

Submission  
No 157

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

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Partially Confidential

# Inquiry into registered nurses in New South Wales nursing homes

*"A group of unscrupulous training providers selling substandard courses will have their contracts terminated under a state government crackdown, after revelations of serious misconduct and non-compliance across the sector." The Age, Victoria. June 29, 2015.*

I believe the same could be said for many private NSW training providers. The article in the Age goes on to say courses for Child Care and Aged Care areas with a high risk of exploitation. With this in mind, I think we need to carefully look at and think about how we train and support care staff in nursing homes.

*"Residents in RACFs may also require a palliative approach when they are dying due to the ageing process, that is, not only as a consequence of an incurable disease. Older persons who are dying are considered to have different palliative needs to those people diagnosed with cancer.[8] These differences may include, that:[8] • they have multiple clinical diagnoses that require a variety of treatments; • they require end-of-life (terminal) care for a shorter length of time (an average time of two days of intense care prior to death); • confusion, dementia, and/or communication difficulties may be present; and • some lack family support. Therefore, there is a special need for older persons with a life-limiting illness or who are dying as a consequence of the ageing process to receive a palliative approach." Guidelines for a Palliative Approach in Residential Aged Care Enhanced Version — May 2006*

*"To enhance the provision of palliative care and advance care planning services to the aged nationally, the Australian Government has funded the Specialist Palliative Care and Advance Care Planning Advisory Services (Decision Assist) Project". <http://www.caresearch.com.au/caresearch/tabid/3104/Default.aspx>*

*"They're missing out on their basic human rights," the anonymous whistleblower said.*

*"It's becoming increasingly worse with the staff shortage. They're totally understaffed overnights - one person responsible for about 40 people, anything can happen," they said.*

*"Because there's so little amount of staff there in the afternoon, we have to start bringing them to bed at 3.30pm."*

*"Then they don't get taken out of bed until 9, 10 o'clock the next day."*

*<http://www.9news.com.au/national/2015/07/02/18/45/victorian-retiree-sets-up-hidden-camera-to-catch-thieving-aged-care-worker>*

I am a registered nurse, and I have worked in residential aged care for many years. I firmly believe the needs of those being admitted to residential aged care have increased as the support in the community delays their admission; with this increase in care needs, there has been no real increase in staffing levels and that the standards of care being delivered in aged care facilities has therefore **significantly decreased**.

As residents have more complex care needs, more co-morbidities and declining health issues, there is a great need for MORE highly trained and skilled staff, rather than less.

When you have under-staffed facilities, with inadequately trained and supported staff, there will be residents whose care needs are not met as individuals, who are treated like cattle on a production line in the mornings to get them up and dressed, and again in the afternoon to get them changed and into bed. There is little room for individualised care; there is not time to talk – which is often what the residents crave for most.

Bullying and intimidation by management are very common in the sector.

I am have recently been on Worker's Compensation due to bullying and excessive workloads. Early 2014, along with other registered nurses, and care staff we formed a branch of the NSW Nurses' and Midwives association at our facility due to very deep concerns about resident care and safety as well as concerns for staff safety and wellbeing. One of our deepest concerns was the fact that there was no attempt made by management to fill rosters. We were constantly working short, with 2 or 3 staff members down, almost EVERY shift. Meetings with management were turned around to blame staff for this – for not picking up shifts, for taking sick leave etc. The fact was that there had been a change in the person doing the rostering (the daughter of the CEO was doing it now) and she did not take into consideration staff preferences and what shifts they could or could not do, or make changes in a timely manner when they were requested. When members of staff in the 64 bed “low care” section of the 144 bed facility complained they were inadequately staffed (even when the roster was full), they were told there were more staff at our facility than at others. No attempt was made to look at the validity of their claims, the work they had to do and the time allocated. We were constantly told by management that if you don't like it there are plenty of others who will take your job. And yet, when staff left, and new staff employed, we were still always short, many new staff don't stay. When it was suggested that some changes were needed to staffing we were told “*there is no money in aged care*”. When we said that residents were suffering, management told us that “*they will have to suffer. By the time you and I reach the age to need residential aged care, the care these people are receiving today will be considered a luxury.*”

Many of the lowly paid assistants in nursing did not want to join the union due to fear of recriminations. They need their job, some working in more than one facility because neither will pay overtime, and the rate of pay is so low they need the money.

Some of these care workers reported to me when I was acting as Secretary of the branch of the NSWNMA, that there was a culture in the workplace to make sure things “LOOKED GOOD”. That is, in the “hostel” section they would have care plans

with check boxes to say that the care was carried out. The check boxes were always completed- management would discipline those who didn't complete it. But, I was informed by the staff that it would be completely impossible to do all the care and other domestic duties (also checked off) in the time allowed. It was the resident care that suffered, as that is hard to check whether or not it has actually been done, as many residents have short term memory loss. But, it all looks good, and so we pass accreditation.

This "looking good" culture can also be seen in management's use of the "Moving On Audits". These are questionnaires and check lists which, when used properly would highlight any need for quality improvement. But with intimidation from management, and manipulation of the forms, our management will report over and over again that we achieved a score higher than the benchmark, and will do nothing to improve or change what is happening in the workplace.

My previous nursing experience had included palliative care. It was an area of great concern to me, as I saw too often that residents in the facility were not receiving the best care, or were being transferred to hospital when they were clearly at a point where there was no reason for active hospital care. A few of my fellow registered nurses did not feel comfortable with palliative care for non-cancer patients. There was no education support for staff on the subject. Residents could be ordered Morphine as needed, but it would not be given by RNs who lacked support and training in this area. I deeply felt the need for education and training in the area. I enrolled in Certificate IV in Training and Assessment – which I successfully completed in May this year. I also looked on-line for information and found the "Guidelines for a Palliative Approach in Residential Aged Care Enhanced Version — May 2006". I then also found the "Decision Assist" project. I did the online self directed learning and attended their 2 day training. I was not the only RN who was attending the training without the support of their facility. A tool kit for the project had been delivered to the facility, but they were reluctant to take up the initiative, and so still have not used it.

The last shift I worked, I was the only RN for 80 residents, I had to supervise the EN who was in charge of 36 of those residents. I also had to give out medications to 44 of those residents (which takes about 5 hours to do properly and carefully.) I had a resident die, and the extra work created by caring for him and his family. We were short AiNs and so I tried to help with feeding residents (at that time we seemed to have about 15 of those 44 who needed full assistance.) The day before this, I had been called in to attend a formal 'fact finding' interview the letter informing me of this stating that as a consequence of the interview it was possible that my employment might be terminated. This, I felt, was a complete over-reaction and threat due to my union activity. I had failed to sign a medication chart. But, as it was Morphine I was signing for, I had signed the Drug book, and administered it with a witness. I had also written it up in the notes. The day the incident took place was about 3 weeks before I received the express post letter informing me of the interview. On the day in

question I had been unusually busy, and had made notes of it in my diary. These 2 incidents were on top of the continued short staffing and bad rostering. There have been other punitive actions taken against other staff who were involved in the union activities and tried to negotiate for change.

I have heard from others in the union that such bullying and constant short staffing are common practices within the industry.

With the lack of proper training and support, residents will continue to suffer. Our aged will continue to be transferred to hospital several times when they are nearing death – much to their own discomfort and against their wishes, and also adding costs to the state public health system.

I have been called down to the 64 bed “hostel” section in the past to assess a resident, only to find that the staff have been trying to stand her and move her, when she obviously had a broken hip.

The fact that the “hostel” was originally only for ‘low care’ residents but now has at least about 12-16 ‘high care’ residents at any given time, with no extra staffing, is another very worrying trend. These “low care” facilities do not have the layout, design and equipment for residents with high care needs. The fact that stand alone “low care” facilities may also now house residents with high care needs (which bring the facility more money) to me is fraught with danger. Danger to the residents in that their care needs will not be met, and danger to the staff due to poor design, lack of equipment and lack of adequate staff for the increased care needs.

I have asked an experienced Endorsed Enrolled Nurse to check a resident I was concerned about. She reported to me that the resident’s observations were fine. As I was extremely busy, I took her word for it. It was not until the shift had ended, the EEN had gone home and I was staying back (unpaid overtime, which was very usual for all the RNs) to write up notes that I checked – the resident’s temperature was BELOW normal. Now, I am sure the EEN would have told me if the resident’s temperature had been elevated, but she failed to realise that a low temperature could be a sign of acute sepsis. (I went and re-checked the resident, the temperature was normal and she was more alert than I had seen her previously. In all probability the ear thermometer had not been used correctly by the EEN in the first place.) But this highlights the need for an RN to fully assess the residents.

Even an EEN can only give medications ordered. It takes a RN to make the clinical decision to withhold an ordered medication. Like when a resident is unusually drowsy, withholding their regular anti-anxiety medication may be appropriate. Or one of the Hostel residents I was called to had been suffering frequent heavy nose bleeds – but, because no RN had been supervising, and the doctor had not yet been in to see him despite attempts to get him to, this resident had been still receiving his daily blood thinning Aspirin. It takes an RN to make the decision about withholding a diuretic for someone who is showing signs of dehydration.

As our residents' condition can change quickly, it takes a registered nurse to know what could be happening, and how urgently attention is needed. Those less qualified are more likely to send to hospital for minor problems or to miss the significance of a serious problem. When is a cough just a minor cold, when is it pneumonia or aspiration that needs suctioning immediately?

When an Advance Care Plan states that the resident and their family consider their quality of life too poor to want to continue, a doctor's order could be written to say that in a certain event, Morphine can be given. For example, one of our dementia resident's had had chest pain, been sent to hospital and diagnosed with significant heart disease. The decision was made that should she again suffer chest pain, an injection of Morphine was to be given and the resident to remain in the nursing home. There is no predicting when such an event could happen – what would happen if there was no RN on duty? The resident would die in acute pain.

I do not believe the need for RNs is any different in nursing homes, where residents have “high care” needs, than it is in any acute hospital's geriatric ward. A registered nurse in both places is constantly monitoring a resident's condition & liaising with doctors; assessing for preventable problems, optimising health care or pain management and palliative care. Rather than doing without RNs in nursing homes, I believe we need better support and education for the RNs that are currently there.

We also need MORE care staff with better support, training and consideration for the care they give. Some providers will talk of “ratios” but then fail to adhere to those ratios, constantly allowing staff to work short; or fail to take the care needs of the residents into consideration. The actual workload is affected by many different things: some residents may need 2 care staff for all transfers (or even 3 for very obese residents); most need assistance with showering and dressing; some need full assistance with meals – actually require staff to spoon feed them; some have wound dressings – sometimes quite complicated; then there is all the behaviours of those with dementia or short term memory loss. Mostly the care staff are involved with domestic duties as well, bed making, delivery of meals etc.

An aged care facility should be a place with a culture of care and support for staff as well as residents. With so many care staff complaining of unreasonable workloads, with no time to care, and managers who won't listen and intimidate staff, there needs to be a change. As the culture of any workplace starts at the top, we need better training and supervision of managers to ensure a culture of support and care and to **stop the culture of bullying that is so rife in the sector.**