

**Submission
No 134**

**INQUIRY INTO REGISTERED NURSES IN NEW SOUTH
WALES NURSING HOMES**

Name: Ms Nilda Miranda

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The Director
General Purpose Standing Committee No. 3
Parliament House

Honourable Members,

I am a Registered Nurse; a Clinical Nurse Consultant in the area of Palliative Care and a nursing teacher at our local university.

The prospect of not having around the clock access to Registered Nurses in Residential Aged Care Facilities (RACF) presents serious problems for adequate and timely delivery of care to residents. I will outline some points of concerns; particularly in regards to provision of Palliative Care to these clients.

Assessment:

Aged care Registered Nurses are qualified and educated on assessment techniques which are based on empirical evidence; personal knowledge; aesthetics, which in nursing refers to empathy and intuition; Ethics is the last way of knowing proposed by Carper (1978). This knowledge is only obtained in tertiary education due to its complexity and the responsibility it places on those called to exercise it.

The complexity of medical conditions encountered in chronically ill clients in RACF is increasing, with increase longevity comes increased morbidity. Research shows that the incidence of dementia exponentially increases as one ages. The recognition of dementia as a terminal illness and the identification of the terminally ill person; entering the final stages of the disease requires a level of sophistication of thought and clinical expertise that often escapes the uneducated.

Referrals

Appropriate and timely referral to specialised services, such as palliative care, also demand accurate assessment.

RACF do try and provide end of life care and although that usually presents no complex issues; there is an increasing number of clients who do require the intervention of Palliative Care teams. Currently our clientele includes at least 15 to 25 % of people living in a RACF. Complex pain control issues are most distressing for clients, families and carers.

Staff trained on delivering medication are certainly able to distribute tablets in the right order and to the right person with little or no knowledge of the effects of those medications. Pain syndromes, such as neuropathic pain require a higher level of clinical knowledge and expertise and the ability of the clinician to administer schedule 8 or schedule S4D drugs, such as opioids and benzodiazepines. This is often needed in injectable form when the oral route is no longer viable. Under the current legislation only a registered nurse; being witnessed by another person; is able to administer such drugs. I foresee prolonged suffering and distress by limiting access to pain control measures; increased demand on our after- hours nursing services, which is already poorly resourced, and a spike on presentations to emergency departments by terminally ill clients seeking relief from suffering at end of life.

Care innovations

The frail elderly client is deserving of care provided at an optimum level. An optimal level of care will be beyond their reach without access to Registered Nurses. Compassion and a nurturing nature need to be accompanied by clinical expertise and evidence based knowledge. The contribution of Registered Nurses in RACF cannot be undervalued or ignored. The innovative intervention developed and implemented by nurses have enriched the lives of those living in RACFs and minimise harm and suffering. Developments in the area of prevention of pressure ulcers; wound care; management of difficult behaviours; strategies to minimise the incidence of falls; policies and protocols to ensure accountability and adequate standards of care are all examples of the contribution of nurses led interventions.

Education and Leadership

Our new nurses commonly begin their nursing careers working in the aged care sector; likewise our undergraduate nurses find pre- registration employment in RACFS. These budding professionals need role models who are inspiring and valued in their work. Removing RNs, even for periods of time, undermines the importance of this specialty of nursing. Gerontology is a well recognised specialty and as such it should be supported by private and governmental institutions. Its principles and philosophies should be upheld and those who work in this field must be acknowledge and supported in the exercise of their profession.

Lastly from a human story perspective; I have witnessed the distress of clients and families in RACF when facing death. There are too many examples of inadequate pain relief, lack of information, perceived mismanagement in hospitals; a feeling of being relegated due to age or cognitive impairment to a lesser level of acuity. We know that crisis don't respond to a set schedule and it is remiss of ours to think that we could plan for all potential problems. There is evidence to suggest that difficult behaviours increased late in the evening. The incidence of falls is greater at night. Pain manifests itself much more pronouncedly at night, when the daily distractions are not present.

Access to general Practitioners and specialised services is at best limited.

I believe those who choose to die in their home, Their RACF, would be severely disadvantaged by the proposed measures and services like ours would be affected greatly, without the possibility of ensuring that adequate care would be provided at all hours. This would add an enormous weight to the grief and loss process undergone by families. The stress place on carers who might have to confront families who are unhappy with services receive would be great.

There is no question that our older Australians are deserving of the best available care; which appropriately matches their needs. We have been entrusted with the responsibility of safeguarding their journey, particularly at the end of life; the least we could do was to set mechanism to ensure their safety and well being.

Employers may need to be creative in the way they attract and retain suitably qualified staff; which enables frail and elderly people to remain in the place of their choosing and to be supported. The

other alternative would be to create after hours services solely dedicated to attend to crisis intervention in RACFs or strengthen the already depleted community health sector to provide an extra layer of support to RACF; which may constitute a cost shifting exercise of questionable value to the consumer.

Thank you for reading my submission. I feel compelled to present my humble words to your consideration and I hope that you would be guided by the core values our society holds dear. Values that have been instilled into us by those who have walked these avenues before us and are now beholden by the compassion and wisdom of the decisions we make.

Nilda Miranda

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