SUBMISSION FOR PRODUCTIVITY COMMISSION HEARING

'Caring for Older Australians'

15 March 2011

My name is Kylie Draper and I am a Registered Nurse in Victoria and my role is the Manager of Nursing and Medical Services for Eastern Palliative Care Association.

OUR SERVICE

Eastern Palliative Care is a fully accredited organisation through The Australian Council on Health Care Standards (ACHS) ensuring quality, safety and performance at all levels of service delivery.

Eastern Palliative Care is a partnership between Outer East Palliative Care Service, the Order of Malta and Sisters of Charity (St Vincent's Hospital).

Eastern Palliative Care's services are provided in the local government areas of Boroondara, Manningham, Maroondah, Whitehorse, Monash, Knox and Yarra Ranges.

Eastern Palliative Care recognises that a person with a terminal / life–limiting illness may choose:

- To be cared for in the comfort of their own home for as long as possible
- To live as normally as possible
- To receive assistance from specialist palliative care nurses to manage symptoms
- To be in the continuing care of their own doctor
- To have the support of their family or caregivers
- To be supported through the decisions and personal adjustments which inevitably accompany serious illness (emotional, social, financial, psychological & spiritual)

Palliative care

- Affirms life and regards dying as a normal process
- Neither hastens nor postpones death
- Provides relief from pain and other distressing symptoms
- Integrates the physical, psychological, social, emotional and spiritual aspects of care
- Offers a support system to help people live as actively as possible until death
- Offers a support system to help the family cope during the person's illness & their own bereavement
- Palliative care is provided to people of all ages who are dying.

While the majority of people requiring palliative care are in the older age groups, it is also needed by young adults, adolescents and children.

Our services purpose is:

'to provide, through an interdisciplinary approach, integrated palliative care services which are focused on the needs of the person living with a life threatening or life shortening illness, their family and carers, and which maximise quality of life, alleviate pain and suffering and offer comfort and support through the period of grief and bereavement'

I provide you with an account of some of the major issues that confront my practise in providing high quality palliative care services from a clinical, planning and in-reach service perspective for consideration as part of the Productivity Commission review of Caring for Older Australians.

1. As a specialist palliative care organisation we visit a variety of different facilities i.e. SRS's, Hostels, Nursing Homes. We find as visiting health professionals to these facilities that there is great variation in care provision and the mix of qualified/unqualified staff. This could suggest that the model is not as robust as is hoped. One of the issues we come across regularly is that in many facilities the turnover of staff is high. We can provide education to staff; however by the next time they refer to us there is no one available who has undertaken the training. Or so much time has elapsed, re-learning needs to take place. The Aged Care Standards and Accreditation Agency processes do not prescribe staffing levels of mix, and operators need to be aware of the needs of the clients when formulating rosters. This is particularly important for clients who are palliative – the client can change quickly and the staffing structure needs to respond to these changes.

2. Unregulated and unlicensed Care Workers and Palliative Care can be quite problematic for our service. It is our view that all PCW's should have to fulfil minimum educational and industry standards whether they work in aged care or any other setting. However, regardless of how much the quality of training is raised, the impact of this regulated training on the outcomes for clients requiring palliative care/a palliative approach may not be evident. Whilst this training will improve the provision of general care, well trained and educated registered nurses are required to increase the quality of care to clients requiring palliative care or a palliative approach. Well trained registered nurses are required to improve outcomes for clients requiring palliative care, particularly around pain and symptom management. One of the cornerstones of excellent palliative care provision is 'impeccable assessment'. This cannot be fulfilled, nor should it be expected to be fulfilled by a PCW.

3. Problems arise in aged care homes our service is involved in when there is no Registered nurse available or rostered on every shift. As a specialist palliative care organisation, our experience is that there are multiple issues that arise in facilities

due to a lack of Registered Nurses. We find that there is often poor identification and assessment of pain and other symptoms.

There is also an inability to administer appropriate medications i.e. Schedule 8 drugs.

There is an inability of staff to assess the effectiveness of these medications on the symptom.

There is a lack of education regarding opioids and the safe and effective use of them.

It is not uncommon for our specialist staff to encounter staff that have 'opioidphobia' and their own personal belief systems/cultural beliefs, prevent them from administering opioids to palliative clients whom require them. This is not exclusive to facilities that don't employ Registered Nurses and is illustrative of the need for more education for all aged care staff. This fear of opioids impinges on the ability of the specialist palliative care team to make recommendations that are implemented. We find that if we have been referred a client living in a residential aged care home that is prescribed and requiring PRN or 'breakthrough' medicine for pain relief that this creates difficulties. In some facilities staffed by unlicensed care workers [PCW's] they cannot administer oral morphine, in accordance with their educational preparation (if they are educationally prepared at all) as it needs to be measured and cannot be dispensed in a Dose administration aid. These workers if they have completed nationally recognised training through the Community Training Package are taught competencies to assist a person to Self Medicate (CHCCS304A) and to Provide Physical Assistance with Medication (CHCCS303A). People requiring End of Life Care usually are no longer able to administer their own medicine and therefore do not require the assistance of this workers scope of knowledge, rather the expertises of a skilled and educationally prepared registered nurse or an authorised enrolled nurse with medication assessment, administration and reviewing competence.

In these situations our service has to suggest alternative opioids options that can be dispensed into a dose administration aid for administration by a PCW's that may be delegated this responsibility by the registered nurse that is responsible for managing medication administration in a residential aged care service. An alternative medicine might be Endone tablets for example. By making an alternative choice in medicine we are often concerned that this may not always be the best choice for the client/resident; however because of the lack of appropriately skilled and qualified direct care staff employed at the facility, or the appropriate skills mix of registered nurses to PCW's almost always dictates the choice of opioid we have to recommend be prescribed by the treating doctor.

Likewise, fentanyl patches are often selected for pain management in these facilities as they are easily applied Trans dermally every three days.

We are aware of situations where we have spent considerable resources teaching willing family members to administer breakthrough medication, however many facilities we visit are reluctant to allow us to do this and are equally reluctant to employ someone qualified [registered nurses] to administer the schedule 8 drugs. We also have had experiences of PRN pain medication not being administered in a timely manner to palliative clients resulting in unnecessarily painful deaths of residents of such homes.

Furthermore, we find that the quality of direct care staff in aged care facilities fluctuates, some facilities have excellent proactive well trained and competent care staff, other facilities employ care staff that have absolutely no understanding of the palliative approach and the specialist nursing care required for good palliative care for these residents. It is our view that a sound understanding of the palliative approach would be 'core business' and imperative in the aged care sector.

Additionally, we experience problems with the clinical skills and competence of some care staff employed in aged care facilities. The specialist palliative care Registered Nurses from our organisation have been called out to facilities to provide consultation on best practice in palliation and find ourselves having to perform basic nursing care, that registered and authorised enrolled nurses are educationally prepared to undertake like insertion of catheters, attend dressings, apply stomahesive bags or management of a syringe drivers because the care staff do not feel competent to do so. Sometimes we observe these problems often occur in facilities that employ registered nurses, however they skills mix and ratios of RNs to residents is untenable.

On occasions we experience problems with referral process to our service. It is common that residents are referred to our specialist palliative care service because the registered nurse has requested some medication for pain for a palliative client and the GP is reluctant to order based on that nurse's assessment. The nurses of these facilities then refer to us as they feel the GP's will listen to a specialist service. This makes it very difficult for these nurses to advocate on behalf of their residents and could be disempowering and demoralising for these registered nurses.

Another issue commonly experienced is the over referral to our specialist service of all clients who they perceive as palliative. The Palliative Approach is not clearly understood – is this due to staff turnover, or the need for the Aged Care Standards Agency to see residents referred to the Specialist Service.