Public Submission
Inquiry into Access to Primary Health Care Services
Standing Committee on Health, Community Services and Social Services.

By Marcia Stuart, Chisholm

As a registered nurse and health professional for approximately 30 years, I have worked for private community service providers in the ACT and from 2007 I have worked in two ACT medical centres, including Wanniassa Medical Centre prior to its closure. I have worked in public hospitals in Melbourne as well as the Royal District Nursing Service of Victoria. I wish to address the terms of reference as follows.

GP closures since 2001.
My position as a registered nurse at Wanniassa Medical Centre became untenable in July 2008. The Medical Centre closed down within weeks of my departure.
The company (Primary Health) did not pay nurses according to the agreement in force between Symbion and the Australian Nursing Federation after Primary's takeover of Symbion.
Some general practitioners did not support Symbion's on-site pathology service which may have been viewed unfavourably by Primary Health.
I was given instruction to cease chronic disease education of diabetic patients because *some* practitioners held the view that they were 'losing power.' Diabetes educators were to talk to diabetic patients, not nurses. Since I had family experience, hospital experience and community nursing experience in the care of diabetic patients I held the belief that the Standards established by the Australian Nursing and Midwifery Council (ANMC) supported the nurses' role in patient education.

Section 7.7 of ANMC National Competency Standards for the Registered Nurse.

7.7 Educates individuals/groups to promote independence and control over their health
● identifies and documents specific educational requirements and requests of individuals/groups
● undertakes formal and informal education sessions with individuals/groups as necessary
● identifies appropriate educational resources, including other health professionals

Linkages between Government and non-Government health care providers including innovative and best practice models

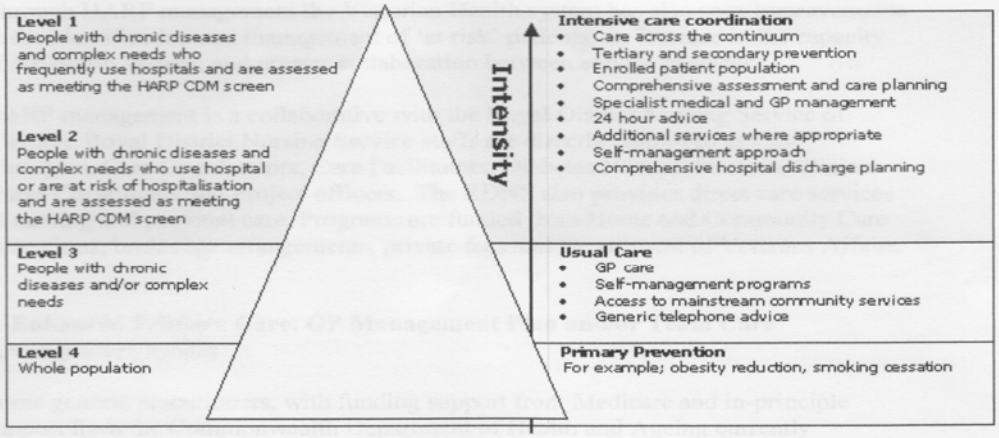
In 2008, I completed a NSW College of Nursing distance education course titled 'Chronic and Complex Care' which included a project considering alternative models of care for the management of chronic disease.
I evaluated the HARP management program, a Victorian Government and Royal District Nursing Service of Victoria collaborative model as a *possible* best practice model of care for the prevention and management of chronic disease.
Under HARP management collaboration with the Royal District Nursing Service of Victoria nursing staffs are employed as Case managers, care coordinators, care

facilitators, diabetes nurse educators, clinical nurse consultants and project officers. The service involves direct care nursing & personal care services to patients in the community. Programs are funded from Home and Community care allocations, brokerage, private fees and Department of Veterans Affairs.
Since the introduction of HARP management in Victoria there has reportedly been improved health outcomes; improvements through education and self-management strategies enabling patients to remain living at home for longer.

Excerpt from page 8 of research project by M. Stuart, 2008 as part of NSW College of Nursing 'Chronic & Complex Care' distance education course.

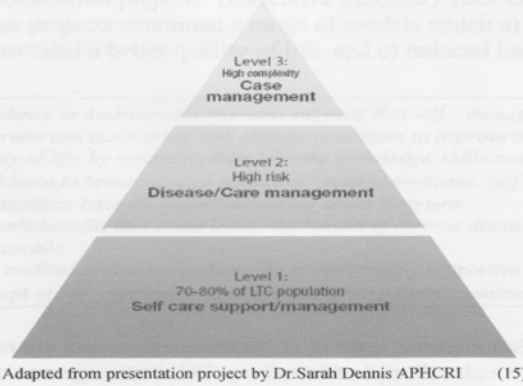
These objectives are met through Levels of Management as identified in Table 1.

Table 1: Levels of chronic and complex care management



Adapted from Victorian Government Health Information: HARP Chronic Disease Management 26/06/2008 (14)

Mainstream populations enter the program at levels 4 & 3 – the Primary Prevention and Usual Care levels. Victoria is divided into 9 community health services which target populations at level 3. As the patient's needs intensify, the levels of service provision increase.
The HARP model is similar to that used in the United Kingdom, in which Level 1 supports the general population, focussing on self-care strategies. Level 2 for those populations requiring disease and care management, and Level 3 for patients requiring case management due to a higher level of need or complexity.



Adapted from presentation project by Dr.Sarah Dennis APHCRI (15)

HARP management is specifically targeted at people, who frequent hospitals or are at risk of frequent hospitalisation, including patients with chronic heart disease; chronic respiratory disease patients; diabetics; aged persons with complex health needs and people with complex psycho-social needs.

Critical Shortage of Nursing Staff & Need for Nurse Practitioners.

Community health organisations of the future risk being staffed in bulk by Certificate 111 nurses. The onus is currently on the employer to provide ad hoc on the job training for nursing staff. Completion of the Certificate 111 is not a prerequisite of employment by *some* community service providers.

The list of Certificate 111 nursing graduates from Canberra Institute of Technology, whose names were published in the Canberra Times on 14th May, 2009 reveals low numbers completed the Certificate 111 in Aged care and Disabilities compared to other disciplines.
Current university based registered nurse training comprises 3 years of study with clinical placements as part of the degree but again course uptake numbers are reduced.

Today registered nurses qualify by completing a three-year university degree. They also supervise the basic patient care provided by assistants in nursing and enrolled nurses, both of whom qualify through Technical and Further Education college courses. Registered nurses can then choose from a large number of nursing specialities. A more recent development is the qualified nurse practitioner who engages in more autonomous advanced practice. http://epress.lib.uts.edu.au/ojs
Excerpt from Nursing Judith Godden P. 33. Accessed 19/5/09

The value in employing more registered nurses plus a nurse practitioner (if available) into aged care facilities may reduce demand for general practitioner attendances to aged care facilities. Registered nurses are trained to provide holistic nursing care that is preventative in focus. Doctors are trained to doctor.

Staffs employed by Aged Care and Disability providers have traditionally received a lower remuneration for the physically demanding care they provide to very vulnerable patients. As humans we mature intellectually and emotionally through respect shown to us by family; friends; our work colleagues and our society in general. True recognition by society of the value of the work undertaken in all caring and nursing roles may help to attract and retain staff.

Quote from Herald Sun March 16, 2009

The Herald Sun has learned there is just one registered nurse for every 42 high-care residents living in Australian aged care homes.
Many homes are without a senior nurse on the wards overnight or at weekends.
Low-paid care workers - some with just three weeks' training - are handing out medicines.
The chronic shortage of university-trained nurses comes as more aged care homes are being accused of endangering residents.
Bedsores, poor nutrition and the failure to administer medication are common problems in homes that fail official checks.
TAFE-trained nurses and unlicensed care workers are increasingly expected to pick up the slack in nursing homes.
"They're just not there," chief executive Rod Young said. "The Federal Government for quite some time has failed to train enough nurses to meet future demand."

School based mandatory Elder & Disabled Education for all secondary students.

As a community nurse I have witnessed neglect of the elderly and disabled by family members; *some* employees of health organisations and by systems of management. In my experience, whistleblower protection is inadequate and a disincentive to open and transparent reporting of incidents of neglect.

I give the example of 'Mrs Patient', a frail elderly woman who a few years ago was assessed by me in her home as requiring hospitalisation. She was refused transport to hospital by ACT ambulance paramedics. Paramedics deemed that because the woman could walk the length of her short hallway with a walking frame hospitalisation was not required. Both ACT hospitals were on 'access block' on Saturday sports afternoon because of increased demand. Paramedics had a difficult choice to make regarding their own resources believing that the elderly woman was better off in her own home than to be waiting for many hours in the back of the ambulance until a bed became available.
The woman's general practitioner did not make house calls. The patient did not have an application for permanent residential care. A locum would not have secured a hospital bed in the circumstances. The woman's family could not provide live-in assistance. The service provider was understaffed. The woman did not qualify for emergency respite due to her severe health co-morbidities. By the time this elderly woman received hospital treatment the following day; she could not be saved or afforded a dignified passing. Such is the situation for some elderly persons.

The neglect within our communities of the aged and/or the disabled person can be reversed by collective change. The frail aged and disabled person requires ongoing care during their last years or weeks of life.
Many years ago, when living in Melbourne, I voluntarily spent four hours of my time every week for approximately two years to clean, shop for and prepare meals for a frail elderly relative. He had very little money and no children of his own. He never required a nursing home bed because he received ongoing assistance with his essential activities of daily living during the last years of his life.

A societal shift in attitude could be accomplished by *mandatory* allocation of a minimum 20 hours per secondary student to the subject of Elder & Disabled Care. Ongoing 'approved training' funds would need to be secured through collaboration between Commonwealth & ACT Governments for special purpose funding that was separate from State and Territory education budgets. These *mandatory* hours would be classed as an accredited unit of study in the Year 12 certificate for *all* courses. Material in the unit could include: education on providing practical assistance with activities of daily living for the elderly or disabled person; awareness of indicators of deteriorating health conditions in the elderly and disabled; mobility issues; first aid; safe methods of transferring elderly or disabled persons; humane care of persons with dementia; plus at least one fully supervised visit to patients in a care facility.

Education of our secondary students in this way could have a fourfold benefit. Introduces students to potential careers in health care occupations; engages both generations to lift the standard of respect shown to the most vulnerable persons; potential benefit of insurance 'risk minimisation'; plus potential reduction in crimes of violence perpetrated on elderly and disabled persons. M.Stuart