

REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 3

INQUIRY INTO REGISTERED NURSES IN NSW NURSING HOMES

CORRECTED

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At Sydney on Monday 10 August 2015

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The Committee met at 9.15 a.m.

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PRESENT

Ms Jan Barham (Chair)

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

CHAIR: Before I commence I acknowledge the Gadigal people who are the traditional custodians of this land. I pay respect to the elders past and present of the Eora nation, and extend that respect to other Aboriginal people present. Welcome to the second hearing of the General Purpose Standing Committee No. 3 inquiry into registered nurses in New South Wales nursing homes. The inquiry is examining the need for registered nurses in nursing homes and other aged-care facilities with residents who require a high level of residential care. Today is the second of three public hearings for this inquiry. We will hear today from two residential aged-care facilities via teleconference—Sunhaven Hostel, Ashford, and Opal Aged Care, Mudgee. We will also hear from Alzheimer's Australia and the Palliative Aged Care Network as well as academic Dr Maree Bernoth and the NSW Division of the Australian and New Zealand Society for Geriatric Medicine. Evidence will also be given by the Combined Pensioners and Superannuants Association.

Before we commence I will make some brief comments about the procedures for today's hearing. Today's hearing is open to the public. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, while members of the media may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing. I therefore urge witnesses to be careful about any comments you may make to the media or to others after you complete your evidence, as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation.

The guidelines for the broadcast of proceedings are available from the secretariat. Media representatives who are not accredited to the Parliament's press gallery should approach the secretariat to sign a copy of the broadcasting guidelines. There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In these circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days following receipt of the transcript. I remind everyone present today that committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. I therefore request that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals or specific nursing homes unnecessarily. Witnesses are advised that any messages should be delivered to Committee members through the Committee staff. Finally, everyone should turn their mobile phones either off or to silent for the duration of the hearing.

ROBERTA ANN THOMPSON, Assistant Manager, Sunhaven Hostel, before the Committee via teleconference, sworn and examined:

CHAIR: I welcome our first witness, Ms Roberta Thompson, who is joining us by teleconference from Sunhaven Hostel in Ashford. Just to set the scene for you, Ms Thompson, we are in room 814-815 at the New South Wales Parliament and I have with me five other members of the Committee: the Deputy Chair, the Hon. Natasha Maclaren-Jones; Government members the Hon. Sarah Mitchell and the Hon. Bronnie Taylor; and representatives of the Opposition the Hon. Walt Secord and the Hon. Courtney Houssos. Reverend the Hon. Fred Nile is not with us at this point in time but he will make himself available to the Committee when he can as he is in another inquiry. Members of the public and the media are also present and the proceedings are being recorded by Hansard. Do you wish to make a short statement?

Ms THOMPSON: Yes, I will. Good morning and thank you for this opportunity to address you all to try and put into perspective the consequences of the proposed 24-hour placement of RNs in aged-care facilities including those in regional and remote locations. Sunhaven is a small regional and remote and community-owned aged-care facility in Ashford and takes great pride in providing an exceptional standard of care for our ageing residents. Sunhaven is the second largest employer of the district and provides employment for 26 staff members. This has a positive flow-on effect for the local economy, central markets and, most importantly, the local central school. Annual training and assessments are available for all staff, having two workplace trainers and assessors on staff to plan, deliver and assess in-house training programs.

Thirteen staff are currently enrolled with Certificate IV in aged care, including one from the local school who has completed her school-based traineeship with Sunhaven. One staff member is studying Certificate IV in workplace training and assessing; four are working through their enrolled nurse studies and one staff member has almost completed her degree in nursing through the University of New England. Sunhaven has an unblemished record in consistently meeting all 44 standards of the accreditation process since 1993. We take great pride in providing the care that is given to our residents and keep all family representatives informed by three-monthly newsletters, personal letters, phone calls and emails.

The management team has an open-door policy and is available to address all issues as they arise, no matter how big or small. Sunhaven has an excellent rapport with the visiting doctor and local community health nurse. It has limited surgery days and services that are available by phone call if required. Burns management, injections and medications used are overseen by the doctor, the chemist and the community health nurse.

Sunhaven contracts the one and only local registered nurse to review care plans when required. This registered nurse is studying to gain additional qualifications to manage a multipurpose service [MPS] in another small town, 70 kilometres east of Ashford that has lost its visiting doctor, so her time will be limited to assess only. We have an ambulance station 24 hours a day with five staff available.

Sunhaven does not require a permanent 24-hour RN. If this becomes a requirement then Sunhaven and all other small, rural and remote facilities will close their doors. We are too far to access agency nurses and even so it would be an expense that Sunhaven could not afford. Our communities are fragile enough without losing more of their soul. Why not leave aged care and its requirements to Federal Government and the Aged Care Quality Agency? They have stringent assessments and legislation in place for the aged-care training and principles to ensure that our aged are taken care of to the best possible standard, that our aged live in a home and safe life environment and that our staff are trained to a required standard—in our case, an exceptionally high standard. We are so proud of our facility and care deeply for our residents.

CHAIR: Thank you. We will begin with questions from the Opposition.

The Hon. WALT SECORD: Thank you for your submission, Ms Thompson. I am the shadow Minister for Health and a member of the Labor Opposition. Would you describe Sunhaven as a low-care or high-care facility?

Ms THOMPSON: Probably more lower care than high. We do have some high-care residents, but they are mainly in the first and second domains of the aged-care funding instrument requirement. For us to have high-care and complex nursing, someone would have to be extremely ill.

The Hon. WALT SECORD: Do you have 16 what would previously have been described as low care and about two as high care?

Ms THOMPSON: We would probably have four or five high care.

The Hon. WALT SECORD: When you say you are a community-owned facility, are you run as a charity?

Ms THOMPSON: Yes, we are not for profit.

The Hon. WALT SECORD: Do you make a profit?

Ms THOMPSON: We do make a bit of money at the end of each year—yes, we do.

The Hon. WALT SECORD: What happens to the profits from your facility?

Ms THOMPSON: We keep those in reserve for unforeseen circumstances, the most recent being we had to have money put aside to put sprinkler systems in—those sorts of things. We have to have a contingency plan. We have to plan it like a business. We must have some sort of savings, so they all go into an interest-bearing deposit and the residential profits are all kept separately from our general funds.

The Hon. WALT SECORD: I did a quick "on the back of an envelope" calculation because I was chief of staff to the Minister for Aged Care in Canberra so I understand how much each patient would provide in subsidies from the Federal Government. I think your turnover was between \$1.7 million and \$2 million a year.

Ms THOMPSON: I beg your pardon?

The Hon. WALT SECORD: I did a bit of a calculation based on the Federal funding model that your turnover is about \$1.7 million to \$2 million a year.

Ms THOMPSON: No.

The Hon. WALT SECORD: What is it then?

Ms THOMPSON: Our turnover does not go into the millions at all.

The Hon. WALT SECORD: How much is your turnover?

Ms THOMPSON: I was not aware that I was going to have to answer financial questions otherwise I would have my books in front of me.

The Hon. WALT SECORD: That goes to the point of the very first thing that you say in your recommendations and observations.

Ms THOMPSON: That is correct.

The Hon. WALT SECORD: You say the future of it would be in jeopardy because you would not be financially viable.

Ms THOMPSON: We are financially viable as we speak because we have put money away and we are ready to take on unexpected expenses. But if we had to start employing registered nurses 24 hours a day, seven days a week the funds would go very quickly.

The Hon. WALT SECORD: But if you say that in fact you will not be financially viable then you are saying that I am simply to take your statement and not put any evidence or rigour to that statement. I am just putting evidence and rigour to that statement. I am sure that you believe that statement, but I am trying to put some rigour to it. If you say that you will not be financially viable and I did a calculation based on your number of residents and Federal Government subsidies, I am putting you to the test. I wanted to know how you would respond.

CHAIR: Ms Thompson, I remind you that if you do not feel comfortable answering, you can take the question on notice and get your answer to us.

Ms THOMPSON: Of course I will. I do not have the financials in front of me to prove it. Firstly, taking costings into account, you have to understand that if we have to access RNs 24/7, they are going to have to be brought in from agencies. We cannot get them locally. We have one local RN. That would mean they would have to fly to Armidale, Tamworth or Toowoomba from Sydney, which is more than three to four hours away from us. We would have to supply them with vehicles to get here. They would come here and work. We would have to offer them overnight accommodation, which we do not have—we do not have a local pub anymore—and then we would have to fly them to their return. So if we have to do that, how long do you think the \$1 million or whatever that you feel that we have got will last—three or four years?

The Hon. WALT SECORD: Back to my earlier question, so if you are not comfortable releasing the financial details—

Ms THOMPSON: I am more than comfortable; I just do not have them in front of me. I will take that on notice and I will provide them.

The Hon. WALT SECORD: Thank you very much. As an organisation that does turn a profit, if registered nurses [RN] are not recommended, what do you propose be the way forward, as a rural and regional nursing home?

Ms THOMPSON: I guess what we propose is what I have suggested in the solutions down the track. We have a staff member who is almost a registered nurse. If a registered nurse is needed to provide a certain standard or to sign off on certain areas we can employ her or contract her to do that, to carry out the supervision, to carry out an instruction, to carry out the reviews of treatments and medications as required in conjunction with the doctor. We will continue to do what we are doing now but we are looking to the future so that is why we have supported this particular staff member in gaining her RN qualification. In saying that we do have one other staff member who has indicated that she wants to do the same when she has finished her enrolled nurse training, so we are preparing ourselves for that future but there would not be the workload for an RN 24/7 and as I said in my submission the board of management would expect the RN to do what we do as a manager to pick up the shortfall—to do the washing, the ironing, the cleaning and catch up on all those jobs, and that would mean the loss of employment for other staff members. I do not know how many RNs would be prepared to do that.

The Hon. WALT SECORD: My time has expired. Thank you.

CHAIR: We will now hear from Government representatives.

The Hon. SARAH MITCHELL: Thank you, Ms Thompson. I am Sarah Mitchell, a Nationals member of the Government. I wanted to commend you first of all for your submission and also for your facility. I had a chance to visit there a couple of years ago with my Federal colleagues Senator Williams. It was very impressive and you are obviously very dedicated to your residents, so congratulations on the work that you do. I want to ask one question and then I will hand over to my colleague. In your submission you mention the fact that if you had to have registered nurses 24/7 the future of your facility would be very uncertain and it is most likely that you would not be able to continue. If Sunhaven were to close what would happen to the 18 residents who are there currently?

Ms THOMPSON: I would imagine that, in conjunction with family, we would have to find them replacement accommodation. That would mean Inverell, Glen Innes, Armidale, Tingha, Barraba, Warialda, wherever we could find placements for these residents.

The Hon. SARAH MITCHELL: It would mean a significant change for them personally to move away from the community that they are a part of?

Ms THOMPSON: Absolutely.

The Hon. SARAH MITCHELL: What do you think that would mean for their care?

Ms THOMPSON: The whole structure of aged care and what is continually reinforced by the department, the Federal Government, and the aged care quality team is that it is looking after the residents and providing care within their community. That is a very strong thing. Especially out where we are the community is very close and people have their families, their friends, their representatives all within this area. Now you take them 60, 80, 100, 200 kilometres away and I can assure you that their overall holistic care will deteriorate drastically, not because of the physical care that they are given but by the emotional upheaval that they will experience.

The Hon. SARAH MITCHELL: Thank you. I will just hand over to my colleague now.

The Hon. BRONNIE TAYLOR: Thank you very much, Ms Thompson. My name is Bronnie Taylor and I am also a Nationals MLC. Thank you for your submission. I would really love the opportunity to visit one time; it sounds like a very impressive facility and it sounds like you are really meeting the needs of your residents, which is fantastic. I have a few questions. You talked about medications being provided to your residents, and they included S4 and S8, would they be Webster packs that are prepared by your local pharmacist?

Ms THOMPSON: That is correct. We do not have a local pharmacist; he comes from Inverell. He has a little out shop here at Ashford every week. They are classed as Webster packs. The S8 drugs are packed separately in a different colour Webster pack. We have an S8 register that we have to keep up-to-date obviously and that is stringently looked at by the accreditation process so that is how the medication happens. When the medications arrive two staff members sit down, go through and check through what the pharmacist has packed—you just never know if there is an error or something is not quite right—in conjunction with the doctor's notes. So every care is taken to give the residents' the correct medication.

The Hon. BRONNIE TAYLOR: That certainly demonstrates that. I am really impressed with your commitment to education within your facility for your nursing staff regardless of what level of nurse they are. Could you elaborate on your annual nursing education? You refer in the third paragraph to the annual training program. What sorts of things do you cover in the annual training program to ensure quality of care?

Ms THOMPSON: We are very fortunate; we have access to some pretty good training organisations, although admittedly they have to travel a fair way. We do things like mandatory handling, elder abuse—that is all mandatory and has to be done every year; occupational health and safety has to be done every year; personal hygiene. Because the manager and myself are workplace planners and assessors we assess the staff annually on medication reviews on personal hygiene—I have just got a mental block.

The Hon. BRONNIE TAYLOR: No, that is great.

Ms THOMPSON: Of course they are doing studies on medication. Medication is done at least annually. That is done by the local pharmacist who comes out from Inverell and goes through medications with the staff, especially if there are any major changes.

The Hon. BRONNIE TAYLOR: I have one final question before I hand over to my colleague. I come from community-based nursing and I find it fantastic that you have the community health nurse who visits your facility. You state that the community health nurse visits three times a week. Does that registered nurse provide a detailed care plan for individual residents that is then implemented by the other nursing staff within your facility?

Ms THOMPSON: Yes. She comes to Ashford three days a week; she does not necessarily come to our facility three days a week, however she is there.

The Hon. BRONNIE TAYLOR: Sure.

Ms THOMPSON: What she normally comes to do, especially when it comes to treatment mainly or a work management plan, she will go into our care plan, the Sunhaven care plan for that particular resident, she will expand on the wound management area of that and she will sign off on a wound management assessment sheet. She will monitor the treatment that she has recommended. This particular lady works in conjunction with the local GP as well. It all works extremely well and very efficiently.

The Hon. BRONNIE TAYLOR: Very good multidisciplinary care. Thank you very much for your time today.

The Hon. NATASHA MACLAREN-JONES: Ms Thompson, my name is Natasha Maclaren-Jones. I am a member of the Liberal Party. I wanted to ask a little bit about the accreditation process. The Aged Care Act states that skilled staff should ensure that the care needs of care recipients are met and that an adequate number of staff are employed. Could you outline how robust the accreditation process is and how whether or not you are providing adequate skilled staff to meet the requirements of your residents is checked?

Ms THOMPSON: I can assure you that the accreditation process is thorough. We have passed all 44 standards to date. Our manager is extremely interested in always having education as the biggest part of our team. Sunhaven staff are a team; we all work together. When we go through accreditation they look at training and our timesheets and rosters. The rosters we are using at the moment provide more than adequate care for our residents. However, if a resident becomes palliative or their care needs increase, the manager will meet with staff and discuss an increase in staff and time. As you are aware, an aged person's condition can change overnight. These decisions are made as the need arises. Never once have we been penalised or even had a mark against us regarding our staffing levels and ratios.

The Hon. NATASHA MACLAREN-JONES: Thank you and congratulations on that work. Well done.

Ms THOMPSON: Thank you.

CHAIR: You said that you have four or five high-care needs residents. What are their ages and what type of high care do they require?

Ms THOMPSON: I handle the finances, but I will do my best. The three or four I mentioned are in their 90s. Their high care includes personal hygiene, and there are also sometimes behavioural issues. Their behaviour maybe a result of dementia or Alzheimer's, and in one case the resident has a disease that affects him mentally. We do not have any high-care resident with complex care needs.

CHAIR: How much time does the registered nurse who visits Ashford spend at your facility?

Ms THOMPSON: It is as the need arises. It is mainly to give vitamin B injections and overseeing wound management. If we do not need her, we do not call her because she is a very busy person and has a large district to cover. She is only a phone call away. She is also trained to use syringe drivers and the Ashford community has two of them. If palliative care is required, we can liaise with the palliative care nurse, the community nurse and the doctor.

CHAIR: Is there any financial support for education and training or is that a responsibility taken on by the individual facility?

Ms THOMPSON: The responsibility is taken on by the individual facilities. There used to be some, but once staff have done certificate III there is not a lot funding for certificate IV and upwards. That is such a shame. However, we have just enrolled 13 girls in certificate IV at a cost of about \$2,000 for each staff member. We will meet that expense ourselves because we feel it is very important that they have that level of training.

CHAIR: Do you think that is an area that could be improved?

Ms THOMPSON: Absolutely. The requirement is for certificate III, and that is fine. However, staff today are multi-skilled and the younger the staff the more willing they are to learn. They are really keen to do certificate IV and finish off. They are really keen to go on to do enrolled nursing. The opportunities are there for country people to extend their training, and that will only be beneficial to small facilities.

CHAIR: Are any of your residents younger people living in aged care for particular reasons?

Ms THOMPSON: What do you class as young?

CHAIR: Under 55. I am referring to people with disability who find themselves unable to get the care and residential opportunities they need. Of course, a Senate inquiry is looking at young people living in aged-care facilities.

Ms THOMPSON: Yes. One gentleman came in when he was in his late 40s or early 50s. He is now well and truly over 55. He fitted in okay. Some of our residents were a little younger. We do not have anyone here in the district in aged care who is younger than 55.

The Hon. WALT SECORD: As part of the financial information that I asked for earlier can you provide a breakdown of senior staff management—people not actually looking after residents but drawing salaries from management positions?

Ms THOMPSON: We work in a small remote aged-care facility and there is no-one here who sits in an office all day, not one person. Our manager is extremely hands-on and she sets the highest standards and we are expected to follow them. Kim Neill is the only full-time permanent employee. The rest are all permanent part-time and/or casual. Kim's salary is \$60,000 to \$65,000 a year; it has gone up to \$36 an hour. I can assure the Committee that she deserves every cent of that. She runs a wonderful ship.

The Hon. WALT SECORD: You said that residents rapidly decline. I feel that that gives more weight to the recommendation about registered nurses in age care.

Ms THOMPSON: That is generally. What benefit is there in having a registered nurse to hold a hand when there is a rapid decline in health? A decline in health does not necessarily mean that they are lying on a bed. They could become more frail, they may find it difficult to swallow medication, and they may have more skin tears or falls. Having a registered nurse on staff will not improve that situation. We are more diligent in regard to those residents who become more frail; we care for them and increase our staffing if necessary. We also liaise closely with the doctor and the visiting registered nurse to ensure that person gets the very best care.

CHAIR: Thank you very much. That is the end the session and the Committee appreciates you making yourself available on the telephone.

Ms THOMPSON: Thank you. In closing, I thank the Committee again for this opportunity to paint a picture of aged care in rural, regional and remote areas. I cannot for the life of me understand how you can make such sweeping decisions that will severely impact our country aged-care facilities while sitting in an office in Sydney. Come out and see for yourselves how efficient, resourceful, caring and viable our little regional, rural and remote aged-care facilities are. See for yourselves how these facilities overcome limited medical services and what excellent systems we have in place to address shortfalls. See for yourselves how well cared for our residents are and how much it means for them to be cared for in their own communities.

CHAIR: Thank you again for your time today. You have taken questions on notice and responses to those questions should be returned within 21 days. The secretariat will contact you about those questions.

Ms THOMPSON: Thank you.

(The witness withdrew)

BRENDAN MOORE, General Manager, Policy, Research and Information with Alzheimers Australia, NSW, affirmed and examined:

IMELDA GILMORE, sworn and examined.

CHAIR: Do you want to make an opening statement?

Mr MOORE: Thank you for the opportunity to present to the inquiry. I will begin with some context as to why this issue is important to us. Over half the residential aged-care facility residents in New South Wales have dementia. We estimate we are talking about and are concerned about at least 40,000 people. We believe there is an estimated 112,000 people with dementia in New South Wales. We also estimate that with 90 per cent of the people with dementia likely to go into residential aged care that as it stands at the moment 100,000 of those 112,000 people will need residential aged care in the future. Therefore dementia is increasing in number in New South Wales, and the levels of complexity and needs of residential aged-care residents is also increasing. At the same time the number of registered nurses in aged-care facilities has decreased over the past 10 years and we understand it now constitutes less than 15 per cent of full-time equivalent direct care employees.

Alzheimers Australia NSW believes that having a mechanism that ensures ongoing safety and quality of care are provided to its vulnerable older population is critical for both social and economic policy reasons. Our members have an expectation of clinical care in residential aged-care facilities and that registered nurses are best placed to deliver and provide oversight and management to other nursing staff. The presence of high level staff can assist in preventing hospital admissions and better approaches to palliative care and dementia care.

The Hon. WALT SECORD: In your submission you refer to cases of bed blockers in public hospitals. On 3 April 2015 in the *Sydney Morning Herald* an article appeared about this very phenomena, that is, about elderly people in public hospitals taking up hospital beds or bed block. You said as part of your recommendation that registered nurses in aged care would help facilitate or remove that. Will you explain that statement?

Mr MOORE: We believe that part of the reason why people with dementia are often blocking beds in public hospitals is the lack of capacity of residential aged-care facilities to enable a return. A person who has gone from a residential aged-care facility to a hospital has a legal right of return but the provider can say, "No, we cannot meet their increased care needs" as a result of whatever they went into hospital for, or whatever has happened within that hospital within that time.

The Hon. WALT SECORD: Do you agree with the *Sydney Morning Herald*, and the freedom of information request for information that shows that, in fact, on any given day in New South Wales 550 elderly people are in hospital beds when they should be in nursing homes?

Mr MOORE: I could not comment on that. I do not know.

The Hon. WALT SECORD: I refer to bed blockers. How do you think that registered nurses in aged care would help, facilitate or improve the quality of life for people in nursing homes?

Mr MOORE: To enable them to return?

The Hon. WALT SECORD: Yes.

Mr MOORE: Obviously, as I have made clear in the submission, hospitals are not great places for people with dementia. The reason for admission often is not dementia but often it is the reason for not being able to be discharged. Complications arise within hospitals. Staff within the hospitals are not often well trained and resourced to manage the dementia whereas in an aged-care facility it is for over 50 per cent of the residents, dementia care is essential and that is what they do. So we believe residential aged care is a better place for people to be than within hospital. But at the same time the residential aged-care facilities are not very well resourced to be able to look after them so they can say, "No, we cannot take that person back into the facility."

Mrs GILMORE: I can offer you an example from about six weeks ago. My husband had a fall and he finished up in hospital. He needed to have an intravenous antibiotic applied over the next few days and the choice was: Would you like him to stay in hospital and have that administered in hospital or is there nursing staff at the facility who can administer the intravenous antibiotic?" The answer was that I did not want him to

stay in hospital. So it could have been a couple of days of hospital expense—a bed block—so he went back to the facility.

The Hon. COURTNEY HOUSSOS: Your submission is really informative and helpful to the Committee as it discusses the need for registered nurses in aged-care facilities. You state that there is a need for a requirement to be put within the Public Health Act in a new form and you make a reference to the fact that there may be a need for a cut-off for smaller facilities. You specifically mention 30 beds. Do you think that small facilities do not have the capacity to accommodate this requirement? Do you think there should be exemptions for small facilities?

Mr MOORE: No, the reason for quoting that number was based on previous statements made by others that it was going to hit at about that mark. That is not, if you like, our calculations—we are not a provider. We were listening to the providers and that is what they said would be about the mark of where this would be unfeasible for them to be able to roster RNs to the requirement and that is where that number has effectively come from.

The Hon. COURTNEY HOUSSOS: Speaking more generally on the principle, do you agree or is it just what you have heard from providers?

Mr MOORE: I do not think that it is reasonable to say that just because you are a small facility you should be exempt from the requirements. The needs of the residents do not change. The needs of people in residential aged care are increasing, as you just heard from the previous speaker. People are living at home longer and when they do arrive in residential aged care often they are very complex, high levels of acuity, often with co-morbidities and from our perspective very often with dementia. You cannot say that a facility with 30 people is a different scenario to a facility with 150 people. The needs are effectively going to be the same; they are just greater in volume. The 150-bed facility obviously has a greater capacity to afford to pay. That is the issue.

The Hon. COURTNEY HOUSSOS: You refer to MPSs in your submission. I guess I can draw a similar conclusion because these are often very small facilities in quite remote areas but do you think the requirement for a registered nurse should be applicable to MPSs?

Mr MOORE: MPSs are slightly different models; they are not straight aged-care facilities. They are also, if you like, pseudo hospitals. As the Government delivering MPSs in New South Wales you would have to make sure you meet both requirements, whatever that is, and that would be the State legislation.

The Hon. COURTNEY HOUSSOS: Just to clarify, we are not members of the Government.

Mr MOORE: I am aware of that. I am just making a comment that if you were the Government then you would have to make rules for the MPSs that accorded to both hospital and aged-care legislation.

The Hon. COURTNEY HOUSSOS: This might be a silly question but do you generally find that someone who has dementia automatically qualifies for what would previously have been classified as high care, or that people with dementia can be accommodated in what were previously called low-care facilities?

Mr MOORE: No and yes respectively.

The Hon. WALT SECORD: I note in your submission that the cost of hospital stays for people with dementia has been estimated to be approximately \$8,500 higher per episode than for people without dementia. Have you done any modelling on the cost of people being in hospital rather than in aged-care facilities?

Mr MOORE: No, we have not but others have. Those figures are from the Australian Institute of Health and Welfare. The corresponding data from the Commonwealth agency responsible for aged care puts the figure at I think around \$250 to \$300 a day as the average cost for a residential aged-care facility. The average cost for a hospital is \$1,500 to \$1,800 a day, so it is a stark difference.

The Hon. NATASHA MACLAREN-JONES: In your submission you mention the Aged Care Act and the skills that are required under the Act. Your statement says that this is open to interpretation and results in residential aged-care facilities employing staff practices that do not ensure the safety of residents. What evidence is that statement based on?

Mr MOORE: Our statement about it employing staffing practices that often do not ensure the safety of residents?

The Hon. NATASHA MACLAREN-JONES: Yes.

Mr MOORE: Stories that we hear from people like Imelda and our other 3,000 members and stories that you hear in the media. There is a litany of evidence to suggest that aged care is currently not resourced and providing care for its residents that would suggest it is doing that. Yes, they can pass accreditation but there is evidence elsewhere to suggest that they are not in all cases.

The Hon. NATASHA MACLAREN-JONES: When people have come to you with that evidence have you referred that to the complaint system at the Federal level?

Mr MOORE: Yes, we direct the people to make those complaints known to the agency appropriate for dealing with that. In some cases they do not want to do that; people have a real fear of raising complaints about a facility that is looking after their relative 24/7. It is difficult. It is a bind for people like Imelda who are in that position.

Mrs GILMORE: I can give you a couple of recent examples of the opposite story where if there had not been adequate nursing care the outcome would have been very different. The first one was 12 days ago. I actually do a voluntary activity once a fortnight. I was in the activities room and a gentleman was about 10 feet away from me and he stood up. He is 97 years old. He was walking normally, he is quite an active sort of person but he has significant dementia. He stood up, overbalanced and fell very heavily on his right side. I immediately called for help and there were three RNs on the spot within 15 seconds who assessed his trauma, assessed injury and the result was he went to hospital and he has a broken hip.

The other incident was last week. My husband, as I said, has young onset dementia. He is in the late stages of the disease. He is still walking, that is his only remaining skill. He was being handled by a staff member who has a Certificate III in Aged Care—fairly new—which is one month's training and one week's clinical training. He wanted my husband to do something. My husband is a frightened child sometimes and he did not want to do this particular thing so he pinned this staff member against the wall. My husband is very tall. The director of nursing walked up to my husband and put her arm around him and said, "Come on, darling, let's go for a walk." There was instant diffusion of the situation. If there had not been an RN with that sort of skill on the spot it could have accelerated. They are the sorts of situations where you have a person who is reclassified because of "behaviours" where it actually is nursing skill that can handle the situation differently.

The Hon. NATASHA MACLAREN-JONES: But is that not also evidence of a facility employing the staff that are needed based on the legislation, which requires it to employ the staff that are needed for its residents?

Mrs GILMORE: Yes, definitely. But there is a range in that facility. There are three young onset people all the way up to—recently we had a 103-year-old lady who died. About 90 per cent of them have dementia.

The Hon. SARAH MITCHELL: I want to ask a few questions not directly related to your submission but in more general terms. I am happy for either of you to answer this but possibly it would be better to hear from you, Ms Gilmore, if you are happy to share your personal experience. On a day-to-day basis what are the sorts of things that your husband or other residents with dementia might need assistance with in an average 24-hour period? What is the sort of help that he needs?

Mrs GILMORE: Everything from how to get out of bed, how to sit on a chair and how to lie on a bed. I can do it with great difficulty; someone who is skilled can do it a little bit more easily. Because he has the ability of about a nine-month-old toddler, he needs help with feeding, medications, of course, and defusing situations like I spoke about, which do not come up very often but they do sometimes. Everything—showering, changing. He is incontinent, of course. This is a 67-year-old man, so he is physically a 67-year-old man. Possibly a lot of people at that stage are still working but he has the cognitive ability of, say, a nine-month-old.

The Hon. SARAH MITCHELL: I know it depends on individuals but when people who are in the earlier stages of the disease go into care are there differing levels of what they are able to do for themselves and areas where they need assistance more so than others?

Mr MOORE: There is tremendous variability in dementia. People can live quite long lives with great quality of life with dementia. Others can progress very rapidly and be in a nursing home within six months from diagnosis. There is tremendous variability. It is very unpredictable.

The Hon. SARAH MITCHELL: Obviously there are times when you need experienced staff and a registered nurse. You gave an example before of that recent experience with your husband. I would also make the assumption that there are times when an enrolled nurse or a carer can help. You really need the whole range of nursing skills to help your husband on a day-to-day basis, is that fair?

Mrs GILMORE: Yes, that is correct. I would not put a percentage on it but a lot of the time the much less skilled staff—they are very beautiful caring staff and it is a small facility—are entirely able to handle everything. Also with medications, the registered nurse watching my husband can just make comments about, "Look, I think you can drop his medication a bit because his behaviours have evened off." Those sorts of things, those sorts of observations, are helpful, and knowing which painkillers to give him in a balance with the medication that he is already on. If he suddenly has a pain need and there is a registered nurse available she can say, "Yes, he's on this one, that one and that one so therefore he can have this particular quick-action painkiller just for this time", or something like that.

The Hon. WALT SECORD: What would happen in a situation if a registered nurse was not in the facility and the issue of medication management came up?

Mrs GILMORE: I could not say categorically but my imagination is that my husband would become agitated and his behaviour would respond to the fact that his pain was not being managed. That would cause him distress and as his wife I have him in a facility where his care for and loved; if I knew there could be times when they would not be able to care for his needs because there was not someone qualified it would distress me because I would know that he would be distressed.

Mr MOORE: That is the personal cost. If you think about how the system might respond to that—if the facility does not have the staffing there then the automatic response is to call for a higher power. Who is the higher power in this instance?

The Hon. WALT SECORD: Who is?

Mr MOORE: An on-call registered nurse, a GP or an ambulance.

The Hon. BRONNIE TAYLOR: Ms Gilmore, thank you for appearing before the Committee to share your stories. I think you are very brave and it is really good of you to be here. Mr Moore, earlier you spoke about the accreditation process. Without putting words into your mouth, you insinuated that you thought perhaps sometimes it was not as rigorous and that people could pass—

Mr MOORE: It is rigorous and it is time-consuming.

The Hon. BRONNIE TAYLOR: So it is a rigorous process?

Mr MOORE: Absolutely, but it has also weeded out operators who have not behaved according to the guidelines.

The Hon. BRONNIE TAYLOR: So it has been successful?

Mr MOORE: Yes. It has been successful but it does not pick everything up. It is only there once every three years. There are occasional unannounced visits, but it is not seeing day-to-day care. You can have staffing and culture change within the period of a pay cycle in a facility. You can go from good to bad and bad to good as well, just through the changeover of a leader at the top of the facility completely changing the tone of the way that place operates.

The Hon. BRONNIE TAYLOR: But you do acknowledge that it has got rid of, as you said, some bad operators.

Mr MOORE: I do not know that it has actually got rid of but it has certainly been brought to attention.

The Hon. BRONNIE TAYLOR: Do you think there is room to relook at how the accreditation process is run and any possible changes? In your opinion, being a representative of Alzheimer's Australia, do you see that as being a requirement for this Committee to look at?

Mr MOORE: As I understand it the Commonwealth is already looking at the accreditation process.

The Hon. BRONNIE TAYLOR: Do you think that is a good thing?

Mr MOORE: Yes. It needs constant reviewing. Every accreditation process needs to be open to scrutiny on an ongoing basis. You cannot ever have an accreditation process that is set in stone forever more. As I made known in my opening comments, the sector is changing—it is increasingly accommodating older people with much higher needs, delivering much greater levels of palliative care and an increasing proportion of people with dementia. You cannot expect that your accreditation system which was designed under the Aged Care Act in 1997 is going to be fit for purpose in 2015 and beyond. So it is appropriate that it is being reviewed by the Commonwealth.

CHAIR: Thank you for appearing before the Committee; it is extraordinary to have a first-hand personal viewpoint. But we are not hearing about the specific issues of concerning the requirement for a registered nurse to be on duty 24-hours a day. We are not hearing how the need arises, when it arises and what it relates to, and this all part of the concern because none of us are really up to speed with the needs of people with dementia. Can you elaborate further about what the specific issues are and why they are specifically about registered nurses? The example you gave earlier was fabulous. Are there any other examples of those acute areas of need that require that level of nursing?

Mr MOORE: In response to paragraph (d) of the Committee's terms of reference: "the role of registered nurses in responding to critical incidents ..." in our submission we talk about the pattern of occurrence of critical incidents. If you like, unique to people with dementia, the symptoms of dementia have been described as behaviours of dementia—we prefer the term "expressions of unmet need"—invariable arise outside of business hours. Our understanding is that current practice around rostering RNs, if they are rostered on, will be during business hours—9.00 a.m. to 5.00 p.m.

Often the requirement for an RN is met by the facility manager being a registered nurse. They are mostly on 9.00 a.m. to 5.00 p.m.—I will just use the example of 9.00 to 5.00 p.m.—but they work very hard outside of that. Most of the issues around dementia management and meeting those unmet needs relate to issues of sundowning, psychosis, aggression, resisting care, noisy vocalisations, nocturnal disturbance, hallucinations and sexual behaviour. I would challenge the aged-care sector that having a personal care assistant—a PCA is their name—with a certificate III that has undergone one hour of training about what is dementia is ill-equipped to deal with those.

The Hon. WALT SECORD: One hour of training?

Mr MOORE: Two hours at best.

Mrs GILMORE: I can add to that, if you like?

CHAIR: Thank you.

Mrs GILMORE: About six or seven weeks ago on a Saturday evening I had a phone call from the nursing home, about 7.00 p.m., saying that my husband had had a fall around 5.00 p.m. but he was fine. They did not know how he had fallen but they said he was fine. Sunday morning I got a call from another RN—so we are talking about Sunday morning now—saying, "Look, I am concerned. I am watching him walking. He seems to be in pain." Even if you ask someone in the late stages of dementia if they are in pain they are likely to say no because it does not register as pain. Anyway he was walking with difficulty and the RN said, "I think we should call an ambulance." That was the incident when he ended up going to hospital. Now this is Saturday night and Sunday morning. I am very conscious that at the stage my husband is at, bearing in mind that he is only 67, he is

probably only one fall away from end stage—so he will fall and fracture something or it will be a brain activity that will cause the fall, which will be a catastrophic brain activity. He walks all night; he is up and down all night. So he can be walking any time of the night and have a fall for some reason.

Now for me to know that there may only be someone with minimal night-watch qualifications sort of childminding a group of people—there are probably four or five of them who are constantly walking—it would not give me peace of mind to know that he could have a fall and not be discovered or trauma not be discovered or injury not be discovered until hours later when an RN did come on duty. That would not give me peace of mind. As his advocate in care my heart's desire is to know that somebody is caring for him the way I would if I could; I obviously can't. So knowing that there is skill there—and I am not saying, "We pay you people to look after him"; it is a case of paying for someone to care for him believing that he is going to get the best care. I could not be confident of that if I did not know there was highly skilled staff available for any incident. With dementia at any age a split second and the whole life scenario changes.

CHAIR: As a carer and an advocate I imagine you come in contact with a lot of other people in your situation. Is there a general discussion going on with them? Is there a position felt by those in the same situation as you about this issue?

Mrs GILMORE: We would not talk about it in a technical sense. This is the first I have thought of discussing the staffing capabilities. It is more a case of saying: "Isn't this a wonderful place to have my husband, my father, my mother. Don't you love the way they care for them? Don't you love the way that they interact person to person?" It is more that sort of discussion. Yes, there are people who are not satisfied. Not everybody is always going to be happy, but the general discussion is: "I love where my loved one is." It is communicated by word of mouth. I tell other people because the place is not well known and it is small. If someone says to me, "Where is your husband?" I tell them, and they say, "What is it like? My mother needs to go into care." I say from the bottom of my heart that it is a beautiful place and I am very happy with the care that my husband gets. I am very confident about the care.

Mr MOORE: There is also an expectation that the type of facility that Imelda's husband, Graham, is in has a great culture and great atmosphere. There is an expectation that the place is homelike and is a nice place to be. There is also the reassurance factor. You know that your relative is being looked after well. They are in a place where they are relatively happy, and in the back of your mind you know that if something goes wrong there are capable staff there to deal with whatever may emerge. As I have indicated, whatever may emerge is going to become more frequent and more severe.

CHAIR: Mr Moore, you have made a few points about issues with dementia. Are there any papers or research that you could present to the Committee, particularly dealing with the nocturnal problems that arise? Do you have anything that could give us further background on that? You have made a suggestion about what could be done to address some of the concerns about the funding approach and the offsetting of funding. That is in paragraph 1 (d) of your submission. Could you please elaborate?

Mr MOORE: It is difficult to elaborate beyond what is in the submission. I do not have much more information beyond what is written down.

CHAIR: Could you please express it for the transcript.

Mr MOORE: The idea is to try to appease parties. Obviously the providers have a view. I have made it quite clear that we do not want the outcome where providers close facilities. That is not an outcome that we seek by any means. At the same time, as a peak consumer body and as representatives we want the best possible care that we can get. We know from the evidence we have seen that without registered nurses and without high-level clinical care in aged-care facilities the cost will fall upon the State, either through hospitals providing care or through market failure, where you have to provide more multipurpose services. The idea that we have put forward is to examine an outcomes-based funding approach for aged-care facilities to offset the additional costs. If that can achieve certain prescribed outcomes such as hospital avoidance and costs saved to the State then we believe facilities should be remunerated for that and supported to have registered nurses on staff. We believe it is an appropriate approach that keeps the State out of service delivery and, in our interests, keeps people with dementia out of hospitals and in residential aged-care facilities, where we know they would rather be.

CHAIR: Do you know if this this approach operates in any other jurisdiction?

Mr MOORE: I do not know, but I do not think it operates in any other jurisdiction. There are variations on that approach. Western Australia has a co-funding model between the health department and residential aged-care facilities for specific clients with significant mental health concerns and comorbidities, but it is not outcomes based.

CHAIR: That seems contrary to the idea of trying to manage these situations. Outcomes are meant to be achieved.

Mr MOORE: Yes.

CHAIR: I was surprised, when reading submissions, at the lack of an outcomes-based approach.

Mr MOORE: It is a reflection of where government policy is heading. It is trying to move to outcomes. I am aware of the New South Wales Office of Social Impact Investment. There have been forays into social impact bonds and outcomes-based funding through that. There are a couple of pilots underway. This would be a great opportunity to further that, for a valid social outcome.

CHAIR: I agree. Thank you for that.

The Hon. WALT SECORD: Could I take you back to something you mentioned earlier. In your view, would having registered nurses in aged-care facilities reduce the number of unnecessary admissions to emergency departments?

Mr MOORE: We believe it should have that outcome.

The Hon. SARAH MITCHELL: In paragraph 1 (d) of your submission you talk about advanced care plans and that often they do not go with the resident to hospital. Can you explain what you think the process is supposed to be?

Mr MOORE: Would you like a personal story first?

The Hon. SARAH MITCHELL: Yes. Where is the problem?

Mr MOORE: I will let Mrs Gilmore give her personal story first.

Mrs GILMORE: We have an advanced care plan in place, which is "do not resuscitate; no intubation". When my husband went to hospital, I asked the doctor at the emergency department what would have been the scenario had my husband had a cardiac arrest on the way or at the hospital. She said, "We would have restarted his heart." So there is a breakdown somewhere in the system. We have the care plan that is online, the *myGov* online advanced care plan. I do not know how the system works, but it is certainly not working in the best interests of people with dementia. As I explained to the staff in the hospital, my husband would not have been able to answer any question or follow any directive, so he would not have understood where he was.

Mr MOORE: We believe advanced care plans should be written down by people with early stage dementia, post diagnosis. We believe everyone should have an advanced care plan, but there is very low uptake. There is also very low adherence, as Imelda has just described. We are aware of stories of people having advanced care plans that are not followed. We understand from legal advice that that constitutes assault on the person because they have had something done to them against their wishes. There seems to be a divergence in culture. The residential aged-care facility is trying to provide good quality end-of-life care, whereas the hospital wants to maintain life at all costs. The advanced care plan does not seem to fit within that paradigm of thinking. It is fairly critical to the delivery of care in an aged-care facility. Unfortunately, as Imelda said, it often does not follow the person and if it does it is not adhered to.

The Hon. COURTNEY HOUSSOS: Mrs Gilmore, I am interested in some of the passing comments you made. How big is the facility where your husband is?

Mrs GILMORE: It has 48 beds.

The Hon. COURTNEY HOUSSOS: You took into account a range of factors when you were looking at facilities to provide care for your husband. Was having a registered nurse available 24 hours, seven days a week one of them?

Mrs GILMORE: No, because having my husband admitted to a residential aged-care facility was part of the learning curve that I have been going through in the last four, five or six years. I would not have known to ask that question. I needed to look for a high-care facility. It was very difficult to find a bed, apart from in one or two places where the advertising showed beautiful lounges and lovely pictures in the lounge rooms. That does not equate to the best care. I only heard about this place by word of mouth because a carer friend's mother had been in the facility and she highly recommended it. Observing the staff with the residents when I went for the interview was a huge plus, but I did not know what sorts of staffing questions to ask.

Mr MOORE: And that is a fairly universal view. That is Mrs Gilmore's perspective but that is what we hear constantly. People obviously seek to avoid talking about it as well—it is a tough conversation about moving a relative into residential aged care. When it does come it is often a very forced, rushed decision, sometimes post-hospital, which makes it even worse. But you are often desperate just to find a place; you actually do not have much choice often. If you do, that is great that you have been able to exercise choice, but then to make a choice around the facility that you are going to go to, as Imelda said, you can mark it on appearance and looks of the facility but it is very hard to market a facility on quality and care; you need to see and feel and watch interactions to form a judgement around that. But how many people have been into an aged-care facility before they need to; so what is their frame of reference to know what is good? But once they have been there for a while they know when it is bad.

CHAIR: Mrs Gilmore, around that issue, there are two points with the accreditation standards. Do you think more needs to be done about people having access to a complaints procedure and knowing what is available for them? The other point around that conversation or the awareness of where a suitable facility might be, is there a need for some other networking discussions about whether there is a chat room or—

Mr MOORE: Often the most reliable witnesses are other people, as Imelda has just described, and that is—

CHAIR: Word of mouth.

Mr MOORE: It is word of mouth. People can go looking on the My Aged Care website, they can look for things but it is often word of mouth referral from others that guides a person in their decision about what is good. But, as I said, what is good can become bad in the period of a pay cycle with the leader of a facility changing.

CHAIR: Is there an appropriate network or somewhere you can connect someone who suddenly finds themselves in need?

Mrs GILMORE: I can only speak for my facility but at every relatives meeting it is reiterated: "These are the complaints forms. If you have a complaint please write it down and hand it in". There have been a few incidents over the last two years—my husband has been in care for two years this week—where I have needed to advocate, put my foot down and say, "I want this changed", and all I have done is to email the director of nursing and she is instantly on top of that; she either rings me or emails me back and says, "I have spoken to so and so" or "I have written that into Graham's care plan". I have found the best way is to approach management, but for people who do not feel comfortable doing that there is a form you can fill in and if you do not want to give it to your own facility you send it to head office if you are afraid—I cannot imagine in this place being afraid but some people are not comfortable with complaining.

Mr MOORE: That is the internal organisation complaints mechanism. The government-run complaints mechanism is also there for people who wish to use that. That has changed its name a bit recently; there have been some changes around that, I believe. That is very much a last-resort kind of place; in good complaints practices you obviously go through that escalation process. Heaven forbid people end up there but they do. Further to your point around where people find out about these things, often it is carer support groups. We run a number of those across New South Wales and it is that word of mouth for referral from others—people come into the carer support group and the other carers are very helpful.

Mrs GILMORE: And if it was not for the advice that we got in the course that we did at Alzheimer's Australia, the Living with Memory Loss course, if it was not for what I learnt in that process I would not have been anywhere near well enough equipped to look for the right facility, to look for what I should be looking for for my husband's care.

CHAIR: The need for greater understanding about the needs of people with dementia—I saw something on Twitter recently about a discussion about delirium and someone being appalled that there was a lack of understanding about that from the professional practitioners that were caring for their loved one. Things have moved but the conversation seems to be lagging a bit.

Mr MOORE: One of our challenges as an organisation, which we gladly accept, is that obviously we have to achieve greater awareness across the whole population of Alzheimer's and dementia more broadly and what is the difference—people still do not understand the difference. So we need to work more broadly around that population-level awareness but also once people come into the orbit of dementia then we have a great challenge on our hands of being able to meet the needs of education and support for people like Imelda and Graham. We then also take very seriously the role that we can play in supporting aged-care providers with our professional education services and our consulting services to help them deliver better dementia care. As I alluded to before, having Certificate III and Certificate IV staff with very low entry-level knowledge of dementia when over half the residents in an aged-care facility have dementia, I do not believe that is providing a sufficient safety and quality mechanism for people with dementia in New South Wales at the moment.

CHAIR: Do I imagine then that you have probably made submissions about that?

Mr MOORE: Yes.

CHAIR: If you can provide any of those that would certainly be valuable as well. Anything that has a higher focus on the issues that you advocate would be very useful.

Mr MOORE: Certainly.

The Hon. COURTNEY HOUSSOS: Can I ask one final brief question of Ms Gilmore? Obviously there are things that you have learnt along the road. What were the things when you first were seeking a place that you were prioritising? What were the factors that you were looking for? Obviously not nice lounges and pictures on the walls.

Mrs GILMORE: I needed to look for high care as it was a couple of years ago. I was looking for somewhere with young people. We live in Engadine and the only place anywhere near us was a little further south—Heathcote, I think—but that was low care. The next thing was just desperately finding somewhere basically, but I really did not want to find a lock-up because my husband had been in two dementia lock-ups as respite and he is not the sort of person to be confined like that and he does not need to be. I knew I had to find somewhere where the care was appropriate and I knew I had to find somewhere, again along the same lines, where it was not just the advertising of "We have lovely visitors rooms".

But the most important thing I learnt from Alzheimer's Australia in connection with putting someone in care is that that does not stop my caring role; it changes the role in that I become the person's advocate, and that knowledge over the past two years has been invaluable for giving me an assertive attitude, because the medical profession for someone who has not been involved with it can be very daunting, and to know that I have a voice and that it is okay to say, "Look, I don't like this". That really equipped me to be the best help to my husband in care.

The Hon. COURTNEY HOUSSOS: Just one final question. If you do not mind me asking: Is it a great distance from you in Engadine to where your husband is now?

Mrs GILMORE: Rockdale—it is half an hour's drive. There has been a large facility opened five minutes from our place but it is one of the multistorey facilities. There is no way I would move my husband because I know he is loved where he is and I do not want him in an institutional set-up.

Mr MOORE: And to conclude probably just to say—I do not think Imelda will mind me saying this—Imelda is exceptional and is perhaps not representative of the other 40,000-odd people in New South Wales. Not everyone goes through our Living with Memory Loss course; not everyone seeks help like Imelda has done; not

everyone knows as much as Imelda does; not everyone is prepared to make those choices of going half an hour away. So yes you have heard great evidence from Imelda but she is not by any means prototypical of carers across New South Wales in this regard. There are a great many people out there who do not come into contact with our organisation and their first contact with the aged-care system is discharge planners desperately trying to find a place for them in a hospital.

CHAIR: Thank you so much for your evidence today. I particularly thank Imelda for coming along. Thank you to Mr Moore and to your organisation for the great work. I think you have taken some questions on notice. The secretariat staff will be in touch with you about the return of answers to those questions within 21 days. Thank you again, it has been really valuable.

(The witnesses withdrew)

(Short adjournment)

MAREE BERNOTH, Senior Lecturer, Charles Sturt University, Wagga Campus, sworn and examined:

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

Dr BERNOTH: Certainly, thank you. I have been a clinical nurse involved in aged care since 1985, as a clinician, as a researcher and as a business owner. The profile of people in residential aged care is that they have multiple chronic conditions with competing care needs. There are people with disabilities, there are people with neurological impairments and there are a lot of people requiring palliative care. All of those require complex care, competing care needs that need to be juggled and prioritised and I contend that we need a sophisticated level of knowledge to provide that care. I am concerned that we are questioning the role of the registered nurse when really we should be looking at how we can support that role and increase the skills and knowledge of registered nurses working in aged care and that has multiple responsibilities.

It is not just up to legislators; it is also the responsibility of managers to facilitate so that the registered nurse can provide the care that they can give and it is also the responsibility of the registered nurse to work within their scope of practice. I feel that sometimes registered nurses are not doing that. I admit that I have seen variability in care that is not addressed by the accreditation system and that our complaints investigation scheme is not looking at complaints and dealing with those appropriately either. I have research that has been published in peer review nursing and business journals and I am here representing, with great respect, the people who participated in my research as well as the clinical research that I have.

The Hon. WALT SECORD: Thank you for your submission and the care and time you have taken to present it. On page 5 of your submission you talk about, in particular, John Hunter Hospital and unnecessary admissions to emergency departments at hospitals because of the lack of registered nurses. Can we explore that a little and can you comment?

Dr BERNOTH: There was a paper presented at a qualitative research conference last year in Newcastle and the emergency staff at John Hunter Hospital presented their concerns about the numbers of older people from residential aged care who are being admitted to their emergency department. They took some steps to address that. They put in place a program that consisted of a multidisciplinary team, they made representations to the aged-care facilities and did some education and set up a phone line so that the staff of the aged-care facility could contact the emergency department and get some advice over the phone before they had to put a frail older person in an ambulance and go through the trauma of being admitted to emergency and lay on a gurney for a number of hours.

Recently I was speaking to the director of nursing at Wagga Base Hospital who was telling me the same sort of thing. He is fairly new to the area but he was bringing together all the directors of nursing of the aged-care facilities in the Riverina to talk to them about the issue and see how they can support the staff with older frail people in residential aged care instead of taking them to the emergency department.

The Hon. WALT SECORD: So what were they doing? As soon as there was a problem they would immediately take someone to an emergency department?

Dr BERNOTH: I do not know exactly what they were doing but most hospitals were saying that people were being admitted there or sent there unnecessarily.

The Hon. WALT SECORD: You would describe it as unnecessary admissions?

Dr BERNOTH: Yes, it could have been dealt with in the facility.

The Hon. WALT SECORD: Are you familiar with the concept of bed block?

Dr BERNOTH: I hate that term. Bed block implies that an older person does not have a right to an acute care bed. Anyone who is ill has a right to an acute care bed and if there is nowhere else for them to be cared for, then they have a right to that bed. Certainly there is cost shifting but my primary focus is in providing the care that person needs at that time, the quality care that they need. Yes, I am very familiar with the term but I think if we use it, there is a stereotype and an attitude that pervades acute care that an older person does not have a right to a bed there.

Further, I think it impacts on the older person and their family that they feel that they are being a burden by being in an acute care bed and then the pressure is on to get them into an aged-care facility when maybe a bit longer in acute care and perhaps with some rehabilitation they could go home with a community package, and they may have to wait in acute care for a community package. I am sorry, I am aware of the term but as you can see, I have rather an aversion to it.

The Hon. WALT SECORD: In your submission you say, "A care worker does not understand atypical presentations". Can you tell me a little bit about that and give me some examples?

Dr BERNOTH: Certainly. As we age, and I am sitting here evidence of that—

The Hon. WALT SECORD: You are doing well.

The Hon. BRONNIE TAYLOR: Are we not all.

Dr BERNOTH: I tell my students I am a model for them; I teach aged care and I am, but certainly as we age there are age-related changes to our bodies. We can still function despite those age-related changes but what they do is make us more vulnerable so that when a pathophysiology happens or when there is some sort of physiological impost that can be as minor as a day or two with vomiting and diarrhoea it can quickly take an older person into a delirious state or into a pathophysiology and it takes real skills to be able to differentiate between what is an age-related change and is normal and what is a pathophysiology and it takes a lot of skill, especially when someone has a neurological impairment—something like dementia—when they then have a pathophysiology and a person can look as if they have got an exacerbation of their dementia when really they have some sort of infection or there is a chest infection or something else is happening for them. It takes a lot of skill.

The Hon. WALT SECORD: Do you think a registered nurse is the person who can pick up those changes?

Dr BERNOTH: They should; they certainly should. And that is what I am saying. You can be a registered nurse and you could be fantastic in intensive care but there are special skills that go with aged care. People need the knowledge and the skills to provide appropriate care in aged care and I am certainly passionate about maintaining registered nurses in aged care but those registered nurses also have a responsibility to work within their scope of practice and to ensure that they have the knowledge and skills to provide the care.

It is also up to managers to make sure that registered nurses are working like that; that they are not in offices filling in paperwork and that they are not away from where the clinical care is given. What happens in our profession across the board is that unfortunately the more skills you have you tend to move further and further away. There has to be value placed on the clinical care—showering people, sitting and talking to them, actually being with the older person and, more importantly, being with the care worker to help them prioritise their work and to help them learn how to access the needs of the person they are working with at that time.

The Hon. COURTNEY HOUSSOS: I found your submission very interesting and informative. I am interested in your comparison of child care and aged care and I think previous witnesses have given some clear comparisons also. You spoke about the question of ratios that applies to child care but not to aged care. Do you know of any examples either within Australia or overseas where there are nurse ratios in aged care?

Dr BERNOTH: No, I am sorry I cannot answer that question. Can I reinforce that my reference to child care was only about the ratios; that there are ratios that exist in child care but we do not have ratios in aged care. It is quite distressing to hear about the numbers of older people in residential aged care that are being cared for by so few carers, whether they be care workers or registered nurses. The role of the registered nurse is impacted by the number of people they are responsible for—they cannot get to see them all. I in no way am I talking about child care. I in no way intimated that aged-care work is like child care.

The Hon. COURTNEY HOUSSOS: No.

Dr BERNOTH: I thought I would make that clear.

The Hon. COURTNEY HOUSSOS: The comparison to me that was made particularly this morning was the need for someone to be an advocate for the person that is in the care. Whether you are a parent or your

loved one is in a care facility you are often on the outside but need some checks on what is going on in there. That could be registered nurses or nursing ratios. Those are obviously things that provide for those people who are outside the facility but who have such a direct relationship with it.

Dr BERNOTH: People are quite surprised to find that there is no ratio. People I talk to—the participants in my research—one of their questions to me is: What is the ratio? How many staff are they supposed to have? It is as broad as being able to provide care for the residents that are in the facility; there is no other guideline.

The Hon. COURTNEY HOUSSOS: The Committee has heard evidence this morning and previously from some smaller providers who say it is either financially unviable or they would find it very difficult to recruit nurses to rural and remote facilities. I am interested in your thoughts on that. Even the submission of Alzheimers Australia made reference to that this morning. Do you have any thoughts on that?

Dr BERNOTH: Yes, I think that is dangerous. Older people are older people in rural or metropolitan areas. I have worked in both metropolitan and rural areas. Usually it is in the rural areas where we need the registered nurses. The first lady this morning was talking about needing to contact specialists when needs change. Who determines when the needs change? Who is doing that? Who is saying we need that specialist now? From working in the rural areas, we need the registered nurses in the aged-care facilities because often there is not a doctor. It is difficult to get a doctor; they are not there. The registered nurse is integral to providing that quality care in those facilities.

Something that I will share with you is that it worries me that people like managers do not go into bathrooms, bedrooms and toilets. I have seen in my work as a consultant, if I am teaching in a facility, I like to work with the staff first so I can identify exactly what are their needs and not just say, "Today we are doing X." I want to know what they need to know. I like to work with them to get an idea. But what I have seen is extremely poor care given by care workers. They do not know that what they are doing is incorrect. So I have seen them get people up in the morning and when the manager comes through everyone is sitting nicely in the lounge room with a crocheted rug over their knees but no-one knows how they got there. No-one knows what went on in that bedroom, and that is really concerning. When I reported that to one manager I promptly had my contract cancelled.

The Hon. WALT SECORD: In relation to rural and regional areas, you said you think registered nurses are more important there.

Dr BERNOTH: More important in rural areas. We wrote a paper called "Forced into Exile: the traumatising impact of rural aged care inaccessibility."

The Hon. WALT SECORD: Could the Committee have a copy of that?

Dr BERNOTH: Certainly. Did I send that? I sent a couple of papers.

The Hon. COURTNEY HOUSSOS: You referred to some in your submission but they were not in ours.

The Hon. WALT SECORD: Can you explore that a bit more?

Dr BERNOTH: Certainly. Again like the first lady this morning who said when you move older people from their areas they die, we actually found that. We spoke to rural communities around New South Wales and we found how important it was that our Indigenous population are not the only ones who find place important; that older people find place important, especially rural older people. Having lived in the country for the past couple of years, I understand that better. Older people want to age where they have lived, especially farmers who have a real affinity with the land. So we certainly need to provide aged care appropriate to what rural people prefer, want and need and we certainly need to keep them in those rural areas.

But I have worked in rural areas as well as spoken to people who live there and I have found that getting medical support was problematic. Getting doctors to come and look at wounds and getting country people in to the doctors to look at wounds was an issue. But having a registered nurse there with the skills to provide that sort of care to alert the doctors appropriately is important—again the importance of the skills of the

registered nurse. If the registered nurse is going to be ringing the doctor for trivial things, without the information that the doctor requires, they are going to lose the faith of the doctor too and have even less service.

The Hon. COURTNEY HOUSSOS: Do you agree with the difficulty in recruiting registered nurses into rural areas? How can we improve on that?

Dr BERNOTH: I know that I have a large number of graduate nurses who are having trouble getting jobs—positions as registered nurses. I teach rural nurses. CSU promotes professionals staying in rural areas. I would contend that. I would suggest that if we had support for our graduate nurses to work in those facilities they would go there. Our rural students, again some of them go to the metropolitan areas to get experience but there is an awful lot of them who come back again.

I would suggest that, given the right supports, we would get registered nurses into aged care. On the North Coast we have got the University of New England, Southern Cross University and the University of Newcastle all providing students for those areas. Again it is systems. What are the systems we have in place to facilitate that? Rather than leave the country facilities on their own, what processes can we build together? Just this week I got some funding for some research to build a partnership along those lines in Dubbo. Watch this space.

CHAIR: What sorts of supports are you referring to?

Dr BERNOTH: First, the legislation will certainly enhance this but we also need to look at the mentoring and preceptor programs that we have in our aged-care facilities because a registered nurse who has newly graduated needs to have a registered nurse there to support them in their first year or so until they are comfortable. We need to think about some sort of program where we provide incentives for our rural aged-care facilities to have a registered nurse and then take on a student registered nurse so that we build capacity. Also the lady this morning was talking about the assistants in nursing [AINs] proceeding on to enrolled nurses and then to being registered nurses. We need scholarships for those enrolled nurses then to go to university and do their registered nursing.

Charles Sturt University and the University of New England both provide the ability for enrolled nurses to study to registered nurse status by distance education. I am taking 360 of those right now, so there is that capacity. Again, it would be a terrific opportunity for us as a tertiary sector and the other universities to not only have those students as distance students but also provide intensives, if you like, in some of the country areas where the enrolled nurses doing their registered nursing could come. The University of Newcastle had such a program in 1999 to 2000.

CHAIR: A placement program?

Dr BERNOTH: Yes, we used to go and we would do intensives. Parkes was one, down the South Coast was another and there was another one in—we had them all around New South Wales. We would go and provide intensive workshops for those student registered nurses. We also did post graduate. I need to remember to say that we need to provide education for our post graduate registered nurses as well. I certainly think that a registered nurse working in aged care needs specific gerontic knowledge and skills.

CHAIR: So whereas some people are telling us that there is a problem for regional areas you are seeing it more as an opportunity?

Dr BERNOTH: Yes, most certainly.

CHAIR: Something you said that was interesting to me was the idea of having a registered nurse in a regional community where they might not have a GP. If a doctor is not available you will have someone who is up there and able to deal with things.

Dr BERNOTH: Yes, and why not have them as nurse practitioners? Why not have a regional nurse practitioner. Instead of a nurse practitioner allocated to a facility, why not have them for a particular area?

CHAIR: But incentives might need to be part of that solution.

Dr BERNOTH: That is right.

CHAIR: Another thing that has been said is that a registered nurse in some of those regional smaller facilities would be bored.

Dr BERNOTH: No, oh dear.

CHAIR: It is like saying that if they are not working to their optimum skills they are not interested and would not like the fact that they would have to do other things. You are presenting a really different approach and saying that everything that is done is important to care and wellbeing, so involvement would not deter someone who is really grounded and educated to understand the whole-of-being approach. Am I hearing that correctly?

Dr BERNOTH: That is exactly right, and attitudes come into it too. If I am employed as a registered nurse and I am looking forward to retirement and I will sit there and do my paperwork—they are not the type of registered nurses that we need in aged care. We need registered nurses in aged care who see the excitement, who see the challenges of aged-care work and who see that registered nurses in aged care are more than just providing clinical care. They are providing education, they are mentoring and they are role models. There is so much. They can be learning managerial skills; it can be a career pathway for them. But they have also got that ability to do their masters in gerontology and go on to be a nurse practitioner.

CHAIR: There is a cultural change that is needed.

Dr BERNOTH: From society.

CHAIR: That is what I mean.

Dr BERNOTH: And how do we pay them? Do we value them?

CHAIR: You mentioned the program that John Hunter Hospital was using. Do you know of the Queensland hospital nursing home program?

Dr BERNOTH: No, I am sorry, I do not. Is it similar?

CHAIR: It sounds like it is. When we heard about it the other day I wondered why there is something like that operating in Queensland but not formally operating in New South Wales.

Dr BERNOTH: But that is another problem with aged care: we do not share. We do not share our knowledge. The papers I have written, they get me kudos and they might get me up to senior lecturer status but we are not engaging in evidence-based care in aged care. We are not using the knowledge. We are not using what people know. All the terrific work being done in Tasmania with the teaching nursing homes that have been set up there—they are in Tasmania and South Australia. There is a big cultural change we need to make. I thought coming to academia and the tertiary sector and doing research would give me a voice. It has in a way.

CHAIR: We have certainly heard it and we thank you for your passion. It has been great. We do have your papers.

Dr BERNOTH: Have you got "Forced into exile"?

The Hon. WALT SECORD: We do now. Staffers have emailed it to us.

CHAIR: We also have "Two dead frankfurts and a blob of sauce".

Dr BERNOTH: That is another one.

The Hon. BRONNIE TAYLOR: Thank you, Dr Bernoth. I can see your passion and your enthusiasm and it is just fantastic. You are a senior lecturer and so you train registered nurses at Charles Sturt University?

Dr BERNOTH: I educate them. I excite them and get them questioning.

The Hon. BRONNIE TAYLOR: I have no doubt that you do.

Dr BERNOTH: I teach undergraduate nurses. I teach the undergraduate aged care subject.

The Hon. BRONNIE TAYLOR: All to become registered nurses?

Dr BERNOTH: That is right.

The Hon. BRONNIE TAYLOR: I can see your passion for education. Obviously that is why your career has taken you to the position of senior lecturer at Charles Sturt University. A previous witness gave evidence about the Hunter New England model that the Chair alluded to. They talked about facilities where there were registered nurses but they were not there 24-hours a day. They looked at admissions into hospital, not to bed block but just unnecessary admissions. The person who gave evidence was as passionate and keen as you. They had looked at an innovative model of care that would be able to use technology to have a direct line into the emergency department to talk about an issue that they might have with a resident to see whether they could solve it there or they could move it on. I wonder how you feel about innovative models of care in service delivery.

Dr BERNOTH: It is great. I am just about to again start some research with CareWest in Orange and Bathurst and Griffith looking at telehealth. Telehealth is a great way to go. We have to embrace technology. There is a lot to offer.

The Hon. BRONNIE TAYLOR: We certainly do.

Dr BERNOTH: I have not finished yet. You forgot the "but". I really do embrace technology. Even though I am an older woman and I struggle with it I still embrace it. The thing is who is there to say that this person needs to be seen on the telehealth? Who is there to say that this person's condition has deteriorated, we need to get them on the telehealth and connect them with the hospital? I am concerned about the assessment skills of our staff in aged care. Things like—I have seen it myself—a resident screaming. This woman was screaming. I was doing some consultancy work at the facility at the time. She had a table on, so she was restrained. She saw me and she put her arms out to me. She was screaming. She was terrified—I thought maybe I am a bit of a terrifying figure—and she was screaming.

As I walked closer there were three or four care workers at a table doing their notes. When I went close to her she grabbed my arm and there was no way that I was going anywhere anytime soon. I looked over to the care workers who said, "Oh Maree, don't give her any attention; she will get worse." When I got the registered nurse and we had her looked at, the doctor prescribed opioid medication. She was in pain. Yes, let's embrace technology but who is going to say who needs to use that and who are the people who need to be seen.

The Hon. BRONNIE TAYLOR: I did not mean to speak over you; I am just so keen to ask you questions because of your knowledge.

Dr BERNOTH: Go for it.

The Hon. BRONNIE TAYLOR: You talked about education. You were present this morning when we heard about the facility that is working so well and how committed they are to education. Surely that is a really big thing. As you have said yourself, just because you are a registered nurse you still have to ensure that you are within your scope of practice and that you are committed to your position.

Dr BERNOTH: That is right.

The Hon. BRONNIE TAYLOR: It is the responsibility of where you are working to make sure that your standards come up to scratch, not just a level bit of tape over the top that says you have to have this. It is about shared responsibility, is it not?

Dr BERNOTH: It is that intersection between legislation, management and the registered nurses themselves. That is what we need. What concerns me about the provision of education in aged-care facilities is that they will publish the education program and someone will come and be the sage on the stage and deliver information but there is no-one there again working with the care workers, being with them, like the old clinical educators who would be there working with people and providing the input immediately, answering questions, giving them the nuances about the care they are giving.

It is really good to have an education program but what is the link across to the actual needs of the residents? What is happening there? How are we making sure that is happening? The education should be at different levels. There should be an expectation of registered nurses to make use of things like, you know, the Nurses association education program, the College of Nursing education program, and then they can be the ones delivering the education to the care workers.

The Hon. BRONNIE TAYLOR: We have been talking a lot about complaints and complaint mechanisms. In your opinion, and from your experience, is there a requirement for an external complaints mechanism? Some of the examples you have given are obviously both concerning and alarming. But we also have to acknowledge that some places are doing wonderful work in providing wonderful care, where people are very happy and well looked after. I am wondering if that is an issue with the complaints. Do you think in your speciality there would also be an opportunity for an independent, external complaints mechanism?

Dr BERNOTH: Certainly. I agree with you about the variability of care. I have seen wonderful care.

The Hon. BRONNIE TAYLOR: Absolutely.

Dr BERNOTH: I have spoken to Ministers about the care which I have seen that is absolutely wonderful, but I have also seen some terrible things. We have published a paper called *Information Management in Aged Care*—did I send that one?

CHAIR: Yes.

Dr BERNOTH: Good. That talks about the dilemma of complaining. I certainly think that we do need an external body to look at complaints but I think it needs to be more effective than the one we have at the moment. The bureaucratic speak that people get back in response to their complaints is not helpful. People who are making complaints are suffering residual trauma for making those complaints. Again, we have to look at protecting the management of the facility and protecting other staff at the facility, but our biggest responsibility is to our vulnerable older people in that facility. From the research I have done, people have told me that when they complain the abuse becomes worse. They are targeted. So they are very reticent to make complaints in the future. Our complaints scheme is flawed; we need to do better with that.

I would like to see complaints seen as a chance for a clinical governance approach where there are opportunities to change—just like you are doing here in addressing this issue. We need to welcome complaints as a way to look at systems and improve them, and we are not doing that now. From what I have seen, especially from Aged and Community Services, they seem to attack. When people complain it is attack and denial. I have experienced that myself; they have attacked me about what I am saying. They said to me, "Your complaint will do you, your students and the residents no good." I am in academia not just to teach people but because of the inability to make a difference in the clinical setting and the sort of bullying that I experienced when I started to see the abuse and neglect when I was doing my Ph.D., which started out looking at safety in aged care and ended up finding just how unsafe some aged-care facilities can be.

The Hon. WALT SECORD: Can I make one observation?

The Hon. SARAH MITCHELL: Point of order: My point of order is that this is Government time for questions. The member has had his time; it is our turn now.

The Hon. WALT SECORD: Her evidence was not about complaints; it was about registered nurses. You have distorted her evidence again.

CHAIR: The Hon. Walt Secord is out of order. I remind the member that he can put any questions he has on notice.

The Hon. WALT SECORD: I will.

CHAIR: The Hon. Walt Secord may ask additional questions if there is any time left at the end.

The Hon. SARAH MITCHELL: I was interested in your comments about regional areas, obviously that is a bit different to some of the other evidence that we have received today in a sense. You also spoke about your paper, which I am interested to read at a later stage.

Dr BERNOTH: My apologies.

The Hon. SARAH MITCHELL: That is not a negative reflection on you in any way. You talked about when people move from their community the chances of them surviving are not good. One of the things that the Committee will no doubt grapple with, and something which I personally try to navigate through, is when we have a situation like we had with Sunhaven this morning and very real concerns that if the facility had to have a registered nurse 24-7 there would be no other option than for the facility to close. Obviously that facility runs well, it meets the accreditation standards, and has happy residents close to home in an outer rural part of New South Wales. How does this Committee navigate through and make sure that people such as the residents of Sunhaven are looked after and not adversely impacted upon by closing a facility that operates well and has a good outcome for its residents? What comments would you make about that?

Dr BERNOTH: Firstly, I would say that the assessment that they would need to close is subjective; we have not got figures—Mr Secord was asking about figures but the lady did not have them. All we have got is their word about that. Again, I would suggest that it is an opportunity for us to look at other ways of doing things. I suggest something like disbanding the accreditation scheme and setting up regional specialist groups like the MedicareLocals but for aged-care facilities, where we have nurse practitioners, a physiotherapist, an occupational therapist or something like that who can be drawn on by a number of aged-care facilities in those smaller communities. That might be worth exploring.

I recognise that we cannot have those specialist people in some of the areas, but to have recourse to them, have them visit and have them look at the standard of the care being given. To be working there with the staff would be more effective than people who come now every three years, and they are now saying every five years, and look at paperwork. It would be much more effective. If you look at the amount of money aged-care facilities pay for accreditation, the whole cost of the accreditation system, the amount of hours that go into the documentation to prove they have met the accreditation standard without ever seeing reality, I am sure those resources would be much better placed by having groups of specialist people who are available to those smaller aged-care facilities.

The Hon. SARAH MITCHELL: I used that as an example, but we have had a few other submissions—and as a regional member of Parliament I have had feedback—expressing concerns from the smaller centres. In your submission you say that you have worked in aged care since 1985. You said before that you have been in Wagga for a couple of years. How long have you worked in a regional area, out of those 30 years?

Dr BERNOTH: We moved from the Hunter to Cowra because of the bullying I experienced in the Hunter. If you look at the *Newcastle Morning Herald* from back then, you will see reports on that. We moved to Cowra to get away from that environment. I was writing my PhD at that stage and I needed room to think. We found the most wonderful community in Cowra. While I was doing my PhD I worked in Canowindra, Eugowra and Grenfell. In those areas I worked with the community, mainly with older people.

The Hon. SARAH MITCHELL: Have you ever worked in a regional residential aged-care facility?

Dr BERNOTH: I have worked in multipurpose services [MPSs] at Canowindra. I loved it, because they belong to the community. Someone will come in to see Betty, but they also know Joe and Jill and Maude, so it is a real community atmosphere.

The Hon. SARAH MITCHELL: The MPS model is a bit different from an aged-care facility.

Dr BERNOTH: I have done consultancy work in rural aged-care facilities.

The Hon. NATASHA MACLAREN-JONES: You commented on the accreditation standard. I assume that you have been directly involved in the accreditation of a home?

Dr BERNOTH: Yes, several.

The Hon. NATASHA MACLAREN-JONES: Have you had to conduct the accreditation?

Dr BERNOTH: I have not done the accreditation, but I have been involved in getting the paperwork ready. I have seen how people subvert it. I have seen managers sitting up for hours, late at night, filling in weight charts and completing other assessments that have not been done so that the paperwork is done for when the accreditors come. You may not be aware that in the Hunter in about 2004 an aged-care facility was fully accredited but the families protested and the accreditors went into the home and worked with the staff. They turned up at 6 o'clock in the morning and worked with the staff. So, two or three months after being accredited, that facility was shown to be contravening 25 of the standards. That was reduced to 22 when the accreditors looked at the care that was being given and not at the paperwork that was presented to the accreditors.

CHAIR: That goes to my question, which is how well you understand the process of accreditation. Is it a desktop type of review, rather than what you are putting forward?

Dr BERNOTH: A picture is presented. It is like the emperor's new clothes.

CHAIR: Have the changes happened since the loss of the distinction between high and low care? Has that had a big impact on how facilities are run? Is there a greater focus on financial gain than on caring for people?

Dr BERNOTH: I have not worked in an aged-care facility since that change in legislation and the removal of the distinction between high and low care. I think that the focus has been on the fiscal for a long time, instead of on the vulnerable older person and the quality of care that is delivered to them.

CHAIR: We have heard evidence from you and from previous witnesses about regional issues. Are we fixated on having a one-size-fits-all approach? You have suggested that we go to a regional specialist group model. Do you have examples of other jurisdictions that deal with these issues differently that might be of value to us? Could we be bold enough to say that this is not delivering the best approach and there are other models to look at?

Dr BERNOTH: I have been to Sweden and looked at the model there, where the municipalities take responsibility for aged-care facilities. I presented some of my research over there and they really did not understand. They did not get it because it is so different. I am fortunate to live in a small community called Coolamon. In Coolamon the council runs the aged-care facility, the community services, the dementia unit and the self-care units. It is a seamless model of care supported by the community and it works beautifully. The community owns it. I am never one to support the one-size-fits-all approach. As with the residents I care for, the students I teach and the people I interact with, everyone is different. We need to have a model that is flexible. The bottom line is to have the best quality care for frail older people in residential aged care. They are getting more frail. They are staying in the community longer, so our responsibility with the complex care we are giving is higher. We have an ethical responsibility, now that we are hearing about these things, to make sure that that the care is delivered.

The Hon. WALT SECORD: I am worried that there might be a bit of confusion. The examples and case studies that you provided in your submission were to illustrate the need for registered nurses in aged care. They were not a criticism or an exploration of the complaints mechanisms. I want to make sure that that is very clear, because of the line of questioning earlier. I want a yes or no answer. The examples you provided were to illustrate the need for registered nurses in aged care.

Dr BERNOTH: Yes, with the skills to deliver quality care.

The Hon. WALT SECORD: Thank you. It was not a criticism of the complaints system. It was about aged care.

CHAIR: You have made some points about the complaints system as well—that you believe changes could be made.

Dr BERNOTH: Yes. That needs to be changed as well.

CHAIR: They are two separate things. I appreciate that you have stated a strong position about registered nurses. I want to go back to the point you made about incentives and opportunities for greater assistance to the smaller facilities in regional areas that deserve to have their needs recognised and to be provided with further support. Do you have any views on how that could happen?

Dr BERNOTH: Not really. I envisage groups of specialists who could provide support to smaller rural facilities. I am not a manager or financial officer.

CHAIR: We often find that Government makes one-size-fits-all decisions, not realising the effect. I am from a regional area, the North Coast. We have fabulous community-based care there, provided by Feros Care, who continue to win awards and are part of the community. That might be a different approach from other areas. Does there need to be greater flexibility in how it is assessed?

Dr BERNOTH: Yes, but with a recognition that there needs to be an openness. There needs to be transparency. There needs to be recognition of the level of skill required by these people. Take palliative care specialists, for example. You were talking about some of the legal parameters around dying and advanced care directives. We need specialists who can provide palliative care, pain relief and symptom management. They are very specialised with small alterations of medications or the inclusion of a medication or a care strategy to ensure that person is comfortable and we have not got older people feeling like they are a burden and asking for euthanasia. These people have built our country.

CHAIR: Regional communities deserve that too.

Dr BERNOTH: Yes. And if there is a Federal Government push for more migrants to go into rural areas, if that is going to be a requirement for a visa to Australia, we should be looking, again, for that support—support employment and provide perhaps a fairer system but also for the provision of aged care and multicultural aged care as well especially.

CHAIR: Thank you for your evidence. I think you have taken some questions on notice. The secretariat will be in touch about returning some answers within 21 days.

(The witness withdrew)

CHAIRMAINE CROWE, Senior Adviser, Research and Advocacy, Combined Pensioners and Superannuants Association, affirmed and examined:

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

Ms CROWE: I would, thank you. The Combined Pensioners and Superannuants Association [CPSA] represents older people and people with a disability. CPSA has a combined membership of around 31,000 people across New South Wales. Aged care is a key area of focus for our membership and we offer advice on entry into care, fees, quality of care and we also assist people to make complaints. What has struck me in this debate is the insinuation, which has come primarily from the industry, that to expect a registered nurse to be on duty in a facility with older people with high-care needs is not a reasonable expectation to have.

Anyone in this room whose health declined to a point where they needed 24/7 care would expect that if they moved into an aged-care facility, paid the average bond of now \$290,000 and 85 per cent of their pension, they would have, at the very least, direct access to a registered nurse at all times. Instead, the message to older people is that they do not need that kind of care, even though their fees have dramatically increased. Let us not forget, there is no Federal minimum staffing ratio or skill requirement in residential aged care. The New South Wales requirement is therefore not a doubling up of regulation; it is, in my view and that of the people I represent, an absolute necessity. It is necessity in the interests of health and safety of care recipients in New South Wales.

New South Wales should be proud that it requires facilities traditionally classified as high care to have a registered nurse on duty at all times. More broadly, much of what is happening in residential aged care is ethically and morally wrong. There has been a substantial shift to replace registered nurses with assistants in nursing and care workers, despite record high acuity levels of residents in care. Many facilities struggle to feed residents let alone provide clinical care or recognise when a resident is deteriorating, and yet profits in the industry are on the rise. The latest Bentleys report showed that profits across the industry between 2013 and 2014 increased by 158 per cent. Removing the distinction between high and low care is also expected to have secured an extra \$3.3 billion in bonds nationally in 2014-15.

I would submit that there probably has never been a better time for nursing home operators to employ a registered nurse at all times. Older people with high needs have a right to high-quality care; they have a right to feel safe in their nursing home. I do not think we have achieved that universally, even with this regulation, and if it was to disappear then I would say that we risk worsening an already dire situation. Thank you.

The Hon. COURTNEY HOUSSOS: I would like to commend you for a really detailed, really informative but very constructive submission. I really enjoyed reading your specific solution—that was really helpful for us as we are considering this issue, and your opening statement just reinforced that. In your submission on page 6 you state that New South Wales has the lowest rate of sanctions against residential aged-care providers compared with other States. Are you referring to the national accreditation process?

Ms CROWE: Correct. A sanction can be applied by the Department of Social Services but often sanctions arise when the accreditation agency goes in and realises that the place is a complete shambles and then that is fed to the department and then the department imposes sanctions.

The Hon. COURTNEY HOUSSOS: But it is through the national accreditation process that those sanctions are being applied?

Ms CROWE: That is right.

The Hon. COURTNEY HOUSSOS: Can you tell us what those sanctions are usually for?

Ms CROWE: Where there is a direct risk to the health and safety of the residents that is primarily when a sanction be imposed. It can also be imposed if there are serious financial problems with the facility.

The Hon. WALT SECORD: In light of your submission and your opening statement, do you believe that aged-care providers are resisting and fighting the retention of registered nurses in aged care 24/7 in New South Wales purely because it would cut into their massive profit margins?

Ms CROWE: I think financial considerations are the chief concern that providers have, and that is demonstrated in the evidence. We have seen, as I mentioned, a huge shift to employing care workers and assistants in nursing over registered nurses and enrolled nurses. Indeed, the Bentleys report makes note of that; it says the top performing providers are in that category because they have shifted to personal care workers and assistants in nursing. Staffing comprises around 70 per cent of a provider's budget; so if there is anywhere that they are going to make savings or cost cuts it is typically reducing staffing and highly skilled staff.

The Hon. WALT SECORD: Would you agree with the statement that the biggest savings that you could make in aged care and increase your profit margin would be to suppress or keep down the wages of staff?

Ms CROWE: I am not an industrial relations expert but I would say that what we have seen in the industry systematically that is what is happening.

The Hon. COURTNEY HOUSSOS: I would just like to draw your attention to page 4 of your submission. We received verbal submissions from the Federal department and the agency that do the accreditation but overwhelmingly the argument to us has been, particularly by providers, that there is an appropriate accreditation process at a Federal level and there is no need for the State to interfere whereas your submission states that whilst these Federal reforms reform the financing of aged care they have not reformed the regulation of aged care. Could you expand on that for us and explain why you think it is very important for such a regulation that is currently in place under the Public Health Act to remain in place?

Ms CROWE: Firstly, the accreditation standards which govern facilities and also the way that the complaints scheme operates was not changed at all following the Living Longer, Living Better reforms. The agency changed its name, that is all that happened, and, as has been discussed, the accreditation agency is not prescriptive when it comes to staffing; the standard is very vague and it is left wide open to interpretation. That is why you have such a wide variation in aged-care facilities' staffing profiles because there is nothing to prevent them from putting on one care worker for 40 people when they might need three or four, for example. More broadly, 97 per cent of aged-care facilities across the country are fully accredited.

Now there has been some great work done by John Braithwaite, who is an academic. I recall him saying that if we had that kind of success rate for high school students we would be wondering what we are doing wrong with the Higher School Certificate. It is an unrealistic pass rate. If you look at the United Kingdom [UK], the failure rate is around 25 per cent on the latest data I have seen and if you look at the United States [US] the failure rate is around 90 per cent, so it is the inverse, and when I say failure rate, they may have failed one or two standards. For a very long time now we have been very critical of the aged-care accreditation standards and the way that the agency conducts its accreditation visits.

I would also like to add that, yes, facilities receive one unannounced visit each year. Now I was under the impression that during those visits around 10 or 12 standards were looked at. I have recently come across some evidence that suggests that in fact in some places it is far fewer. There was a case brought before the Administrative Appeals Tribunal recently which discussed the unannounced visits that the facility has had because they are not made public and it said that on one visit only two standards were assessed out of 44, one of which was lifestyle.

So if you have the accreditation agency going into facilities unannounced and only looking at two to four or six standards, how are they getting a good picture of what is going on in the facility? And mind you, that is happening between nine and five. There are no visits on weekends and at night unless ordered by the Minister whereas if you look at the UK all visits are unannounced, which is great because you get an idea of what is going on in that facility. They go in at night; they go in on weekends. I think that is a model that Australia should emulate.

The Hon. COURTNEY HOUSSOS: So in short you do not believe that we should vacate the field and leave it purely to Federal accreditation?

Ms CROWE: No, and it is not doubling up on regulation. There is no regulation covering registered nurses on 24/7. That is why the State standard is so important.

The Hon. COURTNEY HOUSSOS: I have just one final question on unannounced visits. In your submission you said that none occur outside business hours and it is quite concerning that such a small number

of accreditation standards are actually assessed. Do you have any further information you would like to provide to the Committee?

Ms CROWE: I am seeking further information from the quality agency particularly whether or not they have any guidelines around the unannounced visits because it surprised me and I am happy to provide that to the inquiry if I receive that in time but generally yes, unless the Minister orders it, and that might happen when something goes into the media; the Kepnock Grove example, for instance, in Queensland recently—the aged-care provider is Carinity. The Minister might say, "Okay, accreditation agency, we need to do an unannounced visit asap", which might happen overnight.

The Hon. COURTNEY HOUSSOS: But that is not the norm either?

Ms CROWE: That is correct.

The Hon. WALT SECORD: Is your membership concerned about the quality of aged care? Are you getting more inquiries, complaints or interest in this area? I notice that you have shifted into this area as an organisation?

Ms CROWE: Yes, that is true. We are certainly getting more interest and I would say that there is increasing concern, particularly with shifts at the Federal level. We now do not have a Minister for Ageing or dedicated to aged care and that has been a huge concern for our membership. We also find that people do not realise the extent of the problem until they have direct experience of the aged-care system and that is the issue. By the time they come to us it is normally a family member who is making a complaint about the facility. Their loved one may have been in there for one or two years and they just do not know what to do. They are at the stage where they say, "This is horrible. I don't feel like I can make a complaint to the facility because I fear reprisal and I am not sure what to do about making a complaint to the formal complaints scheme", so that is when we hear from them.

The Hon. WALT SECORD: Do people turn to your organisation for understanding or an explanation of how the bond system works?

Ms CROWE: Absolutely. Over the last 12 months we have been doing a lot of work helping people understand the financial aspects of aged care. The 2014 changes have been very poorly explained to the community and when people need to go into a nursing home or have someone who needs to go into a nursing home they call us and we explain to them how the bond system works and how the daily fee system works to give them an understanding. We have been receiving a lot of calls at the moment about that.

The Hon. WALT SECORD: Has it increased since the change last year?

Ms CROWE: Yes, without a doubt.

The Hon. WALT SECORD: Significantly?

Ms CROWE: Significantly.

The Hon. WALT SECORD: How would you grade it?

Ms CROWE: I can take that on notice but I would say exponentially, particularly around the July 2014 changes.

The Hon. WALT SECORD: Is it causing alarm in the community? Are people confused?

Ms CROWE: Yes, they are confused. I have also heard from financial advisers who are confused about the fee structure in residential aged care because it is; it is confusing. It is baffling.

The Hon. WALT SECORD: Is it a fee structure, from your experience, that benefits the aged care providers in that it increases their profits?

Ms CROWE: Aged-care providers stand to be far better off financially than what they were before 2014 and that is primarily because they can now charge high care residents, who comprise the vast majority of residential aged-care residents, for the full cost of their accommodation.

The Hon. WALT SECORD: High care residents require high levels of care?

Ms CROWE: Yes.

The Hon. WALT SECORD: So they have more complex problems?

Ms CROWE: Yes.

The Hon. WALT SECORD: Therefore, if you have more patients with high care needs should you not have registered nurses with a higher skill level attending to their needs?

Ms CROWE: Yes, at all times.

The Hon. COURTNEY HOUSSOS: Some of the evidence that we have received previously, including this morning—I am not sure if you were here—was that smaller facilities or regional and remote facilities would have trouble adjusting to that particular requirement. Do you have any view on that?

Ms CROWE: Our position is that if you are a facility and you have the responsibility of looking after someone with high care needs, then you have a responsibility to ensure that there is a registered nurse available in the facility at all times and there are examples of smaller facilities in rural areas which are meeting the 24/7 requirement. There is a facility in Parkes which has a registered nurse on 24/7. There is a facility at Singleton which has a registered nurse on 24/7. They have 34 residents. I am happy to provide you with a list.

The Hon. COURTNEY HOUSSOS: Yes, that would be really useful.

The Hon. WALT SECORD: For the benefit of Hansard could you detail some examples now of some of the places?

Ms CROWE: These names probably are not complete.

CHAIR: Just the locality is sufficient?

Ms CROWE: Okay. Is that okay?

The Hon. WALT SECORD: Okay, so Parkes, Singleton?

Ms CROWE: Look, I am happy to provide you with a more comprehensive list.

The Hon. COURTNEY HOUSSOS: That would be really useful.

The Hon. WALT SECORD: Thank you, because earlier this morning we received evidence from a facility in a rural area who said they could not provide this. It would be nice to have examples of rural facilities that are able to?

Ms CROWE: Was that Sunhaven?

The Hon. WALT SECORD: Yes?

Ms CROWE: Sunhaven received on average around \$39,000 per resident in government subsidies in 2013-14. Now that would have increased in this last financial year because subsidies rise and on top of that a resident would be paying on average \$350 a week in rent if they were paying rent and provided they have the means to do so and then every resident pays 85 per cent of the pension at least.

The Hon. WALT SECORD: So Sunhaven this morning is actually getting more—

CHAIR: Mr Secord, we are not going to go into asking a witness to comment on what—

The Hon. SARAH MITCHELL: She does not work for Sunhaven.

The Hon. WALT SECORD: Thank you very much.

Ms CROWE: Can I clarify that? That is just information on the public record.

The Hon. WALT SECORD: It is on the public record.

Ms CROWE: I obviously do not work for Sunhaven.

The Hon. SARAH MITCHELL: No, but it is not for you to have to justify one way or the other their position.

The Hon. WALT SECORD: I was supporting her comments.

CHAIR: Order! Did you want to say something?

Ms CROWE: No.

The Hon. SARAH MITCHELL: With respect to that list and the regional facilities that have registered nurses 24/7, do you have information as to how many residents would have previously been classified as high care under the old system? Do you have a breakdown of that?

Ms CROWE: I could get it.

The Hon. SARAH MITCHELL: That would be good for reference. Your first recommendation on page 10 is that all aged-care facilities that look after high-care or high-needs residents should have a minimum. I guess if they have predominantly low care of previously classed as low-care residents, would your view then be it should be what is appropriate for the centre, not necessarily 24/7, depending on the circumstances?

Ms CROWE: Sure. I guess from my point of view I would see having a registered nurse available even for those few high-care residents is appropriate at all times. An earlier witness explained very well anything can happen at any time. A resident can deteriorate very rapidly at night or on the weekend. It is particularly important in regional areas because there is limited access to GPs particularly at night and on weekends. I am from a regional area myself and I know what it is like. So, if anything, there is a greater need to have a registered nurse in those facilities at all times in the interests of the health and safety of their residents.

The Hon. SARAH MITCHELL: Last Wednesday the Committee heard from the NSW Department of Health that there are 345 aged-care facilities that were just low care, 323 that were both, and 371 were just high care across the State, not just in regional areas. For the 345 that were existing low-care facilities prior to the changes of July 2014, what would your recommendation be for facilities like that no matter where they are in the State?

Ms CROWE: If they only have low-care residents and also did not have residents who were ageing and place in high care, then we would not expect them to have a registered nurse on 24/7. But when they are high-care residents they need a registered nurse. Can I also add that the Federal Government is increasing home care packages at quite a rate at the expense of residential aged-care placements and that expansion will not be completed until around 2024-25. That will see, I suspect, fewer people entering residential aged-care facilities as low care because they are able to get the care that they need in the home. Facilities are going to primarily be providing care for high needs residents.

The Hon. SARAH MITCHELL: In your opening statement you talked about how people come to your organisation maybe when they are looking to go into aged care or thinking of sending a loved one into aged care and that you provide advice. What sort of things do you talk about? I know you mentioned bonds and payment but in general terms what advice do you give? How often do you talk to people in that capacity?

Ms CROWE: I generally talk to people on a daily basis. Aside from financial information I also try to help people with questions that they should be asking nursing homes before they go in. My first question I tell them to ask is what the staffing profile is like because that information is not made public generally. They need

to know whether there is a registered nurse available at night times and on weekends, what the staffing is like at night times and on the weekend. They are the key things. People should also go in and inspect a facility. They should also be asking about things like what the food is like and general stuff. I also try to assure people that they should not be afraid to ask these questions. If a facility is not forthcoming with information about those kinds of things then they should probably look elsewhere.

The Hon. SARAH MITCHELL: Do you take into account that people should be close to their loved ones or environments that they are familiar with, particularly regional people?

Ms CROWE: Yes, and that is a concern for a lot of people, simply so that family members have easy access to the person in the facility. But we also know that it can be such a traumatic experience putting a spouse or a parent into a facility and a lot of people feel a lot of guilt. But if they know that the person is getting high quality care then that lessens that guilt for the person. I think the assurance that the care is of a high standard and they know that their loved one is safe perhaps overrides them being 20 minutes down the road as opposed to one hour. I cannot speak for everyone. Care quality is the chief concern.

The Hon. BRONNIE TAYLOR: When you say you feel that high-quality care is more important than how far away someone is, Dr Bernoth, an earlier witness, said that people lived longer when they could stay closer to home. Do you contradict that?

Ms CROWE: I would be interested to see that study.

The Hon. BRONNIE TAYLOR: You talked about aged-care providers and profit and, correct me if I am wrong, you insinuated that they were really driven by profit. Last Wednesday the Committee heard evidence that charitable organisations that run aged-care facilities actually reinvest a lot of that profit in their facilities that are not as profitable, which tend to often be in rural and regional areas. Are you aware of that?

Ms CROWE: Yes.

The Hon. NATASHA MACLAREN-JONES: I refer to the accreditation process, particularly in relation to Standards 2.4 and 2.5, which requires that clinical care is appropriate for the needs of the resident and that specialist nursing care is provided. Bearing in mind that assessments are done by registered nurses, do you say you are confident that registered nurses are best qualified to make those assessments, to make the recommendation that a registered nurse is required?

Ms CROWE: Assessors work according to the accreditation standards and all a facility has to do is to meet those accreditation standards. Not all assessors are registered nurses. There is also no requirement, it is my understanding, to have a registered nurse as part of an accreditation team. I believe that the majority of assessors are registered nurses, something around 60 per cent or so or it could be a bit higher.

The Hon. NATASHA MACLAREN-JONES: You state in your submission that the initial assessment and care planning be carried out by a nurse practitioner or a registered nurse.

Ms CROWE: That is the quality of care principles, yes. So that is within the aged care Act.

The Hon. NATASHA MACLAREN-JONES: And that is the one who makes the recommendation as to the type of care? If a resident required a registered nurse to be there at all times that would be their recommendation?

Ms CROWE: That would be up to the registered nurse whether or not they consider that necessary as part of the care plan.

The Hon. NATASHA MACLAREN-JONES: I am saying if a registered nurse or a nurse practitioner who you say is qualified to make these recommendations says that a registered nurse is not required at all times because the care could be provided by an enrolled nurse or by other therapists, would that be the case?

Ms CROWE: I am not a registered nurse so I do not know that I can actually make a comment on how they would put together their care plan for a resident.

The Hon. NATASHA MACLAREN-JONES: Do you think the current system is not working where a registered nurse is the one to make a recommendation as to whether registered nurses are required at all times?

Ms CROWE: I do not believe that the quality of care principles ensure that there is a safe level of staffing in facilities across the board. That includes having a registered nurse and enough registered nurses available at all times.

The Hon. NATASHA MACLAREN-JONES: Are you saying that a registered nurse is not qualified to make that recommendation?

Ms CROWE: I am not saying that. I am saying that that specific section of the quality of care principle is inadequate to ensure that there is safe staffing.

The Hon. NATASHA MACLAREN-JONES: Who do you say is the best person to make those recommendations? What would the changes be?

Ms CROWE: I should say that when they are doing a care plan that is just for one moment in time. A resident can deteriorate and the care plan would not necessarily be up to date to deal with that. But, more broadly, for a system of regulation to be robust you need a set of standards which governs all facilities to ensure that there is a minimum standard of care and a minimum standard of staffing. I would like to see, as I said in our submission, for the quality of care principles to be altered or for the accreditation standards to be altered to ensure that where there are high-needs residents that there be a registered nurse available on site at all times.

The Hon. NATASHA MACLAREN-JONES: But is it not more important to provide care for the individual as opposed to a blanket one-size-fits-all approach?

Ms CROWE: I really do not see having one registered nurse in a facility at all times as being inappropriate. I think that these residents—most of whom are very vulnerable, very frail and can decline very quickly—have a right to have access to a registered nurse at least.

The Hon. NATASHA MACLAREN-JONES: I do not think anyone is advocating that no-one has a right to access, or that there currently is no means for any home to access a registered nurse. I think my colleague has a question.

The Hon. BRONNIE TAYLOR: You said that you would provide a list of all the rural and regional facilities that have registered nurses. Are you advocating as your organisation's spokesperson today that the aged-care facilities that are functioning now, getting good outcomes and being very happy with the care that is provided that do not have 24-hour registered nurse cover but get a registered nurse in if the acuity of the resident changes—are you saying that those organisations that exist now are unsafe because they do not have a registered nurse? Just a yes or no answer is fine.

Ms CROWE: I would like to give a longer answer. We have regulation not to regulate those facilities which are doing the right thing and providing high-quality care and safe care—

The Hon. BRONNIE TAYLOR: Sorry, can you repeat the beginning of your comment?

Ms CROWE: Regulation is not there for the facilities which are doing the right thing. It is there to prevent those facilities which are doing the wrong thing from doing the wrong thing and to protect those residents, who have just as much right to high-quality care as the people in the good facilities. That is why we have regulation. I do not believe that the current system of regulation is picking up on those bad homes and is ensuring that those residents are as safe and are receiving the care that they need. Time and time again whenever a facility which is found to be doing the wrong thing and to be providing appalling care is shown in the media nine times out of 10 it is fully accredited. The question is why. If we have such a great system of accreditation why are these facilities falling through the cracks?

The Hon. BRONNIE TAYLOR: If you could just answer the question, which was does your organisation then say that if there is no registered nurse there 24 hours a day it is unsafe?

CHAIR: We have a submission that clearly states a position. You are asking a question about an issue that is not being asked.

The Hon. BRONNIE TAYLOR: I am happy to respect that, Madam Chair. You come back to the facilities that are not doing the right thing, but I think you have acknowledged that there are a lot of facilities that are doing the right thing and providing some really good care regardless of—

The Hon. WALT SECORD: They have registered nurses.

The Hon. BRONNIE TAYLOR: The issue I keep hearing you come back to is one of accreditation. Would your organisation support a review of the accreditation that is happening at the moment?

Ms CROWE: Yes.

CHAIR: I have been surprised to hear that there is no weighting in the accreditation standards—care is equal to administration. It seems odd that when we are talking about the life of a frail or vulnerable person there is no weighting. Is that a concern? I think a number of organisations have put that forward as a concern. Is it one of your concerns?

Ms CROWE: Yes, it is a concern. We would like to see a far greater focus on the health and wellbeing of residents in that the accreditation agency actually looks at the actual health and wellbeing of the residents rather than the paperwork. The process of accreditation is very paper based and it does not give really any idea of what the quality of care is like. That is a key issue. We would say that if they changed accreditation to look at the health and wellbeing outcomes of the residents it would probably reduce the paperwork. It would probably reduce the time that providers spent on preparing for accreditation, and that would be a good thing.

CHAIR: Do you know of any models in any other jurisdictions that perhaps are doing that better?

Ms CROWE: In the Netherlands they actually look at each resident. They survey every resident. Here we are only required to interview 10 per cent of residents. It gives a far better idea of what life is like in the facility and what care is like in the facility. Here you are really only getting a very small snapshot of the quality of care. Speaking to family members and residents, they often say to us that even when they are interviewed by the accreditation agency they do not want to express their concerns to the agency. Even though they can do so in a private way they still have a huge concern that it will somehow get back to the provider and there will be retribution. That is a problem.

CHAIR: It seems to be coming up that there needs to be some separation, independence and some trust built about complaints.

Ms CROWE: Yes.

CHAIR: I will take you to a point that I think people are struggling with. It is the idea of whether it is the quality of care of a facility or a perceived desire for them to increase their financial return. If it is the case that a high-care resident equals a registered nurse there could be a circumstance where there is one high-care patient and therefore a requirement for one registered nurse. I think the point is that the cost of that, as we have seen from some submissions, could be towards \$400,000 a year to provide RNs. Has your organisation looked at the real costs involved with the provision of an RN and would you think that if there is one person with high needs there needs to be one person there 24/7?

Ms CROWE: We have not done any modelling regarding registered nurses in a facility. That is chiefly because we do not have the finances to pay a professional to actually do that and we would only feel comfortable having a professional body do that kind of work. I would add that with the way that the industry is going in terms of the resident profile I would be very surprised if there were many facilities where there is only one high-care resident.

CHAIR: Do you have any idea what the percentage would be?

Ms CROWE: I could provide that to you.

CHAIR: That would be great. We received some feedback from the Government about its steering committee. You are listed. Are you able to provide any information about how the steering committee operated or how your organisation felt? We heard there was no consensus.

Ms CROWE: No, there was no consensus. We were originally not invited to be part of the committee despite having been involved in consultations leading up to the formation of the committee. That concerned us because we were also assured that we would be further consulted about this issue. I corresponded with the Minister's office about it and was subsequently sent an invitation and attended the committee the following day. But you are right, consensus certainly was not reached. It is not surprising. The industry has a very firm view, we have a very firm view and the Nurses Association has a very firm view, so I did not think that there would be consensus.

I would have liked for the committee to have a little bit more information particularly from NSW Health around hospital admissions and use of ambulance services by residential aged-care residents. I think the committee really highlighted the lack of information that we have about the interaction between residential aged-care facilities and the New South Wales health system. That is a problem. If I was NSW Health I would be trying to get as much information on that front as possible.

CHAIR: Are you concerned by what the Committee has heard as to the transfer of residents from those facilities to hospitals, particularly at night? Earlier today representatives from Alzheimer's Australia told us about the nocturnal nature of some and the complex issues that arise. Is that what you are referring to? Do you feel that cost shifting happens because of the nature of aged-care residents and their needs not being met in those hours?

Ms CROWE: Absolutely.

CHAIR: We did ask for that information so hopefully there will be information forthcoming from this inquiry.

Ms CROWE: Minister Skinner included in a report not that long ago concerns by the Ambulance Service of NSW that paramedics were being called to facilities to insert catheters. That is an issue. Registered nurses should be available to do that kind of procedure. National data from 2010-2011 shows that falls of residential aged-care residents alone accounted for around 20,000 hospital admissions, which is huge. I am not saying that residents should not be transferred to hospital if they need it, absolutely, but you can see that falls, for instance, are a problem in residential aged care.

It is necessary to have a registered nurse available either to administer pain medication, for instance, or do an assessment to see whether or not the person should be transferred to hospital because they have fractured a hip or whatever. We have seen quite a few cases of residents going—one went for three months in Western Australia with a fractured hip that was undetected and that resident passed away as a result of septicaemia, if I recall correctly. Things can happen. A chronic thing can happen at night and at weekends, which really underscores the need for a registered nurse to be there as a minimum. It really is a safety net.

CHAIR: Do you accept that in some regional areas some facilities have a working relationship with a hospital where general practitioners and registered nurses are on call and can turn up in a reasonable amount of time?

Ms CROWE: We as an organisation would not be comfortable with that. Often time is of the essence when you are dealing with people at this level of acuity. We really do not see that as being a solution, particularly for those high-needs people.

CHAIR: You are making that distinction for high-needs people. Interestingly, the Councils on the Ageing [COTA] made a distinction about the lack of appropriate residential housing, which is forcing some people to go into care facilities and, having done a housing inquiry in the past two years, I found it interesting that that point was raised. Do you hear that there is nothing in between? If someone can no longer live on their own then that person has to go into an aged-care facility with all the costs involved, rather than there being an interim opportunity for them to have residential living in community or in something more appropriate?

Ms CROWE: Absolutely. We do seniors living very poorly in Australia. If you look at the Netherlands or Scandinavia, they do seniors living really well. You have small clusters of appropriate housing, universally-designed housing, which allows the older person to remain in their home and if they have to access home care then that is also available. That kind of model is very limited in Australia. We would love to see more of it. It would be cheaper to provide and it would better facilitate home care provision. Simple things like stairs can

prevent someone from remaining in their home. But, you are correct, older people really do not have much choice in that respect and often end up in a nursing home as a result.

CHAIR: Do you hear from people who contact your organisation that they are wondering about how to go from home to something else and are looking for something in between?

Ms CROWE: We do; often from renters. For renters it is an issue because they are even more limited in their housing choice. What little seniors living there is, particularly for renters, that is affordable, there are waiting lists of 18 to 24 months.

CHAIR: We hear about people leaving their homes—namely, they then have an asset that propels them into an asset. For people who do not have that financial backup, how difficult is it for them to find appropriate care or are some of them, because of financial reasons, being forced to live with an inappropriate level of care?

Ms CROWE: Good question. Someone with very limited resources would be more likely to have to go into a residential aged-care facility rather than accessing home care because the minimum fee you pay for home care is 17.5 per cent of the pension. If you are paying rent and food on top of that you are suddenly left with very little, so they are more likely to go into a residential aged-care facility. In terms of choice, theoretically providers should not be able to cherry-pick residents on the basis of their wealth. It is hard for me to say because we have not seen the data for 2014-15, since the changes took effect; that would be good to see.

The Government is also doing a review of its policy surrounding supported residents, which are residents with low means. At the moment providers receive a 25 per cent reduction to their subsidy if they do not meet a 40 per cent requirement in terms of supported residents. In short, they get paid less if they do not meet that threshold. That is to encourage providers to take on residents of low means. But it will be interesting to see the data from the last financial year.

CHAIR: Do you know when that is due?

Ms CROWE: It is going to come out in the report on the operation of the Aged Care Act, which does not come out until November typically, so quite some time. But the Department of Social Services might be able to provide you with something.

CHAIR: Thank you for your submission and for appearing before the Committee today. You have taken some questions on notice. The secretariat staff will be in touch about those questions being replied to within 21 days.

(The witness withdrew)

PETER GONSKI, President, NSW Division, Australian and New Zealand Society for Geriatric Medicine, sworn and examined:

LYNDAL NEWTON, Treasurer, NSW Division, Australian and New Zealand Society for Geriatric Medicine, affirmed and examined:

CHAIR: Do either of you wish to make a brief opening statement?

Professor GONSKI: Thank you for giving our organisation the opportunity to address this inquiry. Dr Newton and I represent the New South Wales part of the Australian and New Zealand Society for Geriatric Medicine. We are both on the executive of that society. We represent the view of geriatricians across New South Wales, as the aged-care medical physicians of New South Wales. The needs of the residents of aged-care facilities are personal care, nutrition, function, psychological, social and medical. The medical needs are chronic and at some stage they will become acute for that individual. Chronic care has become more complex with the ageing population, their increasing number of chronic illnesses and the multiple medications that they are taking. Palliation—that is, pain control and comfort care—is often required.

These complexities of conditions and management require registered nurse expertise and cannot be managed by more junior nurses. The care of an acutely deteriorating resident needs urgent recognition, urgent assessment and urgent management. There is good evidence that this is best provided in a person's home—that is, for these people, in their aged-care facility. With the assistance of the general practitioner and specialist services, this can be provided very well without referral to an emergency department.

In my personal work in this area, with the referrals that we have had from aged-care facilities of people who have acutely deteriorated, we have been able to stop 90 per cent of admissions to emergency departments and subsequent hospitalisation. Without registered nurses, there is no way that this reduction could happen. Many of these deteriorating residents will require palliative care, possibly with painkillers being provided through a pump by a needle under the skin—that is, subcutaneously. Others may benefit from intravenous antibiotics or subcutaneous fluids. This treatment can be given only with registered nurse supervision. In summary, we want the best care for aged-care residents, and that is why we are here today. We believe that that requires a registered nurse to be on site for 24 hours a day. Thank you.

CHAIR: Thank you. We will now go to questions.

The Hon. WALT SECORD: Thank you, Professor Gonski. Thank you, Dr Newton. How many years does it take to become a geriatric doctor?

Professor GONSKI: It takes about eight. That is not including becoming a doctor; that is beyond being a doctor. If you add another six, it is 14.

The Hon. WALT SECORD: So it is 14 years experience.

Professor GONSKI: Yes.

The Hon. WALT SECORD: How many doctors are there in New South Wales that would fit into that classification or that category?

Professor GONSKI: I would say there are about 200.

The Hon. WALT SECORD: So you are a very specialist, expert field.

Professor GONSKI: We are.

The Hon. WALT SECORD: Thank you for your submission. It was succinct. I thought your opening statement was very clear. Do you think that the removal of registered nurses in New South Wales aged-care facilities would increase admissions to emergency departments?

Professor GONSKI: Definitely, yes.

The Hon. WALT SECORD: Your colleague is nodding her head. Can you expand on that, please?

Dr NEWTON: Absolutely. I can give you a specific example of a patient on Thursday night who would have gone back to a nursing home from a hospital but could not because there was no registered nurse on duty that night to administer her Endone. She could not go back.

The Hon. WALT SECORD: To administer her what?

Dr NEWTON: Her pain medication. She had to have pain medication overnight for an acute broken arm. She could not return to the facility because there was no registered nurse on duty. I can also give an example of staying out of hospital and in the health system. I run a nursing home liaison service, as does Professor Gonski in his area. I go out to nursing homes in an attempt to prevent patients from going to hospital with conditions can be treated in the facility. Without registered nurses, I cannot keep some of those patients there. I was called to see a patient some months ago for palliative management. They felt that she was dying in the facility. I went to the nursing home and saw her there, and she was in fact dying. She needed pump morphine, subcutaneous morphine. I said to the nursing staff, "Will you have the staff on duty who can manage this?" The sister in charge of that facility said, "Yes. We have registered nurses on tonight who will be able to do it. If we did not have them, we would not have been able to." That is a very specific example. I can give you hundreds of similar examples.

The Hon. WALT SECORD: Do staff tell you that they would like to have registered nurses there for the welfare of the patients?

Dr NEWTON: In the facilities?

The Hon. WALT SECORD: Yes.

Dr NEWTON: Absolutely. The registered nurses in those facilities, the patients in those facilities and the families of—

The Hon. WALT SECORD: Sorry, I meant non-registered nurses, other staff, who want registered nurses there.

Dr NEWTON: Yes, of course. Assistants in nursing in those facilities—some of them are certified, some are not—tell me that they are glad that they have registered nurses there. I hold follow-up clinics every week, at two different nursing homes, and the non-registered staff tell me that they would not be able to look after some of the patients if the registered nurses were not there.

The Hon. WALT SECORD: Not to diminish it, but are there procedures that a registered nurse could carry out as a matter of course that people are going to emergency departments for?

Dr NEWTON: That a registered nurse could do? Yes.

The Hon. WALT SECORD: Can you give me some examples?

Dr NEWTON: The insertion of a nasogastric tube and the insertion of a catheter can be done by a registered nurse.

The Hon. WALT SECORD: How long does that take to do?

Dr NEWTON: The procedure itself?

The Hon. WALT SECORD: Yes.

Dr NEWTON: Depending on the skill of the nurse, the procedure could take 10 minutes. If it is a difficult procedure it could take half an hour. Catheterisation depends on the patient. If a patient is very confused the procedure can take somewhat longer because the nurse has to manage the understanding that the patient may have of that procedure.

The Hon. COURTNEY HOUSSOS: Thank you very much for your concise submission outlining the issues and for coming here today. In your submission you talked about the increasing acuity of residents once they enter registered aged-care facilities. We have heard that consistently from a large number of the medical professionals who have spoken to us. Do you agree that there is a lower use of places that were formerly known as low care?

Professor GONSKI: The answer is definitely yes. Probably the reason is that we are looking after people at home much better. I have been doing this work for about 22 years. When people went into aged-care facilities 22 years ago, all some of them needed was a meal a day. Now those people would not go anywhere near an aged-care facility. All the needs have been moved up. The people who would have been in low-level facilities are usually still at home. Those who would have been in high-level facilities are now starting to move into aged-care facilities at lower levels. Then there is the top of the range, where people need a lot of care.

The Hon. WALT SECORD: At the last hearing we heard that the average age of a person entering a nursing home was 84, and that would be for what was previously described as high care. So the people who enter aged care now would be those who need the services of a registered nurse, rather than what was the case 20 years ago.

Professor GONSKI: Absolutely, and there is much more chronic disease now. We used to have the situation where there was no ageing in place and there was a big difference between low-level and high-level care. If someone needed only meals or personal care and subcutaneous insulin, they had to go into a high-level facility. The only reason they had to go into a high-level facility was that there was a registered nurse there and no-one could administer insulin in a low-level facility. It was ridiculous that someone had to live in a facility in those days with people with severe dementia and total immobility, and had to try to have a quality of life.

The Hon. COURTNEY HOUSSOS: I want to talk about the increasing demands of residence in aged-care facilities. Some submissions, particularly those from providers, have said if we require registered nurses in facilities that were formerly known as low care, the registered nurses who worked in them would probably become bored and leave. So there is a dual problem that they have difficulty attracting them in the first place and a secondary problem that it is likely that they would leave because of the lack of rigorous—I am paraphrasing here—requirements, that they would be left to do this sort of lower-level personal care work that would normally be done. Would you agree with that submission?

Professor GONSKI: The way things are at the moment there is ageing in place. I think it would be very unlikely just to have very low-level people in a facility. The other thing is that the way things are now it is not just providing medical care; it is also looking at models of care—for example, the care we have discussed. Can we provide, for example, full palliative care in an aged-care facility or does someone have to go to a hospice or to a hospital? It is all around having registered nurses, that is, high-quality nurses who will run with these models of care. So I would say no to that because I think the needs are so much more, and if someone is actually interested they will get on and move models of care around to make the best for their residents.

The Hon. WALT SECORD: Why do you think aged-care providers are resisting our concern that we think that registered nurses should be in aged care?

Dr NEWTON: I tend to feel a little bit like Ms Charmaine Crowe felt for her organisation in that there is a financial benefit to not having registered nurses there and although many of these facilities will do the right thing and reinvest these funds for their residents I also think there are a lot of facilities out there who do not do that. With respect to charitable organisations, yes they do have a charitable focus and they like to reinvest, but I would put it to you that if someone had a choice of a slightly more modern facility as opposed to a registered nurse if they were in trouble, I think they would prefer the registered nurse if they were in trouble rather than saying, "Well, it doesn't matter that I'm really sick; I've got a very pretty looking environment".

I think that, yes, charitable organisations do care for their residents but there is a profit motive there and I think that not every facility is run by a charitable organisation and not every facility does the right thing. So do I believe that there is a profit motive? Yes. Does that mean they do not care at all? No, but they do have responsibilities to their own sponsors rather than to the residents themselves.

Professor GONSKI: Can I just add one thing though? I do not think it is totally profit; I just think that they would be much more flexible if their only RN rings up in the evening and says they cannot be there tonight;

they can still run a nursing home, an aged-care facility, whereas if there is jurisdiction obviously they are going to have to run around and find someone. So I think for them it is money and it is flexibility.

The Hon. COURTNEY HOUSSOS: The Committee is probably getting sick of me asking every single witness about this, but there has been a suggestion that there should be exemptions or that there are unique factors within rural and regional areas, particularly remote New South Wales, that need to be accommodated for. Do you have any comments on exemptions from the requirement for registered nurses 24/7?

Dr NEWTON: Yes, I have heard that question. I think that regardless of where you are in this country you are entitled to good care. Giving someone an exemption says that, "Well, we can't meet the need so we shouldn't have to", and I think that we should have to try and meet the need; we should provide quality care whether you live in the country or not. If that proves a little more difficult this is why there are rural incentive schemes in other professions, not necessarily just in medicine, nursing and allied health, and there should be some incentive to have people work in the country if that is proving to be difficult. But we should not just say "You live in the country therefore we should make the standard less for you".

The Hon. WALT SECORD: Professor Gonski, you wanted to add something?

Professor GONSKI: I just wanted to say that I believe the opposite—not the opposite of Lyndal, but if you look at it the other way round, it is probably more likely that you need registered nurses in these facilities because it is quite hard in many cases to get very quick responses from other medical services—even GPs—and at least you would have registered nurses who can probably provide that care. We are now working towards using much senior nurses doing a lot of doctors' work now and that has been extremely useful. Nurse practitioners have gone in and taken the places of GPs in some circumstances. We have nurse practitioners working with us who do a lot of the work on the weekends after hours and it has been absolutely fantastic. So I would just like to say that I would confirm that rural areas should, in fact, have registered nurses.

The Hon. NATASHA MACLAREN-JONES: Thank you very much for coming today. Just for clarity, you are the State president and State Treasurer of your organisation and your society has divisions in each of the other States and Territories. I am interested in any correspondence you have had with them or conversations you have had with the other divisions about how they deliver client-focused care, considering they do not have the section 104 requirement to provide qualified staff to treat their residents. How have they done that over the years to deliver the care, and what makes New South Wales unique?

Professor GONSKI: Just because they do it does not mean it is best for us. We do believe that we provide excellent aged-care facility care. In my submission I mentioned flying squads. I wonder whether they can provide that care. I presented my data at our scientific conference, which is annually, and there were not a lot of that type of service in some of the other States. I do know that they are able to get away with it but whether they actually provide as good a care as we do here I really cannot comment on that.

The Hon. NATASHA MACLAREN-JONES: Would you be willing to maybe speak to your national president about the other States in comparison to New South Wales?

Professor GONSKI: Definitely, and Victoria would be the one to talk to specifically.

The Hon. BRONNIE TAYLOR: Dr Newton, you said you worked at Prince of Wales?

Dr NEWTON: Yes.

The Hon. BRONNIE TAYLOR: Have you worked in your capacity as a palliative care specialist in any rural or regional areas?

Dr NEWTON: Not as a palliative care specialist, as a geriatrician—just to clarify. I am not a palliative care specialist but I do a lot of palliative care. In the capacity of geriatrician, no, but I have certainly worked in other regional areas, yes.

The Hon. BRONNIE TAYLOR: I would like to go to a point in your submission. I have been a registered nurse for 20 years working in cancer nursing and as a palliative care clinical nurse specialist. When you talk about the use of syringe drivers you say this sort of treatment requires registered nurse supervision. In my area I was in charge of running an outreach palliative care service—it all sounds very smart, but it was only

one registered nursing position—and we had a very, very successful home death, we had a lot of success in working with aged-care facilities and providing end-stage palliative care and using syringe drivers in consultation with our GPs.

In some of those aged-care facilities there were not registered nurses overnight where those syringe drivers were going but we would go in every day and we would reload the driver—as you know, once every 24 hours the syringe driver needs to be reloaded unless that care is reviewed and more is required—and I can honestly say to you, hand on heart, there was one situation where we had to be called out over all those years. When you make statements like that in your submission I am wondering if you are aware that there is really excellent palliative care going on at the moment working with these home-based teams in aged-care facilities?

Professor GONSKI: I am aware of it. I have to say that, particularly across Sydney, the palliative care services are very variable.

The Hon. BRONNIE TAYLOR: I would agree.

Professor GONSKI: In metropolitan Sydney that service is not really provided particularly well and—obviously you have the experience—single daily involvement of a palliative care service may not be enough if you do not have a registered nurse or nurses that are at a level that they can manage those syringe drivers. I mean, I know that you say you went in once a day but perhaps the needle got dislodged or something went wrong with the syringe drivers. Obviously they need to have a way of fixing that when you are not there.

The Hon. BRONNIE TAYLOR: With the utmost respect, Professor Gonski, that did happen on one occasion and we were called out and we replaced the driver with no ill effect. The driver had been going, the blood levels were good with the opiates; there was no need. I am just saying that these are real-life examples of a palliative care service that actually works really well and it is regionally based. In the metropolitan areas there is easier access and more facilities; I understand that.

Professor GONSKI: That is one aspect of our whole model. It is only for palliative care using subcutaneous injections.

The Hon. BRONNIE TAYLOR: I understand. I would like to pick up on the point where you talk about models of care. You also talk about the flying squad team to reduce transport to hospital. It is about looking at different models of care in a changing world and our ability to deliver that care to get the best outcomes?

Professor GONSKI: Yes.

The Hon. BRONNIE TAYLOR: Do we want to maintain that flexibility by acknowledging that models of care change and that there is not a one size fits all and that different things working different places?

Professor GONSKI: I would agree with you—

The Hon. BRONNIE TAYLOR: Thank you.

Professor GONSKI: —but at this point in 2015 I do not believe that one can just stop all the registered nurses being onsite.

The Hon. BRONNIE TAYLOR: I am not saying stop all registered nurses everywhere. We are just talking about individualised and models of care, which you mentioned. Nowhere have I stated that.

Professor GONSKI: I appreciate that but I would like to just say that you would be looking at all the models of care for those residents in that particular aged-care facility; it is not just palliation.

The Hon. BRONNIE TAYLOR: No, it is based on care needs. Thank you.

The Hon. SARAH MITCHELL: Thank you for coming along today. Dr Newton, I go back to hospital admissions and the anecdotal evidence you gave at the beginning where you talked about a patient you were aware of who could not go back to their facility. I think you said that they came in with a broken arm, is that correct?

Dr NEWTON: Yes. This was a patient who had come in during the evening with a broken arm.

The Hon. SARAH MITCHELL: The Hon. Walt Secord spoke about an unnecessary hospital admission. I am not a doctor or a nurse but I would imagine that if someone had a broken arm they would have to go to hospital?

Dr NEWTON: In that particular circumstance I was giving you, yes. They need an assessment. If it had been during the daytime hours, Monday to Friday, nine to five they would certainly have been able to call me or a GP out or the registered nurse would have been able to organise an X-ray in the facility and we would have been able to do that there and the patient may never have had to come to hospital.

The Hon. SARAH MITCHELL: But even if a registered nurse was on duty at the time and there was a suspected broken arm—I just do not see that that is an unnecessary hospital admission?

Dr NEWTON: In the evening that is not necessarily avoidable because they would not necessarily be able to get the X-ray services right. During the day it is possible for that patient to never come to hospital.

The Hon. SARAH MITCHELL: Even if they have a broken arm?

Dr NEWTON: It is possible, yes.

The Hon. SARAH MITCHELL: I did not know that.

Dr NEWTON: During daytime hours. I am being very specific here—Monday to Friday.

The Hon. SARAH MITCHELL: In that example you have given, which is after hours?

Dr NEWTON: Yes, it is possible.

The Hon. SARAH MITCHELL: Do you know if there was a registered nurse on duty at the centre?

Dr NEWTON: When she was sent in, in the evening?

The Hon. SARAH MITCHELL: Yes?

Dr NEWTON: Yes, but not for the night when she was returning.

The Hon. SARAH MITCHELL: But in terms of the admission to hospital there was a registered nurse on at the facility where that person was a resident and the resident still had to go into hospital?

Dr NEWTON: After five o'clock, yes, so it is in a very specific time frame that we are talking about.

The Hon. SARAH MITCHELL: I am just trying to get it clear?

Dr NEWTON: The patient had the injury during the day; it was a registered nurse who saw the patient. Unfortunately the time frame had gone that they could not get an X-ray in the facility so the patient was referred in to hospital for the purpose of getting that X-ray. Had that been from nine to five and they called our flying squad service we could have gone out and organised an X-ray during the day. She could have been administered medication in the facility via a registered nurse or myself in the first instance but a registered nurse to follow on with and the patient could have stayed.

Now I cannot tell you if they did not have a registered nurse on for her to go back to the facility; whether there would have been a registered nurse on that night but I would suspect that given that she needed S8 medications they would have had to have facilitated an RN in that facility that night. As it was she came into hospital after five o'clock and had the X-ray done. The X-ray was done, she had some medication, she was good to go back—we are talking a small time frame—to the facility. The facility was rung and the facility said, "We cannot take her tonight. We do not have an RN."

The Hon. SARAH MITCHELL: In that same example but not in a metropolitan example because I am assuming that is somewhere in Sydney?

Dr NEWTON: It is a metropolitan setting, yes, that is correct.

The Hon. SARAH MITCHELL: I live in Gunnedah. If someone in an aged-care facility in Gunnedah, which does not have the capacity to take X-rays, breaks a bone, do they not present a hospital anyway?

Dr NEWTON: In a rural area? I could not tell you what is happening rurally at the moment. I am not from a rural area. I grew up in one but I do not know what they currently do.

The Hon. SARAH MITCHELL: That is all right. I am just seeking some clarity.

Professor GONSKI: There are other places where one can get X-rays, particularly during the day. You do not need a hospital.

The Hon. SARAH MITCHELL: No. I am just trying to get to the bottom of what you would class as an unnecessary hospital admission in the context of that anecdote but it is just me thinking out loud. I should probably stop asking questions. I have one last question on previous facilities that were low care under the classification of low and high care. We heard evidence last week from the department here in New South Wales that there were 345 low care residents out of 939 in New South Wales, so that is just over one-third. What do you recommend for those sorts of facilities? At the moment there is not a requirement for a registered nurse 24/7 if they are a low care facility. I take on board your points about the changing dynamic of the sector, but as it stands currently what would your position be for those low care facilities?

Professor GONSKI: Again 10, 15, 20 years ago they were low level people and they probably would have got away without registered nurses but a lot of the facilities providing ageing in place have mentioned—and we do believe—those people do require registered nurse involvement. The other thing I mentioned before was the subcutaneous injections. It was not us who suggested they go to high level facilities because they needed a registered nurse to give a subcutaneous injection.

The Hon. BRONNIE TAYLOR: Can you elaborate on your flying squads team? I am really interested. Your flying squads obviously prevent admissions to hospitals so that is fantastic. Are they only working with facilities that have registered nurses or do you envisage that flying squads will work with all types of facilities?

Professor GONSKI: All our facilities in my area, which is the Sutherland shire, have registered nurses. Basically what happens is that our team gets called. Within two to four hours a doctor and a nurse practitioner or a clinical nurse consultant will go out and assess the patient and make a decision whether the patient requires hospitalisation or not. If they do not, they will talk to the general practitioner, they will talk to the family and carers and obviously the staff of the facility and they will instigate treatment. In the three-year period we saw 3,000 referrals. We kept 90 per cent of those out of an emergency department and out of hospital. As to the type of treatment that was started, 25 per cent were put on to a palliative care pathway from that time and the other 75 per cent were treated either with medication and, as I have mentioned, intravenous antibiotics, fluids or whatever is required.

The Hon. BRONNIE TAYLOR: Can I ask a further question?

CHAIR: Ms Taylor, you might like to put any further questions on notice. Dr Newton, do you have any comments on the accreditation standards? I am surprised to find that there is no weighting in the aged-care quality agency standards. Is the way it is assessed focussed on the quality care of the residents?

Dr NEWTON: I do have some opinion on this. The standards obviously are there. I think the problem from my experience going around to different nursing homes or residential aged-care facilities recently is that within a small area one nursing home or facility had some 44 issues looked at and one had two issues looked at, yet they are the same type of facility. I would say that if all of the standards were being examined all the time I could feel more comfortable that the quality was very good. Those standards are not adhered to rigorously and, therefore, the quality within facilities within my area is outstandingly different. I would put to the Committee that though they are there they are not always adhered to as they should be.

CHAIR: Do you mean to achieve accreditation or the ongoing monitoring?

Dr NEWTON: Yes, to achieve accreditation. I would suggest that perhaps we need more rigorous adherence. Would that mean that registered nurses are not necessary? No, not in my opinion, but we would benefit from more rigorous adherence to the standards.

CHAIR: Should there be a weighting around priority of meeting some higher standards? I was surprised to find that the care and welfare of the patient is not higher than catering, cleaning and laundry services or the administration.

Professor GONSKI: Of course, all those things work together in giving a good standard. It is really important obviously, the catering is incredibly important for the nutrition. Without that people will not do well, and the cleaning is also very important from the point of infection.

CHAIR: True.

Professor GONSKI: They are all very important but certainly ultimately the care of the resident is the most important thing.

CHAIR: Earlier this morning the Committee heard from Alzheimers Australia who talked about the increasing number of people with dementia who are entering facilities. It still seems the case that there is a lack of understanding about dementia in broader society and it seems to have increased while no-one was looking. Does the complexity of dementia mean that it should be dealt with by registered nurses? The Committee heard about nocturnal problems, that the incidence of behaviour issues are primarily at night and do not fit into the nine to five program. What is your experience?

Professor GONSKI: The actual greatest benefit of management of dementia in aged-care facilities is around personal care; it is about providing all the things that that particular individual will settle with because some of these people can be quite agitated. The best way to treat that is basically to look after the person the way they would like to be looked after. So that does not require a registered nurse. When things absolutely escalate and if the resident is possibly under medication, to settle them—and we would hope that that is fairly rare but it is not—then there may be that requirement.

Dr NEWTON: There are situations where registered nurses are required. As Professor Gonski was saying, there are circumstances where people are very disturbed and do require medication. They would absolutely require a registered nurse for that and those registered nurses would also benefit from further training in behavioural and psychiatric symptoms of dementia and their management. There are only really two facilities in Sydney that deal with extremely complicated behaviour disorder. That is an outstanding lack of service really for those very, very difficult patients.

There are many facilities that deal with behavioural symptoms of dementia, do not misconceive that; there are many facilities that do that. Those with registered nurses and training in that area do it a lot better than many other facilities. But if you are talking about the most complex patients, the most difficult behaviours of residents, many of those people need specific facilities, and there is an outstanding lack of those.

CHAIR: One submission quoted that 53 per cent of aged-care residents have a diagnosis of dementia, although anecdotally the figure is much higher and it seems to be coming through that that is an area of health provision that is not getting the attention it deserves.

Dr NEWTON: Yes.

CHAIR: You made a comment, correct me if I am wrong, that the ability to manage palliative care within an aged-care facility would prevent progression to a hospice. Is that an emerging trend? Are registered nurses required to be there for the provision of that?

Professor GONSKI: Obviously there are models of care that you can avoid when we are talking about that one particular aspect of just palliative care. Really, a lot of these people should be treated at the home which is their aged-care facility and that includes palliative care services. They should get just about the same care as

they do in a hospice if people can come in. Obviously we have got the staff at the aged-care facility and specialist people can come in and help them.

Dr NEWTON: I put to you that no palliative care episode for each patient is the same. Whilst there are good models of care out there that can be provided in the community, not every person dies the same way. If you are in a facility and you are on a syringe driver and you are in very bad pain and there is not someone coming until tomorrow to change your syringe driver, you would love there to be a registered nurse who could give you a dose of breakthrough medication. I am not saying that that is the norm, not every single aged-care patient is dying in a nursing home, but if you are that person that is very important to you.

CHAIR: Is a registered nurse required to provide the best quality of care that is needed, if needed?

Dr NEWTON: Yes. The ultimate best model of care would always involve a registered nurse in it. There are many models but I cannot perceive one where the best level of care does not include a registered nurse.

Professor GONSKI: I completely agree with that.

(The witnesses withdrew)

(Luncheon adjournment)

GWEN CLEEVE, Facility Manager, Opal Aged Care, Mudgee, before the Committee via teleconference, sworn and examined:

CHAIR: Thank you for being with us via teleconference. Would you like to start by making a statement or go straight into questions?

Ms CLEEVE: I will just explain who I am. I first started in aged care in 1988. I became a registered nurse in 1978, so for the last 27 years I have been specialising in aged care. I have worked in various roles ranging from a registered nurse to clinical manager and I have now been the facility manager here at Opal for the past two years.

CHAIR: Can you also tell us a bit about the facility itself?

Ms CLEEVE: Yes. Opal Mudgee is only a small facility. We have got capacity for 47 residents. We have a specialised room set aside for palliative care residents. We are all high care, high acuity for all the residents. We are an older style facility here in Mudgee. It was a nursing home originally built by Moran. Opal Aged Care was in possession of it when they were Domain Principal. We have been named Opal for 12 months now.

The Hon. WALT SECORD: I am Walt Secord, the shadow Minister for Health representing the Labor Party. You have recently changed your name so you have become part of the Opal chain, is that correct?

Ms CLEEVE: Yes, we are.

The Hon. WALT SECORD: Why was the name changed? What were you previously called?

Ms CLEEVE: It was just a name change. It has not been a business change. Originally the acquisition was from Domain Principal, so it is actually only just the name. What Opal is doing, especially in this area in Mudgee here, is we are trying to enhance our presentation out in the community.

The Hon. WALT SECORD: The name change followed the Domain Quakers Hill incident, I understand. During the recess I pulled up the financial records for your aged-care facility. I see that in 2013-2014 your facility received \$2.908 million in Federal Government subsidies. You are quite a profitable operation.

Ms CLEEVE: Getting down the actual financial aspect of it, I am not very clear on that. As I said, I started working here two years ago and basically all our financial dealings are done at head office.

The Hon. WALT SECORD: Okay, but that is on the public record. I did a search of the most recent Australian Aged Care Quality Agency report on your organisation and on the amount of subsidies that you received. Are you what you would consider a very good aged-care facility?

Ms CLEEVE: Yes. I can state that Opal Mudgee delivers an extremely high standard of care. In June this year we had our accreditation.

The Hon. WALT SECORD: From 10 to 11 June.

Ms CLEEVE: Yes, from 10 to 11 June we had our accreditation period.

The Hon. WALT SECORD: You say that you are a very well run aged-care facility. Do you attribute that to the fact that, according to the Aged Care Quality Agency, you have three registered nurses on staff? I think you have passed 44 out of 44 outcomes.

Ms CLEEVE: Yes, that is right.

The Hon. WALT SECORD: Do you attribute that to the quality of your registered nurses on duty?

Ms CLEEVE: Yes, I do. I have a registered nurse on all shifts, 24/7. On my day shift I have a registered nurse and five carers. Of an afternoon I have another registered nurse and three carers. For the night shift I have a registered nurse and two carers.

The Hon. WALT SECORD: During the break I read the accreditation of your facility in which you passed 44 out of 44 outcomes. It said you had three registered nurses. You attribute that score to that. When was the most recent gastroenteritis outbreak or other major public health scare at your facility?

Ms CLEEVE: That would be three years ago. I know prior to my commencing employment here there was a flu outbreak, so that was three years ago.

The Hon. WALT SECORD: You are confident that the registered nurses you have in charge now would be able to handle an outbreak and put controls and systems in place that would respond to such an outbreak?

Ms CLEEVE: Yes, I am. We have ongoing education. We have mandatory education for all the registered nurses and the care staff and one of the mandatory education sessions is on outbreaks. Plus for any disasters like fire we do mandatory training three times a year for the fire training, which encompasses what the protocol is and what happens in the event of having to do an evacuation and things like that.

The Hon. WALT SECORD: I have been through the accreditation and you scored top in every single category. I have gone through the 40 pages and I cannot find a single criticism.

Ms CLEEVE: I am extremely proud of Opal Mudgee. It is a wonderful nursing home. I have great support—even though we are in Mudgee we are isolated from the head office but I get excellent support, when needed, from my peers.

The Hon. WALT SECORD: Thank you for your time and for updating the Committee on the situation with registered nurses at your facility.

Ms CLEEVE: Thank you.

The Hon. COURTNEY HOUSSOS: Good afternoon, my name is Courtney Houssos. I am also a member of the Opposition. The last witnesses before lunch today were from the Australian and New Zealand Society for Geriatric Medicine. They said that the role of registered nurses in rural, regional and remote New South Wales is actually more significant than in metropolitan areas due to the difficulty and often scarcity of other health professionals such as general practitioners or geriatric specialists. Would you agree with that assertion?

Ms CLEEVE: I totally support that, especially in my area here. We do have two medical clinics and the doctors are very good but what we try to do—my registered nurses do a full medical check prior to having to transfer any resident back to the acute care setting or not. So my staff can notify the doctors and give them an outline of the condition of the resident. I mean holistically looking at the resident, not just their disease but the whole aspect of their care. They discuss it with the GP and then the GP will either say, "Transfer to the acute care" or he will be out to review that resident.

The Hon. COURTNEY HOUSSOS: Have you had difficulty in recruiting registered nurses for your facility?

Ms CLEEVE: That is my pet subject at the moment, yes. I have been trying to recruit for some months now. Registered nurses in this area have either retired or they just do not want to come out to the rural areas. They need better enticement.

The Hon. WALT SECORD: During the break I also pulled out your enterprise agreement with your staff. Do you think that part of the reason that you are having difficulty in recruiting is that you are paying significantly lower than the public health system?

Ms CLEEVE: Yes.

The Hon. WALT SECORD: You are paying \$37.37 per hour?

Ms CLEEVE: Yes, I agree with that.

The Hon. WALT SECORD: If the State or Federal governments were to provide a wage subsidy or assistance what steps would you take to ensure that that funding would go to those nurses—that is, if the Committee were to recommend something along those lines?

CHAIR: You are more than welcome to take a question on notice if you feel you need to consult or have more time to answer it.

Ms CLEEVE: I just need clarification.

The Hon. WALT SECORD: If the Committee were to recommend that there is a disparity between the salaries that you offer to registered nurses in aged care and it was to be brought up to what the State hospital system was paying, could you ensure that that funding would go to the nurses and would not be taken by the provider?

Ms CLEEVE: No, it would definitely go to the nurses. Are you aware that the funding we get for the residents goes directly back into the care for the residents?

The Hon. WALT SECORD: Yes, I am familiar with that.

Ms CLEEVE: If there was extra funding it would not go to the providers, it would definitely come out to the staff.

The Hon. SARAH MITCHELL: My name is Sarah Mitchell. I am a member of The Nationals. Can you hear me? I am seated a bit further away from the Chair.

Ms CLEEVE: Yes.

The Hon. SARAH MITCHELL: You said in your opening remarks that Opal Aged Care has 47 residents and they are all what was previously known as high care classification, is that correct?

Ms CLEEVE: Yes, their acuity is high care.

The Hon. SARAH MITCHELL: You said also that you have worked in aged care since 1988. You obviously have had quite a lot of experience. Have you worked in facilities that had low care residents?

Ms CLEEVE: Yes, I did. Just prior to me commencing employment with Opal Aged Care I was on the South Coast—I did a tree change actually—working with the Cook Care group at that time but I know they have just been sold out to Estia Health. It was a facility on the South Coast. I was clinical manager and we had low care and high care residents and extra services.

The Hon. SARAH MITCHELL: In your professional opinion, and from your experience with low care residents, do you think they have the same necessity to have a registered nurse for 24-hours per day or do you think in a low care situation it might be a bit different?

Ms CLEEVE: No. They still needed the indirect or direct supervision by a registered nurse mainly when it came around to medication because in my experience in low care the medications were packed in blister packs—are you familiar with those?

The Hon. SARAH MITCHELL: Yes.

Ms CLEEVE: But those medications still needed to be checked by the registered nurse, especially with the high-risk medication—I am taking about medications such as Warfarin, which are a high risk to resident care. I have always had that; we have had registered nurse supervision in low care.

The Hon. SARAH MITCHELL: Do you think it is necessary to have a nurse on duty 24 hours a day, or is it sufficient for facilities to have access to a registered nurse? The Committee has had evidence from rural and remote centres that currently do not have a registered nurse for 24 hours a day, seven days a week, and are

concerned about their potential viability. They also have trouble recruiting staff, as you alluded to. Some fear that they might have to close if that impediment were put upon them, when they are operating quite successfully now. I want to gauge your professional opinion on that scenario. Where do you think those facilities, which currently are operating well, might be left if an impediment made them unviable?

Ms CLEEVE: If we are talking about a low-care facility without registered nurse coverage overnight, you would have to look at the standard of care or at the expertise of the care staff. The acuity and care needs of residents in aged-care facilities are much higher now because people are staying at home longer. By the time they come into the aged-care facility they are at a stage where they have complex high-care needs. In my experience with low-care residents on the South Coast, we still had 24-hour coverage. There was still a registered nurse in the building because we were all under one roof.

The Hon. SARAH MITCHELL: I guess it depends on the situation for different facilities.

Ms CLEEVE: Yes.

The Hon. SARAH MITCHELL: How important are enrolled nurses and assistants in nursing at Opal Aged Care?

Ms CLEEVE: I do have enrolled nurses here, but they are not accredited for medication so they only work as an assistant in nursing [AIN]. My care staff here are trained. We had our awards presentation last week. I have care staff who have been here for 30 years.

The Hon. SARAH MITCHELL: They obviously are helpful to your organisation because they have experience.

Ms CLEEVE: Yes. They are very experienced.

The Hon. SARAH MITCHELL: I assume they are passionate about what they do if they have been doing it for 30 years.

Ms CLEEVE: Yes; that is right. They do have a passion.

The Hon. SARAH MITCHELL: That is commendable.

Ms CLEEVE: Prior to my tree change, when I worked on the South Coast I taught at the local TAFE. I taught the certificate III in aged care. So I know that the foundation information that is taught to AINs at TAFE is of the highest standard. I thought it was very good. Since I have moved here I have become involved with the local TAFE provider that delivers certificate III in aged care. Students come here for workplace experience. They develop a great love for it or they discover that it is not for them. Education, for them, is very important.

The Hon. SARAH MITCHELL: Thank you.

The Hon. NATASHA MACLAREN-JONES: A number of submissions claim that facilities like yours that are regarded as high care have opted out of having registered nurses on staff. Are you aware of any cases like that?

Ms CLEEVE: Not locally, no. I have not come across that at all. There are two other facilities in Mudgee that are community-based, Kanandah and Pioneer House Nursing Home. I know through meeting their facility managers that they have registered nurses on duty for 24 hours a day, seven days a week, as well.

The Hon. NATASHA MACLAREN-JONES: Is that decision made because it is in the best interests of residents or because facilities have been told they have to do it?

Ms CLEEVE: It is in the best interests of the residents. At Opal Aged Care our mission statement says that we deliver the highest quality of care to residents and their families. We promise to deliver the best care, so that is what we try to do. The best care means having coverage 24 hours a day, seven days a week, with registered nurses.

The Hon. NATASHA MACLAREN-JONES: It has been said previously that care plans are assessed by a registered nurse but that they do not work as well as they could because there can be a sudden change in a resident's health. How often are care plans assessed and checked by nurses?

Ms CLEEVE: Here at Mudgee we have gone over to AutumnCare, which is a paperless system, for all our documents. Our care plans are evaluated every three months or every time there is a change in a resident's care needs. Our registered nurses write progress notes at least weekly, and we still do exception writing. If there is a change in the care needs of a resident it is documented in the progress notes and the care plan is updated and evaluated. Care plans are evaluated regularly.

The Hon. BRONNIE TAYLOR: I am really interested in the fact that you taught at TAFE. You said that you taught assistants in nursing on the South Coast.

Ms CLEEVE: Yes.

The Hon. BRONNIE TAYLOR: You mentioned that you thought it was a well-run course and that students were well prepared. You also said that it is about commitment by individuals working in these facilities and that they need to have a love for aged care. Would you elaborate on the TAFE training course? We have had some discussion about people's ability to provide the care, because of their qualification. Because you work in the field and you taught the subject, you are in a unique position to say what are the important ingredients. Is it education combined with commitment and a love of aged care? Having seen it from both sides, in your opinion what are the important ingredients?

Ms CLEEVE: It was obvious to my students that, as I worked and taught at the same time, I was very passionate about aged care. The units that were delivered were of a high standard. Because the course was formulated for aged-care facilities, the students had a better understanding of what was expected of them before they entered a facility. Aged care can be very daunting for some people, especially younger ones who have not had experience of older people. Aged care is a specialised field. It takes a special kind of person to work in it. We might only work for six or seven hours a day. Families have to contend with behaviours and care for their mother, father or sibling full-time. My students were taught true values. This was taught at TAFE as well. They were taught the true value of looking at a person holistically. They might be 50 with dementia or they might be 90 and unable to get around anymore. Students are taught to look at everybody as an individual. It is person-centred care and holistic care.

The Hon. BRONNIE TAYLOR: Thank you for that.

CHAIR: I am Jan Barham and I am going to ask you a few questions. I am really keen to follow up on the training levels and the skills requirement for the different types of staff that you have. What has been confusing is hearing whether or not some of the requirements to care for someone appropriately can be met by people other than RNs—the AINs or the ENs. Are you able to articulate the things that are vital for the provision of care for those people that require an RN?

Ms CLEEVE: As I said, the acuity of the residents now in any aged-care facility means there are a lot more complex care needs. Pain management is another aspect in our care that we deliver extremely well here in accepting the resident and delivering what is needed. Sometimes with people who are having to have scheduled medications yes they can take it in tablet form but with our guidelines of having to have a registered nurse and a responsible person to sign out that medication we have two people at all times checking the medication, checking them out and delivering the medication as well. This also involves our residents who are diabetic and needing insulination. The insulin is double-checked by a registered nurse and an AIN or care worker.

CHAIR: What about dementia? How many of your residents would need special care because of dementia issues?

Ms CLEEVE: As I said, I have got the capacity for 47 residents; I am down to 39 at the moment. Eighty-five per cent of those residents have got a diagnosis of dementia. We do not have a secure unit here; our format is that they are integrated with all the other residents. Residents with severe behaviour management, we work very closely with the DBMAS—the dementia behaviour assessment team—and if we have got any concerns at all we involve them, and it is behaviour management.

CHAIR: With the accreditation standards, I know you have done fabulously well with meeting yours, we have had a few submissions that indicate that there might be some value in reviewing the accreditation standards. I wonder if you have a point of view on that.

Ms CLEEVE: It is nerve-racking. The standards are set for the care. Yes they are high standards. I must admit prior to my accreditation here Opal does an internal accreditation as well. We have got a quality team up in Sydney and of course we are all online; they can see all our reports and things like that. So if anything comes up we get prompted throughout the year. Nothing is just fixed just before accreditation; we are working for the whole three years towards accreditation all the time—doing improvements, we have a full committee here of quality control, a continuous improvement process and work health and safety. It is all in our structure of how we operate. Yes the accreditation standards are high and yes we did meet them. I thought we did very well and I was very proud of all my staff.

CHAIR: So you should be. Thank you so much for taking the time to provide that really valuable input today. There might be some supplementary questions that members want to ask and in that case the secretariat will be in touch with you to discuss those if you are willing to do that.

(The witness withdrew)

MARGARET DANE, Member, Palliative Aged Care Network (NSW),

BRONWYN HERON, Chair, Palliative Aged Care Network (NSW), and

LINDA HANSEN, Executive Officer, Palliative Care (NSW), sworn and examined:

CHAIR: Would anyone like to make a short submission?

Ms HERON: Thank you very much for the opportunity to address this inquiry this afternoon. The group here today believe we bring a unique perspective to this issue of 24/7 registered nurses in residential aged care. I would like to give a brief background to the Palliative Aged Care Network (NSW). As we enter the second decade of this century as an ageing population living longer with increasing comorbidities, it is posing a new challenge in the provision of care, which involves our colleagues in both palliative care and aged care.

The Productivity Commission states that 50,000 Australians die each year in residential facilities and furthermore 90 per cent of all separations from residential aged care are attributed to a resident dying. For us palliative care is core business for aged-care providers. With an increase in resident care levels and a rise in the number of older people living longer and a rise in residents diagnosed with multiple comorbidities and a variety and variable capacity of our existing work force in aged care, significant challenges exist for those who are working in palliative care and aged care.

Those of us within residential aged-care settings in specialist palliative care roles recognise the need for a coordinated, focused and systematic approach to addressing these challenges and therefore the Palliative Aged Care Network [PACN] of New South Wales was born. PACN is a group of advanced practice nurses, clinical nurse consultants and nurse practitioners, with a little splattering of allied health professionals, with a strong commitment to the principles of palliative care working within the aged-care sector. We believe it is the right of all residents in aged-care facilities to receive a palliative approach to their care.

The palliative approach for people living in residential aged-care facilities who are approaching and reaching the end of their life require a team of people caring for them. Part of that team are the resident and the family but we see people like diversional therapists, recreational activities officers, our care staff members, GPs, allied health, chaplains, pastoral care, maintenance, catering, and many others. There is quite a varying mix of people within residential aged care but the registered nurse is a key member of that team, coordinating and leading that team in the provision of palliative and end-of-life care. Their role extends beyond undertaking care assessments, writing care plans and delivering schedule 8 medications.

I come here today as the current chair of Palliative Aged Care Network (PACN). I am a registered nurse, clinical nurse consultant in palliative care, working for an aged care organisation and I bring a length of experience in palliative care. I indeed began as an assistant in nursing [AIN] in the early eighties, trained as an enrolled nurse. While an enrolled nurse I entered tertiary study and became a registered nurse and I have been a registered nurse for nearly 30 years. I have been a clinical nurse consultant in specialist palliative care for 11 years now, with postgraduate qualifications in palliative care, working in a number of settings inpatient palliative care units or hospices, acute hospital palliative care teams in a community nurse role where I led the palliative care team in a community setting. For the last five years, which has been a real joy, I have been working as a palliative care clinical nurse consultant in aged care.

I think I bring some experience into the area of palliative care and aged care. Ms Dane joins me today as a member of the Palliative Aged Care Network of New South Wales and Linda Hansen joins me as the executive officer of Palliative Care New South Wales, our peak body in New South Wales. The reason Ms Hansen joins us today is as a network group we are currently in discussions with Palliative Care New South Wales about formalising our link with them to become a special interest group within New South Wales.

Ms DANE: I would just like to thank you for the opportunity to be here today to present a palliative care perspective to the issue. I have worked as a specialist nurse in palliative care since 1987 and as a nurse since 1964, firstly as a clinical nurse specialist in a rural setting and then over the past 16 years as a clinical nurse consultant, mainly in the public health setting. I am a hospital trained RN, with a Bachelor of Health Science and postgraduate qualifications in palliative care. I currently work for Ms Jane Mahoney, who established the Palliative Aged Care Consultancy Service, which provides palliative care consultancy to

residential aged-care facilities, a fee for service, usually one day a week. I work two days a week in two separate facilities, one in a rural setting and one in a metropolitan setting.

Ms HANSEN: I am the executive officer of Palliative Care NSW. Just to clarify, Palliative Care New South Wales is the peak body, so the palliative aged care nurse group is a member of us so we, as that peak body, are here to support our members and to start to get more involved in aged care issues that they are facing.

CHAIR: We will now have questions from Opposition members.

The Hon. COURTNEY HOUSSOS: I begin by thanking you for your submission. I think the number of case studies in the submission highlights the range of issues that we are grappling with across both low and high care, rural and regional and metropolitan settings. In your submission you specifically mention resident transfers to hospital and a reliance on the Ambulance Service. How important do you think it is to have registered nurses in aged-care facilities 24/7 in reducing unnecessary admissions to hospital and obviously then burdening the Ambulance Service?

Ms HERON: It is a huge issue and certainly for me it leads into the larger question of why is the person going to hospital? One of our examples was about falling and fracturing and obviously that was an event that absolutely requires the support of our hospital in order that the person's comfort and dignity be maintained in places where they need to be. For us the bigger issue is really around care planning and advance care planning. One of our key areas in that aspect of a palliative approach and palliative care being more than end-of-life care is: Does that person really need to go to hospital? Is that what they want? Is that their wishes? Have we planned that for them or is it a knee-jerk because there is not enough resource on the ground or we are not quite aware what all the clinical needs are for the person?

People have an absolute right to go to hospital if they wish and we have had some conversations and I would see our registered nurses as being the person who needs to lead those conversations and through that planning process know what are the person's wishes or what are the wishes that are being expressed by the person's substitute decision-maker, which is often the person we need to rely on when people are not able to make decisions for themselves if they are not cognitively able, which is a number of the people who live in our residential aged-care facilities. Hospitals should be places where people go to receive that level of care and if we can provide that level of care and decisions have been made about the focus of care, that care can be undertaken within the residential aged-care facility, then you need to go to hospital only if that is appropriate for the situation that presents itself, not as a knee-jerk reaction.

The Hon. COURTNEY HOUSSOS: As a last resort?

Ms DANE: I think that is within the palliative care perspective that we are talking about.

The Hon. COURTNEY HOUSSOS: Then if they are required to be in hospital, do you believe that registered nurses 24/7 then play an important role in allowing that person to return a residential aged-care facility?

Ms HERON: Certainly it has done and in situations that come to mind if the resident is going to hospital—say, it is a situation where the person has gone having experienced a chest infection or a urine infection and they have been very poorly and it is necessary for them to go to hospital and they are receiving treatment like intravenous antibiotics that are not able to be provided in the aged-care setting, we see from our experience and from some of the information and data that our aged care colleagues provide us that the person comes back slightly less well than when they went there. They are certainly better, but they are not at the same level of care need. They often have increased level of care need.

There is some lovely work done by Dr Joanna Lynn in terms of trajectories of dying and we see that with our very frail ladies and gents with dementia that that trajectory is a very prolonged one. We see that at every level of incident of change and infection they are a little frailer and so they come back from hospital, and, in fact, you need to plan that return. We have had conversations about end-of-life care in hospital in relation to this particular exacerbation of illness, but are we being provided with a plan of care for that care home to continue with?

Are there medications required that will require subcutaneous provision of those? Have there been conversations with family? Are we going to need to continue complex conversations with family around the

burden versus the benefit for the resident in returning? Are we able to continue the care of that person when they return to us? I think that does not just happen. I think there needs to be plans in place and communication with the residential facility as to its ability to provide this care and that communication should happen with your registered nurse.

The Hon. COURTNEY HOUSSOS: An earlier witness said that registered nurses play a more crucial role in regional New South Wales in providing care because of the difficulties in accessing other health professionals. I note that several of your care stories are actually based in rural New South Wales and low-care facilities and the need for registered nurses even in those facilities. Do you agree with that assertion? Will you explain why they would still be needed in those facilities?

Ms DANE: I work in a regional facility and a metropolitan facility and the difference is black and white even in that situation. In the metropolitan facility we have the flying squad to come in. We have very few transfers to hospitals for residents. When we are doing the advance care plan with the family we would talk about the flying squad and say it does not mean hospital. We can treat them with acute things here and we can get the flying squad. So you have specialists, you have a whole lot of things—hospice, palliative care specialists. In rural-remote you do not have those specialist backups, I suppose. So a lot does depend on the registered nurse in that rural area and I suppose even more so in more remote areas.

The Hon. COURTNEY HOUSSOS: Do you think registered nurses are more important in those areas?

Ms DANE: Definitely.

The Hon. COURTNEY HOUSSOS: And having them on 24/7 is even more important?

Ms DANE: Yes, I agree. I am talking from a palliative care perspective.

The Hon. COURTNEY HOUSSOS: Absolutely.

Ms DANE: We are not taking on the whole issue; we are taking on the palliative care issue.

The Hon. WALT SECORD: It is very clear from your submission that you support registered nurses 24/7 in aged care. In relation to end-of-life care, can each one of you give details about having registered nurses available in aged-care facilities?

Ms DANE: I would say, firstly, for them to recognise that we are coming to the end of life. That is a huge thing. Often the untrained person does not see that sliding scale of what is actually happening physiologically to a person. In saying that, I would also give 100 per cent to the carers who are there doing the personal care every day and seeing that the person is not able to do what they could do perhaps a month ago or six weeks ago. Again it is a team effort of the care staff having that communication with the registered nurse; the registered nurse then putting that in a more, I suppose, tier picture of what might be going on, to discuss with the general practitioner and start the work of maybe looking at advance care planning: What do the family want? What wishes has the resident expressed in the past?

The Hon. WALT SECORD: You mentioned about a registered nurse being able to pick up the "signs", I think was the word you used. Would you tell me a bit about that?

Ms DANE: I think in each disease there are signs. We have research that tells us that people with cardiac failure, when the pathology says certain things, there is a significant change in what is happening to them. The same happens with people with respiratory disease and dementia. We have quite strong research about those things that tells us when people are entering into that—I am not saying just the last few days of life. Even I guess "end of life" is language that we have been talking about. Language is really difficult when you are talking about high and low care, palliative care, the palliative approach; we are talking about maybe different things. It is really complex and complicated in just getting something that we all understand what we are talking about. So end-of-life care could be months, weeks or three days. I think there are signs for the registered nurse to be able to be taught and, I guess, highlighted that it is time to start planning for end-of-life care.

Ms HERON: Would you please repeat your question?

The Hon. WALT SECORD: How are registered nurses able to alleviate suffering at the end-of-life care?

Ms HERON: The real important role certainly from their perspective in their training, whole-person care. So sometimes we can get caught up in just caring for the physical aspects of care of a person. I think for me palliative care, end-of-life care, the care of the person is certainly much more than the physical person. So I really want to be thinking about holistic care, psycho-social aspects of care, the emotional, the spiritual as well as the physical; having the clinical training and experience to identify those aspects of the person in their care needs, to see how to respond to those when they are being expressed in the person as they are entering end stage, and knowing how to respond to symptoms.

Some of our tools in aged care certainly refer very clearly to pain and you can certainly skill both your care teams and your RNs in picking up signs of pain. But it is also quite intricate that restless agitation and so forth can be the signs of other things, shortness of breath, existential and spiritual distress, and knowing how to pick up those things and manage those appropriately. We do not have to just give one particular subcutaneous medication fourth hourly willy-nilly. Knowing how to respond to those things and how to position people correctly, leading your care staff into the use of positioning to help with upper airways secretions at end of life and helping them to know how to support family, I think that is key.

We have family in crisis, often with protracted dying. Knowing how to come alongside them and explain in a sensitive and clear way about what they are seeing in terms of the process of dying leading up to and actually at end stage, and to really demystify and lower fear. I think that is a really important role, very critical, with a registered nurse.

Ms HANSEN: As a non-clinician, I do not think I can add to that.

The Hon. BRONNIE TAYLOR: I want to flesh out some things that you have been discussing. I also draw on my own experience as a palliative care nurse for a number of years. The geriatric medicine experts who gave evidence talked about syringe drivers and, in your case, story number five. When we ran our service in the country, there were facilities at which we ran things very successfully. There was not a registered nurse overnight but we were on call and provided an on-call service. I was using the example of using syringe drivers.

What you have been saying is that so much of palliative care is planning and knowing about the symptoms as much as we can. I mean, everybody does it differently and we all acknowledge that but in certain situations there has been a plan put in place and it is working effectively. You have a relationship with the closest hospice so you are checking in with the palliative care medical specialist every day, you are visiting every day and they have got you on call but there is not necessarily a registered nurse overnight but the syringe driver works well. I can honestly only remember once when I was called out for syringe driver, but I was there within 40 minutes and there was no ill effect. I did not even have to do a bolus as a break through.

What I am saying is perhaps when we look at models of care we have to also look at differing models of care for different situations. Also coming on to what you said, sometimes we need to accept that someone's care is so complex that we do need to bring them into a specialised facility for a while to stabilise them and then take them back to wherever they were. I was very grateful that you brought that up, because I think that is something that has been missing. My question is I have seen the evidence of that working, so what do you think about that?

Ms DANE: Firstly, I would say that what I have seen over the past 10 to 15 years is the change in the people who are in aged-care facilities, in hostels and nursing homes. I think some time ago people went in and it was a real social model of care for aged care, especially in hostels. That is not what we are seeing now. We are seeing quite ill people—I am not saying everyone but I would say there are a good number of people in hostels who do require nursing care as well as that other aspect of their life, that social sort of lifestyle-type care. The first thing I would say is people are more elderly. We have got a huge number of people in their nineties now who have so many comorbidities as well as dementia. It is quite complex.

In fact, having worked years in the community I would say aged care is the most challenging area I have ever worked in. I think community palliative care is much easier—much easier in understanding where people are up to and understanding the illness-death trajectory. Aged care is quite different. I guess that would be the first thing I would comment on. I do agree that people at home look after a person on a syringe driver and they are untrained, but they look after one person with one lot of drugs. When you have a number of people in a

facility that might require that, which is my experience in the places that I am working, it is a different kettle of fish.

The Hon. BRONNIE TAYLOR: I suppose the point I am trying to make is if in a rural and regional hostel facility someone enters a terminal phase but they have been there forever, they want to stay there, the staff are willing to be educated and learn and there is an on-call community nursing team—team sounds great, it is always one person—then that person is able to stay there. That is one person in that facility who is at that time dying; it is not a high-care facility with 47 people that are perhaps heading towards a terminal phase. There is such a wide variety here that it is not one size fits all.

Ms DANE: I agree one size does not fit all but at the same time I think what we are seeing is more and more people with more and more acuity. It is changing. Those people we used to see in facilities are now at home until they need that extra care.

The Hon. NATASHA MACLAREN-JONES: I wanted to get an idea of your structure and membership base. Are you representing individuals or other organisations?

Ms HERON: We certainly very much are a group of like-minded individuals, so we step out of our particular organisations and connections. I think we came together with like-mindedness and a passion and interest in palliative care and found that we were all embedded in some way within aged care, either employed by a larger organisation, working in a link role between specialist palliative care and aged care or working in a link role between acute geriatrics and aged care. So we found ourselves together as a network with a common passion.

We come very much as individuals to this group in order to bring together our passion and to see if we can move forward into this area of palliative care and aged care where we are seeing such a lot of change and so much more complexity and acuity in the people that we see every day in our roles within these aged-care facilities. We are coming together and trying to work out a way forward to ensure that we are providing best-practice palliative care in all the settings we are in. Also we are hoping to influence other people providing palliative care and aged care.

The Hon. SARAH MITCHELL: My question is in relation to your Care Story 4 and specifically the advance care plan. Earlier today witnesses from Alzheimer's Australia talked a bit about when residents go to hospital and the advance care plan gets lost. You mentioned that the staff did not really know what to do and the ambulance officers did not follow the plan. I want to hear your views and experiences of how the advanced care plan system is working and where it needs tweaking, for lack of a better term.

Ms HERON: This is a huge area of passion for me. I think there has been real recognition by State and Federal government about the importance of advance care planning in all settings. In our acute settings we are trying to raise awareness in community as well as aged care. It is critical in the point of aged care because we have a whole lot of facilities full of elderly ladies and gents with life-limiting illnesses and that, more than any other time, is a time when we should be thinking about wishes. This is about people's choice and about their wishes of where they would like to live and also where they would like to spend their last days. So we should very much be talking about advance care planning. It is one of the most misunderstood areas in any setting where I have been. It becomes very confusing because everyone gets hooked on the bit of paper, the document, whether it be the advance care directive or whether it be the advance care plan or plan of care. They are different things.

I think there is confusion not only within the ambulance service but also with GPs and with our acute facilities and also with our care teams on the ground. One of the things I do most of my education about within my role is trying to upskill people about what is the role of advance care planning and I try to upskill people on the importance of the decision-making. Who is the substitute decision-maker? When does that come into play? And I educate them about trying to use the correct language. There is lots of misunderstanding around the enduring guardian, power of attorney and all those things. They lead to this confusion. I think we really need to work on that. I know there is a program in play at the moment, Decision Assist. There have been some opportunities to get that moving. It is new on the ground and so it is still moving out there but it was a huge opportunity and an endeavour to try to raise this awareness, which is very important because it leads to confusion.

The Hon. SARAH MITCHELL: That is probably across the spectrum of people that work in aged care from what you said. Everyone from GPs on down could probably do with—

Ms DANE: Definitely.

Ms HERON: Definitely, because what is so critical in the way we move forward is whether you have actually had an informed conversation around a person's wishes and whether the person themselves expresses those wishes or whether they are expressed by the substitute decision-maker and you formalise that into a plan of care. That is most of what we are seeing in our facilities, because once you have lost cognitive capacity you are not able to complete an advance care directive. That needs to be clarified.

The Hon. BRONNIE TAYLOR: I have felt during the evidence that sometimes this is seen as a bit of an us-and-them situation, it is the aged-care facility and then that person having an inappropriate admission to hospital. In your opinion should we not all be working together to get the best outcome for the residents? If someone is really unwell—unstable is the wrong word—but let's say their pain is really exacerbated and out of control, which does happen, it is often about stabilising that person, working with the specialist, and then getting them back, when they are in a more stable position, to their facility. Is that not what we should be aiming towards?

Ms HERON: Absolutely.

The Hon. WALT SECORD: Therefore registered nurses in aged care.

Ms HERON: It is absolutely imperative that that planning goes ahead. Certainly we want to make sure that people head to our acute facilities or they have access to all—there are a lot of great things available. Certainly one of our key things as specialist palliative care nurses is that we are aware of those specialist teams and services all over New South Wales. Part of our responsibility is to ensure that we are linking up to those and that people get all the things that they are entitled to as part of that. That could be the In Reach geriatric assessment team, that could be a geriatrician, or that could be into hospital to have something acutely sorted. But when people return to us after they have had an admission to hospital they are more unwell. Although they are more stable, their care needs will be greater. There will be different things that we need to do. There will be a change in the plan and the focus of care, and a registered nurse is key to ensuring that that is able to be provided.

The Hon. BRONNIE TAYLOR: The education you talk about—you have registered nurses educating other members of staff within a facility to carry out the care plan that is set?

Ms HERON: Yes.

Ms DANE: Can I make another point about people coming into the facility, going to hospital and then coming back? What we are actually seeing is people coming into facilities from hospices. They have spent the time that they can in the hospice; they are quite ill—people with motor neurone and those sorts of neurological diseases or cerebral tumours. That is another area where I know that we need RNs to look after people who have that sort of acuity.

CHAIR: Thank you for the work that you do. You have been doing it for so long. It is such important work not only for the person but also the family and everyone else that is around. Ms Dane commented that we are all talking about different things but a big part of care is that you take every opportunity possible to avoid a crisis or problem.

Ms DANE: Yes.

CHAIR: I think everyone understands that. For me the essence of what we are hearing is that you do not take risks with your loved ones. You seem to be saying that to avoid risk a registered nurse gives you the safest guarantee.

Ms DANE: Yes, I would support that.

Ms HERON: Absolutely.

CHAIR: I have been through a fairly recent experience myself and the palliative care was so important for everyone in the process.

Ms DANE: I think it is only when you do go through it personally that you actually see what is needed. People in the community do not realise exactly what is going on with aged care.

CHAIR: I have an interest in the advance care area. I have been shocked to hear that the wishes of some people are not being respected and that their dignity and integrity is taken away. Am I correct in reading some of your case stories, and from hearing from other people, that some of that is due to the lack of expertise, experience or understanding of the importance of that by people who are not RNs or are not experienced enough to know that someone's issues are really integral to the end of their life and how it happens?

Ms DANE: I think the communication around those conversations is so difficult, and that is the thing that we encourage. A lot of our education is towards helping people to just ask those questions or to the resident: "Are you worried about what is going on with you? What do you want?" It is really difficult, even for the people who have worked in the industry for years and years, to start moving people around to thinking. Often these people already have these thoughts but have not had the right person to talk to about it. It is really around the quality of the conversation of the communication that starts the discussion. I think once there is a plan in place and we know that is what they want then their dignity is upheld, is it not?

CHAIR: Do you have an opinion about the relationship that is developed between a professional who has those conversations and then fulfils the requests of that person to then have a contract? Does that allow them to settle with that and be more at ease and comforted by knowing that that is place, and how that might be such a shock when you get case study four—someone's wishes not being respected?

Ms HERON: Are you talking about the care team on the ground?

CHAIR: Yes.

Ms HERON: If the whole team are on the page and really feeling that they are providing the very best care possible and they know that they wanted those wishes, then certainly our experience of our support of them through the death and then subsequent grief after the person has died is better for them than for those where we have seen a really difficult situation. Because one of the other things that we provide is support, debriefing and reflection for our care teams who sometimes are incredibly traumatised by the circumstances surrounding the death of a resident whom they have cared for and known for many, many years. That is one of those unspoken spaces about: Who does that? Who actually is looking after these care teams? Some of them become quite vicariously traumatised by the ongoing death, and there are increasing deaths within our residential aged-care facilities. They are seeing more people dying.

Before you would just come in and give these lovely people a little shower. They are seeing them deteriorating before their eyes and then dying. If we have not had conversations in planning not only are we planning and having conversations with the family and the resident, we are planning and having conversations with our care team members so they too are able to come to terms with the dying and changing of the people that they love and making sure that they are in fact preparing themselves as well for that dying. We can do that well and in a dignified manner with which they feel comfortable, so that they can go home and then come back again the next day to perform their role.

CHAIR: Thank you for appearing before the Committee today. I cannot recall if you took any questions on notice but you may receive some supplementary questions. If you do, you will be asked for a response within 21 days.

Ms DANE: We must say that we were really pleased that we got the opportunity, even though we were so nervous.

Ms HERON: It was great. Thank you very much.

(The witnesses withdrew)

(The Committee adjourned at 3.20 p.m.)
