

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 Wednesday 5 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 first hearing of the General Purpose Standing Committee No. 3 inquiry into registered nurses in NSW 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 first of three public hearings for this inquiry. We will hear today from the NSW Ministry of Health as well as the Commonwealth Department of Social Services and the Australian Aged Care Quality Agency. We will also hear from a number of peak organisations including Leading Age Services Australia, Aged and Community Services, the NSW Nurses and Midwives' Association, and Council on the Ageing NSW. Finally the Committee will take evidence from Leichhardt Municipal Council.

Before we commence I will make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, 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 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. Witnesses are advised that any messages should be delivered to Committee members through the Committee staff. Finally, could everyone please turn mobile phones either off or to silent for the duration of the hearing. I welcome our first witnesses, the NSW Ministry of Health.

LEANNE O'SHANNESSEY, Director, Legal and Regulatory Services, NSW Ministry of Health, and

LUKE WORTH, Director, System Relationships, NSW Ministry of Health, sworn and examined:

CHAIR: Do you wish to start by making a short statement?

Ms O'SHANNESSEY: I thought it might be useful if each of us just explain behind our title what we do and how it is relevant to the Committee. As director of legal and regulatory services I have responsibility for developing draft regulations and draft legislation for the health portfolio. In that capacity I was requested to convene the steering committee of various stakeholders to look at the issue of the legislation about nursing homes. That is primarily why I am here today.

Mr WORTH: I am Luke Worth, system relationship director. My role and I guess the relationship to this is that I have the whole of health portfolio in my branch, which looks at the way we connect and integrate a holistic approach to care through our hospital systems and non-government organisations, residential aged-care facilities and general practice. Also in my branch as a system relationship is the relationship with the local health districts and how we work with them around improving access to care.

CHAIR: I start by seeking some clarification. We do not have a submission from you. Is there a reason we are unable to receive a submission or is there a problem with a submission being provided?

Ms O'SHANNESSEY: No. Ministry was not proposing to put a submission in. I think this is an important committee and we are as much here to hear about the evidence that the Committee gets. Given that we are looking at the issue ourselves, it is an opportune moment for us to hear what is going on.

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

The Hon. WALT SECORD: Following on from Ms Barham's question, who made the decision that you guys would not provide a written submission to the inquiry?

Ms O'SHANNESSEY: I am not sure. I could not say. The view would be, I think, that we do not generally necessarily do submissions for inquiries. But it would have been a view taken on the grounds that I have just said, and I cannot specifically say which officer would have made that call.

The Hon. WALT SECORD: Mr Worth, could you assist with that question? I have sat for four years now on parliamentary inquiries and Ministry of Health makes submissions on everything, including an investigation into quad bikes and things like that, so I am just curious as to who made the decision that you guys would not make a submission.

Mr WORTH: I am not aware of that. In the role that I have that would not have been part of the conversation that I would have been involved in so I honestly cannot comment on that.

The Hon. WALT SECORD: Ms O'Shannessy, I think the Minister last year extended the regulation until December 2015, is that correct?

Ms O'SHANNESSEY: No, it an open-ended extension.

The Hon. WALT SECORD: Your department must have prepared advice supporting that regulation and its extension. What was the department's advice on the regulation at the time?

Ms O'SHANNESSEY: I will give the Committee a bit of the history on this issue. The Nursing Homes Act was repealed in 2005. At that time the general regulation of aged-care facilities transferred to the Commonwealth under the Aged Care Act. There were residual concerns at the time. I was not directly involved but there were residual concerns not unlike many of the concerns that have been put to the Committee about standards of care. For that reason, a regulation was made, as Committee members would know, requiring a registered nurse to be in attendance at the facility 24/7—that is, covering all shifts.

Obviously when you make a law you need something legislative to hang it off so that you have some degree of certainty. At that time the aged-care legislation referenced high-care allocated places and low-care

allocated places. So we basically defined a nursing home as a place with a high-care allocated place. I presume that was on the basis that there was a view that nursing care would be most critical and most appropriate in that high-care area. So that was put into the Public Health Act because the Nursing Homes Act had been repealed.

The crunch came on 1 July 2014 with the changes to the aged-care legislation when the Living Longer Living Better legislation came in. When that happened, it removed the references to high-care allocation and low-care allocation. So basically the definitions we had attached became meaningless. Arguably, after 1 July nobody was required to have those provisions in place. Given there were still concerns, some of which have been raised with the Committee, we made a regulation that basically said if you were caught by the requirement to have a registered nurse on site the day before the Commonwealth changes happened then you would continue to have to have that in place.

I think it was intended to be transitional. But it is a very complex area and we did not actually put in a sunset clause so we would have enough time to look at all the issues. The issue is that it probably cannot stand over a long period of time because it is a snapshot of who was covered then. Obviously as nursing homes close and new ones open it will gradually be less effective. I think that explains the rationale—we needed to put something in place to hold where we were while we looked at it further. That was the reason for the design of the regulation.

The Hon. WALT SECORD: What happens to a nursing home that was required to have a registered nurse on premises but does not?

Ms O'SHANNESY: It would have breached the provisions in the Public Health Act.

The Hon. WALT SECORD: Have there been any cases of that in New South Wales?

Ms O'SHANNESY: Since 2005 I think we have received three complaints that there has been a breach of the legislation. Two of them were several years ago. One of them is quite recent—it has just been received and is being looked at so it has not gone very far. One of them involved a concern that over a month of shifts there were 11 where there was not a registered nurse in attendance. The Ministry of Health visited, looked at the rosters to see what was going on and discussed with the facility the need to have a registered nurse in attendance. I think that was resolved. In the second one there was a similar investigation and a separate industrial issue involved as well. I think the issues were resolved through the fair work legislation and the Federal fair work processes.

The Hon. WALT SECORD: I think according to the latest figures there are about 880 aged-care facilities in New South Wales. Are you confident that all of those aged-care facilities are complying with the current regulations?

Ms O'SHANNESY: They are not all required to.

The Hon. WALT SECORD: How many would be?

Ms O'SHANNESY: Our figures are based on Commonwealth figures from 1 July 2014, and I understand the figures for the next year are not available yet. There are 939 aged-care facilities in New South Wales—271 high care only, and 323 high care and low care.

The Hon. WALT SECORD: So that is a mixture.

Ms O'SHANNESY: We take the view that those two groups are covered by our requirements, which is 594.

The Hon. WALT SECORD: And you are confident that all 594 are complying?

Ms O'SHANNESY: We have had no information provided to us that they are not.

The Hon. WALT SECORD: Are there any regulation checks or do you just take their word for it?

Ms O'SHANNESY: There are different forms of legislation. When we have a stand-alone legislative provision requiring something, we would usually have a complaints-based system. If there is a complaint, we

would investigate it. As I said, we have had three complaints—two of which have been finalised and one that is very recent. If you have a whole regulatory regime then of course you have a lot more checks and balances such as compliance audits and reviews. What we have in New South Wales is a single provision. Obviously the Commonwealth has that sort of broader regulatory regime and accreditation process.

The Hon. WALT SECORD: How many people are employed within the Department of Health to monitor, follow up, investigate and examine these 594 aged-care facilities?

Ms O'SHANNESY: There is no role for us to monitor and follow up. As I said, it is a complaints-based process. If there is a complaint it will be investigated. That role is undertaken through my area. I have a private health facilities unit that previously looked at nursing homes and they take this function on as well.

The Hon. WALT SECORD: Do you know how many people are employed in that unit?

Ms O'SHANNESY: There are about 10 in that unit.

The Hon. WALT SECORD: Ten?

Ms O'SHANNESY: Yes.

The Hon. WALT SECORD: Do you think there is a correlation between the fact there are only 10 people monitoring 594 nursing homes and of those 10 people probably six or seven are administration? How many people are actually looking at this area?

Ms O'SHANNESY: Can I just go back. I need to clarify that they do not have a role monitoring nursing homes.

The Hon. WALT SECORD: So no-one is monitoring nursing homes?

Ms O'SHANNESY: The role of monitoring nursing homes is through the Commonwealth department and accreditation agency. I understand they will be giving evidence, so I think the issues of staffing and how many staff they have is probably more relevant to that broader regulatory accreditation role. What we have is a single provision in the Public Health Act that we operate on a complaints-base process. Where there is a complaint—a complaint of breach of any other of the State laws—we will investigate that, look at the rosters and take action, if necessary or appropriate.

The Hon. WALT SECORD: You think that there have only been three complaints in 11 years?

Ms O'SHANNESY: That is the information I have.

The Hon. WALT SECORD: Really?

The Hon. COURTNEY HOUSSOS: I am interested in the last comment you made that there is no role for the New South Wales department to monitor a New South Wales regulation. I was wondering if you could explain why there would not be a role for monitoring a specific New South Wales regulation and why that would then be covered by the Federal agency?

Ms O'SHANNESY: I do not think I said we do not monitor a regulation. What I said is, where you have different forms of regulatory mechanisms you have different enforcement and compliance tools. Where you have a comprehensive regulatory regime, such as we have with private health facilities legislation, such as we have with registered health practitioners, you will have a range of tools such as regulatory monitoring, inspections, and complaint mechanisms, but when you have a single offence provision that is quite narrow on what it requires—it does not deal with the quality of care in nursing homes; it is simply whether there is a registered nurse in attendance—it is appropriate that we do it on a complaints-based process.

The Hon. WALT SECORD: You said you do not check quality, you just check that there is a nurse there. Do you look at anything else?

Ms O'SHANNESY: We have no powers to check those things. I would presume that if we went to a nursing home and there were those issues, we would refer it to the Department of Health and Ageing [DoHA].

The Hon. WALT SECORD: Mr Worth, are you aware of reports that aged-care facilities in New South Wales that do not have the appropriate staff training are taking elderly patients to emergency departments and dumping them? There were reports in December of this during the Christmas holiday period.

Mr WORTH: No, I am not aware of those reports.

The Hon. WALT SECORD: You do not read the *Sydney Morning Herald*?

Mr WORTH: I mix media myself. I am aware of what is going on in the media. To be fair, what is in the media is not always a clear and accurate reflection of what may be going on.

The Hon. WALT SECORD: Did the department investigate claims that aged-care facilities were, during the Christmas holiday period, taking "too hard to handle" cases, such as people with catheter problems, to emergency departments?

Mr WORTH: I am not aware of that. In my area of responsibility that is not something that would be raised within the remit of my role.

The Hon. WALT SECORD: Has your unit provided any advice to the Minister on the regulation?

Mr WORTH: No. The purpose of my branch is the integration of care with residential aged-care facilities. It is really having a look at how we integrate with those and how we provide an end-to-end continuous provision of care. We have multiple models across the State where we are working with our partners, whether they are at a residential aged-care facility or general practice. Despite there being different data systems, different monitoring systems, we are able to look at how we mismanage patients in the most appropriate place.

In many cases we have a number of examples where we provide support, whether it be through training, whether it be through geriatric flying squads—as we have in south-east Sydney—local health districts, working with the residential aged-care facilities, or the Geriatric Rapid Acute Care Evaluation Team [GRACE] program, which is a program out of the Hornsby Ku-ring-gai Hospital and other hospitals where we have a clinical nurse consultant [CNC] working with 45 residential aged-care facilities in that area. We have a look at the holistic delivery of health care and how we work in partnership with our agencies outside of the State-funded Health service. My area of focus is on how we integrate those systems and work together.

The Hon. COURTNEY HOUSSOS: Do you believe that the increase in the care of residents within aged-care facilities—

The Hon. SARAH MITCHELL: Point of order—

The Hon. WALT SECORD: I thought that was an indication there was two minutes left?

CHAIR: No, that is the final question.

The Hon. SARAH MITCHELL: The question can be put on notice.

The Hon. WALT SECORD: In previous committees we were given an indication that there were two minutes remaining.

The Hon. SARAH MITCHELL: Okay, but that is the time.

The Hon. WALT SECORD: We operated on the premise that we thought we had two minutes left. Can Ms Houssos ask her one question?

The Hon. SARAH MITCHELL: She can put it on notice.

The Hon. COURTNEY HOUSSOS: It is a simple question.

CHAIR: Excuse me.

The Hon. NATASHA MACLAREN-JONES: It encroaches on other people's time.

CHAIR: We will wait to see if there is time at the end. We will move on to Reverend the Hon. Fred Nile.

Reverend the Hon. FRED NILE: Can you clarify for the Committee the activities of the internal committee, the NSW Health Aged Care Steering Committee? Have either of you directly responded to that committee?

Ms O'SHANNESY: Yes. I convene it for the Ministry. It follows on from the transitional regulation that we made. The view was that we could put it in a holding pattern to keep the regulation in place and use the period after that to get a committee together of the key stakeholders with an interest in the area to look at the issues. We had had the regulation in since 2005. It is now 2015. It was appropriate to say let us look again at this with a bit more consideration and get everybody engaged with an attempt to try to reach a consensus amongst the different people about what would be the best way ahead.

Reverend the Hon. FRED NILE: What was the time line for establishing the committee?

Ms O'SHANNESY: The committee was established shortly after the regulation was made. Initially we were hoping to respond with a report from that group to the Minister in July. Then this parliamentary Committee began its work so it seemed appropriate, and having looked at the huge range of detailed submissions that had been put to the Committee I think that is borne out, that we should hold off completing that work to allow us to hear what is said before the Committee and what the Committee's views might be before we finalise that. The only other thing I should say is when we established it, the idea was to try to get a consensus. There is a consensus among all the groups that good patient care is what we should be about, good residential care, and ensuring the health and safety of residents, but there are very diverse views about how to get there. We were in the process of looking at a fairly broad range of options to put forward.

Reverend the Hon. FRED NILE: Prior to this Committee being established, did the steering committee do anything? Were there some considerations?

Ms O'SHANNESY: Believe me, we did a great deal. We have looked at legislation in all the other States and Territories. The Committee is probably aware that no other State and Territory has specific legislation in the aged-care sector. However, it is important to note that all States and Territories have a role in relation to medicines and poisons regulation. That is a critical issue to the availability and oversight of schedule 4 and schedule drugs, prescription drugs and drugs of addiction, which would include serious painkillers. As part of that committee's work, we have been giving the group advice on what New South Wales thinks needs to be done in relation to those medicines, because it is not a question about whether we have a role there or whether there is duplication; it is a primary State role. Falling off the work of the committee, we have recently issued some draft proposals for medicines and poisons, about the level of oversight that is required. Submissions were recently received back. I think the committee met four or five times over that period.

We also had the Commonwealth involved. We asked for data on that. We discussed our positions in quite a lot of detail and we spent a lot of time trying to think up various options. The easiest two options are to say that we will remove the provision—because that is a very straightforward thing to do—or to leave the regulation as it is—because that is simple, although over time it is not very satisfactory—and we were also looking at various options if New South Wales determined that it wished to stay at the State level then how would it design something. One of the major problems with the changes is, as I said, with removing that very clear reference in a statute that you could reflect, it becomes very difficult to try and design a legislative regime that can work with some certainty. I am not saying it is impossible, and it is my job if I am asked to do this then we need to find a way, but it is very difficult. So there has been lots of work done on that.

Reverend the Hon. FRED NILE: That steering committee is to be reconstituted or will have a meeting following the report of this Committee?

Ms O'SHANNESY: Yes. Because people have very strong views everyone wanted to make sure that the material that was sent up to the Minister properly reflected their views. It has taken a while but a lot of it was distributing everything, making sure we got everybody's comments back. We are at a position—my own view is

that we would need to reconvene that group to discuss the position that might be taken in response to this Committee's work.

Reverend the Hon. FRED NILE: I assume there eventually will be a report from the steering committee. Will that report be made public?

Ms O'SHANNESSY: We have been asked to make a report to the Minister. I do not think we have taken it any further than that.

Reverend the Hon. FRED NILE: My next question concerns your earlier comments about complaints—namely, such a small number of complaints. Is there a clear procedure for residents and proprietors as to the complaint procedure? If people do not understand that there is a procedure or how it works then that is an easy way to have a low number of complaints. I find often in government departments, for example, people do not know how to make a complaint or who to make a complaint to.

Ms O'SHANNESSY: Yes. There is no procedure that we have put in place; however, again I think at least two of those matters were either initiated or referred to us through the accreditation processes of DoHA. In the Health system for our doctors we have lots of information for patients about how to make a complaint, I would expect that they may be able to speak to what processes they have for ensuring that residents know their rights and can make complaints.

The Hon. SARAH MITCHELL: My question relates to the steering committee that Reverend the Hon. Fred Nile asked you about. You said the steering committee is made up of key stakeholders. Are you able to provide any information about who is actually involved in the committee?

Ms O'SHANNESSY: Yes. I can give you this little piece of paper.

The Hon. SARAH MITCHELL: You can table that if you want to and you can also talk to it.

Ms O'SHANNESSY: I will just read it out. There are representatives of the Ministry of Health; Age and Community Services, New South Wales and Australian Capital Territory; the Australian Aged Care Quality Agency; Australian and New Zealand Society for Geriatric Medicine; Combined Pensioners and Superannuants Association of New South Wales; Commonwealth Department of Social Services Ageing and Aged Care; Leading Aged Services Australia, New South Wales and Australian Capital Territory; NSW Nurses and Midwives Association; and the Royal Australian College of General Practitioners.

The Hon. SARAH MITCHELL: Concern was expressed in the submission from the NSW Nurses and Midwives Association to this Committee about the final report. Just to clarify what you said to Reverend the Hon. Fred Nile—namely, the steering committee will meet again and its report has not as yet been finalised?

Ms O'SHANNESSY: No, it has not been finalised.

The Hon. SARAH MITCHELL: So there is still capacity to feed into that steering committee process what this Committee may determine or recommend as well?

Ms O'SHANNESSY: Yes.

The Hon. SARAH MITCHELL: I turn now to the area of complaints. You have mentioned three complaints that have come through your section of the ministry. This Committee has received quite a few submissions from people who had concerns about things that had happened to their loved ones in certain facilities. Would it be fair to say that a lot of those complaints would be feed through the federal system?

Ms O'SHANNESSY: That is what I would expect.

The Hon. SARAH MITCHELL: So the figures you have only relate to those you have responsibility for. Questions about where there might be more issues would be better directed to the Commonwealth when they appear?

Ms O'SHANNESY: Yes. In this system of Federal and State governments that we work in you will get people saying generally about the policy position or their concerns about the regulation of aged-care facilities generally, so that would be referred to the Commonwealth.

CHAIR: The bells are ringing. I am having trouble hearing the witness.

Ms O'SHANNESY: There are specific complaints but as in any State and Federal system where there are different agencies involved you will get more general letters to the ministry or to the Minister about unhappiness with aged-care regulation and the like and we would refer those to the Commonwealth.

The Hon. NATASHA MACLAREN-JONES: My question goes to your opening remarks particularly in relation to section 104. You said it was introduced in 2005?

Ms O'SHANNESY: A similar provision was in the old Public Health Act and it has been remade in the 2010 Public Health Act.

The Hon. NATASHA MACLAREN-JONES: No other jurisdiction has this provision?

Ms O'SHANNESY: No.

The Hon. NATASHA MACLAREN-JONES: What is the history behind New South Wales introducing that provision?

Ms O'SHANNESY: As I said, I was not involved with that but from my understanding there were concerns raised similar to the concerns that have been put to the Committee by a variety of stakeholder groups, including the NSW Nurses and Midwives Association and maybe the Combined Pensioners Association. Those types of groups that are very close to these issues had raised concerns. I think that is why it was put in.

The Hon. NATASHA MACLAREN-JONES: How do we compare to the other jurisdictions that do not have this legislation? Have there been a number of problems in other States because they do not have this provision or is it similar?

Ms O'SHANNESY: The complaints data does not appear to show any major differences. We are only using the public data available from the Commonwealth. With any data it is how it is collated. I do not think there is an issue in that data about whether there is a registered nurse on site or not. Again, the Commonwealth may be able to provide more information about its complaints processes and the data that they have had over the last 10 years I presume.

The Hon. NATASHA MACLAREN-JONES: I also wanted to ask about the staffing breakdown in nursing homes—namely, the different types of care provided by different staff. Can you outline that for the Committee?

Ms O'SHANNESY: Probably that is not in my area of expertise. That would be more an operational question. If any aged-care providers are here or the Commonwealth that they may be able to provide more detail. I can only say that I am sure there is a range but that would not be very expert advice.

The Hon. BRONNIE TAYLOR: When you look at the number of 594 what would be the breakdown between rural and the metropolitan aged-care facilities?

Ms O'SHANNESY: I do not know what the breakdown is between metropolitan and rural.

The Hon. BRONNIE TAYLOR: I refer to the questions asked by Reverend the Hon. Fred Nile and the Hon. Sarah Mitchell. Is what you are doing in your inquiry based very much on gathering all of the evidence and then coming up with a conclusion?

Ms O'SHANNESY: We are seeking to reach a consensus, if possible, amongst the whole group. At the point we had got to we had come up with a range of options that different people could, more or less, strongly support.

The Hon. BRONNIE TAYLOR: Has there been collaboration between New South Wales and the other States on this issue? You said previously, "I note that no other State has this requirement." Have there been discussions between your department and equivalent departments in the other States about this?

Ms O'SHANNESY: No. We simply looked at their legislative regimes. So there were some fairly low-level inquiries made of different agencies about what they were doing. The key feature was that there was no general regulation of aged-care facilities and no specific staffing legislation requirements but all of the States and Territories have fairly comprehensive poisons and medicines rules around aged-care facilities, which is what we are also pursuing.

The Hon. SARAH MITCHELL: With respect to the 939 aged-care facilities, 271 are high care. Are they all high-care placements?

Ms O'SHANNESY: Yes.

The Hon. SARAH MITCHELL: There are 323 high-care and low-care facilities. I presume there are, then, 345 low-care facilities to add up to 939 aged-care facilities.

Ms O'SHANNESY: I trust your mathematics.

The Hon. SARAH MITCHELL: So there are some that are just low-care facilities.

Ms O'SHANNESY: Yes.

The Hon. SARAH MITCHELL: At the moment, if, prior to the cut-off day—the day before—they did not have a requirement for registered nurses, that still continues.

Ms O'SHANNESY: Yes; that continues.

The Hon. SARAH MITCHELL: So that is hostel-type accommodation.

Ms O'SHANNESY: Yes. That would be a range of lower-level care.

The Hon. SARAH MITCHELL: So they are just continuing.

Ms O'SHANNESY: Yes.

The Hon. SARAH MITCHELL: At the moment everyone is as they were before until some sort of further decision is made, pending your committee.

Ms O'SHANNESY: Yes. With respect to the regulation we put in place, we basically grandfathered the provisions. Those who had to do it still have to do it irrespective of whatever care they are providing and the others do not. So over time it will gradually be eroded.

CHAIR: Can you just clarify what the position is for new facilities in relation to what existed before.

Ms O'SHANNESY: New facilities will not be covered by the regulation because it is grandfathering in relation to terminology that does not exist anymore.

CHAIR: Do we have any indication about the residents within any new facilities—the needs of those people and who the facilities are providing for?

Ms O'SHANNESY: No. I think there are a range of instruments, guiding principles and accreditation principles. If they are aged-care facilities recognised under the aged-care legislation there are requirements that flow from that more generally in relation to Commonwealth standards.

CHAIR: Is it the case that New South Wales Health does not receive reporting or does not have an understanding of the numbers of people who are in aged-care facilities and the level of care that is being assessed?

Ms O'SHANNESY: No.

CHAIR: So we are operating under a system where it is transferred to the Commonwealth. New South Wales is in an "I don't know" situation.

Ms O'SHANNESY: No. Ten years ago New South Wales brought in a regulation as a baseline, single requirement. That has changed. So if you have a comprehensive legislative regime at the Commonwealth level and no other State and Territory has legislation, that raises the question of why you have it. But on the other side you have very strong anecdotal evidence and concerns in the community about this issue. So you really have to look at all those issues.

The Hon. BRONNIE TAYLOR: In terms of accreditation and the organisations that accredit the aged-care facilities, would it be fair to say that, to ensure accreditation, you would have to have demonstrated a very transparent and, I suggest, robust complaint mechanism? I am looking that as an internal first point of call.

Ms O'SHANNESY: All I can say, because it is really a Federal matter—I am sorry—is that my understanding is that some of the guiding principles include ensuring that there are appropriate complaints mechanisms. But I would suggest you query the Commonwealth more on that.

The Hon. NATASHA MACLAREN-JONES: I have a question in relation to our terms of reference regarding the Living Longer Living Better amendments. Do you believe that there has been any impact on the safety of residents in nursing homes since that has been introduced?

Ms O'SHANNESY: I am not in a position to comment on that.

The Hon. NATASHA MACLAREN-JONES: No complaints have come forward to you saying that there are fears?

Ms O'SHANNESY: We have had a complaint in the last week or so. That is the third complaint that we have received. We have received many letters of general concern from people who are very worried about what they see as a safety net potentially being removed—but nothing specific.

The Hon. NATASHA MACLAREN-JONES: Would you say that the complaints relate more to some of the media and the organised campaigning around that issue?

Ms O'SHANNESY: I think that that brings it to people's minds. Obviously, it makes people think of these issues so we have received a substantial number of pieces of correspondence in the last two months.

Reverend the Hon. FRED NILE: You have listed who is on the steering committee. Will you act as the adjudicator at the end of the committee's discussions concerning the recommendations? I would assume that the New South Wales Nurses and Midwives' Association would have some strong views but may be outvoted by other, administrative people—not hands-on people. How do you assess the steering committee's decision?

Ms O'SHANNESY: Most of the people on the committee are either hands-on service providers such as nurses or medical practitioners or aged-care providers. I think there may be two from the Ministry. So we do not have the numbers but the approach to date has been to get a consensus. That is why, to date, we have not been heading for any firm recommendations. We all agreed on broad principles but, as I said, there were divergent views on how we should meet them. The issue was to design a range of options, put the pros and cons and indicate the views of the various committee members on what they felt was best. What exercised me more was the design of some of those options and trying to make sure, both legislatively and operationally, that they had some practicalities.

Reverend the Hon. FRED NILE: Has there been any pressure from the owners of the nursing homes, as an economic measure, not to have the full-time registered nurse on duty?

Ms O'SHANNESY: No. Each of the stakeholders at my committee—there were some aged-care providers—put forward views. I think there may be some financial issues, particularly if there was a view to extend them to low-care facilities. That would become a big cost issue. But in discussion there has been no pressure.

CHAIR: I would like to ask a question about a submission that was made by New South Wales Health to the Commonwealth about the proposed amendments to the Commonwealth Aged Care Act. I would just like you to read from that submission and ask you for comment. It states:

Under the Aged Care Act 1997 and the New South Wales Public Health Act 2000, high level care residents currently require care to be provided by a registered nurse. NSW Health believes it will be critical to continue these existing regulatory requirements to ensure care quality. The overview paper is silent on this matter. It does not include reference to the role of registered nurses, enrolled nurses and assistants in nursing. It should be a priority that legislation to establish the quality agency includes requirements which specify that a registered nurse must be appointed as the director of nursing, or similar title, at a residential care facility and a registered nurse must be on duty in a residential aged care facility. A strong focus on safety and quality of care is critical if the distinction between high and low level residential care is removed.

The current regulatory framework requires that enrolled nurses and assistants in nursing work under the supervision of a registered nurse. NSW Health believes this should be upheld across all residential care facilities to ensure quality and protection of the public.

That submission is dated December 2012. Are you able to provide any update, change of view, or whether or not what happened in the process resolved any of those statements?

Ms O'SHANNESSY: Can I seek clarification? I am not familiar with that submission. So this was a submission to the Commonwealth?

CHAIR: Yes.

Ms O'SHANNESSY: I think we would probably like to take it on notice and clarify the source of that submission.

CHAIR: That would be good.

Ms O'SHANNESSY: But I would make the observation that one of the issues to look at is whether, with the changes from the previous arrangements to living in place and those variabilities—my understanding is that the guiding principles under the Commonwealth regime have not changed. I think that probably goes more to that question should there be some rethinking of that.

CHAIR: I would be very happy for you to clarify the comments that were made in December 2012 and where we are at at the moment. I will make that available to you so you can respond in writing. That would be valuable. Reference has been made to the issue of transfer of residents to emergency departments. Is it not possible that you would know and be made aware of any callouts to Ambulance NSW and transfers from residential facilities to emergency departments?

Ms O'SHANNESSY: Yes.

CHAIR: Is that information available?

Mr WORTH: The information available is very one dimensional and I will qualify that. As Ms O'Shannessy said earlier, there is a body of information we have available for us within the devolved model of NSW Health. So while we could have raw data on the number of ambulance transfers from a residential aged-care facility to an emergency department, each of those emergency departments are run under a local health district, if you needed to know. For instance, there are legitimate reasons why the elderly need to go to a hospital.

In some cases they may be transferred by ambulance to go there for their dialysis or renal follow-up which is a regular occurrence because often that cannot be delivered, and should not be delivered, in a residential aged-care facility; it needs to be done on site at a hospital facility. There would be legitimate reasons why they may be taken there where their care needs to be provided at an emergency department. We would have raw data on the number of transports by ambulance from a residential aged-care facility to an emergency department.

CHAIR: Just to clarify that, are you saying you would have raw data?

Mr WORTH: Correct.

CHAIR: Are you informing us that you do not have any more detailed data that would inform NSW Health whether or not there is a transfer and a shifting of cost from residential facilities to NSW Health by the transfers that are happening and whether or not there is a reason behind that?

Mr WORTH: You would need to look at each individual case and see why they came to the hospital.

CHAIR: So in this wonderful age of technology you do not have a standardised process for defining that and resolving it?

Mr WORTH: You would need to go through the individual clinical notes for each person who comes through. You could have a look at the level—

CHAIR: My interest is whether NSW Health feels it has a responsibility to review any of that information. Is it possible that you might have raw data about the transfer of patients from residential?

Mr WORTH: I am happy to take that on notice. My comment to that would be at a local health district level—one of the issues we are trying to overcome and one of the barriers we are working very hard on overcoming, and when we talk about integrated care—there is information within the system for residential aged care, the general practitioners and the type of systems they use, and then there are the systems we use in the State-funded health services through our admitted patients and our ED data and all of that. One thing we are working on very hard at the moment is how to bring those two systems, which are completely funded differently, completely monitored differently and have completely different data sets, so that we can look at how you can seamlessly start to flow those patients from one to the other.

So the models I was talking about earlier, at a local health district level there will be cohorts of patients who will be tracked and followed and we will look at how many times they may present, whether they come from a residential aged-care facility or whether they come from a regular arrival to the emergency department from their general practitioner. We have a look at that and then we say, "What are the major causes for why they are coming? What are their underlying health issues? How do we best put systems where we can holistically look at that? Tele-health is a good example—

CHAIR: Any information you could provide would be valuable because the experience we have had from submissions, and I know from my experience on other inquiries and within my local community, is there have been calls for some time for a standardised template based setting from the State to allow the analysis and collation of information uniformly across the State. Technology is the great tool for us to be able to do that, so I would have thought NSW Health might have moved down that path. I turn now to the point about complaints. The regulations, the accreditation standards under 1.4, unless there is further information I am not aware of, states:

Each care recipient, or his or her representative, and other interested parties have access to internal and external complaints mechanisms.

My experience is that it is very difficult for people to find out where and how they complain. If that is a standard, if there is not greater detail needed for accreditation, I would say that is a standard that leaves people in a position where they need to ask, to follow up. What I hear from some people is they go to a lot of trouble to find out where and how they can complain. If they are not able to make a complaint directly to you, is the Health Care Complaints Commission a source of complaints about residential aged-care facilities?

Ms O'SHANNESY: The Health Care Complaints Commission's role is in relation to health services and health practitioners, so one would think there is a considerable overlap.

CHAIR: But you did not mention them in terms of any complaints coming from the commission to you?

Ms O'SHANNESY: No. We have not received complaints from the commission.

CHAIR: Do you think that, for an accreditation standard, it is appropriate that it is not defined that each recipient or representative of the recipient is required to be given the information regarding how they can make a complaint? Is that not a standard that would be more acceptable than a vague thing or is there further detail?

Ms O'SHANNESY: These are not our accreditation standards, obviously. They are the Federal regulatory standards, but my understanding of an accreditation system is that there are standards and then there are processes where they check and they do those visits and they check everything. I do not think it is just that standard; it would be part of that process. Again, as the regulator of aged-care facilities, that would be appropriate to talk to the Commonwealth.

CHAIR: But New South Wales does not take a proactive role in undertaking this?

Ms O'SHANNESY: Because we are not the regulator of aged-care facilities.

CHAIR: It is important for us as we are trying to establish what a defined standard is for people in New South Wales. In relation to references to other jurisdictions, are you aware of any other ways in which other jurisdictions are defining that there can be either a definition of the ratio of support people in residential facilities or any standards for the provision of registered nurses?

Ms O'SHANNESY: No.

CHAIR: Is there no other means by which any other jurisdictions provide a greater level of service?

Ms O'SHANNESY: I am not aware of it but I think the reference I made earlier to the regulation of poisons and medicines is very relevant because all States and Territories have regulations in that area. That does impact. For example, if you have schedule 8 medicines and you require oversight by a registered nurse to dispense those medicines, you automatically need that nurse to be present in the facility. Over the control of poisons and medicines you have to have expert clinicians doing that and all States and Territories have those in place, so that has a flow-on impact on staffing.

CHAIR: So that means that in some circumstances, particularly in high-care facilities, they may have a requirement if the—

Ms O'SHANNESY: I do not feel expert to say in particular high care; it would be about needs of the patient. For example, palliative care is where it usually comes up. There are all the extra requirements and controls and destruction obligations. A broad proposal has been put up by Health to update our regulation of this area. As I said, submissions have just closed and we will go through all the comments we have had back.

CHAIR: Are you referring to the steering committee you mentioned before as looking at other models?

Ms O'SHANNESY: We ensured the steering committee were briefed and consulted on the proposal before it went out publicly for everybody to look at. Irrespective of where New South Wales may end up on the requirement in the regulation and the Public Health Act, New South Wales has to regulate poisons and medicines and will do so. It is a parallel process: whether we keep that requirement or get rid of it or whatever we do with it, we still will regulate the poisons part. That goes on but because it is relevant to this work, we are making sure the committee is kept advised.

The Hon. WALT SECORD: Ms O'Shannessy, you said that you differentiated between a letter of concern and a complaint. When does a letter of concern become a complaint? When you write to the Department of Health do you have to say, "This is a complaint"? How do you differentiate between a letter of concern, using your words, and a complaint?

Ms O'SHANNESY: A letter of concern is basically from people who may have read about some concerns that have been raised about the level of nursing staff or the level of staffing and clinical care in aged-care facilities. They will write saying, "I am very concerned about this." For example, "I worked in an aged-care facility many years ago", or "I had a friend and everybody went to that person; it was a wonderful thing". A complaint is, "This happened at this facility and I have a concern." It is not a matter of labelling it; it is the fact that the letter is raising a concern that suggests there was a breach of our legislation.

The Hon. WALT SECORD: How many letters of concern have you received? You said you received three complaints in 11 years.

Ms O'SHANNESY: Yes.

The Hon. WALT SECORD: How many letters of concern have you received?

Ms O'SHANNESY: I cannot say over the last few months. There have been many pieces of correspondence including some that clearly have been generated as form letters.

The Hon. WALT SECORD: You mentioned, in response to Reverend the Hon. Fred Nile asking about the steering committee, that the commercial providers' expert did not express any opposition to retaining the section 104 regulation.

Ms O'SHANNESY: No, that is not what I said.

The Hon. WALT SECORD: I misunderstood you. Do they want it removed?

Ms O'SHANNESY: No, no. I think Reverend the Hon. Fred Nile had asked me whether there was pressure brought to bear due to commercial interests. I have to say some of the aged-care providers are not commercial; some of them are not-for-profits.

The Hon. WALT SECORD: I understand how the sector works.

Ms O'SHANNESY: But they expressed their views. I did not say they did not object. They do object; I think their view is—and they can speak for themselves; I believe they will be appearing before this Committee—

The Hon. WALT SECORD: Thank you.

The Hon. SARAH MITCHELL: You read out a list of the members. If you table that then we can all refer to it, which might be useful.

Ms O'SHANNESY: Yes.

The Hon. WALT SECORD: I remind you about the question on the data for the number of ambulances from aged-care facilities to emergency departments. That would be wonderful.

Ms O'SHANNESY: Yes.

Reverend the Hon. FRED NILE: To emergency departments, not just to hospitals.

The Hon. COURTNEY HOUSSOS: Is it possible to get a breakdown of the time of day that ambulances go to emergency departments?

Mr WORTH: I will have to take that on notice. I am not really sure.

The Hon. WALT SECORD: Please note Reverend the Hon. Fred Nile's clarification. He said "emergency departments"—there is a difference between hospitals and emergency departments.

Ms O'SHANNESY: I have this list of the membership and it has a blurb at the top about what we were broadly asked to look at, which is basically—it is not very helpful—that we get rid of it, we retain it or we find some other way.

The Hon. SARAH MITCHELL: But you are happy to table that document?

Ms O'SHANNESY: Yes.

Reverend the Hon. FRED NILE: We can edit that document.

CHAIR: Yes. You have taken some questions on notice. Please provide answers to those questions within 21 days. Members of the Committee may submit other questions on notice and they are required to be answered within 21 days.

Ms O'SHANNESY: And you will provide us with a copy of that interesting submission?

CHAIR: Yes, I will. Thank you for attending.

(The witnesses withdrew)

ROSS BUSHROD, Director, Quality and Standards, Australian Aged Care Quality Agency, affirmed and examined:

MICHAEL CULHANE, Branch Manager, Aged Care Quality and Regulatory Policy, Commonwealth Department of Social Services, sworn and examined:

CHAIR: Members have received a package of information that includes your submission.

Mr BUSHROD: Yes, and that may be referred to during the course of the hearing.

CHAIR: Do you wish to make an opening statement?

Mr CULHANE: Yes.

CHAIR: Please keep it short and do not duplicate the information already provided.

Mr CULHANE: The information was provided by the Australian Aged Care Quality Agency and I am representing the Department of Social Services. There is no overlap, although the two relate broadly to each other. The Commonwealth aged-care system is based on a comprehensive legislative framework supported by both the Department of Social Services and the Australian Aged Care Quality Agency. It controls who can become a provider of subsidised aged care and the number and location of places. Importantly, it also imposes a range of responsibilities on approved providers, including extensive quality and corporate standards. These cover things such as human resources management, health, personal care, and lifestyle. Those standards must be achieved and maintained on an ongoing basis by service providers, and they are monitored by the Australian Aged Care Quality Agency. The agency regularly monitors residential aged care facilities and conducts assessment visits and site audits, generally every three years, and does at least one unannounced visit per year.

For its part, the department, among other things, manages the Aged Care Complaints Scheme, which receives complaints and other feedback from the public and users of the age care system. It provides a free service to resolve those concerns in the interests of the care recipient. The scheme also conducts announced and unannounced visits, although they differ from those done by the quality agency in that they focus on resolving complaints rather than looking at systemic issues and adherence to the accreditation standards. When the scheme has concerns about matters that may affect more than one care recipient, it generally makes a referral to the Australian Aged Care Quality Agency, which can then take that information into account during its next visit to determine whether the home is meeting the standards.

The department also has a strong compliance regime, which includes the imposition of sanctions if providers do not meet their obligations under the Act. The distinction between high care and low care was removed from the Aged Care Act in July 2014. The outcome of that is that any person with a permanent residential aged-care approval can now be admitted to any residential aged-care place subject to availability and the provider's agreement. That change has made the system more flexible, simple and transparent. It has also reduced the red tape for consumers and providers without compromising levels of care provided to residents. Those amendments have not changed the Australian Government's requirements with regard to aged-care staff in aged-care facilities.

The Commonwealth legislation requires aged-care facilities to have sufficient numbers of appropriately skilled and qualified staff to ensure residents receive quality care appropriate to their needs. It does not prescribe the qualifications required by staff or the number of staff in any given facility. The relationship between staffing in aged-care facilities and quality of care is complex. There is considerable diversity across accredited homes in Australia. This is expected given the considerable variation in the size of aged-care facilities, the nature of the care provided by individual facilities, the care needs of individual care recipients within those facilities, and the facility design. Residents' needs also change over time. Therefore, a static staff ratio will not necessarily meet residents' needs.

Under the Commonwealth's framework it is the responsibility of individual homes to determine the number and types of staff they require to ensure that individuals receive quality care. As I said, that arrangement is monitored by the Australian Aged Care Quality Agency. However, the Commonwealth legislation does set out some instances where a registered nurse is required in residential aged-care facilities. For instance, a nurse practitioner, a registered nurse or an enrolled nurse acting within their scope of practice must carry out the

ongoing management and evaluation of care recipients' needs. The Productivity Commission's report "Caring for Older Australians", published in 2011, did not make any recommendations in this area. However, it did note the diversity of stakeholder perspectives on the issue and that a simple staff ratio would not be a positive reform because the imposition of such a ratio is a relatively blunt instrument, particularly given that the care resident profile of every facility will be ever changing.

Mr BUSHROD: The Australian Age Care Quality Agency commenced operations on 1 January 2014 and assumed the functions previously performed by the Aged Care Standards and Accreditation Agency. In particular, it assumed responsibility for the accreditation arrangements for residential aged care. However, it has other functions, including the quality review of home care services and promoting high-quality care and continuous improvement in aged-care services. Ours is a national agency and the standards that we administer and that resident care services must meet are national standards—they are the accreditation standards. We apply the standards in the same way in every State and Territory, noting that each State and Territory can have different legislation and regulations covering various matters—some of those matters were discussed this morning—including workplace health and safety, food safety and infectious disease reporting.

The assessments that we undertake of residential age care facilities are done by registered quality assessors. To be registered a person must undertake an approved course of training and satisfy a number of other requirements set out in the submission provided to the Committee. Most, but not all, registered assessors are registered nurses, and almost all have tertiary qualifications—the majority have postgraduate qualifications. The audit processes are set out in some detail in one of the documents provided with the submission. That document is entitled "The Assessor Handbook". The guidelines for the way in which the assessors must interpret the standards are set out in another document provided entitled "The Results and Processes Guide". I have provided separately a copy of the accreditation standards in a single sheet for convenience.

CHAIR: Thank you.

Mr BUSHROD: The standards comprise 44 expected outcomes covering four matters: management systems, staffing and organisational development; health and personal care; care recipient lifestyle; and the physical environmental and safe systems of the care facility. There are some expected outcomes that deal explicitly with staffing, and they are expected outcome 1.6, Human Resource Management, and expected outcomes 1.3, 2.3, 3.3 and 4.3, which concern education and staff development. Over the years in which accreditation has been undertaken—it commenced in 1999—there has been improvement in the performance of residential aged care throughout Australia based on the assessments of each service against the accreditation standards over that time. In the first round of accreditation assessments that ended in December 2000, 64 per cent of facilities were found to meet the accreditation standards. In the last completed round of comprehensive assessments, ending in December 2012, 95 per cent of services then met all of the accreditation standards.

The Hon. COURTNEY HOUSSOS: Do you monitor any of the State-based regulations?

Mr BUSHROD: We are not responsible for nor do we have authority to determine whether a facility is in breach of a State regulation or State legislation. That is a matter for the relevant State authorities. The accreditation standards contain an expected outcome concerned with regulatory compliance. Under that expected outcome our assessment examines the way in which aged-care provider ensures that it meets its requirements, including the requirement to comply with legislation, whether it be Commonwealth or State legislation.

The Hon. WALT SECORD: You said that 95 per cent of aged-care facilities meet the criteria or get the tick of approval from your agency, so that means 5 per cent do not. How many of the 939 aged-care facilities in New South Wales did not meet the criteria in your last period?

Mr BUSHROD: The figure that I can provide to you today is that over the three years to 30 June 2015 nationally there were 371 services that had one or more failures with the standards. Out of those, 93 services were in New South Wales.

The Hon. WALT SECORD: What happened with the 93 that were found? What happens next if a service fails?

Mr BUSHROD: The normal process when a home fails to meet the standards is that we would impose a timetable for the service to rectify the problems, monitor the progress towards rectifying the problems, and

assess at the end of the timetable whether or not those problems have been rectified. In the vast majority of cases the problems are rectified by the end of the timetable, which is usually three months. And in the vast majority of cases the number of expected outcomes that are affected by failures is small.

The Hon. WALT SECORD: At the moment, how many of those 93 aged-care facilities in New South Wales are under surveillance, observation or monitoring by your agency?

Mr BUSHROD: At the end of June 2015, six services in New South Wales had any failures at all, out of 15 nationally.

The Hon. WALT SECORD: So six out of the 15 were in New South Wales?

Mr BUSHROD: Correct.

The Hon. WALT SECORD: Are those six operating at the moment even though they have failed patients?

Mr BUSHROD: Those six are operating at the moment. While I cannot provide you with the details, it is likely that those six have a small number of issues to deal with.

The Hon. WALT SECORD: Can you take it on notice to provide the names of those six aged-care facilities, please?

Mr BUSHROD: I can take it on notice.

The Hon. WALT SECORD: You mentioned earlier that nursing homes get one unannounced visit a year.

Mr BUSHROD: All residential aged-care facilities have at least one unannounced visit per year.

The Hon. WALT SECORD: What constitutes an unannounced visit? Do you say, "We are coming next week for an unannounced visit?"

Mr BUSHROD: No. We arrive unannounced at the facility without any prior notice whatsoever.

The Hon. WALT SECORD: Do you think one unannounced visit a year is appropriate?

Mr BUSHROD: It is a matter of policy. One unannounced visit per year enables us to regularly monitor the performance of each home. It means that over a period of three years the majority of homes have one comprehensive audit for purposes of reaccreditation and they receive three visits from us over that three-year cycle—one per year.

The Hon. WALT SECORD: Do unannounced visits occur during the Christmas-New Year period?

Mr BUSHROD: They occur throughout the year, and that includes the Christmas-New Year period. Naturally we have regard to the interests of families and residents of aged-care facilities who wish to celebrate that season, but nevertheless we conduct unannounced visits throughout the year.

The Hon. WALT SECORD: Regarding those six services, what were the matters that came to your attention that resulted in their description as failure?

Mr BUSHROD: I am not able to provide you with that information today. I do not have it with me.

The Hon. WALT SECORD: Does your agency support the current New South Wales regulation section 102 requiring a registered nurse 24/7 in high care?

Mr BUSHROD: I think that is a matter for the New South Wales Government and Parliament. It is a matter of policy. We administer the accreditation arrangements by reference to the accreditation standards—that is our role. Those accreditation standards are administered the same way in every State and Territory.

The Hon. WALT SECORD: What does the Federal Government or the State Government do regarding the six services that you mentioned in New South Wales that are currently determined to have failed patients? If a service is deemed to have failed or not complied with health standards, what happens to the facility and, particularly, what happens to the residents?

Mr BUSHROD: In the majority of cases in which we find there are problems, it is a small number of problems and we place the service on a timetable for improvement. That requires the service to rectify the problems within a short period of time. In very serious cases it is open to us to review the accreditation of a service and then to decide whether or not we should revoke the accreditation of a service.

The Hon. WALT SECORD: Have you ever revoked accreditation?

Mr BUSHROD: Yes, we have. And if the accreditation of a service is revoked, it is then not eligible to receive Australian Government subsidies, and that will lead to the service closing, because without the subsidies they tend not to be viable.

The Hon. WALT SECORD: How do complaints get to your agency?

Mr BUSHROD: In two ways, essentially. My friend has already explained that the Commonwealth's complaints scheme receives complaints and from time to time—quite regularly, in fact—refers information about those complaints to the quality agency, particularly when it is thought that those complaints might indicate systemic failures at a nursing home. People also contact us directly to provide information about the quality of care and services being provided in a residential facility. When that occurs we take that information into account in our monitoring program.

The Hon. WALT SECORD: For the 939 aged-care facilities in New South Wales, how many complaints have you received?

Mr BUSHROD: I do not have that figure.

The Hon. WALT SECORD: Can you provide that to the Committee?

Mr BUSHROD: I can provide figures about complaints we have received.

The Hon. WALT SECORD: Mr Culhane, do you have data or information on complaints involving New South Wales?

Mr CULHANE: The department has that information. I do not have it with me. I have information about complaints in New South Wales and other states that relate to staff numbers and to training and skills qualifications, so it is a subset of the aggregate.

The Hon. WALT SECORD: Can you explain and take us through that, please?

Mr CULHANE: I can. In terms of the complaints received over the period 1 May 2013 to 27 May 2015—so that is two years and 26 days—New South Wales had 249 complaints about staff numbers, which was the second highest of all the states in Australia, and 111 complaints about training, skills and qualifications. When we look at these as a percentage of allocated places, because not every State has the same number of allocated places, obviously, due to populations—for every resident there is an allocated place—the percentage of complaints in New South Wales about staff numbers was 0.38 per cent of allocated places. That was the second highest of all states. And in relation to training, skills and qualifications, it was 0.69 per cent of allocated places. Again, that was the second highest of all states.

If I could add to an earlier answer by Mr Bushrod about what the Commonwealth does when a service has failed to meet all of the standards, the quality agency also refers its reports to the department when there has been a failure to meet all the standards. The department also monitors services' progress in meeting the standards and has open to it a range of compliance powers that I discussed earlier, so where the department assesses that risk is both serious and immediate, it has a discretion to apply a sanction to the service, which, if you look historically, typically requires the appointment of a nurse adviser or a business adviser, or both, and the suspension of subsidies for new residents for a period that is often around six months, so those are the common sanctions that are imposed. The Commonwealth also has the power to withdraw approved provider status, which

essentially means you cannot participate in Commonwealth subsidised aged care. It is a complementary set of powers, if you like, to the Quality Agency's, who can withdraw accreditation.

The Hon. WALT SECORD: I wish to ask a question about standards. Refresh my memory. Is it 42 or 44 standards?

Mr BUSHROD: Forty-four.

The Hon. WALT SECORD: Do they spell out standards such as hydration, pain management? Can you give me some examples of the criteria that you measure an aged-care facility against?

Mr BUSHROD: You are quite correct, yes. Nutrition and hydration is one of the standards. There is medication management, pain management, palliative care. There are a range of clinical-related standards as well as lifestyle-related standards, such as emotional support, activities and leisure interests, so there is a wide range of standards that relate to the management of the facility, that relate to clinical aspects to meet residents' clinical requirements, that relate to their lifestyle, leisure, emotional support, choice and decision-making aspects and, finally, to the living environment, the condition of the facility, the amenity available to residents in the facility, the catering and laundry services, and so on.

The Hon. WALT SECORD: The six services in New South Wales that you said are currently being monitored because they failed, is it because they are not providing nutrition, water? What are the reasons? You would not be removed for not stocking the stationery cupboard properly.

Mr BUSHROD: The reasons are one or more of those expected outcomes. I am not in a position today to tell you what those particular expected outcomes are.

The Hon. WALT SECORD: Do you know where those six are based in New South Wales? Are they in country areas or in Sydney?

Mr BUSHROD: I do not have that information either.

Reverend the Hon. FRED NILE: Could you take that question on notice?

Mr BUSHROD: Yes.

The Hon. COURTNEY HOUSSOS: I have one question for the representative from the Department of Health. Has there been any modelling conducted by the department about the standards of care and the frequency of adverse incidents based on the types of staff employed?

Mr CULHANE: No, there has not.

The Hon. WALT SECORD: During the Christmas holiday period we received reports of aged-care providers taking elderly patients to emergency departments and I am sorry for using the term "dumping" them there. Have you done any modelling or research into this area, particularly the quality agency? Are you aware of any reports of that?

Mr BUSHROD: I am not aware of any particular reports of that occurring.

Mr CULHANE: Likewise, I am not aware of any particular reports of that happening. The department does not hold data sets in respect of the staff in particular aged-care agencies or the number of residents who are taken to emergency, so there is no data on which to do such monitoring, if you like.

Reverend the Hon. FRED NILE: As you know, New South Wales had a system of classifying the centres such as high care, low care and so on. I notice in your publication "Results and processes guide", on page 39 there is a section which says, "Detail on specialised nursing care needs. Registered nurses or other relevant health practitioners are responsible for the assessment and planning of care for a care recipient." How do you define a care recipient? It seems that your document would imply that a registered nurse should be in that nursing home?

Mr BUSHROD: Yes. The particular reference you are making, which is also in the "Results and processes guide", reflects the content of the quality of care principles that were made under the Aged Care Act. Mr Culhane might want to say more about the content of the quality of care principles. Essentially, the quality of care principles explain what services and care must be provided by a residential aged-care facility and it does include care that relates to nursing services.

Reverend the Hon. FRED NILE: Does it refer to registered nurses? This document does.

Mr BUSHROD: It does.

Mr CULHANE: There are areas where the Commonwealth requires a registered nurse to be in an aged-care service to deliver particular services. I mentioned one of those in my opening statement where either a registered nurse or a nurse practitioner or an enrolled nurse operating within their scope of practice must carry out ongoing management and evaluation of care recipients. A care recipient is a person who is in a Commonwealth subsidised residential aged-care facility.

Reverend the Hon. FRED NILE: They require drugs and specialised nursing care in the centre?

Mr CULHANE: They may require specialised nursing care and they may require the administration of drugs, but they may not. Anybody who is occupying a place in a Commonwealth subsidised aged-care facility would meet the definition of a care recipient. They may receive care for a wide range of reasons and those will often involve medication and specialised nursing care, but there may be circumstances when that is not necessarily the case.

Reverend the Hon. FRED NILE: Under your assessment of that centre, they would be required to have at least one registered nurse?

Mr CULHANE: They require a registered nurse, or if we are talking about this particular activity, a nurse practitioner, a registered nurse, or an enrolled nurse who acts within their scope of practice to carry out that activity. That would not necessarily require a person who has one of those three qualifications to be in attendance 24 hours a day. There are other areas as well where the Commonwealth—if facilities wish to access certain elements of subsidies under the aged-care funding instrument, they also need to have a registered nurse there to administer that particular service, but, again, that does not require a registered nurse on the premises 24 hours a day. There are also laws in place in various States which require registered nurses to undertake particular medical services.

Reverend the Hon. FRED NILE: Dealing with drugs?

Mr CULHANE: Yes, dealing with drugs, related to the administration and dispensing of drugs and those sorts of things. The Commonwealth law does not require a registered nurse on the premises 24 hours a day for seven days. That does not mean that there are no circumstances when the Commonwealth requires a registered nurse to be there.

Reverend the Hon. FRED NILE: Are you suggesting that a registered nurse may only be on duty from nine till five and go home at 5 o'clock? You are saying they are not there 24 hours?

Mr CULHANE: I am saying that services will require a registered nurse to be there to undertake particular tasks under Commonwealth law. They will require a registered nurse to be there to undertake particular tasks under laws as they apply in the relevant State relating typically to medications administration, but also other things. They may require registered nurses to be there to administer particular tasks in order to meet the nursing professional standards. That would not necessarily require a registered nurse there. None of those would require a registered nurse there 24 hours a day.

Reverend the Hon. FRED NILE: You would agree, though, that most aged persons would require a registered nurse in the period after five o'clock, when they are preparing to go to sleep and taking their medication and so on, at about 9.00 p m.

Mr CULHANE: No, I would not agree with that.

Reverend the Hon. FRED NILE: I am pointing out that the requirement to have a registered nurse from 9.00 a.m. to 5.00 p.m. is not practical with regard to an aged person and their medical needs.

Mr CULHANE: State governments at the moment impose legislation with regard to the prescription, dispensing and administration of medications. So if those State government laws require a registered nurse to undertake those tasks and a home has residents who require the prescription, dispensing or administration of drugs during those hours, then I would agree that they need a registered nurse there. But that is a requirement of state law.

Reverend the Hon. FRED NILE: They would need at least one.

Mr CULHANE: If the State law requires that, yes.

Reverend the Hon. FRED NILE: There is some uncertainty whether the State law requires that. That is the reasons we are having the inquiry. It is not clear now that there is a need for a registered nurse to be on duty because of the changes to the definition of high care and low care.

Mr CULHANE: The change to high care and low care does not have any bearing on the existing state law about the prescription, dispensing and administration of drugs, which is the issue that you have raised.

Reverend the Hon. FRED NILE: I understand that. Do you agree, though, that there could be a need for a registered nurse to be on duty 24/7?

Mr CULHANE: I agree that, depending on the care needs of the care recipients there may be a need. The Commonwealth requires service providers to have adequate numbers of sufficiently skilled staff to meet the care needs of care recipients. And if those care recipients' care needs are sufficiently high and sufficiently specific to require a registered nurse then I agree that a registered nurse should be there.

Reverend the Hon. FRED NILE: Should that centre be required to advertise in their publicity that they do or do not provide a registered nurse, so that people who are planning to enter a facility—or their relatives—would know whether there is going to be that very high level of care before they go into that home? They could find out when there is a drama or some concern.

Mr CULHANE: I think the questions of transparency around staffing in aged-care facilities are more properly matters for ministers in the Commonwealth Government or the State Governments.

Reverend the Hon. FRED NILE: So in your accreditation arrangements and so on, you do not have a requirement that they must publicise that they do or do not have a registered nurse on duty.

Mr CULHANE: No.

Reverend the Hon. FRED NILE: It would be a deterrent to people putting a fragile aged person into a home if they knew that there was no registered nurse available 24/7. That would be a factor, would it not, in choosing a particular facility?

Mr CULHANE: I am somewhat reluctant to speculate about what consumers might view as important in placing their loved ones in an aged-care facility. There are many factors that are brought to bear. Price and proximity to the primary family members who provide care are high factors. Going beyond that, it is very difficult to speculate about what consumers find important or to generalise about that.

CHAIR: I do not have a nursing background so I am wondering whether you could step us through this. With regard to the scope of practice and the specific needs, that all comes down to the assessment, does it not, and whether the assessment tool adequately reflects the needs of the person that is requiring care? And that affects the funding and the provision of service. Is that right? My interest goes back to the first point about the assessment and how that relates to the funding tool and the requirement.

Can you clarify for me whether the assessment tool is broad enough to take into account long-term, ongoing needs or the need for episodic or temporary care that would define the scope of services that are required? Some submissions have made the point that they do not feel that the assessment tool identifies clearly enough the broad range of needs, therefore you are not getting the staffing requirements to meet that need. So

there is a flow-on effect and a funding issue. Can you outline, for a layperson, what the process is and whether or not it is working to meet the care needs.

Mr CULHANE: I suggest that there are three assessment tools that are relevant. The first assessment tool is used when an aged person or their family decides that somebody needs to enter care and they get an assessment under the aged-care assessment tool. That looks at the person's levels of capability and assesses their needs. It informs whether or not they are eligible to enter aged care and provides a description of their care needs. The family of that person then needs to locate an aged-care facility that meets their expectations, that has a vacancy and is willing to accept that person as a care recipient.

CHAIR: Who undertakes the first assessment?

Mr CULHANE: The first assessment is undertaken by Aged Care Assessment Teams which are funded by the Commonwealth government, but the services are delivered primarily by outsourced service providers. I know that State Governments play a key role in providing those assessment services. So it is neither the service provider nor the Commonwealth that makes the assessment.

The person fronts up at an aged-care facilities with their ACAT assessment—the aged-care assessment tool. They reach an agreement that the person should enter the facility. The person will then be assessed under the Aged Care Funding Instrument, which is a separate tool. This is the tool that determines the level of subsidy that an aged-care facility receives in relation to an individual care recipient. That is a self-assessment tool and the Commonwealth undertakes an audit process of aged-care facilities—looking at 20 per cent of those—to seek to moderate any unusual claiming patterns or unusual claims and to provide a deterrent for over-claiming and to adjust under-claiming where that occurs. Under-claiming does occur.

The second tool is the Aged Care Funding Instrument tool, and that can be revised from time to time because the care needs of an individual change from time to time—particularly rapidly in aged care, where the duration is quite short. Typically, it is towards the end of life and there can be a relatively rapid deterioration in contrast to the general population with respect to care needs. The third tool is less specific. It is about care planning and care planning revision. In order to carry out effective care within an aged-care home the expectation would be that most homes would develop care plans in relation to individual care recipients. These look holistically at an individual's care needs. They range from medication management and might go so far as individual preferences in terms of engagement in the community, leisure, attending church on a Sunday and a broad section of what services are required to meet the expectations, to the extent possible, of the individual.

So three different tools with three different objectives. The aged care assessment team [ACAT] tool I mentioned at the first is a point-in-time tool and it is not revisited. Well, if the person enters care it is not revisited. Therefore, it does not reflect and is not adapted over time to reflect the change in care needs of the individual. The Aged Care Funding Instrument tool is reviewed from time to time but there are constraints on how often it is reviewed. Therefore, it does not necessarily reflect the care needs of the individual contemporaneously. The expectation is that care plans conducted by the aged-care service are kept up-to-date in terms of reflecting the emerging care needs of individuals in care.

The Hon. BRONNIE TAYLOR: Mr Bushrod, my first question relates to your registered quality assessors. In the document you have given us you say that 197 are registered nurses. Your standard 2 accreditation standards 2.4 and 2.5 refer specifically to clinical care and specialised nursing needs. Within your accreditation process, and having over 50 per cent of registered nurses being your assessors, would it come under there if there was concern that there were not enough registered nursing hours in a facility?

Mr BUSHROD: Yes, the assessments that the registered assessors, the assessment teams, make. When we appoint the assessment team to make an assessment, which is a comprehensive assessment, they would certainly be looking specifically at that, amongst all the expected outcomes of the standards. They would make an assessment about the exercise and actuality of skills available in the facility and about the sufficiency of the number of staff to provide the required care and services.

The Hon. BRONNIE TAYLOR: So are registered nurses making those decisions about registered nursing hours in these facilities that are accredited?

Mr BUSHROD: Making a report about those things, yes.

The Hon. BRONNIE TAYLOR: A report—I stand corrected. I refer to the end of your document, under Performance of Residential Aged Care Services. I am a registered nurse and I have gone through quite a few accreditations so I understand how thorough and extensive they are and a lot of what goes on in the accreditation process.

The Hon. WALT SECORD: Have you passed all of them?

The Hon. BRONNIE TAYLOR: Are you questioning me?

CHAIR: No, he is not.

The Hon. WALT SECORD: Did you fail or pass?

The Hon. BRONNIE TAYLOR: In your first round of accreditations 64 per cent met all accreditation standards; then moving on from that there seems to be a significant improvement to December 2012 of people meeting those accreditation standards. Having experienced numerous accreditations very successfully, would you say that the process provides a great opportunity for facilities to look at themselves under your accreditation standards and perhaps consider they are not meeting those standards and improve?

Mr BUSHROD: An important part of the standards and the accreditation process is to promote and cause improvements to occur. The intention is that they are not simply improvements to rectify problems; they are improvements to improve on good performance. It has been said to me, and I think I would agree, that part of the impact of accreditation is cultural change within the aged-care sector. Certainly it has caused, and continues to cause, all facilities and providers of residential care to regularly self-assess, self-appraise the effectiveness of the processes and the systems they have in place to provide care and services and to consistently look for ways of making improvements because they are the things that we look at. I suppose also because we look at it and it becomes part of the culture, it becomes something that they take an interest in, in any case.

The Hon. BRONNIE TAYLOR: To elaborate on that, when your assessors do an accreditation assessment, in my experience, if there are things that are working well in similar like-minded facilities they are able to share that information after the report is done in terms of guidance and suggestions in terms of improvement for their residents' outcomes and care.

Mr BUSHROD: The role of assessors includes providing information to assist facilities make improvements. They can provide information about what other services are doing but limited, of course, by understanding whether or not those other facilities and the operators of those other facilities are happy to have that information shared, because intellectual property can be involved. However, they have access to information about organisations that have better practice, that have perhaps participated in our better practice awards or in our regular better practice conferences. So they have an awareness about what is out there that is good or best practice and what is out there publicly as well. They can inform providers about those things and where they can get more information about how to do things better.

The Hon. BRONNIE TAYLOR: In terms of the 15 services with outstanding failures, six of which were in New South Wales, is there an ability to know whether those providers continue to fail the accreditation standards? Are they repeat people who fail, or are they different people? You can take it on notice if you want.

Mr BUSHROD: I do not have information about those six to be able to say what kind of compliance history they have. I can say that we plan our visits to facilities based on our understanding of things that create risk. If a facility has had recent problems that would be one consideration in our assessment of the risk associated with particular facilities and therefore how we would carry out and the frequency with which we would carry out visits to a facility.

The Hon. BRONNIE TAYLOR: We have had a question in terms of aged-care facilities, which is what we refer to them—we have high and low people, residents with different care needs. You talked about complaints that come in. Is there any correlation between the complaints that come in and the registered nurses in a facility?

Mr CULHANE: The department does not have information on the numbers and availability of registered nurses in individual facilities so we cannot make that comparison.

The Hon. BRONNIE TAYLOR: Following on from that, as a registered nurse I am conscious of the enormous role and capacity and fantastic work that enrolled nurses and assistants in nursing do within our aged-care sector. They are a vital part of that. When we look at staffing and the complaints, is it more that they are complaints about actual staffing levels, people's loved ones not receiving the care that they feel they need? Is that a staffing issue or a skill issue in your opinion?

Mr CULHANE: I am not sure I am well placed to go beyond the numbers here, but I have realised as the discussion has proceeded that I did not accurately represent the information I provided earlier about complaints in New South Wales. I would like the opportunity to correct the record. Shall I do that now?

CHAIR: If you are able to.

Mr CULHANE: In terms of the raw numbers of complaints, they do not take into account the population of the State, so New South Wales was the second highest over the May 2013 to May 2015 period with 249 complaints about staff numbers. It was the highest of all States with complaints about training, skills and qualifications with 111. When you look at it as a percentage of allocated places, it was the second highest in terms of complaints about staff numbers with 0.38 complaints per allocated place but the fourth highest in terms of training, skills and qualifications at 0.169 per cent per allocated place.

The question was about staff numbers or the skills level of staff. I do not have an opinion to offer on that. The datasets we have drawing from the complaints systems rely on the categorisation of the complaint received by complaints officers. It is not designed or intended as a statistical database for interrogation but to facilitate the broad workflow of resolving complaints. These figures would not have the level of rigour that one might expect if one engaged a university to look at complaints and categorise them this way, because the work is not done that way.

The Hon. BRONNIE TAYLOR: In your experience?

Mr CULHANE: When complaints officers receive complaints and are faced with a range of choices for how to categorise complaints—I have given two of those categories—they are aware that one category is staff numbers and one is training, skills and qualifications. It is reasonable to expect them to place complaints into those categories as best they can on their judgement. That suggests, based on this, that there are twice the number of complaints about staff numbers as there are about skills, training and qualifications. That is what the evidence suggests.

The Hon. SARAH MITCHELL: I return to accreditation standards. In terms of the assessment of these services, you mention twice in your submission centres that fail to meet more than five expected outcomes. Would that mean they have to wait to be reassessed against the accreditation standard? Is a breach of a certain standard more serious than another? I am not a nurse, but for example, is a breach in medication management or clinical care more serious than a breach in information systems or inventory and equipment, or is it a matter of establishing that five have not been met and therefore the facility must be reassessed?

Mr BUSHROD: No single expected outcome is weighted any more than any other outcome; they are all weighted the same. A failure to meet a particular expected outcome can be a minor failure or a very serious failure. It depends upon the particular nature of the failure, the circumstances in which the failure has arisen and what things it relates to. For example, you could have a very serious failure that impacts badly on a resident's dignity and privacy and a failure in something like pain management or medication, which is of a clinical nature, but is minor. It does not automatically follow that because it is clinical it is going to be a worse problem.

The Hon. SARAH MITCHELL: But the nature of the breach is taken into consideration?

Mr BUSHROD: The nature of the failure itself is taken into account in the decision-making we undertake and the nature of the action we take following that as well.

The Hon. NATASHA MACLAREN-JONES: I refer to the submission made by the NSW Nurses and Midwives' Association. Are you familiar with this submission?

Mr BUSHROD: No.

The Hon. NATASHA MACLAREN-JONES: In the submission they state that following the legislative changes providers have opted out of providing registered nurses at all times in facilities that used to be classified as hostels or low care although these people require high care. They state that you have not challenged this. Do you have an opinion in relation to the comments put forward in the submission? Is there evidence?

Mr BUSHROD: I cannot comment because I do not have any of the facts being referred to. We have continued to assess aged-care facilities against the standards as they are. The standards have been in place for 15 years and are applied nationally in the same way. They have been applied to residential care facilities according to the needs of the individual residents in those facilities, not in accordance with how anyone might classify that facility.

The Hon. NATASHA MACLAREN-JONES: Is it fair to say that in New South Wales since the changes have been put in place the standard of care for residents has not fallen?

Mr BUSHROD: Please repeat the question.

The Hon. NATASHA MACLAREN-JONES: Since the introduction of legislation, is it fair to say that the standard of care in New South Wales has not fallen?

Mr BUSHROD: I go back to comments I made earlier. Over time the number of facilities in New South Wales that met all 44 expected outcomes of the standards has increased. Measured by the proportional number of all services that met all standards, on that criterion, performance has actually improved.

The Hon. SARAH MITCHELL: I understand that both of your organisations are involved in the NSW Health aged-care committee. How have you found that process so far?

Mr BUSHROD: I have been involved only recently. Our organisation has been involved but I have not been personally until recently. I have found the process helpful and informative. We certainly had the opportunity to describe and explain how we do things.

Reverend the Hon. FRED NILE: Is your agency under the Department of Social Services or are you independent?

Mr BUSHROD: It is a separate independent agency but is part of the Social Services portfolio.

Reverend the Hon. FRED NILE: But the Commonwealth Department of Health has no role in your areas, as compared to the New South Wales Department of Health which is involved?

Mr BUSHROD: The Commonwealth Department of Health has no involvement in accreditation.

Reverend the Hon. FRED NILE: What about the healthcare area?

Mr CULHANE: The Department of Social Services has a strong relationship with the Commonwealth Department of Health. We work collaboratively with them in various areas where aged care and health overlap, but they do not have a formal role in administering the regulations under the Commonwealth Aged Care Act.

The Hon. COURTNEY HOUSSOS: Do unannounced visits only occur during business hours?

Mr BUSHROD: There is a long answer to that. Not necessarily, but generally our visits are done in business hours. If there are circumstances or issues that we believe we should explore and those issues or circumstances can only be explored outside of business hours then we will visit outside of business hours.

CHAIR: My question is about action taken about complaints. Are residents or their representatives informed when a facility is under review, has sanctions applied or is in timeline? Is that made known?

Mr CULHANE: It is split between the quality agency and the department. The department is responsible for imposing sanctions when that occurs. It engages with approved providers to ensure that residents are advised when and why sanctions have been imposed. That is typically done through what is called a residents' and relatives' meeting, and departmental officers typically attend those meetings.

CHAIR: Can you provide further information to the Committee about how that process is defined? I am interested to know whether information is provided in writing to all recipients and/or their representatives. I imagine that a meeting would be difficult to organise.

Mr CULHANE: It is not an easy thing for the provider to do. However, we can provide something.

Mr BUSHROD: From the quality agency perspective, whenever we conduct an audit we require the provider of the residential care to notify care recipients or their representatives and to inform them in the form of words we provide that they can meet with the assessment team. We also provide a standard notice to be displayed in a prominent place in the facility advising that an audit will be undertaken. Clearly, if the visit is unannounced we cannot notify care recipients first. However, the notice telling people that an assessment will take place is nevertheless used and displayed in a prominent place.

CHAIR: My specific interest is whether written notification is required to be sent either by email or post to representatives or recipients.

Mr BUSHROD: The short answer is yes. However, in the case of unannounced visits that is not possible and a poster is used. Once an audit is completed, a report has been prepared and a decision about the service's accreditation is made, we publish the decision and the audit report prepared by the assessment team on our website.

Reverend the Hon. FRED NILE: Do you always interview 15 per cent of the residents in each facility?

Mr BUSHROD: That is an average; it might be a little higher or lower. The minimum that we interview is 10 per cent, but typically it is 15 per cent.

CHAIR: Thank you for appearing before the Committee and answering members' questions. The secretariat will contact you with regard to the questions on notice that Committee members have asked. Responses to those questions should be provided within 21 days.

(The witnesses withdrew)

(Short adjournment)

CHARLES WURF, Chief Executive Officer, Leading Age Services Australia NSW-ACT, sworn and examined:

CHAIR: Do you have a short statement or are you willing to go into questions?

Mr WURF: I am happy to make a very short statement and then equally happy to take any questions from the Committee. The statement I make is on behalf of Leading Age Services Australia [LASA] NSW, which has represented aged-care providers in this State since 1935, with a range of different names, as I have gone into in my submission. I make two very broad opening points as an opening statement. Firstly, history and, I believe, my submission demonstrate quite clearly that over a very slow and well-constructed evolution Australia now has a very comprehensive national system of aged-care services. Very pleasingly, the most recent reforms rebalance that system to greater home care to support older Australians in their own homes and continue to invest and improve in a first-class residential care system.

The second broad point I make is that there is no driver in any of the reform, nor from any of the providers I represent, to dispute the need for registered nurses in aged care at all levels. Indeed, we would say the opposite. Registered nurses have been and continue to be a vital component of our workforce at multiple levels. Firstly, our registered nurses assess the need for care. Secondly, they are integral in planning care need. Finally, they are absolutely instrumental in the delivery of care to all older Australians who are in the aged-care system. We do not see that changing and there is no driver across the providers for that to change in any way. As we continue to reform and improve aged care, it is all about a much more efficient and better skill allocation to make sure that our really specialised skills at all levels are being harnessed and utilised for the delivery of care need. If I had to conclude with those two positions, I would categorise the most recent reforms as grounded in ensuring that care need is properly assessed for an individual older Australian so that that care can be delivered appropriately in a home setting and, where necessary, in a quality residential care setting.

CHAIR: Thank you. We move to questions.

The Hon. COURTNEY HOUSSOS: Thanks, Mr Wurf, for your submission. Although it was interesting and informative about the history of nursing homes and regulation, I did not find that you addressed some of the specific terms of reference outlined by the Committee that some of the other submissions addressed. So I start by asking whether you think having registered nurses in aged-care facilities can reduce hospital admissions.

Mr WURF: I guess I bring to the Committee an assumption that registered nurses are integral to what we do in aged care, and nothing has changed. Nothing intends to change about that. Certainly the assessment of care need on admission to a residential care service allows the care planning to be developed and then care to be supplied. Registered nurses will always be part of the multidisciplinary team that will make a decision as to whether a hospital readmission or admission from a residential care service is required. I ask the committee not to forget that that will always be a multidisciplinary decision.

We will always talk about a resident and a resident's care needs, but we cannot forget that that resident will translate to a patient in two other relationships. With their doctor or general practitioner, there is a still a patient relationship for every older Australian in a residential aged-care service, and, certainly, if there is an admission to hospital, the hospital system will talk about the patient. So a registered nurse in my opinion will always be involved in that assessment decision as to whether such a transfer is necessary. And there is a range of reasons mentioned in earlier evidence as to why that might occur. There could be a change in condition, there could be a fall, there could be a fracture, there could be a need for medical assessment in a hospital based environment for a particular increase in acuity around health need. So it is not in contention for me to think that registered nurses would not be involved in those decisions as they currently are.

The Hon. WALT SECORD: I missed the very beginning. What is the breakdown of your association involving commercial and not-for-profit providers?

Mr WURF: Historically I have what I call a blended membership. Historically we have had a balance of around about 66 per cent privately owned in all of its forms.

The Hon. WALT SECORD: That is for-profit?

Mr WURF: For-profit, yes, and 40 per cent not-for-profit in all of its firms. Privately would be family companies, publicly owned corporations and then publicly listed corporations, and not-for-profits would be religious denominations, community not-for-profits, charities and, more laterally, ethno-specific not-for-profit organisations.

The Hon. WALT SECORD: So I do not misunderstand, what is your association's position on the regulation? Do you support its retention or would you like to see it removed?

Mr WURF: I would use different language again, if I may. I would take the longer term sweep of the regulatory reform and view that it is perfectly sound and reasonable and I would submit responsible to not renew that regulation. If you look at the specifics of it, it is not the provider base or anything else that has driven the need to review it; it is the evolution of the aged-care system. I put to the Committee that the phrase "nursing home" has not existed in the Aged Care Act since 1997. The phrase "nursing home" does not exist in the regulatory framework for anything to do with Living Longer Living Better, which was a transparent—in some parts contentious—reform that took years. "Nursing home", I would submit, with the greatest respect to the New South Wales Parliament, is a creature of history.

We are probably the only State that created that history. Without taking too much time, very simply, it is a construct from the 1950s and 1960s when a framework through private hospitals and nursing homes was created. It was codified in 1988 in the Nursing Homes Act. The 1997 Aged Care Act came along. In 2004 the New South Wales Parliament repealed the comprehensive nursing homes legislation and these two remaining provisions, critical as they were, were viewed by the New South Wales Parliament as important to continue while the aged-care reforms were monitored and they are now what we view as section 104 of the Public Health Act. They are in a miscellaneous omnibus piece of legislation. They are quite narrow in their scope and I would categorise them as historical. Therefore, my answer to your question is I believe it is reasonable and sound not to renew that regulation, given the further evolution of the national system.

The Hon. WALT SECORD: Have you done any modelling on how much private operators would stand to gain in profits if registered nurses were not continuing in the sector? How much would your sector reap? You must have done modelling?

Mr WURF: No. My association has done no modelling that would remove registered nurses from aged-care services. I say that unequivocally.

The Hon. WALT SECORD: Would you concede that would increase your profit margin if you removed registered nurses and removed the regulation?

Mr WURF: I will concede that theoretically, but I repeat again there is no modelling and no intent to remove registered nurses from age care services.

The Hon. WALT SECORD: If you removed registered nurses from aged care or removed the regulation, do you not think that patient care would suffer?

Mr WURF: No. If the New South Wales Parliament chose not to carry further—

The Hon. WALT SECORD: It is the Minister who makes the decision, not the Parliament.

Mr WURF: Well, it is a statute of section 104. It depends whether there is a repeal of statute or by regulation. If we look at the regulation, and I think it was in evidence before the Committee earlier this morning, the regulation refers to a moment in time—30 June 2014—and it will carry that forward. If you were that on 30 June 2014, this regulation will continue to apply. I would say, with confidence, representing providers, that if that New South Wales provision did not continue, the greater regulatory overlay of everything in the Aged Care Act, all the associated principles, the quality framework and general duty of care principles are going to leave staff pretty much as it is now.

The Hon. WALT SECORD: Using your argument, why not simply leave it if it is not going to have an impact or effect?

Mr WURF: Again, you have heard evidence this morning, and I was in the steering committee that was referred to. We are under confidentiality but I think I can concede that to this Committee. They were the

issues before the steering committee. Remember, the only reason the steering committee came up to review this is because of the Federal reforms. When the Aged Care Act was amended, it unpicked the State-based framework still grounded in the phrase "nursing home" and defined it to high care allocations under the Aged Care Act. The Federal reforms unpicked it. Health NSW has said it will continue it and has put that legislation in place. I would again repeat for the benefit of the Committee, if that was unpicked and the State provisions were allowed to lapse, there is a comprehensive significant overlay of regulation nationally that applies to all aged-care operators, and that will be adequate protection for older Australians.

The Hon. WALT SECORD: Earlier evidence indicated that 93 aged-care facilities in New South Wales had failed accreditation standards. If we had higher standards, why would we remove registered nurses? If we have 93 aged-care facilities failing the system, failing residents, how could you sit here and argue that we not retain registered nurses in aged care?

Mr WURF: There are two parts to that question. I will deal with the first. The evidence demonstrated the logic of our position. There have been three complaints—I believe I heard—in something like 11 years under the State Act.

The Hon. WALT SECORD: Three complaints in 11 years.

Mr WURF: That is the first time I have heard that number. I have been after it for a while.

The Hon. WALT SECORD: Are you surprised by that?

Mr WURF: Not at all. The agency has identified the issues it has monitored and gave its numbers. In the tabulated data I have here—I will not necessarily take you to it—as at 30 June, the transparency of the complaint system that the Department of Social Services gave evidence about is reported there. I am not concerned by complaints. I come from a philosophy that we should be completely and utterly transparent in our complaints process. We do and should promote it. We should make it easily accessible and then we should use it as a basis for both learning and continuous improvement. I come unashamedly from that philosophy and we have done that as an industry association in the whole time of my involvement and that philosophy of how we should go about our accreditation goes back to at least 1986, 1987.

The Hon. COURTNEY HOUSSOS: The focus of your submission is that basically the New South Wales Government should cede any regulation of nursing homes and instead give that over to the Federal sphere, but we heard this morning that there are a number of State regulations that apply to nursing homes, for example, workplace health and safety or food safety, among others. Is this not just one other simple State regulation? It is not really an onerous requirement on aged-care facilities?

Mr WURF: Fair question. I believe I attempted to address that in my submission proper. The distinction I would draw for this Committee is that the national framework for aged care is comprehensive. For its legislative framework and associated principles there is something like \$12 billion of Commonwealth money expended in the portfolio. In the face of that comprehensive framework—again, I am happy to assert and believe it is sound, that the couple of dozen words in section 104 of the Public Health Act can be relinquished in favour of the national framework. Having said that, I will equally accept as sound your proposition—and I have gone to it in the submission—there are a number of areas that are the direct preserve of the New South Wales Parliament and they can and should continue to be well regulated.

I was pleased to hear Health go to the matter of medication administration because I can now say we have been part of that consultation as an organisation. We have got the consultation drafts that would significantly review the poisons and therapeutic goods legislation. That is New South Wales legislation. There is nothing comparable nationally out of the Federal Parliament, and it can and should continue to regulate at two levels—how we store medications, which is State; and how we properly and appropriately use the scope of practice of professionals to make sure that we properly manage and administer all those medications on behalf of our residents.

Again, I would say there is a multi-disciplinary approach to our medication in residential aged care. We are not hospitals, so there is no doctor and pharmacy on site. They are the three relationships that we balance. Any medication and care of a resident is also as a patient of a doctor, which is the point I made earlier, so that is where any medications will be prescribed. There is a professional relationship with a pharmacy to dispense medications, and it is the obligation of the residential care service to manage and administer those medications.

Where the State legislation requires registered nurses, that is not going to change. We fully support it. We expect it to continue.

The Hon. COURTNEY HOUSSOS: Has your organisation completed any modelling on the profitability of operating aged-care facilities, given the Federal aged care Living Longer Living Better reforms?

Mr WURF: Given the sheer complexity and sophistication of aged care, we have participated with the Aged Care Financing Authority in their modelling and collection of survey data of the profitability of aged-care services. The Aged Care Financing Authority was established during the Gillard term of Parliament as part of the reform of the Aged Care Act—Living Longer Living Better. In our view that was a very sound reform because it went to the sheer size, scope and sophistication of the capital requirements to provide something like 180,000 residential care places every day. That is an appropriate mechanism.

The data of the Aged Care Financing Authority is very public. It is very transparent. It has been published. That data goes to an analysis of profitability, through audited reports which are provided each year by each provider to the Department of Social Services.

The Hon. COURTNEY HOUSSOS: But you have done no additional modelling?

Mr WURF: Have we done additional modelling around whether we would take registered nurses out?

The Hon. COURTNEY HOUSSOS: No, I am talking about the general profitability of the sector, given these reforms.

Mr WURF: Again, I would probably categorise our role as leaving the system-wide to the Aged Care Financing Authority and banks' strategic accounting advisors. We have certainly played a role in looking at individual sites and whether they are viable. But that is more about whether they are viable to establish and then run—new services being created in different locations—rather than system wide.

Reverend the Hon. FRED NILE: You made the point very strongly in your submission that you objected to the use of the term "nursing homes", even though you said in your submission that you were a nursing home association. Do you prefer to call them now "residential aged-care centres"? What is the terminology that you want to use?

Mr WURF: The statutory terminology is "residential aged-care facility". Colloquially "nursing home" is still used by some people. I guess I was trying to go to the regulatory framework. The most common usage is "residential aged-care service", "residential aged care centre" or "residential aged-care facility".

Reverend the Hon. FRED NILE: How do families who want to put an aged person into a facility assess what services are available that their loved one would need? Are you going to have category 1, category 2, category 3 and category 4?

Mr WURF: That is an excellent question. One of the things that consumers and providers know is that our system is so complex. In an attempt to explain it to an older Australian it is a labyrinth. It always has been. A key part of the Living Longer Living Better reforms is to try and drive transparency in the information available to consumers. Even as a New South Wales representative I know that that is a national framework. The Commonwealth has established a website called My Aged Care, and that is viewed as the "gateway"—that is term we use for it—for older Australians to access any type of services under the reforms. I categorise it as a continuum of care in three parts. To use the language of Living Longer Living Better there is home support. Those are the things that we can provide to older Australians to stay at home but which are not care based—meals on wheels, transport to the doctor, ramps and access to the personal residence.

Then we move up to home care, which requires an individual assessment of a person to work out what care needs can be delivered in the home. The third is a residential care admission if that becomes necessary. Again, as was evidenced earlier, there would be an assessment. ACAT would do it. Registered nurses dominate the ACAT process. Then, upon admission, ACFI—which is, again, dominated by registered nurses—would work out the care dollars—the resources. There would be a care plan drawn up by registered nurses. The answer to your question about how an individual intersects with the system is that it is primarily through My Aged Care, but we should never discount the health relationship with a doctor. Hopefully, this discussion is going on with the GP. With the system we have attempted to design, over time we hope that an individual older

Australian would engage with home support—I am just picking a figure—perhaps in their sixties to late-seventies—

Reverend the Hon. FRED NILE: They live longer with home support.

Mr WURF: Correct. Then home care may kick in in their mid-seventies to early eighties. We know that the pattern of admission into residential care is now at an average age of about 84 years. We would hope that the construct of this end-to-end system would allow that to happen over time. The New South Wales Parliament has been integrally involved in the bigger reform of home care. It participated in the national transition of home care out of the States into a national framework. That commenced in July 2013 and we now have the fully operational home care home support from 1 July 2015—all of four or five weeks ago.

Reverend the Hon. FRED NILE: You have stated that the regulation does not have any real effect on the operators, but there have been some reports of a decrease in registered nurses employed in this area. Is that a fact? Do you have any figures on this? Is there a decrease and why has there been a decrease in the employment of registered nurses?

Mr WURF: There is a very complex set of factors in play. There have been a couple of census reports that the Commonwealth has brokered—snapshots in time about the size of the aged-care workforce and the skill mix of that work force. That shows a proportional decline in registered nurses and an apparent decline in the raw numbers of registered nurses. There are probably two or three complex factors in that. Firstly, they reflect the size of our services as new services are created. That is without doubt.

Secondly, they reflect an increasing change in skill mix. I would say—this would probably be viewed as contentious by others who may give evidence—that that reflects an increasing professionalism in the role of registered nurse as we have transitioned over 20 years from the old hospital-trained system to a more clinically, academically-trained registered nurse. The College of Nursing has continued to review and expand the scope of practice for registered nurses and enrolled nurses. Where we have done it well we have worked with the scope of practices and that could very well be reflected in the apparent reduction in registered nurse numbers. I repeat that nobody we work with brings an assumption other than that we would have registered nurses 24 hours a day in our services.

Reverend the Hon. FRED NILE: It seems strange that the more highly qualified they become the less necessary they are.

Mr WURF: Can I leave that as a comment?

CHAIR: Certainly.

Reverend the Hon. FRED NILE: Following up on the question about staffing, what guidelines are in place to determine appropriate staffing levels, and are these applied across the industry? Do you have recommended staffing levels in your association?

Mr WURF: We do not. We choose not to. I can stand on the evidence given early from the Federal representatives around the legislative base and, more particularly, the outcome standards in the accreditation system.

Reverend the Hon. FRED NILE: You have had your input through that system.

Mr WURF: Indeed.

Reverend the Hon. FRED NILE: Obviously, it is very much in line with what your association wants. Have you had a major role in making submissions to the Federal Government so that these policies represent your industries' views?

Mr WURF: Yes; that is a fair categorisation. In my submission I also went to the detail of how the reform played out. Our association was a member of the National Aged Care Alliance. That organisation began with about 20 different peak organisations—I was going to call them "providers" but they are not all providers—representing consumers, providers of care, the major religious organisations in their service-provider capacity, and professional representatives from allied health and nurses et cetera. Most of the aged-care reforms

were played out through that very broad collaborative process. There was a Productivity Commission review. National Aged Care Alliance supported most of its recommendations.

The Gillard Government picked up its response to the Productivity Commission review and then this really complex reform came out of the period of a hung Parliament. I used to call the reform bipartisan but I think it is fair to categorise it as tripartisan, given the period. The Australian Senate has a particularly strong focus and a long-term involvement in the outcome. So yes, happy to say that we were certainly there as a strong representative of the providers. We believed that there were certain things that were essential to give us a good quality, viable aged-care system for the next 25 years.

Reverend the Hon. FRED NILE: You were obviously very pleased with the subsidies that the providers receive. What obligation does an employer have to spend the entire subsidy on residential care? If it is not all spent, what typically would it be spent on?

Mr WURF: I would not be doing my job properly if I did not address the first part of that question. In no way can I accept a categorisation that I am pleased with the Australian Government's subsidisation of aged-care services. We would submit that both the indexation of those subsidies and the way some of them have been constructed historically do not properly value older Australians or the care they receive; nor do they properly value the skilled workforce that should be deployed to provide that care.

Reverend the Hon. FRED NILE: Are you saying that the subsidies are not adequate?

Mr WURF: They are adequate, but if we want to continue to provide a better outcome in both home and residential care then there is upward scope for those subsidies by the Australian Government.

Reverend the Hon. FRED NILE: What percentage increase should there be—10 per cent?

Mr WURF: We have consistently asked for there to be a properly constructed cost-of-care study as part of the aged-care system. We have asked it of previous governments. Mr Secord in a different role in a different life may very well be aware of that. I am certainly aware of the submissions.

The Hon. WALT SECORD: It is groundhog day.

Mr WURF: We are certainly aware of the submissions that may have crossed your desk in a different life, and it is a consistent feature and request of coalition governments as well.

Reverend the Hon. FRED NILE: Are you saying that basically there is no surplus left over from the subsidies that the operators receive?

CHAIR: You can take anything on notice.

Mr WURF: I think any analysis of the ACFI data, any analysis of us overall, we are a very complex industry. That is probably the message. Private provision is essential if we are going to have the capital investment for the future of the services we need, but the historical and continuing involvement of the not-for-profit sector in all its forms is also absolutely essential to provide this social service. I would say, and have always maintained, that a blended, diverse provider base will give us the best care outcomes nationally and in New South Wales. Sydney is big enough to look after itself, but both associations will be in unison in saying that we must have a carefully constructed system to make sure that services are provided in regional, rural and remote areas and, equally important in modern Australia, carefully constructed services for ethno-specific and cultural groups. Specific cultural care is critical.

Reverend the Hon. FRED NILE: If there is no registered nurse available, do non-registered care staff get special training for medication management?

Mr WURF: The short answer to that would be yes. The approved provider's legal obligation in the older low care part of the industry there would be specific training around staff. In terms of medications in particular it would be part of a comprehensive system run generally by a medication advisory committee. It is that relationship I referred to earlier. It is cross-discipline between medical doctor or GP, the pharmacist, who has a critical role, and the staff who may be administering the medications. The great technological reform of

the last decade has been about how we package medications and it is the dedicated dosage, the way medications are now delivered.

The Hon. BRONNIE TAYLOR: Webster.

Mr WURF: Exactly. What is colloquially referred to as the Webster pack.

CHAIR: Does your organisation analyse whether or not the facilities are matching with the needs and the funding? I refer to another submission which states that more than 80 per cent of people are living in care facilities and are funded at the high-care level. The figures show that 50 per cent of aged-care facilities in New South Wales were formerly classed as hostels. Do you have information that defines the assessments, the levels of care that are provided and the levels of funding? Do you do an analysis of whether or not those things are being matched and then married against complaints or any other concerns that are raised?

Mr WURF: That is a complex question about data but a good one. The Department of Social Services publishes data around the Aged Care Funding Instrument. It is hard to get that data properly up-to-date but historical data certainly exists. That goes to diagnoses patterns and it also goes to dollar resources allocated across the domains of that instrument. I am not a registered nurse by background either, so some of these clinical matters go to our specialists. That data clearly shows that our old system before 2008, when ACFI was introduced, was roughly 50 per cent low care and 50 per cent high care.

Given the decision that was made around the different models for ACFI, it was easily predicted, and was predicted, that we would end up with a high-care resident population in residential care. There were options for ACFI and the option chosen will guarantee that result. ACFI now shows that the accepted number of about 80 per cent, 85 per cent of the resident population nationally are what ACFI would call high-care residents. High care must be analysed across its diagnoses. A high-care need for someone with dementia may require a different care plan and different care delivery model than a high-care need for someone who is receiving palliative care.

CHAIR: Do you keep records or have access to records about referrals of residents to emergency departments and whether there is any trending in those high- or low-care facilities and how that operates? Are the facilities that were previously hostels and do not provide the care providing more transfers to hospitals?

Mr WURF: Again, the short answer is that I do not have that data. We would not track that data.

CHAIR: Do you think we need to have it?

Mr WURF: I think it would be instructive, yes. I would also add that if you have raw data the analysis is critical. As I said earlier, the philosophy of residential care is we are dealing with a resident. The decision for transfer to hospital can be for a whole range of legitimate causes. It can be assessed by registered nurse or doctor; it can be in response to a critical event—as I said earlier, a fall or an increase in acuities in some persons.

CHAIR: We could do that. Many other complex areas are being managed through people having appropriate tools and broad decisions.

Mr WURF: As long as we are careful about "we", the source of that data would be Health and the Ambulance Service. I am not quite sure what it may or may not show but having access to the data would probably be useful. If I could offer some commentary in relation to that, probably the role NSW Health, and certainly what we would seek to engage Health around, is a targeted bit of operationalising what we call integrated care. We will do that now that the black letter part of the reforms are through. NSW Health will now perform its traditional ACAT role; it will assess, on behalf of the Commonwealth, the need for home care and residential care. But as of 15 July Health also has a role as what is called a regional assessment service [RAS] for the home support level. We would want to engage NSW and particularly Health as the two levels of that integration of care.

If they are doing the assessment we want home care and home support providers to be able to keep an older Australian functioning well and independently in their own home for as long as possible because we know that the primary source of admissions to emergency departments is from the home. The second part is then the secondary admission from a hospital or emergency department, often after a critical event—against most commonly a fall, where there is an admission from hospital to a residential aged-care service. In my opinion, those are the biggest intersections for Health to get right before we get to the third consequence, which is what

I will call a readmission from a residential service to a hospital. I think on any objective analysis the re-admissions are dwarfed by the original admissions to hospital from homes and the community.

The Hon. SARAH MITCHELL: You said you are involved in the steering committee. How have you found the process so far and the opportunity to engage on issues? Has the process been handled well?

Mr WURF: Absolutely, we welcomed it and have been happy to participate. It was in search of consensus but regrettably I do not think such consensus is to be found on this matter because there are very well-meaning and well-intentioned people trying to get to a better outcome but coming at it from different approaches. I repeat earlier evidence: the steering committee only came about as a consequence of the Federal amendments. There has been no desire for us to revisit this except because of those.

The Hon. SARAH MITCHELL: One of the terms of reference looks at the role of assistants in nursing [AINs]. In your submission you say you think there is no need for further regulation of this area. Please expand on that.

Mr WURF: That is the obligation of the approved provider and the most valuable way we will get a continuing improvement in skill mix and skill competency is through the employer-employee relationship. That is why we think there is not a role to regulate it. I am comfortable to note that over my long involvement in the industry virtually the entry point for an AIN now is a certificate III. We have done that in the market to meet our accreditation regulatory framework nationally in a way that would not be helped by State-level law.

The Hon. SARAH MITCHELL: I assume there are equivalents of your organisation in other States.

Mr WURF: Correct.

The Hon. SARAH MITCHELL: New South Wales is unique in having section 104 of the Public Health Act with all other States operating under the Federal aged-care system. From engagements you have with colleagues in other States, has that been an issue? Would it be an advantage for New South Wales to go down that path, as you recommend? Is there evidence from other States?

Mr WURF: It is my understanding that New South Wales is unique in the narrowness of this provision. All of the States and Territories have long traditions of how they have landed in the national aged-care system—we came out of private hospitals and nursing homes. I would go to the longitudinal evidence of the quality agency, in its two different names and forms, that demonstrates over time there is no difference between the States in terms of outcomes, ownership model or big provider versus small provider. There is some evidence that rural and remote small-scale services have greater compliance issues and generally that is access to skilled staff. There is no evidence to support that this law in New South Wales makes any material difference in the face of the national system.

Hearing today that Health has fielded three complaints on this law since 2004 proves the test that Morris Iemma set when he repealed the 1988 Act. I have only extracted a small part of it, but his test for the Parliament was that we will continue in essence the two provisions, have a director of nursing and keep a registered nurse on duty at all times in a nursing home to monitor the impact of the law. The test Morris Iemma, as Minister for Health, set in 2004 has been met. Only three complaints have been made and, by the sound of them, at least one has been in the last six months, which I would categorise as the campaign period. In the pack I have tabled there is comprehensive analysis of the complaints data and that is only one subset, the complaints and complaints-handling system, of the national framework.

For complaints there is a very transparent process including an ability to take completely anonymous complaints. The department will take an anonymous complaint and will investigate it. We grit our teeth in chagrin about that, given some potentially wasted resources, but when I go back to the philosophy I stated earlier, we accept that as a necessary part of the transparent complaints system and a critical part of our quality improvement processes. You also have the accreditation system, which is about meeting quality standards, and overlaying that you have the department that acts as a compliance regulator. I have done that over the years, and when they need a big stick it is wielded.

The Hon. NATASHA MACLAREN-JONES: I thank you for the additional information you provided. On page 81 of the 2013-14 Report on the Operation of the Aged Care Act 1997 the complaints are detailed. I assume that is at a national level and you have listed the top five, which account for 67.7 per cent.

They cover: health and personal care, including for example, issues associated with infections, infection control, infectious diseases, clinical care, continence management, behaviour management and personal hygiene; consultation and communication, including for example, issues associated with internal complaints process, information, family consultation and failing to advise enduring powers of attorney or guardians; physical environment, including for example, issues associated with call bells, cleaning, equipment, safety and temperature; personnel, including for example, issues associated with number of staff and training, skills and qualifications; and medication management, including for example, issues associated with access and administration. The majority of those issues would not be registered nurse-related but would involve other staff. Is that correct?

Mr WURF: I can accept that categorisation as care-related and integrated in that are registered nurses.

The Hon. NATASHA MACLAREN-JONES: When looking at complaints, would it be fair to say that solely increasing the number of registered nurses would not address this when you could increase staff in other areas or improve education and training?

Mr WURF: I would agree with that. Earlier evidence was that the Productivity Commission's view is that is an incredibly blunt instrument. I would go further and say it would be a misallocation of scarce critical clinical resources when the system is designed increasingly to assess the care needs of an individual and make sure that the proper mix of skilled staff are devoted to ensuring the best care for an individual. A blunt instrument is going to misallocate very scarce resources, in my opinion.

The Hon. BRONNIE TAYLOR: I was pleased that you have categorically stated on the record that you have no plans to remove registered nurses from aged-care facilities. It has been said that registered nurses are becoming very specialised and from that we have questioned whether we need more or less training. You spoke about registered nurses being trained at university, and I am one of those. Before we changed to university training, we had first, second and third-year nurses before they became qualified and now we have skilled assistants in nursing and enrolled nurses providing valuable care, particularly in the aged-care sector. Are those nursing needs being met?

Mr WURF: That is a fair categorisation of the changing mix over time of the way we recruit, employ, add skill competency and then deploy a range of workers. We would love to further enhance the role and numbers of enrolled nurses in aged care in New South Wales. There is a range of historical reasons why that has not been successful, but we would like to find the energy to have another go at that in the years ahead as the mix of RNs, ENs and properly trained certificate III and IV workers are well placed, within appropriate skills and competency in scope of practice, to give better care outcomes.

The Hon. BRONNIE TAYLOR: You mentioned multidisciplinary care and how it is the most important focus to get the best outcomes for residents. One thing that has not been mentioned is the important role of allied health services in aged-care facilities when looking at staff allocation. We think of diversional therapists, music therapy and social occasion organisers. I would say they are an important part of the multidisciplinary team mix. Is that correct?

Mr WURF: I agree. That is when you start to get down to the detail of the care planning and delivery. I think I made the generic point that there will be different care needs for different patients. That is a perfect example of that. Using some older language, it is the difference between a fully medical workforce in a nursing home scenario in the past and a more multidisciplinary workforce providing individual assessment of care needs. It was designed and constructed to get to those categorisations. There are about 64 different assessment and price points in the Aged Care Funding Instrument system. It is designed as far as possible to get to a careful analysis of the individual.

The Hon. BRONNIE TAYLOR: If having registered nurses on duty 24 hours a day in aged-care facilities were legislated, would that impact on the ability to service a greater need for speech therapy or diversional therapy? It may mean that services are allocated to a lower level of need.

Mr WURF: Yes. This is a specific point about which I will be a little more strident. If the regulation remains as it is—it is historical and our services are constructed around it—it would gently dissipate as services were renewed, remodelled, closed and rebuilt. If through this committee process the New South Wales Parliament were inclined to regulate that every residential aged-care service come within the provisions of historical section 104, that would call service delivery significantly into question for a range of facilities in that

historical low-care group. As was stated earlier, a couple of hundred services are not subject to this regulation and a blunt instrument may change that. Registered nurses are a critical part of what we do, but in properly reflecting their professionalism they are the most expensive resource in aged care. If there were a requirement to have registered nurses in services where they are not now required that would disturb the viability of a range of service providers. They would be predominantly the smaller rural and regional and more remote services. It is already difficult to find the necessary skills sets and it would be impossible if that requirement were extended.

The Hon. NATASHA MACLAREN-JONES: We have heard a great deal about the national accreditation standards. How do we compare with other countries such as the United Kingdom?

Mr WURF: People from other countries come to visit us to learn about our system.

The Hon. COURTNEY HOUSSOS: Did you write this or is it someone else's report?

Mr WURF: It is an extract. I refer in my submission to the Department of Social Services' annual report to the Australian Parliament; that is not my report.

CHAIR: Thank you for appearing at the hearing today. I advise that questions taken on notice should be answered within 21 days.

(The witness withdrew)

ILLANA HALLIDAY, Chief Executive Officer, Aged and Community Services NSW and ACT, sworn and examined:

CHAIR: Do you wish to make an opening statement?

Ms HALLIDAY: Obviously I agree with everything Charles Wurf said, so I will not rehash it. Aged and Community Services NSW and ACT is the peak body for the church, charitable and not-for-profit sector. We provide aged care in places where the market has failed; that is, we provide it because no-one else will. That means that care in rural and regional areas is my passion. In fact, 83 per cent of our members are small, standalone, rural and regional providers. Sixty-five per cent of aged care provided in this State is provided by the church, charitable and non-for-profit sector. I will not belabour the point about it being a Commonwealth responsibility; I will park it; it is in the submission and everyone has said it.

Many of the submissions call on the Committee to "keep, maintain, continue and retain nurses in aged care". As Charles Wurf said, of course we would want to do that for those 271 high-care facilities. However, I make it clear that there is no responsibility to have a registered nurse on duty 24 hours a day in all aged-care facilities. Now and in the future there will be many facilities and residents who have no need for a nurse to be on duty 24 hours a day. I am not saying that they do not need nurses, but having them on duty 24 hours a day becomes a problem, and that is particularly true in low-care facilities and hostels. Many of them are in rural and regional locations and that is why we care. These people typically do not need nursing care. They may be listed as needing high care and they may need allied care—physiotherapists, diversional therapy. They need help to get dressed, to eat, and to play. They are there to live their lives, not to wait to die. We need to provide them with the right activities, and we must have flexibility so that we can ensure we provide the right person.

An aged-care facility is also not an alternative to a geriatric unit in a hospital. People are in aged-care facilities because they are old and they need help. Many of them have chronic illnesses that they have been managing at home for many years in a stable way and with stable medication. They may not even have an acute illness. Occasionally they do, and that introduces a problem that is being confused. It is a vital problem that with the Committee's help I want to fix. We must avoid inappropriate admissions to hospital. We agree with that; in fact, it is happening now with or without nurses being on duty 24 hours a day. We know that happens sometimes, just as sometimes people are referred to hospital and are sent back without having received the care they need. There are some problems in the system that we must fix, and we want to work with NSW Health to do that.

We have many care models—Geriatric Rapid Acute Care Evaluation [GRACE], Acute/Post Acute Care Service [APAC] and telehealth—and we want to work with them. We would like to participate more because it is important that we work on new models. That needs flexibility, not having a registered nurse [RN] on night duty when that person could be used much more effectively elsewhere at a different time. We want to work on that bigger policy issue. We need help to do that, but it is a New South Wales Government issue.

RNs are invaluable. I was an RN so of course I will say that. However, it is true, and we need them in the aged-care system. They are vital, precious and rare. In fact, they are getting harder and harder to find. We have provided some statistics in the submission, so I will not belabour that point. It can take us months to fill a vacancy in a rural facility. We are competing with the rural hospital for that nurse, so there must be better ways for us to use those resources rather than saying that they are needed 24/7 somewhere where they are not needed now. I am not saying that we would not love to have them, although we may get better value out of a couple of diversional therapists than an RN. That is the flexibility we seek, particularly for the lower and mixed areas.

We have provided some of the figures. I wrote in 2012 that we have a problem, but not with what we have now. We have a problem with the extension of this into the low-care area. If we attempt to extend a 24/7 RN requirement into a low-care facility there will be problems. We have crunched some of those numbers and we are looking at losing 10 per cent or 6,000 of our beds. Already 60 facilities are saying that they will have to close because they cannot cope. It is not even a matter of numbers. They cannot get an RN now when they would like one. Saying they have to suddenly have four or five of them to give 24/7 coverage is putting them in an impossible situation. I have been somewhat dismayed to see it play out as if we are trying to remove RNs from aged-care facilities. We would be insane to try to remove nurses from aged-care facilities. It is never going to happen. They are just too important. But we do need the flexibility to have them in the right place at the right time so we can give the right care to someone based on their care needs and what their care plan says.

I am in contact with and I have analysed what is happening in other states. This provision does not exist in any other State. When you look at it over a longer period of time, we are average. We have the same number of complaints, the same number of sanctions, the same number of anything that you look at in terms of accreditation processes. There is no difference in the quality of care in New South Wales from the other states, but for some reason we have a requirement in the Public Health Act that I do not think is serving us well. There are more important things to do with NSW Health, and that is about getting better models of care into the future. We are delighted to have had a partnership with the Agency for Clinical Innovation to work on that. There are a lot of models in place. That is the big policy question: getting that right care. Thank you.

CHAIR: Thank you. We go to questions.

The Hon. WALT SECORD: Thank you for your evidence. I am familiar with your organisation and I have to declare an interest that I am on the public record in 2008-2009 congratulating you guys on your work in rural and regional areas and your faith-based members. Taking on board what we are considering—24/7 registered nurses—if the regulation continues, how could a State Government assist your organisation and your members, taking into account the fact that you are often the only provider in a rural and regional area? What could the State Government do to help you adhere to this regulation if it was retained?

Ms HALLIDAY: And there is the problem. When you look at the rural and remote areas, I do not know that we can find them. That is why we are talking about closures. The RNs are not there. We have people overseas trying to recruit RNs. They are just not available in those locations. We need to get much cleverer about on-call, about working with the hospitals and being able to use telehealth and get some proper things in place, because even when they want an RN—or some of them have got a high-care end so they would have an RN on duty if they could get one—they fly agency staff in. McLean at Inverell, for instance, has got the figures there showing you how it has cost them nearly \$500,000 a year to try to get the agency coverage when they cannot cover the shifts because they have not got the numbers of staff.

It is not even just a money issue, which obviously we would need, and that is a Commonwealth Government funding issue. They know they have a problem. They are doing a special piece of work now, because the rural and remote are not running at a profit. Most of them are running at a loss, and they are being subsidised—cross-subsidy happens a lot—or they have community support. They are doing it tough. It is not that they do not want the staff; most of them just cannot get those staff to cover the shifts when they need them. That is why we are looking at so many other models of care and attempting to work with local health districts to get sharing of these invaluable people in the remote area rather than saying that we all have to have one on night duty. If we cannot get it, is there another mechanism? Because one of the things—

CHAIR: I do not mean to be rude, but could you please keep your answers short. You took an extended amount of time with your initial presentation so we are pushed for time, and I think there are probably quite a few questions.

Ms HALLIDAY: Okay.

The Hon. WALT SECORD: You used the word "sharing". Are there any examples in New South Wales where there is a sharing mechanism or arrangement that occurs that we can point to?

Ms HALLIDAY: I would encourage you to look at some of the work that was done by the Hunter-New England Medicare Local. They have some very creative use of staff to avoid hospital admissions and to give coverage and good advice to nurses and facilities.

The Hon. WALT SECORD: Could you give us an example of how that works?

Ms HALLIDAY: If someone is unwell of an evening, for example, they ring the hospital. The hospital does a telehealth communication about what is happening. They have the ability to Skype. They take the iPad to the person. They talk about what is happening. If they need an admission then an ambulance is dispatched to get them. Otherwise, if there are other things that can be done to make sure that person is comfortable and not unnecessarily transferred, then that is put in place. They come out, they train the staff in the facility about what to do if such and such happens so that they do not need to call again. There is an outreach program—we love it. In the jargon I think they refer to it as an asset program, where they come out and they will do some training of our staff to say, "When these things happen, you do this, and if that doesn't work then call us and we will work through what needs to happen."

The Hon. WALT SECORD: Charles gave evidence that the average age of people entering aged care was 84 years old in rural and regional areas. Are people in fact older or more frail in those areas?

Ms HALLIDAY: In fact it can be the opposite. Because you are in a regional area, they might be on a farm and they have no-one to provide any care. They are more isolated, so we need to bring them in a bit earlier. They may live there for longer and be lower care rather than high care. That is why we have so many low-care people out in those areas, and they live longer because they have come in earlier. Some of the facilities have to do a transfer point when someone gets very high care. We do not like doing that—it is disassociating them from their community—but sometimes we have to, and we explain that at the point of admission. We can have both, but sometimes it is the opposite of what you might expect.

The Hon. COURTNEY HOUSSOS: Building on the Hon. Walt Secord's question about how this can be better facilitated in rural and regional but particularly remote areas, would you support, for example, implementing an exemption or special circumstances for those areas?

Ms HALLIDAY: I think the residents in an aged-care facility have to get the appropriate care regardless. The system has to be designed around the person's care needs when they are in that facility. For many people the high care does not actually refer to nursing care, so it is being clear that the care plan says what they need. If it is that they need nursing care and it is a complex clinical thing, we may be able to get them to a hospital, get them treated and get them back without that complexity—if it is acute, treat it and let the person come back. I am very nervous about exemptions, because we have to think about the person that is actually in the facility. I am very excited about the opportunities to use technology and improve the other outreach systems that we can do to get the care available, perhaps not in the building but on call.

The Hon. COURTNEY HOUSSOS: In your submission, you said:

Most providers require their staff to undertake the Certificate III in Aged Care training and many support staff through the Certificate IV ...

Would mandating something like this be an onerous requirement?

Ms HALLIDAY: I would not mandate the training, simply because aged care is one of the few career paths left in Australia where if someone has the right attitude, if they come in and they want to work there, which is a lovely thing to do—that is our prime thing: Can we get someone who cares about old people first, please?—we bend over backwards to give them free education and time off to do their study and submissions. We will put them through Cert III, Cert IV, EN, RN. That is a really common pattern of giving people a career path they cannot get anywhere else, because we are paying for it. We are giving them the time. We want them to have these things. If they come to us keen, enthusiastic and caring, we bend over backwards to give them all of that. Nearly everyone does Cert III, but if you mandate it and block people from coming in when they really care about aged care, then we may block out people who would be wonderful in the role.

Reverend the Hon. FRED NILE: You have explained the economic impact on the not-for-profit organisations and you are opposed to exemptions. Is there another way of trying to have categories of aged-care facilities? We used to have high care and low care. The fact that that was scrapped seems to have started this drama we now have. Can we restore that in some way?

Ms HALLIDAY: I wish there was a simple answer to that. That is why I raised it back in 2012. When the Living Longer Living Better legislation came out there were flashing lights all over this as a problem on the horizon. That is why I wrote off about it all the way back then, saying, "Wait a minute. We've got a problem about low care. We can't extend the RN coverage into low care." We have spent 2½ years trying to find a definition or a simple way of saying, "Keep the 271 facilities covered but don't extend it to this, and make sure there's the ultimate flexibility," because you need to make sure you get the mixed staffing.

Lots of time and effort has gone in to trying to find a definitional answer, and we cannot find one because people's needs change, their ratings change, they get short-term needs, they get longer term needs. They may come in with high-care needs and we do all the right things to enable them and they become low care. The individual's needs let alone the individual facility can change quite quickly in respect of the mix of people they have got there and the mix of staffing that they need. That is why we need the flexibility to bring it in.

I have a low-care facility down on the far South Coast, a member of mine, who will occasionally take someone in for palliative care. They are low care and do not have the registered nurses [RNs] on, but they know when they take them in they are exposed to agency coverage until that person has a peaceful death. That is what they do because that is what that person needs, so they have a got a system in place to cope with the needs of the person regardless of the rating of what that organisation may be. Flexibility is what is needed. We could not find a definitional answer. We hunted before we raised it. It is always better to have a solution. We could not get it. The committee has been looking for it and that is why there is not the consensus on this that we would like to see.

Reverend the Hon. FRED NILE: It is also a challenge for the family of the aged person to find a place that will meet their needs.

Ms HALLIDAY: Absolutely.

Reverend the Hon. FRED NILE: It would help them if there was a definition or a labelling. "Our aged person needs high care so we will go to a high-care centre not a low-care centre."

Ms HALLIDAY: A lot of that is explained when people come to talk. I have been a consumer placing someone in care. A lot of that is explained. When you go in, they talk about the level of care that is available and the sort of things you can expect from that. In fact, the Victorian inquiry like this one that was done a couple of years ago, the recommendation they had was about the transparency you mentioned before, about saying, "We do not have RNs on duty at all or 24/7", whatever it is, and being really clear. Every experience I have had, a provider is clear at the point of admission about those things, but we cannot find a simple definition. We have hunted. We have tried, so it becomes something about the disclosure and transparency to people, by all means, and for people to ask questions. But all of the facilities do get the appropriate level of care for that person, matching their needs, as per the Commonwealth standards. We work hard on that.

Reverend the Hon. FRED NILE: The other aspect of trying to tackle this situation is rather than having a registered nurse is to have another person who is—I am trying to think of the definition—an aged-care specialised nurse who has the qualifications of a registered nurse but is not the same; they are specialised in aged care.

Ms HALLIDAY: Part of the challenge we have is that the average age of the RNs who come to work for us is 48. There is lots of data about that age. Many of them leave because we burn them out by asking them to work too many shifts. They typically work part-time; they want only around 17 hours. It is about keeping their practising certificate alive. The younger ones leave us, as I did. After four weeks, I went off to work in intensive care. I have got the university degree and the qualifications and those who are more specialised are looking for a different kind of work. I do not want to do anything that devalues the role of an RN that we have got now.

Some of the nurse practitioners are brilliant and they work so well that we do not need a general practitioner to come in. We need to do more of that. We need more clinical nurse people who have the qualifications so that we can balance off the inappropriate admissions or make sure that people do get to hospital when they are entitled and when they need it. There is a role for them, but you would not necessarily want one in a low-care facility. They would get bored witless.

Reverend the Hon. FRED NILE: Going back to the other problem of complaints, patient satisfaction, how do you handle complaints? We have heard there have been only three complaints in New South Wales, which does not seem to be logical when I have had a lot of contact with people who are complaining about the Health system all the time.

Ms HALLIDAY: That is just about the number of RNs. I was surprised there had been three because I would not have thought to complain about it to the State Government because all the complaints go to the Federal Government because it is a Commonwealth Government responsibility. The report on the operation of the Aged Care Act comes out every year. I can barely wait for it. I drop it down and start analysing it—where were the complaints; were are the sanctions; where are the "did not comply"; who was doing what; how quickly have they done it? We analyse that to learn everything we can.

Is there a system error that we need to improve on? We analyse those things to see what can be done with it. It is a low level of complaint. Most facilities will complain about the quality of the food. They complain

about diversional activities, about the sorts of things that they would like to see for their loved ones, or it is the loved one complaining. We understand where the complaints come from. It is not usually about specifically, "I want an RN." It is about the quality of their life, which is why they are there.

Reverend the Hon. FRED NILE: Is there any variation between the for-profit category and the not-for-profit?

Ms HALLIDAY: Not typically.

Reverend the Hon. FRED NILE: Do you have fewer complaints from the not-for-profits?

Ms HALLIDAY: Not typically. I have not seen any variation between the States. This year apparently we have six pop-ups in that report. Last year it was three. They were all resolved by the time the report went to publication. Other years we might not have any in New South Wales and they are sitting in other States. It is a matter of what is happening at points in time for people. Everything is about average with it.

Reverend the Hon. FRED NILE: Quality of care is the same in the for-profit and not-for-profit?

Ms HALLIDAY: I believe so. We tend to be in places where the for-profits are not going to be. If you go on the other side of the Great Dividing Range, you are going to find the churches, charitables, not-for-profits. We have some facilities that are absolutely beautiful and we make quite a nice surplus on that and that allows us to operate in Woop Woop where no-one wants to operate. It is a completely different model and mindset to what we do with that. The Aged Care Financing Authority [ACFA] report has discovered that there are significant differences in the viability of rural, regional, remote and they are saying they are at risk, and that is why they doing their own analysis of that now. They certainly found that the for-profits ran a more profitable model than we did, but by their own admission they are driven by different objectives. They spend their money in different ways, which is not about staffing. The way they do their business is quite different.

Reverend the Hon. FRED NILE: We certainly do not want to have any negative impact on centres in regional areas.

Ms HALLIDAY: We will still see a need for 24/7 RNs in the large high-care places that people need high-care clinical health support. Just be careful. High care does not necessarily mean nursing care. It could mean other things for dementia patients.

CHAIR: You have raised important issues about the definitional data that is available and whether or not it can be defined. Surely there are means to define whether or not something is clinical or high need that requires medical intervention and support rather than something that is recreational. They do not seem to be difficult to define. We are also looking at the complaints. The way they were presented by the previous witness's submission, they do not really tell you that much. They could be recreational, for example, if someone has fallen, or it could be a lack of care and understanding about the frailty of that person that led to them falling. I am wondering if you have provided any other submissions to the State or Federal governments or any other process such as the Productivity Commission that might provide some further insight that you have alluded to about trying to find ways to resolve some of these issues?

Ms HALLIDAY: No. We have not attempted that. As an industry we have been working on what we can do with the definition.

CHAIR: Is there anywhere we can be further informed? You are expressing a passion about how difficult it is to define when it would not really seem so to a non-practitioner. It seems that you can define whether it is health-based or non-health-based. It is very clear in the submissions we have received that people are complaining about a lack of support or understanding of preliminary signs of their needs that perhaps could have been dealt with better.

The Hon. NATASHA MACLAREN-JONES: Would it be helpful for the witness to have a copy of what is being referred to?

Ms HALLIDAY: Is that from Charles?

CHAIR: Yes. It is broad and does not give a breakdown, but you are speaking about it so I would like to know if you have any further information you can provide. You can take it on board. The other one is the staffing issues. We have heard from the submissions and now from you that there are not enough RNs available, that there is not enough encouragement. Have you been making submissions to State and Federal inquiries that that is where our future is in respect of workforce capability and the need for some sort of response from Government for support and funding and, I agree, particularly in rural and regional areas? We have come up with the National Disability Insurance Scheme because it costs more in those areas because distance is a problem. I would appreciate reading more of your information—it is an interesting submission—and hearing more about you and your sector, and what you have done to make these things known so they can be dealt with.

Ms HALLIDAY: I can provide you with a copy of the submission we made on the workforce for aged care. And I can provide you with a copy of the submission we did about the differences in rural and remote aged care.

CHAIR: Terrific. That would be great.

Ms HALLIDAY: Because those things are pretty close to our heart we have that information. I can provide those submissions. In terms of the breakdown of the individuals with complex needs, it becomes difficult because we need to know why someone is in a complex health area. The ACFI—the Aged Care Funding Instrument—is a very complicated tool. There is a complex health domain within that, in which you are more likely to pick up that someone has dialysis or palliative care—the clinical things that you typically think about as needing nursing and clinical care—whereas some of the behavioural domains are where someone's dementia could kick their needs up into high care very easily.

The Department of Social Security provides some information of the split in the various levels of that ACFI tool. The data is available. It comes out every quarter or so. They give us the data about the patterns across the ACFI categorisation. That is something that would be available to you. But even within some of the complex health-care domain there would be some things that would not need a registered nurse, so long as they have been set up. They would not need a registered nurse to be on duty 24 hours. They will need a registered nurse if they are treating complex clinical needs—absolutely—but it could be that that nurse is laying down a plan for an enrolled nurse or an assistant nurse, who can be doing it during the other hours. That is the area that you would be trying to look at.

We thought that maybe there was something in that but once we unpacked it it became obvious that there were things even in there that you could not use as a blunt definition. So it is about coming back to the assessed need of the person and their individual care plans. So we could not get an answer.

CHAIR: Do you think the assessment for the individual plans are robust enough and take on board future need and funding and staffing requirements?

Ms HALLIDAY: Most facilities have that very refined. Part of the reason they pay attention to it is that their funding from the Government depends on getting that right. Some facilities have paid more attention to it than others, but people are pretty attuned to what needs to go in there. One of the things that we talked about in the complaints coming through—and "did not meet" comes out—is that the documentation sometimes lags behind the care that we are giving someone. If there is a lag between that then you can pick up something that you have to get right around that process.

CHAIR: If you have a change in the care needs what is the lag time for the funding to come through and for you to—

Ms HALLIDAY: You have to do a reassessment.

CHAIR: What is the time frame?

Ms HALLIDAY: I would have to take that on notice. We can tell you when the reassessment points are. There is a limit to how many times you can do a reassessment. I would also encourage you, on your subsequent hearing days, to hear from people like UnitingCare Ageing, HammondCare and Feros Care. They have given you very good submissions. They do all the day-to-day assessments.

I would like to answer one of the questions you asked somebody else. You might want to check some of the Medicare locals—they are now the Primary Health Networks—in terms of analysis of admissions to emergency departments outside hours. I know of one, at least, that has done that analysis. The admissions from aged-care facilities were from retirement villages, because there is no care of any sort on duty at night. There is no-one to call so they ring an ambulance and get admitted. Primary Health Networks have done that micro level of analysis that no-one else seems to do, so they may be a source of data for you.

Reverend the Hon. FRED NILE: If they had had a registered nurse they may not have had to go to the hospital.

Ms HALLIDAY: Retirement villages are not required to have people on staff at all at night. Some do have people on duty. That is another source of data for you.

The Hon. BRONNIE TAYLOR: Thank you very much for your obvious enthusiasm and passion for aged care; it is oozing through, and it is really fantastic to see. With respect to the meatier data that you were talking about, would that be in terms of appropriate and inappropriate admissions, as well? I heard you speak about that before and I am just concerned that we lay on the table that sometimes these admissions are absolutely required and necessary.

You mentioned the Hunter-New England area and what the amazing, innovative staff—they really stand out—are doing. You talked about the iPad and things. I have two questions about the appropriate and inappropriate admissions to get that on the record. When you were talking about the iPad I was salivating; it sounded fantastic. In the facilities where you have had experience using it—they use that iPad, say, in the ED at Newcastle Hospital talking to someone on the South Coast—the carer on duty for that evening would make the collaborative decision.

Ms HALLIDAY: That is where we need to go with that. Concorde Hospital has a state-of-the-art wound management system that is supposed to be used only by that local health district. I have been naughty, and I have told other people, who have rung, used the iPad and got the advice back. The problem is that those models are fragmented and run by local health districts or by particularly good Medicare locals in a partnership, and they are not getting expanded out. Those sorts of models provide wonderful opportunities for us. I know that Feros Care, use a lot of tele-health at their facilities. They communicate with the doctors and with their associated hospitals that way. It is too fractured. We have to get that as a State-wide system. We cannot keep letting it happen at the level of an individual facility or local health district. That is critical.

The Hon. BRONNIE TAYLOR: Perhaps that is where looking at different models of care for the individuals that we are serving is the issue here, not legislating that it has to be a certain profession for a certain hour.

Ms HALLIDAY: Absolutely. You are speaking my language.

The Hon. BRONNIE TAYLOR: The way you talk about rural and regional facilities really resonates for all of us here, I am sure. When you talked about the fact that there would be some risk of some of these facilities closing I wanted to ask you about the impact. I know in my own communities and practices I have seen where the aged-care facility was full and they have had to put someone over 200 kilometres from their home town. That would mean that their grandchild cannot go in with their school merit certificate in the afternoon to show their grandparent. The son or daughter cannot come to help them with lunch. How do you see that impacting if this was to go on to use such a blunt tool?

Ms HALLIDAY: I think that would be a disaster for those small facilities. You have a submission from Ashford. I did not know whether they would be prepared to put a submission in. They do not have an RN on staff at all. It is a low-care facility of 18 or 19 people. They have a wonderful arrangement with the local community health nurse who comes in three days a week and provides all those things that have to be provided. So there are ways around it. That facility is part of the community and those people would otherwise have to go to Toowoomba. You would never see them again; you would be sending them off to die.

It would be horrible to cause that kind of dislocation from their community and their loved ones. That is the real nub of this problem. For the rural and remote communities those are the only facilities for aged care. Typically aged-care facilities are the second or third largest employer. If they close it will not just be the aged-care people that are affected. The local businesses will be affected. They are in rural economic development. So

there will be real effects if this happens. Some of them are saying, "We will close this bit and just keep the high-care bit because we cannot get the RNs to cover the other part." They are on the same site. This is a very blunt piece of legislation and it does not work. It would have terrible consequences for the community and for the families and their loved ones.

The Hon. SARAH MITCHELL: I also commend your passion for this issue and for regional areas. That is something that we share. Because you are, in the main, representing not-for-profit organisations, the concern about the potential to have registered nurses 24/7 is not about commercial viability or about costing too much money. You are not coming at it from that space; this is about what is in the best interest of people who are in these facilities at the moment and continuing their care. It is not a commercial issue.

Ms HALLIDAY: There is no commercial gain to us. Believe me, we have run the numbers as to how we could comply and what that would cost. It is \$150 million and 2,000 registered nurses who are not in the system. We are not liberating money for anyone; it is about making sure we get the right service in the right time.

The Hon. BRONNIE TAYLOR: The Chair was asking about care, definitions and so on. I would like you to elaborate. With the previous witness I was talking about things like diversional therapy and music therapy. In terms of medical need, dementia would be one of our greatest aged-care needs at the moment. It is really tough stuff. If you have a multi-disciplinary care team approach to a plan for a dementia patient that involves a registered nurse, doctor, everyone else, that plan can be carried through 24 hours a day without necessarily the presence of a registered nurse or doctor. Other health professionals that are working there, whether they are RNs or enrolled nurses, are able to successfully care for patients with dementia.

Ms HALLIDAY: Absolutely. In fact, that was a conversation I had with someone who has made a submission saying be careful about saying you need a RN 24/7 because in order to achieve that I would need to get rid of three care workers. And who do you really want with a person who has wandering or behavioural issues for dementia? I would rather have someone doing the things that keep them less agitated and enjoying their life and tired at night so they sleep through, than necessarily saying a RN will solve everything. RNs are great when you need a RN, and we need them. There are other options for some other residents. It is get the right place, right person.

The Hon. NATASHA MACLAREN-JONES: I have one question about complaints. You say that when the information comes through you analyse the data and then you engage with your organisations. What type of training do you provide to them to address some of the complaints or issues that might have been raised?

Ms HALLIDAY: We do it in several ways. A couple of times we will have someone who had a significant issue happen and they are just wonderful people because they will have volunteered to come and bare their soul and do an afternoon seminar and talk to the other people and say this is what happened. This is how we got wrong. This is how we fixed it and these are the things that we will do to avoid it happening again, and you should do that now so it does not ever happen. So there are afternoon seminars. We will include it in conference papers. We put in our fortnightly newsletter some of the things that have come through, if we need to. We use some of those things as live case studies during the courses we run about running a facility, what it is like to be an aged-care don and those sorts of things. We wind them in as live case studies so they are exposed to that.

Reverend the Hon. FRED NILE: I am pleased to support the non-profit agencies. They do a great job.

CHAIR: Thank you for appearing today. There were some questions on notice. The secretariat will contact you. You have 21 days to return answers.

Ms HALLIDAY: We will get them back to you.

CHAIR: If you think of anything else you are more than welcome to make information available.

Ms HALLIDAY: Happy to do that.

(The witness withdrew)

(Luncheon adjournment)

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

HELEN MACUKEWICZ, Professional Officer—Aged Care, NSW Nurses and Midwives' Association, and

JOANNE RUSSELL, Nurse Practitioner—Aged Care, NSW Nurses and Midwives' Association, sworn and examined:

CHAIR: This afternoon we will be hearing first from the NSW Nurses and Midwives' Association. Would you like to make an opening statement?

Mr HOLMES: On behalf of the NSW Nurses and Midwives' Association, I thank the Committee for its attention to this important issue that is clearly widely and deeply felt by both our membership and many people in the community. The NSW Nurses and Midwives' Association represents over 60,000 nurses and midwives across New South Wales, with at least 10,000 of those members working in the aged-care system. Many of those have raised their concern about the potential loss of this piece of protective legislation. Of course, there are two pieces of legislation that are known to provide some protection in this area: the current legislation under inquiry, the Public Health Act, and the pharmaceutical legislation. Both pieces of legislation are important in aged-care service delivery, but we are particularly concerned at this point about the proposal to completely exit the field by the State Government.

We believe it is in the interest of the State to continue to have a role in high-level oversight of one very important component of aged-care provision, and that is the assurance that there should be a registered nurse available at all times to deliver complex care needs, which are within the domain of a registered nurse. A registered nurse has either a hospital-based certificate but is now required to have a degree. These nurses have a broad knowledge and understanding of their area of expertise plus a capacity to deliver complex care needs and, importantly, assessment and supervision of staff. Other workers include the enrolled nurses, formerly with a certificate IV and now diploma level, and they work under the supervision of the registered nurse. The largest component of the workforce and our membership in this sector are the assistants in nursing. There is no legislated requirement for them to have a qualification, but there is an expectation across the industry that they will have a certificate III and some are progressing to a certificate IV-level education.

The assistants in nursing are not covered by any professional requirements. They are not licensed or registered. They are under the direction and control of their employer and most often work under the supervision and direction of the registered nurse. They carry out a range of tasks and basic care for residents. They rely on registered nurses to oversee the provision of care. That provision of care delivery is critical to the welfare of residents, but without the overall assessment of registered nurses they are relying on a lower level of expertise and experience to make judgements about the care that they are required to give.

Obviously we stand very firm that we believe that the State legislation should continue to protect the residents of New South Wales aged-care facilities and protect those people with high and complex care needs. Those care needs cannot always be predicted or confined to an eight-hour roster or 16-hour roster coverage. Anyone who has dealt with aged-care people or family members who are ageing knows that things happen at unexpected times. People do not become sick when the nurse is available. Accidents, injuries, falls do not occur just because someone is rostered on duty, so the importance of 24-hour coverage is to try to provide the best quality of care and the best capacity to respond to the sometimes unexpected needs of residents in aged-care facilities.

Ms MACUKEWICZ: I will provide some information about myself to give context. I am a registered nurse. I also have a Masters in Specialist Community Public Health Nursing in the field of child and family health. I am a registered nurse prescriber in the United Kingdom and a registered nurse with the Australian Health Practitioner Regulation Agency. I started my nursing career in a family business that operated a nursing home and a hostel-type facility in the United Kingdom both small facilities in rural areas. I then moved into the public health sector, where I commissioned a day unit for elderly people. I worked for 16 years for the Care Quality Commission, which is England's national care regulator, and its predecessor organisations. Over those years I visited many aged-care facilities in a regulatory and quality monitoring capacity. I also visited public health services, general practitioner practices—private and public—National Health Service ambulance trusts and any other service where care was provided.

I want to make a point that I do not feel was fully addressed this morning. It relates to the level of need of people now entering aged-care facilities. In the late 1980s and early 1990s when I was working in aged-care facilities the people entering hostels may have had a couple of falls at home and their families were concerned. They were no longer living nearby and they needed to know their loved one was being supervised. People would be walking around the home, collecting the newspaper from local shop, gardening and helping with tasks around the home. Those people might have had a stroke and had a degree of limb contortion. At that time we put people to bed when they had had a stroke and left them there. We did not realise that early intervention could alleviate life-limiting symptoms.

I will fast forward 20 years to what members are now telling us about their experience of people entering aged-care facilities. These people no longer have a lifestyle choice to enter a facility; they need registered nurse supervision 24 hours a day. They do not have only mild dementia; they have complex other difficulties. They often have heart conditions, they could require complex wound care and have continence issues. They are no longer the people who traditionally would opt to move simply because they felt it was the safest place to be. They are people reaching the end stage of life who need us to provide end-of-life treatment and pain relief. I make that point because I do not think it was made clear this morning.

Ms RUSSELL: I am a nurse practitioner and I work in a 100 per cent clinical role in aged care. I have been a registered nurse for 25 years, 18 in aged care. I completed a Masters in Nursing (Nurse Practitioner) in 2008 and have been a nurse practitioner for three years. My current role is to provide advanced nursing care to residents, to undertake advanced assessment, to put plans in place, to avoid hospitalisation where possible, and to facilitate hospitalisation and to get the most out of it when people need it, to refer to specialists, and to undertake advance procedures. I work in aged care specifically as a nurse practitioner because I want to improve the lives of older people, and I see real benefits in that role. However, I rely heavily on having a backup team of registered nurses and could not do my role without them.

The Hon. WALT SECORD: I will cut to the chase. Ms Russell, will amendments to State legislation as proposed by Government members affect patient care and quality in New South Wales?

Ms RUSSELL: Yes, it will.

The Hon. WALT SECORD: Can you elaborate?

Ms RUSSELL: There will be a risk that aged-care providers will not provide registered nurses 24 hours a day, and particularly on shifts when penalties rates apply. They will look at cutting costs by reducing that care. Of course, we know that people need care at all the times of the day and night and on weekends. As Ms Macukewicz said, people coming into aged care are now much older and more frail and they have much more complex needs. We are being asked by the Government to assess everyone on three trajectories of palliative care—everybody. We ask a surprise question: Would you be surprised if this person died within the next six months? For more than 50 per cent of our residents the answer is no. How can we look after people with such complex, changing and unpredictable needs when we do not have registered nurses to deal with changes to medication and the need for pain relief and psychosocial support? Registered nurses are the members of the team who have the qualifications and training to lead that kind of care.

The Hon. WALT SECORD: In your professional opinion, do registered nurses in aged-care facilities save the taxpayers money by helping people to avoid entering the public health system?

Ms RUSSELL: Yes, of course they do. Without registered nurses there is no-one to make a decision. Often it is on a knife edge and the fully trained registered nurse can make an informed, intelligent decision. The person might have a soft tissue injury and we can monitor them for a little longer. However, a person without that training can either assess too weakly—there might be an obvious fracture but it is not picked up and the patient is not sent to hospital—or they might see a bump or a bruise and they do not know how to manage it so they send them to hospital.

The Hon. WALT SECORD: During December/January there were reports that because they did not have nurses on duty aged-care facilities in Western Sydney were dumping elderly patients in emergency departments. Would you care to comment?

Ms RUSSELL: When aged-care facilities do not have registered nurses and a resident's needs increase because they have had a fall and their mobility is not good they say they cannot look after them and the hospital must keep them.

The Hon. WALT SECORD: What can a registered nurse do in an aged-care facility that an average person who is employed there cannot do?

Ms RUSSELL: A registered nurse is able to recognise changing needs and clinical deterioration and can liaise with external teams and the general practitioner to provide extra care and support, equipment and splints. They can manage different procedures. A person might come back to the facility with a nasogastric tube, a catheter, some kind of insulin device or infusion, or even subcutaneous fluids. Registered nurses can manage all of those complex things that hospital discharge people with.

The Hon. WALT SECORD: Do you believe it simply comes down to money that commercial aged-care providers do not want to pay for registered nurses?

Ms RUSSELL: I believe it does to a large extent. They are looking at where they can make money and small gains. Yes, they want to improve lifestyle, but unfortunately if it were all about lifestyle people would stay in their own home. That would be their choice; people do not want to move into residential care; it is not their life-long dream. They have to move into residential care because of their care needs; they have complex health needs. It is in addition to that that we want to provide a lifestyle program and improve their quality of life. However, we cannot take away from the minimum standard of health care.

The Hon. WALT SECORD: Mr Holmes, have you done any modelling, studies or financial impact research on how much registered nurses in aged care save the public health system? Do you have any research in that area?

Mr HOLMES: No, we do not. We do not have that oversight or capacity to look inside of the staffing levels in aged care. It is a very interesting issue that we have to do our own mapping and try to understand what staffing levels might already be there. Our understanding is that there is a large group of good operators who, of course, have registered nurses there. This piece of legislation would have no real impact upon them because they already have registered nurses on duty 24 hours a day. In relation to your question about commercial operators, they are all commercial operators. There is no-one in aged care who is not there to make a surplus or a profit. It just depends on whether you call yourself a not-for-profit or whatever. They all have to make a surplus. We understand and recognise that.

But the information that we do have access to tells us that there are many operators—and large commercial operators—who are very keen to enter this field. This is not a field where people are not making money. There are large companies investing in aged care. Our contention is that if they are receiving money from the Commonwealth which is classed as for high care and complex care then they have an absolute obligation—and we should continue to hold them to account for that—to use our taxpayers' dollars to deliver that care.

The most broadly skilled, well-qualified people to do that are registered nurses, who have a practice of working across all shifts. It is all very well to say that there are allied health people who make a very important contribution to the care of residents, but there are very few allied health people who put up their hand to say that they want to work a nightshift—or afternoon shifts for that matter. That is not necessarily in the culture of many of them. Many allied health people in aged care come in as contractors rather than as employees, so there is a difference in the view that they take about their availability to be there 24 hours a day.

The Hon. COURTNEY HOUSSOS: Thank you for your very detailed and informative submission. I found the testimonials very compelling reading. Previous witnesses have spoken about the concerns of formerly low-care facilities, particularly in remote and regional areas, possibly closing as a result of the extension of this regulation. One of the ideas that we discussed with some of the previous witnesses was that of a new type of classification to capture that previous high care/low care distinction. What are your thoughts on this? Or do you have a view on other things such as exemptions, particularly for remote or rural formerly low-care providers?

Mr HOLMES: I am not sure whether you are referring to classification of the type of facility or staff.

The Hon. COURTNEY HOUSSOS: We are talking about the former classification of high care and low care of nursing homes and hostels—whatever terminology you would like to use.

Mr HOLMES: Statistically we now know that 80 per cent of the people who were formerly admitted to low-care have high-care needs. As has been explained this morning, I am sure, there are three categories within that high care. We believe that there needs to be a reasoned and sensible look at the delivery of high care or complex care that requires registered nurses. There are examples in the submissions that I have read that talk about the successful provision of care in those small rural hostels. That is acknowledged that they are trying to do that. I think people ought to have then a choice and should know very well that they are entrusting their loved ones to an organisation that says it principally will not provide 24-hour registered nursing care. That is one of the proposals—I think it should be clear what is happening. If there needs to be an assessment of just how many high-care people you need before you get a registered nurse, that sounds like a reasoned idea to work at.

The problem is, if it is my mother who is not getting access to a registered nurse 24 hours a day because she lives in a country town and does not want to be in a larger aged-care facility that has someone 24 hours a day, then I would want her to be making a good decision about that. It is very hard for us to say there is a cut-off point. I see in one of the submissions they say they need 70 residents to be able to afford a registered nurse in aged care. I have not seen their actual financial modelling of that, but we know on average an aged-care resident in those facilities can get government funding of up to \$50,000-\$60,000 a year. There is a considerable amount of Commonwealth funding going into those facilities and they get extra support because they are isolated facilities working in difficult circumstances.

So the answer is that there needs to be a reasoned decision making process as to how you can make those services deliver quality care and ensure that people who live in regional New South Wales are entitled to the same standard and quality of care as those people who have the benefit of living in larger centres.

Reverend the Hon. FRED NILE: Thank you very much for your submission and your involvement in this issue. Obviously it is something very close to your interests. I note your recommendation that the Public Health Act 2010 should be amended. You have not actually provided a draft amendment. You have suggested that:

Current legislation should be replaced by that which allows for provision of registered nurses at all times in any residential aged care facility where there are people assessed as requiring a registered nurse to meet their needs and where they are funded at that level.

You have not used the same wording of the regulation. You have not argued to keep the regulation. You have given new wording, which raises questions in my mind around the words "where there are people assessed". Who is doing the assessment? How do you arrive at the situation where you know there is a need for a registered nurse?

Ms MACUKEWICZ: I think it was mentioned this morning as well that there are aged care assessment teams. There is a three-part process to the assessment of need. Our members are telling us that within the assessment that takes place even before somebody enters a residential aged-care facility—

Reverend the Hon. FRED NILE: So you mean the Commonwealth system when you say "the assessment".

Ms MACUKEWICZ: Yes—the Commonwealth assessment framework. There is opportunity within that. There are activities that require a registered nurse to be identified. This is what our members who are working in those areas are telling us. There is opportunity within the current wording of those documents to identify where registered nurses are required to meet need—again, with the funding instrument, that a registered nurse is required to perform the second assessment that takes place once somebody enters a residential aged-care facility, so it is an assessment that is undertaken by a professional person with relevant training.

They also tell us that there is potential within that document for the identification of activities that require a registered nurse to fulfil them. One of those would be the administration of "when required" medications where somebody is having breakthrough pain in the end stages of life. That is just one example. Again, as a registered nurse, as a professional, I would always be identifying activities within a nursing care plan that were nursing-led activities. There would always be opportunities, because that is the safest way to identify who might best meet that need.

Reverend the Hon. FRED NILE: We have already heard from the agency you are referring to. I think it is fair to say that they showed a distinct lack of interest in going back to the approach of high level care and low level care assessment. How would we get the Commonwealth's support? We may have to have some other State assessment process set up if the Commonwealth will not cooperate with New South Wales.

Ms MACUKEWICZ: I think we are looking at a State legislation change here. I think there is opportunity for us to look at the way we are wording the State legislation and to try to frame something around the assessment of need within that so that the funding is following where people need the nurses, so that there is no discrepancy between what we are paying for and what we are receiving. If we clearly link the three—the funding to the assessment to the need for registered nurses—then there can be no lack of clarity about what we are funding for and what we are saying people's needs are. That is one of the issues. At the moment there is a lack of clarity for all parties concerned.

Reverend the Hon. FRED NILE: It would help us if it was possible for you to give us a supplementary submission with the expanded wording of what would be required in the legislation.

Ms MACUKEWICZ: Certainly.

Reverend the Hon. FRED NILE: We heard from the association's representatives earlier that they are happy with the process at the moment because it is reducing their costs and so on. How many registered nurses and people would be required in one centre 24/7?

Mr HOLMES: To cover a full 24/7 shift?

Reverend the Hon. FRED NILE: Yes.

Mr HOLMES: I think Uniting Care in their submission, as far as I can remember, calculated that that was five full-time equivalents or something to cover that, at the minimum. I would have to refer back. They did qualify, of course, that many of them already have either a registered nurse as the director of care or at least one registered nurse on duty, so in their calculations they have extrapolated out the worst-case scenario and then qualified that by saying of course there are many registered nurses already employed. As I see it, definitely what has happened over the introduction of ageing in place is that operators have been able to make their decisions about whether they will or will not expand the numbers of registered nurses, despite expanding the level of care that is being delivered in their facilities.

It has been at their prerogative to decide to do that, and they have not been previously required under State legislation. That changes things now when all of those definitions are gone and we are so bold to say it is time to have another look and make sure that there is protection for all people. If the Commonwealth is prepared to pay money to all of those aged-care facilities to provide high care, then we as the people of New South Wales should be able to say we expect that those facilities operating to look after our most frail elderly meet an obligation to the State of delivering good quality care at all times.

Reverend the Hon. FRED NILE: I note in your submission you use the term "assistant in nursing" [AIN] and that there should be clear minimum standards of qualification. The association talks about enrolled nurses. Are you talking about the same thing?

Mr HOLMES: No. As I said at the start, the definition is different. The enrolled nurse is a licensed worker who has a diploma level education. The assistant in nursing has a certificate III or IV at the highest level, and there is certainly a difference in that level of education. There is a difference in respect of the professional responsibility and accountability. The assistant in nursing, or many other workers do the same job; they are carers, care service employees.

They are accountable to the employer for their practice and there is some oversight and requirement on them to report under various pieces of Commonwealth legislation about adverse actions against residents and so forth, but they do not have a professional body. They are not required to respond professionally to anyone and it is an area that nurses and midwives and the Australian Nursing and Midwifery Federation have been raising for a long period of time. These people are given a high level of responsibility to do the most intimate of care and yet they are not required to be licensed in any way in order to deliver that care, and there is no absolute requirement for them to have a standard of education.

Reverend the Hon. FRED NILE: Your view of the description of assistant in nursing—

CHAIR: Reverend Nile, your time is up. Perhaps if you have other questions they can go on notice.

Reverend the Hon. FRED NILE: Thank you.

CHAIR: On page 25 of your submission you refer to outcomes-based care regulation being available in England. Are you able to elaborate to explain if that is a system that we might benefit from?

Ms MACUKEWICZ: Sure. It has evolved over time, as all things do, and I worked through those changes, but what we are seeing now is that there is a very tight regulatory system based around care provision. It is a separate piece of legislation and with that are quite comprehensive regulations. They provide very clear guidance around what people going in to assess quality in aged-care homes should expect to see. There is also a quite weighty document called "Quality Judgement Framework", which ensures that anybody going in to assess quality in aged care has strict criteria to assess against, so it is very impartial. You cannot go in and use your own personal viewpoint as to how well quality of care is provided. It also provides some very tight staffing guidance.

CHAIR: You are saying there is a model that is a lot broader and gives you better information about what goes on and then defines the assessment and the staffing?

Ms MACUKEWICZ: It certainly does.

CHAIR: Our time is up. If you have something about that we would really appreciate you making it available.

Ms MACUKEWICZ: We can certainly do that.

The Hon. SARAH MITCHELL: Thanks for your submission and thanks for coming today. I wanted to start with you, Mr Holmes. I am happy to be corrected but in your opening statement did you say you have 10,000 members who work in aged care?

Mr HOLMES: Yes.

The Hon. SARAH MITCHELL: I am happy for you to take this question on notice. Do you have a breakdown of how many are registered nurses, enrolled nurses and AINs are in your membership?

Mr HOLMES: I will take it on notice to give you absolute numbers on that.

The Hon. SARAH MITCHELL: Thank you. For clarification, going to page 16 of your submission, and I am happy for anybody to answer this question, in the first sentence you talk about registered workers deliver more hands-on care than registered nurses in residential aged-care facilities, and the reference is to a United Kingdom study. Is there equivalent research in Australia that backs that up?

Ms MACUKEWICZ: I think generally within nursing we have a lack of research and that is one of the advantages of making this a graduate profession. What we are doing now is a lot more evidenced-based care, which is the safest way forward. I think it is widely acknowledged within nursing there is a lack of research around all areas not just around staffing and it is not unusual to draw upon research from other countries to inform because any research is better than none at all.

The Hon. SARAH MITCHELL: Okay, so that one is using the English example.

Ms MACUKEWICZ: It is, yes.

The Hon. SARAH MITCHELL: In the second sentence you referenced Australian studies or papers saying that the AINs feel that they often required to undertake roles that our outside their scope of practice and feel unprepared for the duties they are asked to perform. Is that something that comes through from the members of your association who are AINs? Is that the feedback that you get from them? Is that consistent?

Mr HOLMES: Yes. Ms Russell may be able to give you an answer from a first-hand experience.

Ms RUSSELL: I think carers who were asked to look after frail older people—for example on a weekend or on a night duty when there are no registered nurses available—feel compelled to provide care at a level higher than their qualifications, which are very minimal, enable them to do safely. They may feel pressure from their organisations who say, "This is the staffing level that you have, and you have to deal with it."

The Hon. SARAH MITCHELL: Lastly on page 27 of your submission you say:

It is of primary importance to us that the assessed care needs of the person are matched by the provision of registered nurses at all times.

We have had some witnesses here today—I am not sure whether you were here to hear the witness prior to lunch—who talked about regional areas. Sometimes, a person who lives in isolation on a property might come into a low-care facility earlier in their life than they normally would. They could be a low-care patient for a very long time. So if someone is assessed as a low-care patient in that scenario and they do not need a registered nurse at all times because their circumstances might be different to somebody who is based in the city, what would be your view on that scenario?

Ms RUSSELL: Do you want my personal view?

The Hon. SARAH MITCHELL: Yes, or whoever wants to answer. If you want, it is fine for you to give me your professional opinion.

Ms RUSSELL: I would think that there may be other ways of housing that person without their having to go into residential care—giving them a package in the local township or something. High-care and nursing homes or hostels—the old terms—focus on providing complex care.

The Hon. SARAH MITCHELL: I guess in some regional communities there are no other options, and that is one of the issues.

Mr HOLMES: We are not claiming that because someone comes in to that low-care situation they personally need a registered nurse all the time. Clearly, providers have indicated that they do assessments and provide some level of supervision. We are principally concerned that, where providers are being given Commonwealth funding for high care, and where the resident is there because they have a range of complex needs—many of which are unpredictable; they may have a hypo if they are a diabetic, or they may have a stroke, a fall or some other unexpected outcome—clearly there is a need for a high level of clinical assessment and care and decision-making about where the resident should be going. That is why you have the staff trying to match those residents. There is nothing to stop a low-care person all of a sudden becoming a high-care person once they have a catastrophic event. Of course, you would hope that they would be picked up and transferred to an acute care setting.

The Hon. BRONNIE TAYLOR: Thank you for coming in and thank you for your submission; it is great to have you here. I will direct my initial question to Mr Holmes. I noticed from previous questions you have answered, and evidence that you have given, that you were saying that rural and regional aged-care facilities were "trying", and that they were trying to give "quality care" and "good quality care". When you were asked a question just then you said that it was about matching the care to the resident. From what you have just said in that respect you were acknowledging that in those facilities—where there are no people with very high complex needs, about which we have had evidence here today—we need to make sure we match.

Mr HOLMES: The scenario I was given that a person who is low care has come into a low-care facility because of their relative isolation on their property, for instance. They have chosen to come into town to use the low-care facility. We are not saying that that person, per se, requires 24-hour care.

The Hon. BRONNIE TAYLOR: Thank you.

Mr HOLMES: We are saying that if their needs escalate into high care then they should have access.

The Hon. BRONNIE TAYLOR: Absolutely. Earlier we had evidence from one of the NGO providers in rural and regional areas. You were alluding to the fact—correct me if I am wrong—that they were sometimes in it to make a surplus or a profit. That was what you felt was happening. The evidence that we received was that often the surpluses that are made by those NGOs in metropolitan areas or in areas that are more affluent are

redirected by the NGOs to some rural and regional areas where people would not otherwise provide aged-care facilities. Were you aware of that?

Mr HOLMES: I have read that part of the submission of UnitingCare. ACFA (Aged Care Financing Authority) has undertaken a study across the aged-care industry of the viability of various different types of facilities. That is a report that the committee may wish to look at. We are happy to give you a reference to that, or supply a copy of it.

The Hon. BRONNIE TAYLOR: Thank you.

Mr HOLMES: Our role in advocating for our members and for the community does not necessarily make us experts in the financial management of aged-care facilities. We take it into great consideration, but if no-one stands up for quality care then we will all suffer.

The Hon. BRONNIE TAYLOR: I do not think it is an issue of standing up for quality care.

The Hon. WALT SECORD: I think it is. Everyone in this room thinks that.

CHAIR: I caution you, Mr Secord. And I ask the gallery please not to interject.

The Hon. BRONNIE TAYLOR: I direct this to Ms Russell. In your evidence earlier today you were speaking from your perspective as a nurse practitioner about the care that was provided. You said that registered nurses make informed and intelligent decisions and that they recognise changing needs. Were you suggesting, in those comments that enrolled nurses and assistants in nursing were not capable of making those sorts of decisions about residents that they had been caring for?

Ms RUSSELL: Yes.

The Hon. BRONNIE TAYLOR: Thank you.

Ms RUSSELL: Assistants in nursing would make a very different kind of informed decision to somebody who has university qualifications.

The Hon. BRONNIE TAYLOR: Are you including enrolled nurses in that?

Ms RUSSELL: Enrolled nurses have far greater education than assistants in nursing.

The Hon. BRONNIE TAYLOR: You said that registered nurses make informed and intelligent decisions and they can recognise changing needs. My question was about enrolled nurses and assistants in nursing who have been working in these facilities for a number of years, caring for these people. In your opinion they do not have the ability to make those decisions.

Ms RUSSELL: I am saying that they would make a different decision. Probably another layer of safety would be the general practitioner who comes in and works in the aged-care facility. They would also make a different kind of decision to the registered nurse. We need all those layers of decision-making. So we need an assistant in nursing to decide that that kind of clothing for the resident is too cold to suit the climate today and that they need to wear something warmer. The assistant in nursing may decide that the resident does not look well and is not eating so well today. They would report that to the registered nurse.

The registered nurse then makes a full physical assessment and decides that the vital signs are out of whack for this person and may decide to monitor that resident a bit closely, do a pain assessment or a mobility assessment. If the registered nurse picks up on the fact that something is wrong they may call in the general practitioner. So there are layers of decision-making based on their educational training.

CHAIR: Unfortunately we have come to the end of this session. Thank you very much. You have taken some questions on notice. The secretariat will be in touch with you. There are 21 days for that information to come forward. Thank you for your appearance.

LISA LANGLEY, Police Manager, Council on the Ageing NSW, sworn and examined:

CHAIR: Do you have a short presentation or are you relying on your submission so we can go to questions?

Ms LANGLEY: I am relying on the submission. I hope I will be able to answer everything.

The Hon. COURTNEY HOUSSOS: Thank you for your excellent submission. I found it well researched and a concise summary of the issues that we are discussing in this inquiry.

Ms LANGLEY: Thank you.

The Hon. COURTNEY HOUSSOS: On page 3 of your submission you note a report from Access Economics for the Australian Nursing Federation that states:

... evidence shows that a higher nurse ratio in the staffing mix contributes to better quality outcomes.

As you are probably aware, this directly contradicts the Productivity Commission report on aged care. Can you explain why you disagree with the Productivity Commission?

Ms LANGLEY: When I was doing the submission and the research into it I wanted to find—I acknowledge what the nurses of the New South Wales Nurses Association have just said. There is not a lot of evidence in Australia about the effect of higher nursing levels, nurse to patient ratios, in this country. But I did find a little bit of evidence that there are some studies that indicate that in terms of nursing to patient outcomes, the higher the nursing level, the better the patient outcome. I am sure the Productivity Commission might have found otherwise, but I think there is a tiny bit of evidence to the contrary. In fact, a lot more research needs to be done, I believe, but I think that that little bit of evidence is quite illuminating.

The Hon. COURTNEY HOUSSOS: And some would say quite logical.

Ms LANGLEY: Yes it is.

The Hon. COURTNEY HOUSSOS: On page 5 of your submission you talk about the Queensland Hospital in the Nursing Home Program, which I thought was interesting. Can you explain in more detail about that program and perhaps some of the resources that would be required in New South Wales nursing homes to implement a similar system?

Ms LANGLEY: I do not know about it in a lot of detail, but it is interesting to know that the genesis of the program was as an anti bed blocker initiative. It was an initiative to get people out of the hospital and back to home or back into the nursing home. It was serendipitous that they found that in fact the program itself, which was to deliver nursing care and medical care in a residential care facility, had better outcomes for patients as well. I do not know the study in depth but I think it was an interesting program. From COTA's perspective, we believe that the care of older people is a continuum across aged care and health care. It is unfortunate that there are these artificial barriers—health is the State and aged care is the Commonwealth. The fact is that this person traverses both of those systems all the time. At the end of the day, from our perspective, it is the quality of the care and the outcome of the care of that person that is most important.

We see a program like that as a good way of ensuring that there is a continuity of care and there is hospital level care that can be transferred from the hospital to the nursing home, so there is that continuity. At the same time I think my paper also said that in order for that to work effectively there has to be a registered nurse in the hospital because our understanding—this is just anecdotal—is that hospitals are very reluctant to release a patient to a residential care facility unless they know that the patient will get good care when they get back there, and they will hold on to that patient until they are sure that the patient will be cared for properly.

The Hon. COURTNEY HOUSSOS: This might be a bit too detailed, but why do you think only one organisation in New South Wales was funded by the new arrangements to have these kinds of innovative approaches? Is there a structural problem in New South Wales or it is simply that other States are being more innovative?

Ms LANGLEY: I thought that was quite disappointing when I looked at that and saw that it was only Community Care Northern Beaches that had done that project. By the way, I have not investigated that and asked them about that project and the outcomes of that project but I think it would be interesting to find that out. I do not know. I think it is a shame, as we have the highest population of older people in the country, that there only one project was funded in New South Wales.

The Hon. COURTNEY HOUSSOS: And such a high number. I think we have more than 900 facilities in New South Wales.

Ms LANGLEY: Yes, and the highest number of residential care facilities.

The Hon. COURTNEY HOUSSOS: One of the things we have been grappling with is that previously—you probably heard us discussing this with the nursing association—there was an idea of delineation between high and low care. There seems to be universal recognition that there is a need for registered nurses for high or complex care patients, and an increasing number of these patients are presenting to registered aged-care facilities. However, there is still an unresolved question as to what to do with these formerly low-care facilities, particularly in rural, regional and remote New South Wales. Do you have any thoughts on any other classifications, any other specific exemptions or other grandfathering schemes that we could put in place to allow these facilities to continue to operate?

Ms LANGLEY: I see the problem as sitting within a wider problem of housing options for older people. I think the reason why a person in this newly reformed system, which no longer has low care and high care distinctions, ends up in a situation like that is because there is a lack of other alternatives in the community for them. There are not enough packages because, as you know, packages are still rationed from region to region, which is unfortunate. I understand the Commonwealth Government will try to move towards a non-rationed system at some stage in the future but I do not know whether that will ever happen. But until it does there will probably always be more people who needs packages than packages available.

In my opinion the need is for other housing arrangements. It is quite sad for an older person who has been in hospital and must be transferred somewhere; the only alternative for them is to go into a residential care facility. I know that is the reality in some cases, but our understanding from where we are sitting is that because of the things the Commonwealth is doing—that is, more packages, more supported home—the trend will be that people will enter residential care at a much later time. From our experience people avoid going into residential care. It is the last ditch; it is either when the carer is at the end of their tether and they can no longer care for them at home, or when the patient has complex needs, co-morbidities.

They are already at a point with their dementia where they cannot be cared for at home and they absolutely have to enter care. That is the trend and why our concern is if we remove the need for a minimum of one registered nurse—we are talking about one registered nurse per shift, as I understand it—then it is moving to a market system, which it is anyway, and we are opening up a Pandora's box of problems that could arise if there is no regulation around standards of nursing care for people who are presenting with much more demanding needs in a residential care setting.

The Hon. WALT SECORD: To give us some context, how much of COTA's activity is in aged care or ageing issues in the sense of aged care residential?

Ms LANGLEY: COTA Australia and our chief executive officer [CEO], Ian Yates, are very involved in lobbying on aged care at the Commonwealth level. He has been instrumental in concepts like consumer-directed care and the My Aged Care gateway. He has been working with the National Aged Care Alliance—he is a member. He is also working with both sides of government at the Commonwealth level on these reforms.

The Hon. WALT SECORD: In those processes, has it been articulated why there is resistance or why they want the Government to discontinue this regulation? Has the rationale been communicated to you? Removing registered nurses from aged care does not make sense to me. Has the reason for that been articulated to your organisation?

Ms LANGLEY: No, not directly. However, Ian Yates very strongly supports the idea that registered nurses remain on all four shifts.

The Hon. WALT SECORD: What do you think would happen if they were removed?

Ms LANGLEY: Our concern would be that the system is not particularly regulated anyway. As is stated in some detail in our submission, there are quality standards but there are no real specifics about nursing levels in the quality standards unlike, it seems, the British quality standards, as you heard from the Nurses and Midwives' Association. Those standards might be very specific about ratios of nurses—I have not read it so I do not know. We find it very concerning. We believe that because the type of person in residential care is changing and their needs are becoming more complex, there will always be a need for at least one registered nurse to be on duty 24 hours a day.

There are exceptions to that rule. There are always going to be residents with lesser needs, but in general we see that trend continuing. We are going to a market-based aged-care system with fewer regulations and the market determining what kind of care under what circumstances. Another thing that worries us is that the care you receive is increasingly dependent on how much money you have. If you can purchase a suite of extra services, that is great but for some people that would not be the case—pensioners, for example.

The Hon. WALT SECORD: We have heard repeatedly that the average age of a person entering aged care now is 84, so they are entering when they are frail aged.

Ms LANGLEY: I would agree with that.

Reverend the Hon. FRED NILE: In your submission you make it clear that your organisation supports having a registered nurse in a registered aged-care facility 24 hours a day, seven days a week. However, you do make any distinction between high care, low care and different kinds of facilities. We have had evidence from providers that there is a distinction between high and low care, and city centres as opposed to a rural or remote centres that cannot afford a registered nurse. To you, is this a blanket policy for all residential aged-care facilities?

Ms LANGLEY: Yes, because we feel that is a minimum standard for proper care that needs to be met. I recognise the challenges but if the opposite were true and we removed those kinds of minimum care mechanisms then we would be in danger of putting people in remote areas who are relying on a residential care facility from the time they go in to the time they die in a potentially dangerous situation.

Reverend the Hon. FRED NILE: In your submission you say the change in the legislation should not be seen as an opportunity to undermine care by removing the need for around-the-clock registered nurses. Do you believe there would be a reduction in care if the current New South Wales Government policy removing regulation went ahead as it would decrease the quality of care?

Ms LANGLEY: Yes, we do believe that. We also have a great concern about siloing the care of older people across the health and aged-care systems. It is an unfortunate thing because one is state-run and the other is Commonwealth-run. We will do our best to look at initiatives—and there have been a number of initiatives, some of which I have mentioned—to bridge that gap. The care of older people in New South Wales is everyone's responsibility, not just the Commonwealth's responsibility or the State's responsibility. Continuity of care of people living in this State should be maintained across both the care modalities from the hospital to the residential care facility.

Reverend the Hon. FRED NILE: Providers can apply for Commonwealth subsidies. Could they apply for a subsidy for high care when there is no resident nurse so they cannot give high care only low care?

Ms LANGLEY: As you are probably aware, all the funding and structures of funding for residential aged care and community aged care are in a state of flux and there is a lot of confusion and misunderstanding about how these things are funded. My understanding is an ACAT team assesses a person but there is no high care and low care anymore. Their needs are assessed and the Commonwealth funds a person's care according to their needs but there is no longer delineation between low care and high care. I am not a real expert. You had some people from the Commonwealth earlier today and they are probably all over this. I understand there are continuing problems with the funding models and confusion on the part of consumers and aged-care providers about how it works and will work in the future.

Reverend the Hon. FRED NILE: The basis of my question was whether some providers are getting subsidies for providing high care when they are providing low care. How would anyone know? The subsidy a provider gets is not public, is it?

Ms LANGLEY: I would not like to answer that. I will take the question on notice. It is too complex and not part of my position. There are other people who could answer that question much better than I can.

Reverend the Hon. FRED NILE: If you could take that on notice I would appreciate it. In your submission you say there is a need for new models of care to be developed to meet the complex care needs of nursing home patients. Who is going to do that? Are you prepared to do that?

Ms LANGLEY: We would hope to make recommendations on some models that might work. I know NSW Health already has a project looking at models that better traverse the divide between the hospital and the residential care facility. My understanding is they are piecemeal. There were a couple in Ku-ring-gai through the Hornsby hospital that have been really good, the Aged Care Emergency [ACE] model and the Geriatric Rapid Acute Care Evaluation model. I can provide more detail on those.

However, again, we feel that more work needs to be done. Much more can be done to bridge the gap between what happens when the person leaves hospital and goes back to the residential care facility and when they go from the facility to the hospital. Do they need to go? The other argument is that if they have a high level of care at the residential care facility there is less need for them to go to hospital. In that case, we will save money in that end and they will get better care at home. For many people their home is the residential care facility; that is where they live.

CHAIR: Do people contact your organisation to lodge complaints about the aged-care system?

Ms LANGLEY: They do, but we are not funded to provide that information. We refer them straight to My Aged Care, which is supposed to be the central gateway—the seer and doer of all things.

CHAIR: We have had discussions about the complaints system and tried to understand whether residents and their representatives know where to go to complain. Do they know to whom they should go and how they should do it? It is often a problem. If you refer them on, that is great. I am interested that you brought up the issue of housing and whether we are appropriately assessing people's needs. Have you made submissions about that issue?

Ms LANGLEY: Yes, we have.

CHAIR: Can you make available any submissions your organisation has made dealing with the standard of care or what is missing in the provision of care for older people?

Ms LANGLEY: Do you mean submissions to this Committee or other documents?

CHAIR: To other committees, to Federal inquiries, or to the Productivity Commission. That would be interesting.

Ms LANGLEY: Yes.

CHAIR: Have you also formed a view about the responsibilities of registered nurses, residents' age and their needs when they go into residential facilities and the administration of medication? Is that a major issue? Is that what people are concerned about? Are they concerned that their medication might not be properly administered? Hospitals and nursing homes have the same standards, but that could change. Is that your understanding?

Ms LANGLEY: It is, but I am not qualified to answer that. I am not a registered nurse and I do not think I can add anything.

CHAIR: Your organisation has the interests of older people at heart. Are you concerned about that issue? It is not a technical issue. What are the big picture issues? Why do people think they need a registered nurse? What does that relate to? We have heard that many other services are provided. What do people have high on their list with regard to the need for that high level of professional care?

Ms LANGLEY: We have heard anecdotally and from other colleagues that there is a concern that removing the highest qualified person from the mix—not completely but not to have them on duty 24 hours a day—would have downstream effects on patients. Given the increasing number of residents with co-morbidities, we also know that people in residential care are usually more medicated than the person living at home. If the registered nurses are responsible for those medications and they are not available at some time and something goes wrong, we would have a concern about that.

CHAIR: You raised cross-border funding issues on page five. You refer to the model of care in the aged care and hospital systems. Can you tell the Committee more about that?

Ms LANGLEY: I have alluded to that a couple of times. The fact that aged care is Commonwealth funded and health care is funded by the State means there is an artificial barrier that interferes with a proper traversing of care or the best care possible for a person moving from a hospital back to a residential care facility and from a residential care facility to a hospital. Having those silos and barriers means they are funded separately. That is a whole other area that requires deep investigation of the funding regimes. They are very different for hospitals. Part of the money ultimately comes from the Commonwealth, and the Commonwealth now provides all the funding for aged care. They are completely different.

I believe that residential care will be moving to a consumer-directed model. That will be an interesting process if the funding goes to the person in the care facility and not directly to the residential care provider. I do not know whether that will happen, but it is being discussed at a Commonwealth level. The packages are not now given directly to the individual; they are given to the service provider. There is talk about a similar model for the Commonwealth. That is completely different from the way hospitals are funded. There will be issues.

CHAIR: That raises the cost shifting that happens if people go to hospital and cannot be dealt with in a residential facility. I am from a border area and that creates concerns. You are saying that if we are to have one system we should ensure that it does not work at odds with a State-based system with different cost-sharing arrangements.

Ms LANGLEY: Yes, I think so. It makes it much more inefficient when the systems do not speak to each other very well. There are great little programs in different places that create bridges that work in, for example, local health districts. We see some really good efficiencies for the patient, the hospital and probably the residential care facility, but I cannot comment on that. However, it seems to me that there could be a good conversation about how those bridges could be developed to create a much bigger link between the two systems.

CHAIR: I refer to page 4 of your submission with regard to the accreditation agency also being responsible for home care standards.

Ms LANGLEY: My point in writing that was that it is curious that we have new standards but no definitive ratios or discussions. It is clear if you read between the lines that the decisions will be left to the service providers to determine. They will decide how they will deliver that quality care. If they meet the standards, that is all well and good.

The Hon. NATASHA MACLAREN-JONES: As you are talking about standards, you were not here this morning but a previous witness, the chief executive officer of Leading Age Services Australia was asked about the United Kingdom model. He made the comment that a number of countries look to Australia and our standard, because we have a very good standard of aged care. I thought I would let you know that. My question follows your comments in relation to 24-hour nursing. In your submission on page 5 you state that it will "prevent unnecessary trips to public hospital emergency departments". I am interested to know that that statement is based on evidence. I wanted to know about any data or information you have that proves that facilities which have 24-hour nursing care have lower rates of hospital admissions.

Ms LANGLEY: I would have to take that question on notice to provide that evidence to you.

The Hon. NATASHA MACLAREN-JONES: Returning to the statement that you made, do you have evidence to back up your statement?

Ms LANGLEY: Not direct evidence, no—anecdotal evidence and from speaking to different consumers and our dealings with COTA Australia around the aged-care issue. But no, no direct evidence, so I would have to take that on notice.

The Hon. NATASHA MACLAREN-JONES: So basically it is just more hearsay or based on comments you might have read in the media than actual facts and data?

Ms LANGLEY: Well—

The Hon. WALT SECORD: What was that?

The Hon. NATASHA MACLAREN-JONES: My next question relates to the fact that New South Wales is the only State that has the provision to have nurses, so you would assume that every other State would have high levels of complaints.

The Hon. WALT SECORD: They do. If you look at the data—

The Hon. NATASHA MACLAREN-JONES: Well, actually—

CHAIR: Order!

The Hon. WALT SECORD: No, listen, you cannot just make statements that are untrue—

The Hon. SARAH MITCHELL: Point of order—

CHAIR: Order!

The Hon. WALT SECORD: just because your Minister tells you to say it.

The Hon. NATASHA MACLAREN-JONES: I am actually referring to evidence that was provided.

CHAIR: Sorry, can I ask that everyone—

The Hon. SARAH MITCHELL: Can I raise a point of order, please, Madam Chair?

CHAIR: Yes, you can.

The Hon. SARAH MITCHELL: I raise a point of order in that the member is entitled to ask the questions that she would like to and does not need to be subjected to interjections from the member opposite.

CHAIR: I agree.

The Hon. WALT SECORD: May I speak to the point of order?

Reverend the Hon. FRED NILE: To the point of order: I think it was the commentary that was added.

CHAIR: That is right.

The Hon. WALT SECORD: May I speak to the point of order? I was objecting to the commentary that was absolutely untrue. Data that was presented to this Committee—

The Hon. NATASHA MACLAREN-JONES: I am actually about to refer to that data, if you would allow me, in my question—

The Hon. WALT SECORD: But you made a comment that I objected to, which was not a question.

CHAIR: Can we allow one person to speak at a time?

The Hon. NATASHA MACLAREN-JONES: I had not actually finished my question before you rudely interrupted me.

The Hon. WALT SECORD: I made my point.

CHAIR: You have made your point. I think you very nearly caused me to call order in some comments and inferences that were made in your previous question about the submission.

The Hon. NATASHA MACLAREN-JONES: I will rephrase it.

Reverend the Hon. FRED NILE: That is what we were referring to.

CHAIR: Yes.

Reverend the Hon. FRED NILE: Not your question, but your comments about the last question.

CHAIR: It was close to the line—well, I think it probably went over the line and I hope there was no offence taken by the witness.

Ms LANGLEY: No—none at all.

CHAIR: I ask everyone to stay respectful.

The Hon. NATASHA MACLAREN-JONES: As I mentioned before, my question relates to section 104, that New South Wales is currently required to have nurses. No other State has that provision. The data we have received, which is from the 2013–14 Report on the Operation of the Aged Care Act, shows that New South Wales does not have a significantly lower number of complaints. In fact, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory do, and they do not have that legislation. Do you have any comments in relation to that?

Ms LANGLEY: The only comment I would make is that it is likely there are still registered nurses on staff. I cannot make any factual evidence-based comments in relation to that, but I imagine that if you asked UnitingCare Ageing or some of these cross-State organisations it would be interesting to see what their RN staffing was in those other States as well.

The Hon. NATASHA MACLAREN-JONES: Just on that, we have actually—

The Hon. WALT SECORD: Point of order: I would like to draw to the Committee's attention—and to assist the witness—that in fact independent data from the Commonwealth Government shows that New South Wales leads the country in—

The Hon. NATASHA MACLAREN-JONES: This is interrupting our Government's question time. Following on from that, there are a couple of submissions. One is from Wesley Mission, who said that the model of being able to be flexible has allowed them to deliver patient focussed care. Is it fair to say that it works in other states where they do not have this requirement, so it would work in New South Wales?

Ms LANGLEY: I do not think I can answer that question.

The Hon. BRONNIE TAYLOR: I have a question, Ms Langley. Please correct me if I am wrong, but earlier you were alluding to the fact that it was going to be asked that there be no registered nurses in aged-care facilities. From all the evidence that we have received from everyone, that has absolutely not been on the table. Correct me if I am wrong—were you not alluding to that before when you were answering questions?

Ms LANGLEY: No. If that is how it came across, I apologise.

The Hon. BRONNIE TAYLOR: Great. I just wanted to clarify that.

Ms LANGLEY: We are looking at a sliding scale here. It is not that we are removing registered nurses from residential care. Sorry.

The Hon. BRONNIE TAYLOR: Thank you. In one of your comments you used the words: "If there wasn't a registered nurse available in an aged-care facility, it was potentially dangerous." Do you have some

evidence that you could support that with? The reason I ask is that, when we were given evidence by someone who is providing aged care in rural and regional New South Wales, they referred to the Hunter-New England collaborative approach using technology and not having a registered nurse on site, and there were no instances that were "potentially dangerous". Could you elaborate—

The Hon. WALT SECORD: Point of order: I asked a question to the witness and she gave an answer. You are distorting her answer.

The Hon. SARAH MITCHELL: To the point of order: The member is allowed to ask her own questions.

CHAIR: Yes, the member can ask her own question and the witness has every right to not answer it and to put her own position forward.

The Hon. BRONNIE TAYLOR: I am just seeking further clarification.

CHAIR: Ms Langley, you might wish to wait for the transcript and answer at a later time if you feel you cannot recall or you feel it is not representative.

Ms LANGLEY: I would like to do that.

The Hon. BRONNIE TAYLOR: Certainly.

The Hon. SARAH MITCHELL: Following on from a question that was asked by Reverend the Hon. Fred Nile, I would like to clarify a point. Different parts of your submission say different things, and I do not mean that to be in any way offensive, but I am trying to get to the nub of the situation. In your conclusion you talk about the requirement for just one registered nurse per shift and concern that removing those would put residents at risk, but when Reverend the Hon. Fred Nile asked whether you supported registered nurses 24 hours a day, seven days a week in aged-care facilities as a blanket approach, you said yes—is that right?

Ms LANGLEY: I guess I am confused by the question. Are you asking whether or not there is one registered nurse per shift per residential care facility?

CHAIR: Excuse me, Ms Langley. I am finding it concerning—and I think others have expressed concern—that when the questions that are being asked are an interpretation of an answer the witness has previously given to someone else's question, I think we are going to a degree where it is confusing for a witness. It is hard to keep track of and we have a situation where a statement by a member to a witness then is—

The Hon. SARAH MITCHELL: I am happy to—

CHAIR: Please keep to clear questions without—

The Hon. SARAH MITCHELL: I am happy to rephrase. I guess I was trying to follow on from what Fred said. Is the position of your organisation to support registered nurses in all aged-care facilities 24 hours a day, seven days a week, or do you see a differentiation between what was previously high care and is now low care, including some of the regional examples that we referred to earlier?

Ms LANGLEY: I think probably the first statement that you made: We believe that there should be a registered nurse on each shift, 24 hours a day.

The Hon. SARAH MITCHELL: In every aged-care facility across New South Wales?

Ms LANGLEY: In every aged-care facility across New South Wales.

The Hon. SARAH MITCHELL: Following on from that, one of the things of concern to me as a regionally based MP and not just as a member of this inquiry is the effect on small, regional based facilities. We have had some submissions from and will be hearing from witnesses who operate small, regional-based facilities. There is one from Sunhaven Hostel, which is up at Ashford, north of Inverell. They talk very eloquently about the services they offer, how well they are accredited and the concerns they have about their future viability. For a facility like Sunhaven, if the regulations and legislation were changed to mean that they

would have to find a way to have a registered nurse there 24 hours a day, seven days a week, a witness earlier today said that for many it is just not viable. I think she used the figure of 6,000 beds. How would you suggest we as a Committee should address that issue? Because surely, in a town like Ashford, having an option that services their community very well—which they currently have—has to be a better outcome than nothing at all.

Ms LANGLEY: Do you want me to answer that?

The Hon. SARAH MITCHELL: Yes, I am interested to hear what your view is.

Ms LANGLEY: I think it is a wicked question in places like that. We are saying that we are drawing a line. That is where we draw the line. I can sympathise with those situations and I remember when all these aged-care reforms were going on and there were community discussions and Mr Butler was talking to people. He was pretty brutal. He was saying, "Some of these places are going to go under with these changes." I know that does not really answer the question but some of these things I do not have answers for. That is just our position.

The Hon. SARAH MITCHELL: That is okay. Maybe the solution is that it is a blanket approach or a one size fits all. Is it necessarily going to work? We have talked about different levels and Ms Houssos has asked questions about that, particularly in regional and more remote areas, so maybe it is not as simple as one method is going to work for everybody.

CHAIR: You have brought a very good point about residential facilities to the inquiry today. In rural and regional areas particularly there is a lack of an intermediary opportunity for people who might not need 24/7 clinical care but who are no longer able to live on their own to feel safe or their family feels that they are safe, so the housing issue is a missing link. I thank you for raising that.

(The witness withdrew)

(Short adjournment)

JOHN JOBLING, Councillor, Leichhardt Municipal Council, sworn and examined:

LINDA KELLY, Councillor, Leichhardt Municipal Council, and

ERLA RONAN, Group Manager, Community and Cultural Services, Leichhardt Municipal Council, affirmed and examined:

CHAIR: I acknowledge that we are honoured to have before us a former member of the House—with a title I have never seen before, but I am enjoying looking at it—Councillor the Hon. John Jobling, OAM. Does anyone wish to make a short submission?

Ms KELLY: I do. Good afternoon and thank you very much for the opportunity for Leichhardt Municipal Council to participate in this hearing. I am Linda Kelly, councillor to Leichhardt Municipal Council and represent the mayor. I wish to acknowledge the traditional owners of this land, the Gadigal people of the Eora nation. I pay my respect to elders past and present and any Aboriginal people here today. At Leichhardt Municipal Council I chair the Community, Culture And Recreation Committee and have recently served as deputy mayor for two years. I am a registered nurse with 25 years' experience, the last 12 years as an aged health nurse specialist. In my current position I am the State project lead for the development of aged health education for all clinicians working in NSW Health.

The Leichhardt local government area has 56,000 residents, a population density of 50 persons per hectare and the highest density for funded residential aged-care beds in New South Wales. Over the next 20 years the number of people aged 65 years and over in Leichhardt will double from 12.4 per cent to 21.3 per cent of the population. Leichhardt Municipal Council has a mandate as a planner. I have tabled for you our healthy ageing plan, which we adopted in July this year, and also our community 10-year strategic plan. You have copies of those. We are also a consent authority for approving works with a regulator for fire safety and other systems for our six residential aged-care facilities that accommodate 513 vulnerable older people.

We are a service provider to people who require My Aged Care support and a key enabler delivering the NSW Ageing Strategy objective that people in New South Wales experience the benefits of living longer. We undertake a regional approach to understanding our planning and service delivery. Leichhardt Municipal Council recommends that New South Wales legislation retains safeguards that protect our older people and our neighbours at Marrickville Council, Ashfield Council and City of Sydney have moved the same. The definition of "nursing home" should cover all residential aged-care facilities where people who have been assessed and funded as having high care and complex health needs requiring the services of a registered nurse are living. Only registered nurses can provide the expert and skilled care in regards to this expertise, such as recognising, assessing and managing changes in the conditions of our elderly, providing pain relief and end-of-life care, minimising discomfort and distress and preventing unnecessary hospital admissions.

Removing registered nurses from nurse-led models of care generates risks. These risks include increasing presentations to our local emergency departments and increasing hospital admissions. Aged services emergency teams are not funded to run a 24-hour service. In REACH, NSW health services such as ambulance, aged health care, palliative care and community nursing services rely on registered nurse-led models of care in nursing homes. We ask: Is our publicly funded health system ready for this burden? Another risk is adversely impacting on the health outcomes of our elderly residents. Being admitted to hospital and being away from your familiar environment increases the risk of an older person developing delirium. In fact, 40 to 60 per cent of patients will develop delirium during their hospital stay and delirium has a hospital mortality rate of 25 to 30 per cent. There is another risk of adversely impacting on community confidence.

Families and the communities of the elderly need to be secure in knowing that their loved ones are going to be given the best quality care. There is a great risk with any change to existing legislation that would enable unregulated care workers to administer dangerous drugs of addiction, such as schedule 8 medications. Our elderly are particularly prone to adverse impacts from medications. Often they become acutely unwell because of the medications that they are taking. It is essential that schedule 8 medications like morphine and oxycodone continue to be administered by regulated nurses such as registered nurses, who have the expertise and accountability.

Socially and economically it is much more cost effective for the State Government to mitigate these risks and ensure that our residential aged-care facilities have registered nurse-led models of care that are integrated

with public health supports. The benchmark of a caring, just and civil society is in how we look after and attend to the needs of our most vulnerable community members. We put to you the need to ensure that the State Government, through this inquiry, respectfully maintains our community's commitment to ensuring the continued wellbeing of residents in residential aged-care facilities. This means valuing the roles of all nurses caring for our elderly and retaining registered nurse-led models in all New South Wales nursing homes.

The Hon. WALT SECORD: Councillor Jobling this submission from the council is signed by the mayor. Did it have the unanimous support of council?

Mr JOBLING: That is absolutely correct. All of the councillors looked at this. They are very conscious of the healthy ageing plan, and there was 100 per cent support in the council for the proposal that we put to you today.

The Hon. WALT SECORD: So it had multi-party support.

Mr JOBLING: Indeed it did.

The Hon. WALT SECORD: Thank you for giving us a local government perspective. Why did you feel it was important to give a local government perspective and why did you take it upon yourself to give a local government perspective?

Ms KELLY: Firstly, we are representing our residents. In our local government area we have the densest funded beds for residential aged-care facilities in the whole of New South Wales. So we felt it was important to represent our 513 vulnerable older residents. If we do not, who else will? Secondly, we see ourselves as more than just enablers for people to live longer and healthier lives in their homes. A lot of our services—Ms Ronan can give you more detail about this—are in the nursing homes, where we work in partnership. So the facilities are very much part of our community. There was no question with regard to Leichhardt Council making representation for this age group.

The Hon. WALT SECORD: Ms Ronan, I understand there are 512 residents.

Ms RONAN: There are 513.

The Hon. WALT SECORD: I am sorry. Are they mostly high-care in their needs?

Ms RONAN: There is a range of hostel-style accommodation, through to high care. We can certainly get that data as provided by the aged-care facilities.

The Hon. WALT SECORD: I just want to get a sense of it. Is it overwhelmingly high care or low care?

Ms RONAN: There is a range across each of the facilities. They span that range. I think earlier evidence mentioned that anecdotally for people who are going into hostel-style accommodation or aged-care facilities, invariably their needs increase. They change from low-care needs to high-care needs over time. That is the advice that we have had from our aged-care providers. There is a range in Leichhardt.

The Hon. WALT SECORD: There are six aged-care facilities in your local government area. Do they all have registered nurses?

Ms RONAN: We have been unable to confirm that. We are not the certification body for registered nurses. Certainly two of them strongly promote 24/7 nursing care on their web sites.

The Hon. WALT SECORD: They promote it.

Ms RONAN: That is on the Commonwealth's web site for people seeking information about aged care. But we are not the consent authority in terms of assessing the qualifications of nurses.

The Hon. COURTNEY HOUSSOS: I would also like to congratulate you on taking such a proactive approach to aged care. It is really encouraging to see that from a local government. Have any of the aged-care facilities in your area indicated that they have difficulties in recruiting registered nurses?

Ms KELLY: Not to our knowledge.

The Hon. COURTNEY HOUSSOS: In terms of a breakdown of high care and low care, you do not have that information.

Ms RONAN: We can certainly ask for that and follow it up for the committee.

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

The Hon. WALT SECORD: Ms Kelly, earlier you said that you were involved in aged care.

Ms KELLY: That is correct.

The Hon. WALT SECORD: In your view as a professional, what would happen if the current Minister for Health removed the requirement to have registered nurses in aged care?

Ms KELLY: Firstly, I am very concerned about the health and wellbeing of the residents that may be at risk. I respect the role that all nurses play. They are part of a team but the team is led by a registered nurse. Other nurses have very good skills in delivering personal care, but they do not have the expertise and knowledge that a registered nurses have. They are not regulated workers who are accountable, who can problem solve and do a thorough assessment of the older person. Assessment is the key in trying to resolve many acute illnesses or instances of confusion for the older person. So I would be very concerned about that.

Secondly, I would be very concerned about the impact that it would have on the fantastic services that are reaching into nursing homes from the public sector to support older people remaining in nursing homes so that there are fewer admissions to hospitals. A ride in an ambulance and an hour emergency department could put patients at great risk of delirium if they do not already have it from their UTI or constipation. As I said, the mortality rate for delirium in hospitals is very high.

One of my grandmothers died in a nursing home in rural New South Wales. When my father was phoned and asked, "Would you like your mother to be moved to the hospital?" without consulting his daughter, a registered nurse, he replied "No. She is very comfortable where she is. You are taking very good care of her; I do not want her moved." There are some great innovative services in the public healthcare sector to help us keep vulnerable residents in nursing homes. The key to that—the lynchpin—is having registered nurses on duty and registered nurse-led models of care working together as integrated care. That is really important.

Mr JOBLING: I might add to that answer. My profession for many years was as a registered pharmacist. My experience in that regard was serving in the community, working in a major public hospital in Sydney and smaller public hospitals in the country areas, and servicing nursing homes. My concern is that if there is not a registered nurse, there is nobody there—particularly in the back hours of the night in the smaller places—with the professional expertise to deliver certain medications.

The Hon. WALT SECORD: Are you referring to pain relief?

Mr JOBLING: Not only pain relief. It may be pain relief in relation to an elderly person who accidentally falls from a bed, fracturing a femur or causing compound fractures of arms or legs. Getting the right treatment to them in a short time is very important. But if they are undergoing antidepressant therapy you must be extraordinarily careful about what you give them, when you give it to them and how you deal with this. The schedule 8 drugs are controlled under the Poisons and Therapeutic Goods Act of New South Wales. At the moment a registered nurse is able to handle those drugs, as is a pharmacist, the matron or a medical practitioner who comes in.

My concern is that if those drugs are administered wrongly there is potential for a disaster. The other issue is that necessary treatment is perhaps more critical in country areas where it will take time for an ambulance to get to a major hospital. Even in Sydney five or 10 minutes for an elderly person who is need of palliative care or differential care is critical. You need to know, as a professional, what medication they are on and particularly what contraindications you may create if you give them the wrong matter.

The Hon. WALT SECORD: Ms Kelly, can you give me an example of some schedule 8 drugs? Registered nurses are able to administer schedule 8 drugs.

Ms KELLY: One is morphine, and that comes in many forms now. That can be administered subcutaneously, so people are not reliant on having to swallow tablets, or they will be slow-release tablets, and it can come in a liquid form as well. Oxycodone—these are more common drugs. I heard a speaker before say that they had noticed over the years—I have too over my 25 years—that end-of-life care is very much becoming a big part of residential aged-care facilities. It is a major focus. Many of our nursing homes have palliative care cluster beds, and there is an overflow from those into other beds as well. Palliative care, end-of-life care, has become much more of a major focus than it was even when I started nursing. These drugs—there are many different delivery modes now; they might be a patch to avoid having an injection—are very much regularly being administered in nursing homes by registered nurses. It is the skills and expertise that a registered nurse has in being able to respond to a change.

The Hon. WALT SECORD: What would happen if a registered nurse was not there in a situation where someone needed a schedule 8 drug in the middle of the night? What would happen to that person?

Ms KELLY: I am not sure what the legislation change will say but there is a lot of danger with people who do not have the knowledge and expertise behind them when they are administering medications. At the moment that is not lawful. If there is no resolve with legislation with regard to that, they would need to call a general practitioner in to administer.

The Hon. WALT SECORD: Would Mr Jobling like to add anything?

Mr JOBLING: You have morphine, heroin, pethidine, the opiates, all the opium derivatives. The treatment as outlined by my colleague is quite correct. At this stage most schedule 8 drugs are delivered to a hospital and kept in a recorded number, and they have to account for the use of those drugs and the drug cupboard must balance every so often. At this stage registered nurses are, under the Act, able to administer such drugs. To my knowledge—and I would stand corrected—other nurses are not so authorised.

The Hon. COURTNEY HOUSSOS: Ms Kelly's presentation and the Nurses Association presentation talked about the importance of nurses being regulated but also being externally accountable and responsible, as opposed to assistants in nursing, for example. Can you explain why that is important or why that is a difference between the levels of nurses?

Ms KELLY: To be accountable for your actions as a registered nurse means that you have the knowledge; you just do not have the skill of being able to give an injection. You have all the knowledge that comes behind that skill to assist you with what you are doing, how you assess a patient as a result of what you have done or what you might think may not be a good idea in this case, you might have to escalate this for a higher level of decision making. A registered nurse understands their accountability. They are required to register every year with AHPRA. Every year they are required to demonstrate and be ready to be audited for at least 20 hours of professional development related to their work. When you have an unregulated workforce, which I value very much, they do not have responsibilities. They have responsibilities but it is within the role they are employed as. A registered nurse has many more responsibilities and they will not be able to continue as a registered nurse if they are not accountable for the decisions they make.

Reverend the Hon. FRED NILE: Thank you for appearing today. Congratulations on the initiative of the council in having its own six nursing homes. Were those homes built by the council? Did you fully develop them?

Ms RONAN: The nursing homes are located within the Leichhardt local government area. Council is not the operator or the manager of those facilities. What we draw to your attention is that the 513 residents of those aged-care facilities are residents of the Leichhardt local government area.

Ms KELLY: Council is the consent authority for development up to the amount of \$5 million and that may include health service facilities or places of worship. Anything over \$5 million would be determined by the JRPP or the Planning Assessment Commission.

Reverend the Hon. FRED NILE: So the nursing homes were built by?

Ms RONAN: Independent operators or groups.

Ms KELLY: And not necessarily consented by us.

Reverend the Hon. FRED NILE: Working in cooperation with the council.

Ms KELLY: If they were under \$5 million to build.

Reverend the Hon. FRED NILE: Are you subsidising that \$5 million?

Ms KELLY: No. Council is not the consent authority for works over \$5 million with regard to health service facilities or places of worship. Those matters would be determined by the JRPP or the Planning Assessment Commission.

Mr JOBLING: If I might briefly comment, we have a very dense population in Leichhardt and we have the figures—you will find them in the documents we have left with you. The number of ageing people in our area is growing substantially and will go from those over 65 at about 12 per cent up to about 21 per cent, 22 per cent in the coming years. Therefore, council is particularly conscious of making sure that we are in a position to do the best things and have the best outcomes for the aged in our areas.

Reverend the Hon. FRED NILE: You have made reference to the Leichhardt Healthy Ageing Plan and you have given us copies of that, so we should get that included in *Hansard* now. Without giving a detailed explanation on the plan, what are the main points in this plan from your point of view? Can you summarise it?

Ms RONAN: The plan delivers on the New South Wales Healthy Ageing Strategy for people to enjoy living longer lives. Two key areas of the plan which we draw to the Committee's attention are section 3.5 with regard to housing and section 3.8 with regard to health and social services. We draw these to your attention as local government, mandated by the New South Wales Government, is required to work holistically to support the health and wellbeing outcomes of their communities. Most local government areas in New South Wales have common aspirations: to be safe, healthy and well connected, and have a strong feeling of belonging. As we were consulting for our Healthy Ageing Plan we heard that older people feel vulnerable as they face life choices of perhaps needing to move from their family home.

Some of the choices confronting them are not only about downsizing or leaving home with assisted living, such as the services council provides through our home maintenance and modification services. A very challenging choice for families, individuals and their carers is what choice of accommodation they make in this last stage of life. For many people, they know that entering an aged-care facility might mean for them that they are facing their mortality and they are facing the reality that their health needs will change and potentially grow more intense as they grow older. One of the strong points in our advocacy through our Health Ageing Plan is that council makes a policy commitment to looking at diverse housing choices. We are looking regionally. You will see some of our commentary commencing on page 53 of our Healthy Ageing Plan. We have made a policy commitment that council will be looking at ways that we can facilitate and investigate the availability of land that can be used for the construction of aged-care facilities and retirement villages.

We are looking at different planning mechanisms that will enable diverse living models so that in the twenty-first century, with an expanding ageing population, we are challenging ourselves to plan well for people, not only for their physical needs but also for their community needs. People who are connected have better health outcomes. People who are socially engaged have better health outcomes. Local government takes seriously our part of the integrated government response and we are representing to you the needs of residents once they move beyond our ambit, which is local land-use planning, low-value consent authority, fire safety regulation, community planning and support for people living independently in their own homes. We work with people as they make choices about the next level of services. We present the need to advocate for these residents in the next level of service.

Reverend the Hon. FRED NILE: In your submission you stress concern about some of the proposed changes to the Public Health Act 2010. You support New South Wales legislation continuing to retain safeguards to protect our older people. Is that in particular the requirement for a registered nurse to be available?

Ms KELLY: Yes, it is.

Reverend the Hon. FRED NILE: Why do you feel that is an important need that must be met?

Ms KELLY: It is most important that registered nurses be on duty 24 hours a day. As another witness said, more complex and higher needs older people are now living in our nursing homes than was the case when I commenced nursing just over 25 years ago. The condition of these older people can change really quickly. Registered nurses understand the symptoms and early warning signs in regard to a change in condition or deterioration in condition. Confusion is one of the first signs in an older person. People who do not have the expertise or knowledge and who may be surrounded by people with symptoms of confusion may think being confused is part of the package of ageing. It is not, and registered nurses have the ability to respond to changes. The reason it is important for them to be there 24 hours a day is that we know from our experience in public hospitals that we now respond better and manage and escalate care.

The majority of deteriorating patient incidences occur out of hours—it is over 75 per cent; both my grandmothers died in the middle of the night—and this is when change can occur. It is important that registered nurses assess the situation and escalate to the next layer of decision-making if necessary, to the director of nursing, the nurse manager on call or the general practitioner [GP] for end-of-life care. They can discuss the situation and feel confident that the decision they make will enable them to continue to care for the person and not necessarily call an ambulance for an unnecessary trip to hospital.

CHAIR: I congratulate you on the fine work you have done in bringing to this inquiry the important role of local government. We have heard that the State has vacated the space, but we know that at the end of the day so much care of communities is up to local government. You have submitted great documents. You are obviously playing an active role in the ageing in place programs by offering many services. You say you have 513 people in residential facilities. Do you know the ages of those people?

Ms KELLY: The majority of them would be over 65, but some may have an age-related illness and be under 65.

Ms RONAN: Can we get that from our aged care?

Ms KELLY: We can certainly request that and provide it.

CHAIR: That would be great because we are having trouble getting data. A previous witness referred to housing and the lack of transitional arrangements for people going from independent living to an aged-care facility. It looks like you are trying to address that gap in the market.

Ms KELLY: We are committed to striving to be an age-friendly community, not just with housing but with our precincts and high streets around our community facilities. We have been pushing that through our contributions to development in the Bays Market District and Bays Waterfront Promenade. We think it is very important and there are many options for us to investigate to inform our local environmental plans [LEPs], such as laneway housing. There are different layers of diversity of housing to allow people to age in place and reside with their families. That is part of our healthy ageing plan.

CHAIR: Has that been well received in your relationship with the State Government? Is the Government providing support to enable you to deliver these local outcomes?

Ms KELLY: You would have to test that in relation to our LEP because we only launched our healthy ageing plan in July this year.

Ms RONAN: We have a number of key strategies—for instance, we work in the Metropolitan Mayors Forum and we work with the Southern Sydney Regional Organisation of Councils. The main policy position is that we are seeking to collaborate with the State Government to develop a policy position to enable planning for diverse living models by planning for changing needs as our population ages. We recognise it is a challenge and we are submitting proposals for the redevelopment of the bays precinct that would look at the provision of aged-care facilities in addition to recreational needs of other aspects of our population. We are a constant advocate for affordable housing and a keen investigator of diverse living models. Council has a housing committee with members from major community housing providers and residential aged-care providers. It is a key issue for our community.

The Hon. BRONNIE TAYLOR: Thank you for your submission. I commend you for your plan and your forward thinking. I am in local government and I will show my council your submission. Is your council directly responsible for any aged-care facilities in your area?

Ms KELLY: Yes, we are in that we are the regulator for the fire safety authority for the premises and food—

Ms RONAN: Not food, but other regulated systems such as cooling towers and warm-water systems.

Ms KELLY: Not Food.

The Hon. BRONNIE TAYLOR: Those are your local government responsibilities.

Ms KELLY: That is correct.

The Hon. BRONNIE TAYLOR: The council I am on runs an aged-care facility. Do you run any aged-care facilities?

Ms RONAN: No, we do not manage residential aged-care facilities.

The Hon. BRONNIE TAYLOR: Do you have the unequivocal support of all the providers in your area for your views on 24-hour registered nursing in your submission?

Ms KELLY: No, we have not approached them because we are not representing them. We are representing Leichhardt council. What we discuss in our submission was carried unanimously by Leichhardt council.

The Hon. BRONNIE TAYLOR: You made it very clear that it had bipartisan support.

The Hon. WALT SECORD: Tripartisan.

CHAIR: It had multi-party support.

The Hon. BRONNIE TAYLOR: Did you get support from the aged-care facility providers in your local government area for the content of your submission?

Mr JOBLING: As Ms Kelly said, we have not gone directly to the operators. We have gone out to our precinct committees, our seniors' organisations, various groups such as Healthy Older People Eating [HOPE], and the community with a questionnaire and asked what they think they need. For that reason, we have come back with a structure with which we all agree. We all want people to continue to live in their homes for as long as possible and to supply them with services. The Healthy Ageing Plan covers that. We have also looked at that aspect, which in part answers your question. We have said that if you were a resident of Leichhardt, what sort of ageing accommodation would you want? You would want the best professional care. We have spoken with our medical practitioners, and obviously the people in the area cover all the issues. We believe that that is the view of people across the spectrum of the Leichhardt council area and not specifically in one area.

The Hon. BRONNIE TAYLOR: You have taken a view that reflects the view of providers in your area without consulting them?

The Hon. WALT SECORD: He said it reflects the community view.

Ms KELLY: I wish to clarify that we are not here representing the providers; we are here representing Leichhardt Municipal Council, which represents 56,000 residents.

The Hon. BRONNIE TAYLOR: I understand that. It is something that we need to clarify.

Ms KELLY: I am clarifying it for you. We are not representing health care providers; we are representing Leichhardt Municipal Council, which represents 56,000 residents.

The Hon. BRONNIE TAYLOR: Thank you.

The Hon. WALT SECORD: That is Bronwyn's job; she represents the commercial providers. The witnesses represent the community

The Hon. BRONNIE TAYLOR: It would be a breach of the legislation if anyone other than a registered nurse administered S8 medications. It is done properly and entered into a schedule 8 book and so on.

Ms KELLY: That is correct.

Mr JOBLING: That does not include a medical practitioner.

The Hon. BRONNIE TAYLOR: Yes, thank you.

The Hon. SARAH MITCHELL: I refer to the first paragraph on the final page of your submission, which states:

... the definition of a nursing home to cover all facilities where people are living who have been assessed, and are funded as having high care and complex health needs requiring the services of a Registered Nurse.

Ms Ronan mentioned that there are both levels of aged care in the area. Are you advocating for a registered nurse to be on duty 24/7 in low-care facilities?

Ms KELLY: If a patient's needs have changed and they have been assessed as requiring high-level care and they are stuck in a low-care facility we believe there should be registered nurse available to care for them.

The Hon. SARAH MITCHELL: I am talking about a low-care facility where all the residents are assessed as requiring a low level of care.

Ms KELLY: Ideally I would like a registered nurse on duty in a low-care facility as well. However, I believe the minimum should be linked to the funding. If they were assessed as requiring high care and if the facility is being funded for a high-care service then I expect the provider to deliver the registered nurse.

The Hon. SARAH MITCHELL: Were any of the six facilities previously classified as low care?

Ms KELLY: We will take that question on notice. We said that we will try to get a breakdown of those numbers.

The Hon. SARAH MITCHELL: If one or more are low-care facilities, what is your view of the effect on their future viability if they are required to have a registered nurse on duty 24/7?

Ms KELLY: We will take that question on notice.

The Hon. SARAH MITCHELL: I again refer to the last page of your submission and the last dot point. You mention some of your concerns about changes to the Commonwealth Aged Care Act. At the fourth dot point you state that the changes will potentially remove the role and importance of aged-care assessment teams. Representatives from the Commonwealth Government who appeared before the Committee earlier today did not raise that issue. Who has raised that concern with the council?

Ms KELLY: We will take that question on notice and provide more information.

The Hon. BRONNIE TAYLOR: I refer to the first page of your submission. You mention a meeting on 23 June and there is a list of unanimous resolutions. The submission states that the resolutions were disseminated to community and aged-care groups. Does that mean it was not disseminated to the aged-care providers?

Ms KELLY: No, the resolution does not say that. The council officers respond to the resolutions. My understanding is that the resolutions were passed on to relevant committees and aged-care groups with whom we are in partnership. I made an inquiry about that with the council officers.

CHAIR: Did I see a media statement released by the council? I think I saw a media report.

Ms KELLY: Council has included this information and the support that it has given. Details of the inquiry were in one of our newsletters, which are disseminated once a week to residents who have registered to receive such information.

Mr JOBLING: It is certainly disseminated to the public and the media. Just for the record, discussion on this is always held in open council. We met a number of members of the public who were present. They all have the right to speak for up to three minutes for or against a proposition and to raise any concerns or problems. That is unusual.

Ms KELLY: It was a busy night; we could not have fitted anyone else in the chamber that evening.

The Hon. BRONNIE TAYLOR: I refer to your local environmental plan and your obligation through the State Government to consult widely, as we all do. Did you feel it would be appropriate when you made your submission supporting the move to legislate mandatory hours for registered nurses in nursing homes to consult with aged-care providers in your area?

The Hon. WALT SECORD: Point of order: The Hon. Bronnie Taylor has asked this question three times in a row and has received three answers. She can ask it again.

CHAIR: There is no point of order. If Ms Taylor wishes to ask the same question in various ways that is her prerogative.

The Hon. BRONNIE TAYLOR: That was my question.

CHAIR: You will get the same answer and it will be pointless.

Ms RONAN: The council's policy position in respect of this is based on its evidence base, its community engagement and the professional expertise of the officers. That was the track taken bearing in mind the council's resolution and the clarity of our community's desire to be able to plan well for the future and the expertise in relation to the impact of these changes from the council's viewpoint. Council did not seek to duplicate or replicate the activities of this committee by running an independent process with the providers. We also respect that providers have a range of needs and imperatives that council might not share. We are aware that they would be making their own submission and their voice would be heard in this chamber.

The Hon. SARAH MITCHELL: So you did not consult the six providers, and that is fine. Did you think you should have or are you happy that you did not?

Ms RONAN: In this case, certainly. Our submission is published by this Committee. In these processes there is always friendly collaboration. We have members of some of the organisations of these bodies—for instance, last night our lesbian, gay, bisexual, transgender and queer community had representation from one of the key providers. They complimented Leichhardt Council on taking an interest and making a submission. So we work in partnership. We keep our partners informed. In this case we made council's policy position clear.

Ms KELLY: In addition to that, the providers could have made a submission to council in regard to the position that we have taken here. The motion was given the same notice that all the business papers are given. It was publicly available on the website for one week beforehand, as are all the business papers for our council. They did not attend the public gallery to make representation and speak in regard to this. We have a policy of open council. As Councillor Jobling has said, we do not limit the number of people that would like to speak in regard to an agenda item, and they usually get more than their three minutes as well.

CHAIR: Thank you. I have one clarification. Is your current population 60,000?

Ms KELLY: It is 56,000, and it is about 10.23 square kilometres in area.

CHAIR: Thank you for doing that important role of local government in representing your community—great work. Thank you very much for coming along to the inquiry and offering another point of view. You have taken some questions on notice. The secretariat staff will be in touch with you. There are 21 days for the return of those answers.

Reverend the Hon. FRED NILE: I move that the Committee table the documents presented by Leichhardt Municipal Council.

Documents tabled.

CHAIR: Thank you, Reverend the Hon. Fred Nile. As all members are in favour, we will circulate them and make them available for publishing.

(The witnesses withdrew)

(The Committee adjourned at 4.31 p.m.)