

**Submission  
No 153**

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

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Dearest policy makers

As I write this, I am sitting with my dying Grandmother. I have had barely any sleep in the last four days in order to keep a bedside vigil. My grandmother has been at this facility for 4 years, but just in the last four days alone I could write a hundred pages with concerns about the inadequacy of care from RNs and carers. This is indicative of the multitude of care related problems we have had since the first day my grandmother entered the facility. I think I have come to gain a unique lens in my grandmothers nursing home as the Carers see me as 'young' so they can get away with poor standards of care in front of me, as opposed to my intimidating mother and aunt. However, although I may be young I am not blind or dumb, I know what is right and I am going to tell you about it. There is an injustice in the care being provided to residents and it is occurring in nursing homes all over NSW. While the injustice to the frail elderly may be happening somewhere that is out of sight from mainstream politics, DOES NOT mean it is not an important issue. The mere fact that you want to take away 24/7 RNs from an already stressed system is beyond me. As you go on to read this I want you to keep in mind if it was your grandparents, your parents or you. What kind of care would you want?

The first time my family noticed the true shortcomings of our Residential Aged Care Facilities (RACFs) staffing was when my grandmother, who has dementia, began to miss most meal times wandering the corridors as the few carers would not notice her absence. Added to this was the poor sanitary state they allowed her to remain in. Aware of the unintentional neglect, as the nursing home was severely underfunded and understaffed, my family stepped up and tried to attend most meals and additional care. It is important to note that the level of care my family has provided is not the reality for many who are without family or unwilling carers. This situation has thus allowed me to observe the major problems and inadequacies associated with carers and RN's in Residential Aged Care Facilities.

While there are many systemic issues I could talk about, my major concern over the last four years has been with the poor quality yet essential health care that these Australian citizens are entitled to and the subsequent failings of the Australian Government to uphold Residents basic Human Rights. I understand that from a political point of view that the number of people living in residential aged care is relatively low (120,800 (4%) people over the age of 65 in 2011)(ABS, 2013). However, this is a large amount of people and the number is going to rapidly increase in the next 20 years. The current issues associated with underfunding and one of its chief corollaries in the form of lower than optimal standards of care are of importance as a critical period looms in relation to how Australia's ageing population is to be cared for, managed, and understood in coming years.

It is therefore important to understand what you are allowing to happen in the workforce that is causing such low quality care. The Australian Government's 2012 Aged Care Workforce report found that residential aged care facilities were workplaces for an estimated 202,344 people, of whom 147,086 were in direct care roles (King et al., 2012: 8). Aged care workers are crucial to the system, being directly responsible for the quality of residents' day-to-day lives. The increase in demand for aged care services has led to several adjustments in workplace characteristics, and specifically manifests in terms of the rapid growth of the workforce, which has increased from 156,823 in 2003 to 202,344 in 2012—some 29% over the period (King et al., 2012:8). The occupational group with most significant growth in numbers employed in the sector was the 'personal care attendant' (PCA)—from 67,143 in 2003 to 100,312 in 2012, a change from 58.5 percent to 68.3 per cent (King et al., 2012:9). However, while there was growth in the total numbers of all workers employed, since 2007 the number of RNs has fallen from 24,019 in 2003 to 21,916 in 2012, a change from 21 per cent to 15 per cent. This is due to residential facilities decreasing their reliance on RNs to provide direct care to residents (ibid:9), transferring it to a cost effective and lower skilled workforce. This was further supported in the report as in the major cities the majority of residential facilities (76%) reported a skill shortage; of this group, 62.5% of all facilities experienced shortages in numbers of RNs (King et al., 2012: 57).

The failure to employ sufficient numbers of appropriately skilled workers in RACFs has been caused by various factors that are specific to each facility, but which suggest sector-wide challenges implicating education and training, planning of social services, employment processes (and particularly recruitment),

and employment conditions (and especially absolute and relative levels of remuneration) (CPSA, 2014; King et. al, 2012).

Among direct care workers in both residential and community sectors there are comparatively low levels of satisfaction with total remuneration packages (wages and benefits). This issue is widely recognised as one affecting recruitment and retention (King et al., 2012: 96) Other issues, not included in the 2012 report but considered elsewhere, include the wage gap that exists between nurses working in hospitals and nurses working in aged care (CPSA, 2014).

From my own experience I can confirm these issues as relevant to the quality of the workplace in my grandmothers RACF. I observed mainly that the lack of staff ratio to patient was never consistent and could range from 1:7 to 1:30. This would involve one RN on duty for an entire floor with a couple of AINs. Which meant that only one person was responsible for clinical care, leaving both the carers and residents extremely vulnerable. Poor care would then arise as there was a lack of staff and skill mix to provide good quality care. The problems that I saw that were directly related to poor staffing, involved residents going up to 8-12 hours without incontinent pads being changed; not being fed properly-rushing, which often led to choking and underfeeding; people wandering out of facilities for hours on end; allowing bed ridden residents to sit and stare at walls for hours on end; allowing residents to freeze due to lack of bedding. The list goes on.

I recognise that these challenges may be evident in particular contexts, but they also appear to be the result of larger and systemic industry, governmental and societal pressures and failures. Either way, staff are caught in an unhelpful cycle—affected by the knowledge that the care they are giving is suboptimal and that the policy context is part of the problem. I observed that staff are constantly frustrated, as they don't have the time and resources to do their jobs properly and feel bad about doing their work. Many want to have the time to sit and connect but are run off their feet as they are understaffed. People should want to work in place that has a positive culture of learning and adapting to better care, which has a much better impact on the quality care given long term.

Everyday is different in a care facility and the current system doesn't allow for this living changing environment, instead it is stale and limiting and breeds poor quality care. Residents are marginalised socially and mentally, which in a dementia ward allows residents to deteriorate much faster. As people age and their difficulties in relating at a very caring level diminishes RACFs just do not have the staff to offer the one-to-one attention. They are lot of the time involved in the physical care and feeding. Which is only a part of what people are needing, people are needing to feel human and connected with, and some staff are very good at that, but they are totally understaffed.

While our facility provided the odd music days, there was little to no stimulation. So my grandmother would wander around the facility. She had almost 8 falls where she went unnoticed for several hours until a carer happened to walk by. Her last fall she broke her femur and an AIN picked her up and put her in bed. They did not know she had broken her leg, and my grandmother suffered for an entire day until the RN checked on her later in the day. While this is an example of understaffing, it also shows that even with one RN on duty there is still terrible clinical care being given. My Nan never walked again after that fall.

Finally, I would like to talk about how power has significant influence in determining the outcomes of residents' care and impact on how their bodies are consequently affected. I have observed that staff often have quite a lot of power over residents. They have power when to choose or not to choose when to do something, to say something in a nice way or say something in a mean way. What I think is lacking in RACFs is accountability in care where undertrained staff are getting away with terrible care because they undervalued, under skilled, under resourced and stressed. It is therefore important that you reconsider the change to the Aged Care Act and allow 24/7 RNs to remain in RACFs.

Regards

Hannah Barclay

King D, Mavromaras K, Wei Z, et al. 2012. The Aged Care Workforce, 2012. Canberra: Australian Government Department of Health and Ageing

CPSA (Combined Pensioners and Superannuants Association of NSW Inc). 2014, Aged Care Policy: Residential Aged Care. CPSA, accessed April 25th 2014 <<http://www.cpsa.org.au/aged-care/aged-care-policy>>