**ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY**

**CANBERRA HEARING: INTERFACES BETWEEN THE AGED CARE AND THE HEALTH CARE SYSTEM**

**SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION**

## INTRODUCTION

1. This submission is provided by the Australian Nursing and Midwifery Federation in response to the matters the Royal Commission inquired into at the Canberra Hearing 9 December 2019 - Friday 13 December 2019.

2. The Canberra Hearing explored whether older people, particularly those living in residential aged care facilities, are able to access the health services they need as they age.

3. As will be discussed below, and consistent with the body of our submissions to the Commission, a substantive contributor to both the issues of health care delivery in residential aged care and the most efficient and effective way to resolve them, is to ensure the right number and type of staff providing care to residents are available. The ANMF adopts the Royal Commission's observation in its Interim Report:

> "Workforce issues affect every aspect of our inquiry into Australia's aged care system." (Interim Report, Volume 1, page 218)

The themes explored in the Canberra hearings are no exception.

4. The ANMF notes the opening submissions from Senior Counsel Assisting, which outlined the broad areas of interest to the Commission for the Canberra Hearing and propositions for the consideration of the Commissioners.[1]

5. This submission will not revisit information provided in previous submissions by the ANMF around transfers. A list of the submissions previously provided to the Royal Commission by the ANMF is set out in the appendix to this submission.

6. This submission addresses:

   a. the need for health care in residential aged care facilities;
   b. health care delivery within residential aged care facilities;
   c. addressing barriers to health care; and
   d. solutions to address some of the issues identified.

[1] P-7192:38 to P-7195:31

**The need for residential aged care facilities to deliver health care**

7. There is an urgent and increasing need for health care in residential aged care facilities (RACFs). Ageing is not a disease, but the likelihood of having comorbidities (diseases and conditions that affect our physical and/or mental health and impede our ability to care for ourselves unaided) increases as we age. The incidence of chronic disease increases with age, as does the rate of complications and the length of time between onset and diagnosis. Professor Gray summarized the health care needs of RACF residents in his statement to the Commission emphasizing their vulnerability, chronic conditions and multi-morbidity (Exhibit 14-26 WIT.0619.0001.0003 – 0004 at [19] – [27]). He also made the following observation about the consequence for RACFs of increasing care in the home:

> "The deliberate shift emphasis away from residential care (and the relatively greater investment in community alternatives) has led to a progressive increase in case complexity within the RACFs. On the other hand, there has not been a commensurate increase in the sophistication of health care offerings within the RACF environment. This has led to possible reductions in the quality of care and increasing reliance on external assistance." (WIT.0619.0001.0010 at [56]).

8. The Professor also referred to the relationship between care delivered in hospitals and RACFs and the "boundary" at which hospital care is required and the possible need to increase funding and skills in RACFs in order to competently manage a range of conditions in house (WIT.0619.0001.0006 at [36] – [37]). The present funding and staffing arrangements have not addressed this policy issue, but rather reflect historic arrangements and RACF proprietor preferences. Despite the evidence about resident acuity there remains misconceived industry discussion that RACFs should be staffed as a resident's "home".

9. The average RACF resident is frail, aged over 85, has more than one chronic health condition[2] (including at least one mental health or behavioural condition, including dementia), complex high-level care needs, and is highly likely to be prescribed more medications than someone of a similar age and condition living independently.

> *... people in residential care are some of the most complicated medical case patients in the system. They have the most profound disability of anywhere in Australia and they have very complicated health issues.* – Professor Flicker[3]

10. There was a time when the main function of RACFs was housing and hospitality, with some personal care provided as required, but the level of debility and need of RACF residents has significantly grown over the past decade or so. Drs Hullick and Burkett

[2] Cheek J, Gilbert A, Ballantyne A and Penhall R (2004) Factors influencing the implementation of quality use of medicines in residential aged care *Drugs and Aging* 21(12):813–824
[3] P-7498: 22-25

summarised some of the key data on this question in their evidence (Exhibit 14-12 WIT.1298.0001.0005 [24] – [27]). The data is matched by the experience of nurses:

> *Nursing homes now are sub-acute hospitals; ten or fifteen years ago, people would live in them for many years, but increasingly there's a push to keep people at home for as long as possible. Now people are admitted to a RACF much later in life, with complex medical conditions and usually because support services have failed or are no longer enough, or because they have not received their home care package services. Residents are dying, on average, within 6-12 months of admission to a facility.* – Nurse practitioner (NP), palliative care, ACT[4]

11. This increase in acuity has been felt across the health care sector, which has responded by measures including reducing in-hospital and in-patient rehabilitation to serve only those who cannot receive that care in other settings, assessing patients for elective procedures in pre-admission clinics, and launching hospital-in-the-home programs. Today, people are rarely admitted to hospital unless they cannot be safely cared for anywhere else, and the same is true for residential aged care (See the evidence of Susan Irvine Exhibit 14-8 WIT.0621.0001.0003)

**Delivery of health care in RACFs**

12. The sector as a whole has not only failed to adjust health care provision to the increasing needs of residents, many facilities have gone backwards, both reducing the total number of staff and their level of education and practice capacity. Regardless of the increasing medical complexity and frailty of this population, and despite the expectations of representatives from their respective departments of health,[5] it has become evident throughout evidence tendered to the Commission that a worrying number of RACFs seem to regard managing residents' changing health care needs as the responsibility of others, predominantly the acute health sector. Ms Oxley a NSW Paramedic gave evidence about her experience of RACFs and expressed a conclusion about cost and care shifting in very direct terms. (Oxley Exhibit 14-16 WIT.1303.001.0015 at [63])

13. In many cases, this failure to provide appropriate, necessary health care by RACFs results in cost shifting to the public sector. Acute review and management of complications would largely be avoidable with higher numbers of staff and a skill mix that allow resident's health care needs to be met.

> *... these findings show there is a level of avoidable cost shifting from RACFs which is placing pressure on an already overstretched public health system in NSW. Whilst*

[4] Member communication with ANMF, 26 November 2019

[5] Per evidence tendered to the Commission by Terry Symonds, Ross Smith, Michael De'Ath and Dr Maggie Jamieson on 13 December 2019

*hospital admissions might be unavoidable for some, our members have offered practical solutions as to how the incidence might be reduced.*[6]

14. The ANMF's acute hospital members report that this cost shifting results in decreased availability of paramedics, prolonged wait times in emergency departments, and bed blocking, affecting the wider population as well as aged care residents:

    a. *Many patients could be managed in the facility if more RNs were available to assess, treat and monitor. Currently these people going to EDs for these procedures that could be managed at the RACF with more professional employees is contributing to the ramping issue where EDs are unable to accommodate all patients requiring care.* – Registered nurse, public emergency department, WA[7]

    ANMF National Aged Care Survey 2019

and:

    b. *Due to inexcusable lack of skilled staffing and resources needs cannot be physically met, so there is no other choice except to transfer to an acute facility and therefore contributing to bed blocking and ambulance ramping.* – Registered nurse, public hospital bed flow coordinator, Victoria[8]

    ANMF National Aged Care Survey 2019

15. In some cases, this responsibility shifting includes not only the provision of care, but even the impetus to seek it. As Professor Ibrahim told the Commission in May, and has been demonstrated by direct evidence throughout the hearings, without a daughter many residents would have nobody advocating for their health care needs and, too often, those dedicated daughters' valid concerns are dismissed.[9] A just, equitable system cannot rely on the advocacy of family members to ensure residents receive health care.

**Identified barriers to health care in RACFs**

16. Before minimising, treating, and preventing health care issues, their precipitating factors, signs and symptoms must be recognised and acted upon. This can only be done by people who have the knowledge and skill to recognise potential issues, and opportunity to observe individuals' baseline and evolving states – a position nurses are uniquely equipped to occupy.

17. Inadequate health care of any kind within RACFs means that changing health care issues are not quickly detected, properly assessed, and appropriately treated, often leading to

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[6] Australia and New Zealand Society for Geriatric Medicine, NSW Division (2019) Perspectives on hospital avoidance from residential aged care in NSW *Aged Care Round Table joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharges* p. 13

[7] Exhibit 11-1 (Tab 6) RCD.9999.0203.0054 - ANMF National Aged Care Survey 2019

[8] Ibid

[9] P-1805:13-14 (16 May 2019)

avoidable transfers. In addition to difficulty attracting medical practitioners to provide in-facility care, this is primarily attributable to insufficient numbers of nurses, and facility policies that restrict nurses, de-skill the RACF workforce, and mandate transfer to the acute sector.

18. Care workers play a vital role in the provision of care to residents, but they do not have the educational preparation to equip them to assess health. The increasing reliance of the sector on care workers means both external practitioners and families find it:

> *... quite difficult to actually get to speak to the right person because the carers that actually do most of the manual work and caring, hands on caring in these facilities have no clinical skills. So communicating with them about something that concerns you because you're unable to access the one registered nurse that's looking after 70 residents...*[10]

19. This was echoed by Professor Gray – doctors need someone to coordinate the resident's health record, and access to "capable, informed nursing staff,"[11] to both assist the resident and enact the recommendations made as a result of the evaluation. He went on to say:

> [Nurses] *basically provide the day-to-day care, make the day-to-day observations and, really, are the people who make that person's life as good as it can be. And if they're not there, no matter how many outside specialists and, you know, kind of shouting at them to do things, you're sort of wasting your time. You really have to have a core of people in the facility who can take and use advice.*[12]

20. Improving staff numbers and skill mix is an essential part of improving the care provided to aged care residents, and the critical first step in improving resident access to quality, timely health care in RACFs. Dr Dawda identified the lack of adequately trained staff in RACFs as a key barrier to residents accessing primary health services and also identified opportunity for more treatment to undertaken by RACF staff. (Exhibit 14-5 WIT.0618.0001.0010-0014 at [8.1] and [9c])

21. There are not enough nurses in the aged care sector, and many of those who have been there for some time are unable to practice to their full scope. This has resulted from workload that demands a focus on tasks over assessment and evaluation, and organisational policies that restrict nurses' scope of practice.

22. ANMF members report that facility policies limit their scope of practice, even though they have been educated to perform procedures:

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[10] Kristine Stephens, P-7230: 10-15
[11] P. 7494: 1 - 24 (12 December 2019)
[12] P. 7498: 13-17 (12 December 2019)

a. *You need a piece of paper for everything you do in aged care. Recently we had a resident that needed suction due to disease process and we watched him gurgle and plead for suction - but none of us had that piece of paper according to management that deemed us a "suction nurse."* – RN, not for profit RACF, NSW[13]

ANMF National Aged Care Survey 2019

b. *Policy will not allow RNs to change male IDCs [in-dwelling urinary catheters], but allows the change of SPCs [suprapubic catheters] and female IDC changes. If this was changed, male residents would not require hospital transfer nor locum visits costing the resident money.* – EN, not for profit RACF, Victoria[14]

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23. As a result, clinicians lose the competence and confidence to perform procedures they have been educated to perform. This problem is not only the responsibility of RACFs. The evidence from Dr Montalto about the Hospital in the Home (HIH) demonstrated that HIH nurses were to provide care to RACF residents admitted to the programme and:

"... staff of RACF are not required to be involved in the delivery of acute care, such as administration of intravenous therapy, or management of intravenous lines, taking blood or other samples or acute wound care."

24. Nonetheless some expectations of RACF staff from the HIH programme remain:

"RACF staff will be required to continue to care for the daily physical needs of their resident, including washing, feeding, and social interaction, and the administration of oral medication as charted and approved. HAH may ask their assistance with administration of oxygen, and simple monitoring such as behaviour, temperature, weight, or fluid intake. HAH is conscious of not over burdening the RACF staff during a HAH admission. Clearly, **HAH patients will require more attention**, and **we hope that there is flexibility in RACF staffing to allow this to occur**. " (Emphasis added)

(Dr Montalto Exhibit 14-15 WIT.0624.0001.0005 at [29])

25. The ANMF observes that in the absence of improved nurse staffing in RACFs the hope expressed by Dr Montalto is entirely misplaced.

26. The waste of potential expertise is a matter of frustration from qualified nurses:

*I have always worked in the acute setting before the nursing home. I was astonished that the residents were transferred to hospital when we as RNs are*

[13] Exhibit 11-1 (Tab 6) – RCD.9999.0203.0054 - ANMF National Aged Care Survey 2019
[14] ibid

> *very capable of caring for the residents in their own home. I feel I have lost a lot of necessary skills because of this fact.* – RN, for profit RACF, SA[15]
>
> ANMF National Aged Care Survey 2019

27. As Professor Eager reported in her evidence to the Commission,[16] these restrictions to nurses' scope of practice are endemic in residential aged care,[17] and contribute to avoidable utilisation of acute health services. This was a theme throughout the ANMF's member survey, from nurses working in RACFs (as above), and nurses working in the acute sector, particularly in emergency departments. Some of them specifically identified the issue:

> *This is so very common. Not enough registered nurses to begin with and the practice of routine transfers to acute care leads to the deskilling of staff.* – RN, emergency department, Victoria[18]
>
> ANMF National Aged Care Survey 2019

28. The Commission heard that NSW has attempted to compensate for this by increasing the scope of practice of some paramedics, known as extended care paramedics who, after additional training, can "do further assessments such as like a urine analysis to see whether it looks like there might be a urinary tract infection... catheter changes, NG tubes..." and wound assessment and management.[19] These skills are, however, all components of registered nurse education, and proficiency is a requirement of course completion. Sufficient numbers and types of aged care nurses, review of facility policies that permit nurses to practice to the extent of their scope, and stocking the required consumables would mean this care could be performed by aged care nurses, allowing paramedics to return their focus to emergency health care.

29. The NSW extended care paramedic initiative is responsive to identified need. It is however an example of costs and care shifting by RACFs. Dr Bendall referred to RACFs factors impacting on ambulance demand as "staffing and skills mix, RACF staff confidence assessing and managing acute conditions, policies and procedures ... [and] lack of alternative options" (Bendall Exhibit 14-2 WIT.1300.1000.0005 at [27]).

30. Dr Wallet wrote that Registered Nurses were generally not available for GP assistance during GP visits and observed:

> "Well trained Registered Nurses (RN) employed by RACFs make a big difference to the care of the resident in ACFs. They are able to communicate effectively, clearly and relevantly to other members of the health care team including GPs. The GP sees the patient for brief snapshots of time and are reliant on the information they gather

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[15] ibid
[16] P-5777-9 (14 October 2019)
[17] Davis, J 2017. Future of Australia's aged care sector workforce - Submission 306, p. 4
[18] Exhibit 11-1 (Tab 6) – RCD.9999.0203.0054 - ANMF National Aged Care Survey 2019
[19] P-7371: 19-21

from the RACF team including RNs." (Wallett Exhibit 14-6 WIT.0617.0001.0005 at [25] and [27]).

31. The RACGP through Associate Professor Morgan submitted:

> "Suitably qualified and appropriately trained staff in RACFs is essential to the quality and standard of care provided to residents. While the GP will ideally play a role in RACFs as 1he coordinator of their patient's medical care, the implementation, administration and adherence to directives are highly dependent on RACF staff and providers. Often, there is insufficient suitably qualified or trained RACF staff on hand to provide a briefing or handover, or carry out management or treatment plans.
>
> The RACGP believes a national, consistent regulatory framework around minimum staffing and appropriate skills mix in RACFs is vital, including appropriately trained nursing staff. A commitment to ongoing training in aged care issues for all staff should be an essential component for RACFs. For example, the RACGP strongly encourages further training specific to palliative care, pain management, and use of psychoactive medication and antibiotics."
>
> (Morgan Exhibit 14-10 WIT.1317.0001.0023)

**Improving access to health care in RACFs**

32. Residents in aged care should have timely access to the quality, coordinated, multidisciplinary health care they need, delivered by the right practitioner at the optimum time and appropriate to the context.

33. Terry Symonds (Deputy Secretary, Victorian Department of Health and Human Services) identified an underlying policy problem with current arrangements for care delivery. This issue was picked up by Counsel assisting in the course of the hearings (P-7195:9). Mr Symonds wrote:

> "...there is little clarity in relation to specific services that are to be provided by nurses and other clinical staff working in residential aged care settings, and similarly, no clear description regarding the level of health care that should be provided in these settings.
>
> The standards and principles are not clear enough in regard to which services a resident would reasonably expect to be funded and delivered by their residential provider, and which are appropriate for the primary health or broader healthcare systems (including the Victorian health system) to provide."
>
> (Exhibit 14-36 WIT.0565.0001.0005 at [29] – [30])

34. The emergence of a series of outreach services in every State and Territory designed to supplement RACF care capacity is a symptom of this unresolved policy problem. The default solution has been determined by the staffing decisions of RACF proprietors and the associated funding arrangements.

*Staffing levels and skill mix*

35. The problems of health care in RACFs are systemic, entrenched, and complex, and a range of responses is needed. However, no intervention will create meaningful improvement in residential aged care without an increase in the number of staff providing care within RACFs, and improvement in how many of those staff are accountable, skilled, educated professionals enabled to work to the full scope of their practice. Ms Gardner gave evidence of the arrangements adopted at Buckingham Gardens Aged Care for General Practitioner visits and the presence and role of a Registered Nurse. That evidence and the importance of the Registered Nurse's role was consistent with that of medical practitioners. (Exhibit 14-20 WIT.1312.0001.0005 at [26]). Fiona Lysaught gave similar evidence about the involvement of registered nurses with GP visits at Whiddon Narrabri (Exhibit 14-21 WIT.1311.0001.0003 – 0004 at [19] – [21].

36. Early intervention improves outcomes by every metric, but requires swift detection of new and worsening issues. Nurses are not only educated in observation and assessment but are also skilled in initiating appropriate interventions. Having both the right number and combination of staff in RACFs will allow aged care nurses to promptly detect and respond to changes in residents' clinical condition. Dr Lyons (Deputy Secretary, NSW Health) in his statement to the Commission addressing the question of resident access to primary health care responded by reference to the AMA Aged Care Survey Report:

> "The AMA Aged Care Survey Report 2017 [RCD.9999.0019.0003] shows that 63.75% of respondent medical practitioners visit RACFs and 10.51% of them have stopped visiting RACFs during the past five years...
>
> Respondents to the survey prioritised access to nurses and other health professionals as the most 'urgent' and 'extremely urgent' methods to improve access to medical care in RACFs.
>
> AMA members have raised concerns regarding lack of nurses available for medical practitioners to provide a clinical handover, and to administer medication after-hours in RACFs. These issues pose a serious risk to the health of patients living in RACFs."
>
> (Exhibit 14-27 WIT.0568.0001.0004 at [22]-[24])

37. Drs Hullick and Burkett of the Australian College of Emergency Medicine gave evidence about the need for access to registered nurses in RACFs and recommended to the Commission the prescription under the *Aged Care Act 1997* of registered nurse to

resident ratios related to the frailty and complexity of care required. (Exhibit 14-12 WIT.1298.0001.0011-0012 at [38]–[39]; Exhibit 14-1 (Tab 49) AWF.600.01256.0002 - ACEM Submission to the Royal Commission into Aged Care Quality and Safety).

38. Dr Burkett in response to a question by the Commission said:

> "I think it's fundamentally important in order to improve the care in a sustainable fashion that there be attention to staffing levels, particularly in aged care facilities and beyond staffing levels the staffing mix so that there are registered nurses." (P-7322:33)

39. The Australian Medical Association (AMA) in its submission dealing with the relationship between doctors and RACF staff called for legislated minimum acceptable staff ratios that also ensure 24 hour Registered Nurse availability (Exhibit 14-1 Tab 45 AMA.9999.0001.0011 - 0012). The AMA also expressed concern over deskilling of aged care nurses (AMA.9999.0001.0012) – a theme noted by Mr Gilbert in the Workforce hearings. In its submission, the AMA also submitted that:

> "...increasing the availability of RNs in aged care services will significantly improve quality and safety for the care of older people" (AMA.9999.0001.0012)

40. Palliative Care Nurse Peter Jenkin in his evidence to the Commission also commented on the need for registered nurses on site in the context of palliative medicine and barriers to accessing palliative care and wrote:

> "It is nowhere near best practice for a RN to not be able to make a hands-on assessment of a person whose condition is likely to change over time." (Exhibit 14-23 WIT.1314.0001.0013 at [81])

*Continuity of care*

41. Continuity of care facilitates optimal health outcomes. Consistency reduces communication and knowledge gaps, there is greater opportunity for practitioners to have a holistic picture of the individual, a foundation of trust improves interactions, and alterations from the person's normal behaviour and baseline health status are more readily noted.[20] This continuity is beneficial to residents at every level.

42. In some cases, continuity covers an episode of care - across an acute hospital admission, or in a person's last days. Ms. Davis's evidence to the Commission during the Canberra Hearing included the difference the involvement of a palliative care NP made to both her peace of mind and her mother's dying:

[20] Tammes P and Salisbury C. 2017. Editorial: Continuity of primary care matters and should be protected. *British Medical Journal* 356:j373

> *That continuity of care was integral. While I don't feel that I saw lots of Nikki in the beginning, she was always there, and she was always – she always knew what was going on, and I always felt in the loop. She would always call me, and there was that interaction, whereas previously I had felt that I had been cut out of the loop to a point, and I think for carers and – obviously, not everyone has someone that is by their side all the time; so to have that continuum of care is crucial.*[21]

43. Dr Clare Skinner's statement to the Commission came from the perspective of both Emergency Physician and family member. She emphasised the importance of qualified nursing staff in RACFs, enhancing capacity in RACFs to reduce unnecessary transfers to hospital, to enhance end of life care, and to allow care (WIT.1302.0001.0003)

*Holistic primary care*

44. People enter residential aged care with multiple health concerns and risk factors from medication interactions to increasing debility. This combination of clinical complexity and frailty demands coordinated, holistic, proactive care that should be driven by the welfare of residents, rather than crisis management and hospital avoidance.

45. NPs, guiding and supporting nurses working to their full scope of practice, are best placed to provide ongoing, complex care to residents. As Profession Ibrahim told the Commission:

> *A lot of the issues that we currently face require non-pharmacological techniques, so particularly for dementia which would be better applied through nurse practitioners, rather than medical specialists.*[22]

46. Embedded primary care is the best solution – that is, practitioners onsite or (for small facilities) in networks, who regularly and routinely review residents, who are accessible to and have therapeutic relationships with residents, their families and the rest of the staff. This results in familiarity with residents and their baseline health status, facilitates family members reporting concerns, and enables nursing staff to escalate issues quickly and easily.

47. Evidence has been tendered to the Commission about information gaps between RACFs and hospitals[23], between GPs and other health practitioners[24], and Ms Payget's evidence on December 13th, illustrated the need for and lack of holistic care on several occasions.[25] Dr Skinner also noted the importance of holistic care,[26] concluding that nurse practitioners are a group that have the potential to work in the aged care environment delivering and coordinating holistic clinical care, functioning as a liaison with and referral to GPs, specialists, and other health practitioners. NPs can provide clinical oversight and assist in upskilling

[21] P-7414: 26-31
[22] P-1806: 46 - P-1807: 2
[23] Stevens P-7230:6-18; Irvine P-7266:18-19; Gardner P-7442:5-32
[24] Stevens P-7231:8-33
[25] P-7592: 6, P-7594: 21, P-7595: 23, P-7653: 20
[26] P-7603: 37, P-7609: 4, P-7609: 17

nurses and care staff in facilities, while also improving and facilitating medical practitioners' interactions with RACFs to provide medical care.

*The role of NPs in RACFs*

48. The flexibility of NPs allows them to play multiple roles in the sector. As the Commission has heard, in addition to performing and assessing the effectiveness of palliative care, NPs like Nikki Johnston and Peter Jenkin spoke meaningfully about end-of-life decision making in a way that is useful for the resident, the family, and other staff. Education is a key component to improving the capacity of care providers in the sector, and as Ms. Johnston submitted, "facility staff soak [education] up like a sponge, they absolutely love it. They - their ability to care for people really changes and they are much happier in their workplace."[27]

49. Ongoing education allows nurses and care workers to better and competently perform care, and the associated costs are balanced by fewer preventable complications that are detected and treated earlier. In addition, understanding the rationales for how, what and when care is best delivered increases staff interest and engagement, and investment in staff increases retention, reducing the costs associated with turnover.

50. Between the growing numbers of people living with dementia, and the prevalence of mental ill health, there is also an urgent need for NPs with specialist mental health experience, particularly for staff education and individualised care planning. Appropriate management can substantially reduce the distress of residents, and thus how much disruption is caused. Accomplishing this, however, requires both enough staff to be able to provide it, and the expertise to identify the triggers and the most effective interventions for each affected person.

51. The potential NPs have to benefit the Australian health care system can be clearly seen from their use in the United States, where the role was established over 50 years ago. There, NPs work well across all sectors, with primary health identified early on as a key area for NP practice.[28] In 2010, the National Academies of Sciences, Engineering, and Medicine called on NPs to adopt a bigger role in America's health care system to help meet increasingly complex and changing demands, recommending NPs work as full partners, with medical practitioners and other health care professionals, in redesigning United States health care.[29]

52. In his evidence, Dr. Bartone incorrectly characterised the relationship between NPs and medical practitioners, and the NP scope of practice.[30] This error was briefly addressed by Ms. Johnston,[31] but the ANMF will take this opportunity to clarify any confusion about the accountability and practice of NPs.

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[27] P-7451: 8-10

[28] Keeling, AW. 2015. Historical Perspectives on an Expanded Role for Nursing in The Online Journal of Issues in Nursing 20(2):2-8

[29] National Academies of Sciences, Engineering, and Medicine 2010

[30] P-7275: 39-46, P-7276: 1-6

[31] P-7467: 1-7

53. As is the case with other regulated health professionals, NPs have an obligation under the *Health Practitioner National Law Act 2009* to work within their scope of practice. This scope is described by the national regulator, the Nursing and Midwifery Board of Australia, in the *Nurse Practitioner Standards for Practice*. Like all nurses, this is founded on what the individual nurse is:

> *... educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.* [32]

54. The ANMF submits that there is no requirement for medical supervision of NPs. In Australia, though not internationally, NPs are required to have a collaborative arrangement with a medical practitioner. The purpose of this collaboration is often misunderstood. The intent of the arrangement is to facilitate collaboration, between NPs and their medical colleagues, for advice or to discuss individual cases. There is no requirement for the collaborating medical practitioner to be in the same state or territory, and there is no condition of supervision or accountability by either party for the practice of the other.

55. NPs are not a substitute for medical practitioners. Many GPs and other doctors find that working with NPs does not lead to unnecessary duplication (or competition) in the provision of care. Rather, working collaboratively with NPs allows many doctors to concentrate on specialist work specific to a medical practitioner. Ms Irvine provided helpful evidence about the role and functions of NPs (Exhibit 14-8 WIT.0621.0001.0011-0012 at [15])

56. NPs currently intersect with residential care through the provision of primary care, and in gerontology, palliative care, acute emergency management, mental health, and chronic disease management. There is significant potential for increased utilisation of NPs in aged care and, therefore, the expertise they can provide Dr Dawda's evidence endorsed the increased use of NPs. (Exhibit 14-5 WIT.0618.0001.0014 at [9d]) The ANMF supports the proposition that Commonwealth funded scholarships should be provided to allow experienced registered nurses to undertake NP qualification, which Ms. Irvine estimated could add 500-600 NPs equipped to work directly and in conjunction with residential aged care, within six years, provided career paths were also made available.[33]

57. In addition, specific incentives and support should be provided to qualified candidates from areas of high need, including Aboriginal and Torres Strait Islander nurses, and nurses from underserved rural and remote areas.

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[32] Nursing and Midwifery Board, 2018. Nurse practitioner standards for practice https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/nurse-practitioner-standards-of-practice.aspx

[33] P-7261: 38-42

58. This would be a rapid solution to a number of issues in residential aged care, including support for nurses in the aged care sector, educating care workers, and improving residents' outcomes and quality of life, without need for major restructuring, provided the Nurse Practitioner Reference Group recommendations are adopted by the MBS Review Taskforce.[34]

[34] Nurse Practitioner Reference Group. 2018. Medicare Benefits Schedule Review Taskforce: Report from the Nurse Practitioner Reference Group https://www1.health.gov.au/internet/main/publishing.nsf/Content/BEB6C6D36DE56438CA258397000F4898/$File/NPRG%20Final%20Report%20-%20v2.pdf

## Appendix

## Previous ANMF submissions to the Royal Commission

| Document ID | Commission Reference | Title |
|---|---|---|
| ANM.0002.0001.0001 | - | Aged Care in the Home |
| ANM.0003.0001.0001 | AC 19/965 | Residential Dementia Care |
| ANM.0004.0001.0001 | - | Person-Centred Care |
| ANM.0005.0001.0001 | - | Aspects of Care in Residential, Home, and Flexible Aged Care Programs, Rural and Regional Issues for Service Delivery of Aged Care, and Quality of Life for People Receiving Aged Care |
| ANM.0006.0001.0001 | - | Regulation of Quality and Safety in Aged Care and How Aspects of the Current System Operate, Different Approaches to Regulation (including in other sectors) and How Regulation and Oversight of Quality and Safety in Aged Care can be Improved |
| ANM.0007.0001.0001 | AWF.600.01255 | Younger People in Residential Aged Care |
| ANM.0012.0001.0001 | AWF.600.01309 | Diversity in Aged Care |
| ANM.0013.0001.0001 | AWF.600.01307 | Aged Care Workforce |
| ANM.0014.0001.0001 | AWF.600.01356 | Aged Care in Regional and Remote Areas |
| ANM.0015.0001.0001; ANM.0015.0002.0001; ANM.0015.0003.0001 | AWF.650.00048 | Workforce Submissions |
| ANM.0016.0001.0001 | - | Canberra Hearing: Interfaces between the Aged Care and the Health Care System |