine, nursing and care in the aged care sector and your thoughts about what is currently operating? Importantly, there is the same question about the improvement of palliative medicine, nursing and care in aged care facilities. We hear from time to time—and take it as anecdotal—of examples whereby clearly a person is approaching the end of their life, may be very shortly, and is being transferred. There is a calling up of the ambulance and being transferred to a hospital and having to enter through an emergency department and onto a ward and perhaps their life may come to an end pretty soon thereafter.

The counterargument is that if we were able to do palliative care much better in terms of the medicine and in terms of the access to palliative care specialists and obviously specialised palliative care nursing or RNs with some particular specialty in the area, and the care as well which includes perhaps access to and working with the volunteer network that operates with Palliative Care NSW, we could really uplift the whole ability to deliver palliative care in our nursing homes. Any general comments about that? You do not have to specifically reflect on your own organisation but just working with others and other major players in the aged care sector, do they talk about palliative care much?

Mr MILLARD: Palliative care for a residential aged care operator is everyday business; it is a core competency which you need to have. Palliative care is a pathway, it is not just a week or a moment in time. So some people who are in palliative care can be in that program for months. I know there are some people—in fact, there was a resident in Newmarch House who was in a palliative care pathway and they got better and were no longer on that pathway. So it is a journey. Advanced care plans and advanced care directives are really, really vital.

So this issue about hospital transfer, having early discussions with residents when they are cognitive about their own desires, what they want to see in their final days, it is vitally important that you have that and that we are able to honour the resident's wishes, and that can be complex where family members may not be aware of the resident's wishes and might have a different view about hospital transfer. It is a heightened emotional environment, but we seek to take out the confusion and have a real clarity about what the resident's wishes are and we seek to honour those. They can be updated, and a resident's desires as well as their capacity to make decisions need to be evaluated on an ongoing basis; it is not just a once in time, set and forget issue. But palliative

care is core business. There needs to be, I suggest, more training investment in competency in all of residential aged care so that we can honour the wishes of residents so they may die in dignity and in the way that they choose.

The Hon. GREG DONNELLY: Thank you very much.

The CHAIR: Mr Millard, our time is running out. I have one final question and I may use the Chair's discretion to ask it. You outlined extensively that there have been shortages in terms of your workforce, particularly during the COVID pandemic. During that time there were additional staff that came to work at Newmarch House. Is it true that some of those staff are now being made redundant?

Mr MILLARD: A large number of staff who came to work at Newmarch were provided through Commonwealth government assistance from agencies like Healthcare Australia, Aspen and Maple. They would have been cycling down after the outbreak was held, sort of going back to the normal agencies because there is no way that you can run your 28, some days 40, registered nurses a day because you are running a hospital in a residential aged care home, and that is not normal staffing for a residential aged care home. Redundancies, in terms of Newmarch House there may well be some staff in terms of the current restructure we are undertaking in order to get to financial viability where there may be some redundancies—voluntary—that are being offered to staff. I could provide details of that to you.

The CHAIR: That would be very helpful. Unfortunately, time is against us so we will have to end it there. Thank you very much for your time and for coming today and for your answers to this Committee. It is certainly a very important part of our deliberations and we really appreciate you making yourself available. The Committee has resolved that answers to questions taken on notice be returned within 14 days. Committee members may have some supplementary questions for you, but the secretariat will be in contact with you to make arrangements for those.

(The witness withdrew.)

(Short adjournment)

HELEN MACUKEWICZ, Professional Officer, NSW Nurses and Midwives' Association, sworn and examined

BRETT HOLMES, General Secretary, NSW Nurses and Midwives' Association, affirmed and examined

LISA ROBERTS, Transitional Nurse Practitioner, Palliative Care, and Member, NSW Nurses and Midwives' Association, affirmed and examined

The CHAIR: Welcome. Did you want to start with an opening statement?

Mr HOLMES: Thank you. I acknowledge the traditional owners of the land on which we meet, the Gadigal people of the Eora nation and I thank the Committee for giving the NSW Nurses and Midwives' Association the opportunity to address you today. We believe it is essential for all New South Wales' residential aged care facilities to have a director of nursing and at least one registered nurse on duty at all times. The Royal Commission into Aged Care Quality and Safety has drawn a line in the sand of the debate as to whether or not existing standards and regulation of the sector are sufficient to safeguard our most vulnerable elderly. It is impossible not to be shocked by their findings and to agree that urgent improvements are needed. However, the first course of action taken by the Federal Government has been to throw further money at the sector without any transparency as to how these Commonwealth funds should be spent.

Unless funding is tied to the provision of direct care, this tactic is futile; it will not prevent the cost-shifting onto New South Wales' health services and undesirable late-night hospitalisation of residents that are all too common features of residential aged care in New South Wales. Other States, in particular Victoria, have mandated staffing and skills mix ratios for their public residential aged care facilities in recognition of the level of complex health care required by residents. We have seen the positive benefits of this in the current COVID-19 pandemic where State-run aged care facilities were able to keep people safer and save lives compared to their privately owned and operated counterparts.

The Productivity Commission 2021 report also highlighted that only 57 per cent of New South Wales' aged care facilities met their clinical care outcomes in the past year following assessment by the aged care regulator compared to 90 per cent of Victorian aged care facilities. It is clear that New South Wales is falling behind. Long-term aged care in and outside of the current pandemic is not a lifestyle choice; it is a necessary destination for those who have exhausted all other care options. Aged care facilities resemble subacute hospital wards and residents have complex comorbidities, dementia and are often at end of life. However, whereas people in New South Wales hospitals can be assured of nurse-led care, those in residential aged care facilities cannot, leading to the widespread neglect evidenced through the royal commission.

We have heard the arguments around financial viability and the need for rural and remote exemptions. The royal commission suggests the latter be addressed in part by outreach services provided by local health districts [LHDs]. Whilst we believe there should be more collaboration between health and aged care services, outreach models can only work if there are registered nurses onsite to provide, receive and carry out clinical instructions. Upskilled personal care workers, whilst a highly valuable part of the care team, simply cannot deliver the professional nursing care required. We have with us today Lisa Roberts, a highly experienced transitional nurse practitioner for palliative care, who will be able to talk more about that if required.

The recommendations of the royal commission are a step in the right direction. They identify the need to schedule minimum staffing and skills mix, including the provision of an onsite registered nurse at all times. However, they offer no guarantees. There has been no commitment by the Federal Government so far to adopt any of the recommendations relating to staffing and skills mix. The royal commission's recommendations fall almost 58 minutes short of the research undertaken by the Australian Nursing and Midwifery Federation in conjunction with two South Australian universities. So they are not shooting very high at all. This means that it is even more important that New South Wales takes the lead in providing a benchmark for staffing and skills mix by adopting this bill to ensure the people of New South Wales can be assured of a dignified end of life. We believe it is the right thing to do, what the people of New South Wales want, and can see no reasonable argument as to why it cannot be adopted. It is, in fact, urgently required.

Aged care providers and their union, the National Aged Care Alliance [NACA] are intent on shipping workloads clauses in enterprise bargaining agreements [EBAs] and deleting nursing position nomenclature from agreements despite everything that has been exposed in the royal commission. As you have heard earlier, the royal commission does not suggest it should be in place until 2024, the requirement for registered nurses 24/7, yet we have that opportunity to make sure that happens now, and, as you heard from Newmarch House, they have been able to do it and have, on principle, undertaken that. They should not be disadvantaged in the mark against other aged care operators.

My last question: How much suffering can occur in three years until the Commonwealth, if it takes the recommendations and puts in place these very important but basic safety measures to look after those most vulnerable elderly?

The CHAIR: Thanks very much, Mr Holmes. Did Ms Roberts or Ms Macukewicz want to make an opening statement.

Ms ROBERTS: No, thank you.

Ms MACUKEWICZ: No.

The CHAIR: Mr Holmes, in your opening statement you touched on the fact that Anglicare in its previous testimony said that two years ago they decided that it was in line with community expectations that there needed to be an RN on 24/7 as a minimum. Are you aware of any other providers that have taken this position? I would also be interested in your feedback on that announcement from Mr Millard.

Mr HOLMES: I am not aware of other aged-care operators that have changed their position as what appears from the evidence given today. Unfortunately we see the opposite occur. We have been campaigning around this issue for more than five years as we have seen the deterioration in care. As anyone who has read the royal commission or listened to the testimony would know, things are not getting better in aged care. They will not until all of the issues that have been identified are addressed. New South Wales has an opportunity to put in place a step in resolving that and a protection for the people of New South Wales. The opportunity to expand that to cover all aged-care facilities rather than just the few that are currently covered by the current regulations of the Public Health Act is an important step. Nobody could deny that it is necessary. It is about putting in place the requirements to do so. Until there are requirements, operators will not do it and the Commonwealth will not fund it. The New South Wales Government has the ability to empower operators and require that these are standards that New South Wales residents deserve.

The CHAIR: In effect we are penalising good operators by not regulating. Is that correct?

Mr HOLMES: That is correct. A number of operators have benefited from ageing in place. They have moved into receiving the funding for what was high care—the higher level of funding for residents who are clearly ageing in place—and yet they have had no requirement to increase their staffing beyond the very bland current legislation that says there should be sufficient numbers of suitably required staff. That has proven woefully inadequate. Without regulation and very clear legislation, then this industry will continue to deliver poor outcomes.

The Hon. MARK PEARSON: At the beginning of your opening statement, you said that you did not particularly want to address registered nurses as a specific issue but more the importance of staffing and skill mix ratios. Can you elaborate on that a little?

Mr HOLMES: Well, obviously the core proposition from us is that there must be a director of nursing and a registered nurse 24/7. One registered nurse in a large facility does not cut it in terms of being able to provide care. One registered nurse for 120 residents cannot possibly deliver a professional standard of care. With that situation, the Commonwealth Government needs go further in terms of its response to the royal commission. But there is an opportunity for the New South Wales Government to set standards for the people of New South Wales as well. The royal commission did come down on the side of saying that there needs to be minimum staffing numbers or minimum minutes per resident. They scaled that at an average of 200 minutes per resident in 2022 or 2023 and then scaling up to 215 minutes. As I said, that is 58 minutes short of what the only piece of research that has been done in Australia on care needs has said. They are saying that in that first 200 minutes there should be 40 minutes of registered nurse care and in the second, when it becomes 250 minutes per resident, 44 minutes.

These recommendations from the royal commission are extremely moderate and they give the industry a long time to get there. We believe that New South Wales has an opportunity to set a change to the current standards that are being achieved in New South Wales—or failing to be achieved comparatively to Victoria—and adopt higher expectations of the care in New South Wales for aged-care residents and therefore manage some of the consequences of those lower staffing levels or the lack of registered nurses and the consequences that that has on our public health system and the consequences on residents who move into ambulances, off ambulances, into emergency departments, are left in emergency departments for observation for four hours or more, and are then possibly shifted back onto an ambulance trolley, back into an aged-care facility—

The Hon. MARK PEARSON: Are you saying that that is more likely to happen because a registered nurse is not on duty?

Mr HOLMES: Absolutely. Because aged-care facilities that do not have registered nurses on duty—if a resident has a fall, it is unknown whether they have lost consciousness. They must be observed for four hours and that observation needs to be undertaken by people with clinical expertise at least at the registered nurse or enrolled nurse level. Where they do not exist, they go to hospital.

The Hon. MARK PEARSON: It is a major disruption to an already—a person who has a lot of health issues and often psychological issues as well. I will move on to you, Ms Roberts. On average what percentage of residents in aged-care facilities in New South Wales, for example, would require palliative care and of that, intense palliative care?

Ms ROBERTS: I think that 100 per cent of residents require palliative care. Palliative care is symptom management. You will always have some symptom in a person that requires management. So, you know, I consider palliative care to be looking after people who have urinary tract infections because you are trying to improve the quality of life for them. Specifically as an advanced practitioner, I would see a smaller proportion of people within the residential aged-care facilities. They are normally people who may have been referred from hospital to me directly. It can be the staff themselves referring a resident for me to see them. I would probably see maybe three to five residents per day requiring intensive palliative care symptom management.

The Hon. MARK PEARSON: But the average percentage of the residents requiring intense palliative care in situ—

Ms ROBERTS: Is smaller. But there is a requirement as a registered nurse to manage the symptoms of everybody.

The Hon. MARK PEARSON: Are you saying that if a resident is in an aged-care facility and is on palliative care—

Ms ROBERTS: So end-of-life care.

The Hon. MARK PEARSON: Yes. For end-of-life care, the minimum would be a registered nurse to be at that facility 24/7.

Ms ROBERTS: Definitely.

The Hon. MARK PEARSON: Why do you say that?

Ms ROBERTS: Because if I could just reflect on a day in the life of a nurse—on Friday I was requested to come to a facility. I want to sort of highlight the complexities of needs for our residents in aged care. It is true what we say. The comorbidities are huge. The average time that somebody is in aged care for is a very small period of time now before they are dying. People are coming in when they have exhausted the services of the community so they are requiring that intensive care that cannot be required elsewhere. I saw three residents on Friday. I had one registered nurse that was with me for those visits. Resident one was a lady who had bladder cancer and bowel cancer. She had issues of breathlessness. She required opioid for that and that opioid is pro re nata [PRN], which means "as needed". It required the registered nurse to assess the symptoms of breathlessness. This lady was not well managed with her opioid. The opioid was an order that came from the hospital with the best intention of providing good symptom management, but it was not enough to meet the needs of her breathlessness.

Opioid is well known for helping with breathlessness in cases of cancer, so that required the registered nurse to contact the doctor to get telephone orders. The doctors are very busy in their practice. The doctor was not able to answer the phone at that particular time. The registered nurse also then has to communicate with a very distressed family because the symptoms are not being managed. Not only that, due to this lady's poor condition she has had oral thrush, which is very painful. It stops you from eating and it stops you from drinking. So that requires an additional level of skill to be able to meet the needs.

In the same facility we have a gentleman who is dying and who is on a syringe driver. A syringe driver has morphine for pain, midazolam for agitation and maxolon for nausea. He has ongoing nausea. This is 24/7. He requires specialist palliative care to try to manage the symptoms of that. This man is very frightened of dying. This man, when he takes off his oxygen, desaturates. He becomes confused. He tries to get out of bed. He tries to go to the toilet. He is asking constantly for people to stay with him, which is what you would expect to have happen when somebody is dying. For him, it is very distressing. It requires the registered nurse to be in there a lot because you need to meet the needs of a resident for that quality of life.

The Hon. MARK PEARSON: If a resident cannot say their pain is seven between one and 10 because of their cognitive or medical impairment, would you say a resident nurse is more skilled to detect the degree of pain a resident is experiencing even if they cannot tell you, just like a child, the amount of pain?

Ms ROBERTS: I do, yes, definitely. Because we were using Abbey pain scores in aged care, which requires a level of assessment. There are a number of different components that you need to look at when you are doing an Abbey pain score, and you have to put all the information together. With somebody who has a cognitive impairment, it is really about assessing their facial expression. But not even that, is somebody gripping the sheets? Is somebody—

The Hon. MARK PEARSON: Frightened.

Ms ROBERTS: —wringing them and trying to take their clothes off and trying to get up and down? So it does, it requires a lot more.

The Hon. MARK PEARSON: Mr Holmes, does the very fact that there is a 24/7 registered nurse in a facility affect the culture and standard of care? Maybe you can answer that, Ms Macukewicz.

Mr HOLMES: I believe so, but I invite Ms Macukewicz to answer.

Ms MACUKEWICZ: Yes, certainly, and in particular a director of nursing, because they are able to provide a layer of clinical governance over the whole of the resident cohort. Often a registered nurse working on their own is so busy that they are not able to attend to the big picture issues as well, like the clinical governance audits and infection control—that sort of thing—whereas they have an individual responsibility towards that, often they are working in staffing levels that are so dire that they have not got the time to do that. So that is where your director of nursing comes in and why it is so important to also have that embedded in this bill across the board—across the entirety of aged care.

We heard evidence this morning and also from the people now that the resident acuity is high in all aged-care facilities. They do not discriminate against residents. Whether that is in rural areas or in metro areas, you get the same needs within your resident cohort. It is vitally important to have a director of nursing. But registered nurses themselves are also skilled. They undertake three years of graduate education. Part of that deals with the holistic nature of care needs. So registered nurses do not just provide direct care and undertake tasks, they also provide clinical judgements. They also have a role in preventative health as well. That is often a forgotten element of nursing practice: that prevention that we also do—observing and trying to prevent issues from happening before they become a crisis and require somebody to be admitted to hospital.

The Hon. GREG DONNELLY: Thank you all for coming along today, it is greatly appreciated. Mr Holmes, I may have missed this in the royal commission documents and it may well be found elsewhere as well. If we look at a nursing home that has, as the union provides for, a director of nursing and a registered nurse as a minima and one that does not have either a director of nursing or a registered nurse, on notice are you able to list—and it might be in a matrix—the deficiencies of nursing homes? In other words, much is not able to be done to a satisfactory level if we do not have the director of nursing and the registered nurse. I want a list, in as much detail as can be reasonably provided, of all that is effectively being missed out on in that aged-care facility that does not have personnel in place. I know your submission picks up on part of that, but are you able to list as extensively as one can—dare I say—the deficiencies?

Mr HOLMES: I am happy to take that on notice. I think we have pointed out some of the very obvious ones in our tables, but we take on that challenge to try to give you that even longer list if you like.

The Hon. GREG DONNELLY: As thoroughly as you can. I appreciate that much is covered in your submission, but just so that we have a clear understanding. You would probably appreciate that I do not think we have any registered nurses around the table, so as much detail would be useful.

Mr HOLMES: I will take that on notice.

The Hon. GREG DONNELLY: Sorry, I withdraw that. The Hon. Mark Pearson was a nurse.

The Hon. MARK PEARSON: Yes.

The Hon. GREG DONNELLY: I apologise for that.

The Hon. MARK PEARSON: That is okay.

The Hon. GREG DONNELLY: I just realised that.

The Hon. MARK PEARSON: I am not registered anymore, so you are okay.

The Hon. GREG DONNELLY: Ms Roberts, just for my understanding—and forgive me for not knowing—in the term "transitional nurse practitioner", what does "transitional" refer to?

Ms ROBERTS: To become a nurse practitioner, you are required to do three years of a master's of nurse practitioner. I am transitioning into that. I am still within the study period.

The Hon. GREG DONNELLY: That is fine, I was just unsure of what the term meant. Thank you for your evidence, it was very helpful. Can I press you a bit further about the ability to provide for quality palliative end-of-life care in an aged-care facility? One of the issues that does get raised in New South Wales is the limited number of palliative care specialist doctors in this State, the effect of which—it is argued—is that they are very busy individuals. In fact, they are so busy that sometimes it is very hard to speak to one if one needs to to provide that expert advice. Would that be your experience, that there is a macro issue of insufficient numbers of palliative care specialists? I ask that because there is a cascading effect, which I want to come to in a moment, of being able to assist the nurses working in an aged-care facility.

Ms ROBERTS: Sure. Within my role in aged care, I needed to reach out to all the palliative care doctors. I cover an area with five LHDs. So the palliative care doctors—when you build up a position from within an organisation, you then make those connections. That is where the importance of having those internal palliative care advanced practitioners helps. I then communicate generally with the palliative care doctors, triaging. But a major part of my role is also educating the registered nurses to get to that same level of assessment skill so that they are able to identify who is actively dying, because lots of people die in aged care and do not have complex symptoms. They are just dying in a natural way. The people that palliative care specialists need to see are those complex care needs such as unresolved pain and the potential for bowel obstruction—those things that are going to cause suffering within that end journey.

The Hon. GREG DONNELLY: On that particular point of the specialised skill arising from the training to deliver what you have just described, and that is very top-end nursing and palliative care—and if this is the course you are doing then please tell me, and perhaps Mr Holmes might want to chip in here as well. Is there sufficient quality in the training available for our registered nurses to be able to enrol in and pass through programs to be able to carry out this highly skilled work in our nursing homes in New South Wales?

Ms ROBERTS: Part of the registered nursing course is a three-year degree, so a lot of comprehensive assessment is required for that. Palliative care is quite a specialised field, so there is a number of different educational opportunities that our registered nurses can use. For example, we are using Palliative Care Outcomes Collaboration [PCOC] data to benchmark our services against all of residential aged care. We have programs where you can go into different facilities or hospitals to increase that. That opportunity is available to all registered nurses within aged care. There are some additional courses that can be done. My nurse practitioner course is very specialised because at the end you become endorsed and you can prescribe. That is a very high level for a registered nurse to do, but there are different variations of education that can be provided. I think that is where having educators within your residential aged care facilities to provide that high-level education comes into play. If we can find champions in our registered nurses, that will certainly prevent a lot of hospital admissions and it will prevent a lot of suffering that is happening to our residents.

The Hon. GREG DONNELLY: Mr Holmes answered this in the affirmative, and I presume that you have some experience of being on the ground working. Obviously you have a roving role and you move between various parts of the State. I think Mr Holmes' phrase was that there are undesired hospitalisations of residents overnight. Would you make the same observation? This is the issue of not having registered nurses there who are able to deal with matters that otherwise could be dealt with on site, so they feel compelled or it might in fact be a specific policy of the company that runs the nursing home—

Ms ROBERTS: Generally with falls, yes.

The Hon. GREG DONNELLY: —to ring 000 and an ambulance comes and takes them to the emergency department.

Ms ROBERTS: Generally in aged care, if somebody has an unwitnessed fall and you suspect there is a head injury then there is a policy to transfer them to hospital. When you are looking at registered nurses on the floor, particularly for a night shift, if you have somebody who has had a fall and somebody who has a delirium and somebody who is dying then it is very difficult to manage all of those when you are one registered nurse to 120 residents. It is important to have the registered nurse, but more than one in that circumstance.

The CHAIR: Can I just ask a follow-up on that specific question? You mentioned three specific cases: a delirium, a fall and someone who is dying. Across 120 residents, how common would it be to have three?

Ms ROBERTS: Very, common. If we are just looking at the three examples that I was going to present, I had somebody who had pain, I had somebody who was dying and we also had somebody who had heart failure symptoms—swelling within the arms and legs and they could not breathe. We need to be doing something about that straightaway. Not only that, but you also have very distressed families when that is occurring. You are not just looking after the resident; you are looking after the resident and their family.

The CHAIR: Of course.

Ms ROBERTS: So even with advanced care planning and a registered nurse, to do a proper advanced care plan would need a minimum of an hour and a half.

The Hon. WES FANG: Thank you, witnesses, for appearing today. I really appreciate you making yourselves available and making the time to provide your insights to the Committee. Mr Holmes, in your opening statement you talked about the royal commission findings and the exemptions for rural and regional locations. Can I just confirm—you said that you were not in favour of those occurring?

Mr HOLMES: I do not believe I said that in my opening statement. If you pressed me then I would say that they need to be looked at very seriously. The whole question that if you live in the country then you do not deserve the same standard of care as if you live in the city bothers me deeply. I grew up in the country in the little town of Wellington and my mother died in an aged care facility without registered nurses 24/7, so I lived this experience. I saw what happened to my mother and to the health system. She was a Gold Card person and she had Parkinson's. When you have Parkinson's you must have your medication right on time. As soon as you deviate from that then your symptoms escalate, and then you fall over and then you get transferred by ambulance to the local hospital.

In Wellington, it so happens that it is on one block. There is an ambulance at one end of the block, a hospital on the other side and an aged care facility on the other side of the block—so a complete circuit. But the flag fall went to repat of $900 to come around, pick her up, take her to the hospital and then take her back four hours later after the observations because there was no registered nurse on duty after four o'clock in the afternoon and no registered nurse on weekends except for night duty. There was one for 100 residents on duty in the dementia unit, but not available to the rest of the facility because they could not leave those acutely unwell dementia residents.

The Hon. WES FANG: I think you and I are on a unity ticket, Mr Holmes, in believing that those in rural and regional communities deserve what is provided to those in metropolitan settings. My sympathies about your mother.

Mr HOLMES: Thank you.

The Hon. WES FANG: I just want to drill down a little bit more on some of those issues. You said that you were not in favour of the outreach model either, is that correct?

Mr HOLMES: No, we were supportive of the outreach model but we said very strongly that in order for that outreach model to work in the example that Ms Roberts has given, there also needs to be registered nurses on site. You simply cannot rely on staff coming into the hospital and the home-type situation for a short period and managing the care of a resident and being able to transfer enough of their knowledge, skills and expertise to people who have a certificate III level qualification to be able to carry on all of that care. There is an important component of outreach services from the local health districts into aged care. The royal commission comes down strongly in favour of that and we have seen that it can work, but it requires that there be registered nursing staff in the aged care facility to be able to carry out that care and continue that care when the outreach service has gone home.

The Hon. WES FANG: My concern, which has been largely articulated throughout this hearing, is that we know in rural and regional communities—and you would know through your experience—that the smaller centres for aged care tend to have fewer residents and a lower financial viability. There is also the issue of workforce. There may be a requirement to have a nurse 24/7, but in a place like Wellington that may mean that if they are not able to get a nurse 24/7 and be able to provide cover and backup and the like, that facility may not be able to operate. If you are not in favour of those exemptions for those communities where workforce is an issue or potentially cost is an issue, what do you say to those residents where a home becomes unviable? Where do they go?

Mr HOLMES: The really hard question that everyone in the community has to decide is: Do we want a different standard of care for our residents in those small, unviable facilities? Is it okay that they do not get the benefit of palliative care 24/7? Is it okay that they are completely reliant on paramedics and nurses in the public

health system to cover the clinical services, where we hear that there is higher and higher acuity of those residents? People have to make a decision. Is that where I want to place my beloved mother or father? Is that the standard of care that I will accept for the benefit of saying, "We have got to have this facility in a small community?" That is the question, but the answer is: If you create the opportunity for decent work, then people will undertake decent work. That does require you to pay decent wages and it does require you to provide reasonable working conditions. That includes having enough staff—

The Hon. WES FANG: I understand—

The Hon. MARK PEARSON: Can I just ask a question?

The CHAIR: Order! Mr Holmes can finish.

Mr HOLMES: That includes having enough staff to support you so that when you go to work, you do not have 120 residents—or that you are the sole person in town, with no backup, to supply all services. This is the dilemma that government has. If the community says, "We elect you to provide our services," then government has to be honest with the community about what services it will provide. It should not be saying, "You can have an aged care facility, but you can run it without registered nurses and you will accept a lower standard of care." People do not accept a lower standard of care. When it comes down to it, when their mother is in front of them, dying and in pain, they do not accept that that is an acceptable standard of care.

The Hon. WES FANG: I accept what you are saying—and you and I had this conversation only a few days ago in a separate hearing—but it is almost the same vexed issue that we all face. In smaller country towns we find it hard to attract that workforce. For a place like Harden, for example, where they had an aged care facility which has now closed because the parent company said it was unviable for a number of reasons, there is the issue of—do we enforce something like this? You have talked about the need to potentially attract people by paying higher wages and the like.

That puts a cost impost very much on those smaller facilities in rural and regional settings where they already have a stretched financial position. But then we also have the issue that if we have that requirement, we may take that workforce away from other areas, like the hospital, which is what you were speaking for in the other inquiry around having increased workforce numbers in multi-purpose services [MPSs] and smaller rural and regional hospitals. As the nurses' union, you are advocating for this to occur. How do you propose that we force your members, if they do not volunteer, to actually go out there? That is one of the only ways that I can see that we could actually get around this.

Mr HOLMES: I do not think there is any proposition that you can force people to move. You can encourage people to move to different workplaces. I think we would all agree that trying to force people to relocate is not beneficial to anyone, including the residents—

The Hon. MARK PEARSON: Just on that—

The CHAIR: Sorry, I think Mr Pearson has a follow-up.

The Hon. MARK PEARSON: I have a question in relation to that, and maybe any of you could answer this question, if you are aware. Has there been a cost analysis as to the cost of sending an ambulance to attend to a resident, take that resident to a hospital, treat the resident in the hospital and then send the resident back in an ambulance to the nursing home? Has there been a cost analysis done of what that costs and what it would cost to give an incentive for nurses to move to Wellington or wherever to work in a nursing home?

Ms MACUKEWICZ: As far as I know—and Mr Holmes may know a little more about this than me—we have been unable to find any exact, concise costings from New South Wales as to how much these avoidable hospitalisations are costing. We have sought that data in the past and been unsuccessful in acquiring it, so we are uncertain. However, I think we need to consider not just the financial cost but also the cost to the person who is involved, because it concerns me when we talk about older people in terms of finances and costings. These are people. It is often end of life and we need to think about what is in their best interests. If we are looking at it purely in a cost shifting or costing point of view, an older person in an aged—

The Hon. MARK PEARSON: Sorry. We certainly would not want to look at it purely in that way, but if there is a cost saving or an equal cost by having a registered nurse permanently in a nursing home, that can be used as an argument that it is going to save costs in the emergency health care sector.

Ms MACUKEWICZ: Absolutely. Our submission alluded, for instance, to hip fractures, where there is a cost saving. I understand from Ms Roberts' experience that a large amount of hospitalisations follow a fall, where the staffing ratios are wholly inadequate for people to be adequately supervised and monitored. Certainly

we have some of those figures in the submission that we have made around that particular area. I am sure that if you looked into other areas you would see similar savings that could be achieved if you had a registered nurse on site. Unfortunately those costings can only be worked out if there is data to draw from.

The Hon. MARK PEARSON: Sure, that is right.

Ms MACUKEWICZ: Unfortunately in a lot of cases we have not been able to draw from a lot of data around how much it costs. The costings are there, but not necessarily the source of the referral. You may know how much it costs to provide wound care or care for a urine infection, for instance, but that is not necessarily traced to a source at all times.

The Hon. MARK PEARSON: But you would agree that one thing that is dealt with by having a registered nurse permanently in an aged care facility, which prevents many admissions to hospital—it also demonstrates a lot more respect for the wellbeing of the person who is going to have to go through all the trauma of different people, ambulances, bright lights, emergency wards, lying on an uncomfortable bed and all these unknown people around them, et cetera. If that can be prevented for a person who is already suffering a great deal, would you say that it is worth taking that step of ensuring a full-time registered nurse?

Ms MACUKEWICZ: Absolutely. The quality of care that can be achieved when you have got a skilled, experienced clinician there has got to be wholly more desirable than having—we have to remember that there are no minimum training standards for assistants in nursing or care workers. The Certificate III level is just an industry-set standard. There is no minimum training requirement. When you have a registered nurse, you do have a minimum training requirement, and that is a three-year degree. So there is bound to be, by default, a huge difference in terms of the resident experience when the care is delivered by a registered nurse compared to an unskilled workforce or an untrained workforce.

The Hon. WES FANG: Mr Holmes, I return to my original line of questioning. Noting that we have aged care facilities in rural and regional communities already closing, like Harden at the moment, without the financial impost that is potentially being put on them by the requirement that is before us, would you agree that it is better for a community to have an aged care facility that may not provide 24/7 on-site RNs than not to have one at all?

Mr HOLMES: No, I find that very hard to agree with, particularly with the acuity of the residents when they enter aged care now. I would say that that is where a government has a responsibility to step in. So an MPS is appropriate at a place like Harden, a small facility.

The Hon. TAYLOR MARTIN: For the benefit of Hansard, would you mind clarifying "MPS"?

Mr HOLMES: Multipurpose service, commonly the connection of acute care and aged care run by the State health services. As we said in our previous interaction, there are over 90 of those in New South Wales already. Whilst they do not have enough registered nurses to deliver some of the acute care, they are at least one way of making sure that there is some availability of registered nurses. There is an opportunity for New South Wales to play its part in those small communities in making sure there are adequate numbers of registered nurses in MPSs to make sure that those residents cared for by the MPS receive a standard of care that they deserve and that the community has the benefit of registered nurses in their acute care.

The Hon. WES FANG: I just find that extraordinary because you have effectively said that you would prefer to see them closed if they are not able to provide 24/7 nurses, yet our communities have been very clear when we have spoken to them that that is not what they want.

The Hon. DANIEL MOOKHEY: Point of order: Firstly, I think that Mr Fang is perhaps verballing the witness. Secondly, Mr Fang is entitled to his opinion, but he should save it for the deliberative because we have 10 minutes left and I would like to ask the witness questions.

The CHAIR: Given the time and given the fact that Mr Mookhey has been waiting patiently, we will move on. We have canvassed that point extensively.

The Hon. DANIEL MOOKHEY: Thank you for appearing today. I have some preliminary questions. Mr Holmes, do you accept the royal commission finding that the quality of aged care in Australia is inadequate?

Mr HOLMES: Yes.

The Hon. DANIEL MOOKHEY: Do you agree that it is, effectively, a disgrace?

Mr HOLMES: Yes.

The Hon. DANIEL MOOKHEY: Do you accept that that is because the sector is underfunded?

Mr HOLMES: I believe that underfunding is a major issue that must be addressed, but it must be addressed in a way that makes sure that whatever additional funds are provided to aged care are transparently provided and that there is a direction of those funds towards the delivery of direct care.

The Hon. DANIEL MOOKHEY: Yes, I accept that. Do you accept that one of the ways in which the sector has responded to underfunding is, effectively, to reduce the amount of labour it would otherwise employ?

Mr HOLMES: That is our experience—that we do constantly have those battles about staffing levels. Staffing is 70 per cent of aged care costs at the minimum. So it is not surprising that the first and the biggest part of a budget is staffing, and that is where most accountants start looking when it goes to, "Where can we save money?"

The Hon. DANIEL MOOKHEY: Were you here for Mr Millard's evidence earlier today?

Mr HOLMES: Part of his evidence.

The Hon. DANIEL MOOKHEY: Did you hear that part of his evidence in which he talked about them currently reducing the amount of hours, including RN hours, as a response to the financial distress he feels his centres are under?

Mr HOLMES: Yes, I did hear that. I found that very distressing, similar to the problem that we face where both for-profit and not-for-profit are constantly trying to undermine basic opportunities for workers to raise their concerns about workload issues in this sector. Clearly, there is a deaf ear to the concerns of staff about the levels of staffing, their inability to deliver care to their residents. These people really do try their very, very hardest. They are not all angels, but they are angels at $22 an hour. There is this constant attempt to disempower them from even speaking up.

The Hon. DANIEL MOOKHEY: Remuneration of $22 an hour is for—

Mr HOLMES: A care service assistant or an assistant in nursing, as a base level.

The Hon. DANIEL MOOKHEY: That is currently $2 above minimum wage.

Mr HOLMES: That is correct.

The Hon. DANIEL MOOKHEY: Do you agree that currently both the RN and the care work side are both underpaid, as it is right now in your opinion?

Mr HOLMES: Yes, overall that is the case. As you heard from Mr Millard, there are some employers who have tried to match some registered nurse rates with public sector rates, but the registered nurses obviously make up a small component of the workforce. Anywhere we can negotiate parity of rates, we are very happy to do so. We also know that those registered nurses are in a very, very difficult job. As described, Mr Millard recognised the complexity they work under and the workloads that they have. It is just hard to imagine how you keep running all night to look after 120 residents and oversee eight other staff who may have varying levels of expertise and skill.

The Hon. DANIEL MOOKHEY: Mr Holmes, in your opening statement you made the point that Victoria is further progressed along a reform path than New South Wales?

Mr HOLMES: That is right. The Productivity Commission identified that in terms of meeting standards Victoria was, in terms of Standard 3, clinical care—this is from the Productivity Commission—Victoria met that on 90.2 per cent and New South Wales met that on 50.7 per cent. I mean I cannot even believe that it is that bad here in New South Wales compared to Victoria.

The Hon. DANIEL MOOKHEY: What are they doing so much better than us in New South Wales?

Mr HOLMES: I suppose when you use statistics, if they are using their statistics across their publicly run aged care facilities—so Victoria has a larger component of publicly run aged care facilities than New South Wales, and they do have ratios, significantly better ratios in those aged care facilities, and they have registered nurses and they have a nursing structure in them. So that would be where I would look first to find the basis for that. That is statistically because Victoria did not go down the New South Wales path of selling off or giving away its residential aged care facilities that used to be run by the State. Victoria kept it; New South Wales gave it away. So that would be my initial place to look.

The Hon. DANIEL MOOKHEY: Mr Holmes, I only have two more questions for you before I hand back. The first is: As a result of Victoria maintaining the ratio structure in their public health facilities, has that led to the ruin of the Victorian aged care sector and the collapse in service provision in regional Victoria?

Mr HOLMES: Not that I am aware of.

The Hon. DANIEL MOOKHEY: Great. A final question: In terms of your call for the introduction of ratios, is it paired with a call for additional investment in care support and care workers and the other aspects of the non-nursing workforce?

Mr HOLMES: Yes.

The Hon. DANIEL MOOKHEY: Thank you.

The Hon. GREG DONNELLY: Ms Roberts, you may not be able to answer this question—if not, you might be able to direct me to where I can find the information. You explained your transition to become a nurse practitioner in palliative care. Is there a way of establishing how many nurse practitioners in palliative care are actually working in nursing homes in New South Wales?

Ms ROBERTS: I think that information could be found. I do not know it off the top my head.

The Hon. GREG DONNELLY: If I ask you where would one go looking for such information, what would be your best guess? Mr Holmes might be able to help. Given there is paucity of information, sometimes it is hard to obtain information from NSW Health.

Ms ROBERTS: With outreach models and things from LHDs they generally all have nurse practitioner-led models. A breakdown of the outreach services would probably find that. I do not know whether the Australian College of Nurse Practitioners may have that information as well.

The Hon. GREG DONNELLY: I am talking about ones who actually—

Ms ROBERTS: Who work in aged care?

The Hon. GREG DONNELLY: Have I misunderstood—you obviously have a roving role. You described where you move between—

Ms ROBERTS: Yes.

The Hon. GREG DONNELLY: Are there any nurse practitioners in palliative care who actually work specifically full-time—

Ms ROBERTS: Yes.

The Hon. GREG DONNELLY: So there are rovers like yourself and full-time who work inside?

Ms ROBERTS: Yes. Internally there are less; externally there are more. I think there is a need for more internal.

The Hon. TAYLOR MARTIN: Would you agree with the royal commission into aged care that there should be a required minimum standard for staff time per resident patient?

Mr HOLMES: Yes. That is another way of putting ratios in place. Their recommendation was less than the National Aged Care Staffing and Skills Mix Project, which indicated that there should be almost 58 minutes more per resident, but they came to the conclusion that there needed to be a minimum standard of staff to resident time—as we talked about, 200 minutes from 1 July 2021 and 215 minutes from 1 July 2024.

The Hon. TAYLOR MARTIN: Is that basically just an average of time across the whole sector or would you be able to provide a bit more detail as to how you got to that number?

Mr HOLMES: They are numbers that the royal commission concluded. The numbers that we concluded as a federation are available in the research project document. I think we attached that to our submission.

Ms MACUKEWICZ: No, but we have a copy that we can give to the Committee.

Mr HOLMES: We are happy to leave you the copy.

The Hon. TAYLOR MARTIN: That would be great, thank you for that. I think some of my other questions have already been canvassed.

The CHAIR: We have had a wide-ranging discussion. Mr Holmes, if you wanted to provide us anything on notice between that disparity—obviously that was a very rigorous set of work that you worked with the South Australian universities to come up with the set of minutes. Thank you for tabling the document, we will be able to look through that closely. Our time has expired so I thank you all for your time today. The secretariat will be in contact with you about the questions you took on notice. We have now allowed 14 days for answers to those

so there is plenty of time to get back to us. We appreciate the time that you have taken to appear before us today and your valuable evidence and informative submission, which is excellent. Thank you for the work you and your members do within aged-care facilities generally. It is valuable and important work and we know that they are not paid enough for it.

(The witnesses withdrew.)

(Short adjournment)

LAUREN HUTCHINS, Manager, Aged Care Division, Health Services Union, affirmed and examined

GERARD HAYES, Secretary, Health Services Union, sworn and examined

The CHAIR: Do you have an opening statement that you might like to read?

Mr HAYES: I will make it reasonably short. As the Committee would well know, aged care has been subject to a royal commission at the national level. The things that we want to focus on is workforce—consisting of RNs, also consisting of carers, catering people, admin people, allied health professionals and so on. Many things need to be considered at the moment. The first thing is transparency—transparency of funding that actually will go some way to delivering these outcomes. The second thing that needs to be considered is attraction and retention. When women are working for $20 an hour with superannuation balances of $18,000, it is not something that will be sustainable in the future.

The transparency of the funding that gets delivered is vitally important as we are seeing now many CEOs on significant salaries while complaining that the ability for them to pay wages is not there. We look at cost transfers; we look at clinical care; the lack of allied health professionals, which promotes drug addiction; fire compliance, which is another issue that is worthwhile throwing into the mix here. Some facilities in New South Wales cannot maintain a fire code and have to close. It is a very important that we get the right clinical standing; that we get the right caring mix; the right collegiate workforce that will promote a positive outcome for our older New South Wales residents. That being said I think we have been able to provide a video which would indicate, very sadly, what is common practice within an aged care facility now.

The CHAIR: Thank you very much. We will play the video now.

Mr HAYES: Thank you.

Video played.

The CHAIR: Thanks very much, Mr Hayes, for your time and for the video as well. I will pass to Committee members. We will start with Mr Mookhey.

The Hon. DANIEL MOOKHEY: Thank you, Chair. Thank you, Mr Hayes, and thank you Ms Hutchins. It is good to see you. Mr Hayes, do you mind tabling your opening statement, if you happen to have a written copy?

Mr HAYES: I have a couple of dot points here that I am happy to table.

The Hon. DANIEL MOOKHEY: Good.

Mr HAYES: But it may not be worth the exercise.

The Hon. DANIEL MOOKHEY: Fair enough. Mr Hayes, do you accept the core finding of the aged care royal commission that the current level of service provision is inadequate?

Mr HAYES: Totally inadequate. I think when people have to die by themselves, when people know that they are dying and have to walk away to do other things, I do not think it is an Australian way at all. I think it is worse than inadequate. It is actual disgraceful on our generation that lets these things happen, particularly these people who have put us in the position that we are in today.

The Hon. DANIEL MOOKHEY: I was about to ask you whether or not you would agree that it is a disgrace.

Mr HAYES: That puts it is mildly. My anger and shame to see how we choose to deliver care to those who put us in this position—and, to be clear, these are people who went through significant hardships, significant wars and significant poverty—and our endgame to them is that we will put you in a room. Nobody will be with you when you die and we are going to put you through a lot of indignity before you get there. I think it is pretty awful.

The Hon. DANIEL MOOKHEY: One of the reasons why it is a disgrace is because it is underfunded, is it not?

Mr HAYES: It is grossly underfunded. We have come to this position nationally and at a statewide level. I thank the Committee for the time to allow us to be today to continue to ventilate our concerns, not only for our membership but for the broader membership of nurses as well. It is just so fundamentally important that we get this right. We have done economic modelling which would indicate—and we propose an outcome as a

discussion point because I do not think that governments have any outcome at the moment—but to put 0.65 per cent increase to the Medicare levy would promote 59,000 extra jobs, would promote a 25 per cent pay increase and would also promote 90 minutes of extra care to people on a daily basis. I do not think that is too much to ask, but if there is a better idea of being able to fund that, we are all ears.

The Hon. DANIEL MOOKHEY: That recommendation around the Medicare levy was one of the recommendations made by the royal commission, was it not?

Mr HAYES: That is correct.

The Hon. DANIEL MOOKHEY: On notice, are you able to provide us with the detail of that modelling that you referred to?

Mr HAYES: In terms of the breakdown of the model?

The Hon. DANIEL MOOKHEY: Well, just the actual modelling, or the report that perhaps it is contained in, if that is appropriate.

Mr HAYES: We are happy to provide that report to you.

The Hon. DANIEL MOOKHEY: Thank you very much. Can I ask this: One of the ways in which the sector has responded to its underfunding has been to underinvest in staff hours and resources. Do you agree?

Mr HAYES: Absolutely.

The Hon. DANIEL MOOKHEY: And equally, to hold it down the wages of people who work in the sector. Is that fair?

Mr HAYES: Even worse than that: To outsource to other groups who are—"dodgy" would not even actually equate to what they do. I can mention recently about an organisation known as Guardian, who we have taken on. Two people who technically are on $20 an hour and who certainly were not paid that; $45,000 back pay to one person and $55,000 back pay to another person. These are people who did not get group certificates, who got paid cash in hand, who did not get a weekly salary payment. It is really concerning. There was an article written about this and good employers were saying, "We find it hard to compete when people are undercutting like this." But, again, there is another concern that we have in relation to aged care being a for-profit industry. I think that is something that needs to be really heavily considered if we use our elderly as commodities that we can make money on.

The Hon. DANIEL MOOKHEY: You mention that case, which is disturbing, about a person being paid cash in hand at $20 an hour. Is that widespread?

Mr HAYES: I think it is—well, the model that we engaged this organisation on, their model was basically catch us if you can. If we had broad spectrum members in that particular organisation, which we did not at the time, we would have been able to do something broadly about it. It was a matter of okay, they will pay out here and they will pay out there, and if you find anybody else well we will deal with it on a one-on-one basis. Trying to have the resources to go and search through people who may not be members of the union and who are being exploited is something that—I do not know that it is commonplace but I think certainly there is enough out there to be concerned.

The Hon. DANIEL MOOKHEY: But you are finding this. You are investing the union's resources to detect this issue.

Mr HAYES: Absolutely.

The Hon. DANIEL MOOKHEY: And that is not being done by the aged care regulator?

Mr HAYES: No.

The Hon. DANIEL MOOKHEY: So you are having to effectively subsidise the work of the aged care regulator to identify the set practices and flush them out.

Mr HAYES: That is right.

The Hon. DANIEL MOOKHEY: Going back to the issues of wages, a typical member of yours who works in an aged care facility, what they earn per hour?

Mr HAYES: Approximately about $20-$21 an hour.

The Hon. DANIEL MOOKHEY: So $1 above the minimum wage, or actually 50c to 60c above the minimum wage.

Mr HAYES: To be clear on that, they probably are not full-time employees.

The Hon. DANIEL MOOKHEY: Yes. Tell us about that.

Mr HAYES: They are probably—well, many employees and I do not know why this has been the culture, but it is—are on minimum hours contracts. So you may be on eight hours a week but you are generally working 38 or you are working 35 hours a week. So you have got to ask yourself the question: Why would I only be on an eight-hour contract? Well, maybe if I step out of line, I suddenly go from 38 hours a week down to eight hours a week. You get starved out. Those things concern me. So there is a range of cultural issues in aged care where for many years people have been undervalued and moved around. We have just seen the pandemic show that people have got to work three and four different jobs just to be able to make ends meet and, suddenly through a pandemic, a whole range of things are exposed. One of the important things was the spread of any virus, whether it is COVID-19, whether it is gastro or whether it is the common flu, of course it is going to spread when you are working at three or four different facilities to make ends meet.

The Hon. DANIEL MOOKHEY: Is it unfair to say that the entire aged care sector is being propped up on the backs of an underpaid workforce?

Mr HAYES: There is no doubt that many CEOs—and there are a lot of decent CEOs out there—are saying, "We are struggling to make ends meet and to be able to do what we need to do in an appropriate way, in a way that is actually going to value-add to people's later lives as opposed to exist until you do not exist anymore", and I think that is a concerning part of where we are at at the moment.

The Hon. DANIEL MOOKHEY: In terms of what we should do about this, apart from the fact that we pay people what they deserve, your view is that the sector needs more investment?

Mr HAYES: Yes.

The Hon. DANIEL MOOKHEY: And that would require investment in all aspects of the labour force?

Mr HAYES: Yes.

The Hon. DANIEL MOOKHEY: Can you take us through specifically the service provision that is non-nursing, as to what level is required?

Mr HAYES: Lauren Hutchins might be in a better position to indicate that or elaborate on that, but certainly we would see at the moment when you have 300 people in a residence of an evening, three people to look after 300 is nowhere near adequate. We would be promoting that there needs to be a collective workforce review that looks at not only the caring area—at the moment we would suggest probably 80 per cent of the workforce are carers; that is clearly not enough, as that video showed—but is it easier to give someone a pill and take away their depression as opposed to having a social worker or a psychologist sit down with them for a while so they can actually talk? Is it okay that a person who presses a buzzer because they need to go to the bathroom and someone does not get there for an hour and they have to then be cared for in that state of indignity, but then that whole process then takes an hour by the time you change someone, shower someone, change everything else, so it becomes a false economy at the same time? So I think there is a common sense view, but underpinning all of this is this is an ageing society. The problems that we are seeing now are going to be dramatically worse in 10 years and 15 years.

The Hon. DANIEL MOOKHEY: I have only got two more questions before I hand back to the Chair, who has been very generous with me. Earlier this morning we heard from the CEO of Anglicare, who was making the point that he is currently in the process of reducing hours, and he made the point that he is reducing what is described as ancillary services of which, from what I can understand, he mentioned catering costs amongst other things. Firstly, would you agree that catering is ancillary to the service's care and can you tell us what is the consequence for residents when we start to pare back on staff hours, particularly for services like cleaning and catering? What does it mean for a resident?

Mr HAYES: It is just a further level of indignity that they have to suffer. I can speak to my own mother, who thankfully is still at home at the moment, but she got into her early eighties, she had her licence restricted, then she got a little bit older and she had her licence cancelled. Bit by bit she is watching her independence fade away. If we have to get to the point where I cannot actually choose what I want to eat or have a reasonable choice, but let us take a step back: what about when you get $6 per day for meals—not for a meal, for all meals? That is

what is going on. So this becomes an existence, not a life, not living. And then when you get people who feel as though "I just want to get out of this world", how did we get to that point?

The Hon. DANIEL MOOKHEY: Six dollars a day is the budget for food in some of these facilities?

Mr HAYES: Yes, for meals.

The CHAIR: The royal commission obviously made their recommendation that there needs to be an immediate $10 a day increase for food and that there should be transparency measures associated with that. How important is it that that be implemented?

Mr HAYES: It needs to be implemented immediately and post haste. But let us just not stop there. Let us talk about incontinence pads that get rationed out. That is just disgusting, quite frankly. We have got a memo from Bupa, who said their average in their organisations is three per day and "you people have been using seven. How dare you?" sort of thing. Are we seriously doing this to people? Are we seriously doing this? I do not understand it. A dollar is not worth that much.

The CHAIR: Absolutely. Ms Faehrmann?

Ms CATE FAEHRMANN: Thanks for your submission to this inquiry. It is an important submission because it has so many voices, obviously, of people working in the sector and your members. I just wanted to turn to a few comments in relation to this, but particularly if you could explain to the Committee the importance of this particular sentiment, which is the fear that the establishment of staff ratios for nurses only, for example, or if this Committee made a recommendation around registered nurses, the fear that that would be at the expense of other care staff. If you could talk to that particular issue?

Mr HAYES: I might start off and Lauren might join in with a closer practical example. If there was an infinite amount of money, anything is possible, but there is not; there is not enough money at the moment. We have seen the Federal Government and the Federal Opposition say, "We will see what comes out of the aged care royal commission. Now we will see what comes out in the budget", and, meanwhile, people are still there. To put on more RNs—and I think RNs should be on 24/7; I think it is inappropriate that you have two or three carers on a night shift but the cover is that "Oh yes, we've got an RN on call." How do you make that decision? That goes into a bit of cost-shifting as well. So a person who could have a catheter change at three o'clock in the morning in an aged care facility because you have got a clinician there to do that, no, you will call the ambulance and cost-shift onto the public health system; they will then take the person out in the middle of winter and then 10 hours later they will be brought back. That is not what someone needs. So I think there is an absolute need for that.

Ms CATE FAEHRMANN: Just that situation, is that a common situation that you are referring to?

Mr HAYES: Yes, absolutely, of course it is.

Ms CATE FAEHRMANN: So ambulances are brought in because of the lack of registered nurses for, I am assuming, a range of different treatments.

Mr HAYES: Yes, and I can say that even in facilities where there are registered nurses ambulances are brought in. If you have got a fractured neck or a femur or a queried fractured neck or femur, sure, you want to be careful on that, but surely to do a catheter change, are we really making someone that uncomfortable to be able to do that? I think there needs to be a focus on those things. But in terms of the salary rates at the moment, to be able to put on a full range of registered nurses it has got to come from somewhere and at this point in time you are going to have to cut your workforce further, and that just means people are not getting anywhere near the level of care or service that they need, which, as I indicated, takes up 80 per cent of the workforce at this point in time.

Ms HUTCHINS: Just to add to that, the fear is that if you are to mandate one part of the workforce without looking at the entire care service, money has to come from somewhere and obviously that will come from other areas. So the first area we would see, the fear is you would see a reduction in the number of diversional therapists, the further outsourcing of services like catering and cleaning; and then obviously the next area would be care staff. If we look at, for example, cleaning staff being outsourced, that work then is picked up by care staff. So even if you are not reducing directly the number of hours that they are working, that work will need to be picked up from somewhere.

If you are looking at outsourcing catering, and, to be frank, the service provision then drops, you will have greater behaviours from residents, you will have people who are losing weight. That shifts then again to the carers to have to pick up that slack. And the fear is the economics of it. If you are putting on an RN 24/7 and there is not a requirement for you to maintain your caring hours, you will find that those carers will be reduced. So the

fear is real. Our members see if there is no consistency in that mandating of staffing that their workload will dramatically increase and it will have a detrimental outcome for residents.

Ms CATE FAEHRMANN: Also in your submission you have people who talk about—I think there is a care service employee in north-western Sydney who talks about facilities being filthy because of understaffing because not enough cleaners are hired. So, essentially, care service workers are having to sweep and mop floors to ensure that residents are not living in a filthy environment. This is happening already, of course. Is this also a frequent thing that you are hearing, that care workers are having to do the cleaning because there are not enough cleaners and aged care service providers are essentially trying to save money that badly?

Ms HUTCHINS: Absolutely, yes.

Ms CATE FAEHRMANN: That is a common theme?

Ms HUTCHINS: Yes, absolutely.

The CHAIR: Just on that point, because it is not just about contracting out cleaning and contracting out kitchen staff, it is also then that carers do not have time to feed residents as well. Do you want to just explain how then they are just providing the food and are not actually able to assist the residents?

Ms HUTCHINS: I spoke to a member recently who works in a dementia wing. It is not just about feeding; it is also about encouraging residents to eat. Those who can feed themselves, if you have dementia sometimes you need some reminding, some prompting, some special encouragement to get you to eat. If you are moving between resident to resident and in the middle of all of that trying to manage some just superficial cleaning on top of that, you do not have the time to sit down and have that conversation, to watch, to monitor, to make sure that someone is eating an adequate meal. It just compounds if you are adding onto the duties there. The residents suffer as a result of that. It was heartbreaking for her to have to move between resident to resident to return back to the resident—particularly her particular behaviours—and find that he had essentially thrown his meal out of his room. Then she had to go and get another meal and try and do that piece of work on top of what she was required to do through the rest of the day.

Ms CATE FAEHRMANN: My mother headed up a nursing home and as a young girl I used to go in there after school and help feed residents. She would say what a difference that made, because they would get quite excited that a young girl was helping them eat and engaging them in stories. I understand the difficulty. I want to get a sense of the change, say, over the last 10 years in terms of staffing and just how much worse it is getting. I believe we have an interesting submission from the Australian Health Services Research Institute, which is in the next session after lunch, that documents the decline in aged-care workers, which is just incredibly alarming. The complexity of cases are increasing in terms of the complexity of care for residents, but meanwhile we have seen a significant decline of RNs employed in aged care from 21 per cent in 2003 to 14.6 per cent in 2016. There are other declines as well. What do you put that decline down to?

Mr HAYES: I would have to say it is a matter of attraction, retention and funding. If the funding is not there and the work is a lot more complex and difficult from a carers point of view, it is easier to go and stack shelves at Woolworths at night. It was put to me at one point in time that if you drop a can, it is not going to do too much damage, but if you drop a person, it could kill them. When we value—and no disrespect at all to people who work in the retail industry—people to look after commodities like that, what value do we put in aged care?

But clearly the aged-care issue has been under attack for many years. The funding has been cut at a Federal level. People are trying to do what they can and it is getting to the point where it is too much. It falls onto the workforce. The workforce says, "We are leaving." That is my biggest concern going forward. Now this could be an incredibly valuable workforce and so interesting. I think before in these committees, I have related stories from when I was a paramedic and talking to people at the back of the ambulance who used to fly Lancasters in the war. The experience and the history of these people—and we are just saying, "No, you are just a book on a shelf somewhere."

Ms CATE FAEHRMANN: Have you talked with people who have left working in the sector about what it would take to come back? I am assuming quite a few people potentially miss the work in terms of the caring nature or potentially miss it but would need certain things to change.

Mr HAYES: I will start with that but Ms Hutchins will have a lot more to advise there as well. Just recently I spoke to one of our members from Lithgow and how over Christmas she would bring things—they did not have the goods there, so she would bring them in out of her own pocket, you know, 20-odd dollars an hour. She would use her phone to contact this person's relatives in Canada, I think it was, and the United States, so she could connect the woman with her children. She loved this, but she said that she just could not do it. You would

not go that far if you did not have that commitment. I have said this before. This is the only job that I know of—and I have seen a lot of death—where you befriend somebody, you become like a family member and they die and then you do it again and again. So that has got to take a psychological toll.

Ms HUTCHINS: The feedback that we have had from members who have left the sector is that there are two key issues for them. One, absolutely, is wages and the fact that you can move into retail, for example, or into other care sectors that have had some review of their wages, for example, disability, and earn up to $7 more an hour. That is a huge issue for the aged-care workforce. The other is the security of employment. If you have a job where you are engaged for eight hours a week but the flexibility is all with your employer to flex you up and down on those hours, that means you need to have multiple jobs just ensure that you meet your own bills. The stress of that just compounds the stress of the work. But you need to have enough staff on the floor as well. People are going home exhausted. They are going home tired and they are very emotional as a result of all of that. So wages, secure jobs, decent staffing—then you would have a vibrant, engaged workforce.

The Hon. DANIEL MOOKHEY: Just a quick follow-up, is the turnover greater in aged care than in the other sectors in which you represent members?

Ms HUTCHINS: In terms of disability, that is the case. I cannot talk for private or public health.

Mr HAYES: Totally. Absolutely. Private health, public health and ambulances are far more stable compared to aged care.

The Hon. DANIEL MOOKHEY: In terms of your members who are engaged in the hospital system, they have minimum hours, do they not, through the hospital system?

Mr HAYES: Their minimum hours are on average the hours that they were doing and on an annual basis are reviewed to ensure that they are reflective.

The Hon. DANIEL MOOKHEY: You will have to say yes or no in addition to that comment, Mr Hayes. So, yes, they do have access to an entitlement to minimum—

The Hon. WES FANG: Mr Hayes is very capable of answering.

The Hon. DANIEL MOOKHEY: No, but we just need to get the actual answer.

The Hon. WES FANG: I know and he can say yes or no.

The CHAIR: Is that a point of order, Mr Fang?

The Hon. WES FANG: No.

The CHAIR: Okay, then, Mr Fang, let Mr Mookhey ask his questions and Mr Hayes can answer.

The Hon. DANIEL MOOKHEY: In the public hospitals they are entitled to a minimum amount of hours on a weekly basis.

Mr HAYES: Yes.

The Hon. DANIEL MOOKHEY: That is an embedded industrial entitlement.

Mr HAYES: Yes.

The Hon. DANIEL MOOKHEY: So aged care is abnormal in not providing that, certainly compared to public health. Is that fair?

Mr HAYES: There are minimum hours in aged care similar to public health; however, in public health the minimum hours are based on the average hours worked whereas the minimum hours in aged care are based on a minimum-hours contract not reflective necessarily of the hours that are generally being worked.

The Hon. DANIEL MOOKHEY: Basically the employer decides in aged care and the worker has a legal entitlement in public health. Is that a nice way of putting it?

Mr HAYES: Yes.

The Hon. DANIEL MOOKHEY: Great.

The Hon. WES FANG: I will turn to your opening statement and the video that was shown to the Committee. What prompted you to want to show this Committee the video that you displayed?

Mr HAYES: I think it is to give a sense—if people in the Committee do not have a full understanding of what aged care is—of the reality of it. I think it is trying to give an understanding that that happens. I do not

think the average person would know that people die by themselves. I do not think people understand that. They die by themselves because the person who could potentially have been with them has to go and do other work. There literally is nobody else to get there. I am not trying to be too dramatic but it was just about that. It was nothing more than that, but unless we open the Pandora's box of aged care, which I think the royal commission has done somewhat at the moment, people do not really have an understanding and out of sight is always out of mind.

The Hon. WES FANG: Is it your contention that the majority of people in aged-care facilities die on their own?

Mr HAYES: No.

The Hon. WES FANG: Or was that a unique—

Mr HAYES: From time to time that is what occurs. I cannot think of another setting—unless you live by yourself—or any other facility-type setting where the potential of that would be real.

The Hon. WES FANG: I imagine that both of the people who appeared in that video were actors.

Mr HAYES: Definitely.

Ms HUTCHINS: But can I say that that was based on the experience of one of our members who, in fact, had to go on workers compensation after her experience. She had a day where two residents were at end-of-life. They needed end-of-life care. Both of them had independently asked her to sit with them and hold their hands. Buzzers were going off. She had to go and respond to those other buzzers. Both of those residents died by themselves. She went home and could not return to work for some time as a result of all that. So although they are paid actors it was absolutely based on the experience of one of our members who could not cope because of the issues in her workplace.

The Hon. WES FANG: Because I did note that the aged-care resident depicted in the video was extremely lucid and seemed rather well. It was certainly implied that that was the person who had passed away in the video.

Ms CATE FAEHRMANN: I did not get that.

Mr HAYES: I do not think that was the intent of it. But bear in mind, not everyone in aged care has got cerebral issues. Many people, as we all get older, may have a problem with their head or a problem with their body. One is not equal to the other.

The Hon. WES FANG: No. While I accept that, I was reflecting on the fact that she was sitting up in bed and seemed quite sprightly given that I have had some experience with people who are less so.

The CHAIR: Mr Fang, are you challenging the acting abilities of the people in the video or are you asking a question?

The Hon. WES FANG: No. I am coming around to the point that I am trying to tease out and discuss.

The CHAIR: We have limited time with the witnesses, so perhaps you could move on.

The Hon. WES FANG: I want to understand why that video came to this Committee.

The CHAIR: We have had that question asked and answered. If you have a different question—

The Hon. DANIEL MOOKHEY: Point of order: The witness has notified the Committee of an intent to show a video. The Committee deliberated on it and agreed to it. In many senses, the member is asking the witness a question where, in fact, he is reflecting on the deliberations of the Committee. He would be better off asking the witnesses questions about their expertise and leave the discussion about the video to the Committee.

The Hon. WES FANG: To the point of order: Certainly the Committee agreed to view the video and that is why it was shown. My question is why that video was brought to this Committee when we have a union presenting a video that I suspect was not produced just for this Committee. I am trying to elucidate on why it feels this is an appropriate forum to display it.

The CHAIR: I am going to stop it there because we have limited time with these witnesses, and this is not the best use of their time. You have had the opportunity to ask that question. If you have a further question, I ask you to ask it. Otherwise, I will move on to other Committee members.

The Hon. TAYLOR MARTIN: Mr Hayes, I will bring you back to your written submission. Would you be able to explain how the recommended mandate for the minimum amount of time would work in practice?

Mr HAYES: In terms of the 90 minutes a day?

The Hon. TAYLOR MARTIN: Yes.

Mr HAYES: The research that we have done with the funding that would be available to deliver that would be employing obviously more staff who have the appropriate training. This is an important thing: There are some organisations out there that are less than adequate in terms of training and what they produce, but the appropriate amount of care minutes or hours would follow through from the enhanced staffing level that comes from giving that extra care.

The Hon. TAYLOR MARTIN: On that point, how would you envision allied health professionals fitting into that mix of care that you are advocating for?

Mr HAYES: Thank you for that question because it is really important. A lot of people do not think about allied health, but many of us do not talk about people being medicated and those sorts of things. I do not think it is just people like us who get to have depression and so forth. So people in aged care—that breakdown would be in different ways. We would promote, in terms of regional New South Wales, an allied health hub where you could have a shared service. An occupational therapist [OT], a speech therapist or a psychologist would be able to go to several different facilities that could afford to collectively utilise those services. At the moment it is very difficult to attract an allied health person to regional New South Wales. While the demand is there, the money is not there for them. So moving them into that mix—there is proactive care and reactive care, and the allied health would be proactive care.

The Hon. TAYLOR MARTIN: Would it be fair to say that some less acute people—patients, residents—living in aged care might benefit more from an increase in allied health services than having a registered nurse [RN] at their facility?

Mr HAYES: You are absolutely correct. Having an RN for a particular clinical need—yes, I accept that. We do not want people giving out schedule 8 [S8] drugs and so forth. But also, having an allied health professional who can proactively engage to decrease the potential of depression and of other psychological issues, or indeed diversional therapists who can enhance someone's quality of life, will draw down less on problematic issues that would develop.

The Hon. MARK PEARSON: Has it come to your attention that, over time, the culture and spirit of the people providing care in aged-care facilities caused them to become more and more stressed in their workplace? Has not being able to meet deadlines or not being able to comfort someone when they are about to die built up over time? Has that tense, pressured, stressed atmosphere with the staff had an impact on the wellbeing of the aged residents?

Mr HAYES: I think it will have an impact on the aged residents, and Ms Hutchins might correct me if I am wrong. I do not think it is the stress levels so much, it is the lack of ability to engage with someone to be able to enhance their quality of life. A pure example is when we are all pretty busy, we give a curt response or a response that is not what you would expect because people have a range of other things to do. As an individual you would feel less than adequate in terms of that. I think we are very fortunate, to a large degree, that the people working in aged care are working above and beyond. And, as I indicated before, they are bringing out of their own pocket and their own care above and beyond psychologically as well as financially to commit to those aged-care facilities.

The Hon. MARK PEARSON: Have there been any complaints or concerns brought to your attention that because there are not 24/7 registered nurses or adequate registered nurses available, restraint—including chemical restraint—increases with the residents? So aged-care facilities being given a certificate to allow them to give extra PRN medications.

Mr HAYES: I would not have thought they would have been giving those medications. I do not think that would generally be the case. Have you seen anything like that, Ms Hutchins?

Ms HUTCHINS: No. Obviously those medications are prescribed by a GP or the other health professionals involved in the care of the residents. So in terms of an increase, it is probably a question that needs to go to someone else in terms of that particular aspect.

The Hon. MARK PEARSON: Okay. I was wondering if it had been brought to your attention.

The Hon. GREG DONNELLY: Mr Hayes, you might need to take this question on notice or perhaps we can work this out for ourselves in terms of what is contained in the submission. We heard from the nurses this morning about their position with regard to the position of having a director of nursing and a registered nurse in

each aged-care facility. I am trying to understand the complete universe of staffing inside an aged-care facility. In other words, other than those with nursing qualifications, is there a complete list of the other classifications inside a nursing home? Obviously your submission contains a number of individual titles, but do they shape the complete universe or are there other employees in aged-care facilities beyond registered nurses and those contained within the submission?

Mr HAYES: I would think that 80 per cent of the people who work in aged-care facilities are not nurses. Is that correct, Ms Hutchins?

Ms HUTCHINS: That is correct.

Mr HAYES: As I said, it is important to have clinical people to do clinical roles. On a night shift, when there might be 200 or 300 people to look after, just undertaking a particular role will not facilitate the whole needs of the organisation. If people do need to have beds changed or assistance in toileting and so forth, that will happen many times a day. The disbursement of medications will happen possibly twice a day. If there is an injury and so forth, that will happen on an irregular basis. This is a complementary workforce. As Ms Hutchins indicated earlier on, to fail the older people of New South Wales would be to focus on one particular area and not the full complementary approach. It goes to Mr Martin's point, as well, that proactive engagement through allied health care is certainly beneficial to reactive engagement following a problem—or indeed people being medicated.

Ms HUTCHINS: Just to add, one role that probably is not spelt out—it is not new but it is certainly not old, if you like—is the homemaker or household model of specialist dementia carers, as they are called in HammondCare. That is a specialist carer who will work directly with a smaller group of residents to create what is like a home model of care, so that there is continuity of care and a carer who has taken on additional training. The model itself has proved to be beneficial for residents in terms of behaviour and in terms of weight gain or stabilisation of weight. That might not be spelt out in our submission in terms of that particular role, but we can provide some examples of that through current registered agreements with the Fair Work Commission if the Committee would like that.

The Hon. GREG DONNELLY: Yes, that would be helpful. Thank you, we will follow you up in regard to that. I will take you to page 6 of the submission, if I could, and the heading beneath the chart or the histogram at the top: "All aged care work is care work". The case is laid out to make it very clear that is the case. Do you think the New South Wales community and the Australian community at large has a full understanding of the significance of the allied health workers—along with the people doing the fundamental key work like cleaning and cooking et cetera—and how integral they are to the delivery of a high standard of care in the fullest sense of the word to our senior citizens?

Mr HAYES: No, I do not think so. Up until probably the past three years, this was not even a political issue at a Federal level. People were happy for elderly Australians to drift off and to think about other things. But anyone who understands any kind of structure or organisation knows that one area has to complement other areas. To put all your eggs in the basket of A, B, C or D will enhance disaster because the appropriate resourcing for the appropriate need at the appropriate time cannot be delivered. It does take a broad view of how we can not only get this right now—I am very concerned about getting it right now, but for the next 10 or 15 years it could be devastating if we do not get this right. I think the focus is there at a national level, and thankfully at the State level as well, that we can get a workforce that is complementary and reflective of the needs so that we can provide dignity.

The CHAIR: There is a lot of talk within aged care about person-centred care. That holistic care actually requires all of those other different parts and each part is as important as each other. Would you agree, Mr Hayes?

Mr HAYES: Absolutely. The most important thing that we can be doing is actually sitting and having time for someone, to value them as human being. If we want to get caught up just in the high-level medicating or other levels of the organisation that do not provide that humanistic approach in the first instance, we have already failed.

The Hon. GREG DONNELLY: I will take you to page 11 of your submission and specifically the paragraph starting "Increasingly, the work time" and then the next paragraph that starts "The allied health care workforce". The matter of the way in which training is conducted, the availability of training and the qualifications that underpin the work of allied health workers and those who are involved in cleaning and cooking et cetera—does there need to be a fresh look taken at this, as well, as part of looking at the whole sector and seeing where the improvements and the uplifts need to be made?

Mr HAYES: I think any kind of review is always helpful. We are looking at different training organisations and we certainly support organisations like TAFE, which are well accredited and deliver good

quality training. You will see other organisations where it is just basically, "Tick a box and we will give you a certificate." That is not good enough at the end of the day. Good scrutiny of appropriate training will deliver better outcomes.

The CHAIR: We heard some pretty remarkable evidence from some personal care workers at our previous hearing. They gave a really good example of how additional personal care workers at night help prevent falls. The numbers you gave, Mr Hayes, were pretty remarkable—three workers for 300 residents who need to get up and go to the bathroom, not to mention dementia patients who obviously could be just as wakeful at night as they are during the day. There is a need for these workers. They talked about how if residents are waiting then they will try to go to the bathroom themselves, and that causes falls. There is a direct relationship where more personal care workers can mean less falls. Is that your experience across the sector?

Mr HAYES: I would agree with that.

Ms HUTCHINS: Yes. One of the other preventative examples that were given is that if you have time to moisturise then you have a prevention of skin tears. That proactive work that a carer is able to do is so critical in preventing incidents down the track that may require quite significant clinical care.

The CHAIR: Yes, absolutely, and that preventative care is such a crucial part of it. We also heard some evidence about a personal care worker who said there might be an RN who is on call but there is a lot of pressure not to call them. If they are not in the facility then the expectation is really that you need to be able to deal with it yourself and then they can come in at six o'clock and mop up. Is that a common experience? If you do not have an RN on location then you are actually pushing the responsibilities back onto the personal care workers. Is that your experience?

Mr HAYES: I think that would be correct. To contact an RN on call, bearing in mind that RN has probably just done a day shift or an afternoon shift—you would be reticent to undertake that sort of activity unless it was really necessary. I am not aware that the RNs would then come in if they were on call. I think the answer would generally be to call an ambulance and deal with it that way. People would try to avoid undertaking that sort of activity.

The CHAIR: The situation you have just outlined there actually means that instead of having an RN there, it is a direct cost shift onto the State Government in terms of calling an ambulance or requiring that additional support instead of the aged care facility being able to manage it.

Mr HAYES: Absolutely right, and that has been going on for many years. The fact of the matter is that an aged care facility should be able to care for people. It is not a hospital; it is their home and it should be able to care for people. Unless there is significant injury, why would we be transferring people to hospital? But if it is easier to do that than engage someone with the clinical ability to be able to undertake certain procedures, it is an easier thing to do—and cost effective.

The CHAIR: The video that you showed was really powerful and it really goes to the increasing intensification of the work—that there is more and more being asked of the personal care worker and less time to do it. Ms Hutchins, you gave us a pretty powerful example of the person who inspired the particular video. Do you or Mr Hayes have any other examples of the impact this increasing intensification is having?

Ms HUTCHINS: We hear it every day. I have to say, in terms of the conversations that we have with members, overwhelmingly it is regarding the lack of staff and the increased pressure for them to finish their work within a set period. One of the questions that was posed earlier was with regards to Anglicare and the roster change there. It was inferred that those changes are only to catering staff. Well, that is just simply not true. The roster reviews that are taking place across Anglicare will cut care minutes across the board, including at Newmarch House. This is not unusual in aged care at the moment.

The number of roster reviews that my team of organisers are having to attend has increased significantly since the beginning of this year. There are organisations that have been established to review rosters; I understand one of them that has been raised is StewartBrown. That is on the basis of meeting a benchmark, but that benchmark is not in relation to care. That is not in relation to the needs of residents. It is in relation to how many staff you have on the floor compared to the rest of the sector. Every day, aged care workers are coming back exhausted. That experience of trying to prioritise work, as played out in the video, is common practice across the board.

The Hon. DANIEL MOOKHEY: Can I just pick up on that?

The CHAIR: Yes, of course.

The Hon. DANIEL MOOKHEY: Ms Hutchins, is it the Stuart Broad benchmark? Who is it?

Ms HUTCHINS: StewartBrown.

The Hon. DANIEL MOOKHEY: Broad is a fast bowler. Brown is a person who provides benchmarks to the aged care sector. What status does that benchmark have? Is it a Federal Government mandated benchmark?

Ms HUTCHINS: It is created by this organisation that then acts as a consultant to aged care providers, to provide that advice on rosters.

The Hon. DANIEL MOOKHEY: But it is not a benchmark that has been set by any government?

Ms HUTCHINS: No.

The Hon. DANIEL MOOKHEY: So, an employer has chosen its own benchmark. Is that fair? Let us talk about Anglicare.

Ms HUTCHINS: They have chosen to use the benchmark set by StewartBrown's analysis.

The Hon. DANIEL MOOKHEY: Yes, and then sought to change their staffing ratios and rosters in order to bring about that benchmark. Is that what you said?

Ms HUTCHINS: Yes.

The Hon. DANIEL MOOKHEY: And that is all of the discretionary choice of that particular employer?

Ms HUTCHINS: Yes.

The Hon. DANIEL MOOKHEY: And it is not like anyone has told them to do so?

Ms HUTCHINS: No.

The Hon. DANIEL MOOKHEY: And you are currently in the process of challenging them, or you are in an industrial dispute with them about that?

Ms HUTCHINS: Yes, with Anglicare.

The Hon. DANIEL MOOKHEY: To the extent to which we are told that this is a benchmark, in fact it is a justification by an employer to reduce hours. Is that fair?

Ms HUTCHINS: Yes.

The Hon. WES FANG: And have you booked the actors for that program yet, for the video?

The CHAIR: I rule that out of order.

The Hon. WES FANG: I was just asking.

Ms HUTCHINS: We do not need actors. Our members will quite openly come and speak to you about that.

The Hon. GREG DONNELLY: Hear, hear.

The CHAIR: But it is a financial analysis, as you said. It is not a care analysis. Is that correct?

Ms HUTCHINS: Absolutely, yes.

The Hon. DANIEL MOOKHEY: To the extent to which it is being advanced to close a $21 million deficit—did you hear that part of the evidence? Were you aware that that is what Anglicare told us?

Ms HUTCHINS: I did not hear that part of their evidence.

The Hon. DANIEL MOOKHEY: Well, trust me; Anglicare said that is required to close a $21 million deficit across their 23 facilities. Does that not sound like an employer is cutting care for their residents to make up a financial deficit? How else should we interpret this?

Ms HUTCHINS: That is what it sounds like to me.

The Hon. DANIEL MOOKHEY: Mr Hayes, my colleague Mr Donnelly was asking you about some training requirements for the personal care workers in the aged care sector. Firstly, is there currently a minimum required standard that applies across the sector?

Mr HAYES: Most people in aged care have a Certificate III in Aged Care. That is generally undertaken through TAFE. There are people who possibly are in aged care who may not have that, but most of our membership would be based on that.

Ms HUTCHINS: I think the aged care royal commission final report indicated that 63 per cent of aged care workers and personal carers had a Certificate III in Individual Support and there were an additional amount who had the Certificate IV in Ageing Support.

The Hon. DANIEL MOOKHEY: Yes, and that is a requirement that is set by an employer who offers a contract of employment. That is the way in which that requirement is established. It is not like there is a registration scheme or anything?

Mr HAYES: No.

Ms HUTCHINS: No.

The Hon. DANIEL MOOKHEY: What about the labour hire component of the labour force? What standards tend to be set in the labour hire component of the labour hire force?

Mr HAYES: The main issue I suppose we could identify their is the issue that we had with Guardian, where clearly there was no standard at all. Ms Hutchins may have some more experience than me, but I have not seen a lot of labour hire with the aged care facilities generally.

Ms HUTCHINS: There is a tendency to use agency staff where there are shortfalls; however, that is challenging to have staff attend and it becomes more challenging the further away you get from metropolitan Sydney. One group that we are aware of—and my understanding is that they were engaged at Newmarch—is Mable, which is an agency firm that has independent contractors working as carers. My understanding is that as a result of that, Anglicare was required to take out additional workers compensation insurance for those workers during the outbreak because Mable does not provide that. There is great concern that the Uber of agency care will find its way into aged care and that people who do not have decent pay and conditions will find themselves on a platform, moved around the sector. We are acutely aware of that and trying as best as possible to discourage it around aged care.

The Hon. DANIEL MOOKHEY: Well, you should come to tomorrow's hearing, which I think most of us are turning up for. We just change the chairs.

The Hon. WES FANG: Reluctantly.

The Hon. DANIEL MOOKHEY: I think my final question—you made the point that there is competition for aged care workers. How much additional competition for aged care workers has come in from the NDIS?

Ms HUTCHINS: Our major employer, UnitingCare—we meet with them on a very regular basis. We have a quarterly joint consultative committee where it is discussed in particular areas that they are unable to attract residential aged care workers because of that competition with the NDIS. They would put out an ad and will be unable to fill three or four roles because those workers have found themselves as disability support workers with better hours, better pay and a more regulated system. It is probably one of the biggest competing sectors with aged care because people who worked in aged care have a passion and they have skills in caring that they are able to transport into other sectors. When the competition has better pay, secure hours and a more supportive workforce, it is a no-brainer.

The Hon. DANIEL MOOKHEY: The NDIS is funded by a levy on Medicare, yes?

Ms HUTCHINS: Yes.

The Hon. DANIEL MOOKHEY: As a result, additional labour costs on the NDIS are cost-recovered through the Medicare levy. Is that correct?

Ms HUTCHINS: Yes.

The Hon. DANIEL MOOKHEY: In the absence of the levy that you were talking about, Mr Hayes, there is no ability for the aged care sector to compete with the NDIS as it grows over time. Do you agree?

Mr HAYES: That is correct.

The Hon. DANIEL MOOKHEY: So we are more likely to lose more workers out of aged care to the NDIS, which is a false competition which should not be emerging. But, nevertheless, it is present in the marketplace right now. Should we be worried about the loss of workforce skills to transfer to other sectors?

Mr HAYES: I think we should be very concerned about whichever way there is a lack of retaining or attracting people into aged care. At the moment we are waiting on a Federal budget to see what is going to happen there. It is not really a good way to be dealing with aged care proactively. I think there needs to be a planned

approach to be able to look at aged care and the NDIS—that we can actually put the services into place. But if we are just waiting on, "Here is a pot of money; we won't tell you what it is yet, and then we'll throw it somewhere," in my view that is not a really good way of dealing with ongoing and appropriate funding.

The Hon. DANIEL MOOKHEY: To pick that up, even if we were to get a very welcome increase in investment from the Federal Government, if it is not tied to a funding source that grows over time, it is just a matter of time before we are back in the same place where we are, is it not?

Mr HAYES: We absolutely will be. A really important part of this is that there has got to be transparency in funding. We have seen one organisation make a $59 million profit in 2019. If the funding is going there and we are skimming off the top—and skimming quite deeply—how can we ever keep up with actually funding aged care? There is a bigger program that needs to be had here. The funding is important. The transparency of funding is even more important—the transparency now, as opposed to just what happens later on. And then the structure that we can put in place now that will last for the next 30 years, as opposed to—you are absolutely right. We will be back here very shortly with the same sad stories.

The CHAIR: Mr Fang did have one final question, which I will give him a minute to ask.

The Hon. WES FANG: Thank you very much, Chair. Mr Hayes, earlier we heard evidence from aged care workers who were not registered nurses, who I presume would be represented by your union. In a situation where they had either more assistance on the floor or 24/7 RN cover, they said that they felt that extra hands and bodies on the floor would be of more assistance to them in their day-to-day routine. Do you agree with your members that that is a more appropriate way to provide support to aged care residents? Or do you support what the bill, which is what we are looking at the moment, is aiming to achieve?

Mr HAYES: I think day-to-day, hour-to-hour support on the ground is absolutely vital. I do not think it is impossible to walk and chew gum at the same time. But it has got to really be a matter that I keep saying—a collective workforce that complements each other and delivers the right need at the right time.

The Hon. WES FANG: Thank you.

The CHAIR: Mr Hayes, thank you very much for your time. I thank you for taking the time to survey your members, as well. Your submission was really informative for us, especially off the back of that survey. There were a couple of questions taken on notice. You have 14 days to return those and the Committee secretariat will be in contact about how to do that. Thank you very much. Please thank your members for the incredibly valuable and important work they do in aged care.

Mr HAYES: Thank you all very much for your time.

(The witnesses withdrew.)

(Luncheon adjournment)

CORRECTED

ANITA WESTERA, Research Fellow, Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong, sworn and examined

The CHAIR: Good afternoon. Welcome to our afternoon session. I also welcome our next witness. Thank you very much for your very informative submission. Do you have an opening statement that you would like to make?

Ms WESTERA: Yes, I do. Thank you for inviting me to talk to you this afternoon. Together with Professor Kathy Eagar, I co-authored the submission that you just mentioned. Unfortunately, Professor Eagar is not available to talk today. By way of background, I am a registered nurse, and I have over three decades of experience working in aged care policy, in governance roles, in advocacy and in research, both within New South Wales in the New South Wales Government as well as nationally. AHSRI, the Australian Health Services Research Institute, where I work, has been responsible for completing three key projects in the last three years. One is the development of the new funding instrument for aged care. That was for the Commonwealth Department of Health. We also conducted some reviews for the royal commission looking at staff levels in residential aged care and looking at public reporting on staffing quality and safety.

I guess the key thing that I would like to say first up is that people do not go into residential aged care because they are old. It sounds like a bit of a misnomer, but the fact is that people go into aged care because they have health issues. They have complex health conditions, functional as well as cognitive limitations that mean they can no longer live at home independently. Only 15 per cent are fully independent. One-third are bed-bound. More than four-fifths need assistance with showering, getting dressed, going to the toilet. Over half find it difficult to communicate and interact with each other. Two-thirds have memory or communication difficulties. Around one-third of residents die each year and the lengths of stay within residential aged care are getting shorter. So, effectively, you have a highly vulnerable population in residential aged care with complex care needs.

The international evidence is really clear about what is needed to ensure people with this level of need have quality and safe care. There are four key things: registered nurses on the premises; a mix of staff according to the types of needs of residents; consistency of staff; and an organisational culture and governance that supports quality and safety. People entering aged care are incredibly vulnerable and many are nearing the end of their lives. As citizens of New South Wales, they have a right to safe and quality care, regardless of which level of government has primary policy responsibility. So having an RN, registered nurse, on site at all times is a critical step. It is not the only thing, but it is a critical step in ensuring that they receive the level of care and support that they need. Thank you.

The Hon. COURTNEY HOUSSOS: Thank you very much, Ms Westera. I did not think that you could add to the submission, but your opening statement has, so that has been really informative. I open up the Committee hearing for questions. Mr Donnelly?

The Hon. GREG DONNELLY: Thank you very much for coming along to enable us to seek some elucidation on what is a very good submission that has been made with a lot of useful information in it. I circle back to a comment you made in your opening statement that the international evidence is very clear. I think you enunciated four particular points. Could you expand on that in general about the international evidence and how long that international evidence has shown that this is the case. Then, if you could, perhaps you could give us a little bit of extra insight on each of the four points.

Ms WESTERA: Sure, thank you. In terms of the international evidence, it has been around for quite a long time, and we really highlighted this when we undertook the review for the royal commission when we looked at international standards for staffing in residential aged care. We looked at international benchmarks and international systems for recording and reporting on staffing levels in residential care, and we found that the most developed and the most relevant for the Australian context was the US Centers for Medicare and Medicaid Services Nursing Home Compare system. That has been in operation since 2000, I think, so it has 20 years of quite solid evidence where US nursing homes are required to report on staffing levels, as in not necessarily the staffing on the floor but they are required to report their payroll data so we get an idea—so it is publicly reported payroll data, accreditation issues, complaints et cetera and quality issues. We recommended, based on the wealth of information and resources and research that has gone into that system, that there is very clear evidence of the role or the impact of these four factors particularly in the care and support of people in residential aged care.

The Hon. GREG DONNELLY: In regard to the four that you have enumerated, could you just go through them again and add extra points that you might think are relevant?

Ms WESTERA: Sure. The first one is that there are registered nurses on site. In the US, the mechanism by which they judge the quality of residential aged care is, as I said, through that Nursing Home Compare system. They have categorised the amount of time that staff have on site per resident per day. What they found is that there are certain thresholds at which quality is compromised if staffing levels do not reach that particular threshold. They call it the five-star rating system. I do not know if you have heard of that. We recommended it also be adopted for Australia.

Basically, it is a mix of RN—registered nurse—and other staff. I think in the US their benchmark for five stars says that at five stars, at the peak amount of time that registered nurses and other health staff are involved, there are no benefits to quality by having more past a certain point. It found that at three stars, which is 215 minutes of care per day, of which 30 minutes is an RN, below that level there is likelihood that there will be risks to care and quality, more so than the others. So we recommended to the royal commission that we should have a minimum of three-star rating. In Australia we only have 180 minutes of care per day, which actually places us at a two-star rating, so effectively we have nearly two-thirds of Australian residents in aged care living in what we would regard as unacceptable staffing levels.

The Hon. GREG DONNELLY: Just the other three points?

Ms WESTERA: Sure.

The Hon. GREG DONNELLY: Sorry to put the pressure on, but others will have questions.

Ms WESTERA: Sure. The mix of staff is also about—you do not need all registered nurses; you need a number of staff according to the needs of residents. That can include allied health, and that is something we also recommended to be incorporated in the five-star rating. In order to determine whether that mix of staff is appropriate for the residents, you actually need to have a casemix funding model, and that is exactly the model that we developed for the Department of Health, which the royal commission has recommended be implemented as well. So there can be a range of staffing, but the baseline is that for an acceptable level of staffing, we would say you need at least 215 minutes of care, of which 30 minutes is a registered nurse. That, again, is based on those over 20 years of comprehensive research. The other element is consistency of staff, and I think that is particularly well understood in terms of dementia care—that staff know their resident, they know their needs, but also they know how to anticipate their needs. So if they are likely to be stressed or likely to be exhibiting pain but cannot communicate that, then they have staff who actually know that resident and understand and can foresee and prevent any exacerbations of issues.

The fourth one is the culture and the governance of the organisation. That means an organisation that is driven to—that is person-centred, that actually facilitates staff to have systems and processes that allow staff to operate in a way that they can use their professional skills and judgement to the best of their ability. But it is also about having systems in place within the organisation around quality assurance, quality improvement et cetera, staff training. So those characteristics are really critical for an aged care organisation.

The Hon. GREG DONNELLY: I have more questions, but I will share the time with others. Thank you.

The CHAIR: Can I just ask a follow-up question to that, which was—I am not sure if you saw this morning but the CEO of Anglicare revealed that they are looking at a rather broadscale restructure at the moment, which would result in less minutes of care across their facilities. That is because of a $20 million financial deficit that they are facing. They are benchmarking at something called StewartBrown. Given your background, how do you think that will impact on care that is provided in New South Wales and perhaps some insight into StewartBrown and the financial benchmarking?

Ms WESTERA: StewartBrown, as you correctly said, is about financial benchmarking. I do not know a lot about the detail of their work, but this is not about funding; it is about how much time is required to ensure that a resident gets proper care. If they are reducing their—I would be interested to see the outcomes and the evidence that they have that with those reduced hours and reduced hands-on time with residents they can deliver the same amount of care. StewartBrown does not really look at that and, again, the only benchmarks we have—people are using the Aged Care Funding Instrument [ACFI] as the sort of baseline. Prior to our work for developing the new funding instrument, we undertook a review of the ACFI. We concluded that it is not fit for purpose because it only measures what you give somebody; it does not measure what that person needs. Fundamentally, the benchmarking that is being done in aged care is on a flawed basis. What we need is a case mix system that groups like with like so that you can compare what staffing levels are needed for that particular group of older people with those particular care needs.

Ms CATE FAEHRMANN: I just want to draw on that further, thinking about the ratings using the Centers for Medicare and Medicaid Services [CMS] model, which was particularly interesting, with 57.6 per cent of Australian aged-care residents in homes that have one- or two-star staffing levels. Of the remaining residents, 27 per cent are in homes of three stars, 14.1 per cent are in four star and 1.3 per cent are in homes with five stars. I am trying to get to the bottom of what that discrepancy is based on. I would have thought that in Australia there would potentially be more consistency—even if, for example, they were all two stars—because of the aged-care funding model. Why is there such a discrepancy between, for example, four-star homes and one-star homes here?

Ms WESTERA: It is a very good question. Again, there is no mechanism to report on—there is no way we can definitively say that. We know that there are number of aged-care providers that are making a lot of profit from the centre. We benchmarked which groups were more likely to fall into the different categories but I cannot say with accuracy—I cannot remember exactly the details. I can provide you with that information because we did look at what sort of groups were more likely to fall into a one star versus a five star.

Ms CATE FAEHRMANN: When you say that there are different providers and, for example, some providers are making a lot of money, are you inferring that those providers then reinvest the money in the sector or are you inferring that they are making too much of a profit because they are cutting costs?

Ms WESTERA: I cannot say for certain because, again, I do not know their financial modelling. I find a consistent theme—I think we have to acknowledge that the sector has been underfunded. The primary problem with increasing funding currently is that there is no mechanism for us to know whether the additional funding will be spent on care or how it is going to be spent. There is a need for funding but we also need to have some transparency about how that money is spent. At the moment we do not have transparency so we cannot say why some facilities—we can guess but we cannot say for certain—will run at a one star and some at a five star. Unless we look at the financial modelling of the different providers we would not be able to say for certain. We recommend this five-star rating system so that the public has some transparency and there is accountability for the funding for aged care.

Ms CATE FAEHRMANN: So the 1.3 per cent of homes which are five stars, you said that is basically when all their care needs are met and therefore more staffing would not make a difference. Is that—

Ms WESTERA: Yes, that is the US model and that was saying that with this combination of registered nurses and all staff at this particular amount of time, there are no further benefits to the quality of care. We would argue, though, that in that system that was only looking at the nursing staff and the support care staff. We actually think it missed the mark in terms of allied health because it did not take that into account. We know very clearly that allied health has a significant role to play in both preventative health, rehabilitation and additional support.

Ms CATE FAEHRMANN: Can I also ask—and sorry if you have put this in—if this was from activity time data?

Ms WESTERA: Yes, that is correct.

Ms CATE FAEHRMANN: One particularly striking part of your submission are the statistics around the decline in staffing. You have the reduction here in registered nurses employed in 2003—there were 21 per cent and that goes to down to 14.6 per cent in 2014; enrolled nurses from 14.4 per cent to 9.3 per cent; and allied health professionals from 7.6 per cent to 4.1 per cent. That is over a period of 13 years. Do you put that decline down specifically to funding? I suppose there are a range of factors. Do you have a view on why there is such a decline?

Ms WESTERA: Yes, it is combination of factors, not just one. The Aged Care Act 1997 introduced the concept of this being a person's "home". There was a lot of rhetoric and emphasis on "homelike" environments and therefore you effectively allowed the system to not focus on the clinical side of things. It enabled a less clinically oriented environment. Perhaps back then that may have been relevant or appropriate but certainly today with the complexity and clinical needs of residents that is not appropriate; people do not go into residential aged care for a homelike environment or lifestyle change. The other factor is that the Commonwealth Government has been—as was revealed in the royal commission—clear on limiting the funding within residential aged care.

You could see over time that a lot of the introduction of new funding was iterative. It would be introduced for specific reasons and then perhaps it might be pulled back. There were decisions made about holding back on giving CPI increases to the sector, primarily as a mechanism for fiscal management. There were also concerns, which was very clear in the Commonwealth department's evidence before the royal commission, that there was an inherent mistrust about certain elements of the aged-care sector. Therefore there was this reluctance to pour more money into the system if they had no mechanism to ensure that it would deliver the outcomes they had anticipated. So there is a range of factors that will have contributed to that.

The Hon. MARK PEARSON: Can you elucidate on what the distrust was about? How did that come about?

Ms WESTERA: Oh, I use that expression.

The Hon. MARK PEARSON: Yes.

Ms WESTERA: I am not saying that they do, but there is this sense that there is not a direct relationship between the—the Commonwealth funds programs. In my view, it actually puts the risk back onto providers to deliver the care in the way it is structured. The providers have consistently said, "We're not getting enough money", but the department and the Government have said, "We are constrained in our funding but also you are not demonstrating openness or transparency." I do not know for sure what the actual reasons are. That is again my own personal view. I think the critical thing, you know, is that over time what we have seen is a systematic reduction of emphasis or understanding of the changing needs of the clientele in aged care. The department is very clear.

I used to work in the department. They were very clear that they would do no cost of care study because that would expose—and that is under both Labor and Liberal governments. That has been a very clear message when I was working in government. So our work when we did the development of the funding instrument was actually the first time an independent assessment of a representative sample of aged care residents had been undertaken in aged care. The aged care funding instrument [ACFI], as I said before, was not a measure of need. It was a measure of what people provided to a client but the Australian National Aged Care Classification [AN-ACC] system, as it is called, delivers an independent assessment by qualified, experienced aged care registered health professionals.

Ms CATE FAEHRMANN: Can I just jump in and ask when you refer to some instructions within the governments of both sides that there will be no cost of care study, can you expand on what a cost of care study is?

Ms WESTERA: Well, sorry: Again, that is my interpretation, having worked in that environment. I do not think there was ever any explicit—but it was simply that you are exposing yourself to finding out what might be.

Ms CATE FAEHRMANN: We do not want to know the truth of exactly how much it is costing to care for all of these elderly people who are coming into the system. Is that kind of what you are saying?

Ms WESTERA: Well, I think so, but it is also that we had no measure. They had no means to objectively measure what those care needs are. As I said, the funding tools were all about funding processes and it was about how you allocate funding. It was not necessarily about what is the need for those residents. I can give you a case in point. Under ACFI, in order to employee physiotherapists, they employ them to do pain relief, which is massage. The physiotherapists themselves say how frustrating it is because they cannot—massage does not actually resolve the pain and there are far more useful things that they could do to improve outcomes for their residents than simply to do this. But the ACFI tool only allowed them to be employed to do this one particular task.

Ms CATE FAEHRMANN: You as a research fellow could cost that care. Could your institute—

Ms WESTERA: That is what we did.

Ms CATE FAEHRMANN: It can be costed.

Ms WESTERA: That is what we did, yes.

Ms CATE FAEHRMANN: So the State Government has not done it. I think you just provided a reasonable excuse for the State Government before, but it has been done.

The CHAIR: Oh, no, I think—sorry—I think it was the Federal Government.

Ms WESTERA: It is the Federal Government, yes.

The CHAIR: It should be funding it.

Ms WESTERA: Yes.

Ms CATE FAEHRMANN: Yes.

Ms WESTERA: The Federal Government does.

Ms CATE FAEHRMANN: The Federal Government. Yes. Sorry.

The CHAIR: Ms Westera was talking about the body of work that you have done. Would you maybe explain why you came to do the work on the new funding instrument?

Ms WESTERA: Sure. The Commonwealth had known for a long time that the aged care funding instrument had problems. It was an additive model so that if you have got dementia and you are bedridden or bed-bound, et cetera, you get more money for all these things. That does not actually make sense. It is not clinically plausible that you should get more money just by adding up these particular items. It is not like a shopping list. But the ACFI itself actually also had perverse incentives. For example, you got more money—and aged care facility was paid more money if a person had behavioural issues, than if they did not. So in the funding model there is no incentive to prevent behaviours. Similarly, there is no incentive for rehabilitation or preventative—yes, rehabilitation or re-ablement, as they call it, because you get more money the more dependent a person is. So there are these perverse incentives.

The Hon. MARK PEARSON: So would you say ACFI is flawed?

Ms WESTERA: Yes, absolutely. Absolutely.

The Hon. MARK PEARSON: Because it is reactive rather than proactive in terms of its application is a reactive process and about finding funding for that nursing home—

Ms WESTERA: Yes, yes.

The Hon. MARK PEARSON: —and therefore maybe some exaggerations are done in order to get the ACFI?

Ms WESTERA: Certainly there is a big industry called ACFI maximisers and that is people who will go around and look at the documentation and identify how you can score more on your ACFI claims. That is why we actually looked at the distribution of scores under ACFI. It was implausible that the majority of people were all high care needs.

The Hon. MARK PEARSON: And you said earlier that when that assessment is done and the funding is provided, it does not actually fit the real needs of the resident.

Ms WESTERA: The need—no, no. It is not needs—

The Hon. MARK PEARSON: It has another purpose.

Ms WESTERA: That is correct, yes. It is not needs. It is not driven by an independent assessment of needs and that is exactly why the Government contracted us. Once we undertook that review there were a couple of reviews done at the same time and our review was very clear: We found it had significant faults. That is when we argued that a case mix system, similar to as happens in hospitals and in education, et cetera: It is about your groups, like verses like. You get groups of people who will have a range of needs and some population groups will have higher levels of need and so that is where you allocate the funding, according to those particular categories or classifications.

The CHAIR: I might just ask if you have one last question and then I will pass to Mr Martin.

The Hon. MARK PEARSON: I am fine.

Ms CATE FAEHRMANN: I do have one last one, yes. You also talk in your submission about the fact that our aged care homes today are equivalent to non-acute wards that used to exist in the public hospital system. Has there been research on the potential cost shifting from aged care homes to the public hospital system as a result of this? We heard from the Health Services Union before of residents being transferred to get catheters removed, for example.

Ms WESTERA: Yes.

Ms CATE FAEHRMANN: Has there been research to cost that, to your knowledge?

Ms WESTERA: I think there has been but, again, it is not something that we have done ourselves. I think fundamentally it is not about cost. It is really about the principle.

Ms CATE FAEHRMANN: Yes, of course.

Ms WESTERA: And that is why we suggested a non-acute care category because this level of clients, these are not age-related issues that they are coming to aged care for. These are health issues. For so long people have been conceptualising this as a lifestyle choice in that it is their home, it is a lifestyle and we will have all these wellness and wellbeing elements to our services. We will offer them to our residents, but when you have

only got 15 per cent of people who are totally independent and one-third are totally bed-bound, these are health issues and the staffing profile—not only the staffing profile but also the systems. The health system is very good at capturing data. It has systems and processes in place about quality outcomes and measuring outcomes, et cetera. The professionalism within the health system—health professionals are really sustained in a system that values their expertise. The decline of registered nurses in aged care is also because so many did not want to work there anymore because they were just limited to primarily maximising ACFI or addressing the accreditation issues, or worrying the quality assessors are going to come around, et cetera. They have been able to use their full scope of professional skills. So a lot have left the sector for that very reason.

The CHAIR: I will just pass to Mr Martin.

The Hon. TAYLOR MARTIN: Thank you for your time this afternoon. Can I ask a bit more about your submission, specifically where it talks about how the staffing mix can help increase the level of care that people receive, and ask you what mix should the staffing arrangements possibly be?

Ms WESTERA: The mix of staff needs to be according to the needs of the resident. That is why you need to have an independent assessment of need and that should determine the level. So if you have got people who have the potential for rehabilitation then they should be offered support, whether it is allied health, whether it is occupational therapy et cetera.

The Hon. TAYLOR MARTIN: So how do we go about mandating minutes for patients, so to speak, when their needs are individual? Do you see the issue?

Ms WESTERA: I do, but they are not individual; they can be grouped within certain—

The Hon. TAYLOR MARTIN: As a category?

Ms WESTERA: Yes. And what we found when we did the research for the AN-ACC is that the major issue, the first what we call split of the residents, is on function. We have very capable statisticians at work who did all this regression analysis—that is not my forte and I am more than happy for them to give you more information if need be. But the major needs were structured around function and then complicating factors—function, then cognition and then complicating factors. So you have groups of people where if they are high functioning, if they are independent and they do not have any cognitive impairment, their needs are fairly consistent regardless of where they live. If they have cognitive impairment and they are fully independent then those needs are different again. There are 12 classes in the new funding model, so there are 12 potential groups where you can actually adjust for the appropriate level of staffing.

The Hon. TAYLOR MARTIN: Okay. Thank you.

The Hon. MARK PEARSON: Just for clarification, so we can get our head around it a bit, obviously aged care facilities will change over time, depending who the residents are, as to the package, if you want to call it that, of the carers attending there—there might be more need for physiotherapists or mental health workers. For example, if a home has more mentally ill people than the average home, then really the care package should be looking at that—

Ms WESTERA: That is correct, yes.

The Hon. MARK PEARSON: —rather than finding a way of turning their need into a high care in order to be able to get money to pay for something which might not be the most appropriate intervention for them. That is what you are saying.

Ms WESTERA: That is correct, yes.

The CHAIR: Can I ask a couple of questions? I thought it was pretty remarkable, your submission outlined how we have seen basically a halving in the number of allied health care professionals within aged care, and we certainly received evidence this morning from the Health Services Union that talked about how contracting out of catering and of cleaning, these kinds of parts that are crucial to holistic care, we are seeing all of those things are really going from aged care facilities. Can you perhaps explain what the impact of that would be? You talk about it a little bit within your submission. What is the impact of that on these very vulnerable people with complex health care needs that you explained?

Ms WESTERA: Again, that is probably the allied health professionals who can best explain it, but as I mentioned earlier, simple things like if a person has a fracture or a fall, their ability to be rehabilitated if you have got a physiotherapist or an occupational therapist, or they have had a stroke, for example, they can actually work with them to help individuals get back to their best ability or best status. That is not a registered nurse's forte; they have a different skill set, so that is why you need those specialist skill sets within the mix of your staffing model.

Again, with the five star rating system we have recommended allied health be incorporated in that because the end product we would like to see is public reporting on the staffing levels, on the case mix, on the sorts of clients.

So each facility, if we know that they have X amount of category 11 people, or class 11, or if they have more high care or more low care, to be able to judge whether or not that staffing mix and that staffing level is appropriate for that client group. That is not just something that is going to be easily—there is a whole process that has to be undergone behind the scenes to get to that point, but it should be a very transparent algorithm basically so that people in the community can say that residential aged care has this many stars because its staffing, its quality levels, its allied health inclusions are all appropriate for the mix of those residents. The judgement is made behind the scenes but it is through a benchmarking process.

The CHAIR: That question of transparency is something that has come up time and time again from different angles by the lack of information particularly for residents' families. I think that is certainly something that we need to be looking at. I want to ask you one more question. You talk about care minutes, and I can see that you have talked about it in the context of the star rating, but we have received—and I am not sure if you have seen it—the submission from the NSW Nurses and Midwives' Association that their Federal body has done some work with some South Australian universities that talks specifically about the specific care minutes that should be provided. Do you have a view on that model?

Ms WESTERA: Again I would just say it needs to go back to what are the needs of the resident. I think a registered nurse needs to be on duty, absolutely—that is a given—but in terms of the quantum of time that somebody spends with a resident, it will really depend on the needs of that resident. I have seen it, I have read it, but I have not really analysed it in detail.

The CHAIR: That is fine. Thanks very much, Ms Westera. We will come back to Mr Donnelly.

The Hon. GREG DONNELLY: Just going back to your submission for a moment, at the bottom of page number one, going up onto the top of page number two, the paragraph immediately below that says, "Over the same period, the profile of residents has become increasingly more complex and frail." Can you expand on that? What do you mean by greater complexity and greater frailty?

Ms WESTERA: Frailty is a clinical term. There are tools to assess frailty. When we were developing the AN-ACC, or it was under the Resource Utilisation and Classification Study [RUCS]—you might have heard about the RUCS, or you may not have, that is okay—

The Hon. GREG DONNELLY: It is in that paragraph actually.

Ms WESTERA: We had clinical advisory committees informing us all the way along with that project and they were commenting on the changes in complexity in frailty in particular. Again, because our own mechanism at the moment is the Aged Care Funding Instrument [ACFI], the Commonwealth used to invest quite heavily in the aged care assessment program, the ACAP, where they used to collect data and do benchmarking et cetera nationally. They no longer invest in that program in the way that it used to happen. We used to have another sort of data source where we could confirm that, but at the moment there is no other data source. So it really was a matter of what the clinicians had told us and the providers had told us throughout the RUCS process, as well as our own history working in the sector.

The Hon. GREG DONNELLY: The next line in the same paragraph says:

> Around half of all residents have dementia, many are at end-of-life, including some admitted for short-term palliative care, and one in three residents overall die each year.

I could be wrong but, in terms of reading the submissions to the inquiry and hearing evidence from some of the witnesses who have presented before the inquiry hearings, I am just drawing the conclusion that palliative care, whilst it is understood it should be an important feature of what is provided for in an aged-care nursing home by virtue of the cohort of people who reside there, is somewhat underdone. I do not know whether that is an accurate broad general statement that has any merit. In fact, if you look at all the things that need to be done in such a facility and given that we are in large measure dealing with people who have got complex health comorbidities—and indeed many people's lives will end there sooner perhaps rather than later—one would have thought that palliative care ought to have some significant overarching feature in the way in which the whole delivery of care is provided for in those facilities. But that is not the impression I am getting. That is more of a statement on my part, but do you have any observations about that?

Ms WESTERA: Absolutely. I think you are exactly right. I think there is good palliative care that goes on but not everywhere. I think the major issue is when the Aged Care Act 1997 came in. It was a big shift to opening it up to the market and seeing aged care as a market. In a competitive environment where you are

competing for places against private for-profits, not-for-profits or whatever no-one is going to be saying, "Come to my lovely aged-care home to die", because that is not a selling point. I have heard one aged-care worker describe a lot of the workplaces now as "chandelier mausoleums" because you have these beautiful buildings that are attracting the baby boomer children of the ageing parents. They think, "This is a beautiful place. My parents will get lovely care here." But it is not an attractive proposition to say, "Come here and die."

The Hon. GREG DONNELLY: Yes. I understand the messaging here.

The Hon. MARK PEARSON: No discharge.

Ms WESTERA: I think marketisation has been shown to have a significant impact on the way that the system and the aged-care operators operate. There is no collaboration. There is limited collaboration between facilities in the local area because they compete. They are competing for residents and clients. So you have actually lost that capacity for collaboration, community, professional cohesion and working collaboratively between services, not only aged-care services but health and so forth, because of this—you know, it is all about competition. It is all about getting the clients, keeping your market share et cetera.

The CHAIR: I am mindful of time and we have a busy afternoon, so I am sorry but we are going to have to leave it there, Ms Westera. You did take a couple of questions on notice so the Committee secretariat will be in contact with you. We do ask that answers come back within 14 days if that is possible.

Ms WESTERA: Sure.

The CHAIR: Thank you again very much for your time, the very valuable work that you do and your very informative submission and testimony this afternoon.

(The witness withdrew.)

CORRECTED

DEB PARKER, Member, Palliative Care Nurses Australia, and Professor of Nursing Aged Care (Dementia), School of Nursing and Midwifery, University of Technology Sydney, affirmed and examined

JOSH COHEN, Vice President, Palliative Care Nurses Australia, and Palliative Care Nurse Practitioner, Calvary Health Care Kogarah, affirmed and examined

KYLIE MISKOVSKI, National Policy & Strategy Adviser, Dementia Australia, affirmed and examined

JENNY FITZPATRICK, Carer and Dementia Advocate, Dementia Australia, sworn and examined

The CHAIR: Would you like to make a brief opening statement? Perhaps we will start with Dementia Australia.

Ms MISKOVSKI: Thank you for the invitation to appear at the hearing today. I am going to make a brief opening statement and then hand over to Ms Fitzpatrick to make her statement. My name is Kylie Miskovski and I am a national policy and strategy advisor at Dementia Australia. I have a thorough understanding of the experiences of people impacted by dementia through my career but also through my personal experiences. Dementia Australia is the peak body for people impacted by dementia—the estimated half a million Australians living with dementia as well as their families and carers. We have talked with many people impacted by dementia to understand what quality care looks and feels like, and what it looks like when it is lacking. Although I am sure you are familiar with what dementia is, I think that it is worth noting that the term "dementia" describes the symptoms of a large group of neurocognitive conditions that cause a progressive decline in a person's cognitive functioning.

Symptoms can include a loss of memory, which is what is most commonly associated with dementia, but also aspects such as thinking and planning, physical functioning and social relationships. Dementia is a terminal condition and there is currently no cure. It is the leading cause of death of women and the second leading cause of death in Australia overall. According to recent estimates, almost 70 per cent of people living in residential aged care have moderate to severe cognitive impairment. It makes sense, then, that the aged-care sector and workforce should have the education, skills and experience to care for people living with dementia and to support and work in partnership with their families and loved ones. Yet as the Royal Commission into Aged Care Quality and Safety has shown, there have been multiple failings for people living with dementia in the aged-care system, not least in staffing numbers and education.

As outlined in our submission to this inquiry, Dementia Australia has advocated for registered nurses [RNs] to be available 24/7 in residential aged care. But we also want to stress that this requirement alone—along with mandated nurse ratios—will not guarantee quality dementia care. All aged-care staff must be dementia educated. People living with dementia also need continuity-of-care staff in greater numbers, with an appropriate skills mix determined by residents' needs. Registered nurses are and should continue to be a key component of a multidisciplinary care team, but they also need to be supported by a senior leadership that understands what it takes to provide quality dementia care. Thank you. I will now hand over to Jenny.

Ms FITZPATRICK: I am Jenny Fitzpatrick. I am here as a dementia advocate and a loving and determined advocate for my husband, Noel Hackett, who has younger onset dementia. He is now 71 and he has spent the last six years and 10 months in a Sydney nursing home. I have spent three to five hours—mainly five—a day with him throughout that time. Other friends have also remained faithful except, of course, during the COVID restrictions. I want to make three points this afternoon, which I am happy to talk further about. The first one is that residents, especially those with dementia, need to be surrounded by a community of care. For continuity of care in that community, there needs to be permanent RNs, personal care assistants [PCAs], family members and allied health professionals, as well as doctors and management. The community of care needs to communicate and work in a transparent, collaborative, respectful and supportive way with and for the resident.

Second point: COVID has not just revealed gaps but gaping holes in aged care. We all know that. My husband lost three kilograms in the first six weeks of lockdown despite having assurance from the regional manager of the time that he would be fed in an intelligent and measured way given the disabilities that he has with eating due to his advanced dementia. He lives in a wheelchair, so it is pretty hard to lose three kilograms in six weeks. I intervened then to cancel two allied health appointments by saying, "Feed him." This is a small example of where staff on reduced hours are blamed, and the only missing component in his community of care was myself. I would like to read, to get it exactly right, a letter that I received from the general manager of residential services:

> We staff our homes to provide complete care rather than being reliant on families to fill gaps.

Point three: There is a great need for dementia education at all levels in aged care. I am talking board members to gardeners, residents to regional managers, board members to the handyman, RNs, PCAs, residents, kitchen, laundry—every single aspect. More than 50 per cent of people living in nursing homes have some form of the 100 types of dementia, so every person in aged care needs to have some understanding of some of the implications for the person with dementia and why some of the changes in behaviour are happening.

Mr COHEN: I will be making a joint statement for Professor Parker and myself. My name is Josh Cohen and I am Vice-President of Palliative Care Nurses Australia. I am a palliative nurse care practitioner working within residential aged care and the community setting for a specialist palliative care service. Professor Parker, as mentioned, is a member of Palliative Care Nurses Australia and Professor of aged-care nursing, specialising in the research of the palliative care needs of people living with dementia. Our membership strongly advocates for the presence of registered nurses in residential aged-care facilities at all times. Our goal is to support membership to provide high quality, evidence-based palliative care in residential aged-care settings for people with life-limiting illnesses and their families. Many Australians will die in residential aged care, some well and others not so well, because of the capacity of any individual site to manage a person's palliative care needs at any time.

We know that people living in residential aged-care facilities are at risk of receiving inappropriate and futile care when advanced care planning discussions are not had. Registered nurses can make a difference here. We understand that the diagnosis of dying is often not recognised in a residential aged-care facility, and that the frail aged are particularly vulnerable to lack of assessment and lack of communication, resulting in residents and their families being surprised by a loved one's death. The presence of registered nurses can make a difference here. We know that not having a registered nurse onsite in residential aged-care facilities at all times, but especially at night, may result in a dying person being transferred to a hospital emergency department, where they will not be known, where they and their family will almost certainly be in distress, where they will be at risk of being subjected to unnecessary and invasive interventions that will make little difference to their outcome, and where they will spend the last hours of their life surrounded by strangers. A registered nurse can make a difference here.

We know that many people living with residential aged care have complex pain needs, and that their pain is very often not being managed in a way that reduces their distress and makes their lives better. We know that their pain needs are often poorly recognised and poorly understood, and can result in the need for a hospital admission to manage a pain crisis. A registered nurse can make a difference here. We acknowledge that the palliative care needs of residents will change over the course of their admission to a residential aged-care facility. This means that acuity can change daily and is fluid rather than consistent. We acknowledge that the staffing skill mix required to manage these residents, with fluctuating levels of complexity but always with baseline complexity, is not easy. A registered nurse can make a difference here.

The CHAIR: Professor Parker, did you want to add to that?

Professor PARKER: No, I am happy to take any questions that you have.

The CHAIR: I thank you all for your time and for those powerful opening statements. I will ask one question at the outset to both organisations. Mr Cohen, you talked about the need for a registered nurse but both of your opening statements, specifically Dementia Australia, spoke about the need for continuity of care and the ability to develop a familiarity with the residents, and that is central to providing best person-centred care. Can that be provided by a single registered nurse at an aged-care facility or should we be looking at actual levels or numbers of registered nurses comparable to the number of residents—almost like a ratio-type situation?

Ms MISKOVSKI: I would say again that I think a ratio, while it is useful, is a bit of a blunt instrument. I think it needs to be a bit more nuanced than that and it needs to be determined by the residents' needs. I heard Ms Westera speaking before and I know that it is difficult to deal with fluctuating health circumstances and care needs, but I really think that we need something that is responsive to care needs that will differ in different homes. Certainly where there is a large proportion of residents with dementia, perhaps we need more registered nurses but we would also need other staff—we would need PCAs, we would need more allied care staff. We need something that is nuanced that can be responsive to residents' needs.

The CHAIR: Did you want to add anything, Ms Fitzpatrick?

Ms FITZPATRICK: I worry about "nuanced" and words like that in terms of the aged-care sector going with the minimum. So once we have a ratio, if that is the way it goes, that will be the absolute standard and all the nuance will go. But if it is just nuanced, the aged-care sector has a proven record of making that work for financial gain. So I think it is very difficult to know, that is my experience.

The CHAIR: I appreciate that, Ms Fitzpatrick. Mr Cohen, Professor Parker, what do you think?

Mr COHEN: Palliative Care Nurses Australia would say that it is essential to have some type of mandate to manage the complex care needs of residents. As I said, they fluctuate each day. I think there would be times when a registered nurse would struggle to cope with 16 patients let alone 60, so I think there is no question that a single registered nurse would not cut it.

Professor PARKER: I heard the conversation earlier. I think this is a complex area around staffing that we are embarking on. People talk about different things and I think you have tried to uncover some of that today, so let me try to assist you. Ratios exist in the Victorian public sector homes, the ones that are State funded. On the morning shift you have one to seven, which is one RN or EN to seven residents. In the afternoon it is one to eight. For night duty it is one to 15. That is what we mean when we talk about ratios, so it is blunt. One of the things you have to understand about ratios is that if I am a newly graduated registered nurse who has just finished my university training then my skill set compared to that of Mr Cohen, who is a nurse practitioner, or a registered nurse who has been working for 20 years are quite different. A ratio of one is blunt, because is it one person with very little training or one person with lots of training? That is the problem with ratios, although as Ms Fitzpatrick says they are useful to at least get some minimum staffing in there. That is better than what we have in the non-public homes.

In Queensland they went more down the Australian Nursing and Midwifery Federation [ANMF] skills mix path. What you find in Queensland is they have a mix. They have the minimum number of minutes per resident per day set at 219 minutes. The way that they have broken that up is that 30 per cent of that should be registered nurse time, 20 per cent should be enrolled nurse time and 50 per cent should be personal care attendants—or the other term that you will hear is assistants in nursing. There is slight variation around the country. That is actually below what the ANMF recommend, but again it is higher than you would find anywhere else and it only came in quite recently. But Queensland only has a small number of public-funded aged care facilities compared to Victoria and of course compared to the rest of the country. Then what we have coming out of the royal commission—and I am sure you are well across that—is the minimum number of minutes per resident per day. They talk about the fact that by 1 July 2022 we want a minimum total of 200 minutes per resident per day and 40 minutes should be registered nurse time, and then that ramps up by July 2024.

I did not hear all of Ms Westera's testimony, but Kathy Eagar and her team have linked that to the star rating system. Even at that level, from the royal commission recommendations, we are really only just hitting three stars. I am not sure how much you have listened to the royal commission testimonies from people like Ms Fitzpatrick and people receiving aged care services—Mr Cohen and I both testified at the commission as well—but I am not sure that Australians would be expecting a three-star system. I think it would be incredibly disappointing if that is the outcome of the royal commission, and I think it would be incredibly disappointing for New South Wales residents if we cannot even get to that level. Sorry I was a bit longwinded but it will give you an idea of the complexity, ratio, skill mix and minutes per day. They do have to be adjusted for case mix, so that was one of your earlier questions. Is it a blunt "Everybody gets this many minutes"? We do not have a lot of data on this. That is another thing that came out of the royal commission. We do not have good data about how you adjust this. What is the right level? Will it be linked to quality? How does it link to quality? What is the right number of minutes? We do not collect that information.

The CHAIR: But we do have a lot of stories that show that we need to do better, that we are not doing well enough at the moment and that we need to improve things.

Professor PARKER: We do have a lot of stories, yes.

The CHAIR: Perhaps that is one way of shifting forward. I really appreciate that. That certainly answered my question.

The Hon. MARK PEARSON: Professor Parker, would you say that it would be a good recommendation in aged care facilities that it be part of the standard for each registered nurse to have X amount of experience either working with aged people and/or at the facility where they know the residents? Do you think that is an important factor in order to lift the standard of care even higher?

Professor PARKER: Yes, absolutely. I am a part of a group of aged care professors across the country who have been looking at what standard of training occurs in the schools of nursing and universities across Australia and we know that is variable as well. Every nurse who comes through the schools of nursing in their three-year degree has to tick certain criteria around their knowledge of the older person. Some universities, like my university, have specialised courses within the three-year training that are particularly around aged care and students go out and do placements. But not everybody does that because it is not mandatory to do that. It is not just in your three-year training that you need that. If you are going to be leading and working in this area then there is also postgraduate training that people should be doing—so a Graduate Certificate or a Master's in Aged

Care. That is if you are a registered nurse. I am sure you have heard other stories about the training of personal care workers and the lack of quality of that training. Mr Cohen is a palliative care nurse practitioner. His specialty is palliative care; that is his expertise. What we have to do is professionalise the training in aged care.

Ms FITZPATRICK: Yes.

The Hon. MARK PEARSON: Would you say that is in part or mostly because the residents often find it very difficult to communicate what they are experiencing?

Ms FITZPATRICK: Yes.

The Hon. MARK PEARSON: And therefore a registered nurse, or other staff for that matter, who knows the resident is well and truly ahead of what is required to prevent—et cetera?

Professor PARKER: I think it comes back to that complexity of need that the previous witness spoke about. It is communication from people with dementia, strokes or other neurological conditions—it may not be dementia. But is not just the communication issue. It is all of that complexity of need. It is not just the registered nurse; you are right. Dementia Australia advocates that every person should be trained in the care of the older person.

The Hon. MARK PEARSON: The cleaners as well. Mr Cohen, you said that a registered nurse on duty with experience and with the right ratio of registered nurses to residents is likely to prevent an admission to an emergency ward.

Mr COHEN: Yes.

The Hon. MARK PEARSON: What does that registered nurse do? Give us a scenario as to what they would do to prevent that.

Mr COHEN: A registered nurse would have the capacity to assess a patient who may be deteriorating. First of all they would be aware of their life-limiting illnesses, whether it is dementia or respiratory failure or heart failure. Based upon their assessment and potentially a person's symptoms, they could see that they are differing from their previous baseline. It may be as simple as taking a set of observations—blood pressure, temperature, heart rate—and they think, "There is something different here." What is good about having a registered nurse on site is that they can then say, "Who do we now need to involve in the care of this person? How do I prioritise my day to prioritise this person to ensure that their needs are being met?" Sometimes it may be that a hospital admission is exactly what that person requires. But it also may be that through timely and educated assessment they can involve the right people—like myself—to turn up and offer the right sort of care, to ensure the right medications are available, to speak with GPs, to communicate with families and to ensure that that particular person's needs are recognised on that day because of the bag of tricks that clinician has.

The Hon. MARK PEARSON: Ms Fitzpatrick, just one question to you: Through doing an extraordinary amount of work helping and supporting your husband, did you ever recognise that he would respond differently or better to staff whom he knew and who knew him?

Ms FITZPATRICK: Yes, absolutely, on a daily basis. In January, when I was absent for an extra three weeks because I live in the Canterbury ward of Canterbury-Bankstown, Noel went into a decline and was not responding to staff. But with my re-entry, he is responding again. He reaches out to staff and smiles at them. It is quite amazing. Yes, he has his favourites and gives them his best smile and will talk to them—"Ah, hmm"—in that sort of language. He is engaging with people, yes. Definitely.

The Hon. GREG DONNELLY: Thank you all for coming along this afternoon. Starting with Dementia Australia, thank you for your submission. It is very helpful for us. On page four of your submission under the heading "People living with dementia in residential aged care" it says:

> There have been multiple failings in the aged care system for people living with dementia, their families and carers – both at the individual provider and systemic level.

It goes on to talk about these matters. Is there a view the organisation has about how we have come about having multiple failings in the aged care setting for people with dementia? It will help us better understand because I would have thought, obviously incorrectly, that it would be almost taken as a given that—

Ms MISKOVSKI: You would hope, wouldn't you? Unfortunately not.

The Hon. GREG DONNELLY: I am displaying my ignorance and I should apologise for that up-front.

Ms MISKOVSKI: No.

The Hon. GREG DONNELLY: It is more than a curiosity. It is tragic that, in fact, the aged care settings do not have it as a baseline cornerstone that there are going to be people—perhaps many people—within the facility who have dementia. That would feed in so much to the way in which they offer their care, but obviously that has not been the case.

Ms MISKOVSKI: No, unfortunately not. The recent estimates we have are that about almost 70 per cent of people in residential aged care have moderate to severe cognitive impairment. We can account that most likely to dementia. The aged care sector has talked about dementia being core business but we have not seen that in reality. There is no mandatory dementia education, so you have people working in residential aged care with residents with severe dementia who do not have mandatory dementia education. There are people who do not realise that dementia is a terminal condition, so when it comes to the palliative care stage, that is severely lacking. Unfortunately, as you said, you would expect that the aged care workforce would have a good understanding of dementia, but we see that that is not consistently the case. I think Ms Fitzpatrick wanted to share a story.

Ms FITZPATRICK: Yes, I would like to share a story with you. If you will excuse me, I will read it.

The Hon. GREG DONNELLY: Sure.

Ms FITZPATRICK: This was one of three episodes within a week in early 2020 and it is a direct quote from an email:

> Mum's episode on 24 February was the most severe and lasted for 3 hours. Why did the RN on duty that night allow a resident to be in such an extreme state of agitation for so long? You stated that this RN was new and that she did not know whether this behaviour was normal for mum? Regardless, no patient should be left in such a heightened degree of agitation for so long. I am aghast that any RN would accept mum's behaviour that night as 'acceptable' and not, at the very least, needing some psycho-social intervention and a medication review by her GP. And where is the continuity of care, if a new RN can't ask her Carers—

or PCAs—

> on duty with her if X behaviour is normal for X patient? Why did this RN not phone me to check in with me? She had met me that afternoon, only 4 hours earlier, when I was visiting mum …

She goes on:

> It still causes me distress to know that my mother was allowed to be in a heightened stated of distress and suffering for 3 hours.

Her mother—I do not think I said that—has dementia. I think this is neglect and perhaps even falls under the category of abuse. I do not think aged care facilities or the aged care sector is on top of it, for the most part, so there is a secrecy, a covering up and an unwillingness to talk openly about what is happening. That is why I would like to go back to that need for transparency. I have been lucky to create that where my husband is. We have formed a community of care around him. I assure other people that this would never happen where my husband is. They just would not do that.

The Hon. GREG DONNELLY: Thank you for that very powerful example. Just to direct a couple of questions to Palliative Care Nurses Australia—thank you for your submission, as well. I am wondering about your thoughts on the matter of nurse practitioners with that palliative care specialty, and your views about the need for aged care facilities to have such people on the books, so to speak, as part of their registered nurse team, to deal with the manifest needs to do with end of life care. And that is really a starting position—they ought to be there. We heard evidence this morning from another person, who is from the NSW Nurses and Midwives' Association.

She is a transitional nurse practitioner. She is training in the area and her work has her roving around multiple local health districts in New South Wales. She is called in to go from site to site to deal with specific needs for specific people on site. The question is: Should we be shooting high and saying that nurse practitioners with specific palliative care expertise are what we should be shooting for? Or alternatively should we be shooting for registered nurses who are able to access, for example, specialists and/or palliative care specialist doctors to provide the answers to the questions they need to deal with an immediate requirement to do with an end of life question?

Mr COHEN: Look, thank you for the question. I think you are right. There is no "one size fits all". I do think that the model with a nurse practitioner within the aged care organisation itself is certainly a good one and has merit, and there are very successful models of that within Australia.

The Hon. GREG DONNELLY: Sorry, the organisation being—

Professor PARKER: The aged care organisation employs the nurse practitioner.

Mr COHEN: That is right. What I would say is that they are few and far between. The ones that do work, though, are absolutely a gold standard. Also, with outreach or in-reach—however you would like to frame

it—services within New South Wales with local health districts where you have nurse practitioners coming in who are either specialists in aged care or palliative care can certainly help build capacity within a residential aged care facility. It can help build capacity of the registered nurses, the capacity of the carers, and also the capacity of the family to understand the palliative care needs of the residents within that particular site. So, I think it is a mix. I would hate to see a "one size fits all" because that does not work, but I think that we absolutely need to aim high. I think nurse practitioners are key to the delivery of that type of care.

The Hon. GREG DONNELLY: Just quickly, with the shortage of—when I say "shortage of", I mean the relatively limited number of palliative care specialist doctors working in the State of New South Wales, as large and geographically dispersed as the State is. Does that reality create challenges for the delivery of high-standard palliative care in aged care facilities, given that presumably the fallback position—and I say this with the greatest respect to our general practitioners—is to make contact with a general practitioner practice and seek advice and guidance from a GP about how to deal with an individual patient or resident?

Professor PARKER: Again, as Mr Cohen has said, it probably varies across the State. On the whole I suspect that a resident with complex needs in an aged care facility could probably be managed by the general practitioner or the nurse practitioner. The specialist palliative care medical team is not called very often. Mr Cohen can refer to his medical person within the team. If the assessment is good and the plan of care is good, you can anticipate a lot of things. Really, that crisis management is exactly what we are trying to avoid. I would just go back to what Josh was saying about it would be great to have nurse practitioners everywhere. Maybe we will get there in Australia. There are also other levels of nurses that we have.

In the hospital system, you would be aware we have clinical nurses, clinical nurse consultants. They are called different things around the country, but they are not the same level as the nurse practitioner, but they are advanced practice roles where people specialise. Even if Josh went to a facility at night or got a call from a facility at night, if that call was from a personal care assistant, the things that Josh would be asking them to do or even suggesting, "You should do this because that might help prevent this", they are not going to have the skill set. So the critical thing is you have to have everybody in the picture so, as Jenny, I think, rightly said, it has got to be this whole-team approach. We have all got to be—it is personal care workers, it is enrolled nurses, it is registered nurses, nurse practitioners, it is the GP, it is the geriatricians. Older people in Australia deserve to get the same care that you and I can access, and they do not.

The Hon. GREG DONNELLY: Thank you for that great evidence.

The Hon. TAYLOR MARTIN: I have a question more specifically for the two advocates from Dementia Australia. Would you be able to elaborate a bit more on what specific dementia training you believe aged care staff should probably undergo?

Ms MISKOVSKI: We think that everyone working in aged care should have a minimum level of dementia education, and then that should be specialised depending on the role. Dementia Australia currently run what is called Dementia Essentials, which is funded by the Australian Government and run through Dementia Training Australia, and we deliver it on their behalf. We think at a minimum all aged care staff should be doing dementia essential training, but there also needs to be dementia education included in undergraduate and postgraduate courses for nurses, for allied health professionals.

There needs to be a greater level of understanding of dementia, and I think we need people who understand what it takes to empathise with that person, to understand their communication needs or their communication barriers. But I think, importantly for registered nurses, we need nurses who can detect pain because we know that untreated or unrecognised pain is a major cause of what is termed behavioural and psychological symptoms of dementia. Often that is just regarded as, "Oh well, that's a symptom of dementia, that's how the dementia's manifesting", but I think so often it is unrecognised pain. So I think that, in particular, is really important for registered nurses—to be able to detect that and respond appropriately.

The Hon. TAYLOR MARTIN: Ms Fitzpatrick, do you have anything to add?

Ms FITZPATRICK: It kind of goes back to continuity of care, but Jason Ward in his report and submission to the royal commission stated on page 12 that of our particular aged care provider—not our actual nursing home—44 per cent of the staff employed are casual, so not only are they, for the most part, untrained, they do not know the residents. The ones who know my husband will know when he is in pain and I also know, but if there is a constant flow of people through that they do not know—

The Hon. TAYLOR MARTIN: Just out of curiosity and not to take away from that evidence, does that include the auxiliary staff in the facility, like gardeners, cooks, cleaners, or is that specifically about face-to-face care?

Ms FITZPATRICK: I do not know.

The Hon. TAYLOR MARTIN: That is all right.

Ms FITZPATRICK: I am sorry. I could look it up.

The Hon. TAYLOR MARTIN: No, that is okay. It is just interesting.

Ms FITZPATRICK: There is another thing that Dementia Australia offers, and it is called EDIE, which is a 3D experience—Educational Dementia Immersive Experience—and I think that would be good for all people who are working in the aged care sector to have that experience to actually know what it is like to see and hear as a person with dementia does, and to step into black holes like for walking from here, if this was the floor, from the wood to the black rubber part. That is just devastating. It is terrifying. To have some understanding through that immersive experience is another possibility for people.

Ms MISKOVSKI: That uses virtual reality technology. You put these goggles on, essentially, and it puts you in the place of a person with dementia. The EDIE program has been recently evaluated, and it has shown to improve practice in residential aged care. People who have done the training talk about how valuable it is and how they have changed their practice. The other thing that we advocate for is that there needs to be community of practice for residential aged care staff. It is not enough just to do the education or to do the training. You need to be able to implement that in practice and be supported by your leadership to implement that as well. That is another thing that we are advocating for.

The CHAIR: I am sorry, Mr Martin. We only have a few minutes left, and I want to give Ms Faehrmann the chance to ask some questions.

Ms CATE FAEHRMANN: I have one question. Just on that and going further, Dementia Australia's submission suggests that one of the results of having the aged care staff who are not appropriately equipped to deal with dementia is potentially the ongoing and increased use of chemical restraint. Is that what is happening?

Ms MISKOVSKI: That is what we hear. Not so much people with dementia but their carers certainly tell us that they see restraint being used because there is a lack of staff. We know there is overuse of, particularly, chemical restraint.

Ms CATE FAEHRMANN: Is it a lack of staff as well as the ability—

Ms MISKOVSKI: I think it is a lack of staff and it is a lack of training.

Ms CATE FAEHRMANN: The lack of training as well.

Ms MISKOVSKI: Yes, it is a lack of staff who understand the residents and how to respond to them. We know that people living with dementia are over-medicated. I think it is something—I do not have the figures in front of me, but I am happy to get them. But we know that antipsychotics to chemically restrain people are widely used in residential aged care, and it is shown that there is very little benefit and there are significant side effects.

Ms CATE FAEHRMANN: Ms Fitzpatrick, you were talking about your husband and other patients with dementia being in pain. I assume that is exactly the worst thing you could potentially do to a patient if they are in pain and trying to get pain relief, and instead they are given the wrong medication, which makes them even less able to say they are in pain.

Ms FITZPATRICK: Absolutely.

Ms CATE FAEHRMANN: Is that what we are seeing?

Ms FITZPATRICK: Well, they cannot for the most part speak and explain their pain so it is demonstrated in behaviours. It is only the people who know them who know what that behaviour is.

Mr COHEN: Can I add to that? It is a vicious circle when it comes to the use of those medications. First and foremost, to give a medication, it has to be prescribed, so you cannot just decide to give it. It needs to be there and something that you can give, so it also comes down to the prescribers. There are not enough of them. They cannot go back to review what has occurred after a particular medication has been used. They are not looking at pain assessments because very often they are not being filled in within an aged care facility. So I think we need to be careful around this whole issue—that it comes down to there being a lack of staff, a lack of the ability to re-evaluate interventions that you have begun for pain or behaviours or whatever it is, and a lack of then being able to refer to appropriate other health professionals to be a part of that care.

Ms MISKOVSKI: I think that is a really good point. There is a real lack of clarity around roles and responsibilities when it comes to prescribing any ongoing prescription of these antipsychotics. There was a recent—within the last two years—Federal inquiry that looked at the use of restraints and trying to clarify exactly the responsibilities around who prescribes and what the process is for ongoing prescription.

The Hon. MARK PEARSON: Would you also say that a lack of understanding and a lack of education about dementia would cause staff to react—as we saw in a lot of the vision put on *Four Corners* et cetera—in an aggressive and reactive way that they would not do if that staff member was trained properly or had a different nature?

Ms MISKOVSKI: Yes.

The Hon. MARK PEARSON: If they are better educated they will respond to the behaviour better?

Professor PARKER: I think you have to think if you had a child who was misbehaving and you are at the end of your tether, you know that you have to de-escalate that. It is inappropriate—you feel it, but you check yourself and calm down.

Ms MISKOVSKI: I think it is about training but it is also about employing the right people—people who have the right nature and personality.

Professor PARKER: It is. Unfortunately, we cannot not employ people who perhaps do not have what we would consider the right nature, but I think we have to appropriately skill people to be able to be clear about their own values and responsibilities and how they would react to these situations. It is documented that, unfortunately, there are many instances of aggression from people with dementia to staff and that is part of their condition. But the reaction should not be to react back; the reaction as a trained professional would be, "I understand where that behaviour is coming from. Have I done anything that might have inflamed or triggered it? How do I de-escalate that?" That is what we need to get to. But there are instances where you are short-staffed and you have people who are coming at you with a walking stick or whatever and you have to put on that professional hat and know how to manage that situation. For people who have had no training at all, how would they know how to de-escalate that situation?

Ms FITZPATRICK: Can I just add, as well as education and experience there needs to be enough staff on the floor because a lot of those situations should only be approached with two people to start with. I have thousands of stories, but there needs to be enough staff as well as the education. It is not an either/or, it is "and".

The CHAIR: I am sorry but we have to draw this session to a close. Thank you all very much for your time, expertise and the incredibly important work that you do, whether it is advocating on behalf of or working directly in aged-care facilities. I think everyone has taken some questions on notice. The secretariat will be in contact with you about those. We ask that you have those answers back within 14 days if that is possible. Again, let me thank you for your time, your attendance, your testimony and submissions.

(The witnesses withdrew.)

(Short adjournment)

CORRECTED

MARGARET ZANGHI, President, Quality Aged Care Action Group, affirmed and examined

DEAN MURPHY, Member, Quality Aged Care Action Group, sworn and examined

The CHAIR: I welcome our final witnesses for this afternoon from the Quality Aged Care Action Group. I begin by thanking you for your submission and for watching the proceedings today. Would either of you like to make an opening statement?

Ms ZANGHI: Yes. Thank you for the opportunity to speak. It is always great when a consumer group gets invited to speak at an event like this. The Quality Aged Care Action Group [QACAG], of which I am president, is a community-based group in New South Wales that aims to improve the quality of life for people in residential and community aged-care settings. We are a consumer-focused group and our membership covers a variety of backgrounds ranging from people receiving care, their families and friends, to aged-care workers, including registered nurses, carers, enrolled nurses et cetera—people who are currently working or have worked in the past and are now retired—and concerned community members. We also have representation from organisations such as the Older Women's Network NSW, the Combined Pensioners & Superannuants Association of NSW, the Seniors Rights Service and the New South Wales Nurses and Midwives' Association.

One of the most important contributions that QACAG can make to any debate on aged care is our collective knowledge about daily life in a nursing home setting. Many of our members have spent extended periods of time either working in a residential facility or visiting a relative in a facility. I am typical of that latter group, having visited my late husband over a period of just over three years on a daily basis in a residential facility. Collectively, we have insights into residential care and details into daily life in residential care that can only be acquired by real and lived experience. Our shared information has a direct link to the terms of reference of this Committee. Through our first-hand experience we are alarmingly aware of the acuity of aged-care residents. We have observed that people who enter residential aged care do so because all other options for their care—family care, in-home care, home care packages—have been exhausted because their health has now deteriorated to a stage at which their continued wellbeing depends upon constant clinical care.

Residents are people at the end stages of their lives with degenerative diseases plus comorbidities. Many are unable to articulate their needs. It should be no surprise, therefore, that the residents have absolute reliance upon the skill and training of the registered nurses for their clinical care. The registered nurses are the most qualified professionals working within a facility. Because of their training they can respond to the suffering in other residents in a whole variety of ways that we have just heard described in previous witnesses' statements. Lesser trained staff simply do not have that skill and cannot do that. I can testify to the fact that I frequently sought the help of a registered nurse whenever my husband's health seemed to be deteriorating and also got help from the director of nursing, who is a very important person and able to give extra backup in terms of clinical care. That was also an important role in that nursing home.

I realised that across the board in that nursing home residents and their families frequently looked for that assistance in the deteriorating health of their families and loved ones. So I find it unthinkable that the removal of a requirement to have a registered nurse on duty at all times in New South Wales nursing homes would even be considered. To do so would create an unsafe environment and a failed level of care. As a society we cannot place our most vulnerable citizens in a situation where their clinical care needs have to vie for precedence with business and profit.

The CHAIR: Thank you very much for that very powerful opening statement. Ms Zanghi, I noticed that you were in the gallery today for some of the hearing.

Ms ZANGHI: Yes.

The CHAIR: As a consumer group, you would have heard the consistent calls for more transparency, more information and more ability, particularly for residents' families, to be able to see what is the level of care and what is available. What do you think the New South Wales Government could do to mandate that? Obviously, there is one party that is about mandating the care requirements but then also providing information for the public. Do you have a specific ask around that?

Ms ZANGHI: Well, yes. I think we do need absolute transparency and explanation, and perhaps within the care home itself. We have a very active residents' relatives group where we could raise issues. We had good care staff, particularly a director of nursing, who could explain issues in care and what was happening. I think that perhaps in a lot of other facilities they do not have that. There are a couple of us who are relatives of residents who have some skills in doing non-judgemental confrontation, asking in a good negotiating way and we were

always heard: But there were others, often relatives, who get angry and then the communication stops. I think there is, yes, a lot of support needed within a facility in terms of managing. Somebody mentioned earlier, one of the people, that you are also working with the relatives' families and they do have a lot of issues and a lot of concerns. I do not know if that is answering your question: maybe there is another aspect?

The CHAIR: No. Absolutely. Mr Murphy, do you have something you wanted to add?

Mr MURPHY: Obviously, as an organisation, the Quality Aged Care Action Group [QACAG] supports the Australian Nursing & Midwifery Federation [ANMF] skill mix project report, which is around the four hours and 18 minutes of care per day will with a skill mix of 30 per cent RNs, 20 per cent enrolled nurses [ENs]—ENs often get left out of the conversation, I have noticed, largely in the royal commission as well—and 50 per cent care workers. In terms of communicating both with obviously the residents or the consumers if it is a community nursing aspect, also the families, you know, highly trained nurses have the skills to deliver the information that is needed, make the assessment and deliver the information. Also with other parties—allied health as come up today as well—allied health is severely lacking in aged care, but you need staff that are highly trained to be able to communicate effectively with everyone involved.

The CHAIR: Absolutely. Mr Fang?

The Hon. WES FANG: Thank you very much and thank you for coming today to share your experiences and provide us some information. I have had a look at your submission and you talk about the advocacy with which you and your members look at aged care issues. But if you have got somebody who is going into aged care and they want to join your group, how do they actually join? I have just done a search on the web and I cannot find any reference to your group. I have checked on Facebook as well and I cannot find any reference to your group there, either. How does your group operate? How do somebody join and seek advocacy through your group? How many members do you have?

Ms ZANGHI: I might ask Mr Murphy to answer that because he has an administration function with the group.

Mr MURPHY: Okay. So, yes, we are a small community group. Off the top of my head currently we probably have roughly 65 members. In terms of how do people find us currently, at the moment it is largely word of mouth. We are in the process currently of reviewing our flyers. Given COVID as well, I am sure you know it is the same here and everywhere but we have started to meet via Zoom. But, yes, I take on notice what you have said. We probably are difficult to find currently and it is primarily word of mouth at the moment.

The Hon. WES FANG: Do you operate with email lists? Do you communicate through email and send out newsletters and the like?

Mr MURPHY: Yes, we do.

The Hon. WES FANG: And how do you elect office bearers? Do you operate under a model rules constitution and the like?

Mr MURPHY: Yes, we have a constitution. We are incorporated under Fair Trading and we have a constitution. Every year we have an annual general meeting where we elect, you know, president, secretary, and so forth, yes.

The Hon. WES FANG: Right. Cool. Thank you very much. How many people are on the executive?

Mr MURPHY: Four.

Ms ZANGHI: Yes: president, vice-president, treasurer and secretary.

Mr MURPHY: Yes, four.

The Hon. WES FANG: Okay. When you do submissions I noticed when I searched for your group there were plenty of submissions for a lot of inquiries. Who formulates the policy for that? How do you generate your policies and your recommendations for inquiries and the like?

Mr MURPHY: Okay. So, a submission is written. Obviously, the president looks over the submission that is put together and we involve our members as well in the submission-writing process. I am not sure if that answers your question.

The Hon. WES FANG: When I was reading your submission, as I said, you have got a lot of anecdotal stories of members where they have actually made—

Ms ZANGHI: Yes.

The Hon. WES FANG: Is it a collaborative approach?

Ms ZANGHI: Yes.

Mr MURPHY: Yes.

The Hon. WES FANG: Okay.

Ms ZANGHI: We might discuss this at a meeting you know, the possibility of putting in a submission to what is an upcoming inquiry that is happening. We would ask for their thoughts and over a period of time they would get back to us, or maybe we would do a mini survey. With that information then we write it and review it.

Mr MURPHY: We have conducted—some of the stories, for example, in the submission that are relevant today, they did come from a member survey.

The Hon. WES FANG: Right. Thank you.

The CHAIR: Mr Donnelly?

The Hon. GREG DONNELLY: Thank you, Chair. Thank you both for coming along and thank you for what is a very comprehensive submission. It is great to receive submissions from grassroots organisations which are very close to dealing with issues and who can speak firsthand to matters that are directly relevant to the terms of reference for these parliamentary inquiries. Can I just take you to your submission and specifically on some of the pages I just want to ask you a couple of questions to elucidate and expand a little bit, if you would not mind. On page 10 and going over to page 11, the submission specifically deals with:

> … the administration, procurement, storage and recording of medication by non-registered nurses in nursing homes and other aged care facilities …

Then beneath that there is a paragraph and there are further paragraphs over the page. Then you have:

> ***QACAG Recommendation: that RNs (and ENs under the supervision of RNs) are responsible for the administration, procurement, storage and recording of medications in all RACFs.***

One can draw from that and from reading the footnotes that you can provide some insights where this is not going on and that in fact there is some evidence of the provision of scheduled medication that normally would be required to be administered by a specialist doctor or a doctor or a registered nurse, and that that is being administered by someone without those specific qualifications. Can you expand on that to the extent that you are able to give us any details of how broadly this might be going on?

Mr MURPHY: Through members, in Ms Zanghi's opening address, we have non-nurses and nurses as part of QACAG. We have heard stories from members around where non-nurses are essentially administering medications and even in some cases, for example, insulin, which is a quite dangerous scenario. It has come up in the royal commission as well, the use of Webster-paks.

The Hon. GREG DONNELLY: Yes, I am familiar with them.

Mr MURPHY: Webster-paks are an aid to assist people in giving their own medication themselves.

The Hon. GREG DONNELLY: At certain times, yes.

Mr MURPHY: Yes. That is what they are designed for, but unfortunately in the aged care sector increasingly, and largely due to lack of staffing, the Webster-paks, which were not ever intended or designed to be, nor should they be, an administration aid, have become that. If someone is not of sound mind, if a resident cannot say, "Hey, it's four o'clock, I need my medication now", they might need assistance with themselves administering, but where the line is crossed is they might have dementia or whatever the case may be and then the Webster-pak then becomes administration, which should be only undertaken by a registered nurse or an enrolled nurse under the supervision of a registered nurse, but quite often it is a personal care attendant or an assistant in nursing [AIN] that is doing that.

The Hon. GREG DONNELLY: Just a couple more questions; I have to share the time with colleagues. Thank you for that, that is helpful. May I take you to the next area I want to question you on? I think it is linked together. On page 11, you are talking about the cost-shifting theme, and that is addressed on pages 11 and 12, which brings us on to page 13 and the top of page 14, which I think is an excellent proposal: "the collection of data on hospital admissions and discharges of RACF residents be mandated". This issue of cost-shifting has been raised by a number of submissions and, indeed, by witnesses to the public hearings. I am wondering, with your membership base and other ways of establishing details of what is going on in aged care facilities, can you elucidate a bit on the cost-shifting—how it is happening, as you understand it to be? I am very keen to find out

the full extent of it as far as we practically can, because obviously that has implications for the New South Wales State budget, particularly the health budget.

Ms ZANGHI: QACAG is a part of the NSW Aged Care Roundtable and they conducted a survey, not onto the cost-shifting but onto the unnecessary transfer of residents to public hospitals, and we do have a copy of that here today, but it is on PDF and it can be sent to you.

The Hon. GREG DONNELLY: That would be very helpful.

Ms ZANGHI: But stories abound. One member of the Aged Care Roundtable, a GP, describes the situation where someone in a country area—I am not sure if it is one of the people that she visits—needed pain relief. There was no RN on duty, so that pro re nata [PRN] medication could not be given. So the carers, who were not qualified, sent for an ambulance. She made a very long journey to hospital and once they arrived at hospital it was found out through the doctors and the RNs that she had actually had that pain relief a few hours ago and it was dangerous to give her anymore and she made the long, long trip back to home. If you look at the cost of the ambulance, the cost to the poor resident and their health, that is just an example of some of the things that seem to be happening.

The Hon. GREG DONNELLY: On the top of page 13—very helpfully this is drawn from your submission and thank you for that—there are very specific examples of what has led to hospitalisation. You say, "The most common reasons for avoidable hospitalisations were identified as", and then you list them. That is quite a long list, is it not, when you go through it?

Ms ZANGHI: Yes.

The Hon. GREG DONNELLY: And those percentages are pretty high.

Ms ZANGHI: Yes.

The Hon. GREG DONNELLY: Finally—obviously this is why it is a recommendation—it is your understanding that with respect to the situation in the State of New South Wales now and our hospitals, there is no collection of data of patients coming in who are from aged care facilities to actually track what is going on in terms of their admissions and their discharging.

Ms ZANGHI: Yes. You are referring to something said earlier in the day and that was that they cannot track the source of that.

The Hon. GREG DONNELLY: Yes.

Ms ZANGHI: Yes, I agree.

Mr MURPHY: It is very inadequate. There is no official or systematic collection—maybe some local health districts collect some data, I do not know, but there is no systematic collection of that data across the board.

The Hon. GREG DONNELLY: So there is no way to aggregate, therefore, the amount of what that might be on an annual basis a cost to NSW Health.

Mr MURPHY: That is exactly right.

The Hon. GREG DONNELLY: Thank you. Ms Faehrmann?

Ms CATE FAEHRMANN: Thanks for coming and thanks for the great work you do. Reading your submission I was quite surprised to see that a director of nursing is not a standard or mandatory in all aged care homes. Obviously some have them and some do not. Is that the situation?

Ms ZANGHI: As I understand it, yes.

Ms CATE FAEHRMANN: Why do some aged care homes choose to have, do you know, a director of nursing? What is the difference there in terms of the governance, that they would choose to have a director of nursing where others do not?

Ms ZANGHI: I am not really sure. I guess it gets back to the provider. I do know that in some facilities—for example, a friend of mine whose mother-in-law went into a nursing home, they had a director, a sort of business manager director. So some providers, I guess, feel that it was more important to have that business manager, that model, than to have the director of nursing. I do not know the difference between what determines whether a facility will have a director of nursing; all I can say is it does lie with the provider. What triggers that? I guess, perhaps those with a greater understanding of the clinical needs of the residents that they care for.

Ms CATE FAEHRMANN: Do you think that that therefore carries over into the overall staff in terms of having registered nurses, more RNs on duty, from your experience?

Ms ZANGHI: Yes, that would do. The facility my husband was in, one of the directors of nursing, who was really great, he employed a friend who was in transit and going to live somewhere else but had a long history of work as an RN in aged care, and he just got her to run in-service with staff members. But that was his own management structure and skills. I would think it does not happen in perhaps many other places.

Ms CATE FAEHRMANN: I notice one of the examples given in your very good submission to this inquiry in relation to the director of nursing talked about the error in terms of the fact that the director of nursing discovered that a GP had re-signed or reissued certain drugs to a patient that was not right.

Ms ZANGHI: That was my husband's experience, yes.

Ms CATE FAEHRMANN: Would you care to give that example today?

Ms ZANGHI: My husband had Lewy body dementia. People with Lewy body dementia can hallucinate, get a bit aggressive and so on, so he was prescribed risperidone. I since know that these sorts of, what are they, anti-psychotics and so on, react very badly with people with Lewy body disease and they can even cause death. I noticed that he had deteriorated, so I spoke to the GP and he said, "We will try him on a bit of Valium", and that did not work either; he got very unresponsive. So that was taken off. About six weeks later I went to the facility one day and he was totally unresponsive and was sent to hospital. I got a call while I was travelling there to say that he was totally unresponsive, they did not know the outcome, and I called my son and daughter and we went there.

When I got there the geriatrician said, "So we are going to have to put a tube down your husband's throat because you cannot just go, to use the layman's term, cold turkey off risperidone." I said, "But he does not take risperidone." And I was spoken to as if I was the prize idiot. He said, "Madam, it is on his chart." Now I went back to the nursing home and that director of nursing absolutely saved the day because he got the medication charts out and he we went through and said, "Oh yes, the doctor did this and this. He signed off on this on this date." Then he went down and said, "Oh my goodness. He signed them all on again."

The theory is that he came back in as the GPs have to do to sign on the medications every three months or whatever and he just went "tick tick tick" all the way down and he was on the medication again. The director of nursing said, "Okay. I am going to call the doctor." And he explained what had happened and he said, "Margaret is here too." And the doctor said, "Can I speak to her?" He said, "Margaret, I remember the conversation I had with you. We took him off the drugs." I said, "Yes." He said, "Please look at that chart. Please tell me it is not my signature." I said, "It is." He said, "I am so sorry." But the director of nursing—or the unit manager or whatever it was in the dementia unit— just phoned and it was resolved. I went the next day and I was not a silly woman anymore.

The Hon. GREG DONNELLY: It's a powerful story.

Ms CATE FAEHRMANN: Yes. Of course, I think this is one of the strengths of an organisation like yours. Your members are people who have loved ones who have had, I am assuming, very poor experiences in the aged-care sector and have decided to join an organisation that is advocating for better outcomes. How long has your organisation been active?

Ms ZANGHI: Since 2005. It was incorporated in 2007.

Ms CATE FAEHRMANN: Yes. There are just so many stories and recommendations. But, for example, one of the areas that you deal with is avoidable hospitalisations particularly as a result of falls. I am sure some of your members have experience that as well—situations where if there were more staff on duty and registered nurses that may have been prevented. Do you have any stories you would care to share in relation to that?

Ms ZANGHI: Yes, certainly. I was once present in the lounge of a facility on a Sunday morning and it was short-staffed. The other care workers ushered most of the residents on that floor into that lounge area and put on a film or something. But the lounge was L-shaped and the person in charge of the group was that diversional therapy officer. She actually could not see around the corner. There was an 100-year-old lady who got a bit agitated. She was in a water chair. She tried to get up. She fell and was badly injured. The diversional therapy officer felt dreadful. I said to her, "But it was not your fault." The other staff had gone off to do other duties like make beds and that was totally avoidable.

Another horrific experience was that there was a woman who was only in her fifties with early onset dementia—and I think this is something relatives do not understand until somebody goes into care. You think that they are there now and that they are safe. But there are all the other residents. Some of the residents have aggressive behaviours and wander around and touch or even push or hit other residents. So this poor lady had early onset dementia and she wandered and could be aggressive. I saw her wandering down a corridor one day and nobody was around. I did my public duty and followed her. It is just as well I did. She went into a room where there was a man who had a pack feeding tube in his stomach and she had been trying to pull it out. I just had to yell for help. Now that purely happened because there just were not people there.

The Hon. MARK PEARSON: I want to ask you a question, Mr Murphy. You said that enrolled nurses were not considered sufficiently enough in the royal commission and maybe other inquiries. Can you explain a little more why you think that might have happened and how it happened?

Mr MURPHY: I am not sure, to be honest, why it has happened. Certainly there is a need for more registered nurses, enrolled nurses and care workers. I think there is so much wrong in aged care that needs to be fixed it is hard to focus on everything. That is just my personal view on that. As I mentioned earlier, QACAG as an organisation does support the ANMF's work. I know it has been mentioned throughout the day that the recommendations that have come through the royal commission around nursing hours per day per resident fall short of the ANMF's recommendation, but we certainly support that and the ANMF's recommendation is for 30 per cent registered nurses, 20 per cent enrolled nurses and 50 per cent personal care workers or attendants or assistants in nursing [AINs], however you want to define them.

The Hon. MARK PEARSON: Just so we are clear, we have a registered nurse and then an enrolled nurse, who is skilled enough to give and withhold medication under the direction of a registered nurse without that registered nurse necessarily being in the room when the medication is being administered.

Mr MURPHY: Yes.

The Hon. MARK PEARSON: And after that we have an assistant in nursing?

Mr MURPHY: Yes.

The Hon. MARK PEARSON: After that we have—

Mr MURPHY: I know that there are a lot of terms. There is a lot of terminology.

The Hon. MARK PEARSON: Would there be four different categories of direct care?

Mr MURPHY: I would say three.

The Hon. MARK PEARSON: Three.

Mr MURPHY: So registered nurses and enrolled nurses are on the register through Australian Health Practitioner Regulation Agency [AHPRA]. They are nurses. An assistant in nursing is not a nurse.

The Hon. MARK PEARSON: That is right.

Mr MURPHY: Yes. That can be confusing to the public or laypeople.

The Hon. MARK PEARSON: Do you think some of the confusion has come about because we had evidence earlier that when the Aged Care Act—I think it is called that.

Mr MURPHY: Yes.

The Hon. MARK PEARSON: When the Aged Care Act came out, it tended to be pitched more at aged people going to a new home. This is going to be their home and comfort in that sense. I have learnt that the private sector of aged care decided to go in the direction of a hospitality model. So a lot of people who were directors or CEOs or executive officers actually worked running five-star hotels. Do you think that is part of where we have steered the ship in the wrong direction and this is part of our problem? It is actually what the earlier evidence said—that really these people require chronic and acute care and most are facing their last days.

Mr MURPHY: I think so. It has come up again earlier today. We would reiterate that it is a homely environment but people do not go into aged-care facilities because they want to be there. They have usually exhausted every other avenue—and there is home care, which is obviously a whole other side of things. People want to stay in their own homes. I am sure everyone in this room wants to stay in their own home until the day they die. People exhaust every single avenue of care, including home-care packages—and people die waiting for home-care packages. That has come out in the royal commission. But by the time you end up in a residential

aged-care facility—that is why people in residential aged-care facilities have such high needs, because they have exhausted every other avenue. Hopefully I answered your question.

The Hon. MARK PEARSON: You have. It is interesting—when some of these private aged-care facilities took on this hospitality model, you would walk into the front foyer and you would think you are walking into a hotel, with all the flowers in the middle et cetera.

Mr MURPHY: Yes.

Ms ZANGHI: Yes.

The Hon. MARK PEARSON: Obviously that has to be addressed.

Ms ZANGHI: Yes.

Mr MURPHY: Yes. On a slightly personal note, my mother is not in aged care, she is at home. I am grateful for that. She volunteered for about a decade after she retired in aged-care facilities. It is interesting what you say. She said to me that these places often look lovely—the brochures are lovely, they present nicely—but it is not until you spend a good amount of time in these places that you see through the thin veneer and see what is going on underneath that.

The Hon. MARK PEARSON: Do you think she might use the word "exploitation"?

Mr MURPHY: Well, she did not use that word but there is exploitation, yes. I am speaking personally. Ms Zanghi, do you have anything to add to that?

Ms ZANGHI: I just think there is a lot of obfuscation. They show these beautiful entrance halls and lounges and so on, and there is even talk of extra care packages—additional things like a glass of wine and so on—but that is not what the residents need. They need care. It might be very nice but they need care. There is a lot of—well, I do not know if it is misunderstanding, but it is smoke in the eyes of potential clients' families' potentially bringing their loved ones to live there. Yes, it may look nice but you have to ask the right questions. The NSW Aged Care Roundtable has put out a series of leaflets about 10 questions to ask when you have a member of your family going into aged care. You really do have to ask questions about the care delivery. Of course you want to go to a place that looks nice—you do not want something run-down or, heaven help us, dirty—but do not try to market yourself on the looks, market yourself on the care.

The CHAIR: I particularly commend the group for producing those kinds of leaflets. Either as a resident but more likely as a carer of a prospective resident, often you do not know the questions to ask. That is a powerful thing you can be doing, to provide consumers with that information. Your submission was very comprehensive. I thank you for appearing. Ms Zanghi, you said from the outset that it is really important that we have the consumer voice as part of what we are talking about. Thank you for your time, your submission and the important work that you do on behalf of consumers. That brings today's hearing to a close.

(The witnesses withdrew.)

The Committee adjourned at 16:52.