Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge

NSW AGED CARE ROUNDTABLE 2019

NSW Nurses & Midwives' Association

MCCI Multicultural Communities Council of Illawarra

CSGPN Central Sydney GP Network Ltd

asmof The Doctors' Union

Seniors Rights Service

Country Women's Association N.S.W.

Australian & New Zealand Society for Geriatric Medicine NSW Division

Palliative Aged Care Network NSW

QACAG Quality Aged Care Action Group Incorporated

CPSA Combined Pensioners & Superannuants Association

NSW Aged Care Roundtable

The NSW Aged Care Roundtable consists of medical, clinical and consumer advocacy organisations. The Roundtable works collaboratively to further consumer rights and enhance quality in aged care. The diversity of organisations represented provides opportunity to undertake projects from the perspective of consumers, frontline workers and advocates. Collaborations are purposeful and have included a highly successful series of consumer facing leaflets based on *10 Questions to Ask when seeking Residential Aged Care* **www.10questions.org.au**

Engagement in projects is optional for members and supporters. This report has been co-produced by 11 of the member organisations.

We would like to thank the members of those respective organisations and care consumers for their valuable contributions and insights in developing this report.

Members and supporters of the NSW Aged Care Roundtable who contributed to this report

Australian Salaried Medical Officers' Federation (ASMOF)

Australia and New Zealand Society for Geriatric Medicine NSW Division

Central Sydney GP Network

Combined Pensioners and Superannuants Association

Country Women's Association NSW

Multicultural Communities of the Illawarra/Partners in Culturally Appropriate Care NSW/ACT

NSW Nurses and Midwives' Association

Palliative Aged Care Network NSW

Professor Dimity Pond, PhD, BA, MBBS, FRACGP

Quality Aged Care Action Group Inc.

Senior Rights Service

Executive summary

In 2018-19, 11 NSW Aged Care Roundtable members consulted with their own members and supporters on the issue of **avoidable hospitalisations** and **delayed hospital discharges** relating to residential aged care facilities (RACF). This was prompted through recognition of a lack of national data and reporting systems to inform this area, and the need to enhance safety and quality in residential aged care. This report presents the findings and offers a number of broad recommendations based on the experiences of frontline workers including hospital, community and RACF based medical, clinical and nursing professionals. It also explores the issue from a consumer perspective.

Avoidable hospitalisations of RACF residents occur as a result of systemic or incidental inability to provide the level and quality of personal and clinical care that might be reasonably expected to be available in a RACF compliant with residential aged care regulation.

Delayed discharges can occur as a result of the inability of a RACF to provide the level and quality of care required by residents fit to return from hospital.

Reasons for avoidable admissions and delayed discharges

The findings of our organisations consistently identify that avoidable hospitalisations from RACF frequently occur. Hospital and community based **medical professionals** cite falls, palliative care, behaviour management of people living with dementia, catheterisation and pain management as the main reasons why people are transferred to hospital. Other causes of avoidable hospitalisations are a requirement for simple wound care, medication errors and pain relief. Lack of both GP availability and registered nurses at the RACF are perceived as the main causes for avoidable hospitalisation. In addition, care staff lack knowledge on how to safely manage people's care in the RACF.

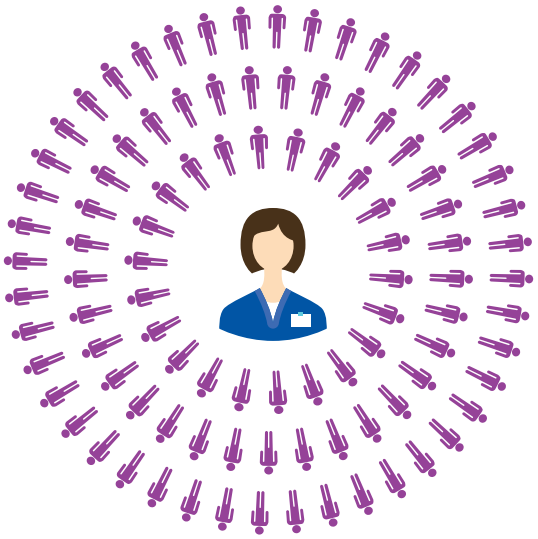
The report identifies that residents or their representatives often request avoidable transfers to hospital. Surveys conducted by consumer organisations confirm that **residents and their representatives** have low confidence in the ability of RACF to provide care and treatment when residents' health deteriorates. Consumer surveys confirm the judgment of medical professionals that low availability of registered nurses and numbers of aged care workers, and lack of GPs lead to delays in hospital discharges of RACF residents.

GPs confirmed that access to their service in RACF is currently poor and set to get worse in the future. GPs cite poor remuneration and lack of qualified RACF staff to liaise with as the main causes of this availability crisis.

The survey of **RACF staff** confirms the perception among other professionals and consumers that staffing levels in RACF are dramatically inadequate both in terms of overall numbers as well as qualifications. More than half of respondents employed in RACF said that they worked in facilities where there was one registered nurse for 50 residents, in some cases one registered nurse for more than 150 residents per shift.

Responses by RACF staff also confirmed the opinions of hospital staff and consumers as to the causes of avoidable hospital presentations of RACF residents.

There was evidence to suggest that avoidable delays in discharges back to RACF are also prevalent, with duration ranging from several hours to several weeks. Whilst lack of transport was a major factor, many frontline workers attributed delays to the absence of a registered nurse at the RACF and lack of knowledge and skills of RACF staff generally.



More than half of RACF staff said they worked in facilities where there was

1 RN : 50 residents

Actions to reduce avoidable hospital presentations of nursing home residents

There was consensus among medical, clinical, nursing and consumer groups about what needed to be done to reduce the incidence of avoidable hospitalisations from RACF:

1. Staffing levels and the qualifications and training of RACF staff need to be improved. Without an adequate presence of numbers and clinical care skills a RACF cannot:
   - provide the care that keeps residents out of hospitals;
   - interface with external health professionals.
2. Access to specialist nursing services and other health professionals need to be improved through the provision of geriatric outreach services and employment of additional specialist nurse practitioners in RACF.
3. Medication management needs improvement to eliminate an important and direct cause of avoidable hospital admissions.
4. There needs to be national clinical care benchmarking for residential aged care to reduce avoidable hospital presentations.
5. Clinical care benchmarking needs to be supported by the national collection of data on hospital admission and discharges of RACF residents.
6. RACF should be considered healthcare providers and better integrated within primary care services.
7. Cultural competency should be part of an ongoing development plan across all staffing levels within RACF.

RECOMMENDATIONS

1. **Staffing levels, skills mix and training** of RACF staff should be improved

2. **Access to specialist nursing services** and other health professionals should be improved through the provision of geriatric outreach services and employment of additional specialist nurse practitioners in RACF.

3. **Medication management** should be improved to eliminate an important and direct cause of avoidable hospital admissions.

4. There should be **national clinical care benchmarking** for residential aged care to reduce avoidable hospital presentations.

5. Clinical care benchmarking should be supported by the **national collection of data on hospital admission and discharges** of RACF residents.

6. RACF should be **considered healthcare providers** and better integrated within primary care services.

7. **Compulsory cultural competency training programs** for RACF workforce to develop inter-cultural capabilities to enable them to interact effectively with older people from culturally and linguistically diverse backgrounds.

8. Incorporate cultural competency units into **programs at TAFE and universities** for health professionals.

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Public health implications of delayed discharges and avoidable ED presentations

CHAPTER 1

Australian Salaried Medical Officers' Federation (ASMOF)

ASMOF (NSW) is a strong and democratic union which represents the interests of medical practitioners, from Interns to Senior Staff Specialists, working in the public and non-government health systems in NSW.

Our strength lies in our members' dedication and commitment to the provision and development of quality health services, and our role in defending and promoting members' professional and employment rights.

In 2019 we surveyed our members on the issue of avoidable hospital presentations and delayed discharges specifically related to residential aged care. We received 88 responses, 70% came from members working in emergency medicine who are often the first to see people presenting at hospital from residential aged care. Just over 11% worked in geriatric medicine. 87% were employed in metro areas and 13% in rural areas.

Just over half (54%) reported witnessing potentially avoidable hospitalisations from aged care facilities on a daily basis, and a further 27% on a weekly basis. Of those who responded, none had never experienced a potentially avoidable hospitalisation.

The most common potentially avoidable hospital presentation was due to falls, with 74% of members having witnessed this. 73% had experienced people being hospitalised for palliative care, 70% for behaviour management and 62% for catheterisation or re-catheterisation. Other hospitalisations included treatment for simple wound care, pain relief and in some cases, elder abuse.

54%+ witnessed potentially avoidable hospitalisations from aged care facilities **on a daily basis**, and **a further 27% on a weekly basis**

Causal factors were identified as lack of GP availability, lack of registered nurses, lack of knowledge and skills of staff employed in aged care facilities and lack of advanced care directives. 44% stated that insufficient staffing was a factor and 35% registered nurse workload. GP and family referral to hospital also featured highly, which might reflect lack of confidence in the aged care facility to manage the symptoms in-house, for the aforementioned reasons.

92% had experienced a delay in discharging a person back to a residential aged care facility. The length of delay was cited as between several hours to several weeks.

> Most commonly it would be 1/2 day as unable to take patient after hours. Sometimes weekend (2 days) due to lack of staff/protocol refusing to take patients. I could not tell you how many occasions in the last 15 years of practice, but very often.

> Varies, most common scenario is 3 day delays for facilities not accepting residents on Fridays (i.e. delayed to following Monday).

> I have experienced many ED delays, often overnight due no RN in the facility. Ward delays can be many days due to lack of approvals, inability of the facility to provide services or support, or patient refusing to go to any available facility.

92%
had experienced a delay in discharging a person back to a residential aged care facility

Transport was the highest rated reason for delayed discharge (66%). However, 46% stated that refusal by a relative to have the person returned to a facility and insufficient staffing levels at the facility were causal factors. 43% attributed the delay to the absence of a registered nurse at the facility and 31% to lack of staff knowledge at the facility.

66% perceived collecting data on hospital presentations and delayed discharge to and from residential aged care facilities might help. However, other approaches that were viewed as beneficial included: the provision of additional geriatric outreach services; more specialist nursing services both in-house and community based; mandated minimum training competencies for care workers; national clinical benchmarking in the sector; greater incentives for GPs to attend facilities; greater clinical governance in facilities; greater after hours staffing and skills mix in facilities and safe ratios of registered nurses at all times. Around a third considered imposing penalties, or a 'pay back' system when avoidable hospital presentations or delayed discharges were identified might reduce cost-shifting.

“

Unnecessary transfers to ED harm patients by increasing confusion, distress and the need for sedation and restraint. Most RACF could manage patients better in their own environment with better outreach and staffing.

Coverage of RACF with RNs at all times with a reasonable ratio would be the most important factor.

These hospitalisations are very distressing for the patients as they feel scared in the ED and have painful procedures which they do not benefit from

Residential care is a medical disaster. High need isolated population with poor access to the health services needed. Many see RACF’s as a lifestyle accommodation choice. In reality residents have no choice and no power and great vulnerability. Providers need to be required to provide health care needed.

”

A small number of qualitative responses highlighted that avoidable presentations to ED was a complex area and needs a wider public health strategy to increase health literacy and self-efficacy. However, it is clear from the results that significant cost-shifting, and more importantly, unnecessary movement of a person from their home environment to hospital often at end of life, is occurring at a significant level. Whilst everyone is entitled to receive hospital care, this is not always the most appropriate place for older people and can cause further harm.

This survey suggests that much better quality care could be provided in-house in aged care facilities, supported by well-resourced outreach services.

CHAPTER 2

Perspectives on hospital avoidance from residential aged care

Australia and New Zealand Society for Geriatric Medicine (ANZSGM) NSW Division

The Australia & New Zealand Society for Geriatric Medicine is a society of medical practitioners engaged in the practice of Geriatric Medicine or related disciplines. We have over 1050 members, including consultant physicians, psychogeriatricians, academics, and more than 220 trainees in Geriatric Medicine.

Membership of the Society is open to registered medical practitioners who demonstrate a commitment to clinical practice, research, education and administration in Geriatric Medicine and allied specialties and to those undergoing training in these fields.

In 2018/19 we surveyed our members on the issue of potentially avoidable hospital presentations from residential aged care facilities (RACF) and delayed discharge to a RACF. There has been recent attention to this issue, including mentions in the current Royal Commission for Aged Care Quality and Safety. It was therefore deemed appropriate to engage our members specifically for their perspectives.

> “Often the presentation is for a dying patient that cannot be managed in RACF or in diagnosing that a patient is dying. Presentation to hospital occurs for behavioural symptoms in dementia with limited attempt to have reviews in RACF prior to transfer to hospital and refusal to have back unless admitted and behaviour modified. **#10**”

> My work is in subacute care, so most of the 'most avoidable' presentations have been filtered out before they get to us, but I would still see on average one new patient per week, whose prior acute hospital admission I would consider avoidable. **#4**

> I have seen presentations for worsening BPSD, simple UTI/ Pneumonia/Cold/Fever who were sent to hospital because a GP was unable to attend on the day. **#28**

Of the 36 responses received, 82% were from geriatricians, followed by staff specialists and other medical specialists. Almost 70% worked in an inpatient ward or unit and 14% in community settings. 88% were in metro locations, with almost 12% in rural.

38% stated they came across avoidable hospital presentations on a weekly basis, with 14% seeing this on a daily basis, and 14% on a monthly basis.

Reasons for avoidable presentations

The most common reasons for avoidable hospitalisations were identified as: behaviour management (78%); falls (62%); urinary tract infections (62%); dehydration and/or poor nutrition (53%); upper respiratory infections (50%); simple wound care (including pressure sores) (47%) and pain relief (47%).

Medication errors and urinary catheterisation/re-catherisation each had 34%, and depression or self-harm was reported in 25% of the cases. A lack of a particular medication at a facility was reported as 15% of cases. Over 9% were identified as elder abuse – including neglect and/or attack by another resident.

The most common reasons for avoidable hospitalisations

behaviour management (78%)

falls (62%)

urinary tract infections (62%)

dehydration and/or poor nutrition (53%)

upper respiratory infections (50%)

simple wound care (including pressure sores) (47%)

pain relief (47%).

Contributory factors

In order, the most likely stated factors that influenced the avoidable presentations were: GP not able/willing to attend (78%); lack of knowledge /skills of staff employed in the RACF (70%); person/ family requested transfer to hospital (67%); lack of RN available (60%); Lack of clinical supervision (52%) and lack of an *Advanced Care Directive* (48%).

55% considered that the presence of a behaviour management plan would be beneficial and 33% felt that easing workload pressures on RNs would assist. 30% of respondents stated to their knowledge it was is the policy of the RACF to transfer residents requiring clinical care to hospital for treatment.

> Some RACFs appear to have no RN on at night, or their staffing levels are such that residents with poor mobility fall and are simply sent out to acute care, clinical evidence of a fracture or not. Personal experience with aged relatives in RACF care shows that it is a default position for many staff to simply send a person out for ED assessment, even when local assessment with GP/RN alone could sort the problem out. **#4**

Delayed discharge

Over 90% had experienced delayed discharges to RACFs ranging from a day or two up to 120 days. Some identified that some RACFs refuse to accept patients back over the weekend and after hours, and mentioned that increasingly RACFs are refusing to accept the return of complex and 'difficult' patients.

The main reasons for delayed discharges were the family/person/facility refused to allow them to return (54%) or no places were available (50%).

> Delays to find a suitable nursing home. Average delay is around 30 days, one patient has been delayed for 397 days. **#22**

> Some nursing homes want to review patient prior to sending them back – some have only three days a week for admission of new patients. **#9**

> Certain facilities in our area will not accept residents back on Friday or over the weekend. **#15**

> RACF unwilling to accept complex patients. **#17**

> Usually the delay is due to decreased staff levels over weekends. **#6**

> RACFs need to be recognised and resourced as an integrated component of the health system for our frailest, most disabled and most vulnerable older people. RACFs are not an elective accommodation option for older people with other options. RACFs are a last resort. The system as a whole fails older folk who have no other option. Appalling. **#17**

27% identified that having no RN available at the RACFs prevented timely discharge from hospital, and 27% identified insufficient stafing levels in the RACF.

23% identified that staff in the RACF needed more training and 19% identified a lack of equipment at the RACF to support the discharge.

Respondents were asked to identify what measures would best reduce avoidable presentations and delayed discharges. Specialised outreach services and greater incentives for GPs to attend RACFs were strongly supported. 45% of respondents felt that collecting data on hospital presentations and delayed discharges would also help to improve quality.

In order, measures considered important were: provision of geriatric outreach services in every LHD (82%); provision of Nurse Practitioners in outreach services with specialist skills in palliative care, mental health and gerontology (81%); greater incentives for GPs to attend RACFs (79%); safe ratios of RNs at RACFs at all times (79%); better after hours staffing and skills mix (79%); safe ratios of all workers in RACFs (67%) and 54% supported national clinical benchmarking for RACFs in line with public hospitals as a quality indicator.

There was also limited support for the establishment of a 'pay back' system for public health expenses where avoidable admission/presentation and/or delayed discharges are identified (24%). Also the establishment of penalties for RACF providers where avoidable admissions/presentations and/or delayed discharge are identified (21%).

In conclusion 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 hospital admissions might be unavoidable for some, our members have offered practical solutions as to how the incidence might be reduced.

Lack of staff with specialist skills impacts this situation. We would support staffing ratios where there is evidence of improved resident outcomes.

CHAPTER 3

Primary care perspectives

Central Sydney GP Network

Central Sydney GP Network represents General Practices from the Inner West of Sydney and have over 450 members, many of whom care for patients in Residential Aged Care Facilities (RACF). Our vision is to "To support and strengthen Central Sydney General Practice."

We provide "cradle to grave" care for patients on a lifelong health journey. We witness firsthand the challenges of aging in our community. Inevitably some of our patients end up in Aged Care Facilities (RACF) when too frail to be safe in the community. This is usually a time of great upheaval and loss. Many of our patients are moved into RACF out of area due to lack of beds locally. Sadly, this will mean that access to their usual doctor can be too difficult making continuity challenging. Many good General Practitioners (GP) work in RACF but not all GPs can afford the time and cope with the low remuneration provided by the Medicare Benefits Scheme (MBS) for care of our patients with complex care needs.

"I am on call 24hrs a day for Registered Nurses (RN) in aged care facilities. I have been able to avoid inappropriate transfers to hospitals on many occasions, all for no pay at all. On one occasion I was providing palliative care to an 85yr old man with dementia who was being kept comfortable in his RACF. At 9pm one night, staff called me. The staff member was an RN who was new to the RACF and told me that the gentleman's wife wanted him to be transferred to the hospital. After a lengthy discussion it was agreed that he was comfortable, and a hospital transfer was not needed. He died peacefully later that night avoiding a potentially disruptive, unhelpful and costly hospital transfer. I do not get any remuneration for being on call. **GP, Central Sydney**"

"In the past 5 years in particular, I have seen an increasing demand for home visits from not only my patients but for new patients who ring my practice as they cannot find a GP in the surrounding area who has the capacity to either see disabled elderly patients at home or in RACFs. With this increasing demand, I have reduced my clinic time to focus on providing a half day of dedicated home visits for elderly and disabled patients. This cannot be sustained in the long term if adequate support is not given to GPs to continue to do this type of work. The work is complicated, not only by the complexity of chronic disease these patients have, but in terms of communicating with other services e.g. my aged care etc. including family members and carers. My concern is that younger GPs in their career are not mentored or required to train to provide this type of care for the elderly. Many of my new patients who are elderly, and their families tell me that the many GPs they contacted say they do not conduct home visits, nor do they visit RACFs. **GP, Inner West Sydney**

In 2017, the AMA reported[1] that 35.67% of doctors plan to stop taking on new patients in RACF, to reduce the number of visits to RACF or stop completely over the next two years. The proportion of respondents who visited RACF had dropped by 13.55% since 2015. Perhaps even more concerning is that the age of the GPs doing most of the RACF visits is increasing and that they are approaching retirement. Access to primary care in RACF may be a looming crisis.

The Royal Australian College of General Practitioners and the Specialist Colleges do not require specific training for in-house calls or visits to RACF. Changes to the training requirements of the colleges could potentially address this oversight. We would support this change.

- 13.55%

the proportion of respondents who visited RACF since 2015

1 AMA (2017) AMA Aged Care Survey Report

MBS funding for care of patients in RACF is inadequate and many GPs cite this as a large barrier to care. GPs are not adequately remunerated for their time. GPs do not get paid for the travel time nor the increasing administration work required. It does not compete with the rebates for patients seen in the surgery. Complex patients require longer visits and frequent unscheduled visits. The AMA survey shows that there is an urgent need for adequate funding to ensure Australia's ageing population has access to quality medical care through a quality aged care workforce.

Patients are increasingly frailer and more complex when moved to a RACF than in the past[2]. Research has shown that unnecessary hospitalisations can be avoided by incorporating primary care services in RACFs[3]. Older people have a right to obtain the highest achievable level of health, and timely access to a medical practitioner is essential.

Respondents to the AMA survey have prioritised access to nurses and other health professionals as the most 'urgent' and 'extremely urgent' method to improve access to medical care in RACFs. The proportion of registered nurses in RACF is in decline[4]. Gaining access to RNs available to administer medicine after-hours is increasingly difficult. This poses a serious risk to the health of patients living in RACF.

Access to services including specialist care is extremely hard to access. Many patients are sent to Emergency Departments with conditions of low acuity due to lack of access to outpatient facilities or specialist care in the RACF. This is not appropriate nor cost-effective care but the only option open to many patients in RACF.

GP visits to patients in RACF are often more difficult and time consuming now due to lack of staff. There is often very limited or no clinical handover. The RNs on site appear overworked and over loaded. At times it can feel like it takes as long to find the RN as see the patient. Patients transferred from acute hospitals can arrive with lack of discharge planning and documented discharge summaries adding to the complexity and load on the RN and GP.

RNs play a vital role in care of our patients. They are key to good clinical care and co-ordination. The proportion of RNs is in decline . Staff turnover would appear high in some RACF and staff communicate their distress to GPs visiting facilities. Poor access to GPs is adding significant load onto the RNs.

The multi-faceted role of the RN in RACFs underpins the provision of collaborative, coordinated and integrated care. RNs collaborate with general practitioners, health professionals and

2 Australian Institute of Health and Welfare (2014; 2016)

3 Morphet et al (2015) Resident transfers from aged care facilities to emergency departments: can they be avoided? *Emergency Medicine Australasia*. **27**(5), pp.412-418

4 Mavromaras et al (2016) *The aged care workforce*, 2016. Department of Health

Poly pharmacy and medication errors

amongst the elderly are rife and a main cause of hospitalisation for patients in this age group

service providers in the provision of care in RACF[5]. RNs are able to recognise and ensure early intervention and management in response to changes in an individual's health, thus reducing the risk of deterioration and potentially reducing the need for unplanned admissions to acute facilities or transfer to emergency departments[6]. This not only assists in maintaining quality of life for care recipients but also reduces overall costs to the health system.

Poly pharmacy and medication errors amongst the elderly are rife and a main cause of hospitalisation for patients in this age group. GPs and RNs play vital roles in medication management. Every transfer of care from home/hospital/ RACF gives opportunities for medication error. Poor communication and inability of GPs to make urgent visits to check medication charts, especially with poor discharge planning increases the risks. Increased support by pharmacists and funding from the MBS to establish these essential services which remunerate GPs for their time in medical management and coordination of aged patients, would help avoid these risks and improve significant medication errors amongst the elderly.

In summary, Central Sydney GP Network support increased funding for care of patients in RACF and anticipate the care of this vulnerable population is at significant risk. An aging population with increasing complex health needs makes this an urgent issue.

5 Australian College of Nursing (2016) The role of registered nurses in residential aged care facilities – Position Statement

6 Dwyer, R. et al (2015) Unplanned Transfer to Emergency Departments for Frail Elderly Residents of Aged Care Facilities: A Review of Patient and Organizational Factors, *Journal of the American Medical Directors Association*, **16**(7), pp. 551-562

CHAPTER 4

Results of the CPSA Survey

Combined Pensioners and Superannuants Association

CPSA is a non-profit, non-party-political membership association founded in 1931 which serves pensioners of all ages, superannuants and low-income retirees. CPSA has 92 branches and affiliated organisations with a combined membership of approximately 22,000 people living throughout NSW. CPSA's aim is to improve the standard of living and well-being of its members and constituents. CPSA receives funding support from the NSW Government Departments of Family & Community Services and Health and the Australian Government Department of Social Service.

In the first half of 2019, CPSA conducted an online survey of its membership and supporters to discover consumer perceptions of aged care generally and of hospitalisation of nursing home residents specifically. Out of 85 respondents, 57 (67 per cent) gave their responses from the perspective of visitors to Residential Aged Care Facilities, 7 (8 per cent) did so as residents, 10 (12 per cent) as employees and 11 (13 per cent) had no direct experience of residential aged care.

To the question if they thought there were enough staff to provide safe care in residential aged care facilities, not a single respondents replied: yes. Seventy per cent replied: no. The remainder was unsure (21 per cent) or offered a qualitative response (9 per cent), none of which was positive about staffing levels:

> "Sometimes, but it's the quality and training that really matter.

> Staffing is usually skeletal to say the least and staff by unskilled nursing assistance who are expected to provide all cares plus give medication that they do not know what it is prescribed for, nor do they know the side effects of the medication."

> I have observed as a volunteer that the operator keeps the staff ratio down so as to make more money. If the money that the residents pay is all used only for that facility, then they would have plenty of money to have enough staff.

Ninety-five per cent of respondents thought that nursing homes needed one or more Registered Nurses on duty at all times.

In reply to the question whether respondents had witnessed any avoidable transfers from nursing homes to hospitals, almost three-quarters said that they either had not witnessed such transfers or were unsure whether the transfers they had witnessed were unnecessary or not. Out of those three-quarters of respondents, one in three was unsure.

Certainly, the responses from clinicians to the same question seems to indicate that in the order of three-quarters of transfers from nursing homes to hospitals are avoidable. This is the exact opposite of the consumer response, which seems to indicate that consumers may not generally be able to judge the merits of individual transfers.

However, there is very obvious concern among consumers about staffing levels and the qualifications of care staff and a recognition that this can and will result in avoidable hospitalisations.

none

thought there were enough staff to provide safe care in residential aged care facilities

95%

thought that nursing homes needed one or more Registered Nurses on duty at all times

CHAPTER 5

Views on avoidable hospitalisation and quality of care in residential aged care

Country Women's Association

The CWA is the largest women's organisation in Australia and aims to improve conditions for country women and children. We reach that aim in various ways including lobbying for change, helping the local community, creating a network of support and meeting together in towns and cities.

CWA of NSW is a member of CWA of Australia and the international organisation Associated Country Women of the World.

We surveyed our members during 2019 on matters relating to hospital avoidance from NSW residential aged care facilities (RACF). The findings show our members consider staffing, and in particular the on-site presence of registered nurses (RN) to be a pivotal factor in relation to the provision of good quality care and hospital avoidance. In addition, timely access to in-house support from GPs was also considered important.

It is wholly in the interests of older women that wherever possible, they have the option to be cared for in their place of residence, be that home or in a RACF. This is particularly important in rural and remote areas where the nearest hospital may be located some distance from the persons home, family and community. We hope the findings of this survey will help build a case for mandated staffing and skills mix in RACF. In addition it demonstrates a gap in the provision of GP services to RACF which will also require Government attention.

Findings

Of the respondents 79% had direct experience of RACF as a visitor, 26% as a staff member and 5% as a resident (more than one option applied to some).

77% considered there were insufficient staff provided to ensure safe care for residents, compared to 10% that did feel staffing was sufficient. The remainder were unsure.

“

It is not always the quantity of staff but the quality and qualifications of staff that is of concern. Naturally there needs to be sufficient carers but there needs to be more RN staff to care for the complex needs of residents.
This is especially urgent on night duty where often one RN is expected to oversee 160 or more residents. How can one RN provide pain relief, assess residents post-falls, monitor complex care and assess palliative residents all at the same time. That's the norm not the exception. **RACF employee and CWA member**

At various times during the day, e.g. lunch breaks staff seem to be very thin on the ground.
RACF visitor and CWA member

Relatives feel they need to come in to feed their kin – carers should be having time to do this.
RACF visitor and CWA member

It depends on the number of clients are there. In larger facilities the ratio is far too low.
RACF visitor and CWA member

It depends on the village. Where I live there are sufficient staff and excellent ones at that.
RACF resident and CWA member

”

77%

considered there were insufficient staff provided to ensure safe care for residents

“

You shouldn't need to get a registered nurse from another wing to come down and talk to you about a resident. There needs to be one in attendance at all times who is familiar with the residents of that wing. **RACF visitor and CWA member**

The people who are admitted to these facilities increasingly are more incapacitated. If at all able, people stay in their own homes with support. It stands to reason that more surveillance by qualified staff will be required for these vulnerable people. They often have one or more illnesses, i.e. heart disease, diabetes etc. often requiring medication. These should be supervised by staff who know what they are doing. **RACF visitor and CWA member**

One RN cannot complete the needs of patients requiring assessments frequently, attend treatments, give medications on time or at all, complete unrealistic paper work, liaise with relatives. Needs to be more of a level of three per 12 residents. Carers cannot be responsible for giving the higher levels of physical and mental care that residents of the “home” require. They are given instruction in basic general care. **RACF visitor and CWA member**

”

Overwhelmingly our members felt that a registered nurse should be on duty at all times in a RACF. 98% said this should be the case, compared to only 2% that felt this was unwarranted.

Over half (58%) of the respondents said they had not experienced, or were unsure if they had experienced anyone being sent to hospital for treatment that could have been provided in-house. However, of the 42% who had experienced this, the highest reasons for transfer were following a fall, care of a chest infection, urine infection, simple wound care, behaviour management and depression/anxiety. 5% said this had occurred owing to abuse.

We asked our members what might have prevented someone having to go to hospital. Staffing was considered the main factor. This was closely followed by better access to GPs. Then better staff knowledge.

In your opinion, what might prevent someone having to go to hospital from a residential aged care facility for treatment?

“

My mother was sent to hospital with flu type virus for rehydration and it was extremely difficult as my mother has dementia and my sister and I had to stay with her as staff were busy. She didn't understand that she was to stay in the room in isolation etc.

RACF visitor and CWA member

This has been mainly because there has not been adequate RN/EN supervision available. Restrictions on equipment i.e. continence pads.

RACF employee, visitor and CWA member

With poorly trained staff the presence of the registered nurse is essential.

RACF resident and CWA member

In my experience I consider it essential for all aged care facilities to have a General Practitioner available to provide clinical care as required. I understand that the crossover of primary care services and aged care facilities is problematic regarding funding allocation. However I believe the current system of residential nursing homes having to contact resident's GPs when it is clinically indicated for advice and medication changes is inadequate, and unworkable. Not sure what the solution is, but there has got to be a more streamlined pathway for residential staff to access support when caring for residents with high care medical needs.

RACF employee, visitor and CWA member

Often the hospital transfer is undertaken as it may be the only way the resident can have treatments ordered as GPS are not willing or able to visit.

RACF employee and CWA member

”

CHAPTER 6

Hospital avoidance from CALD perspectives

Multicultural Communities of Illawarra/ Partners in Culturally Appropriate Care NSW/ACT

The Multicultural Communities Council of Illawarra (MCCI) is a peak not for profit community based organisation supporting multicultural communities, for over 40 years, with services and programs that promote well-being, community harmony and social inclusion.

As the regional peak body for multiculturalism, we advocate for better services which meet community needs and contribute to policies and programs which promote inclusion and respect. We partner with a wide range of community, business, government, and non-government organisations to provide a broad suite of diversity of services.

Multicultural Communities of Illawarra (MCCI) is the host organisation for Partners in Culturally Appropriate Care (PICAC) NSW & ACT, and a key partner in the national PICAC Alliance.

We undertook a survey of both staff and community members in March 2019 on matters relating to hospital avoidance from NSW residential aged care facilities (RACF). The findings show survey participants consider staffing, the on-site presence of registered nurses (RN) and primarily the lack of RACF ability to meet the cultural needs of older people from culturally and linguistically diverse (CALD) backgrounds in relation to the provision of good quality care and hospital avoidance. In addition, timely access to in-house support from GPs was also considered important.

It is worth noting that older people from CALD backgrounds face a higher risk of miscommunication occurring due to language barriers and lack of easy access to language assistance and supports. They can often be labelled as a difficult resident or patient, which may be simply because they are not being listened to or understood and therefore can become frustrated. Added to this the lack of appropriate language supports and little attention being given to developing and implementing effective communication strategies with people who fall outside of the English language proficiency and who may not be on-line users or tech-savvy.

“

It is understandable that it is challenging to cater for so many residents however there are little things that can be done to deliver culturally appropriate service. Food still and always will be an issue. Cultural activities are improving but still a long way until they are fully inclusive. One point that needs attention is the fact that CALD people experience high levels of isolation in RACF. Not enough is being done to: keep the resident actively engaged in their communities; bring their communities in when community access is not possible; provide language assistance and cultural media to keep residents mentally active e.g. language TV/radio/newspapers, performing groups/artists, engage volunteer visitors.

RACF visitor

With diverse communities it is difficult to cater for all cultures however connections with Multicultural services who can ensure that residents have access to the outside community to continue to be immersed with their culture and language is extremely important.

MCCI staff member (working with multicultural seniors living with Dementia)

”

Findings

Of the respondents 71% had direct experience of RACF as a visitor, 29% as a staff member.

57% considered there were insufficient staff provided to ensure safe care for residents, 29% said there were sufficient numbers in some facilities and 14% were unsure.

Depends on the facility, management and the owners.

MCCI Staff member

(with previous experience working in RACFs)

Some seem to have considerable staff and routines are easily completed and timely delivered, while others seem to be understaffed and residents are waiting considerable periods for assistance and tasks. **RACF visitor**

Just over 86% of respondents felt that a registered nurse should be on duty at all times in a RACF, compared to only 14% that felt this wasn't necessary.

One registered nurse per unit is sufficient if there are also a significant number of trained care staff rostered on. **RACF visitor**

Less than a third (43%) of the respondents said they had not experienced, or were unsure if they had experienced anyone being sent to hospital for treatment that could have been provided in-house. Those that had experienced this (57%), cited the highest reasons for transfer were following a fall, simple wound care, urine infection, and chest infection.

Lack of good equipment and aids for bed bound patients and training of staff in terms of turning, re-dresses etc. **MCCI staff member**

In terms of what might prevent someone having to go to hospital from a RACF for treatment, responses were as follows:

- Registered Nurses on site 24/7 = 43%
- Better staff knowledge = 29%
- Better staffing ratios = 14%
- Better access to GP and other medical support = 14%

Could only select one, but better staffing ratios, GP access as well.

MCCI staff member

MCCI also had a focus on the cultural aspects of service delivery in a RACF and included a question about individual cultural needs and whether they felt these were being met/looked after. Overwhelmingly, the response was no (100%).

Perspectives of Nurses and Midwives: Results of a NSW Nurses and Midwives Association member survey on clinical issues in aged care

CHAPTER 7

NSW Nurses and Midwives' Association

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes: registered nurses; enrolled nurses and midwives at all levels including management and education, and assistants in nursing/care workers (however titled, who are unregulated).

The NSWNMA has approximately 64,500 members, including 10,000 employed in aged care and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

In 2018/19 we conducted a survey of our members on the issue of clinical care in residential aged care facilities. Over 1600 responses were received and the findings are summarised.

Around 90% of responses were from registered nurses, enrolled nurses and assistants in nursing (however titled) employed in residential aged care facilities (55% not for-profit, 36% for-profit).

The responses related to workplaces in both metro and rural areas in equal numbers.

42% were employed on a ratio of one registered nurse to between 50 to 100 residents/patients on each shift. 9% had a ratio of one registered nurse to between 100 and 150, and 3% one registered nurse to over 150 residents/patients.

> Night duty RN are responsible for 140-150 residents. Morning and afternoon shifts 40+. This number may increase if the facility is not fully staffed.
>
> **#1587 Registered Nurse, for-profit RACF**

> If RN coverage couldn't be found for night shift in one facility, there was one RN to two facilities with approximately 260 residents.
>
> **#1388 Registered Nurse, not-for-profit RACF**

95% of aged care workers

had transferred a resident to Hospital in the past year

95% of respondents had transferred someone to hospital in the past year for treatment such as urinary tract infection (65%), dehydration and poor nutrition (29%) and pain relief (21%). 78% stated that these transfers were avoidable.

The top reason for transfer of a resident to hospital was for treatment following a fall (94%). Many of these residents will have a resulting fracture of some form. Available data on hip fractures in NSW, combined with our findings, suggest that the cost to the public health system of treating hip fractures originating from RACFs, could have been well in excess of $3M in the past 12 months.

74% stated that better staffing ratios could have prevented the transfer of people to Hospital. 49% said lack of GP availability was a contributory factor.

35% of respondents reported not having enough time to assist someone to eat or drink in the past week. The association between lack of staff availability and the number of transfers to hospital for poor nutrition and dehydration is a concerning finding. Poor quality of meals also featured in qualitative responses as a contributory factor.

Around 70% had experienced a resident/patient having a delayed discharge back to the RACF. Most cited availability of transport as the reason. 12% said staffing ratios were too low to safely discharge.

The findings of this survey show that there is significant burden on hospitals caused by inappropriate staffing ratios in residential aged care facilities, across all sectors and regions in NSW. Enhanced shift-by-shift staffing ratios and skills mix, GP availability and timely access to transport upon discharge could reduce this burden.

We would like to thank our members who contributed to this survey.

“

A resident may have a beautifully written management plan but if there isn’t the staffing levels to support that plan it becomes worthless. If facilities aren’t prepared to train staff in different areas it’s very difficult for care plans to be carried out as they were intended, and in most cases staff feedback they don’t have time to read care plans in the first place. **#614 Registered Nurse, Agency**

My facility offers good meals but there is a lack of time to ensure all residents have had sufficient nutrition. The need for good hydration is poorly understood by staff.

#495 Registered Nurse for-profit RACF

Quite often residents are transferred to hospital (on family request and staff request) when doctors are unavailable to give orders for treatment to commence e.g. antibiotics.

#449 Enrolled nurse not-for-profit RACF

A person with dementia is being bullied by other residents during meal times. We have insufficient staffing to be able to assist her through her meal time with dignity, in the same or another area, so she can actually finish her meal for just nutritional needs, let alone just pleasure. **#1446 Assistant in Nursing, for-profit RACF**

”

CHAPTER 8

Viewpoints on avoidable presentations and delayed discharges from aged care facilities

Palliative Aged Care Network NSW

PALLIATIVE AGED CARE
NETWORK NSW

Acknowledgements

Thank you to the NSW Nurses and Midwives' Association for providing the survey for our members and for all Palliative Aged Care Network NSW (PACN) members who completed the survey.

Abstract

The focus this report is to ascertain viewpoints on avoidable presentations and delayed discharges from aged care facilities. Members of the PACN group participated in an online survey asking both open and closed ended questions. PACN membership includes academics, senior registered nurses (RN) and allied health working in the field of palliative care. The results indicated that avoidable presentation is common in aged care with common themes including lack of GP coverage, training needs of staff, RN workload, lack of advance care planning and family education identified as the most likely factors influencing avoidable presentations. The results confirm that greater support is required from both outreach and in-reach services to support aged care facilities to build capacity to care for residents in their home environment.

Introduction

Residential aged care facilities (RACF) are currently under the spotlight to assess that standards of care are being met. This report focuses on common themes that may contribute to avoidable presentations and delayed discharges back to RACF. Members of PACN were invited to participate in a voluntary survey to identify common causes of hospital presentations, influencing factors, reasons for delayed discharges and strategies to reduce presentations and delayed discharges. The results are presented below.

Results

57% of survey respondents were RNs and 42% from universities. The RNs were a mix of Nurse Practitioners, Clinical Nurse Consultants and Clinical Nurse Specialists. Survey respondents worked in both community, residential aged care and universities with 85% in metropolitan areas and 14% in rural areas.

42% of respondents identified avoidable hospital presentations on a daily basis and 42% on a monthly basis. The most common causes for avoidable presentations were for pain relief (83%), palliative care (66%), falls (66%) and upper respiratory infections (66%).

The most likely influencing factors identified were lack of knowledge/skills of staff employed in the RACF (100%), lack of clinical supervision (83%), RN workload (83%), GP not able/unwilling to attend (83%) and person/family requested to be transferred to hospital (83%). Lack of Advance Care Directives and no RN at the RACF were also influencing factors (66%).

> "Staff not having adequate training, skills and confidence to have effective Advance Care Planning (ACP) conversations with families.

> No clear discussion, support and completed ACP's.

> Families given power to make medical decisions on very little information.

> Families have insisted on admission despite plans in place to avoid hospitalisation often when no RN is on duty."

42%

identified avoidable hospital presentations **on a daily basis**

+ 42%

on a monthly basis

The most common causes for avoidable presentations

pain relief (83%)

palliative care (66%)

falls (66%)

upper respiratory infections (66%)

Respondents had a 50:50% response to experiencing delayed discharge of a resident back to a RACF. The main reasons for delayed discharges were family refused to allow them to return (100%), staff in the facility need more training/lack skills (67%), lack of available equipment in the RACF (67%), insufficient staff levels (67%) and no places available (67%).

57% of respondents identified that data collection would help improve quality.

Measures to reduce presentations and delayed discharges included the following: Geriatric Outreach Teams in every Local Health District (LHD) (100%); mandated minimal training competencies for RACF workers (100%); safe ratios for all workers in RACF's, Nurse Practitioners in RACF's with specialist skills in palliative care, mental health and gerontology (85%); greater incentives for GP's to attend RACF's (85%), national clinical benchmarking in line with public hospitals as a quality indicator (85%) and enhanced clinical governance in RACF's (85%).

We see residents on the continuum and bench mark the service using a death audit tool. This shows a decrease in ED presentations in the last weeks of life, an uptake in ACD's and increased family satisfaction. **In-reach respondent**

GP's engage with us, we take the pressure off them and do extensive case conferencing and teach staff to recognise deterioration. **In-reach respondent**

I do not agree with the payback or penalty system, if anything it will impact on people being medically treated appropriately if needed.

Data collection useful, keen to roll out ambulance care plan to avoid inappropriate CPR and medications will be charted in the very least.

Keen to see more consistencies in LHD Nurse Practitioners, outreach services, in-reach services provided to RACF's.... LHD's don't seem to grasp that Aged Care Organisations (ACO's) have many RACF's across many different LHD's leading to confusion for ACO's as each different LHD provides their own service, expectations, resources etc.

GP Perspective

Professor Dimity Pond, PhD, BA, MBBS, FRACGP

CHAPTER 9

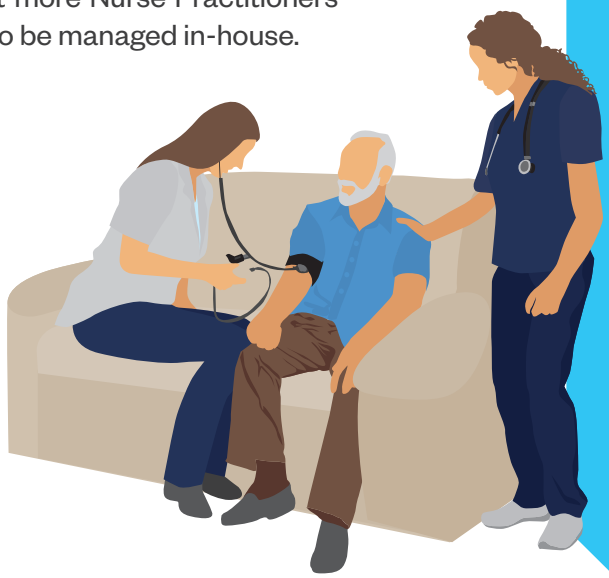
The lack of GPs going to residential aged care is problematic and multi-faceted. However, my personal experience over many years is that the environment of residential aged care facilities is often chaotic. This is mainly attributed to a lack of staff generally, and in particular the loss of Registered Nurses to support GPs.

Often after-hours services are not actually staffed by GPs. The doctors who work for those services often don't have full GP accreditation. Therefore they are more inclined to send patients to hospital. This is also attributed to their lack of personal knowledge of the resident, and their medical history. They interact with evening staff in the facilities who may not have the full story and it is often hard to work out complex medical histories in the time available.

The current climate, in which GPs are being strongly criticised for their actions in residential aged care, is likely to dissuade the younger GPs still further. Moreover there are fewer medical graduates than usual applying for GP training. Compared with other aspects of medicine it is less attractive. Remuneration was frozen for five years until July 2018. The work is complex and demanding.

There are a range of actions that could be undertaken to reverse this trend for residential aged care. For example, the RACGP is currently re-writing the "Silver Book" which supplies guidance for GPs going into residential care. There are also a lot of training courses being developed for GPs to manage dementia. I would also support more Nurse Practitioners (NP) in the facilities as care is often more likely to be managed in-house.

... the environment of residential aged care facilities is often chaotic. This is mainly attributed to a lack of staff generally, and in particular **the loss of Registered Nurses to support GPs**



CHAPTER 10

A Consumer Perspective

Senior Rights Service

The Seniors Rights Service provides aged care advocacy for anyone receiving subsidised aged care services. Seniors Rights Service provides free and independent advice, education and individual advocacy to care recipients or their representatives, who have concerns about aged care in NSW. There are similar services in every other state and territory and since 2017 have had a united national voice represented through the Older Person's Advocacy Network.

Seniors Rights Service receives funding from the Commonwealth Government Department of Health to promote self-advocacy or to give a voice to those who feel unable to speak up about their experience of aged care services. Seniors Rights Service has a long-standing objective to assist older people with aged care and accommodation issues.

Seniors Rights Service comprises dedicated staff members, including aged care advocates, social workers, solicitors and volunteers. The organisation is also governed by a volunteer Board of Directors. Additionally we have a register of more than 150 members, which include community groups, and from the general public including staff, board members, and volunteers.

The Survey

In 2019 we surveyed our members on the issue of avoidable hospitalisations from RACFs. The survey mirrored that of other organisations in this report, with slight shift in focus to reflect the target audience and gather a wider range of stakeholders' experience. All Seniors Rights Service members were sent the survey via email and given a short 2-week period to complete it if they wished.

The respondents identified themselves as follows: visitors to aged care homes (65%), advocates (29%), non-advocate employees (18%) and aged care residents (6%).

Staff to Resident Ratio

In relation to the question regarding staff to resident ratios in aged care homes, 65% believed there were insufficient staff to care for residents. Another 23% were unsure about the staff to resident ratio. Furthermore, no respondents answered there were enough staff in aged care. All respondents believe a registered nurse should be on duty at all times.

Reason for hospitalisation

Respondents were asked whether they had encountered any possible avoidable hospitalisations from RACFs. They were aware of residents being admitted to hospital for the following: urinary tract infections (29%); following a fall (21%); with depression (21%); chest infection (21%); simple wound care (21%) and with behaviours which were not being managed (14%). Knowledge of admission following alleged abuse was nil.

Prevention of hospitalisation

When asked for opinions on what may prevent hospital admissions for many of the above presenting problems, 53 % of the respondents stated that having a registered nurse available on site could potentially prevent transfer to hospital. A further 12% stated that better staffing would be a potential solution, 6% staff knowledge, and 18% stated that having access to a GP or medical support would allow the resident to remain in their aged care home for appropriate treatment.

All respondents believe **a registered nurse should be on duty at all times**

Closing Remarks

Our Seniors Rights Service Advocates are commonly faced with these scenarios, and refer to guidelines and law contained in the *Aged Care Act 1997* and associated legislative instruments. These specify the care and services which should be delivered and supervised by a qualified nurse.

Our Seniors Rights Service Advocates assist the Older Person receiving care, or their family or other representative, including staff, to understand rights and the standards of care expected in Australian aged care homes. Unnecessary admissions to hospital cause distress and confusion to older people. Additionally the long waiting time in emergency, being placed on narrow trolleys, missing critical meals and lack of hydration must be avoided for the comfort and dignity of the older person.

Delayed transfers between hospital and the aged care home is also a problem. Family members commonly inform us that their loved ones are prevented from returning to their home (RACF) because the facility cannot manage the older person's condition, whether it is behavioural or complex dressings or treatment. The results of our survey show that more could be done to prevent admissions and delayed discharges.

Advocates can assist by ensuring the appropriate guidelines are followed, and that all the possible options have been followed to provide supports to the resident, along with training and support for the staff caring for the older person. If the older person is being evicted and it has not been done fairly, we can also assist in making a complaint to the Aged Care Quality and Safety Commission.

For any information about rights or advocacy, please do not hesitate to contact us.

CHAPTER 11

Findings from the 2018 QACAG Survey on quality issues in aged care

Quality Aged Care Action Group Incorporated (QACAG)

Quality Aged Care Action Group Incorporated (QACAG) is a community group in NSW that aims to improve the quality of life for people in residential and community aged care settings. QACAG is made up of people from many interests and backgrounds brought together by common concerns about the quality of care for people receiving aged care services.

QACAG was established in 2005 and became incorporated in 2007. Membership includes older people some of whom are receiving aged care in NSW nursing homes or the community, relatives and friends some who are carers, people with aged care experience including current and retired nurses and care staff and other community members concerned with improving aged care. Membership also includes representatives from:

> A nurse knows what they are doing. Most of the staff have little or no qualifications. I am horrified at the thought of there being no qualified nurses on duty at weekends etc. **QACAG member**

> The RN when giving personal care, medications and dressings is observing the resident and notices a problem arising before it becomes an urgent transfer to hospital. **QACAG member**

> It is vital to have a registered nurse to cope with emergencies, an untrained person is incapable of this. **QACAG member**

Older Women's Network; Combined Pensioners & Superannuants Association of NSW Inc.; Senior Rights Service; Multicultural Communities of the Illawarra; NSW Nurses and Midwives' Association and the Retired Teachers' Association.

Many of our members have had first-hand experience of residential aged care facilities (RACF) over extended periods of time, either as a resident, member of the workforce, aged care proprietor or as a visitor to family members. This experience gives unique insight into the daily happenings of life in residential care and the situation and needs of residents.

We surveyed our members in 2018 and found inadequate staffing of RACF to be a major concern. 72% of responders said they had a negative experience of a RACF. Of all responses, almost 90% said that having a registered nurses (RNs) available on site at all times was extremely important to them. Issues where registered nurses were deemed valuable included dealing with emergency situations, correct handling and administration of medications and to liaise with doctors and other external professionals. We believe these factors are essential to avoid unnecessary hospitalisations.

However, our members also believe that a single RN cannot adequately deal with the number and complexity of residents accommodated in aged care. For this reason we call for not only RNs on site at all times, but adequate numbers of RNs, Enrolled Nurses (ENs) and care workers (however named).

± 90%

said that having a registered nurses (RNs) available at all times was extremely important.

Issues where registered nurses were deemed valuable included

dealing with emergency situations

correct handling and administration of medications

liaise with the doctors and other external professionals

Full list of NSW Aged Care Roundtable members and supporters

Members

- Association of Salaried Medical Officers
- Australia and New Zealand Society for Geriatric Medicine NSW Division
- Cancer Council NSW
- Carers NSW
- Central Sydney GP Network
- Combined Pensioners and Superannuants Association
- Council on the Ageing NSW
- Country Women's Association NSW
- NSW Council of Social Services
- NSW Nurses and Midwives' Association
- Older Women's Network
- Palliative Aged Care Network NSW
- Partners in Culturally Appropriate Care NSW/ ACT Inc. Multicultural Communities of the Illawarra
- Quality Aged Care Action Group
- Royal Australian College of General Practitioners NSW Faculty
- Royal Australian College of Physicians
- Seniors Rights Services
- Women's Electoral Lobby

Supporters

ACON

Allied Health Professions Australia

ANZ Society of Psychiatric Medicine

Australian Dental Association

Australian Nursing and Midwifery Federation

Charles Sturt University

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

Dementia Australia

Health Consumers NSW

LGBTI Health Alliance

Mental Health Carers NSW

National Rural Health Alliance

Older Persons Advocacy Network

Senior Smiles

Swinburne University

University of Newcastle

Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge

NSW AGED CARE ROUNDTABLE 2019

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