SUBMISSION TO PRODUCTIVITY COMMISSION HEARING

15/03/2011

My name is Saskia Van Deventer. I am a registered nurse and have been employed in residential aged care as a RN Division 1 for 7 years and as a manager for 1 year.

I provide the Productivity Commission with an account of my experiences at the coalface of the residential aged care sector and trust the Commission considers these views in coming to its final recommendations in relation to reforming care of older Australians.

1. Accreditation, Aged Care Funding Instrument (ACFI) and staffing.

- Accreditation standard 3.5 requires RACF to promote independence in our residents.
- ACFI provides us with most funding when our residents are fully dependent.
- It is often more time consuming to encourage independence than to do something for a resident, yet the funding does not reflect this.
- ACFI does not accurately reflect the real time and staff resources required to care for a resident.
- Appropriate management of a resident's behaviour can take a considerable amount of planning and intervention by registered nurses and direct care staff. It requires a great deal of specialised knowledge and skill for staff to implement planned behaviour care. Unfortunately, the Aged Care Funding tool does not accurately reflect this and oddly it is the domain which attracts the least amount of funding.
- Neither the ACFI nor the accreditation standards provide a model for determining skills mix.
- There must a mandate that requires at least one enrolled nurse on duty in each care unit at any one time in a ratio to match the assessed care needs of residents. (This could be determined by the ACFI care needs).
- There must be registered nurses on duty to maintain the professional obligations of the RN in relation to supervision of enrolled nurses and personal care workers/direct care staff in a RACF, 24 hours a day.
- Apart from the necessary assessments which are necessary to individualise each resident's care, there is an increasing burden on nurses and direct care staff to manage excessive documentation that is required in residential aged care.
- With having to constantly review and audit documentation to prove that standards are being maintained, an inordinate amount of time is spent doing documentation which is time better spent in caring for residents.
- Medicine should only be administered by registered or authorised enrolled nurses where a resident is classified as high care.
- In circumstances where a low care resident can initiate the management of their own medicine, direct care staff that have completed the unit of competence from the nationally recognised training package and gained the necessary knowledge and skills could be delegated this role from their supervising registered nurse.
- Some times there are errors made in packing the medication sachets, [with some research suggesting packaging error rates of 12% at any given time] or a change has been made by the doctor and with multi dose sachets, an untrained person will not necessarily have the knowledge base to be able to remedy these sorts of errors, potentially leading to adverse outcomes for residents if the medications are administered.

2. Retaining staff

- It is difficult to recruit and then retain them; more has to be done to promote the value of nursing work in this sector.
- This is compounded by the fact nurses wages in some care homes are considerably lower than their colleagues employed in the acute public and private health care sectors.
- Personal Care Workers [PCW's] are not paid enough for the work they do.
- Often the PCW's have very high work loads, working on a ratio of 1:8 or even 1:12. Ideally, a ratio of 1 care worker to 6 high care residents would encourage workers to stay in the industry.
- This would also enable care workers to encourage residents to maintain their independence which is sometimes difficult to do, with a high work ratio.
- It is very embarrassing for continent residents who have impaired mobility to have episodes of incontinence due to the fact that care workers are not able to take them to the toilet on time.
- A better work ratio would also enable care workers to spend more quality time with residents and provide them with emotional care and quality time.
- Many workers leave the industry as a result of burn out resulting from high work loads, not enough equipment, and dealing with challenging behaviours and at times disgruntled relatives.
- Another major issue is the fact that colleagues in the acute sector view aged care as an inferior area of care in which to work.

3. Regulation of workers

- PCW's need to be regulated.
- This will ensure that they are more accountable for their actions and take responsibility for their actions.
- It may also give them more pride in their work knowing that they belong to a registering body.

4. Industry standard for PCW's

- The registering body should also ensure that there is a standard of training which is identical for all students doing that course.
- This would mandate the course to be taught by all teaching colleges providing the training as well as a mandated number of hours of practical experience.
- If the student is found to be lacking in expertise on assessment by a qualified assessor or tutor, there should be a mandated extension in the number of hours to be completed before re- assessment.
- Proficiency in English should also be a requirement prior to commencing training.
- This includes the ability to be able to read, write and speak English.

5. Minimum Education standard

- I feel that PCW's should do a minimum of 6 months training. This should include 4 weeks of theory- covering basic anatomy and physiology, nursing ethics, OH +S, infection control, mandatory reporting ,fire and emergency and documentation.
- This should also include a practical component of bed making, sponging residents in bed, oral and dental hygiene, toileting residents, assisting with meals and fluids, and pressure area care.

6. <u>What happens when there is no registered nurse on a shift</u>

- Over the past several weekends, I have been on call for our facility when there has not been a registered nurse on duty
- This has been due to the fact that the weekend supervisor resigned and recruitment for a replacement was in progress.
- I am a manager, and do not necessarily know the residents. I am therefore fully reliant on the information that I am given by the acting (Division 2) supervisor to enable me to make decisions.
- This means that I cannot assess the actual condition of the resident and am dependent on someone else's assessment before making a call on giving PRN medications.
- It is also unfair for an Enrolled nurse division 2 to be placed into the role of supervisor and to deal with some of the issues that can arise.