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PRODUCTIVITY COMMISSION INQUIRY – CARING FOR OLDER AUSTRALIANS

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I am a registered nurse currently working within the aged care sector. I love working in residential aged care and have chosen to work in this area of clinical practice for many years. I have experienced in the sector in both residential and community aged care.

I believe the value I add to the lives of frail elderly people is fundamental to the quality of their lives. For this reason I feel I it is important the Productivity Commission hears what it is actually like to work in residential aged care. I submit the following points of concern for your consideration:

1. Unregistered care workers

   It is disheartening to witness people coming to work in aged care as either students undertaking studies to become personal care workers, or just people 'off the street', coming through, many of whom have chosen this area to work in not because of any great desire to assist the aged but more so it is easily obtainable employment.

   I note with dismay the looks on some of these workers faces, when they are new to the sector, and are actually confronted with the reality of aged care work – there is much resident care to be done in a very short time span.

   For many, English is not their first language, which makes communication with both residents and supervisor staff at times quite difficult.

   It is my observation that many of workers who can communicate in English, assume that aged care work means sitting around with the residents and having a leisurely chitchat, often engaging in conversations that are quire inappropriate for elderly people. I believe the Productivity Commission needs to put forward a

recommendation to the Government, that 'not just anyone' is suitable for this specialist work and there ought to be a nationally recognised course these worker must complete that regulates their practice and makes them accountable in the same way as nurses are for their actions. They need to be registered workers so they abide by a set of national standards.

2. Skill-mix/staff ratios

All nurses have to comply with regulation and legislation standards for their practice. Similarly, we have a duty of care to our residents, yet sadly the current staff levels in most aged care homes I have worked in, impact markedly on the quality of resident care that is (or not) at the end of the day actually delivered.
At my current workplace, which is classified as a low level with ageing in place facility, comprising 60 beds, and at time of writing housed 40 high level care residents. There is often no registered nurse on site and at times not even an enrolled nurse. It is difficult to persuade management to provide an extra 'supernumerary' staff member related to budgetary constraints.

The implications of this lack of trained staff are numerous:

- Residents have been left without timely pain relief or no pain relief medication at all – untrained staff do not have the necessary underpinning knowledge and skills development to appropriately assess the resident. Ultimately they are not permitted to administer PRN analgesia that cannot be purchased over the counter without a written prescription from a medical officer or nurse practitioner.
- Residents experiencing anxiety/agitation/restlessness/or other behavioural issues cannot be appropriately assessed or managed because to skills deficits.
- Oxygen cannot be administered
- Sedatives (PRN) cannot be administered
- GP's visiting are unlikely to have any requested changes effected until the following shift/day – often the RN following is totally unaware of any changes

in treatment/medications due to untrained staff having been present at the time of the visit

Common staffing levels are as follows:

Morning (AM) shifts

1 care-staff member/PCW to 15-18 residents. This may also incorporate a medication round of 1hr duration; i.e. for 1hr, residents within that PCW allocated area do not have carer coverage.

Of these 15-18 residents, an average of 10-12 may require showering assistance on any given day relating to continence status and/or resident choice.

Duties not only include hygiene & toileting assistance, but also bed-making, room-tidying, assistance with meal delivery and last but certainly not least, documentation.

Afternoon (PM) shift

Nursing and care staff levels are even less than above in the afternoons.

Two full-shift carers with 1 short-shift carer; again this also incorporates medication rounds (two).

Night Shift

Overnight resident care is covered by two staff only – reiterating, a total of 60 residents.

Night-staff duties also include multiple housekeeping chores, i.e. folding of linen, dining-room table-setting, vacuuming of lounge & dining-room areas to name but a few and *documentation.*

As a supervisory RN with multiple Personal Care Workers', pertinent issues remain:

- Accountability – *huge.* This incorporates medication errors made by care-staff – the RN's role is to 'supervise' care-staff. This accountability of responsibility may occur in a facility of 60-120+ beds.

Much of the RN's role is problem-solving. The RN relies heavily on the care-staff to report any issues of concern. If unreported, the concern will subsequently not be addressed = poor resident care.

- Palliative care in this instance can only be described as 'tragic'.
- Documentation – all entries documented by care-staff require follow-up entry, and/or action by the RN.
- Medication changes – all must be followed up by the registered nurse – this usually includes the entire facility, i.e. 120+ beds.
- There may be four GP's visiting in any one shift making medication changes. There may not be an RN to follow-on. – meaning that there are delays in changes to medication regimes being implemented, leading to sub-optimal care outcomes.
- Communication re protocols is paramount – all direct care-staff must be quite clear in protocols & procedures and level of care required. Frequently this is not the case - care-staff unknowingly due to lack of training, over-step the boundaries of care – and cross over into what I observe as the blurring of professional boundaries.
- Where the approved provider does not have a registered nurse on a shift and no supervising registered nurse available to provide indirect supervision of care workers, there is little alternative but these people to assist resident with complex medication administration (which is outside of their role and responsibility) or the resident simply suffers.
- Dignity and respect – also in relation to lack of training this is commonly overlooked – an example being a care-staff member calling loudly from one end of corridor (to another care-staff) - 'have you toileted Mary yet?!' ….'what about Lucy?'…. 'can you bring me a pad for Nellie?, 'I haven't got one!'…'Fred is *wet*'.
- Care-staff repeatedly leave residents uncovered and compromised.
- When I was first employed at this home, I have care-staff regularly showering residents while they sat on toilets, when I questioned this practice; I was advised that 'it's easier to shower them on the toilet in case they are incontinent'. I immediately, stopped that practice.

- Safety issues – again in my experience I have discovered care-staff utilising wheelie frames as wheelchairs. Care-staff need prompting to activate brakes on beds/wheelchairs/shower chairs and to activate installed bed alarms.
- Legality/safety issues – care-staff and unsupervised enrolled nurses' have been found to sign drug registers as administering medicine without the knowledge of the registered nurse, and at time of 1-2hrs prior to the medicine actually being prescribed to be administered – with the explanation being 'it's a time-thing'. Care-staff are unaware of technical procedures, ie catheter care.
- Leg straps & bags are incorrectly positioned compromising urine flow creating back-flow/pain/urinary retention which may well eventuate in hospitalisation that would otherwise have been avoided.
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3. Remuneration

Most registered nurse salaries do not compare to our public hospital colleagues. If a facility manager is on site the hour rate for a nurse usually (i.e. day-shift) reduces.
On-call rate quite insulting - $12.53 for all-night coverage.
This may well be a period of up to 13 hours; there is no additional allowance or extra monies paid if called.
When nurses claim overtime it is usually not paid.
The RN's never ever leave on time.
For PCW's – average rate of hourly pay currently $16-19.00/hour.

4. Aged Care Funding Instrument (ACFI)

There is a continuous push from management exists to increase ACFI funding and *maximise -* continuous pressure to meet goals set by management, always looking at care needs and funding with ongoing difficulties in ensuring staff with skills to deliver those claims. GP's are often resistive to write diagnoses accordingly, i.e. anxiety & depression. As a funding tool, ACFI is not 'all bad', but the ageing in place component increases the work for nursing staff – 28 days low level care then reassessed for high level care.

In summary it must be noted that non-compliance equals no funding; gaps in documentation equals non-compliance in Outcomes. This could subsequently deem the site non-compliant which then halts all admissions.