Submission
No 53

INQUIRY INTO REGISTERED NURSES IN NEW SOUTH WALES NURSING HOMES

Name: Name suppressed

Date received: 16/07/2015

Partially Confidential

My submission is brief and is based on the stress my family endured when my mother became ill. My mother is and the age care facility was at The facility is 100 bed facility and predominately for high care residents. My mother became a resident in November, 2013, having moved from the family home (where she had lived with support from daily aged carers, through the Veterans Affairs Department). At the facility her mobility declined, to the extent that after six months she was confined to a large wheel chair. My observations were there were limited staff and it was easier to take her to dining room by chair then to be with her at a slow pace waling.

On 16 June, 2015, my sister phoned in response to discussions with the facility that I should quickly visit mum, as she was not expected to live much longer. I was told that mum had a blocked bowl and there was little that could be done. I was handed a pamphlet by the the Executive Director whom I had not previously met, on" handling death". No Doctor had visited my mother, the diagnoses was an opinion, supported by the Director. After exchanges, a local doctor made tests and arranged for my mother to be admitted to . My mother was admitted, the diagnoses was proven wrong, as she has survived and is alive and well as I write. Needless to say, she is now in another facility.

In my exchanges and reading since, I have formed several observations on the care of the elderly that is wanting and is "veiled euthanasia" for economic benefit.

1- The accreditation system is focusing on care without necessary linking the care to medical treatment. In the last accreditation report I read for the home, the focus was on care at the time of death (palliative care), but does refer to any medical treatment. My mother's prime care at hospital was hydration, by drip. The aged care facility could not administer a drip, the view expressed that it was the artificial prolonging of life. My view and that of my family, is it was basic health care. Although narcotics for "comfort" could be freely administered.

2. There is an economic threat to nursing independence if the Executive Director is also the head nurse. I am unsure how many registered nurses were roistered at any one time at the facility. The accreditation report in November, 2013, does not state the number. The report does state the bed occupancy rate, and it was 88/100. This occupancy rate is marginal. Coming out of the discussions was the feeding, it is likely that the slow hand feeding of elderly residents with swallowing difficulties may be outside the economic care of residents.

3. While a Doctor had been called, a day earlier, no visit had been made. The regular Doctor was away on leave. I do not know the alternatives that may be in place, other than no Doctor had visited my mother for 48 hours until at my family's insistence, a Doctor was called. The point I make with so many elderly and often unwell residents, would it be appropriate that a Doctor visit the premises daily as routine. Rather than wait for the vagaries of call out from medical centre.