By Jane Burns

FUTURE CARE: AT WHOSE EXPENSE?

How does a legal team correctly determine the cost, hours of care and what qualifications a nurse must hold to provide safe nursing care to a catastrophically injured claimant over their lifetime?

The qualifications of the staff required and commercial nursing provider charge-out rates are hotly contested issues between experts in cases where the client has a catastrophic injury. The costing of future care can vary greatly, depending on the nursing care prescription and the nursing provider chosen to provide staff rates for costing purposes. Nor is future nursing care a 'set and forget' prescription based on a set point in time, as requirements change as the client experiences complications and the inevitable physical challenges of ageing with a disability.

BACKGROUND

The face of nursing has changed enormously over the past 25 years. Accurate prescription of community-based nursing care services has become a very complex issue.

Numerous important industrial relations changes have occurred and legal factors need to be considered in order to ensure that a person who requires complex nursing care is receiving that care from an appropriately qualified professional and is not placed at unnecessary risk.

This article hopes to encourage solicitors and health-providers to become involved in a lively discussion about how to ensure that a catastrophically injured person is prescribed adequate and safe nursing care that meets their individual requirements over their lifetime. In order to achieve this outcome, and protect the public, it is important to understand the delivery of nursing care services in the context of a currently largely unregulated home care industry.

WHAT DUTIES CONSTITUTE NURSING CARE?

As the home nursing care sector has grown, a great deal of confusion has arisen regarding what duties constitute and are classified as 'nursing' care. In a broad context, the proper role of nursing is to 'provide the required self-care under those circumstances where the individual is unable to provide for himself'.[1]

All persons who provide or assist in the provision of self-care tasks to any individual or group are therefore deemed to be performing nursing work. The provision of nursing care may require the performance of simple nursing tasks such as washing a person's hair (low skill level) or a complex clinical task such as inserting a catheter; changing a tracheostomy tube; using clinical decision-making to determine a medication dosage or diagnose an episode of life-threatening autonomic dysreflexia;[2] and provide immediate and appropriate treatment. Even with a basic nursing task, such as assisting with showering, the individual nursing care requirements of the person being cared for must be evaluated. Showering a ventilator-dependent quadriplegic or severely brain injured person as opposed to an ambulant aged care client requires a completely different set of nursing skills.

In order to ensure that safe nursing care is delivered, which in turn protects the person with a disability, all persons performing nursing work should be appropriately qualified and assessed as competent to practice the skill required according to recognised standards.

QUALIFICATIONS OF NURSING STAFF IN AUSTRALIA

Traditionally, Registered Nurses and Enrolled Nurses occupied nursing positions. Over the past 20 years, a new category of unregulated healthcare workers who perform some aspects of nursing work has evolved.

It is useful to examine each category of nurse to understand their training or tertiary qualifications and whether they are regulated by an independent statutory body.

A Registered Nurse (RN) undertakes a three-year course at university and a health facility to achieve a Bachelor Degree in Health Science (Nursing) or Bachelor Degree in Nursing, following the completion of Year 12. The RN must then apply for national licensing with the Australian Health Practitioner Registration Agency (AHPRA) and meet standard licensing requirements, which are ultimately governed by the *Nurses and Midwives Act* 1991 (NSW). Following registration, most RNs enter a one-year hospital-based training program, which operates much like a medical internship, before electing to work in an area of specialty. Registered Nurses are trained to systematically assess clients using a standardised 'Nursing Diagnosis' framework.[3]

RNs must re-license every 12 months and must also complete 20 hours of continuing professional development units annually. They can go on to undertake additional tertiary qualifications in a specialty area (such as wound care) by studying a Masters in Nursing or a Doctorate in Nursing, or undertake further educational study to become a Nurse Practitioner (NP). Registered Nurses are bound to practise in accordance with their Professional Code of Professional Conduct for Nurses in Australia,[4] and the Code of Ethics for Nurses in Australia,[5] and can be de-registered for professional misconduct, as outlined in the *Nurses and Midwives Act* 1991.[6]

An Enrolled Nurse (EN) undertakes an 18-month or 2-year course at TAFE or related health facilities to achieve a Diploma in Enrolled Nursing. The EN must then apply for national licensing with the Australian Health Practitioner Registration Agency (AHPRA) and meet standard licensing >>

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requirements, which are also governed by the *Nurses and Midwives Act* 1991. An EN is classified as a second-level nurse who provides nursing care, working under the direction and supervision of an RN. The supervision may be direct or indirect, according to the nature of the work delegated to the EN. ENs are bound to practise in accordance with the same Professional Code of Conduct and Ethics as RNs and can be de-registered for professional misconduct, as outlined in the *Nurses and Midwives Act* 1991.

A Medication Endorsed Enrolled Nurse (EEN) undertakes further practical and theoretical training (following qualification as an EN) and, on successful completion of their training, are authorised to administer Schedule 2, 3, 4 and 8 medications via all routes, except intravenous, epidural, intraventricular and intrathecal. Any medication that requires checking prior to administration (that is, S4 or S8 drugs[7]), must be checked with a Registered Nurse. EENs are further excluded from administering fluids or medications via CVC lines (central venous lines), PICC (peripherally inserted central catheter) lines, femoral lines, implanted devices or arterial lines. EENs continue to work under the direction and supervision of an RN. Incidentally, there seem to be very few ENs practising in the home care situation, as most are employed in the hospital setting.

The Unlicensed Health Care Worker (UHW) is known by many titles in the home care industry, such as Assistants in Nursing (AINs), Nurses Aides (NAs) Personal Carers (PCs), Disability Support Workers (DSWs) and Attendant Carers (ACs). In order to avoid confusion, this group has collectively been defined by the Australian Nursing Federation as Unlicensed Health Workers (UHWs).[8]

An UHW may hold a TAFE qualification, such as an Assistant in Nursing or Certificate 3 in acute or aged care. To enrol in the Certificate 3 course, a Year 10 education is preferred, but not mandatory. This course is generally completed over 14 weeks and successful completion allows the UHW to work under the direction and supervision of an RN. An UHW does not, however, need any formal qualification to be employed in a nursing role and there is no regulation of employment of UHWs at present. An UHW is not bound by any formal code of conduct or ethical guidelines, and can work with no formal training. Many have poor English skills and are not registered on any roll. Nor can they be formally disciplined for misconduct or barred from working in the personal care industry. This category covers the TAFE-trained UHW through to backpackers in casual employment.

There are no 'absolute' guidelines or laws that outline who may perform a particular healthcare task or role. This has led to inconsistent and unregulated delegation of complex or invasive healthcare procedures to UHWs by commercial providers. *'However the law does insist there is a standard of care in relation to each task or role that will apply generally, irrespective of who is performing it. For people working in a health or aged care setting, there is no doubt that a duty of care exists. Therefore, it is imperative that they and their employer are confident that they have the knowledge, skills and experience to perform their role, and the requisite moral, ethical and legal standard.'*[9]

A definite hierarchy within the nursing profession has been deliberately established to protect the often vulnerable general public from unnecessary risk and harm. There is increasing concern among RNs and ENs[10] regarding the *'lack of consistency in standards of educational preparation, competence and employment arrangements for workers who nurses share care responsibilities with and who they are often supervising or supporting'.*[11] This concern has led to studies that confirm[12] that there is *'now ample unequivocal evidence that finds patients have better health outcomes with more highly skilled staff. This challenges the widespread worldwide obsession with reducing costs.'*[13]

It is important to note that the only nurse who is licensed to work autonomously is the Registered Nurse. *'The comprehensive educational preparation of registered nurses provides the necessary skills and knowledge to enable them to carry out assessment, planning, delivery, delegation, ongoing monitoring and evaluation of nursing care.'*[14] The EN and the UHW must have all nursing tasks delegated to them following assessment by an RN, taking into account the complexity of the task and education and competence of the worker, as *'Registered Nurses retain overall responsibility for any aspect of nursing care delegated.'*[15]

The introduction of the UHW into the nursing care team has immediately increased the pool of staff available to fill the growing demand for home nursing services. While this may be appropriate in a few low-skill tasks (such as helping an ambulant elderly person to shower or dress), UHWs now provide the majority of care to catastrophically injured clients who often have complex medical histories and complex nursing requirements. The introduction of the UHW has not only created access to a greater pool of staff, but it has also created an opportunity for the funding body[16] to significantly reduce its costs in providing such care. While funding bodies have undoubtedly benefitted from this new arrangement, it is important to consider also if the recipient of care has been placed at risk. Now that

independent evidence is available that the reduction of RN involvement in the skill-mix has led to preventable, adverse health outcomes, groups within the United Kingdom, the United States and Australia are currently advocating the introduction of some form of licensing in order to protect the public and independently regulate and monitor this group of workers.

The catastrophically injured client remains at high risk of adverse medical events due to their complex medical history and often high nursing care needs. The home nursing care industry is currently self-regulated, and commercial nursing providers are forced to compete in a highly competitive market by providing a tender for nursing care at a lower cost to the funding body. The funding body then relies on the nursing provider to provide the resources necessary to provide safe nursing care, which is not independently monitored. Inappropriately resourced nursing care regimes can have disastrous results.

WHAT PROBLEMS HAVE ARISEN WITH THE INTRODUCTION OF THE UHW INTO THE HOME CARE ENVIRONMENT?

The de-skilling of the nursing workforce and removal of direct RN care has led to the development of several critical issues.

Impact on patient and family

- Clients experience significant preventable adverse health events due to inadequate clinical nursing assessment (such as serious pressure areas or medication errors);[17]
- Privacy is compromised;
- A burden is placed on the client/family to continually direct his/her medical care, which is stressful;
- A burden is placed on the family to intervene in staff conflict situations;
- If the client lives in a small community, they can then become 'well-known' or perceived unfairly as being 'difficult' and, therefore, recruitment becomes even more challenging;
- Community access lessens, because the client is not confident enough to leave home due to high staff turnover; isolation therefore occurs; and
- Client/family rejects new staff and the loss of confidence grows. In turn, the family becomes angry with the provider who cannot supply the required number of staff. The burden of care is then shifted back to the family.

Impact on efficacy of care

- UHWs are unaware of their rights and responsibilities in regard to receiving adequate supervision and training;
- UHWs do not receive adequate, or ongoing training;
- UHWs are being given the responsibility of directly training other UHWs and delegating care activities which clearly falls outside their scope of practice;
- Injured clients are being asked to directly train their UHWs;
- UHWs do not understand their rights and responsibilities regarding duty of care and limits to their knowledge and scope of practice;
- UHWs are delegated complex medical tasks by an employer which fall outside their level of competency or training (such as changing a tracheostomy tube or inserting catheters);
- UHWs do not have the knowledge, or skills, to advocate for the client in a medical setting (such as a hospital);
- UHWs may not respect or understand expected professional boundaries;
- The UHW may have poor written and spoken English skills;
- Clinical competencies are not formally maintained;
- UHWs suffer stress when the client becomes unwell, or is medically unstable and no immediate resources are available for them to contact. They report that they do not want this level of responsibility and are not trained for it, so they consequently look for less stressful and better paid work (such as domestic cleaning) – therefore, staff turnover can be high, which is frustrating for the injured client;
- Perceived hierarchy among the UHWs becomes dysfunctional, and inter-personal conflict occurs within the team;
- UHWs do not have the knowledge or skills to identify subtle changes in the client's medical condition and seek appropriate help, nor do they understand the consequences of failing to act;

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- Increases in recruitment costs occur, since staff turnover is very high due to stress; and
- If clients become unwell due to poor health maintenance planning, nursing care needs to intensify and, in turn, staff turnover increases.

Impact on regulation

- It is difficult for consumer protection agencies to take action when a serious complaint is received that relates to the conduct, health or performance of an unregistered health professional;
- Employers are not regulated by an independent body in regards to how they deploy their UHWs which has led to poor or non-existent ratios of UHWs to RNs; and
- UHWs are not bound by a formal code of conduct that is overseen by a statutory body – therefore, serious offences (such as abuse, assault or theft) occur and do not result in any formal disciplinary action (such as criminal prosecution or deregistration).

DISCREPANCIES IN NURSING PROVIDER TENDERS AND COMMERCIAL NURSING CARE RATES

Commercial nursing provider rates can vary enormously and are often vigorously debated in settlement conferences and court. It is absolutely imperative to make sure that when reviewing rates you are comparing 'apples with apples'. Vast differences in rates can be accounted for by asking for evidence from each provider of the following:

- Copy of professional indemnity insurance *application form* from the provider to ensure that UHWs are actually covered to perform specific nominated nursing tasks. A certificate of currency will not disclose the tasks that the UHW is actually insured to perform as these must first be disclosed by the employer in order for the UHW to be legally insured. The insurer has a right to deny any claim due to non-disclosure if the specific task was not originally nominated by the insured;
- Evidence that the UHW is a *direct employee* of the provider and not a sub-contractor. If the commercial provider uses a sub-contracted workforce, payroll tax may not be being paid, superannuation may not be being paid, adequate professional indemnity insurance may not be in place and the UHW may not be covered by workers' compensation;
- Evidence that a nursing care assessment was performed by an RN and that nursing tasks were delegated by that RN and that he/she remains directly responsible for the regular review and delegation of those tasks; and
- Evidence that UHWs are regularly and directly assessed and supervised by the delegated RN who provided the initial assessment during the course of their work. (It is often best to ask the UHW directly what level of supervision they are provided with or ask for a statement. It should not be assumed that a documented commercial provider policy on supervision is actually being implemented).

All of the above variations in how commercial providers operate can affect nursing care regimes and provider rates greatly, and place the client at unnecessary risk.

WHOSE RESPONSIBILITY IS IT TO ENSURE THAT CATASTROPHICALLY INJURED CLIENTS RECEIVE SAFE AND ADEQUATE NURSING CARE?

The injured client is reliant on outside expertise for advice on what level of nursing care they will require over their lifetime (based on their individual circumstances). Consumers have a right to know the name, designation and qualifications of the person providing nursing care and who is supervising them.[18] Legal and licensed healthcare practitioners have an ethical responsibility and an inherent duty of care to ensure that those who are vulnerable are not placed at unnecessary risk and will be adequately funded.[19]

Those who have suffered a catastrophic injury usually require increasingly higher levels of nursing intervention over their lifetime due to the complex nature of their injuries and subsequent inevitable complications experienced as they age. Clients with a cognitive impairment are particularly vulnerable. Each person must be independently assessed and a nursing care prescription formulated using formal nursing diagnosis to ensure that the proper mix of care is prescribed. The only licensed nursing professional who is educated to perform such assessments and delegate nursing tasks is the Registered Nurse. It is imperative that an independent nursing assessor is retained to avoid a conflict of interest when nursing care is prescribed. If a nursing service provider performs the assessment, it may well stand to derive direct financial benefit from providing that nursing care at a later date.

CONCLUSION

Solicitors and licensed allied health professionals are encouraged to undertake further research on the delivery of nursing care to catastrophically injured clients in the home care setting in Australia. I would encourage the reader to review the material referenced in this article as a starting point to consider the emerging literature surrounding this important debate and to then examine the ramifications of these changes from their own professional perspective.

Those of us who represent this vulnerable group of people have a duty of care to ensure that each client's genuine nursing care needs are not being compromised by an obsession with cost-cutting, lack of competence of delegated nursing care staff, lack of resources or training, and inappropriate delegation of high-level nursing tasks. There is most certainly a duty of care to ensure that such clients are not being exploited in any way and that a simple independent complaints process is available to them to report any professional misconduct.

This article does not advocate any one particular method of delivering a nursing care regime or a particular ratio of nursing skill mix. Each client is an individual with differing requirements. These requirements inevitably fluctuate and change over a lifetime and nurses and funders must acknowledge and be responsive to these changes. It is clear that with an ageing population and advances in medical science, the UHW continues to play an important role in the nursing care team that provides adequate home nursing services. This article aims to highlight the very

real problems that are being faced on a daily basis by those who are in direct receipt of home nursing services and to acknowledge that this industry has continued to grow with no appropriate or adequate, independent oversight or regulation in place.

When a damages claim is greatly reduced due to the prescription of an UHW instead of a licensed nurse, the client's nursing care is compromised significantly, or funders are the sole beneficiaries through reducing their costs, it is worth asking who is actually benefitting from the introduction of the UHW to the nursing care team, and what is the real cost of removing RN supervision altogether? ■

Notes: **1** Dorothea Orem, (1986), *American Journal of Nursing,* Vol. 86, Issue 1, p1. **2** Autonomic Dysreflexia (AD) is a potentially life-threatening condition which can be considered a medical emergency requiring immediate attention. AD occurs most often in spinal cord-injured individuals with spinal lesions above the T6 spinal cord level, but can occur in people with brain injury. **3** http://www.nanda.org/. **4** Available online. http://www.nrgpn.org.au/index.php?element=ANMC+Code+of+Professional+Conduct. **5** Available on line http://www.nrgpn.org.au/index.php?element=anmc+code+of+ethics. **6** *Nurses and Midwives Act* 1991, s4. **7** S4 drugs are restricted (require prescription); S8 drugs are controlled. **8** Australian Nursing Federation, *Balancing Risk and Safety for our Community: Unlicensed Health Workers in the health and aged care systems* (2009) published by the Australian Nurses Federation. Available online http://www.anf.org.au/pdf/publications_reports/Unlicensed_Health_Workers.pdf. **9** Australian Nursing Federation, *Balancing Risk and Safety for our Community: Unlicensed Health Workers in the health and aged care systems* (2009) published by the Australian Nurses Federation. Available on line http://www.anf.org.au/pdf/publications_reports/Unlicensed_Health_Workers.pdf. **10** Brett Holmes, 'We can't replace skilled nurses in public hospitals', *The Lamp* (magazine of the NSW Nurses' Association), Vol. 66 (6) July 2009, p12. **11** See note 9 above. **12** C Duffield, M Roche, L O'Brien-Pallas, D Diers, C Aisbett, M King, J Hall, (2007) *Gluing it together: Nurses, Their Work Environment and Patient Safety.* Available for download at http://www.health.nsw.gov.au/pubs/2007/pdf/nwr_report.pdf. **13** Brett Holmes, 'There's no substitute for a qualified Nurse', *The Lamp,* July 2009, Vol. 66, p5. **14** Royal College of Nursing Australia and the Australian Nursing Federation, *Joint Position Statement. Assistants in nursing and other unlicensed workers (however titled),* 2008. **15** *Ibid.* **16** Such as CTP insurers, the TAC in Victoria, Insurance Commission of WA (ICWA) and the Lifetime Caer and Support Authority (LTCSA) in NSW. **17** See note 12 above. **18** Royal College of Nursing Australia and the Australian Nursing Federation, see note 14 above. **19** This refers to clients whose nursing home care is being funded by a third party keen to keep costs down, such as the funding bodies mentioned in note 16 above.

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