Productivity Commission Hearings Melbourne, March 2011

Caring for older Australians

My name is Irene Murphy. I am a registered nurse and nurse practitioner with Melbourne Citymission Palliative Care. I have extensive work experience in aged and community care to provide the Productivity Commission with an account of my professional experiences, and the experiences of other expert team members and colleagues, and the challenges and complexities encountered in the supported aged care sector. This account is from a specialist health care practitioner's perspective. This submission is for consideration as part of you review and reform of "Caring for Older Australians".

Ageing populations are due, at least in part, to increasing life expectancy, due to declining death rates (frequently related to behavioural changes, such as dietary improvements, reduced smoking and increased physical activity). However, reductions in mortality do not translate into similar reductions in morbidity and ageing is generally accompanied by ill-health "*the triumph of modern medicine is the creation of the chronic illness"*. Ageing is associated with a higher prevalence of certain health conditions including: arthritis, diabetes, hypertension, heart disease, high cholesterol, osteoporosis, dementia, and renal disease. Chronic conditions become more common with increasing age and older people often require ongoing support and assistance in daily living with the inevitable consequence of having to move eventually to a supported aged care facility.

Residential aged care facilities (RACFs) face unique and ever changing difficulties in managing and caring for their residents effectively. Not only the majority of residents have some form of dementia but they also generally have a number of co morbidities that involve dealing often with the physical, psychological emotional and social issues. Over the last two decades, research has indicated that the proportion of people living and eventually dying in Residential Aged Care Facilities (RACFs) has steadily increased. This has led to the recognition that a palliative approach enhances the care already provided to both residents and families.

The palliative care perspective intends to offer residents in RACFs who may be identified to benefit from a palliative approach because of the ageing process. The ageing process may not necessarily be a consequence of an incurable disease but the result of reaching the end stage of a long protracted chronic illness and other associated co morbidities.

Increasingly residents of RACFs are older, frailer and experiencing complex and acute exacerbation of symptoms. Nursing and direct care staff are constantly faced with the challenge of identifying, addressing and managing such symptoms. Periods of exacerbation of physical symptoms frequently lead to acute episodes which require robust clinical skills to identify, triage and manage. These residents are generally highly dependent and take multiple medications.

There is a variety of sound and well established clinical and decision making skills and knowledge required to effectively assessing these residents. There are, however, significant differences that are crucial when first discerning and subsequently establishing appropriate

management and interventions for residents who develop acute exacerbation of symptoms. Important elements to consider when reviewing these residents are:

- multiple clinical diagnoses that may require a variety of treatments
- periods of acuity and exacerbation which may or may not be reversible
- may be entering the terminal phase and consequently require end of life care
- if terminal care required, this is often for only a short period of time with an average of two days of intense care prior to death
- confusion, dementia or other communication difficulties may be present making assessment and reporting of symptoms even more challenging
- many residents don't have family support

There is also a wide spread recognition across the aged and palliative are sector that the benefits of palliative care are not limited to the final days or weeks before dying.

There a number of ongoing concerns that have been identified through my experience in working with RACFs, through the conduct of my role as a nurse practitioner with Melbourne Citymission Palliative Care, when providing consultancy, education and support for residents who may be approaching the final phase of their lives. Many of these concerns have been corroborated when reading the findings by the Productivity Commission's recent report particularly the statements related to RACFs workforce recommendations or lack thereof, planning and future projections.

Some of these concerns closely relate to the suggested questions for comment:

Question 1

The Aged Care Funding Instrument reviews the diagnoses and care needs of all residents. The residents in aged care facilities providing a high level of care are medically very frail with complex care needs and co-morbidities. For some residents some slow stream rehabilitation may be possible. For many others, person centred care with maintenance only is possible e.g. prevention of contractures, assistance with walking. Understanding of the behaviours demonstrated by people with cognitive impairment is essential.

However, for many of the providers of aged care, there is a lack of understanding of the biopsychosocial needs of residents, particularly those in high care facilities or those with cognitive impairment. For all providers, a business approach is required in order to meet the operating budget. The Standards do not provide clarity regarding the staffing skill mix required. Instead they offer flexibility in achieving the outcomes. As a result, staffing is very finely attuned to the budget available and the needs of the resident and staff can be overlooked.

There is an ongoing tension between the budget managers and the Registered Nurses who, as advocates, aim to provide the care required by these old people as well as meet the Accreditation Standards with very little time and experienced staff to both manage a facility as well as prepare for Accreditation. The required level of care is not assisted by the lack of

a structured and effective evidence based training that offers an acceptable level of optimal care:

- the current Aged Care Standards & Accreditation Agency process standards fail to provide clear and unambiguous guidelines to articulate a clinically robust model of care for Aged Care providers. This is fundamental to ensure appropriate staff mix to address and manage all aspects of care needs of residents in accordance with Aged Funding Tools, within a framework of quality and safety. Some elements of these standards are vague and open to interpretation. Specifics items are for example:
    - adequate staff/patient ratio. Always only one RN Div 1 per shift; *20-30% of RN Div 1 time is spent on medication management. Average RACF: 40 residents each at average of 6 tablets per day= 87.600 dispensation of tablets per facility per year*
        - critical issue for RN Div 1 staff in aged care is the lack of confidence in measuring and managing end of life medication; *not enough time for professional development, lack of support and little time available during the shift to spend supervising other less qualified staff*
    - the level of quality in communication skills and professionalism from staff; RN Div 1,2 and less qualified staff, differ enormously and is often less than satisfactory. This is particularly evident when attempts are made to educate, coach and train on important resident's care elements such as: approaching end of life, demystification of dying and death, medication management and communication skills when establishing dialogue with families and hands-on activities; such as providing basic and elementary good nursing care, etc, etc
    - the amount of paper work and documentation to comply with regulatory requirements is ever increasing. These often mandatory requirements seldom reflect increase in quality and effectiveness of care for residents
    - RACFs vision and principles is often dictated by the DONs approach therefore professional respect and collaboration vary enormously from one to the other. These leaders' individual conflicting directions and vision can erode notions of solidarity, respect and collaboration among senior and less qualified staff
    - the rapid turnover and transitional "aspects" of the current RACFs workforce makes it very difficult to prepare and adequately train staff in aspects of aged care particularly palliative and end of life care and timely identification of "champions"

Question 2

The remuneration paid to aged care workers is historically deficient and linked to the expectations of aged care providers that were run by a philanthropic or religious organisation, staffed by volunteers mostly. Research into old age as well as expectations of the experience of old age of the baby boomers will raise the bar of service provision.

Currently, staff providing hands-on aged care work do not need a high level of education to obtain a Certificate 3 in Aged Care. Many new comers can use the work as an income earner

while completing a higher degree, often in another completely different field of interest that is not related to people or aged care:

- aged care compared to other fields of nursing practice is viewed from the general public and other members of the health landscape as the *inferior relative.* It is not glamorous to work in aged care; often part-time *"middle age woman with no aspiration for further career paths"*
- good aged care is seldom profiled in the media, on the contrary, the tendency is to vicariously report and sensationalize serious issues related to neglect and errors of "under qualified" workforce

Question 3

The current training of personal care workers (PCWs) requires a regulated outcome that is higher than that provided currently. The PCWs need to e.g. understand the ageing process, be able to recognise pain and understand the progressive changes of cognitive impairment. They should not be 'trained on the job' as the trainers will not be qualified in the latest evidence based practice:

- wages and conditions are inferior to those in the acute health system *"pay peanuts get monkeys"* is what is often heard
    - conditions of employment are dictated by the facility which frequently reflects poor regulation: *it is often seen that managerial and organizational needs (seen in low care facilities) require the RN Div 1 to come on their days off, particularly on weekends, to assess a resident whose condition may be changing and to administer injectable medication*
    - when an RN is not employed for ongoing observation of the residents, new or changes in illness IS/can be overlooked by staff who do not have the observation skills and training of an RN. Admission to hospital for management of an acute illness can be overlooked. Duty of care is thus ignored.
    - many residents who are not yet 'labelled' as needing the provision of high care are, however, in the hostel because they cannot remain in the community. These will continue to 'age in place' once admitted to the hostel and will need review of health status and medications at least 2 monthly.
    - Enrolled nurses (EN) are often required to become coordinators of care which translate into managerial and administrative responsibilities which prevent them from exercising hands-on care and to effectively supervise, support and coach PCWs
- the level of education and training undertaken by PCWs should be more strictly regulated. Curriculum, content and context should be ratified and endorsed by the Australian Qualification Framework with direct input from aged care expert clinicians to properly defined scope of practice. This would surely lead to better wages and conditions
    - currently any educational setting (largely TAFEs) is allowed to provide this type of education with little regulation related to course content and requirements

    - there should be a minimum educational and industry standard for PCWs to achieve to be able to effectively and safely work in the aged care sector. *This must include demonstrating effective written and verbal English expression; considering that many residents in RACFs have communication deficiencies due to dementia related illness or other physiopathology i.e. sequelae from stroke*
    - the industry does not need a PCWs who is only in the job until their higher qualification, often in another field not related to aged care or people focussed, is completed. The understanding of resident needs through the experience of a good and committed PCW is pure gold!
- The level of baseline education of PCWs needs to be raised so that they are able to understand the aged care work requirements; be able to read all documents and reports related to the resident, understand policy & procedures and write well. Currently this does not happen.
- All providers are vicariously legally responsible for all actions by a PCW
    - PCWs should be trained at the basic level of an enrolled nurse <u>without</u> having to be medication endorsed
    - well trained staff will understand the biophysical changes demonstrated regularly by the ageing resident, the work requirements and are efficient and committed to the aged care workplace

Finally the level of funding from state and federal government, in comparison with the acute sector, reflects the amount of money spent in researching issues affecting the aged care particularly qualitative research related to those affected by dementia. This is disproportionately low compared with other serious conditions. If we wish to push the standards of care, we need to better understand the lived experiences and issues afflicting the aged when they are no longer able to care for themselves but where they can still be included as a significant part of society.

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Acknowledgments:

- **Pamela Johnson, Director of Nursing Melbourne Citymission Aged Care Precinct. Eltham Retirement Centre.**
- **Katherine Kearney RN Div 1, Dedicated role as a Clinical Nurse Specialist working with RACFs within Melbourne Citymission Palliative Care catchment area.**

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