20 April 2011

Submission for the Productivity Commission

Post draft report submission

We are submitting this advice as two registered nurses with collective nursing experience in emergency nursing and cancer care, management experience as a Nursing Unit Manager in a large metropolitan teaching hospital, and research experience in the area of dementia, palliative care, and hospital systems/governance. We are currently nurse academics (one still practicing clinically once a week), with membership of several national nursing organisations.

Executive summary

Individuals do not generally choose to enter residential aged care facilities (RACF); this is in response to limited ability to self-care due to the effects of chronic illness. The presence of chronic illness in high care has been silenced in the Productivity Report and this submission aims to increase awareness of the value of clinical care in high care residential facilities. In this submission, we want to emphasise two key points:

1. The 'Aged Care and Support – Building Blocks approach' (Figure 3, pXXIX) ***must include clinical care*** as a complete level, between specialised care and personal care, in order to address the systemic issues associated with preventable hospital admissions for acute management of complications of chronic conditions; and

2. There are opportunities to ***promote the engagement of residential care facilities and universities*** for development of a sustainable workforce.

We offer some examples to highlight issues raised by these points and some potential solutions.

1. The value of clinical care.

People in RACF are living in their home. While we recognise that their homes should have a focus on wellness and quality of life, it also needs to be acknowledged that residents of high care facilities, formerly known as nursing homes, are likely to be living in these facilities due to difficulty managing the symptoms of multiple diseases in their private home. Multiple diseases, or co-morbidities, require significant clinical care including symptom monitoring through assessment, administration and evaluation of treatment, and changes in treatment as various chronic diseases progress or new acute diseases such as gastroenteritis are acquired.

In Australia and other industrialised countries, clinical care is the domain of regulated nursing:

Enrolled Nurses monitor the symptoms of the disease to determine health and report changes to the registered nurse and deliver routine medical treatments under the supervision of the registered nurse;

Registered nurses evaluate treatments and can determine the need for medical consultation or other allied health service, deliver complex medical treatments, and determine the need for specialised care.

Cellulitis project (Sutherland hospital). Wound care nurse specialist (CNS), provides RACF with support and equipment to diagnose and treat cellulitis within RACF. Intravenous antibiotics and equipment taken from hospital to RACF.

Dementia Cafes (Concord Hospital). Offers a place for consumers and health clinicians to engage informally, discuss service availability, respite options, prognosis, management strategies, debrief. Led by a Dementia CNC.

Clinical nurse specialists or consultants (CNC, CNS) offer specialist skills and knowledge in a particular health focus; eg aged care, dementia care, wound care, ostomy care, continence care, palliative care. Traditionally, clinical nurse specialists are focused within an area health service and may be available as consultants to residential care teams. (See examples in orange boxes of CNC/CNS led initiatives)

Nurse Practitioners (NP) provide education and leadership regarding health program development and complex care management, perform diagnostic tests, differential diagnosis, and prescribe medications and treatments within their area of specialty. Nurse practitioners are also skilled at working across discipline, institutional and specialist knowledge boundaries, and as such are able to play a role in preventing hospitalization. (See examples in blue boxes of NP led initiatives).

DEMOS – Dementia Outreach Service, in Queensland. Outreach service provided by NP specialising in dementia. Particular focus on BPSD. Train and model suggestions for practice in interventions. Service ensures that recommendations made by the team at the initial assessment are implemented. Borbasi, 2009

Because clinical care is silent in current models of residential aged care, and continues to be silent in the proposed model, the role of the registered and enrolled nurse has been limited to managing other unregulated workers and delivering medical treatments. There is emerging evidence regarding the value of clinical care provided by nurses, in acute settings (Duffield et al 2007). While this evidence is yet to be consistently transferred to the residential sector (Nakrem 2009), there is evidence that the presence of clinically-focused registered nurses improves health outcomes by reducing complications (Needleman et al 2002, Johnstone et al 2006). Expert clinical assessment and treatment from aged care nurse practitioners can potentially reduce expensive complications that would otherwise require transfer to hospital (ACT Health, 2007). Approximately 25% of RACF residents visit hospital each year (AIHW 2010). These figures do not include presentations to the Emergency Department if they are returned to the RACF within 24 hours (which is not uncommon). Many of these hospital visits are potentially preventable.

RADAR: Rapid Assessment of the Deteriorating patient Aged at Risk. (ACT) **A** team of Nurse Practitioners, geriatricians, access to allied health, see patients in the community (their homes or RACF) to provide timely assessment and treatment of conditions that don't (yet) warrant hospitalization.

By emphasising clinical care, resources for registered nurses working in a clinical, rather than management, capacity can be legitimate. Examples of conditions that clinical RNs, supported by Nurse Practitioners, could manage without admission to hospital include:

- Infections such as cellulitis, upper respiratory tract, urinary tract, wound;

- Falls for investigation (for injury assessment, and also to identify cause or contributing factors)
- Dehydration;
- Gastroenteritis;
- Pain management;
- Palliative care;
- Delirium; and
- Behavioural and psychological symptoms of dementia (BPSD).

ASET Aged care Services Emergency Team. (NSW)
A team, usually led by a CNS, identified aged patients with unmet needs presenting to emergency departments. In many instances, this role has evolved to extend support and leadership into RACF – because prevention is better than presentation to Emergency.

'Geriatric Rapid Acute Care Evaluation (GRACE) Model of Care' (Hornsby)
GRACE provides an outreach service and a system of prioritised hospital treatment to improve the 'patient journey' for residents of RACFs. Works collaboratively with residential aged care facilities and GPs to achieve our outcomes. Works closely with the ASET team**,** who take responsibility for providing a similar service for hostel patients.
http://www.archi.net.au/e-library/moc/older-moc/grace

Shared Nurse Practitioners: Some RACF have developments under way to collaborate and share the cost of a NP between 3 organisations within the one jurisdiction. Job satisfaction and equivalent renumeration to the public sector is an important part of recruitment considerations.

The nurse practitioner role is essential to support the increasingly complex clinical requirements of people living in high care facilities, particularly when there is limited access to a general practitioner. NPs are best used in the provision of clinical evaluation of residents in the early stages of acute illness; thus reducing the impact of the illness on the resident. (See examples in the blue boxes. The examples in the orange boxes also apply; but keep in mind that many of the deliverables (eg CNC delivery of antibiotics) will be relying on 'standing orders' from a medical officer, or other 'outside the box' strategies). The examples provided demonstrate services that do not just provide a single clinical intervention (eg suprapubic catheter replacement) but a offer a hub for conferral of decision making, seeking advice, referrals, discussion, service linkage, and community development.

Summary

The proposed framework is not rich enough to meet the needs of residents. Currently the needs are being met by creative responses and innovations responding to identified local needs. A lot of this work is negotiated across services and clinical disciplines, filling gaps in the system. Information and support is provided to aid RACFs to be more self sufficient; thus making it a sustainable and context-sensitive approach. Our proposed clinical level supports these innovations.

Inclusion of other health professional services (such as physiotherapy, pharmacy, nutrition) as an essential element to address symptom management for residents living with chronic illness needs and wage parity for nurses in the residential aged care sector must be urgently addressed. This can be facilitated with clear recognition of the importance of clinicians and clinical care within the national framework.

2. Mutual engagement of residential care facilities and universities to develop a sustainable workforce.

It is evident from the Productivity Report that the requirement for primary health services for older Australians will be increasingly important. Training health professionals in the aged care sector can provide opportunities for students to learn about the effects of chronic disease and ageing as well as develop skills in assessment, therapy delivery and evaluation of care. To date, the invisibility of clinical care has hindered university engagement with within the aged care sector for student training.

Further to clinical care, there is a need for a broad framework that encourages continued learning in the day-to-day business of residential aged care services. Opportunities for transboundary or outreach models of nurse practitioners should be considered in order to reduce avoidable hospital transfers (see blue boxes). Incentives for facilities, as well as for aged care nurse practitioners, to engage and develop initiatives to meet their local needs will be imperative for these to be successful. Partnerships with universities can provide an avenue for continued development and service improvement through education and research. This kind of relationship between sectors offers opportunities for social and intellectual inclusion for residents through participation in seminar series, educational programs and social activities.

RIC (Referral and Information Centre) (Concord Hospital)
8am – 10pm 7 Days Phone service. Triage/support service for anyone. Mostly accessed by public in community, and nurses at RACF. A single phone call to open door to other areas – clinical advice and support, outreach services, ambulatory care appointments, facilitate transfer to hospital, organise direct admission. Can activate CNC, Geriatrician, community nurses, allied health for support services.

References:

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To improve implementation of aged care NPs offer:

- wage parity with acute sector;
- ample educational and mentoring opportunities (equivalent to the acute sector);
- job variation and satisfaction;
- recurrent funding for permanent positions (not just trials/pilots);
- collegial and service collasboration from multidisciplinary colleagues;
- reduction of red tape/confusion for NP Practice Guidelines;
- reduction of limitations to PBS access regarding the cross over between employment by the public health sector but delivery of health care outside of the public health institution
- support with sufficient staffing levels, education and resources for a functional team of RNs, ENs and AINs in RACF