The New South Wales College of Nursing

ACN 000 106 829

Submission to the Productivity Commission

Inquiry into Nursing Home Subsidies

(In response to the Position Paper, October 1998)

Friday 27 November 1998

Tamworth

Representing The New South Wales College of Nursing:
Ms Julienne Onley, RN, Cert Gerontological Nursing, MSc (Mental Health), FCN (NSW)
Manager, Professional Services and Policy

On behalf of the Executive Director of The New South Wales College of Nursing, Professor Judy Lumby, I would like to thank the Commission for the opportunity to respond to the Position Paper here today.

The Commission will have already read the detailed submission made by the New South Wales College of Nursing (the College) in conjunction with the New South Wales Nurses' Association, prior to its preparation and dissemination of the Position Paper on Nursing Home Subsidies which is the subject of discussion here today. Therefore I do not intend repeating the details of that submission, but will elaborate on the reasons that professional, qualified nurses are vital to optimal outcomes for those older members of the Australian community who are in need of residential care. Before doing so, I would like to indicate to the Commission the substance and credibility of the College as a participant in proceedings such as these.

The organisation

The New South Wales College of Nursing is a national professional nursing organisation established in 1949 to promote nursing and facilitate the ongoing development of the nursing profession. The College is the largest, longest established and most innovative provider of quality speciality skill development and post graduate nursing education in Australia. It is a professional organisation providing education and professional services nationally for around 6,000 nurses each year. The mission of the College is to facilitate the education and professional development of nurses, influence the process of policy development and improve the health care of the community. Through its membership the College has continuous contact with nurses working in clinical areas, management, education, research and academic fields.

The College's values incorporate the following areas: nursing orientation; membership; collegiality; enthusiasm; authority and accountability; quality and customer focus; economic management; commitment; encouragement and recognition; and, environmental awareness. The College liases strongly with other education providers, professional organisations, industry

bodies, consumer groups, public and private health care establishments and government departments, local, state and federal. These relationships, established over a number of years, ensure that the College's activities remain current, diverse and relevant to their needs.

The College's involvement in activities relevant to the aged care sector is well recognised. These activities include: professional liaison with peak industry bodies, professional organisations, consumer groups, special interest groups and aged care facilities., active participation in conferences and seminars; representation on working parties and committees at federal, state and local levels; consultation on policy development, implementation and evaluation with government and industry; and, development and provision of education programs in a range of settings and delivery modes.

I am representing the College, whose credibility is well established, today. As well as representing this professional organisation, I also have considerable experience in aged care and the health sector. I have a strong background in education, clinical nursing and management in aged care, having worked in the field since 1973. Throughout my professional career I have been an educator, a proprietor, a Director of Nursing and a clinician in aged care facilities in the private sector. I also am involved with Geriaction, which organisation is also represented here today, through my positions on both the NSW and National Executives. I have, with the support of the College, undertaken the education program necessary to become an aged care quality assessor, and have been appointed as a member of the Aged Care Industry Panel for the Quality Society of Australasia Register of Certified Auditors, the body responsible for the certification of those assessors. I share, in common with the College and Geriaction, an ongoing commitment to maintaining a professional nursing presence in aged care. My current position at the College is Manager, Professional Services and Policy. I believe my experience and professional involvement in aged care will, in a very practical sense, contribute to your deliberations and discussion.

The issues

The College's main objective in this proceeding is the provision of safe care for residents in aged care facilities. The College is firmly of the view that residents, whether their needs are deemed high level or low level, deserve and require the provision of care by suitably qualified persons. The assessment in partnership with the residents and their significant others by which their level of care needs is established, must remain the realm of nurses. Any strategies which remove qualified (registered and enrolled) nurses from aged care and replace them with lesser educated and skilled carers will have dire outcomes for residents and will be firmly opposed by this College. The Commission will have also heard supporting views from representatives of the medical profession and consumers.

The skills mix and qualifications of formal carers cannot be determined by market forces; they cannot be determined by the accreditation process; they cannot be determined by financial constraints. There is only one criterion for determining staff experience, qualifications and skills.

That criterion is the level of dependency of the care recipients, in whatever setting they happen to be.

In the context of residential aged care, there are four major issues which potentially adversely affect older people. These issues, which must be taken into consideration in any deliberation of staffing mix, are: multi-systems disorders; earlier hospital discharge; high levels of acuity and associated care needs; and, responses to relocation within and to residential aged care facilities.

Multi-systems disorders

Commensurate with the increasing population of aged persons in Australia, the advances in technology and the greater awareness of adapting lifestyle to enable longevity, there are now and will be in the immediate future significant numbers of older people with multi-systems disorders. The nature of these disorders often leads to disabilities, which in turn exacerbate frailty, both physical and mental. The result is that many older persons need extensive, skilled support. An additional burden faced by a great deal of older people, especially those living beyond 85 years, is the onset of a dementing disorder, often Alzheimer's disease. The nature of dementia's progress on its own leads to the need for specialised care and support. When it is concomitant with multiple problems, all too common in older age, for example osteoarthritis, osteoporosis, cardiac disease, chronic airways disease, strokes, neurological disorders such as Parkinson's disease, renal disease, liver failure and cancer, the resultant acuity requires even more highly skilled nursing.

Earlier hospital discharge

A predominant fear is that, in the current health care system, older people are being discharged quicker and sicker. Many working in the Australian health care system are still undecided on this issue, but data do exist which indicate that some hospitals are redefining what is an appropriate functional or health status level for discharge and hence transferring responsibility for care from the hospital to community-based organisations and families. Several factors contribute to decreasing length of stay: improved anaesthetics; changes in hospital practice such as pre-admission work-ups; and, redefining when patients are ready for discharge. It is the last reason, often financially driven, which concerns aged care providers in wider setting's outside of hospitals: families and other informal carers at home; workers in community based services; and, residential aged care facility staff. Older people with significant care needs at the time of a relatively early discharge require these needs to be met outside the hospital setting. A large burden is then placed on all those service providers and, especially, for the purposes of this submission, residential aged care facilities.

In the case of residential aged care facilities, the perception of the acute hospital that Registered Nurses working within those facilities are more than capable of providing care for an acutely Ill person, discharged early, is usually right. But only if they are indeed there, which is often not the case in hostels. Certainly, appropriately qualified nurses are only present if they have sufficient resources (which of course means sufficient funding) to provide the high level of care required.

Discharge one or two days post surgical hip replacement or repair of a fractured neck of femur is not uncommon. This in itself demands a high level of skill and resources, but combined with the existence of the aforementioned concomitant disorders, with or without dementia, the required level of skills and resources, human, technological and other, rises markedly.

A further temptation to relieve acute care sector hospitals of the 'burden' of older patients is to avoid admitting them at all. There has been some recent publicity about the rationing of surgical procedures on a chronological basis. It would be naive to assume that this practice does not exist and its extension would be that some older people are left with high levels of care needs. Cost saving strategies in health care do not necessarily correlate with a humane approach towards older people and there is no doubt at all that-the health care dollar is uniformly 'tight' across this country.

Common themes emerge in the literature about the effects of early hospital discharge: a greater acuity level in older patients; a need for more skilled staff hours to service the greater needs of those acutely ill patients; more deficits in patients' activities of daily living; more nursing assistant time required; more rehabilitative services needed; and, an increase in the number of nursing home deaths and the amount of palliative care provided. Older people thus are at risk of re-hospitalisation, may need increased numbers of acute or emergency care visits by health professionals, or will be too sick for families to care for, requiring care more complex than most families can provide.

The last observation, about the need for care more complex that most families can provide., is one worthy of further consideration. It is often stated, especially by older health care consumers themselves, that they do not choose to move into residential care. The necessity to move comes from increasing frailty or illness, disability and the inability to cope with the resources available to them and their families at home. In short, they need support, skilled care and a high level of resources. When they move to nursing homes, they expect, indeed demand (as is their right, dictated by their needs) a high level of care commensurate with their acuity, provided by speciality educated Registered Nurses who are assisted by appropriately trained, supported and supervised nursing, ancillary, allied health and care staff.

High levels of acuity and associated care needs

A study conducted in a major Victorian teaching hospital and reported in the literature in I996 revealed that 30% of patients who were transferred to long term care facilities died within four days. Older age was reported as a significant factor in death after discharge, whether to lone, term care facilities or elsewhere. Of the 60 to 69 year age group, 21.6% died within 28 days of discharge, in the 70 to 79 year age group the percentage was 31.3%, and in the 80 plus group, 29.9%. The closest figure in all other age groups was a much lower 10.4% in those aged 50 to 59 years. Of those transferred to long term care facilities, 15.4% of deaths occurred within two days, 24% within three and 29.7% within four days. The timeliness of transfer may have been

a factor in the higher rates of death within a shorter period of time for those transferred to long term care, as those transferred may have been extremely ill and less 'salvageable' than patients who were transferred to other acute treatment centres, or they may not have been expected to recover anyway. Consistently, literature indicates the need for a high level of nursing care, including palliative care skills, in long term care facilities which receive patients transferred from the acute care sector.

The Commission has heard from other contributors to their deliberations that the average length of stay in a nursing home is approximately eight months and reducing and that palliative care is increasingly being delivered in those facilities.

If residential aged care facilities are able to employ suitably educated Registered Nurses and provide the equipment and other resources necessary, the transition from acute care hospitals to those facilities will be better managed, continuity of care will be provided, acute illness will be managed and palliative care will be delivered in surroundings which are familiar to residents and more accessible to families, and re-admissions to acute hospitals will be lessened. Advanced nursing practice by specialist nurses would be able to monitor acute and chronic illnesses, decrease rates of hospitalisation and provide the educational expertise necessary in aged care facilities to improve nursing assessment and care planning and delivery skills of staff in those facilities.

Responses to relocation to aged care facilities

Many older residents in aged care facilities are not admitted directly from or via an acute care hospital. The effect of relocation on them is not dissimilar to those effects outlined above, although an acute illness may not be present or they may not be in the aftermath of major trauma such as stroke or surgery. Nonetheless they will be suffering from a chronic disease state (or more likely several), physical frailty, perhaps the cognitive impairment resulting from dementia, or a combination of those factors. Therefore they will have needs which cannot be met by under-trained and unsupported staff. The effects of relocation in older people, as with all life changes, is a transition which combines losses and opportunities. Enhancement of the factors which promote successful adaptation and minimise personal loss is a necessary imperative in the nursing care of older people relocating to an aged care facility. These residents face the losses of youth, health, productivity and independence. Helping them to manage these losses, cope with the physical and symbolic transitions and provide care for their mental and/or physical frailty and chronic illnesses are not tasks for untrained carers. On the contrary, these are the types of skills embodied in speciality prepared gerontic nurse practitioners - that is Registered Nurses with advanced post registration qualifications in aged care.

A relocation stress syndrome, defined as physiological and/or psychological disturbances resulting from transfer from one environment to another, has been described in the literature. The major characteristics of the syndrome are anxiety, apprehension, increased confusion in older people, depression and loneliness. Contributing and related factors are perceived losses

of support systems, of familiar environments and of health status. Nurses are crucial to the well being of older residents by being trained and able to recognise if certain behaviours are stemming from the psychological responses to moving to an aged care facility. Inadequately educated staff, or insufficient staff, may result in residents being medicated in an attempt to ‚control behaviours', especially if they suffer from dementia. Admission to a long term care facility, considering the loss of choice involved, is a stressful event, which may well result in a relocation stress syndrome. For such a syndrome to be recognised and the effects minimised with appropriate interventions, highly skilled professional nursing staff would be required, working with a multidisciplinary team. This would not be feasible in under-resourced environments.

Conclusion

By highlighting and expanding on the issues of the multi-systems disorders in older persons, the effects of early hospital discharge, resultant high levels of acuity and associated care needs, and responses of older people to relocation to aged care settings, I hope I have raised the awareness of the Commission to the absolute necessity of maintaining a professional nursing presence in aged care facilities.

There is every evidence that our nursing homes are actually acute medical units but are staffed at 50% of equivalent units in the acute hospital sector.

Unless Registered Nurses with appropriate post registration qualifications are employed in such facilities, the residents, who are members of an already vulnerable group, will be not only more vulnerable, but will be at risk. The literature shows that they will be increasingly liable to be admitted to hospitals. This will result in an exacerbation of their illness resulting in higher levels of acute confusion and increasing the incidence of translocation syndrome. There is every evidence from both the literature and practice that professional nursing care is essential to ensure the provision of pain and symptom management; administration, review and evaluation of complicated medication regimens; palliative care; rehabilitation; and, nursing management of highly complex multi-systems disorders.

I have brought with me a copy of a discussion paper, fully referenced, prepared and disseminated widely to the aged care industry by the College which details these facts I have spoken about this morning. I would be very happy to leave it with the Commission as reference material.

Thank you for your time and attention; the College wishes you well with your task.