Response to:
NSW Legislative Council Select Committee Inquiry on the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020.

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Foreword

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 registered nurses, enrolled nurses and midwives at all levels including management and education and assistants in nursing and midwifery.

The NSWNMA has approximately 70,000 members 10,000 of which work in aged care and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

NSWNMA exists to be a strong, influential union of members respected as a contemporary leader in society for its innovation and achievements. We welcome the opportunity to provide a response to this consultation.

This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association

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Terms of Reference

That a select committee be established to inquire into and report on the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020, and in particular:

(a) the need to have a registered nurse on duty at all times in nursing homes and other aged care facilities with residents who require a high level of residential care,

(b) the impact registered nurses have on the safety and dignity of people in care,

(c) the impact on residential care of a lack of registered nursing staff on duty in a nursing home or other aged care facility at all times,

(d) the need for further regulation and minimum standards of care and appropriate staffing levels in nursing homes and other aged care facilities,

(e) the administration, procurement, storage and recording of medication by non-registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, as compared with hospital clinical settings,

(f) the potential for cost-shifting onto other parts of the public health system as a result of any legislative change to the current provisions for care in nursing homes or other aged care facilities,

(g) the role of registered nurses in responding to critical incidents and preventing unnecessary hospital admissions and unnecessary ambulance call outs and the consequent effect of this upon the provision of ambulance services to the wider community,

(h) the lessons that can be learnt in New South Wales from the impact of the COVID-19 crisis on private aged care facilities where staffing ratios are not mandated, and

(i) any other related matter.

Introductory comments

We are pleased to contribute to this important inquiry for the many vulnerable elderly in NSW and aged care workers whose continued professionalism throughout the COVID-19 crisis has invariably saved lives. However, we are disappointed that five years on from the initial inquiry examining the need for registered nurses in NSW nursing homes[1], it has once again taken a political intervention in the form of an Inquiry to determine whether or not federal legislation extends far enough to protect our most vulnerable elderly in NSW.

In the context of a Royal Commission into Aged Care Quality and Safety (Royal Commission) we should not be debating whether a single Registered Nurse (RN) and Director of Nursing (DoN) in residential aged care facilities (RACF) should be required in every RACF where high care is provided. Rather we should be determining how NSW can legislate for minimum staffing and skills mix ratios to ensure we never need to call a royal commission again.

As will be evidenced in this submission, the state of Victoria has demonstrated the power of mandated ratios in keeping older people in RACF safe during a world pandemic. With the largest population, and highest number of aged care places in any state or territory across Australia, we question why NSW is falling behind.

For years accountability for safe staffing and skills mix in NSW RACF has been shifted back and forth between federal and state jurisdictions. The Royal Commission has provided yet another rationale by which NSW Government can delay and defer taking meaningful and decisive action. A tactic we believe has now run its course.

The Royal Commission has effectively shone a spotlight onto a dire aged care system but is not in itself a solution. In the time it takes for the proposed three-year implementation of any recommendations, it will be too late for the 60,631 residents living in NSW RACF and 1,073 in multipurpose services aged care[2] and their families. Statistically, many will die in a system that denies them the right to receive nursing care.

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[1] NSW Government (2015) *Legislative Council GPSC 3: Inquiry into registered nurses in NSW nursing homes*. Available online at https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2275

[2] Department of Health (2020) *2019-20 Report on the Operation of the Aged Care Act 1997*. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf

As will be evidenced in this submission, there exists an inequitable system for older people in NSW RACF. Current NSW legislation affords some residents with high care needs access to RN 24/7 but does not extend far enough to capture all RACF, effectively creating a care lottery for NSW's most vulnerable elderly.

Although federal legislation requires aged care providers to schedule appropriate staffing to meet the nursing and personal care needs of residents. This submission will show weak regulatory systems and unclear terminology render this safeguard invalid.

Mandated ratios of staffing and skills mix do not achieve safe quality care in isolation, but they do provide a foundation from which quality can be achieved. Without them, it simply cannot. The *Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020* as proposed would provide a minimum ratio of skills mix. This will at least offer a safety net for many vulnerable elderly that current legislation does not.

However, as the Royal Commission has clearly evidenced, we have moved beyond requiring a single RN and DoN to keep residents safe. It is time to legislate for a staffing model that allows greater levels of all types of workers matched to resident acuity. Having ratios mandated will not only allow providers to increase, and where necessary decrease staffing, but will provide a benchmark for the Federal Government to regulate against.

We can be certain that residents of NSW and those who care for them will either be winners, or losers as a consequence of any decisions made in respect of the *Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020*.

Brett Holmes
General Secretary
NSW Nurses and Midwives' Association

Summary of Recommendations

1. We support the extension of the requirement to provide a RN on duty at all times and DoN in all NSW RACF as proposed through the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*. However, we call for mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs:

    - to reflect the increasing level of high care required in NSW RACF
    - to maintain the safety and dignity of NSW residents in RACF
    - to enable all residents to receive safe care
    - to enable safe administration and management of medications and effective supervision of Assistants in Nursing/Personal Care Workers (AINs/PCWs) assisting with medications
    - to manage care in-house supported by GPs, and to facilitate the effectiveness of any outreach services required
    - to enable timely detection and management of residents deteriorating health status
    - to enable effective infection prevention and control.

2. The *Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020* affords only a minimum skills mix. Evidence suggests a much greater number of RNs, ENs and AIN/PCWs are required. We recommend the NSW Government adopt the ANMF staffing and skills mix methodology as a benchmark for all NSW RACF.

3. The committee should consider the potential benefit of expanding NSW state-based health services into the provision of additional state-run RACF. This would ensure the same industrial agreements, staffing and skills mix, governance and standards that apply to NSW public hospitals would also apply to RACF.

(a) The need to have a registered nurse on duty at all times in nursing homes and other aged care facilities with residents who require a high level of residential care.

RACF are increasingly used as a last resort when all other care options have failed or are simply unable to meet the persons high care needs[3]. Those entering RACF typically have multiple co-morbidities, disabilities, dementia, and complex care needs. A third of all residents have high care needs in all three funding domains[4]. More than half are aged 85 years and over[5]. The average length of stay is below three years suggesting many residents use RACF at end of life and require palliative care[6].

Analysis of data trends have led researchers to predict a greater concentration of residential care services on a very high dependency population, with multiple comorbidities and care needs across multiple domains, including complex healthcare needs[7]. Given what the data tells us, it is essential every resident in NSW RACF is afforded a safe level of staffing and skills mix, including guarantees that RNs and ENs will always be present to deliver clinical care.

Scheduling of clinical input is largely determined by aged care providers and our members tell us this can lead to ad-hoc scheduling of RNs out of hours. Peripatetic nursing care is inappropriate for residential aged care. People's care needs do not disappear after 5pm or on weekends.

Consequently, aged care providers who employ an RN only during office hours often expect them to be on-call to provide telephone advice out of hours. This requires them to make a clinical judgement or delegate care without being able to sight the resident. This professionally compromises the RN and can be a wholly unsafe method of care delivery.

An RN does not simply perform pre-determined tasks. The International Council of Nurses (ICN) defines the role of a nurse as:

"Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention

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[3] The Grattan Institute (2020) *Reforming aged care: A practical plan for a rights-based system*. November 2020. Available at: https://grattan.edu.au/wp-content/uploads/2020/11/Reforming-Aged-Care-Grattan-Report.pdf
[4] AIHW (2020) *GEN aged care data: People's care needs in aged care*. Available at: https://gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care [Verified 8 December 2020]
[5] AIHW (2020) *GEN aged care data: Admissions into Permanent residential care, by age and sex, 2018–19*. Available at: https://gen-agedcaredata.gov.au/Topics/Admissions-into-aged-care/Explore-admissions-into-aged-care [Verified 8 December 2020)
[6] Department of Health (2020) *2019-20 Report on the Operation of the Aged Care Act 1997*. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf
[7] Gibson, G. (2020) Who uses residential aged care now, how has it changed and what does it mean for the future? *Australian Health Review* 44(**6**) pp. 820-828.

of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles."[8]

An RN employed on a peripatetic basis would simply be unable to provide the holistic care required under this definition. The role of a RN in health promotion and prevention are forgotten elements of nursing practice but are vital for resident's quality of life and life enhancement.

At 30 June 2020, just over half of all residential aged care residents with an Aged Care Funding Instrument (ACFI) assessment had a diagnosis of dementia[9] and 87% will have at least one diagnosed mental health and/or behavioural condition[10].

The removal of RNs and Enrolled Nurses (EN) from the aged care workforce has often been attributed to the home-like environments needed for the provision of dementia care. However, a diagnosis of dementia does not exclude other comorbidities. People living with dementia have at least four comorbidities on average[11] and around 17% have six or more[12].

It is recognised that as numbers of people living with dementia and comorbidities rises the delivery of healthcare becomes increasingly complex and challenging[13]. This directly contradicts the theory that good dementia care can be achieved through delivery of personal care by unregulated workers in homely environments.

Evidence points to the need for skilled nursing care and acceptance by the sector that health care is an integral part of residential aged care[14]. It is recognised RACF need to look more like sub-acute hospital rehab or a geriatric assessment ward with staffing and skills mix aligned[15].

We would argue that the *NSW Public Health Act (2010)*[16] in its current form is outdated and does not account for the level of acuity within the resident cohort in RACF. *The NSW Public Health Amendment*

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[8] ICN (2002) *Nursing Definitions: Definition of Nursing*. Available at: https://www.icn.ch/nursing-policy/nursing-definitions. [Verified 8 December 2020]
[9] AIHW (2020) *GEN aged care data: People's care needs in aged care*. Available at: https://gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care [Verified 8 December 2020]
[10] Ibid
[11] Poblador-Plou B et al (2014) Comorbidity of dementia: a cross-sectional study of primary care older patients *BMC Psychiatry Online* 14 (**84**). Available at: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-14-84
[12] Browne J et al (2017) Association of comorbidity and health service usage among patients with dementia in the UK: a population-based study *BMJ Open* 7(**3**). Available at: https://bmjopen.bmj.com/content/7/3/e012546.long
[13] Banerjee S. (2015) Multimorbidity – older adults need health care that can count past one *Lancet* 385(**9968**) pp 587–589.
[14] Gibson, G. (2020) Who uses residential aged care now, how has it changed and what does it mean for the future? *Australian Health Review* 44(**6**) pp 820-828.
[15] The Grattan Institute (2020) *Reforming aged care: A practical plan for a rights-based system*. November 2020. Available at: https://grattan.edu.au/wp-content/uploads/2020/11/Reforming-Aged-Care-Grattan-Report.pdf
[16] NSW Government (2020) *NSW Public Health Act (2010)* Available at: https://www.legislation.nsw.gov.au/view/html/inforce/current/act-2010-127 [Verified 15 December 2020]

(Registered Nurses in Nursing Homes) Act 2020 would at least allow our most vulnerable elderly access to limited nursing care 24/7 at end of life.

However, there needs to be robust methodology to determine adequacy of staffing and skills mix ratios, consistent with resident's needs[17]. The Royal Commission has moved the goalposts since the 2015 NSW Inquiry into Registered Nurses in Nursing Homes[18]. It has identified that RACF are a place of last resort when all other options have been exhausted. Rather than needing a single RN, staffing and skills mix need to reflect the acuity of residents[19].

We support the extension of the requirement to provide a RN on duty at all times and DoN in all NSW RACF as proposed through the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*. However, we call for mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs on each shift to reflect the increasing level of high care required in NSW RACF.

[17] ANMF, Flinders University and University of South Australia (2018) *National Aged Care Staffing and Skills Mix Project Report 2016*. Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf
[18] NSW Government (2015) *Legislative Council GPSC 3: Inquiry into registered nurses in NSW nursing homes*. Available online at https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2275
[19] Royal Commission into Aged Care Quality and Safety (2020) *Counsel Assisting's final submissions: proposed recommendations, p37*. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2020-10/RCD.9999.0540.0001_1.pdf

(b) The impact registered nurses have on the safety and dignity of people in care.

RNs are among the public's most trusted professionals. This is not randomly defined but borne out of the historical contribution RNs have made to the health outcomes of the general population, and the professional regulatory protections they adhere to.

The ICN defines a Nurse as:

"A person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country. Basic nursing education is a formally recognised programme of study providing a broad and sound foundation in the behavioural, life, and nursing sciences for the general practice of nursing, for a leadership role, and for post-basic education for specialty or advanced nursing practice. The nurse is prepared and authorized (1) to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; (2) to carry out health care teaching; (3) to participate fully as a member of the health care team; (4) to supervise and train nursing and health care auxiliaries; and (5) to be involved in research. (ICN, 1987)." [20]

The level of study for a Bachelor of Nursing (RN) is currently set at Australia Qualifications Framework (AQF) level 7 and takes three years to complete. A Diploma of Nursing (EN) at AQF level 5, taking 18 months to complete. The public can be assured that RNs and ENs have a level of predetermined education and skill based on attainment of safe patient outcomes.

The evidence presented to the Royal Commission has dispelled previous provider claims of an absence of evidence to suggest greater numbers of RNs increase quality in RACF[21]. Indeed, there is a plethora of both local and international research demonstrating enhanced patient outcomes and the economic costs/benefits of employing RNs[22]. It is evidenced that as more RNs are employed on a given shift, the better quality of care is delivered, including lowered mortality rates[23].

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[20] ICN (2002) *Nursing Definitions: Definition of a Nurse*. Available at: https://www.icn.ch/nursing-policy/nursing-definitions [Verified 8 December 2020]
[21] ACSA NSW/ACT (2015) *Submission to the Registered Nurses in NSW Nursing Homes Inquiry, p2*. Available at: https://www.parliament.nsw.gov.au/lcdocs/submissions/37863/0113%20Aged%20and%20Community%20Services%20NSW%20and%20ACT.pdf
[22] NSW Nurses and Midwives' Association (2018) *Ratios and Safe Patient Care*. Available at: https://www.nswnma.asn.au/wp-content/uploads/2019/02/Ratios-and-safe-patient-care-FINAL.pdf
[23] Needleman J.et Al (2011) Nurse staffing and inpatient hospital mortality *The New England Journal of Medicine* 364(**11**) pp 1037–45

"The detection of the deteriorating condition of a resident can save lives if there are enough qualified staff." Registered Nurse, NSWNMA member

The Australian Nursing and Midwifery Federation (ANMF) along with Flinders University and the University of South Australia were able to evidence through research that lack of RNs in RACF led to episodes of missed care. Inadequate pain management; missed wound care; failure to effectively monitor vital signs and blood glucose levels were all reported as being a consequence of poor ratios and skills mix[24].

It is without question that any resident experiencing these missed care episodes would have their dignity and safety compromised, a situation that could easily be avoided if more RNs and ENs are provided.

"Particularly on night duty where there is only one RN for 120 residents, the sole RN cannot give pain relief in a timely way and sometimes other, less time critical medications are also given later than optimal time." AIN, NSWNMA member

By contrast an AIN/PCW requires no formal qualifications and there is no minimum training requirement. The current industry set standard is AQF level 3, although this is not mandatory. The Australian College of Nursing defines an AIN/PCW as:

"A health care worker who supports the delivery of nursing care by assisting people with personal care and activities of daily living… The provision of such care is delegated and directly supervised by a registered nurse. AINs are accountable for accepting and carrying out the care delegated to them. However, the registered nurse delegating care retains the overall

[24] ANMF, Flinders University and University of South Australia (2018) *National Aged Care Staffing and Skills Mix Project Report 2016*. Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

responsibility for all delegated activities. The introduction of AINs into nursing care teams must never be as a substitution for registered or enrolled nurses."[25]

Whilst AIN/PCWs contribute greatly to the aged care workforce, RNs and ENs are subject to professional regulation afforded by the Australian Health Practitioner Regulation Agency (AHPRA), whereas AIN/PCWs are not accountable under such legislation. Their accountability or expected scope of practice is largely left to their employer, utilising the relevant industrial instrument covering their employment and/or workplace policies applied by the employer themselves.

The safety and dignity residents benefit from when their care is managed by a RN is without question and will be further evidenced throughout this submission.

We support the extension of the requirement to provide a RN on duty at all times and DoN in all NSW RACF as proposed through the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*. However, we call for mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs on each shift to maintain the safety and dignity of NSW residents in RACF.

[25] Australian College of Nursing (2016) *Assistants in Nursing (however titled) Position Statement*. Available at: https://acn.edu.au/wp-content/uploads/2018/02/ps_assistants_in_nursing_c5.pdf [Verified 9 December 2020]

(c) the impact on residential care of a lack of registered nursing staff on duty in a nursing home or other aged care facility at all times.

Where RACFs are exempted from the *NSW Public Health Act (2020)* the availability of RNs to residents is determined by the provider. This is influenced by a range of factors which may not always follow the care needs of residents. This can lead to rationing of nursing services and a direct aged care workforce largely consisting of unregulated AINs/PCWs.

A consequence of rationing is that residents only receive peripatetic nursing input which does not enable holistic care delivery and relegates clinical activities to tasks. It does not allow for health prevention and promotion. Nor does it allow for effective supervision of care delivery by AINs/PCWs.

Rationing of resources forces nurses to adopt a default task-based approach and to skim off all those elements of nursing practice that enable not only the delivery of life preservation procedures but life enhancement measures to residents. A meaningful life with purposeful goals cannot be delivered unless RNs and ENs are always available in sufficient numbers.

Care needs do not present consistent with a staffing roster. Around half of those living in NSW RACF will have some form of Dementia[26], a condition well-known to cause behavioural symptoms during evenings[27]. It is well known over-sedating older people as a form of managing behaviour occurs in RACF[28] an issue subject of much criticism by the Royal Commission[29].

> "Poor behaviour management is a major issue that occurs. If you have enough staff and good skill mix you can de-escalate a situation when a resident is beginning to get aggressive. If we don't have enough staff to intervene this can have devastating results."
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> Registered Nurse, NSWNMA member

[26] AIHW (2020) *GEN aged care data: People's care needs in aged care*. Available at: https://gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care [Verified 8 December 2020]
[27] Dementia Australia (2020) *What is Sundowning?* Available online at: https://www.dementia.org.au/about-dementia/carers/behaviour-changes/sundowning
[28] Westbury, J. et Al (2018) More action needed: Psychotropic prescribing in Australian residential aged care, *Australia and New Zealand Journal of Psychiatry* 53(**2**) pp 136-147
[29] Royal Commission into Aged Care Quality and Safety (2020) *Interim Report: Neglect Vol. 1-3*. Available at: https://agedcare.royalcommission.gov.au/publications/interim-report

However, a well-qualified RN with the right staffing ratios would have the training and experience to identify if the behaviour is resulting from delirium, pain or associated health condition, the treatment of which could de-escalate a situation without medicating[30].

Most people enter RACF requiring palliative care[31] and subsequently many residents need 'as required' pain relief to ensure a dignified and comfortable end of life. Our members have reported times when residents have waited until a RN can attend the facility to receive pain relief where an RN is not on duty at all times, or where they are working in RACF where poor staffing and skills mix ratios do not enable them to respond quickly.

> "We have two facilities side by side, comprising of 96 beds total. One does not have an RN employed at all times. We had a situation where a resident was at the end stage of his life. There was only one care worker caring for forty residents. The resident was alone and in pain and had to wait several hours for pain medication because the RN (myself) was busy in the other facility."
>
> Registered Nurse, NSWNMA member

These points and many more were clearly articulated through the earlier NSW inquiry into the need for registered nurses in NSW nursing homes[32]. However, having heard overwhelming evidence supporting the benefit to resident care, the NSW Government stated it neither supported retaining legislation in NSW securing RNs in some RACF, nor supported extending occupational licensing of AINs/PCWs, despite both being recommendations of the Inquiry[33]. This effectively left an open door to the further de-professionalisation of the aged care workforce in NSW.

This was a clear signal by the NSW Government that they did not wish to pursue a role in determining safe standards for aged care. It also provided a clear signal to the aged care sector that they trusted its ability to self-determine what level of skill and qualifications workers require to care for the most vulnerable elderly in NSW.

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[30] Jenkins, C. et Al (2016) Dementia 4: The nurse's role in caring for people with dementia *Nursing Times* 112(**27/28**) pp 20-23.

[31] Department of Health (2020) 2019-20 *Report on the Operation of the Aged Care Act 1997*. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf

[32] NSW Government (2015) *Legislative Council GPSC 3: Inquiry into registered nurses in NSW nursing homes*. Available online at https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2275

[33] NSW Government (2016) *Government response to the Inquiry into Registered Nurses in NSW Nursing Homes*. Available at: https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2275#tab-reportsandgovernmentresponses.

It is therefore with a degree of confidence that the Industry is pushing ahead with further reducing the level of skill rather than increasing it, even in the wake of a Royal Commission which has found widespread neglect of residents, and a pandemic that has resulted in many preventable deaths.

The interim report by the Royal Commission entitled 'Neglect'[34] directly linked poor resident outcomes to unsafe staffing and noted there was a need to increase clinical care within the overall skills mix. However, this was given scant regard by the Industry who proposed to fix the staffing crisis in aged care through the introduction of an aged care assistant role[35].

This position, offered as a workforce solution, requires a mere 10 hours online pre-learning before being directly engaged in employment with vulnerable elderly with advanced dementia and complex healthcare needs[36]. A lower, not greater standard of training and preparedness than currently exists.

Rather than heeding the findings of the Royal Commission, the Industry is actively going against recommendations, aided and abetted by a wholly inadequate regulatory system administered by the Aged Care Quality and Safety Commission (ACQSC).

It is clear neither to Federal Government, nor the Aged Care Sector can be trusted to fix the problem in RACF. It's time for NSW to legislate for safe staffing.

We support the extension of the requirement to provide a RN on duty at all times and DoN in all NSW RACF as proposed through the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*. However, we call for mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs on each shift to enable all residents to receive safe care.

[34] Royal Commission into Aged Care Quality and Safety (2020) *Interim Report: Neglect Vol. 1-3*. Available at: https://agedcare.royalcommission.gov.au/publications/interim-report
[35] LASA (2020) *Aged Care Assistant Program*. Details available at: https://lasa.asn.au/aged-care-assistant-program/ [Verified 17 December 2020]
[36] *Aged Care Assistant Employment Program* (2020) Available online at: https://dashcs.com.au/agedcare/#:~:text=The%20Aged%20Care%20Assistant%20role%20will%20include%20assistance%20with%20activities,meal%20distribution%2C%20preparation%2C%20and%20supervision [Verified 17 December 2020]

(d) The need for further regulation and minimum standards of care and appropriate staffing levels in nursing homes and other aged care facilities.

Residents requiring high complex healthcare rose from 13% of the total in 2009 to 52% in 2019[37]. However, data reveals the percentage of RNs in the aged care workforce fell from a high of 21% in 2003, to 14.6% in 2016 and the proportion of unregulated AINs/PCWs grew from 58.5% in 2003 to 70.3% in 2016[38]. The growth in residents with high complex healthcare needs, and the reduction of clinical expertise within RACF suggests the care needs of residents has not been factored into any decision making by Aged Care Providers around staffing and skills mix.

Evidence has shown that staffing numbers and skills mix also fall well below expected benchmarks compared to other countries[39]. Leading researchers to question how quality aged care can be achieved without increasing the number of RNs providing direct care and effective supervisory structures for unregulated care workers[40,41].

> "With ratios we can provide safe quality care, not rushed care. There will be more nurses and PCWs willing to work in aged care for it will become a more attractive career option."
> Registered Nurse, NSWNMA member

The staffing situation in aged care is in stark contrast to that in NSW public hospitals, which enjoy some of the highest levels of professional nurse staffing in the world due to industrial agreements. However, mandated minimum nurse staffing standards (for numbers and skill mix) are deeply unpopular with aged care providers[42,43] many of whom regard them as a blunt instrument, lacking in flexibility[44].

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[37] AIHW (2020) *GEN Aged Care Data: People's care needs in aged care*. Available at: https://www.aihw.gov.au/reports/aged-care/gen-peoples-care-needs-in-aged-care/contents/summary
[38] Department of Health (2017) *The Aged Care Workforce, 2016*. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf [Verified 9 December 2020]
[39] Eagar, K. et Al (2019) *How Australian residential aged care staffing levels compare with international and national benchmarks*. Canberra: Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong
[40] Broad, J.B. et Al (2013) Where do people die? An international comparison of the percentage of deaths occurring in hospital and residential care settings in 45 populations, using published and available statistics *International Journal of Public Health* **58** pp 257–67
[41] Wise, S. (2020) Staffing policy in aged care must look beyond the numbers *Australian Health Review* 44(**6**) pp 829-830.
[42] Duffield, C. et Al (2020) Harnessing ward-level administrative data and expert knowledge to improve staffing decisions: a multi-method case study *Journal of Advanced Nursing* **76** pp 287–96
[43] Eagar, K. et Al (2020) The Australian National Aged Care Classification (AN-ACC): a new case mix classification for residential aged care *Medical Journal of Australia* **213** pp 359–63
[44] ABC (2018) *Four Corners' report 'Who Cares?' Interview transcript*. Available to View at: https://www.abc.net.au/4corners/who-cares/10258290

The ANMF provides a benchmark solution through its National Aged Care Staffing and Skills Mix Project Report, 2016[45] which is flexible to accommodate fluctuating resident needs, but robust enough to eliminate episodes of missed care. It outlines an evidence-based staffing methodology that would enable every resident to receive the five-star care standard suggested to the Royal Commission by independent experts[46] removing any concerns regarding inflexibility.

The staffing model proposed by the ANMF would allow NSW residents to receive an average of 4.30 care hours (or 4 hours and eighteen minutes of care per day), with a skills mix requirement of RN 30%, EN 20% and Personal Care Worker 50% as the minimum standard.

The RN hours contained within the Royal Commission preliminary recommendations[47] are an improvement on current levels but fall short of the five-star care standard the ANMF model would provide. Therefore, the recommendations of the Royal Commission cannot be relied upon to ensure NSW residents are not subjected to missed care episodes.

The *NSW Public Health Act (2010)* affords some NSW residents accommodated in RACF minimal ratios of RNs and access to a DoN, because it was deemed that older people in NSW needed additional protections that the *Aged Care Act 1997* simply did not provide.

Indeed, a recent independent report to the Royal Commission identified higher levels of neglect in Australian RACF compared to international rates. Just over 9% of residents consulted reported staff rarely had time to attend to their individual needs[48]. This shocking situation has flourished in an industry with no fixed staffing ratios further demonstrating the lack of protections afforded by the *Aged Care Act 1997* and supporting the need for state-based legislation.

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[45] ANMF, Flinders University and University of South Australia (2018) *National Aged Care Staffing and Skills Mix Project Report 2016*. Available at: http://www.anmf.org.au/documents/reports/National_Aged_Care_Staffing_Skills_Mix_Project_Report_2016.pdf

[46] Ibid, Eagar, K. et Al (2019)

[47] Royal Commission into Aged Care Quality and Safety (2020) *Counsel Assisting's Final Submission Recommendations*. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2020-10/RCD.9999.0540.0001_1.pdf [Verified 18 December 2020]

[48] Commonwealth of Australia (2020) Experimental Estimates of the Prevalence of Elder Abuse in Australian Aged Care Facilities. Report prepared for the Royal Commission into Aged Care Quality and Safety December 2020. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2020-12/research-paper-17-elder-abuse-prevalence-aged-care-facilities.pdf

However, changes occurring as a result of the Federal Governments *Living Longer, Living Better* aged care reforms[49] removed the distinction between high and low care effectively excluding all NSW RACF commissioned post 1 July 2014 and those offering no low care places prior to 1 July 2014 from the requirements of the *NSW Public Health Act (2010)*.

The impact for NSW residents accommodated in RACF commissioned post 1 July 2014 and those offering no low care places prior to 1 July 2014 could not be greater, effectively creating a lottery of care for those receiving residential aged care (Table one).

Table one

Resident A	Resident B
RACF approved pre 1 July 2014 for high care operating within existing legislation	RACF approved post 1 July 2014 or no low care places as at 30 June 2014 operating within existing legislation
• Clinical governance overseen by a Director of Nursing • 24/7 access on-site to an RN • RN management of each shift • Management and administration of all prescribed medicines by an RN • Immediate access to 'as required' medications including s8 and s4d for pain relief • RN administration of dangerous drugs of addiction (DDA)	• Access to RN determined by the provider • Unregulated AIN/PCW administering medication including dangerous drugs of addiction (DDA)

It is now more important than ever to fix the broken and inequitable aged care system in NSW. The public need to be assured that wherever they receive aged care, there will be a minimum legislated standard of staffing ratios and skills mix for those requiring high levels of complex healthcare as provided through the *Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020*.

[49] Australian Government (2013) *Aged Care (Living Longer, Living Better) Act, 2013*. Available at: https://www.legislation.gov.au/Details/C2016C00170 [Verified 9 December 2020]

"In our facility there's only one RN on the afternoon and night shifts for 120 residents, including 20 dementia. If a resident has a fall, sometimes with obvious head injury, you might wait 10-20 minutes before an RN can attend if they are in dementia unit on the other side of the campus."

AIN, NSWNMA member

Aged care providers and representative bodies have previously argued against continuation and expansion of the *NSW Public Health Act (2010)*, suggesting it would render some RACF unviable[50]. However, the Government spent $13.4 billion on residential aged care during 2019-20 and NSW aged care providers received almost $4.4 billion dollars of that total, an above inflation 2.5% increase in funding on the previous year[51].

It costs approximately $532,300 p/a to provide an RN 24/7[52]. Lack of transparency about how commonwealth funds are spent makes it difficult to establish whether claims of unviability are based on the actual cost of providing an RN 24/7, or because of failure to ring-fence funding for staffing.

However, substantial funding does not necessarily equate to substantial staffing without legislation securing minimum staffing ratios and skills mix. The largest NSW RACF has 356 aged care places, 256 of which were high care at the last ACQSC accreditation audit[53] and received $23,620,931 for the year 2018/19 in government funding[54].

A recent ACQSC report on this RACF noted there were staffing shortfalls resulting in missed care episodes including failure to assist mobility, activities, and meals[55]. Despite this, no non-compliance under the *Aged Care Act 1997* was identified and the RACF was accredited for a further three years until 01 March 2021[56].

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[50] ACSA NSW/ACT (2015) *Submission to the Registered Nurses in NSW Nursing Homes Inquiry, p2*. Available at: https://www.parliament.nsw.gov.au/lcdocs/submissions/37863/0113%20Aged%20and%20Community%20Services%20NSW%20and%20ACT.pdf

[51] Department of Health (2020) *2019-20 Report on the Operation of the Aged Care Act 1997*. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf

[52] Cole, M. (2017) Additional Cost Estimates by State to cover RN posting 24/7 at all aged care facilities. *UCODA, 2017*. Report to ANMF Federal Office.

[53] Aged Care Quality and Safety Commission (2020) *The Whiddon Group Glenfield: Audit Report*. Available at: https://www.agedcarequality.gov.au/services/whiddon-group-glenfield-2135

[54] AIHW (2020) *GEN Aged Care Data: Aged care service list: 30 June 2019*. Available at: https://www.gen-agedcaredata.gov.au/Resources/Access-data/2019/September/Aged-care-service-list-30-June-2019. [Verified 9 December 2020]

[55] Ibid, Aged Care Quality and Safety Commission (2020)

[56] Ibid, Aged Care Quality and Safety Commission (2020)

These commonplace missed care episodes which are directly attributed to low staffing and skills mix have now been recognised as serious incidents requiring attention by the ACQSC. However, it is concerning that once again, the regulator is relying upon providers to both recognise and report incidents[57], an issue that has been subject to much criticism by the Royal Commission.

It is clear the *Aged Care Act 1997* overseen by the ACQSC does not offer sufficient protections for NSW residents. However, neither the *NSW Public Health Act (2010)* as it stands, nor the proposed *Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020* which still only provides for a single DoN and RN on duty for 356 residents in the largest NSW RACF, offer sufficient additional safeguards.

> "We regularly work understaffed, this results in residents not getting showered, toileted, assisted to eat/drink and socialise with others etc. as they need. Repositioning is not attended to; staff rush and don't use correct manual handling techniques, and this results in skin tears. These simple wounds may turn into chronic ulcers if the resident has vascular impairments, diabetes etc. Aids such as compression stockings may not be applied." Registered Nurse, NSWNMA member

> "The close relationships between residents and staff are compromised as staff don't have the time to stay and talk or are rushing the cares provided, this results in staff missing health issues also negatively impacting psychosocial issues, further adding to resident loneliness and isolation." Registered Nurse, NSWNMA member

By contrast Victorian public sector RACF nurse ratios require one RN to seven residents in a morning shift plus a nurse in charge (DoN), one RN to eight plus a nurse in charge and one RN to 15 at night[58]. Victoria was the first state in Australia to have mandated staff to resident ratios in its public sector RACF. The impact of this was evident throughout the COVID-19 pandemic when only 15 positive cases

[57] Information available at: https://www.agedcarequality.gov.au/consumers/serious-incident-response-scheme
[58] Victoria State Government (2020) *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*. Available at: https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/safe-patient-care-act. [Verified on 15 December 2020]

arose (3 in residents) with no deaths, compared to 655 COVID-related cases occurring in Victorian facilities without mandated ratios[59,60].

The Victorian Government in November 2020 indicated it would provide $40 million to extend mandated staff ratios to private aged care if matched by the Federal Government as primary regulator of aged care[61]. Queensland Government also recently introduced measures to secure minimum staffing and skills mix ratios in its publicly run RACF[62]. Those States have identified the Federal Government cannot offer their residents effective safeguards. Once again, NSW falls behind other States in ensuring safe quality aged care for its taxpayers.

> "Mandated ratios will ensure residents are delivered the care they require as per their care plans and ACFI. Ratios would result in less issues re: preventable hospital admissions, infections, weight loss, pressure injuries, skin tears, constipation, better relationships with the residents, improved social interaction between the residents - ultimately a better quality of life."
>
> Registered Nurse, NSWNMA member

Preserving the requirement not only for RNs but a DoN is vitally important for residents' clinical outcomes. A DoN is a senior RN who can supervise clinical practice and facilitate clinical governance. Where RACF have a General Manager overseeing care who is not also an RN reduces clinical capability across the entire facility.

The *Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020* affords only a minimum skills mix. Evidence suggests a much greater number of RNs, ENs and AIN/PCWs are required. We recommend the NSW Government adopt the ANMF staffing and skills mix methodology as a benchmark for all NSW RACF.

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[59] Department of the Premier of Victoria The Hon. Daniel Andrews (2020) *Media release: Nation First Ensuring Aged Care Staff-To-Resident Ratios 24 November 2020*. Available at: https://www.premier.vic.gov.au/nation-first-ensuring-aged-care-staff-resident-ratios [Verified 15 December 2020]
[60] Department of Health (2020) *COVID-19 cases in aged care services – residential care*. Available at: https://www.health.gov.au/resources/covid-19-cases-in-aged-care-services-residential-care [Verified 15 December 2020]
[61] Ibid, Department of the Premier of Victoria The Hon. Daniel Andrews (2020)
[62] Queensland Government (2019) *The Health Transparency Bill 2019*. Available at: https://www.legislation.qld.gov.au/view/html/bill.first/bill-2019-011 [Verified 17 December 2020]

(e) The administration, procurement, storage and recording of medication by non-registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care, as compared with hospital clinical settings.

The safe administration and management of medicines must never be under-estimated. The whole basis for scheduling of medicines is recognition that any medication has the potential to do harm. Older people are among the highest risk category for prescribing practice owing to physiological changes associated with ageing which can lead to build-up of toxins in the body from certain medications[63]. A RN is most likely to be able to identify and address medication issues in RACF. The professional assessment skills of whether to withhold medications is an often-overlooked part of the RN role.

Polypharmacy in RACF is commonplace, people living with dementia can average 10 different medications and at least half may be taking at least one inappropriate medication[64]. In addition, around 60% of residents may be prescribed a dangerous drug of addiction (DDA)[65]. Owing to the level of comorbidities in a resident cohort, older people in RACF require the same degree of due diligence with administering medications as those receiving care in hospital.

Concerns have been raised through the Royal Commission about over-use of anti-psychotics to restrain residents displaying behavioural and psychological symptoms of dementia (BPSD)[66]. A recent study showed almost 75% of residents are prescribed anti-psychotic medications[67] which can lead to serious side effects including over-sedation.

Each State and Territory has legislation and regulations governing the use of scheduled medicines. They describe among other things, the settings in which scheduled medicines are used, and the correct methods for supply, storage, access, use, and record keeping. They also specify the persons authorised to handle and administer scheduled medicines in health and aged care settings.

The *NSW Poisons and Therapeutic Goods Regulations 2008*[68] (The Regulation) relies upon the definitions described in the *NSW Public Health Act (2010).* Therefore RACF that included one or more

[63] Holbeach, E. and Yates, P. (2010) Prescribing in the Elderly *Australian Family Physician* 39(**10**) pp 728-733 f
[64] Somers, M. et Al (2010) Quality use of medicines in residential aged care *Australian Family Physician* 39(**6**) pp 413-416
[65] Giron, M.S. et Al (2001). The appropriateness of drug use in an older non demented and demented population *Journal of the American Geriatrics Society* **492** pp77–83
[66] Royal Commission into Aged Care Quality and Safety (2019) *Background paper 4: Restrictive practices in residential aged care in Australia*. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2019-12/background-paper-4.pdf
[67] Westbury, J. et Al (2019) More action needed: Psychotropic prescribing in Australian residential aged care *Australian and New Zealand Journal of Psychiatry* 53(**2**) p 136
[68] *NSW Poisons and Therapeutic Good Regulations (2008)*. Available at: https://www.legislation.nsw.gov.au/view/whole/html/inforce/current/sl-2008-0392

high level of residential care allocated places approved under the Aged Care Act 1997 on 30 June 2014 are required to procure, store, record and administer medications that have been prescribed and dispensed for residents in accordance with the requirements for a 'nursing home' as a 'hospital' under the Regulation[69].

The fact the Regulation only applies to selected RACF falling within the *NSW Public Health Act (2010)* means many residents in NSW RACF are not assured their medications will be managed and administered by RNs and ENs working under their direction. Poor management of medications can lead to avoidable hospitalisation[70] and even death so medication safety is vitally important.

Removing or limiting the scope of the *NSW Public Health Act (2010)* effectively limits already inadequate medication safeguards afforded to residents in NSW. It is impossible to consider whether to extend or remove this legislation without considering its impact in relation to the safety of medication management in NSW RACF. The current reach of the Regulation as it applies to NSW RACF is explained in table two.

Table two

Resident A	Resident B
RACF approved pre 1 July 2014 for high care operating within existing legislation	RACF approved post 1 July 2014 or no low care places as at 30 June 2014 operating within existing legislation
• Same legal protections as patients in NSW Hospitals • Management and administration of all prescribed medicines by a licensed and regulated RN or EN with a minimum training of AQF level 5 including in pharmacokinetics, pharmacodynamics, and nursing assessment • Immediate access to 'as required' medications including s8 and s4d for pain relief • RN administration of all dangerous drugs of addiction (DDA)	• Limited protections through good practice guidelines • Access to RN determined by the provider, including for the administration of 'as required' pain medication • Unregulated AIN/PCW administering medication including dangerous drugs of addiction (DDA) • No minimum training requirements before medications can be administered

[69] https://www.health.nsw.gov.au/pharmaceutical/Pages/residential-care-facilities.aspx#bookmark1

[70] NSW Aged Care Roundtable (2019) *Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge*, Available at: https://www.nswnma.asn.au/nsw-aged-care-roundtable-hospitalisations-report/

It is clear there are wholly inequitable safeguards afforded to some residents in NSW RACF compared to others under existing legislation.

The Regulation and *NSW Public Health Act (2010)* cannot be relied upon to protect NSW residents. Peripatetic use of RNs and ENs, or insufficient numbers of RNs and ENs on each shift, has led to widespread administration of prescribed medications by AINs/PCWs even in RACF required to adhere to the Regulation. A situation that is simply overlooked by the ACQSC and to our knowledge has never been monitored or challenged through NSW Ministry of Health initiated action.

> "I recall an incident where a resident with terminal cancer received substandard care. They required large amounts of S8 medications for pain relief. The resident experienced unnecessary pain because I was busy managing another resident who had sustained a fall in another facility. I was the only nurse (RN) on to cover two facilities. There were also insufficient care workers."
> Registered Nurse, NSWNMA member

The Nursing and Midwifery Board of Australia's Code of Conduct for Nurses[71] requires RNs and ENs to:

"Comply with relevant poisons legislation, authorisation, local policy and own scope of practice, including to safely use, administer, obtain, possess, prescribe, sell, supply and store medications and other therapeutic products."

and

"Not participate in unlawful behaviour and understand that unlawful behaviour may be viewed as unprofessional conduct or professional misconduct and have implications for their registration."

The Association has had to challenge providers to protect our members who are professionally compromised if they oversee a shift and supervise AINs/PCWs undertaking a legally prohibited activity under the Regulation. A situation that would be entirely preventable if sufficient numbers of RNs and ENs are employed, and a scenario unheard of in NSW public hospitals.

[71] NMBA (2018) *Code of Conduct for Nurses*. Available at: https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

"When I went to university, we had to achieve 100% to pass the medication subject. We spent significant time learning medications, legal administration of the same and the importance of knowing what the medication you administer does/side effects etc."
Registered Nurse, NSWNMA member

"As an RN, training and education is through a University and is much more extensive than that of an AIN. AINs do not need to know what the medication is or what it is used for. Nurses understand when it would be unsafe to administer a medication. For example, an anticoagulant if a person has a suspected inter-cranial haemorrhage following a fall. Withholding a sedative when a person is drowsy and is a high falls risk. Withholding Insulin when the blood glucose levels are low."
Registered Nurse, NSWNMA member

For those RACF falling outside the scope of the Regulation there are *Guiding Principles for Medication Management in Residential Aged Care Facilities*[72] designed to promote safe, quality use of medicines and medication management in RACFs. However, it is good practice guidance only and therefore open to interpretation, making the principles difficult for the ACQSC to regulate.

"The Federal Government - Guiding Principles for Medication Management in Residential Aged Care Facilities - hasn't been updated since 2012 and is very wishy washy - not a policy directive." Clinical Teacher, NSWNMA member

Indeed, medication mismanagement has consistently ranked amongst the top areas of non-compliance, including in the latest available data[73]. Which questions why the regulator does not pay due regard to state-based legislation designed to protect residents on accreditation audits.

[72] Commonwealth Department of Health (2012) *Guiding principles for medication management in residential aged care facilities*. Available at: https://www.health.gov.au/sites/default/files/documents/2020/02/guiding-principles-for-medication-management-in-residential-aged-care-facilities.pdf.
[73] ACQSC (2020) *Sector performance data July to September 2020*. Available at: https://www.agedcarequality.gov.au/sites/default/files/media/ACQSC_Sector_Performance_JUL-SEP_2020_v12.pdf [Verified 22 December 2020]

There is over-emphasis on administration being a task and over-reliance on the presence of dose administration aids (DAA) also known as blister packs for the storage and administration of prescribed medications. This has perpetuated the belief that few errors occur when administering from a DAA, and widely used as a rationale as to why unregulated care workers can safely undertake this activity.

However, a study revealed DDA packs can incur a 10% error rate[74]. Even with additional safeguards the proportion of DAAs with an incident that was considered likely to have major or catastrophic consequences was 4% [75].

> "AINs routinely administer the majority of s4 medications every day from Webster packs. There are a couple of residents that self-administer. There are none that we assist, they all require their medications to be fully administered." Registered Nurse, NSWNMA member

> "PCAs administer all regular webster packed medication including S4 and S8." Registered Nurse, NSWNMA member

Although most AIN/PCWs would hold a certificate three qualification[76] this is not mandatory. There is no legislation at Federal or State level to determine the minimum standard of education required before an AIN/PCW can administer DDA's from a pre-packed dispenser.

> "AINs do not have the requisite education in pathophysiology and pharmacology for the critical analysis required in the administration of any medication." Clinical Teacher, NSWNMA member

[74] Gilmartin, J. et Al (2013) Medicines in Australian nursing homes: a cross-sectional observational study of the accuracy and suitability of re-packing medicines into pharmacy-supplied dose administration aids *Research in Social and Administrative Pharmacy* **9** pp. 876–883
[75] Gilmartin, J. et Al (2016) Improving Australian care home medicine supply services: evaluation of a quality improvement intervention *Australasian Journal on Ageing* 35(**2**) E1–E6
[76] Mavromaras, K. et Al (2017) *The aged care workforce, 2016*. Canberra: Australian Government Department of Health. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf

"AINs are taught how to assist a resident with taking their medications. They are not taught how to administer medications. They do not need to know what the medications are used for. Nearly every one of our residents need to be administered their medications because they are unable to do this safety themselves. AIN's do this every day. We have turned a blind eye to this practice. I am unsure of what our local medication policy entails." Registered Nurse, NSWNMA member

Whilst some providers would expect workers to have completed a TAFE delivered programme of study to AQF 4 before administering medications to residents in the absence of a RN or EN, many do not. Our members have raised concerns about inadequate training often delivered on-site in as little as two days, leading to 74% of AINs reporting they were concerned about making decisions regarding administration of medications[77].

"AINs/PCWs administer medicines in the low care facilities/hostel but most of the residents there are high care residents. How can AINs/PCWs 'assist' with medication when most people there have cognitive impairment?" Registered Nurse, NSWMA member

"Nurses assess residents prior to administering medicines, through their knowledge and skill they can determine whether a resident is suffering delirium, dehydration, pain or exhibiting side-effects of medication or infection. How would an AIN/PCW know this, they have not been trained and are unregistered?" Registered Nurse, NSWNMA member

There are also inadequate arrangements for reviewing resident medication. In a recent study Just four of the 2,800 facilities in the study had provided a medication review to 100% of new entrants, while 303 nursing homes had provided no reviews in that time[78]. An RN with their knowledge and understanding of health, pharmacokinetics and pharmacodynamics could facilitate this process with GPs and Community Pharmacists providing additional safeguards for NSW residents.

[77] NSW Nurses and Midwives' Association (2017) *The state of medication in NSW residential aged care*. Available at: https://www.nswnma.asn.au/wp-content/uploads/2017/12/Medication-in-NSW-RAS-FINAL-LR.pdf
[78] Sluggett, J.K et Al (2020) Variation in provision of Collaborative Medication Reviews on Entry to Long-Term Care Facilities. *JAMDA*. Published online 4 December 2020. Available at: https://www.jamda.com/article/S1525-8610(20)30902-6/fulltext

"AINs/PCWs administer medications via Webster packs. The 3rd year nursing students on placement are invariably shocked at the blasé nature of the staff, as they have very little, to no knowledge regarding the medications, the pharmacological actions, pathophysiology, interactions, side effects etc. For example, they generally do not assess the resident's heart rate prior to administering digoxin." Clinical Teacher, NSWNMA member

Medication administration requires clinical judgment with full understanding of the implications for patient safety[79]. The act of administering a medication requires an assessment of the resident and deep understanding of how the medication might impact them physiologically and psychologically. This is even more important where a resident is cognitively impaired and cannot actively participate in the process and where a person is taking multiple medications.

"RNs/ENs have more depth of knowledge regarding medications, what they are prescribed for and possible side effects/interactions with other drugs. Also, when to withhold them. For example you may not administer diuretics if a resident is dehydrated." Registered Nurse, NSWMA member

It is without justification that the protections afforded to people in NSW hospitals are not extended to those living in RACF. We support the extension of the requirement to provide a RN on duty at all times and DoN in all NSW RACF as proposed through the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*. However, we call for mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs on each shift to enable safe medication management and effective supervision of assistance with medications by AINs/PCWs.

[79] Reese-Doyle, G. et Al (2013) Clinical Procedures for Safer patient Care *British Columbia open Textbook, Chapter 6*. Available at: https://opentextbc.ca/clinicalskills/chapter/6-1-safe-medication-adminstration/#:~:text=Medication%20administration%20requires%20good%20decision,its%20implications%20for%20patient%20safety

(f) the potential for cost-shifting onto other parts of the public health system as a result of any legislative change to the current provisions for care in nursing homes or other aged care facilities.

The evidence presented throughout this submission shows the high level of acuity amongst the resident cohort in NSW RACF and the lack of clinical expertise available. This invariably creates potential for avoidable hospitalisations and cost-shifting onto state health services as also evidenced within the COVID-19 section of this submission.

Rising acuity, increased need for palliative care and lack of clinical expertise in RACF have necessitated outreach programs such as hospital in the home (HITH)[80] across NSW. Although a better option for many, given the poor health outcomes associated with hospitalising older people, this shifts the cost of care onto NSW public health services, since outreach services are funded and provided by local health districts (LHD).

Despite the obvious shifting of costs onto LHDs, there are a growing number of programmes in place such as the GRACE programme in Northern Sydney LHD[81] and South Eastern Sydney LHD Geriatric Flying Squad[82] and REAP[83] programs. However, these are labour intensive services provided by LHDs without any memorandums of understanding to recoup associated costs from commonwealth funding received by providers to provide high complex healthcare.

In addition, these programs rely upon the presence of RNs in the RACF to enable them to both receive and provide clinical information and follow instructions given by Geriatricians and outreach Nurse Practitioners. A situation that could be resolved through implementation of the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*.

An evaluation of the REAP program to reduce re-admissions to a Sydney hospital evidenced cost-effective reductions in the utilisation of hospital-related services. However, the program required monthly contact from a Geriatrician and Nurse Practitioner for six months[84] which although cheaper

[80] Gibson, G. (2020) Who uses residential aged care now, how has it changed and what does it mean for the future? *Australian Health Review* 44(**6**) pp. 820-828
[81] Information available at: https://www.nslhd.health.nsw.gov.au/Services/Directory/Pages/GRACE-HKH.aspx
[82] Information available at: https://www.seslhd.health.nsw.gov.au/sites/default/files/groups/Sutherland_Hospital/southcare/Geriatric_Flying_Squad_2017Sep.pdf
[83] Cordato, N.J. et Al (2018) Management of nursing home residents following acute hospitalization: Efficacy of the 'Regular Early Assessment Post-Discharge (REAP)' Intervention *JAMDA* 19(**3**) online publication available at: https://www.jamda.com/article/S1525-8610(17)30693-X/pdf
[84] Ibid

than a re-admission is still a cost to the LHD borne out of low clinical and medical expertise within RACF, a point raised by one of the researchers following its evaluation[85].

Similarly, although an evaluation of the Geriatric Flying Squad revealed $1.4 m potential cost savings, its implementation costs the LHD $400,000 annually to run[86]. Despite the savings, clearly an annual expenditure of this amount could only be justified following extensive examination as to the causative factors necessitating hospital admission from RACF.

Studies in NSW have shown inadequate staff ratios impede the ability of RACF to manage conditions on-site, leading to avoidable hospitalisations[87,88]. In a recent survey 94% of nurses had transferred a resident to a NSW hospital following a fall in the past year, 75% said the fall could have been avoided if there were better staff ratios in their workplace. 43% were employed on a ratio of one nurse to between 50 and 100 residents, and in some cases, one RN to over 150 residents[89].

The same survey data showed referrals to hospital for falls incrementally reduced when workers were employed on a ratio of one RN to between 30-50 residents. This suggests risk of falls is reduced as ratios of RNs to resident increase[90].

At least 10% of falls in the elderly result in a fracture, with the incidence being higher in RACF[91]. Even with a conservative estimate, the cost of treating these residents in NSW hospitals could exceed $3 million annually[92]*

Given the evidence that employing additional RNs can reduce incidence of falls by up to 75% the cost savings in NSW based on hip fractures alone could well exceed $2.2 million.

*figure based on hip fractures

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[85] Cordato, N.J. (2018) Aged Care Residents REAP the benefits of a new study (quoted in) *Aged Care Guide* online article. Available at: https://www.agedcareguide.com.au/talking-aged-care/aged-care-residents-reap-the-benefits-of-a-new-study
[86] ACI (2012) *ACI Clinical Innovation Program: Evaluation of a Geriatric Flying Squad Program of South Eastern Sydney Local Health District*. Available at: https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0020/262802/Evaluation-of-Geriatric-Flying-Squad.pdf
[87] Stokoe, A. et Al (2016) Caring for acutely unwell older residents in residential aged care facilities: Perspectives of staff and general practitioners *Australasian Journal on Ageing* 35(**2**) pp. 127-132
[88] NSW Aged Care Roundtable (2019) *Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge*. Available at: http://www.asmofnsw.org.au/NSW%20Aged%20Care%20Roundtable%202019%20LR%20FINAL.pdf
[89] NSW Nurses and Midwives Association (2019) *Why Ratios Matter: Hip Fractures in Residential Aged Care*. Available at: https://www.nswnma.asn.au/wp-content/uploads/2019/03/Why-Ratios-Matter.pdf
[90] Ibid.
[91] Berry, S. and Miller, R (2008) Epidemiology, Pathophysiology and relationship to Fracture *Current Osteoporosis Reports* 6(**4**) pp. 149-154
[92] IHPA (2018) *National Efficient Price and National Efficient Cost: Pricing Framework for Australian Public Hospital Services 2017-18*. Available at: https://www.ihpa.gov.au

Aged care providers are funded by the Federal Government to provide high complex healthcare, yet in a statement to the Royal Commission the CEO of Anglicare openly stated approved providers would benefit from the State Government making experienced clinicians such as nurses available to implement the policy HITH in NSW RACFs. He also recognised that to achieve hospital-like care in RACFs they would need substantially more RNs but that a residential aged care home did not operate that way[93].

It is clear from this statement that some providers see the provision of complex healthcare to be beyond their current capacity, despite receiving funding for the same. Unless challenged this will undoubtedly lead to further cost-shifting onto the state funded health services.

> "Where there was no nurse in the Hostel, a resident choked in the dining room at lunch time. I was working in the Nursing Home dementia Unit and was called by the PCW to assist as the Paramedics were stuck in traffic." Registered Nurse, NSWNMA member

As acuity rises in NSW RACF the potential for cost-shifting to NSW public health services is likely to increase unless this is matched by a rise in clinical expertise within RACF. The *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020* in its current form will assist.

However, we would recommend mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs to manage care in-house, supported by GPs and to facilitate the effectiveness of any outreach services required.

[93] Royal Commission into Aged Care Quality and Safety (2020) *Hearing Transcript 11 August 2020 evidence by Mr G Millard and Ms Roy*. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/11%20August%202020%20-%20Transcript.pdf, commencing p 8474

(g) the role of registered nurses in responding to critical incidents and preventing unnecessary hospital admissions and unnecessary ambulance call outs and the consequent effect of this upon the provision of ambulance services to the wider community.

There is local data to support the role RNs have in relation to avoidable hospitalisations including reduction of falls, enhanced medication management and palliative care[94]. GPs rely on the availability of RNs to transfer information and carry out clinical instructions, the absence of which reduces willingness of GPs to visit RACF[95] and compounds unnecessary hospitalisation of residents.

In addition, services in rural and remote NSW are increasingly using Telehealth models to support complex healthcare. Telehealth requires GPs to transfer clinical information to on-site RNs, the absence of which would render Telehealth less effective and may result in the resident being transferred to hospital further compounding local pressure on the public health system.

The current *NSW Public Health Act (2010)* legitimises the absence or rationing of RNs and ENs in the aged care workforce in RACFs. It is therefore entirely predictable that anyone requiring nursing care under these circumstances would need to be transferred to hospital for a range of issues that could be treated in-house. In addition, delays acquiring nursing care can lead to exacerbation of health conditions, unmanaged pain and even death.

We support the extension of the requirement to provide a RN on duty at all times and DoN in all NSW RACF as proposed through the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*. However, we call for mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs on each shift to enable them to respond quickly and appropriately to residents deteriorating health status.

"I work in a non-RN 24/7 facility. We don't have RNs generally between 20:00 - 06:30 Monday to Friday and from 15:00 to 06:30 on weekends. This results in numerous unnecessary hospital admissions. It is the organisations policy that anyone who falls and can't be assessed by an RN must be transferred to hospital." Registered Nurse, NSWNMA member

[94] NSW Aged Care Roundtable (2019) *Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge*, Available at: https://www.nswnma.asn.au/nsw-aged-care-roundtable-hospitalisations-report/
[95] Meade, C. et Al (2016) Implementation of a team model for RACF care by general practice *Australian Family Physician* 45(**4**) pp. 218-222

"I have been on call many times when staff have phoned to advise a resident has fallen. As there is no RN on site the organisations policy is to call the ambulance. Many residents have been either assessed by Paramedics or transferred to hospital as no RN is available. This unnecessarily adds to both the burden on the ambulance system and hospital system."

Registered Nurse, NSWNMA member

(h) The lessons that can be learnt in New South Wales from the impact of the COVID-19 crisis on private aged care facilities where staffing ratios are not mandated.

There have been 61 COVID-19 cases and 29 deaths in NSW RACF since the start of the pandemic[96]. Despite the Federal Government's spin that Australia has done well, 75% of the country's deaths have occurred in RACF giving Australia one of the highest rates of deaths in residential aged care as a percentage of total deaths[97].

Whilst no staffing ratio can anticipate the events of the ongoing COVID-19 pandemic, it is clear from the evidence a lack of clinical expertise at point of care delivery, poor local surge staffing solutions and inadequate leadership and management of Infection Prevention and Control (IPC) contributed to a failure to effectively manage NSW outbreaks[98,99].

There is evidence locally and internationally that the higher the staffing ratios the more favourable COVID-19 outcomes for residents[100,101,102] . This was no more obvious than in Victoria where there were 29 COVID-19 related deaths in federally regulated RACF that have no set staffing and skills mix ratios compared to zero deaths in publicly run, Victorian State regulated RACF that have mandatory staffing and skills mix ratios[103]. It is clear the Victorian Government, having only 20,000 less residents living in their RACF than NSW[104] can provide a safety net which is beyond the current reach of the *NSW Public Health Act (2010)*.

The Chief Executive of one not-for-profit company operating 39 approved residential aged care facilities with 2,808 places in NSW[105] is on record as saying " *Aged Care Homes are designed and operated as*

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[96] ACI (2020) *COVID-19 Critical Intelligence Unit report – Evidence Check Aged Care*. Available at: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0007/623626/20201210-Evidence-Check-Aged-Care.pdf [Verified 14 December 2020]
[97] Cousins, S. (2020) Experts criticize Australia's aged care failings over COVID-19 *The Lancet* 396(**10259**) pp. 1322–1323
[98] Gilbert, L. (2020) COVID-19 in a Sydney nursing home: a case study and lessons learnt *MJA* 213(**9**) pp. 393-396
[99] Gilbert, L. and Lilly, A. (2020) *Newmarch House COVID-19 Outbreak: Independent Review Final Report*. Available at: https://www.health.gov.au/sites/default/files/documents/2020/08/newmarch-house-covid-19-outbreak-independent-review-newmarch-house-covid-19-outbreak-independent-review-final-report.pdf
[100] Gorges, R.J. and Konetzka, R.T. (2020) Staffing Levels and COVID-19 Cases and Outbreaks in US Nursing Homes *Journal of the American Geriatrics Society* 68(**11**) pp. 2462 - 2466
[101] Li, Y. et Al (2020) COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates *Journal of the American Geriatrics Society* 68(**9**) pp. 1899 - 1906
[102] Harrington, C. et Al (2020) Nurse Staffing and Coronavirus Infections in California Nursing Homes *Policy, Politics & Nursing Practice* 21(**3**) pp. 174 - 86
[103] Victoria State Government (2020) *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*. Available at: https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/safe-patient-care-act]
[104] Department of Health (2020) *2019-20 Report on the Operation of the Aged Care Act 1997*. Available at: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/20366-Health-Report-on-the-Operation-of-the-Aged-Care-Act-2019%e2%80%932020-accessible.pdf
[105] GEN Aged Care Data (2020) *New South Wales Service List, 30 June 2020*. Available at: https://www.gen-agedcaredata.gov.au/resources/access-data/2020/october/aged-care-service-list-30-june-2020

home-like communal living environments with an emphasis on social engagement and interaction. The risk of cross-infection in an aged care home is therefore significantly higher than in a hospital from both a staff and physical environment perspective." "COVID-19 has proven it requires superior clinical skills and purpose built and equipped facilities which only a hospital can provide."[106]

It is worth noting this provider was receiving funding to provide complex healthcare to 729 residents as at 30 June 2014[107]. Given what we know about rising acuity, it is likely this figure is much higher today. It is therefore questionable as to how they could have perceived their main functions did not include infection prevention and control. Whilst we are not suggesting this provider is any better, or worse than others, it is an example of a sector that seems to on one hand, be happy to accept government funding at the highest available level, yet on the other abrogate responsibility for providing what in other healthcare settings might be a basic right. That of providing a safe environment for care delivery.

We also know that infection control was poorly regulated in the 18 months prior to the first recorded COVID-19 case at Newmarch House, where NSW saw its biggest outbreak. The ACQSC had deemed this home met 44 of the 44 expected outcomes of the Accreditation Standards and had "effective infection control arrangements". The facility was accredited for a further three years until 30 December 2021, receiving no further recorded monitoring visits prior to the outbreak[108]. It was recorded that 92 of the 102 residents accommodated had high care needs at the time of that audit.

The ACQSC rely heavily on provider self-assessment to determine compliance against Quality Standards[109]. In a statement to the Royal Commission, the CEO of Anglicare who operate 22 facilities within NSW including Newmarch House, confirmed they had rated all their facilities as achieving best practice in one such self-assessment of COVID-19 preparedness issued by the ACQSC[110].

It was later found in evidence to the Royal Commission, Anglicare had underestimated their level of preparedness and had made inaccurate statements including around staffing[111]. A matter that went without admonishment by the ACQSC until 23 April when regulatory action was commenced at

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[106] Garcia, P. (2020) Safety first: Why aged care residents with COVID-19 should be transferred to hospital *Nursing Review* **Issue 6** November-December 2020, pp. 12
[107] GEN Aged Care Data (Accessed 3 December 2020) *Aged Care Service List: 30 June 2014*. Available at: https://www.gen-agedcaredata.gov.au/Resources/Access-data/2014/October/Aged-care-service-list-30-June-2014
[108] https://www.agedcarequality.gov.au/services/newmarch-house-0974
[109] Commonwealth of Australia (2020) *The Senate Select Committee on COVID-19: First interim report December 2020*. Available at: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024513/toc_pdf/Firstinterimreport.pdf;fileType=application%2Fpdf
[110] Royal Commission into Aged Care Quality and Safety (2020) *Hearing Transcript 11 August 2020 evidence by Mr G Millard and Ms Roy*. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/11%20August%202020%20-%20Transcript.pdf, commencing p 8474
[111] Ibid

Newmarch House[112]. This was 35 days from the ACSQC commitment to contact every provider by telephone; 11 days after the first recorded case at Newmarch House and followed four resident deaths and confirmed cases in 31 residents and 17 staff[113].

Indeed, it was identified by the Royal Commission that the head of the ACQSC had participated in a webinar which was broadcast to families of Newmarch House residents on the same day regulatory action was commenced by them. In which, the regulator was '*certainly not critical of the response that Anglicare was engaged in, in response to the outbreak*'[114]. Yet in their evidence to the Royal Commission representatives of Newmarch House admitted with hindsight it would be best practice to have a greater number of better skilled staff available during the outbreak including RNs. Also when a resident is acutely unwell, the usual practice would be to transfer them to hospital for acute care[115].

In response to the Royal Commission's findings on COVID-19 in RACF, the Federal Government now require all RACF to have one or more trained infection control officers as a condition of accreditation and who must be a RN or EN who has completed (or initially is in the process of completing) an identified IPC course. This requirement was placed at nurse level (RN or EN) in recognition of the need to be involved in the clinical aspects of a service, level of expertise expected and ability to have influence at a service[116].

However, although superficially this appears to negate the necessity for additional legislation securing a RN 24/7 at State level, the Federal Government also suggested this role could be fulfilled by an existing member of the nursing staff. Rather than increase the time available for RNs and ENs to provide direct care and management this would reduce it and add additional burden to what are already untenable workloads.

The Federal Government also provided a second COVID-19 supplement to be used to fund the IPC lead and their training[117]. Yet only half of nurses working in NSW RACF responding to an ANMF survey

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[112] https://www.agedcarequality.gov.au/commissions-regulatory-actions-response-newmarch-house-outbreak
[113] https://www.health.nsw.gov.au/news/Pages/20200424_00.aspx
[114] Royal Commission into Aged Care Quality and Safety (2020) *Hearing Transcript 11 August 2020 evidence by Mr G Millard and Ms Roy*. Available at: https://agedcare.royalcommission.gov.au/sites/default/files/2020-08/11%20August%202020%20-%20Transcript.pdf, commencing p 8474
[115] Ibid, Royal Commission into Aged Care Quality and Safety (2020)
[116] Australian Government (2020) *Australian Government Implementation Progress Report on the Royal Commission into Aged Care Quality and Safety report: Aged Care and COVID-19: a special report*. 30 November 2020. Available at: https://www.health.gov.au/resources/publications/australian-government-implementation-progress-report-on-the-royal-commission-into-aged-care-quality-and-safety-report-aged-care-and-covid-19-a-special-report
[117] Ibid

reported they had an appointed IPC lead on their facility by the cut-off date of 1 December 2020 and only 20% knew of plans to appoint a lead in the future[118].

Despite the Federal Government stating the ACQSC would have regard to this when assessing compliance with the standards[119]. To our knowledge there have been no sanctions against aged care providers not complying with this timeframe to date, and no transparency as to how funds allocated to Providers for this purpose have been spent.

The people of NSW cannot be assured that either the Aged Care Sector or Federal Government have the capability to implement or enforce required IPC measures. Therefore, it is essential there is some legislation in place within NSW to ensure people have access to clinical expertise provided by sufficient number and skills mix to ensure effective management of IPC as a safeguard.

Conservative management of COVID-19 require 'as required' morphine to be administered in patients not suitable for mechanical ventilation[120], which would be the case for large numbers of elderly. This can only be administered by a RN. Therefore, residents without 24-hour access to an RN, or with insufficient ratios of RNs in the RACF would have to either wait for this medication until an RN is available or be transferred to hospital.

Whilst hospital transfer might be a preferable choice for the resident, there has been much emphasis on the part of the Federal Government and NSW Government to initiate 'Hospital at Home' (HITH) for the elderly[121]. Joint protocols for managing future outbreaks in NSW recognise lack of clinical capability within the sector, recommending that clinical outreach services provided and funded by LHDs are used as standard[122].

It is worth noting that the largest RACF in NSW received $23,620,931 for the year 2018/19 in Federal Government funding[123] a figure likely to be much higher in 2020/21. In addition, the Federal

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[118] ANMF Survey available by request to the ANMF.
[119] Ibid, Australian Government (2020)
[120] Fusi-Schmidthauser, T. et Al (2020) Conservative Management of COVID-19 patients – Emergency Palliative Care in Action, *Journal of Pain Symptom Management* 60(**1**) e27 – e30. Published online April 8 2020. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7144848/
[121] Department of Health and NSW Ministry of Health (2020*) Protocol to support joint management of a COVID-19 outbreak in a residential aged care facility (RACF) in NSW*. Available at: https://www.health.gov.au/sites/default/files/documents/2020/07/commonwealth-and-nsw-protocol-to-help-manage-a-covid-19-outbreak-in-a-residential-aged-care-facility-in-nsw-protocol-to-support-joint-management-of-a-covid-19-outbreak-in-a-residential-aged-care-facility-racf-in-nsw_0.pdf
[122] Ibid, p5.
[123] AIHW (2020) *GEN Aged Care Data: Aged care service list: 30 June 2019*. Available at: https://www.gen-agedcaredata.gov.au/Resources/Access-data/2019/September/Aged-care-service-list-30-June-2019. [Verified 9 December 2020]

Government have made payments totalling more than $1.5 billion to support the aged care sector COVID-19 response[124].

On this level of funding, it is unclear how an industry that makes its living from caring for the most frail elderly in NSW can ill-afford to provide a safe level of clinical care without having to rely on state funded health services. It is also unclear why historically the NSW Government perceives staffing and skills mix in NSW RACF is not their responsibility[125].

The Senate Select Committee inquiry on COVID-19[126] identified the Federal Government failed to adequately prepare the aged care sector for COVID-19, was too slow to respond to issues with outbreaks in RACF, and failed to accept full responsibility for the sector despite being responsible for funding and regulating aged care in Australia. This led to what was described as '*unacceptably poor outcomes, including hundreds of tragic and preventable deaths*'[127].

It is wholly relevant for this Inquiry to determine whether the Federal Government can be relied upon to keep residents of NSW safe in the absence of state-based staffing and skills mix mandated ratios. Given the evidence, existing legislation does not appear fit-for-purpose, furthering the case for NSW to take affirmative action in both securing, and extending legislation securing RNs in all RACF through this proposed Bill.

We support the extension of the requirement to provide a RN on duty at all times and DoN in all NSW RACF as proposed through the *NSW Public Health Amendment (Registered Nurses in Nursing Homes) Act 2020*. However, we call for mandated staffing and skills mix ratios in all RACF tied to acuity of residents to provide sufficient numbers of RNs and ENs on each shift to enable effective Infection Prevention and Control.

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[124] ACSA (2020) *COVID-19 Aged Care Funding: A brief summary of COVID- related funding measures*. Available at: https://acsa.asn.au/ACSA/media/General/Documents/Aged%20Care%20Emergency%20Planning/COVID-19-Funding-Summary_August2020.pdf. [Verified 14 December 2020]
[125] NSW Government (2016) *Government response to the Inquiry into Registered Nurses in NSW Nursing Homes*. Available at: https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2275#tab-reportsandgovernmentresponses.
[126] Senate Select Committee inquiry on COVID-19 (2020) *First Interim Report December 2020*. Available at: https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024513/toc_pdf/Firstinterimreport.pdf;fileType=application%2Fpdf. [Verified 11 December 2020].
[127] Ibid. p 54

(i) any other related matter.

NSW can lead other states and territories in providing state-based legislation which assures residents accommodated in RACF safe levels of staffing and skills mix to enable a fulfilling and dignified end of life.

The provision of guaranteed minimum staffing ratios not only benefits residents but creates a professionally safe and attractive workplace for aged care workers. RNs and ENs frequently cite burnout and untenable workloads when explaining why this sector is not appealing to work in. Unsafe staffing and skills mix put considerable pressure on their ability to maintain and work within the scope of their professional responsibilities.

The exposure of serious deficits in the models of care within RACF and public scrutiny of these shortcomings could be addressed by making RACF more aligned to chronic care and end of life care wards within NSW Health. Good clinical governance and safe and secure working environments supported by ongoing education and professional development opportunities will make aged care a clinical specialty that can appeal to current and future generations of nurses and other health professionals.

This has many knock on effects, such as providing employment and generating income for rural economies, taking some of the clinical burden from GPs who are often not prepared to work in a failing system. Also preventing cost shifting to the acute health system and relieving pressure on overstretched hospitals. And of course, the benefit to current and future residents of RACFs and their families would be greatest of all. This is a moment in time when we have an opportunity to re-design our aged care system and make NSW the leaders in this area.

Other states such as Victoria and Queensland have a much higher level of publicly run RACF which allows them to determine staffing and skills mix and ensure care standards equate to those expected in other publicly owned and operated healthcare settings (such as hospitals). Given what we know about the high level of healthcare required by residents in NSW RACF we recommend the committee consider the potential benefit of expanding NSW state-based health services into the provision of additional state-run RACF. This would ensure the same industrial agreements, staffing and skills mix, governance and standards that apply to NSW public hospitals would also apply to RACF.

Response to:
NSW Legislative Council Select Committee Inquiry on the provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020.

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