



New South Wales Nurses & Midwives' Association

*Submission to Senate Select Committee on Health
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*NSW Nurses and Midwives' Association &
Australian Nursing and Midwifery Federation – NSW Branch
50 O'Dea Avenue, Waterloo NSW 2017
Phone 02 8595 1234
www.nswnma.asn.au*

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales.

The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes assistants in nursing (who are unregulated), enrolled nurses and registered nurses and midwives at all levels including management and education.

The NSWNMA has approximately 60,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions. Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also dedicated to improving standards of patient care and the quality of health and aged care services.

NSWNMA is committed to the notion of health as a public good with shared benefits and shared responsibilities. We believe that access to adequate healthcare is the right of every Australian and a crucial element of the Australian social compact. We are committed to publicly funded universal health insurance as the most efficient and effective mechanism to distribute resources in a manner that generally ensures timely and equitable access to affordable healthcare on the basis of clinical need rather than capacity to pay.

We are also faithful to the principles and philosophy of primary health care: social justice, equity and self-determination, with a focus on early intervention to promote health and prevent illness.

While we recognise there are substantial reforms that can be made in order to improve the system, we believe that the principles on which Medicare was founded must be preserved: equity, efficiency, simplicity and universality.

NSWNMA rejects the notion that Medicare is unsustainable. The reality is that in the coming decades, spending on healthcare will grow but so will our incomes. This increased spending can be done as individuals in a user-pays system, or it can be done as a community in the form of a system of universal insurance such as Medicare. Either way, healthcare spending will grow and someone will be paying for it.

The difference is, in a highly privatised, user-pays system there will be winners and there will be losers as we see in the United States. Excellent care is available to those who can pay for it (or insure against it) but many who fall ill cannot afford care and they and their families suffer terribly as a result. The highly privatised US healthcare system costs far more and delivers far less than systems based on universal insurance.

The rest of the developed world economies have chosen to rely on universal insurance because it is costs less, it is more civilised and equitable and results in better outcomes. Beneficiaries pay according to their means through progressive taxation and have access to the system on the basis of need.

No one is pretending that there are no changes that could be made to a 30 year old system like Medicare to make it more efficient – there certainly are many. But the notion that dismantling universalism, privatisation and shifting costs to individuals is the answer to making the system more sustainable is a recipe for higher costs overall and rising social inequity.

Serious commitments must be made to ensure that the rate of inflation of costs in health is contained in the future. It is vital that the Australian Government maintains the lever of universal insurance to maintain a downward pressure on costs. The shift towards greater user pays, greater privatisation and co-payments as a barrier to primary health care is profoundly inconsistent with the goals of efficacy and equity and must be rejected.

This submission seeks to provide a sample of the key issues we see arising and to highlight the keys issues of concern for our membership: poor staffing leading to excessive workloads and compromised standards of care; cost-shifting

- a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;*

We are deeply concerned by a number of measures in the Federal Budget related to the health portfolio, principally the issue of increasing co-payments and the news that the Federal Government is walking away from the agreed funding arrangements with the State and Territory governments under the National Health Partnership Agreement.

We believe that the commitments negotiated under the previous government were appropriate. The National Partnerships Agreement had a strong emphasis on efficiency whilst recognising the reality that growth in Federal Government funding is necessary to respond to growing public hospital costs.

This move away from the Commonwealth sharing the cost of the growth of hospital admissions and other activity is anticipated to cost the States and Territories billions of dollars in health funding, cuts which will commence almost immediately. This move creates deep uncertainty for the people of NSW in regard to our already stretched public hospital services.

It is vital that States have certainty with regard to public hospital funding. We have no doubt that this move by the Federal Government will be used by the NSW Government to justify further privatisation of health services in NSW. Privatisation will lead to less efficiency and less equity of access for the people of NSW. The evidence also shows that privatisation is not associated with improved quality and safety.

We are also concerned about the dire consequences this funding uncertainty will have on the capacity of NSW hospitals to sustain safe staffing levels. Safe staffing and workloads are the most critical issues for nurses and midwives in NSW, and while we have made some progress in establishing minimum staffing in some sections of the system, more progress is required to ensure that all NSW residents have access to safe care.

Of all the members of the multidisciplinary healthcare team, the nurse and midwife is the only one who provides a continuous, 24/7 presence at the bedside. This, the nurse or midwife is the member of the team most likely to

pick up deterioration in a patient's condition and initiate interventions that minimise the impact of adverse events and prevent negative outcomes for the patient.

Following on from the seminal work by Needleman et al.¹ many researchers have investigated a number of key patient outcomes known as 'outcomes potentially sensitive to nursing' (OSPN) i.e. adverse events that lead to increased length of stay in hospital and in-hospital mortality. Eleven OPSN have been identified for both medical and surgical patients (urinary tract infection, pressure ulcers, hospital-acquired pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, hospital-acquired sepsis, deep vein thrombosis, central nervous system complications, in-hospital death, failure to rescue²) and an additional three have been identified for surgical patients only (wound infection, pulmonary failure and metabolic derangement).³ A variety of other adverse patient outcomes, including falls and adverse drug events, have been investigated with respect to their relationship to nursing.

In the majority of costing models, the cost of an adverse event is calculated by comparison of costs between similar patients i.e. costs of a routine inpatient stay contrasted with those associated with an inpatient stay during which complications developed.⁴

All members of the interdisciplinary healthcare team have a role to play in prevention of adverse outcomes; however, numerous studies – both national and international – now describe the significant link between nurse-to-patient ratios/nursing hours per patient day and patient outcomes. The growing body of evidence clearly demonstrates that inadequate nurse staffing leads to an increase in negative outcomes for patients and ultimately a greater burden of cost to both the healthcare budget and society. In order to progress the implementation of safe mandated minimum staffing in NSW there must be some level of certainty in terms of the Commonwealth contribution.

¹ Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine*, 346(22), 1715-1722.

² Failure-to-rescue is defined as patients who have died after developing a complication while in the hospital, i.e., patients who, under normal circumstances of care, might have been 'rescued' from the complications of pneumonia, deep vein thrombosis/pulmonary embolus, sepsis, acute renal failure, shock/cardiac arrest, gastrointestinal haemorrhage/acute ulcer (Cook et al., 2012).

³ Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *New England Journal of Medicine*, 346(22), 1715-1722.

⁴ Carryer, J. & Budge, C. (2010). Calculating Outcomes Potentially Sensitive to Nursing. A literature review. Report for the New Zealand Ministry of Health. Wellington: Ministry of Health Available: www.moh.govt.nz

Reduced Commonwealth funding will undoubtedly affect the capacity of NSW health services to maintain optimal staffing levels, leading to diminution of quality of care and patient safety. It will also create other pressures that result in inefficient use of resources and poor patient outcomes through cost shifting.

We were recently contacted by a member who described the following scenario in a regional district of NSW:

Emergency Departments (ED) are forcing people presenting to ED who are diagnosed with an infection requiring Intravenous antibiotics (IVAB), to purchase their own IVABs from the local pharmacy after getting their script from their GP. So, on presentation, they would be have a cannula inserted, given the initial dose/s, the sent to their GP to get a script which once filled will be administered in primary & community health, or the outpatients clinic in the ED. They're also required to reimburse the ED the initial dose/s that they were given in the ED, out of the filled script.

On early discharge as an inpatient from hospital, patients who require ongoing IVABs are given a script to get filled out at the local pharmacy which they pay for & then told to represent to the clinic (Mostly EDs), to have the medication administered, which can be up to 4 times a day.

Patients may be provided the choice to be admitted into hospital instead, and in this circumstance they are not charged for the medications. The facility managers are being verbally advised to cut costs by implementing this type of procedure.

In association with this practice, we are aware of at least one patient who developed a life threatening systemic infection requiring emergency transport by air ambulance to a larger hospital.

Such unsafe practices emerge frequently as a result of the incentives to cost shift that will inevitably increase with the proposed reduction in Commonwealth funding.

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

The evidence is also clear in relation to co-payments for access to primary health care: they do not discriminate between serious and non-serious occasions of service; they are not efficient because they hinder prevention and early intervention; and they increase inequity because they deter only already marginalised sections of the community from accessing care.

We reject the Government's proposal to implement a \$7 co-payment for GP visits and out of hospital pathology and radiology. It is a false economy to implement this barrier to access to primary health care. General practice is where prevention, early intervention and hospital avoidance occurs. It flies in the face of logic for a Government seeking to contain health costs to create new barriers to access for this most cost effective area of healthcare.

The data shows the out-of-pocket expenses in Australia are already high, too high for some, and this is creating an unacceptable barrier to effective healthcare for some people. The evidence indicates that in 2013, 16% of Australian adults reported that they had experienced cost-related access problems (did not fill/skipped prescription, did not visit doctor with medical problem, and/or did not get recommended care) and Australians' out-of-pocket expenses were second only to the United States.⁵ Imposition of a compulsory co-payment on general practice visits will exacerbate these concerns.

We know already that Australians most in need of health care are the ones least able to afford it⁶ and the evidence shows that co-payments impact disproportionately on vulnerable groups:

The empirical evidence likewise indicates that vulnerable groups, including individuals with low income and in particular need of care, reduce their use relatively more than the remaining population in consequence of co-payment.⁷

Delaying or avoiding consultations, diagnostic tests and prescriptions can have catastrophic consequences both for outcomes and costs of care. Australia is facing a major chronic disease burden in the future and it will become increasingly important to find more efficient ways of managing chronic illnesses.

⁵ Schoen, C., Osborn, R., Spies, D., Doty, M. Access, Affordability and Insurance Complexity are Often Worse in the United States Compared to 10 Other Countries, *Health Affairs*, December 2013 32:122205-2215, November 2013.

⁶ AIHW 2012. Australia's health 2012. Australia's health no. 13. Cat. no. AUS 156. Canberra: AIHW.

⁷ Kiil, A., Houlberg, K. How does co-payment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011. *European Journal of Health Economics*, August 2013.

This will require more emphasis on primary health care and better integration of healthcare. It will be increasingly important that people with chronic diseases avoid expensive hospitalisations through easy access to early intervention, prevention and education about self-management in the most cost-effective settings.

Elimination of bulkbilling, imposition of a co-payment on general practice visits and creating barriers to access is exactly the opposite of what is required to respond effectively and efficiently to this future challenge. Hospital costs account for around 40% of health expenditure in Australia. The way to contain growth in this sector is through investment in prevention and early intervention in primary care services. This is a fundamental principal of healthcare.

In terms of the idea that a co-payment will discourage only unnecessary contact with health professionals, this of course is nonsense. Most people attend GPs precisely because they don't know if their symptoms are a sign of something more serious. Irritability and fever in a toddler may be associated with teething or it could be the early stages of a potentially catastrophic meningitis infection. Early intervention in diseases such as cancer, diabetes and those related to the cardiovascular system is critical in avoiding the need for more complex and expensive treatments down the line. Similarly, patient education delivered in the primary health care setting will contribute to the lifestyle changes that are critical in preventing the so called 'lifestyle diseases'. Imposing a co-payment to discourage early intervention in such situations is a profoundly regressive move that could result in serious harm and far greater expense in the longer term.

With regard to the increase in co-payments for medicines, consider the issue of medication compliance following myocardial infarction recently studied by Choudhry, et al, 2011.⁸ Medication following myocardial infarction has substantially reduced morbidity and mortality and compliance with prescribed regimes is crucial. Costs are one of the key reasons that many patients do not adhere to prescribed drug regimes. The study examined almost 6,000 patients who had had one infarction, the impact of co-payments on compliance, outcomes and costs. It was clear that the group who had their co-payments waived were more compliant with prescribed regimes, they were less likely to experience further cardiovascular events, and most importantly, none of these benefits came at a net monetary cost. That is, the investment in access to medications avoided expensive complications down the line. Indeed, the New

⁸ Choudhry, N, et al., Full Coverage for Preventative Medicines after Myocardial Infarction, *New England Journal of Medicine* 2011; 365:2088-2097.

England Healthcare Institute estimates that the cost of hospital admissions associated with non-adherence to prescribed medications in the United States is as high as 10% of overall hospital costs.⁹

In terms of the role of private health insurance, local and global evidence shows that the more private health insurance is used to fund healthcare, the more expensive that system becomes, without any improvement in the quality of care. The administrative costs of private health insurers including profit margin are about three times that of Medicare. Australians pay \$2.5 billion per year towards private health insurers' administration fees and profits.

In Australia only 84 cents in every dollar collected by private insurers is returned as benefits, the rest goes to administrative costs and corporate profits. By contrast Medicare returns 94 cents in the dollar. Private insurance does not contribute to efficient distribution of resources because competition among insurers renders them powerless to influence the prices demanded by providers. In contrast, a single national insurer like Medicare has the market power to put some discipline into prices and utilisation.

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

The Association is fundamentally committed to the philosophy of primary health care and a commitment to its values and goals through health promotion and preventive health behaviours. We are bitterly disappointed in the Government's response to health promotion, preventive health and early intervention in the Australian government Budget 2014-15. The cuts will have a very damaging impact on health promotion, prevention and early intervention, especially for youth and families with mental illness and disadvantaged low-socioeconomic families whose health would really benefit from preventive health media campaigns, early intervention and preventive programs. NSW has a large workforce of registered nurses and midwives, and who are committed to primary health care but who will be unable to work to prevent illness and

⁹ New England Health Institute, Thinking Outside the Pillbox: Improving Medication Adherence and Reducing Readmissions, A NEHI Issue Brief, Oct 2012, <http://www.nacds.org/pdfs/pr/2012/nehi-readmissions.pdf>.

promote health in the families identified due to severe Commonwealth Government Budget cuts to these vital service areas.

The Government has argued that by scrapping the large National Partnership Agreement on Preventive Health over 4 years (\$130.5 mill) and ceasing other Health Department Grants and, for example, schemes like Partners in Recovery, to add to the cash amount, they are able to invest \$367.9 million in the *Medical Research Future Fund*. In other words future medical research into chronic diseases and funding cures for these is more important than funding involvement in preventive programs targeting prevention of heart disease, obesity and diabetes; early intervention strategies such as screening tools to assist the detection of possible illness conditions, as well as promoting peoples' health and well being, right now.

This huge medical research commitment by the Government detracts from health promotion, prevention and early interventions programs and campaigns, and defies logic. Instead of helping people, especially disadvantaged families, by investing money into health programs and improving the health and preventing illness conditions in the Australian population, we will invest millions of dollars into funding and finding cures for diseases way into the future. There is a high likelihood that it will be future wealthy Australians who are more oriented to health promotion and prevention that will be more likely to benefit from this research in the future.

Australians need more dedicated and consistent funding over longer periods for preventive health measures and early intervention, not only in terms of physical health but mental health as well. Although preventive research into physical conditions has proved beneficial the positive effects of early intervention in psychotic mental disorders is demonstrated by research, and savings can be made through prevention and early intervention. We also need a national approach towards mass media education campaigns in all health areas, especially mental health. There can be no doubt that mental illness is a big problem in Australia today. As well as funding for preventive measures in mental health we need mass national media education campaigns raising awareness of the whole range of mental illnesses and the stigma which exists towards people who are mentally ill in order to stamp out negative attitudes that society has incorrectly labelled as appropriate. Somehow there needs to be a foundation for embedding prevention and early intervention approaches within

sustainable systems like health bureaucracies, which is only possible through adequate and long term funding.

In contrast to this approach, the Government has only provided short term funding for Indigenous teenage reproductive health and young parent support for 2014-2015, along with some funding towards youth mental health issues, some of which is also short term. They acknowledge the youth period as – 12 to 25 years – this being the important time when mental illness episodes for youth spiral out of control, according to research. The funding provided in the budget ranges from that provided for a National Centre of Excellence in Youth Mental Health – establishment, of \$18 mill over four years. This will be allocated to the centre of excellence - Orygen Youth Health Research Centre to improve treatment and support options but it won't deliver services to young people affected by mental illness and their carers. The Mental Health Nurse Incentive Programme – continuation 'will enable mental health nurses, who care for clients with severe and complex mentally ill conditions, engaged by community general practices, and private psychiatric practices to provide 'clinically relevant services to approx 60,000 patients,' appears to provide services for all people whether they are 'youth' or not. However this program is only viable for two years. Meanwhile the headspace Programme – additional funding provides \$14.9 million over four years with ten headspace sites which appear to be the only service allocated specifically to 'youth,' who have or who are at risk of mental illness. Will this be adequate to stem the rising crisis in youth mental health? Indeed youth suicide is prevalent in Australia as current research figures show.

Unlike the short term nature of funding provided by the current Budget, chapter 7, from the Senate Former Committees of Mental Health and the resulting Report – Promotion, prevention and early intervention – opts for a whole of life approach which starts at birth and follows through into adulthood. It suggests that a large funding amount – to include mass media campaigns and intervention strategies and target resources – over a long term is needed to address mental health problems for Australians. One example provided by examining maternal health is the argument that mothers who have post natal depression affect their young babies and depressed patterns of behaviour can affect their siblings. They can depress their infants and this scenario can set the family on a path initially influenced by maternal depression. Every attempt should be made therefore to support such mothers and their children by providing adequate mental health resources, like specialist counselling and

psychologist and psychiatrist support visits, even online support, which protect/help to insulate families against these issues. These long term preventive steps may assist the affected families to establish patterns that promote resilience and establish healthier patterns in youth.

Our Association has members who are community nurses, women's nurses, early childhood nurses and community mental health nurses – all of whom could assist young families, youths and adults with the inclusion of mass media campaigns and the resources enabling preventive health programs, and early intervention services designed to work with the client and their families in the community. Consideration should be given to employing more of these nurses in health promotion, prevention and early intervention in the areas identified above. Whilst mental health is a priority area overall both physical and mental family health is important. A dedicated approach to funding Australia's family health in terms of prevention, health promotion and early intervention will achieve better health for families and savings in the long term – this is a health investment for the future.

The abolition of the Australian National Preventive Health Agency, achieving a saving of \$6.4 million is also to be invested in the *Medical Research Future Fund*. This is a loss for preventive health as is the cessation of the Medicare Locals (MLs), who had substantial Commonwealth funding, and will be ceased by June 2015, to make way for Primary Health Networks (PHNs). In some places Medicare Locals were only set up to work in late 2012 so their ability to set up networks and be productive would have been severely limited. The move now is to make Medicare Locals, which were originally designed to administer primary health care, much bigger so that they are increased in size and numbers of them are reduced.

The Review of MLs which took place has concluded that problems created by system fragmentation and unco-ordinated care for patients, can be fixed by the creation of a further structure – Primary Health Networks (PHNs) – this is an assumption which has not been tested. At the end of 2014 Primary Health Networks (PHNs) will begin to be set up and they will take over the role of Medicare Locals. Moreover the Horvath Review indicates that General Practitioners (GPs) will have a central role, unlike other health practitioners. These PHNs will be actively brokering services. NSWNMA does not support the privatisation approach which will be adopted by the PHNs in the delivery of services. The concern is that services involving health promotion, prevention

and early intervention to clients will increase in price and will not necessarily be appropriate in terms of a 'quality' service.

Nurse practitioners are an untapped resource of advanced practitioner nurses who could be employed as experts in health promotion, preventive health and early intervention in various areas of practice such as women's health, child & family health, aged care, mental health, and pain management. The Association commends nurse practitioners as appropriate persons to be involved in aspects of nursing care associated with their particular speciality – they are able to prescribe medications and their clients can receive Medicare rebates, and they provide a cheaper as well as a quality service to their clients.

With the cessation of the Medicare Locals the main issue that arises from this is the dislocation with regard to staffing movements that will be caused through the closing down of Medicare Locals. Implications are that some staff will be shed (already we have had notice of this occurring for a nurse who has received her redundancy notice from a Medicare Local in Northern NSW). In this case the Medicare Local will be retaining Administrative staff but other staff will go. The implications for clients/patients are also problematic. Services they used to attend will not be available and there will be general confusion and the delivery of essential primary health care services will suffer.

The Association is committed to primary health care and advocates for the delivery of this care through nurses and midwives and Nurse Practitioners (NPs). Although the numbers of NPs are increasing, a move like reducing Commonwealth funding in the areas of health promotion does not assist their further development. They are experts in delivering health promotion , prevention and early intervention, as has been already explained, and they are a cost effective means of this kind of patient service which needs to be more fully utilized.

d. the interaction between elements of the health system, including between aged care and health care;

The health and wellbeing of older people in our community connects with many public sector services in NSW, as well as services in the non-government and private sectors. Most people in NSW will continue to age in their own homes

with support of family and friends, and from a range of primary care and community services. A smaller proportion will access Commonwealth funded in-home packages or residential aged care.

There are over one million people aged 65 years and over in NSW, comprising 13.8% of the State's population, slightly higher than the National average. Life expectancy has increased, and birth rates have declined and these factors change the age profile of our communities. It is predicted that by 2020, residents aged 65 years and over will make up nearly 20% of the state's population.¹⁰

Overall, older people in NSW have a high standard of health and good access to health care services.¹¹ However, as the proportion of older people increases, so will the incidence of age-related health consequences, including acute and chronic illness, frailty and disability. Most significant are dementia, cardiovascular illness, some disabilities and some cancers. Other factors that are not specifically age related but impact on health and wellness during ageing include insecure housing or homelessness, lack of transport, social isolation, poverty, mental illness, violence and exploitation, and effects of drug and alcohol use.

There are 885 residential aged care homes in NSW operated by federally funded providers. About three quarters are run by non-government providers such as church, and charitable provider, with some run by community organizations and local government. The rest are run by private operators. There are also a small number of nursing homes managed by the NSW Government, although the government is in the process of transferring its state-run homes to the non-government sector, and has only ten remaining residential aged care homes.

Aged care beds are also operated by the NSW government in Multi Purpose Services. These are attached to public hospitals in rural and remote areas, and include a mix of beds for short term and long term stay. Overall, NSW Health has 1714 high care, low care and transitional aged care beds, across 56 services.

¹⁰ Long-Term Fiscal Pressures Report: NSW Intergenerational Report 2011-12, Budget Paper No. 6, http://www.treasury.nsw.gov.au/__data/assets/pdf_file/0013/22018/bp6_ltfp.pdf

¹¹ People: Population Atlas of NSW, 2012, <http://atlas.nsw.gov.au/>

Older people, especially those who are very old, frail or living with illness, dementia or disability, do not fare so well in a hospital environment, and strategies must be in place to ensure alternatives are available to minimize admissions.

The length of stay for older people tends to be longer, there is an increased risk of deterioration and recuperation post-discharge is slower. In recent years, there has been an 8% annual increase in attendances by people aged 80+ years in Emergency Departments, and this is the entry point for 90% of older people who are admitted to hospital. Emergency departments create added burden on older people, particularly those with complex health problems, dementia or other cognitive diseases. These environments have high stimulus, are unfamiliar, bring contact with multiple new people and systems, long wait times, and can increase anxiety, confusion and immobility, even in a relatively short period of time.

There must be commitment to reduce reliance upon hospitals and emergency departments as the main response for older people, through better alternatives that support quality of life and care at home. These include ensuring support services, early intervention and health promotion and prevention services are prioritised. For example,

- allocating extra funding to the Dementia Services Framework 2010-15 which is largely allocated within existing resources
- ensuring specialist services that support older people at home and in their community such as palliative care services and advanced care planning services are granted secure funding so that people's end of life choices are clear and enacted;
- support of informal carers, who are the main support for older people in the community;
- extending Hospital in the Home programs;
- increasing the number of Nurse Practitioners in LHDs who can provide quick response to older people in their own homes or within residential aged care homes to intervene before escalation of health problems and prevent unnecessary hospital admissions; and
- a requirement for safe staffing and skill mix.

The NSWNMA is constantly engaged in issues arising from poor staffing and skill mix in NSW nursing homes and has a vast record of scenarios involving

compromised standards of care due to cost shifting between the aged care sector and the hospital system.

Case Study – regional NSW aged care facility

In 2012 the facility had 3 main areas; a Nursing Home or high care area comprising 20 beds, a dementia area comprising 10 beds and a Hostel or low care area comprising 43 beds.

Prior to 1 February 2012, the facility was operated by a regional shire council. On 1 February 2012, a not-for-profit provider (the Provider) took over ownership and control of the facility.

When the facility was operated by the shire council, there were around 17 nursing staff employed. Generally, shifts were rostered as follows;

Nursing Home

Morning Shift:

- 1 Registered Nurse (7am to 3.30pm)
- 1 Enrolled Nurse (7am to 3.30pm)
- 2 Personal Care Assistants (6am to 11am and 6am to 1.30pm)

Evening Shift:

- 1 Registered Nurse (2.30pm to 11pm)
- 1 Enrolled Nurse (2.30pm to 11pm)
- 1 Personal Care Assistant (3.30pm to 9pm)

Night Shift:

- 1 Registered Nurse
- 1 Enrolled Nurse (10.45pm to 7.15am)

Hostel and Dementia

Morning Shift: 3 Personal Care Assistants

Evening Shift: 2 Personal Care Assistants

Night Shift: 1 Personal Care Assistant

At or just prior to the Provider taking over the operation, 9 Registered Nurses were made redundant and a large number of Enrolled Nurses (around 6) and Personal Care Assistants resigned. As a result, staffing levels at the facility were reduced by around two thirds.

Thereafter, only two Registered Nurses (one full time General Manager and one part time Care Manager) were employed at the facility. These two Registered Nurses were engaged in a managerial capacity and as such were extremely busy with administrative tasks and had little time to devote to residential care. As a result, under the new Provider shifts at the facility were then staffed as follows;

Nursing Home

Morning Shift: 2 Care Service Employees

Evening Shift: 2 Care Service Employee (one between 2.30pm and 11pm and one between 3.30pm and 11pm)

Night Shift: 1 Care Service Employee (10.45pm to 7.15am) who worked in conjunction with the Care Service Employee rostered in the Hostel

Hostel

Morning Shift: 2 Care Service Employees (one between 6am and 1pm and one between 7am and 3.30pm)

Evening Shift: 1 Care Service Employee (2.30pm and 11pm)

Night Shift: 1 Care Service Employee (10.45pm to 7.15am) who worked in conjunction with the Care Service Employee rostered in the Nursing Home

Dementia

Morning Shift: 1 Care Service Employee

Evening Shift: 1 Care Service Employees (3.15pm to 9pm)

Night Shift: None (the Care Service Employee rostered in the Hostel at night also had responsibility for the dementia area)

The General Manager and Care Manager worked between 8.30am and 5pm Monday to Friday. The Care Manager's role was shared between

one Registered Nurse who worked two days per week and one Enrolled Nurse who worked three days per week. After 1 February 2012 there was no Registered Nurse at the facility to care for residents either before 8.30am or after 5pm Monday to Friday, or at any time on weekends. This was a major problem given that the nearest base hospital to the facility is around 2 hours away.

At this time, there were around 29 residents in the facility that required a high level of residential care. The youngest of these residents was around 70 years of age and many were in their 90s. At least two of the residents had cancer and many were bedridden.

Soon after February 2012, the Association was contacted by a number of employees at the facility and told that the quality of care had declined since the Provider took over. Specifically, the Association was informed of the following issues:

- Staff at the facility no longer had enough time to properly care for all the residents in the facility.*
- Residents were often now found lying in soiled beds because there was simply not enough staff to attend to them.*
- On one occasion the facility almost ran out of incontinence pads (due to a missed order) and staff were directed to use towels if necessary (although this did not actually occur).*
- Many of the more frail residents either did not or could not use the buzzer to call for assistance and consequently these residents tended to now receive less care and attention than others.*
- It became common for buzzers to now go unanswered for longer periods of time due to the lack of staff.*
- Certain less urgent tasks were now either no longer being done or were being delayed e.g. such as the cutting of fingernails.*
- Staff now had a diminished opportunity to comfort and reassure residents at the facility.*

The lack of Registered Nurses now meant that the key for Schedule 8 medication at the facility was to be kept by the General Manager. The General Manager however, worked between 8.30am and 5pm Monday to Friday. Accordingly, outside of these hours there was no ability for staff at the facility to access Schedule 8 drugs if needed. In response to this, the

Provider indicated that the General Manager was on call. However, the Association subsequently discovered that the General Manager did not live in the area.

The absence of Registered Nurses meant that residents began to be transferred to the District Hospital with relatively minor problems. Employees at the Hospital began to complain to the Association about the resources being wasted on these presentations given that these problems could easily have been treated by a Registered Nurse at the nursing home.

On around 15 April 2012, a resident at the facility who suffered from dementia was found knocking on the door of the District Hospital. She had wandered out of the facility without apparently being seen. The absence of Registered Nurses at the facility reduced the Provider's capacity to identify problems and risks of this kind.

The Association wrote to the Provider pointing out its concerns about the facility and stating that we believed they were in breach of their obligations under the Public Health Act 1991 (NSW). The Provider did not immediately seek to comply with their legal obligations. Instead, they attempted rearrange their aged care places with the Commonwealth Department of Health and Ageing (i.e. to convert their high care places into low care places) in order to avoid the legislation. It was only after discovering that avoidance was impossible, that they agreed to obey the law and engage Registered Nurses at all times at the facility. Within a few months the facility had recruited enough Registered Nurses to ensure that there was a Registered Nurse on duty at all times. Since that time the Association has not received any complaints from employees at the facility or the local hospital regarding the standard of care at the facility.

At the time of the dispute, 29 of the 51 residents at the facility required a high level of residential care. These residents were not cared for by a Registered Nurse at night or on weekends. Instead, there were only two care service employees engaged to care for the residents at these times. A recent inquest into the death of a resident at a Mid Richmond aged care facility located in Coraki found that this kind of staffing arrangement was unsatisfactory (see Inquest into the Death of Martha McKee, Magistrate R Denes, Lismore Coroner's Court, 26 August 2011).

The Association has ongoing concerns about poor staffing and skill mix in NSW aged care facilities and the way this impacts on the rest of the health system. The unfortunate reality is that if aged care providers are not obliged to maintain a minimum standard of Registered Nurse staffing at all times to care for residents with complex care needs, they will simply not do so due to economic pressures. Reputable aged care providers who currently provide constant nursing care will soon be forced to compete with more unscrupulous operators who are willing to compromise care.

As a result the quality of care for these frail people will diminish and costs will be shifted to the public hospital sector. The absence of Registered Nurses in nursing homes will lead to aged care facilities simply shifting the burden of high care residents to the NSW public health system.

In our view, it is time for a consensus to properly deal with this issue by requiring all residents who need a high level of care to be cared for by a Registered Nurse at all times, regardless of the kind of facility they are in and regardless of whether they are aged in place. This is entirely consistent with the principle that aged care residents should receive the type of care they need as an individual.