REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON THE PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

PROVISIONS OF THE PUBLIC HEALTH AMENDMENT (REGISTERED NURSES IN NURSING HOMES) BILL 2020

UNCORRECTED

At Macquarie Room, Parliament House, Sydney, on Monday 22 February 2021

The Committee met at 11:15.

PRESENT

The Hon. Courtney Houssos (Chair)

The Hon. Mark Banasiak (Deputy Chair)
The Hon. Greg Donnelly
The Hon. Wes Fang
The Hon. Daniel Mookhey
The Hon. Mark Pearson

PRESENT VIA VIDEOCONFERENCE

The Hon. Lou Amato
Ms Cate Faehrmann
The Hon. Natasha Maclaren-Jones

The CHAIR: Good morning, everyone. Welcome to the first hearing of the Select Committee on the Provisions of the Public Health Amendment (Registered Nurses in Nursing Homes) Bill 2020. The inquiry is examining whether there is a need to have a registered nurse [RN] on duty at all times in nursing homes and aged-care facilities with residents who have a high level of care. In examining the bill, we will look more broadly at the need for further regulation, minimum standards of care and appropriate staffing levels in aged-care facilities, the potential for cost shifting onto other parts of the public health system and lessons from the COVID-19 pandemic.

Before I commence, I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respect to the Elders past, present and emerging of the Eora nation and extend that respect to other Aboriginal people present today. Today we will be hearing from a number of stakeholders, including registered nurses working in the aged-care sector and NSW Health. While we may have some witnesses later on in person, our session now will be by videoconference. I thank everyone for making the time to give evidence to our inquiry. Before we commence, I will make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available.

In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments they may make to the media or others after they complete their evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard it is important that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2019.

I also remind witnesses that, if they are unable to answer a question today or they want more time to respond, they can take a moment or you can take a question on notice. We ask that written answers to questions taken on notice are provided within seven days. If you wish to provide any documents, then the Committee's secretariat will liaise with you to do that. I remind both Committee members and witnesses to speak into their microphones. As we have a number of witnesses via videoconference, identifying to whom questions are directed or that they are directed to the panel entirely is helpful. Those with hearing difficulties who are present in the room today, please note that the room is fitting with induction loops compatible with hearing aid systems and have telecoil receivers. Finally, everyone present should turn their mobile phones to silent for the duration of the hearing.

CATHERINE SHARP, Registered Nurse, CEO, The Wound Centre, Expert Witness, Expert Witness Nurse Consultants Australia, before the Committee via videoconference, sworn and examined

MAREE BERNOTH, Registered Nurse, Community Engagement Lead, Charles Sturt University, before the Committee via videoconference, sworn and examined

MARY GIBBS, Registered Nurse, NSW Nurses and Midwives' Association, before the Committee via videoconference, sworn and examined

Ms SHARP: I have been in self-employed roles since 1997 as well as working in numerous hospitals.

Associate Professor BERNOTH: I have been in the industry for 35 years.

The CHAIR: Thank you very much. Would you like to make a short opening statement, Ms Gibbs?

Ms GIBBS: As I said, I am here today as a registered nurse [RN] representing the industry of aged care. I have been nursing in both the private and public hospital system and in for-profit and non-profit aged care over my years. I have had senior leadership roles in the last 20 years. My last experience was recently during COVID, when our home actually experienced COVID and I had to implement a plan. Today I am representing the NSW Nurses And Midwives' Association. I had also participated in the skill-meets-workforce survey that was done a few years ago. The aim of today for me is, as a passionate RN who has been in the industry for a very long time and who has seen very many commissions, inquiries and outcomes promised but not delivered in respect to the safety and governance of the residents that we look after—I think it is very important that today's submissions are reviewed and any evidence that I can give from a first-hand experience be used to support recommendations of a proper skill mix in the workforce and mandated ratios at least to start the ball rolling. Because there are no regulations to help us provide the fundamental care that we need in aged care.

We have an unskilled workforce. Whilst it has some minor education, it does not have the skills required today to manage and work within an aged-care facility. The aged-care facilities are now all sub-acute units—extensions of sub-acute units from the hospitals with the complexity of the residents that are coming out of those facilities. We are getting early discharges and complex care. We are getting residents with behavioural and mental health issues. The junior workforce is not skilled to manage that. It is solely reliant on a registered nurse's ability to do clinical assessments and work with the general practitioners in the community. Today I really want to focus on and provide evidence in relation to the leadership and clinical supervision and also the need for a qualified and skilled workforce, because fundamentally, if we do not improve those, the industry will continue to not survive. The royal commission at the moment—we have already seen the interim report but hasten to see the final report. The fundamentals behind that are about skill mix and a lack of education.

We need to be treated as a part of and similar to the health system. My colleagues and I have always felt that aged care here is the second cousin to the health industry. We deserve the opportunity to be treated and provided with the resources that they have in the hospital system, particularly if we are expected to take sub-acute residents. Sub-acute residents are those that are on slow stream rehab. We have to put physiotherapists in place and do a multidisciplinary team. We have clinical pathways and polypharmacy reports. We are now mandated to have a registered nurse because of the infection control policies that have been put in place. They are directed to the registered nurses, not enrolled nurses or aged-care workers. I want the committee to be aware that it does not matter what position I have held on the front line as a registered nurse. I still provide care to the residents that they deserve, whether they are public, private, profit or non-profit. At the end of the day we need to do the right thing by the residents at all times. Thank you.

Associate Professor BERNOTH: Good morning. This is my fiftieth year as a nurse. Since 1985 I have worked predominantly with older people. I have worked in residential aged care, palliative care and acute care. I have been a senior nurse educator at a number of large aged-care facilities. I am also very much involved in research. I have worked in regional and rural aged-care facilities—in the facilities and the services. I have a PhD, a Master of Education by research and a Bachelor of Health Science in nursing. I was also a registered psychiatric nurse and a gerontic nurse under the older systems of level A and B nurses. I chair the Murrumbidgee Primary Health Network Aged Care Consortium. I am a member of the Australian Association of Gerontology and a member of the NSW Nurses And Midwives' Association. I have been at Charles Sturt University [CSU] for 10 years, focusing on trying to ensure that the nurses who graduate as registered nurses have a sound knowledge of ageing wherever the person is. To that end, we have written and edited a book to make learning about ageing more attractive.

We have an aged-care or an ageing well research group at CSU. We also have герontic postgraduate courses for registered nurses. I have also submitted to a number of inquiries. My research career started with looking at abuse and neglect in aged care and, when I reported that to management, became the target of the abuse. I am very well aware of deteriorating standards. Unfortunately I have watched aged care go from a fabulous place to work to something that is challenging us all in Australia. What else do I need to say? Now that I am working at Charles Sturt University I am particularly interested in our rural and remote aged-care facilities and services. To that end we have been trying to support them through a transition-to-practice program and at two o'clock this afternoon we will submit a tender to the Federal Government initiative to provide a transition-to-practice program for newly registered nurses. I think that is enough from me.

The CHAIR: There is plenty of experience. I have no doubt we will have plenty of questions for you. Ms Sharp, would you provide us with a short opening statement?

Ms SHARP: I am a registered nurse, founder and CEO of both a women's centre in Sydney and Expert Witness Nurse Consultants Australia. I have been in that self-employed role since 1997, as well as working in numerous hospitals. I qualified in general and paediatric nursing in Sheffield in the UK in the 1970s. So I have been at it for longer than you, Associate Professor Bernoth. I hold several other qualifications including a Master of Clinical Nursing, Master of Public Health and a Master of Health Law from the University of Sydney. I am a PhD candidate at the University of New South Wales studying residents who died in residential aged-care facilities with pressure ulcers and who died at home as well. I was really honoured to be asked to speak at the aged-care royal commission at the Darwin Supreme Court in 2019 specifically on pressure ulcers in aged care.

Now I have a sizeable and ever-increasing workload through my business Expert Witness Nurse Consultants Australia because people sue healthcare facilities unfortunately. I have written many expert nursing reports for law firms in every State and Territory in the country. Many of the cases have involved the age of developed pressure ulcers—but not just age as some are as young as 40—a foreseeable and preventable condition in aged-care facilities and in hospitals. The sad tragedy of this is that people who develop heel pressure ulcers often end up having an above knee amputation or both legs chopped off, which I cannot imagine at the age of 40 nor can I imagine it at 80. I cannot even see how an elderly person can manage with one leg or no legs. Why do I think it is important to have a registered nurse on site for visiting professionals?

Well, imagine that you have to have open heart surgery and your hospital tells you that they cannot afford to pay heart surgeons but there are a couple of very clever med students: "They will have a go. They will do your surgery for you. You'll be okay. Just sign here on this charter of rights." It is no different in aged care when we do not have trained, qualified registered nurses on duty [audio malfunction]. Firstly, registered nurses in aged care are educated about the Charter Of Aged Care Rights; the Aged Care Quality and Safety Commission's book entitled *Guidance and Resources for Providers to support the Aged Care Quality Standards*, in particular standard 8; the Aged Care Act 1997, section 3; and item 3.2 of the Australian Quality of Care Principles 2014 that ensures an air mattress is provided to those at risk of pressure ulcers. The talk about air mattresses is a whole other section, and I will not go into that now unless there is time later. Care staff will not be aware of any of these documents and it is not their responsibility to know about them. All those documents are huge; there is no time even for registered nurses to read them.

The CHAIR: Ms Sharp, I might just stop you there because I am mindful our time is going to run out very quickly this morning. I will pose a quick question to Associate Professor Bernoth to get us started. The inquiry has received submissions—and I know certainly in our previous inquiry we heard particularly from rural and regional aged-care facilities that stated they would go out of business if it they were to be required to have a RN on site 24/7. Can you provide us with any insight on that over your 50 years as a nurse but particularly in your role now at the CSU.

Associate Professor BERNOTH: Thank you for that question. Please be aware that I am not an accountant or a financial expert, and my husband will attest to that. About the issue of going out of business, I find that a little bit curious on a number of levels. Firstly, how do we know that when there is no transparency required of aged-care facilities? Except for those in Queensland, I believe, these facilities do not have to share with us their financials. We do not know how much they are spending on staff. We do not know how much they are spending on equipment. We do not know where our taxpayer money is being used. That lack of transparency does not enable—it means that the aged-care facilities cannot claim that they are going out of business. We need to see where their money is being spent and then maybe we can make some comment, but until then we cannot. That is the first thing.

Secondly, if that is so, why do we have so many aged-care facilities in rural areas that are doing very well? There are a number of aged-care facilities that I have worked with; I will not name them because I am not

sure of the legal requirements but I am happy to provide those names to the Committee. But there are quite a few aged-care facilities that have registered nurses and are doing very well. Recently I spoke to ABC Statewide Drive. They were interested in the aged-care facilities that are closing down. I was contacted by an accountant from northern New South Wales—I am also happy to provide his name in confidence—who told me that he had been able to work with a number of smaller facilities in northern New South Wales to take them from the brink of going broke to making them very financially viable. It is possible.

My question is: If the claim is I am going out of business because I have to have a registered nurse then why do so many other facilities work really well? A number of rural aged-care facilities have contacted us now they have found out we are applying for this tender for the transition-to-practice program because they want their registered nurses enrolled in the transition to practice program. They want to keep them in the facility and they want to provide them with a career pathway. Working with us, we can do that. If we have some that can, why can't all?

The Hon. MARK BANASIAK: I have two questions. I think one of the witnesses touched on people in the middle-aged bracket, around the 40s, being in aged-care facilities as well because of some difficulties they are experiencing. What is the percentage of people in aged care who would not necessarily traditionally fit in that "aged" bracket but are highly dependent?

Associate Professor BERNOTH: The audio is very, very difficult. It is not clear at all. Can I just ask who that question was directed to, please?

The Hon. MARK BANASIAK: Sorry, Associate Professor Bernoth. I will direct that to you to start off with and then see whether anyone else has any comments.

Associate Professor BERNOTH: Could you then repeat the question? I am really sorry.

The Hon. MARK BANASIAK: That is alright. The question is around people in aged care who are not necessarily in that aged bracket but have highly dependent medical needs that mean the only facility they can go in is an aged-care facility. I was wondering what is the percentage of residents that would fit into that category. Are we adequately catering for the needs of those people?

Associate Professor BERNOTH: Ms Gibbs, do you think that is a question that you could answer more appropriately?

Ms GIBBS: Currently in my experience we have probably 10 per cent of our residents who are under the age of 65 and we have some under the age of 50. Those residents really fall a lot under the NDIS scheme, which has now changed a lot to meet the requirements such as the aged-care provisions. We provide the same level of care to those residents at the time. The issue for them is the socialisation and the difference in the ages between the residents and those young people in nursing homes. The youngest ones we have seen are 40. We have nursed them because they have had very serious comorbidities and are not suitable for home placements.

The Hon. MARK BANASIAK: You talked about how we have not got the staff mix right. Would it be your submission that we not only need to look at increasing the number of registered nurses in aged care but also increasing the care workers as well, as we have heard from other submissions?

Ms GIBBS: I think, yes, basically you definitely need a registered nurse on shift. The care does not change 24/7. It is not a nine to five. The registered nurses provide that clinical governance and that strength and direction, and the ability to identify actions that need to be delivered promptly. With the skill mix that we have currently got—and because it is not mandated—we have got aged-care workers that have only had three to six months' experience. That experience is basically ticking the boxes and doing 120 hours of clinical practice wherever they have been sent. They do not understand the concept of aged care and gerontology. They do not understand the dementia reasons. They do not understand the behaviour management strategies that they have got to put in place.

The workforce that we have sees us as a stepping stone to other career paths. The junior aged-care workforce overall are seeing us as a stepping stone as they go on to another career. People such as registered nurses who have already qualified and done their postgraduate training before they come to us are dedicated to do the assessments and work for that. Enrolled nursing is another area that I have been debating about this morning. It is a model of care that I think would strongly support the requirements within aged care at the moment. The model of care has to be looked at to strengthen it for the care that we need to provide.

The Hon. WES FANG: Thank you to the witnesses for appearing today. My first question is for Associate Professor Bernoth. In relation to the testimony that you just gave from the Chair's initial questioning

around rural and regional facilities, and the discussion around whether a 24-hour registered nurse would create financial difficulties, you indicated that you require more financial disclosure from facilities. Let us assume for a minute that what they are saying is correct and that the provision of 24/7 nurses would have a financial impact on rural and regional facilities. Would you expect that cost to be borne by the organisations themselves, or do you think that cost could potentially be passed on to the residents? Secondly, as you are involved with CSU—and just for declaration, I live in Wagga Wagga, so I am regional myself—you would be well aware that the ability to recruit and retain medical staff, not so much in regional but certainly in rural and remote areas, is difficult. How would you imagine the requirements would affect those communities that are not readily able to have a registered nurse 24/7 because of staffing requirements?

Associate Professor BERNOTH: Great questions, thank you, and hello to a fellow Wagga Wagga person. To the first question about costing: I think of aged care and providing services to older people as a community thing and as a collaboration. I like the concept of working with rather than caring for. In all structures, we need to be working with—seeing aged care not as a competition but as a collaboration. If an aged-care facility in a rural or regional area feels that it is not managing—that it is not working things out—then how can we as a teaching organisation, you as a Government or other aged-care organisations work with that facility to help them, to support them and to try to provide them with some guidance or input? Rather than looking at where costing has to go, let us have this collaboration. People in the bush do that really well. Let us work together to support those smaller facilities. How can we do that? I am throwing the university in there as well. We all need to be in there. The primary health networks, the acute facilities—we all need to be in there helping.

As far as attracting registered nurses to smaller areas, we are trying to do that through the work that we do here at CSU, but it is a fabulous initiative that the Hon. Sarah Mitchell is doing with teachers. She is looking at valuing the teaching professional. Would that not be a fabulous opportunity to again work together and look at valuing registered nurses in smaller facilities? To get teachers to the bush, they get rental subsidies between 50 per cent and 90 per cent, $5,000 retention bonuses, $10,000 bonuses and 10 weeks' trial in the facility to see how they go. We can do that and we can provide them with a career pathway. Currently once nurses finish our Transition to Practice Program we then enable them to roll into our graduate certificates in nursing, management, teaching and research. Together we can do great things. I really am glad of this inquiry and of the ability to push my barrow about collaboration. People in the bush do that really well and we can teach metropolitan people a lot about it.

The Hon. WES FANG: I am very much liking what you have to say, Associate Professor Bernoth. My concern, though, is that—I certainly think that you paying credit to Minister Mitchell is appropriate, but I guess in that instance we are talking about teachers being employed in schools that in effect are run by government. What we would see in this policy would be aged-care facilities competing with other hospitals and medical facilities for nurses to be on staff. We have submissions here that nursing care for smaller facilities may be able to be provided by an on-call service, which reduces the burden of having somebody on staff and the impact on rosters et cetera that that provides. For those smaller facilities, do you think that having the same impost as larger facilities by having to have a nurse 24/7 is worth the flow-on effects that they may face by doing this—particularly for rural and regional communities? Would that potentially have an impact on people looking to open facilities into the future, given that they may struggle to find appropriate staff for a small town of a couple of hundred people?

Associate Professor BERNOTH: I will give you the example of Deniliquin, which has an aged-care facility on one side of the road and a hospital on the other. The hospital has nursing staff, palliative care staff, all of the specialties and education but the aged-care facility is not allowed to engage with that at all. That is a really good example of how we could be working together. Why does a road prevent older people from having services that they deserve and need? Why can we not collaborate? I know that the Federal Government funds aged care and the State Government funds acute care, but surely working together is a great way to prevent old people being admitted to acute care. If a registered nurse from the acute facility could walk across the road and provide some advice about pain relief, swallowing problems or whatever then that would be a great way to work together to ensure the older person gets the care that they need. Can we not have consideration about that sort of cooperation in our smaller areas? Do we dismiss that out of hand, or can we think about it?

The Hon. WES FANG: So we should possibly be looking more at how we can better utilise and connect existing services than mandating that smaller rural and regional communities have a 24-hour nurse.

Associate Professor BERNOTH: Yes. The Murrumbidgee has the Primary Health Network Aged Care Consortium. We have a community of practice where all of the aged-care facilities and managers get together and

share. They share what is going on, they share initiatives and the Primary Health Network supports them in various ways.

Ms GIBBS: In the metropolitan area, we network exactly the same way. We work closely with the Geriatric Flying Squad. We use them as our ports of consultation and education. We work with Calvary Hospital. We with the palliative care clinicians. It is collaborative. When we had the COVID experience the networking that we had to put into place here was conducive—it was so well done between the collaboration of a primary health nurse, the aged-care flying squad, the home itself and the Government as well. We all worked as a team to contain the outbreak that I had in my home. That required a lot of work effort and planning from a registered nurse and a lot of dedication to the point where our staff actually slept here overnight to ensure that the services were provided 24/7 because of the impact of COVID.

But I think what the professor is saying is correct: The relationship should be able to happen in the rural area just as it happens in some of our Sydney local area health services. I can say that South Eastern Sydney has a tremendous model that works extremely well with the aged-care facilities. We virtually reduced our planned admissions to other hospitals because we bring the hospital to here. So, we try and do our best but I do support the idea of a collaborative approach for the rural area if the decision was made not to have registered nurses 24/7 onsite. There needs to be that partnership for 24/7 from the hospital.

The Hon. MARK PEARSON: Thank you very much for attending. I will move closer to the microphone. Can you hear me, Professor Sharp? Can you hear me, Catherine Sharp?

Ms SHARP: I am sorry. I still cannot hear. I think I heard my name but I do not know what the question was.

The Hon. MARK PEARSON: Okay. This question is to all of you: Would you agree that the monitoring of medications given to elderly residents is a complex area and needs supervision of a registered nurse?

Ms SHARP: Absolutely. I would like to make a short comment on that. I was in a facility doing a Wound Care consult. This is not just one time, but this has happened several times. I saw a careworker—no registered nurse in sight—had popped all the pills out of everybody's Webster-paks into little pill pots. You cannot do that. The Webster-paks have the residents' names on and the morning, lunch-time, evening medications. Why would anyone think that it was faster or better to pop them all out? This careworker went around to a bunch of demented residents in a locked up dementia ward and just handed out pill pots. I said to her, "You know I am a registered nurse. I have to report you."

I do not believe this would have ever happened if a registered nurse had been in that ward, in that part of the building at the time, but we do not know who got whose meds and, you know, who might have died overnight and it was considered an expected death. So I reported that careworker to the Director of Nursing but the same thing happened in the same ward just a couple of days later and I said again to the girl—because they all knew I am a registered nurse—"I have to report you. This is so dangerous." But I was saying I do not believe that that would happen if a registered nurse was overseeing. Nobody would be popping out all the Webster-pak pills into pots.

The Hon. MARK PEARSON: Would you say that a lot of these medications, because the person, the resident, often already has brain damage of some kind, whether it be dementia, Alzheimer's disease or any other sort of trauma to the brain, therefore the way the brain responds to typical medications like antidepressants, anxiolytics, et cetera, can be very confusing or very complicated? For example, to see a resident who might be exhibiting different symptoms to the usual, and that could be a delirium from an anticholinergic reaction to some of the medication, would it be the case that a registered nurse would know when to withhold medication—

Ms GIBBS: Correct.

The Hon. MARK PEARSON: —where an assistant in nursing would not? I am not saying anything negative about assistants in nursing. I am just talking about the skill of training.

Ms GIBBS: You are right. May I answer that from a registered nurse's point of view? At the end of the day the responsibility for any medication under my shift is mine. It does not matter what—if it is an enrolled nurse or an aged-care worker. The way that the medication is administered within aged-care facilities is generally through a Webster-pak or a sachet. The principle behind those is so that the person administering it, if it is an aged-care worker, does not necessarily need to know what the drugs are but they have just got to give the drugs there. But for a registered nurse, we understand. We tick the medication charts. We are familiar with all the drugs. We know to take their blood pressure before they take their blood pressure tablets in case they are hypotensive.

We know that if they have got heart arrhythmias to take their pulse for the digoxin. We know to do the blood sugar levels for insulin.

As I was saying earlier when I started about the complexity of the residents that are coming through, there are on multiple medications. Some are oral and we have to crush them. Some are given through an infusion and we have the palliative care crisis medication. So we are dealing with S8 and S4 drugs—scheduled drugs—through a syringe driver and we are aware of the side effects and the monitoring that is required. For example, you raised the issue about a resident with dementia being commenced on a new psychotropic drug. Currently the standards that we have through the Aged Care Quality require us to monitor these, put in a monthly report and look at the indications. We had to watch them for 28 days once they commence the new medication, looking for changes in their behaviour: Is it effective? If it is not effective, what have we done about it? How are we recording it? The escalation process with the GP and the consultation with the family. The residents, if they have some form of capacity, we invite them to have the feedback, but we are responsible at the end of the day for all that monitoring of the medications that they receive.

So it does not really matter who gives the medication. At the end of the day I go home worried that I—making sure that I signed off that every resident has received medication. Now the argument has been that errors happen even if the registered nurses give them. That is correct. I am not downing that, you know. But what I am saying is that we have the ability to identify if we have made an error quickly. We have got the ability to assess and the ability to escalate straightaway and not wait for the adverse outcome of the resident to be escalated. So, again behaviour management—this is a key focus of our standards and requirements, and also with antimicrobial stewardship. This is part of the clinical governance again. It comes back to a registered nurse to coordinate the antibiotics, make sure that residents are not given antibiotics unnecessarily, that we record these documents and we look at the sensitivity. All of this has to be done before we actually administer the medication. We do not just rely on the prescription. To give out medications, it is a really big component and it is within our scope practice whereas this might be a level of a Certificate IV or a Certificate III giving the meds and just giving the prepping, there is a lot more to just handling the medication. What they technically do is assist with medication.

The Hon. MARK PEARSON: That is very helpful, thank you. I have just one quick question to Ms Sharp, if you can hear me? In your study that you did in relation to pressure sore or pressure care of heels which related to the removal of half a leg—can you hear me?

Ms SHARP: Yes, sort of. Which paper are you talking about?

The Hon. MARK PEARSON: You referred to a study that you did, which was looking at pressure care of heels of residents which led to amputations of legs or halves of legs. Correct?

Ms SHARP: Yes.

The Hon. MARK PEARSON: You indicated that some of those amputations could have been prevented. Would you say that if a registered nurse was in the facility 24/7, the nurse's supervision would help to prevent the pressure sore from occurring to the extent leading to amputation?

Ms SHARP: I have no doubt. This happens in hospitals as well, where patients are left with their heels on a bed. They may have no feeling in the heels because they have diabetes and peripheral neuropathy. Tissue death can start as soon as after half an hour of unrelieved pressure. The cases I have done that I was referring to are those medico-legal reports that I have written, which I have been asked to write because pressure ulcers are foreseeable and preventable. A registered nurse would or should know that they can access a really good alternating-pressure air mattress the minute the patient is admitted or even before the patient is admitted so they have got this mattress on the bed. It has to be a specific alternating-pressure air mattress with side formers. I will tell you about those in a while.

If they are on one of these, then they have complete pressure relief to the heels and all parts of the body every few minutes throughout the 24 hours. One study I did with another aged-care consultant a few years ago we presented at the aged-care royal commission in Darwin. We were able to, over a period of weeks, have no pressure ulcers whatsoever in this facility, and they were all at high risk. I know it can be done. I have done it in several facilities over the years. I have been in 200 or 300 aged-care facilities since 1997, trying to bring in good alternating-pressure air mattresses to prevent pressure ulcers. They will prevent them. I do not want to be 80 and have an above-knee amputation.

The Hon. GREG DONNELLY: Thank you all for making yourselves available to participate in this inquiry. My question is a general question in its nature. I will direct the same question to each of you, because you bring high levels of experience to this area, and allow you to answer it as generally as you can. What are the

key disadvantages faced by aged-care residents who do not have access to onsite RNs compared with those who do? We have a situation of a facility that has 24/7 availability of registered nurses working in conjunction with the carers, and then we have other facilities, which do not have that 24/7 RN access. What are the key disadvantages for the residents in those facilities that do not have that 24/7 RN availability that you apprehend? Perhaps we will start with Associate Professor Bernoth.

Associate Professor BERNOTH: Thank you for your question. In the research that I have done where I have spoken to people where there is not—it is not just not having RNs but also not having sufficient RNs. Having RNs tied up in an office or an RN who is responsible for 160 residents is going to have the same impact as not having an RN there at all. We have already talked about medications. Medications are packed in a chemist's shop but not by a chemist, so there are huge errors before the medications even get to the older person. There are issues there.

The other thing is that aging brings about a number of physiological changes and those physiological changes mean that pathophysiologies or illnesses do not present in the same way as they would to a younger person. So it takes a skilled registered nurse to be able to assess an older person and see if they has a delirium, which is treatable, or dementia. The issue there is that failing to identify and address a delirium can lead to serious illness—sepsis, for example—and death. An untrained person will have difficulty with differentiating between delirium and dementia. The other really sad thing is that not having registered nurses there and overseeing what is happening—we hear so much about dehydration and malnutrition in aged care. We know that, whatever food is provided, a lot of residents, if they need assistance, often do not get their food.

Another issue for me is that people who have dementia are trying to communicate in ways that are foreign to an unskilled person. We need to be really skilled in being able to identify that. Challenging behaviour or an angry outburst could be caused by pain or distress or an inability to communicate a need rather than a need to be restrained physically or chemically. Being able to communicate effectively with a person with dementia, who cannot communicate effectively, is something that a skilled registered nurse can do. Other staff may not have the skills to intervene. Hence we have more risperidone and more angry and sedated people with dementia. I will stop there and let the others have a go.

Ms GIBBS: I support everything that Associate Professor Bernoth has said. I think it is really important that we also look at what is happening in our industry now. We have a regulated body in respect to the aged-care quality commission. They have changed their recent standards to look at the clinical infrastructure, focus on risk management, focus on complexity of residents, how we work with those residents. A registered nurse is ultimately the prescriber of all of that, the coordinator, the collaborator with all the other disciplines to ensure that we provide the care that needs to happen. We also look at the risk management point of view. The expectations of the quality agency for the infection control program now—we have all been mandated to have a registered nurse as our infection control leads. One nurse per home is dedicated to that role on top of everything else that they have got to do. We do a lot of admin duties. We do a lot of work planning. We look at the skill mix. The RN on site compared with an aged-care worker—when we come on, we look at what is happening across all our levels to ensure that we have the appropriate skill mix across all floors.

The reliance on unregulated staff creates a lot of issues. And we have seen—and I think it will come out on the twenty-sixth of this month, when we publish with the royal commission report—the amount of neglect, isolation, the poor care outcomes. Even if there was a registered nurse in, there was not the sufficient support in the back for these teams on the floor to understand, as we said, the dementia behaviours. I have recently undertaken training for one year with Dementia Australia to look at that complexity and how we can change the model for care, because I need to educate my workforce to understand simple behaviour management strategies. So I think it is very important that we do not substitute the aged-care workforce for a registered nurse.

A registered nurse is essential. They are the ones that are called upon all the time, even doing it remotely, giving that consultation. The families expect to be given that care. That is a part of their expectation. When they come into a home, they are extremely disappointed if there is not a registered nurse able to address them. I take the calls after hours. I am up at midnight or 2 o'clock, taking all these calls, because I need to provide that sound clinical judgement and support the teams that are on the floor. So there is a lot of pressure on the registered nurses. I think not having a registered nurse on the floor will mean that we will continue to see what we have seen come out of the royal commission's interim report. So I do not think substituting or replacing—aged-care workers definitely have a value to the industry; I am not saying they do not. But they do not have the skill set to be able to manage a clinically deteriorating resident or redirect resources to manage a situation that is occurring.

The Hon. GREG DONNELLY: Thank you. Ms Sharp, did you have anything to add about disadvantages for facilities that do not have an RN 24 hours a day, seven days a week?

Ms SHARP: Our registered nurses in aged-care facilities know all about the Aged Care Act 1997. They can actually do something about this. For decades aged-care facility residents at risk of pressure ulcers have been repositioned every two hours throughout the 24 hours, sometimes for months and years on end. The downsides of being repositioned are that it will not necessarily prevent pressure ulcers and that it keeps residents awake. They are so sleep-deprived that I have seen them asleep at the breakfast table; they are asleep on bus trips. They become angry. There are challenging behaviours. A registered nurse will be able to order an alternating-pressure air mattress to be delivered quick as, whereas the care worker will not. They do not have that authority. One particular mattress, which is outstanding in aged care, costs $1.40 a day to rent. That's all: $1.40 a day. We are not looking at thousands of dollars. But they will prevent pressure ulcers.

There is a chap in Queensland called Nicholas Graves, who showed the cost of pressure ulcers in hospitals and aged-care facilities to total $1.65 billion. Even though I am not here talking about costs, that is a huge amount. That is not even looking at the surgical care that is required when somebody does develop a huge sacral or heel pressure ulcer. Even in 2019 the Clinical Excellence Commission reported on pressure ulcers in aged care, mainly on the sacrum and heels, yet they are foreseeable and preventable. This makes up a huge amount of my expert witness nurse business, which is very, very sad.

The CHAIR: Thank you very much, Ms Sharp. I apologise. We are rapidly running out of time. We only have a few minutes left. So I am going to pass to my colleague Mr Mookhey.

The Hon. DANIEL MOOKHEY: Thank you for all of your appearances and for sharing your sesquicentury of experience in nursing with us. I know very little about it and certainly could not match your expertise whatsoever, so I am going to ask really basic questions here. I presume that the basis of your argument is that everybody is entitled to first-class aged care. Would you agree with that?

Ms GIBBS: Yes.

The Hon. DANIEL MOOKHEY: Some people have been making fleeting references to the interim report of the royal commission, which has found that we are not currently providing people with first-rate aged care. Would you agree that that is an accurate summation of the interim report?

Ms GIBBS: Yes.

The Hon. DANIEL MOOKHEY: Is part of that because the system is understaffed and under-resourced in general?

Ms GIBBS: The aged-care industry is not a well-resourced structure. It lacks a mandated structure of the minimum required. If you compared us with a hospital, you would see that we do not have the requirements of mandatory training to the extent that the public sector does. We do not have the guidelines that say that you must have a minimum of X amount of staff. I do not always agree that having an exact number of staff per floor is the right answer; it is about the quality and the skill mix of your staff. We have an unregulated workforce that holds no accountability. We as registered nurses come in and take on that extra level of burden because the staff who work underneath us do not take any accountability. They have a scope of practice that they have to abide by, whereas we have our Australian Health Practitioner Regulation Agency registration, which has a lot of complex domains in it. I think it is really important that we start being looked at. Like I said early in the piece, we are a subacute unit. And I can guarantee you—

The Hon. DANIEL MOOKHEY: I understand that and the point that you are making. Just in the interest of time I am going to try to go through this relatively quickly just to see if we can get the evidence in. Your basic argument is that, to turn around the systemic underperformance of the system, we have to invest more in the quality of both care staff and registered nurses and enrolled nurses. Is that correct?

Ms GIBBS: Yes.

Associate Professor BERNOTH: We also have to look at the way standards are monitored. I think the Aged Care Quality and Safety Commission has let us down badly. They are one of the reasons that we are where we are at. We need to have a whole other look at how we maintain standards. That is supporting our aged-care workers, not hitting them with a big stick.

The Hon. DANIEL MOOKHEY: I want to now open up and return to this issue that my colleague Mr Fang was raising, which was about the cost of turning around systemic underperformance to be able to increase investment in both care staff and registered nurses. One of the propositions that Mr Fang put was that that would have a price impact. But listening to the rest of your evidence, I could not but help notice that you are effectively

arguing that earlier investment at this level saves the system money at the acute level. Is that a correct summation of your view?

Ms GIBBS: That is correct.

The Hon. WES FANG: Point of order—

The Hon. DANIEL MOOKHEY: I am just putting the proposition.

The CHAIR: No, Mr Fang. I gave you wide-ranging latitude to ask a lot of questions. I am going to allow Mr—

The Hon. WES FANG: I am just raising a point of order, though.

The Hon. DANIEL MOOKHEY: What is your point of order?

The Hon. WES FANG: I think the Hon. Daniel Mookhey has put words into my mouth. I think that he is certainly entitled to put a question—

The CHAIR: What is your point of order?

The Hon. WES FANG: I do not believe Mr Mookhey has correctly represented what I asked of the witness originally.

The CHAIR: That is not a point of order. I am going to allow Mr Mookhey to continue. I am also going to say, Mr Fang, we do not need to head down this path.

The Hon. DANIEL MOOKHEY: Basically your argument is that, if we were effectively reallocating resources towards the actual aged-care facilities and not the hospitals, we would actually be in a position where we would be providing better care and care which was more cost-effective. Is that the correct argument? Am I understanding that correctly?

Associate Professor BERNOTH: That is a question to us, I assume.

The Hon. DANIEL MOOKHEY: Yes.

Associate Professor BERNOTH: It is again very hard to hear. None of us are making any comments about the acute system. Again this competition—we are not saying deprive one to feed the other. We need to have a look at the whole system and have a look at this transparency with finances: Where is the money going? Is it being spent in the most effective way? It may not be that we need more money; we need to do things differently, perhaps. But until we see where money is going, we cannot make comment about what extra financial support these facilities need. Let us get some transparency happening, please.

The CHAIR: Associate Professor Bernoth, I am just going to stop you there. I am going to give Mr Mookhey one last question, because we are quite over time.

The Hon. DANIEL MOOKHEY: My final question picks up this point. To turn around the system at a systemic level requires collaboration between aged-care management, the registered and enrolled nursing components, as well as the care staff, and the system needs to be reorganised to reflect that collaboration. Is that the take-home of your evidence that you are giving us?

Associate Professor BERNOTH: I would also say that we need to be collaborating with the wider acute systems, the primary health networks, the other community services, with Government, the university system, the VET system. We need to be working together to make sure we are enhancing this system. Also we need to hear what the royal commission's recommendations are.

The Hon. DANIEL MOOKHEY: Basically we have to stop thinking of aged care like an afterthought.

Associate Professor BERNOTH: I didn't hear that.

The Hon. DANIEL MOOKHEY: That we have to stop thinking about aged care as an afterthought to the health system. That is your argument.

Associate Professor BERNOTH: As a—sorry—to the acute system?

Ms GIBBS: I suppose I have always said that aged care is the poor cousin to the healthcare industry. That is what you will sense from a majority of registered nurses who have been in the industry for a very long time. We have been overlooked so many times. This is the outcome that you are going to see and will continue to see.

The CHAIR: I am mindful of time. We have gone over because your testimony has been so valuable. I am going to put a series of quick questions to you. I think some of the other members might have some questions on

. Can I just ask you for a yes or a no. A lack of a registered nurse leads to poorer health outcomes and unnecessary hospital admissions. Would you agree with that?

Ms SHARP: Yes.

Ms GIBBS: Yes.

Associate Professor BERNOTH: Yes.

The CHAIR: We have yeses from all witnesses. Do you agree that there is a need for more care staff to undertake work such as preventing falls and that that would then allow registered nurses to utilise their clinical skills and their expertise?

Ms SHARP: I really cannot hear anything that you are saying.

Ms GIBBS: It is hard to understand what you are asking.

Associate Professor BERNOTH: Are you asking—

The CHAIR: Would you agree that there is a need for more care staff to do work, including preventing falls, that would then—

Ms GIBBS: No, I am saying we need more skilled workforce to do it. You can have as many staff as you want, but that does not necessarily mean the outcome is going to be better. It is about the skill mix.

The CHAIR: We need a skill mix. I understand that.

Associate Professor BERNOTH: It is the registered nurse's assessment skills of the patient that will prevent the falls.

The CHAIR: That requirement for a registered nurse does not end at 6.30 p.m. In fact, it is actually exacerbated by things like sundowning in dementia patients. Is that correct?

Associate Professor BERNOTH: That is correct.

Ms GIBBS: That is right, yes.

The CHAIR: Do you think a single RN for an entire facility, which can number up to hundreds of residents, is enough to provide appropriate clinical care?

Associate Professor BERNOTH: No.

Ms SHARP: No.

The CHAIR: Unfortunately, we have gone well over time. Thank you so much for sharing your expertise with us today. We may have some follow-up questions for you as a result of your testimony today. I also thank you for the incredibly important work that you do in a sector that is, unfortunately, undervalued by our society. You are certainly at the cutting edge of it and your incredible expertise has been well utilised by the Committee this morning. Thank you so much for your time.

(The witnesses withdrew.)

(Short adjournment)