ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

AGED CARE IN REGIONAL AND REMOTE AREAS

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

INTRODUCTION

1. This submission concerns the provision of aged care in regional and remote areas.

2. This submission is provided in response to the matters the Royal Commission will inquire into at the public hearings to be held in Mudgee between Monday 4 November 2019 and Wednesday 6 November 2019.

3. The Royal Commission will inquire into the provision of aged care in regional and remote areas with a focus on;

    - the perspective and experience of people who access or are involved in aged care in regional and remote areas;
    - challenges associated with delivering aged care in regional and remote areas, and;
    - models for and approaches to delivering aged care in regional and remote areas, including Multi-Purpose Services (MPSs).

4. This submission focuses on the above issues from the perspective of Australian Nursing and Midwifery Federation (ANMF) members' delivery and/or involvement in care.

THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION (ANMF)

5. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 275,000 nurses, midwives, and care workers across the country.[1]

6. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations including in MPSs. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals, and achieve a healthy work/life balance.

[1] Care workers can be referred to by a variety of titles, including but not limited to 'assistant in nursing', 'personal care worker' and 'aged care worker'. In Australia, these staff are unregulated in contrast to registered nurses and enrolled nurses. For the purposes of this submission, workers who provide assistance in nursing care within RACFs are referred to as care workers.

7. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

8. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

9. The ANMF represents almost 40,000 nurses and care workers working in the aged care sector, across both residential and home and community care settings.

10. The ANMF's position is that all people should have access to and experience safe, appropriate, best practice care regardless of their location, health conditions, personal circumstances, and background.

11. Nurses and care workers are central to the provision of care encompassing all aspects of health care as well as in providing clinical and functional assessments and assistance and support with activities of daily living. This includes health promotion, prevention of illness and injury, care of the ill, disabled and dying. Care should be evidence-based, person-centred, and holistic in addressing physical, mental, social, and emotional wellbeing and should also be delivered in a manner that is appropriate and consistent with the individual preferences, values, and beliefs of each person.

12. It is the ANMF's view that along with the range of actions and improvements that are urgently necessary to address the systemic issues with Australia's aged care sector, appropriate, safe, quality care will not be feasibly achieved or sustained without the gradual introduction of mandated minimum safe staffing levels and skills mix across all residential aged care facilities including MPSs and other residential aged care facilities (RACFs) in regional and remote areas. Funding that is transparently directed towards care, diverse skills, resources, training, and capabilities, is required to care for everyone in aged care, but without the minimum numbers of the right kind of staff, that care cannot be delivered effectively or appropriately.

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13. The Aged Care Act 1997 defines 'people with special needs' for whom there should be additional consideration in the planning and delivery of aged care services.[2] These groups include but are not limited to people who live in rural or remote areas.

[2] Australian Government. Aged Care Act 1997. No. 112. Section 11.3. Federal Register of Legislation. Available online: https://www.legislation.gov.au/Details/C2017C00047

14. People who live in regional and remote areas may belong to more than one group that has been identified as 'people with special needs'; people from regional and remote areas are more likely than their metropolitan counterparts to be Aboriginal and/or Torres Strait Islander people, financially or socially disadvantaged and/or homeless or at risk of becoming homeless. People living in regional and remote areas may also be care-leavers, veterans, culturally and linguistically diverse, and/or gender and sexually diverse.

15. The provision of safe, quality care in regional and remote areas must ensure that this care is safe and appropriate for all members of the community. However, as each person should receive individualised, person-centred care that is sensitive to their unique preferences and needs, this level of care cannot be assured when there is an insufficient number and skills mix of staff. This the importance of this has been discussed at greater length in a previous ANMF submission.[3]

16. Younger people living in regional and remote areas have even poorer access to appropriate long term residential and home care services than their metropolitan counterparts. Any consideration of the provision of aged care in regional and remote Australia must also consider the importance of safe, appropriate, quality care for this vulnerable group.[4]

17. Including the submissions referenced above, among its previous submissions, the ANMF has also brought considerable evidence before the commission regarding rural and regional issues for service delivery of aged care.[5] As such, this submission largely focuses on a topic which has as yet not been discussed thoroughly; models for and approaches to delivering aged care in regional and remote areas, including MPSs. It addresses this topic by providing evidence from the perspective and experience of members who are involved in aged care in regional and remote areas and outlining the challenges associated with delivering aged care in regional and remote areas.

MULTI-PURPOSE SERVICES (MPS)

18. The MPS Program is a joint initiative of the Australian Government and State and Territory Governments. Multi-Purpose Services are designed to provide integrated health and aged care services for small regional and remote communities. They allow services to exist in regions that cannot viably support stand-alone hospitals or aged care homes. Multi-Purpose Services exist in every State and Territory apart from the Australian Capital Territory, and also run in Norfolk Island and Lord Howe Island (See Figure 1).[6]

19. The ANMF recognises and values the role of MPSs in regional and remote areas and understands that MPSs, when working effectively with appropriate staffing levels,

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[3] ANM.0012.0001.0001
[4] ANM.0007.0001.0001
[5] ANM.0005.0001.0001
[6] Australian Government Department of Health. 2019. Aging and Aged Care: Multi-Purpose Service Locations in Australia [Internet]. Australian Government Department of Health. Available at: https://agedcare.health.gov.au/multi-purpose-service-locations-australia

can provide a practical solution for delivering aged care in these locations.[7] Their efficient, robust links to primary, acute, and allied healthcare is a particular strength. It is important however, that RACF components are not neglected as sometimes occurs (described in this submission).

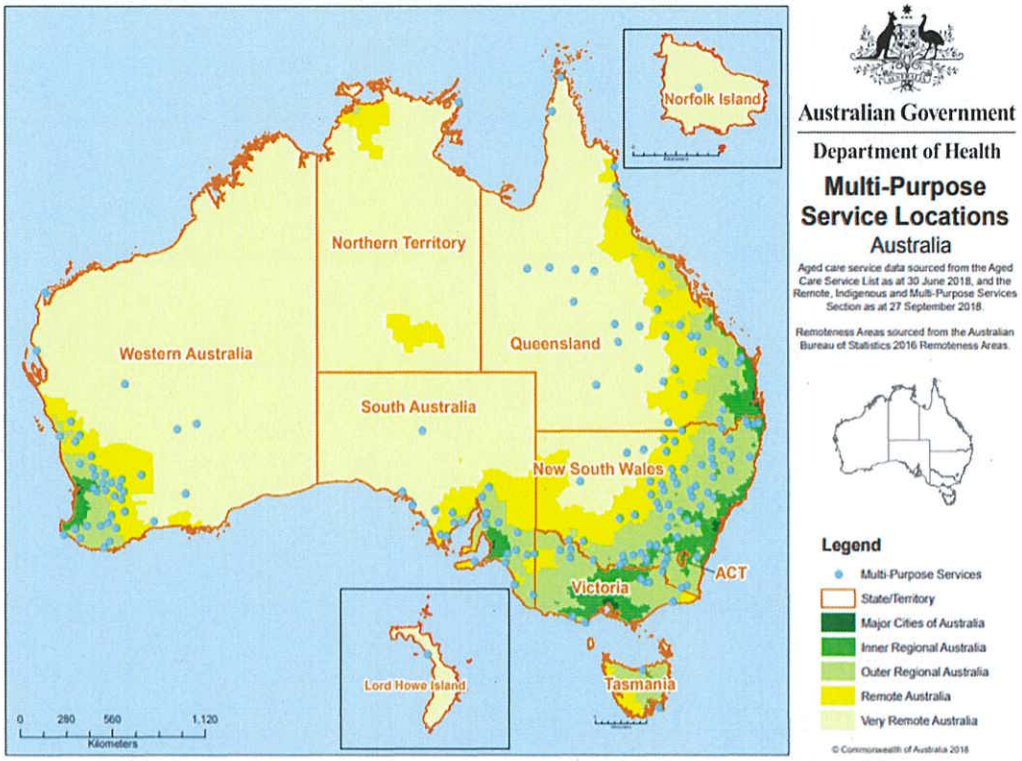

Figure 1. Multi-Purpose Services Locations in Australia as at 30 June 2018.

20. Under the *Aged Care Act 1997* and associated Aged Care Principles, MPSs receive Australian Government funding to deliver aged care services. State or Territory Governments provide further funding for the delivery of health services and the necessary capital infrastructure.

21. The operation of MPSs is summarised in Figure 2 below.

22. Anderson and colleagues conducted a literature review which found that the MPS model has significant strength in being responsive and flexible to community needs.[8] Staff members were noted as requiring to be multi-skilled across the scope of practice required by the two combined services. Low staffing introduced concern where staff were required to leave residents and/or patients unattended where emergency presentations occurred. Attraction and retention of staff to perform the

[7] Anderson J, Malone L. 2014. Suitability of the multi-purpose service model for rural and remote communities of Australia. *Asia Pacific Journal of Health Management*.9(3):14-8.

[8] Ibid.

required multi skilled roles in the rural and remote sector were also described as issues of concern.[9]

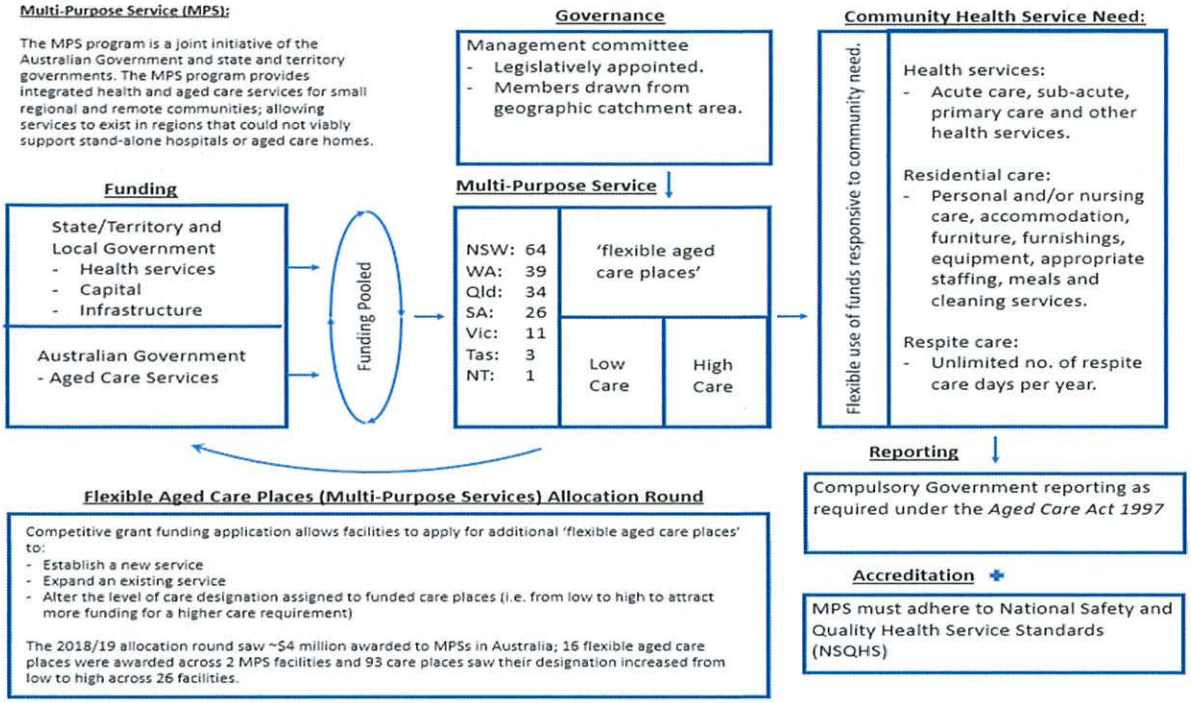

Figure 2: Summary of the Intended Operation of MPS in Australia

23. To understand the need for MPSs in rural Australia, Malone and Anderson conducted a literature review of 147 articles. The study found that in the absence of an alternative, the MPS model appeared to be the most practical in ensuring the appropriate delivery of healthcare to small rural communities. The implementation of MPSs were noted as being of varied configurations dependent on the requirements of the community in which they serve. This configuration was described as arising through community consultation and health service planning initiatives involving state and federal requirements.[10]

24. Funding and resource shortages similar to those evident throughout the wider aged care sector were also noted to exist in MPSs.[11] These funding shortfalls were noted as resulting in reduced staffing, placing significant pressure on, and reducing, the capacity for adequate delivery of care. Further systemic issues common in the wider aged care environment were also noted, such as an increased number of and utilisation of carers beyond their normal roles.

25. New South Wales (NSW) has been particularly proactive in establishing MPS around the State, hosting the largest number in the country, with community attitudes to

[9] Ibid.
[10] Malone L, Anderson J. 2015. Understanding the need for the introduction of the multi-purpose service model in rural Australia. Asia Pacific Journal of Health Management. 10(3).
[11] Henderson J, Willis E, Xiao L, Toffoli L, Verrall C. 2016. Nurses' perceptions of the impact of the aged care reform on services for residents in multi-purpose services and residential aged care facilities in rural Australia. Australasian Journal on Ageing.35(4):E18-E23.

the services being reported as often positive.[12] Members of the New South Wales Nurses and Midwives' Association (NSWNMA)/NSW Branch of the ANMF have provided a number of insights into the provision of care in the MPSs they work at.

26. NSW ANMF members broadly agree that, in principle and when functioning as intended, MPSs provide a valuable service to small rural and remote communities in NSW. However, as is so often the case across Australian aged care services, members report that the aged care services of MPSs are always the first to suffer when resources are 'tight' or inappropriately allocated.

27. Nurses, both registered and enrolled nurses, and care-workers (assistants in nursing in NSW MPSs) are employed by NSW Health under the NSW *Public Health System Nurses' & Midwives' (State) Award 2019* (the Award), which outlines the staffing requirements for MPSs (categorised as peer group F3 hospitals in NSW).

28. The Award stipulates the staffing arrangements for NSW MPSs as follows

    i. ***(53) Section III: Staffing Arrangements for Peer Group D & F3 MPS***

    ii. *(a) The following provisions will apply to hospitals designated Peer Group D1 Community Hospitals with community inpatient acute beds and a level 2 or above emergency department function; and to F3 Multipurpose Service facilities with community inpatient acute beds and a level 2 or above emergency department function:*

        (1) During the hours that the Emergency Department is open there will be a minimum of two registered nurses on duty, to ensure that there is a registered nurse available on the acute ward when a registered nurse is required to attend the Emergency Department. One of these registered nurses may be a NUM/NM who also performs clinical functions on the shift who is on duty and on site.

    iii. *(b) The parties recognise that where implementation of the provisions at (a) (1) above requires a change in the classification mix this will be achieved progressively from the date of this Award and is determined by the rate of staff turnover experienced in those facilities where the provisions apply.*

29. However, the transition to having two registered nurses on duty has not occurred across the NSW MPS system, resulting in many services frequently lacking appropriate staffing with only one registered nurse on duty to cover the entire hospital.

30. Members report that in this circumstance, the emergency department and the acute service of the hospital 'always take precedence' over the aged care service. The registered nurse, of course, must attend to emergency presentations and acute

[12] New South Wales Ministry of Health. 2016. Position Paper: Reshaping the Multipurpose Service (MPS) Model in NSW [Internet]. Health System Planning and Investment. Available online: https://www.health.nsw.gov.au/rural/rhhsp/Documents/reshaping-mps-model-nsw.pdf

needs of hospital patients, but when there is only 1 registered nurse on duty this results in, often, an assistant in nursing being left responsible for the care of the aged care residents.

31. While members generally report that they consider the staffing and care to be better than that in many private residential aged care facilities (RACFs), as in other RACFS, staffing in MPSs can be such that workers do not have time to provide the standard of care that they themselves know is required and expect of themselves. As the Commission has heard, lack of staff and poor skills mixes are common reasons for rushed and missed care as staff hurry to provide care for too many residents. This can, and often does, result in poor outcomes for residents and unsafe, unacceptable working conditions for staff:

> *"Pressure on care staff to get patients washed and dressed against their wishes."*
>
> *"I don't get meal breaks most days. Working 12hr shifts to cover lack of staffing."*

32. While being attached to an acute care facility can be beneficial in many instances, as residents may be able to quickly access required care from staff working in the hospital, stretching staff across the two services to the point where care may not be safe or high-quality for one or both services can occur. As one registered nurse reported:

> *"...*[A] *RN from the whole service needs to check S8s* [medications that can cause addiction]. *Therefore, this means a delay in getting pain meds, taking from the public health purse to prop up the aged care, and also takes the RN from the public hospital side.* [There are] *No problems accessing medical support, usually allied* [health] *is also OK but can find it difficult to access an OT* [occupational therapist]*."*

33. Poor outcomes may also be occurring in the connected hospital facilities, as limited staff are stretched over different services. Lack of staffing can occur because there are not enough staff employed or rostered on, or as a result of staff having to provide care across both the hospital and the MPS. As two enrolled nurse members in NSW told us:

> *"A patient fell in* [the] *bathroom. When the incident occurred there* [were] *two staff to twenty patients working one staff* [member] *down, which happens often. Alternatively, a staff member is taken to another ward because they are short staffed."*
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> *"A dementia patient was given Lorazepam because she got out of bed too many times going to the toilet. It was found the patient had a UTI. This patient never had a UTI before* [but] *becoming a permanent patient - she had had more than 6 UTI. The family purchased a bed alarm so staff would know when she got out of bed. Also, this patient was left restrained in a chair for up to 12 hours with no food or fluid and her pad wasn't changed so she*

received pressure sores on both heels, some RNs remain in nurses station and the EN is expected to attend to the RAC end and subacute and also help in the Emergency Department."

34. As the Commission has heard, falls are one of the most common causes of injury and death in aged care.[13] Ensuring that there are enough staff with the right skills mix working in the MPS (and the hospital), would do much to ensure that incidents like that above do not occur.

35. With the increasing demand for MPS in some areas, the size of MPSs and the number of residents has grown beyond the ability of the existing workforce to provide safe, effective care.[14] Problems can occur when staff who lack the education and training required to provide safe, quality care are moved from domestic services roles to direct care roles without adequate preparation, education, and experience with clinical supervision. As one manager of a rural MPS told us:

"We have increased the footprint of our facility and doubled the resident number. There has been an increased rate of falls, pressure injuries and skin tears. Domestic staff from domiciliary care environment are changing status to AINs [Carers] *in a clinical environment with higher-level care needs. The transitioning staff have a knowledge deficit in regard to care needs in high care and unfamiliar with chain of command and working under direct supervision of RN."*

36. Insufficiently trained and educated domestic services, or other staff, do not have the skills and experience of qualified nurses and carers and cannot and should not be expected to fulfil roles that require staff to be able to effectively and efficiently identify and respond to or escalate potentially life-threatening issues such as falls risk factors, pressure injuries, and wounds. In the following example provided by a registered nurse in NSW, a security guard who works across the entire facility was employed as a carer in the MPS, but still must respond to incidents in the hospital while working in the aged care facility:

"...They usually have 1 EN and 4 AIN on shift, however they have introduced a security guard for 4 hours in the afternoon to work as an AIN [carer] *as the workload is increasing as people are becoming more infirm and need two to assist. This staff member has very low levels of training in aged care. Also, when there is a security issue in the main hospital the security guard is moved out to assist and could be absent for the whole shift."*

37. Members have also told us that carers employed in MPSs are also on occasion required to administer medications as there are insufficient trained and qualified staff to do this. This not only increases the risk and likelihood of poor outcomes amongst residents but is also in breach of NSW Health policy.

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[13] Ibrahim JE, et al. 2017. Premature deaths of nursing home residents: an epidemiological analysis [Internet]. Medical Journal of Australia. 206(10):442-447. Available online: https://www.mja.com.au/journal/2017/206/10/premature-deaths-nursing-home-residents-epidemiological-analysis

[14] Ibid.

38. As the Commission has heard, the quality of food and nutrition in Australian RACFs can be poor. This can lead to worse outcomes for residents. One registered nurse member explained how MPSs, as they are attached to hospital healthcare services, may need to alter practice regarding the food that is provided as well as policies regarding food brought by visitors to their loved ones living in the MPS:

> *"I worked three evening shifts in a row and the food was disgusting. No food value in what was served, same vegetables (frozen veggies). Residents never get fresh vegetables and don't eat because they don't like the food, therefore are malnourished. One occasion they were served just dry chips, no sauce or gravy to help wash them down, not even served nicely with a bit of colour e.g. garnish. My thoughts are MPS's are under the Health Service providers and food in a hospital situation is meant to be short stay, where residents continually get processed pre-cooked food with little value or nourishment in it. At this MPS the food doesn't look like it is served with love to make it look anyways attractive. Anyone who brings in food, even fruit have to sign a register, so therefore residents miss out because of litigation if they get sick. This is hospital policy. Maybe policy for Aged Care needs changing to allowing for flexibility."*

39. Cost-shifting may also occur, where services and resources funded by one part of the MPS arrangement are utilised by the other. Members report that although the NSW Health Department 'enjoys' the funding provided the Commonwealth to deliver aged care services, that funding is frequently directed away from aged care services. And, as with so much of the aged care sector, it is the elderly who suffer.