Submission by the Australian Nursing and Midwifery Federation

Department of Health and Aged Care - Aged Care Rules - Residential Care Service List Consultation

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Australian Nursing & Midwifery Federation

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Introduction

1. 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 326,000 nurses, midwives and care-workers across the country.

2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. 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.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides 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.

4. 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.

5. The ANMF thanks the Department of Health and Aged Care for the opportunity to provide feedback on the Residential Care Service List (the service list).

6. This submission sets out our key concerns with respect to the delivery of care and the need to ensure that the service list enable nurse-led care across the full spectrum of care delivery.

Nursing Care

7. Aged care is the only sector in the broader healthcare field where clinical and personal care are not currently considered intrinsically linked as part of a care continuum. Nurses must be central to aged care and have a vital role in providing continual oversight and coordination of

care for older people in residential aged care and in-home care. To help ensure that nursing is not erroneously viewed and treated as a ‘specialist service’, the service list must ensure that nurses are involved in all aspects of care – from intake assessment to care management, direct and indirect supervision of care delivery, and direct clinical and non-clinical care. The ANMF believes that aged care is *health care* and must be treated as such where health professionals coordinate and deliver care.

8. The service list makes a distinction between ‘nursing’ and other services (e.g., ‘Personal care assistance’, ‘continence management’ etc.). Here, it will be critical that the pricing of services under both be developed with recognition that both nurses and other staff including care workers will be involved in delivering personal and non-clinical care and that registered and enrolled nurses will have key roles in clinical and direct care supervision. For example, while the service list does not explicitly state that nurses would *not* be involved in providing continence management, if the service list is not clear that nurses would be involved here, there will be little to no incentive to ensure that nurses are involved in delivering this important service that they are optimally placed to deliver. Unfortunately, based on the extensive evidence that has been reported by successive inquires including the Royal Commission, the ANMF has little confidence that providers will implement best practice unless compelled to do so. Sadly, a provider mindset of compliance rather continuous quality improvement seems to prevail in the sector. Likewise, ensuring that staffing and skills mix levels are sufficient and that nurses are engaged in the gamut of personal and clinical services is vital,[1] as care delivered by nurses and ensuring nurses ‘at the bedside’ has well established links to better care experiences and outcomes.[2,3,4]

9. While this discussion paper does not deal with the costing of services, it is a connected issue. It is important that services provided by nurses are costed within relevant personal care and non-clinical care items as nurses are responsible for providing holistic, person-centred care and should not be excluded from this care. Nursing has long since moved away from lists of skills and competencies and adopted contemporary ‘standards of practice’ and a focus on holistic, person-centred care that encompass the breadth and depth of nursing practice which

involves everything from personal care to complex clinical care. Any return to a task or list-based approach to nursing care is a retrograde step which will be vigorously opposed by the ANMF. Whenever care is provided for an older person, such as assisting with hygiene, or mobilisation, a nurse is also using their clinical expertise and experience to observe and assess the individual for potential health and wellbeing issues or conditions.[5] By ensuring that services provided by nurses and nursing models of care are recognised in the pricing of personal care and non-clinical services, safer, more effective, and appropriate care will be better supported by the service list and cost efficiencies are also achievable.[6] Aligned with this also, is that the term 'assistant in nursing' be retained to embed nursing models of care in aged care providing that assistants in nursing must work under the supervision and delegation of registered nurses and work to their defined scope of practice. Similarly, personal care workers, who may have a range of job titles (including under the Aged Care Award as being classified as 'aged care employees- direct care') also work under the supervision and delegation of registered nurses. This approach will also assist with the wider aim of reinforcing the workforce pipeline of people who choose to work towards becoming enrolled nurses or registered nurses and ensure that clinical care is nurse-led.

10. Related to the issue described above, is the potential risk that the service list could perpetuate an outmoded conception 'task focussed care' instead of holistic 'person-centred care'. Here, while it is clearly important that there be a defined and well-specified list of services provided in the context of aged care, task focussed care that is aimed at the prioritisation of efficiency is known to be detrimental to the delivery of high-quality, dignified person-centred care.[7] Further, task-based care is known to be linked to nurses feeling unable to meet professional values and standards which in turn can contribute to moral distress and workplace dissatisfaction characterised by the current aged care workforce crisis where high levels of staff turnover and intention to leave remain very concerning. By ensuring that services can clearly be delivered by nurses as well as care workers and that the amount of time allocated to each service is sufficient to ensure services are not rushed holistic, person-centred care can be better supported and engendered by the service list.

Care and services – Care planning and clinical care

11. Care planning and clinical care contains clear and positive reference to nursing and nursing care in recognition of the vital role that nurses – registered and enrolled – play across all aspects of care in nursing homes. Importantly, nurses are the primary coordinators of care in the sector where medical practitioners and other health professionals generally provide only episodic care. The Discussion Paper outlines the inclusion of a care and services plan oversight item in the new service list (pages 21–24). In terms of the proposed new text under 'Care and services plan oversight' the service list should also include a clear indication of who should be responsible for this oversight. Without clear specification here, the risk is that a person with inadequate clinical and professional expertise and training would have oversight which could engender poor care and outcomes for residents and deficiencies in terms of clinical governance frameworks supporting staff. Here, a healthcare professional with the requisite expertise, education, and training including a registered nurse should be responsible for each individual's care and services plan, that all aspects of the care and services plan are carried out, and that progress against the goals of the care and services plan is monitored appropriately and effectively. Our members have told us of instances where non-clinical managers have had inappropriate input into clinical decision making. Members in Queensland have told us how a non-clinical nursing home manager had repeatedly given directions of a clinical nature including advice about staff calling ambulance services, medications administration, and catheter care. These are all high risk and potentially harmful contexts where residents could be harmed or even die. Here, the non-clinical manager was the 'on-call' staff member that staff were required to speak to prior to being able to contact a manager with clinical expertise and qualifications. Other members have alerted us to an instance where one nursing home in Queensland required enrolled nurse staff to report to a manger with no clinical expertise or background who had the responsibility to make clinical and health service delivery decisions and oversee enrolled nurses. Another example from New South Wales members relates to a nursing home manager making decisions regarding the provision of clinical supplies including personal protective equipment based on budget considerations rather than clinical needs or the safety of residents and staff. Further, at some nursing home

sites, members in New South Wales have told us that managers have proposed trialling the use of non-direct care kitchen staff to provide feeding assistance to residents. This raises the risk of serious safety concerns where residents are put in danger of choking, aspiration of food, and other harms. From a policy perspective, there must be clear and consistent signalling from the Government, Department and the Aged Care Quality and Safety Commission that this is not appropriate.

Care Minutes

12. While it is understood that this service list does not explicitly relate to the issue of mandated direct care minutes provided to nursing home residents, it is important to recognise that what is included in the service list items will clearly have direct influence on the delivery of care and that the allocation of care responsibility to staff will be impacted. Here, it is critical that residents receive a sufficient amount of care from a suitably qualified and skilled workforce including registered nurses, enrolled nurses, assistants in nursing, and personal care workers and that sufficient direct care time as well as personal care time is allocated to support the best possible experiences and health outcomes. To ensure clarity and consistency with providers' responsibility to adherence to legislated direct care time requirements including the need to have that at least one registered nurse is present at every shift, the service list should clearly specify the mandated direct care time requirements including what aspects/activities of care are eligible for inclusion in direct care time.

Nurse practitioners

13. Nurse practitioners deliver safe, high-quality care and are a widely underutilised group of advanced healthcare professionals in Australian aged care.[8] The service list should include reference to nurse practitioners to provide clarity that nurse practitioners are to be included amongst the health practitioner services that must be made available to residents (e.g., see Item 2.7 on page 32). Here, the item should be renamed 'General access to health practitioner services' rather than 'General access to medical services' to expand the definition of the item to include a wider range of healthcare professionals working to their scope of practice. This will also help address issues of access where services can be delivered

by nurse practitioners particularly in areas where access to medical and general practitioners might be challenging.

Residential clinical care

14. The discussion paper specifies nursing as an Item under the service list. Here, all assistants in nursing or personal care workers must always work under the direction and supervision of a registered nurse and only provide aspects of nursing care at the delegation of the registered nurse. At Item 4(c), it states that "all other nursing services carried out by a registered nurse, enrolled nurse or other appropriate health professional". This statement needs to be adjusted and '*or other appropriate health professional*' be deleted. The delivery of nursing services can only be delivered or supervised and delegated by nurses.

Emergency assistance

15. Further detail is needed in terms of the requirements and expectations for administrative activities and additional details are also necessary in terms of explicit information around what constitutes and emergency. This will be necessary to ensure clarity regarding who a 'suitably skilled employee' could be. On page 13, 'Operational administration and emergency assistance' is listed as a service type for Residential everyday living where at "all times, having at least one suitably skilled employee of the registered provider onsite able to take action in an emergency" is stipulated. It remains unspecified what 'suitably skilled employee' means, however, as registered health professionals, registered nurses are well-placed to act in this role as first responders. While every nursing home is required by law to have at least one registered nurse on site and on duty 24/7, for many facilities (particularly those with multi-story layouts, multiple buildings, or larger homes with many beds), one registered nurse would not be sufficient to be able to act in an emergency. Here, the type of employee(s) this service should be delivered by must be clearly defined and the requirement must be increased to ensure that enough qualified staff are onsite and able to act. The service list should also be clarified in terms of including clear requirements around Workplace Health and Safety Representatives and Workplace Delegates who are needed to respond to workplace health and safety issues that involve clients, staff, and site visitors.

Meals and refreshments

16. The wording on page 16-17 regarding meals and refreshments is somewhat vague and subjective in terms of specifying what is meant by ‘quality’ and ‘quantity’. Based both on the extensive evidence of aged care providers serving nutritionally deficient, poor-quality foods and unplanned weight loss among older people in aged care (as recognised by the Royal Commission and Government), as well as the vast array of individual differences and preferences around food and eating, these terms should be more clearly specified to provide stakeholders with a clear benchmark in terms of what level of quality and quantity must be achieved.

17. The way that different dietary requirements and preferences are detailed is also problematic. It is unclear what the rationale is for separating individuals’ medical, cultural, or religious needs in terms of food from what is described as an ‘individual’s social preferences on food sources’. The current language could be interpreted as creating an artificial hierarchy or distinction between peoples’ choices to avoid certain food sources. For example, while some cultures and faiths encourage a vegetarian or vegan diet, for many people the decision to eat vegan or vegetarian food sources might better be described as an ‘individual’s social preference’. Here, it is important that the service list does not create confusion and potential issues due to some people’s dietary preferences and requirements being considered more important or valid than others, as currently it would appear that a person’s decision to avoid genetically modified food – which they might have done throughout their lives before entering residential aged care - would be considered unreasonable while a person’s decision to adhere to a vegan diet would be considered incorporated within the wording of the rules and therefore reasonable.

Medication management

18. The ANMF strongly opposes the legitimisation of medication administration by unregulated workers due to safety concerns. Medication management must not provide for the administration of medications by workers who are not registered nurses or enrolled nurses. The wording currently implies that these activities are only undertaken under the delegation

and clinical supervision of a registered nurse or other appropriate health professional. The administration of prescribed medication in certain circumstances by persons other than a nurse in New South Wales is illegal. Despite this, members from New South Wales have told us of instances where nursing home managers have pressured unqualified trainees and staff to administer medications to residents resulting in medication mismanagement. Such occurrences have been reported to the Aged Care Quality and Safety Commission. We believe it is not the intent of this legislation that it should sanction any activity that is illegal in other contexts. On page 40-41 the Item Medication management part (b) should be re-worded to state: 'administration and monitoring the effects of medication (via all routes (including injections)), including supervision and physical assistance with taking both prescription and over-the-counter medication by a registered nurse and enrolled nurses under the supervision and delegation of a registered nurse. By increasing the direct care time provided by nurses and ensuring a sufficient number of registered and enrolled nurses in nursing homes, medications can and must be safely managed and administered by nurses rather than unregulated care workers.

Bedroom and bathroom furnishing

19. The ANMF suggests incorporating the phrase 'assessed care needs' into sections 6(a) and (b) concerning adjustable beds, equipment, and technologies. Older people often require additional support specific to their individual health care needs. These additional words will ensure the service list adequately addresses the unique and specific support needs of older individuals.

Motorised wheelchairs

20. The ANMF supports providing residents with access to motorised wheelchairs but emphasises the importance of addressing work health and safety considerations. Ensuring the safety of the workforce, residents, and family members is essential. This should include comprehensive

training and clear guidelines on liability concerns.

Dementia and cognitive management:

21. The ANMF supports all elements of multidisciplinary team care and identify that both nurses and care workers work closely with their multidisciplinary colleagues. However, both nurses and care workers also care for older people with dementia and cognitive impairment. Further, registered nurses undertake comprehensive assessment and develop behaviour support plans and programs to support older people. This needs to be reflected within the service list. The ANMF also re-enforce the importance of dementia care being provided by suitably trained and qualified staff.

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