

Submission
No 5

INQUIRY INTO ELDER ABUSE IN NEW SOUTH WALES

Name: Name suppressed
Date received: 25/10/2015

Partially Confidential

Inquiry into Elder Abuse.

I have been a registered nurse since 1982. My main areas of experience have been in community nursing, palliative care and most recently aged care.

I am very concerned about elder abuse that is happening within the current system of Residential Aged care Facilities.

There are 3 main areas of my concern:

Financial abuse.

I was working at _____ Nursing Home in _____ until early April this year. It is a stand-alone aged care facility with about 140 beds. Low Care residents found out that the facility was charging them for things such as packaging medications into Webster packs for staff to administer. (Which should have been a cost to the facility, not the resident.) At first the Management would not refund the money, then refunded only to the complainant, telling her not to tell others. The resident did tell others, and did go to Aged Care Complaints. Eventually money was refunded to all.

The facility was also found to be charging high care residents for food supplements (Sustagen) and basic skin care product (Sorbolene). It was only after Aged Care Complaints stepped in that this was rectified.

The fact that the initial complaint about the Webster packs did not result in an immediate apology for the mistake, and the immediate refund to **all** affected residents, puts management's excuse that it was a genuine mistake in a **very** unfavourable light.

There are other unfounded stories I have heard about the management and board of _____ to make me wonder if more serious embezzlement is happening.

I then worked at _____ . (Another stand-alone facility, which, like _____ passed accreditation.) Talking to staff who have been there for a very long time, they recall that they previously had a Director of Nursing who was taking money from the facility. She was eventually found out, and dismissed by the board of directors.

Residents at the facility are very distrustful of handing over any money to some staff members who are in senior positions and should be trusted. There was a very

recent case of a care recipient questioning money, and the employee who was questioned (responsible for banking and accounting) turned red, and said it was a banking error.

Another staff member said a friend of hers who works at another aged care facility and has proof that management and board members of that facility are embezzling money, but does not know where to go with the information. *(I told her about this inquiry and suggested also that she contact her local MP about going to the ombudsman.)*

There is a definite potential for fraud and embezzlement in the industry. And for small stand alone facilities, the potential probably increases. If the board is complicit in the fraud, what course of redress is there? It is the residents who suffer, with funds that should be spent on staffing or other care needs diverted elsewhere.

I wonder what safeguards there are for this sort of financial abuse in community settings, with all the new aged care packages and client directed care?

Neglect:

While there is potential for embezzlement in the smaller aged care facility, larger facilities, with the eye on the overall costs, are just as likely as smaller ones to cause their residents to be neglected.

Short staffing is a constant problem in residential aged care facilities. Every facility I have worked in, or have friends who work in or have heard about through colleagues in the NSWNMA will have difficulty replacing staff who are off sick or on holidays. Leaving shifts working short.

As more residents are supported to stay in their own homes for longer, those entering RACF, have more care needs than ever before. With very complex care needs, and the need for sometimes 2 or 3 staff to attend the care of one resident at a time, other residents are forced to wait for attention.

Many high care residents need 2 staff members and a lifting machine for all transfers. Some obese residents need 3 staff. In many facilities staff numbers have **not** increased to reflect the increase in resident needs. Many need to be individually fed their meals and drinks. It all takes time – time that staff often do not have. Residents are forced to wait: wait for pain relief, wait for help to toilet, wait for everything! Meals get rushed, drinks get left out, residents lose weight and become dehydrated; residents that may be continent with help become totally incontinent. Residents who could walk with assistance, become bed and chair bound, because it is quicker and easier for staff not to walk them.

(Residents' conditions do deteriorate without neglect, and do lose weight, become dehydrated and bed bound for other reasons. Residents near the end of life do refuse to eat and drink, and artificial feeding becomes not an option when it would only prolong the suffering and dying process rather than doing anything for quality of life. Neglect causes the deterioration to happen much more quickly.)

When staff are so busy doing basic care, there is no time to look more holistically at how a resident's quality of life could be improved. Medications are administered late, because it takes so long to administer so many medications to so many high need residents. Resident preferences for how care needs are met, come a very poor second to just getting as much done as possible with the staffing hours available.

Education of staff is often a case of ticking boxes on a brief questionnaire, often the same ones repeated over and over. It fulfils the facility's requirements for ongoing education of staff, but does **not** translate into increased skills of staff, or improved care of residents. Staff at _____ were given the opportunity to watch Aged Care Channel at work, but never had time to do so. Other facilities may expect these low paid workers to do online training in their own time – which again can cause resentment, may not happen, and is very unlikely to lead to better training or any improvement in the quality of care provided by staff.

Recently, both BaptistCare and CatholicCare facilities in _____ advertised for an educator. On inquiry, I found that both had previously had Nurse Educators, but, under their new Enterprise Agreements, such a position no longer existed. They were looking for someone to do the SAME job for less money. This shows the complete undervaluing of education and disrespect shown to staff. Most facilities these days require their care staff to have Certificate III or IV in Aged care before they are employed. But, instead of calling them "Assistants in Nursing" they are classified as "Care Service Employees" or "Personal Care Assistant" and paid at a lesser rate. Again showing the complete undervaluing of education and disrespect towards staff.

Punishing and blaming staff for honest mistakes leads to fear and increase stress on staff which in turn leads to more mistakes and the under-reporting of mistakes.

Ignoring mistakes, or failure of giving meaningful staff appraisals can also have a negative impact on resident care.

A colleague, who also used to work at _____, recently told me that where she now works, at _____ in _____, there is no bullying of staff (unlike _____). But the care standards are worse, saying she has encountered residents with crusty dried excrement on genitals, and rashes from navel to knees due to poor care. Some staff there, she says, are very incompetent, but nothing is done about it. Perhaps because some staff is better than none – staff shortages being a constant and major problem.

The work is hard, the pay is poor. And in many places the treatment of staff is appalling – so no wonder staff shortages are common!!

I believe it is totally immoral to employ staff with cert IV and calling them CSEs instead of AiNs so they can be paid less! But it happens very often, and shows the complete disrespect and lack of support shown to those who give the day to day care to the residents.

All too often, the rosters only just have enough staff to do the care. In an office, when someone is off sick, or on holidays the work can be picked up later. But the work in aged care facilities cannot be postponed to another day. All too often, facilities try to manage with chronic understaffing.

In many facilities, the care workers who do most of the day to day care of the residents are not included on “handover” (because they are not nurses) so are not informed about changes in resident care needs. With the poor education and support of these workers, there is an under-reporting of resident needs and conditions. Staff need time to discuss their residents with a mentor or senior staff, they need time to debrief, they need time for education. But, there is a trend to reduce shift hours (and pay), leaving little or no time for handover, or any discussions anyway.

It is all too easy for care facilities to have the paper work that **says** care is given. , in the low care section had care plans that had to be ticked off by staff, supposedly when it was completed. But, it would have been impossible, with the number of staff on shift, and the number of residents to do all the care that was “ticked off” as being done. But, as staff were fearful of punishment for not ticking things off (which was easily checkable by management), it all looks good when accreditors come to check – even though not all the care was actually given. Many residents know how busy the staff are, and will not buzz, even though their care plan says they need to be assisted to the toilet etc – they do it alone, risking falls and injuries. This sort of thing goes on in all the facilities I have worked in or heard about.

There is no regulation on how the funding to RACFs is to be spent. As dementia residents get tired towards the end of the day, they become more restless and confused - “sundowning”. It is very much a time of high care needs, as meals are to be given out, medications administered and residents assisted to change and ready for bed. At this time, there is usually less staff than in the morning. There is a need for diversional therapy activities at this time. It is easier to sedate – it costs the facility less money. Or as I, and other RNs at had to do, take an anxious, confused resident with us as we tried to do our medication rounds without making a mistake, and without running too late. Often at I would have about 40 high care residents to give medications to of an evening. Medications were due at 6pm. I would start the medication round by about 4pm, and consider myself doing well if I

finished by 7, often not finishing till later. Constantly interrupted by needing to supervise or review somewhere, or by the confused residents or concerned relatives, meant that medications were often not given within a reasonable time. When we did raise our concerns with management we were told “there is no money in aged care” and no money for more staff. I was called for a fact finding interview, with the possibility of dismissal due to the fact I failed to sign for a medication, but the issue of how busy I was on that shift was not addressed in any way.

Even when residents are dying, there can be neglect and lack of quality care. When RNs are too busy to support the family, and to anticipate and manage the symptoms of the person dying, there is abuse. Pain and symptom relief medications delayed, or only administered after the pain or symptom has escalated rather than before it becomes so intense.

At there is only an RN on duty during the working week day. It was considered a “low care” facility, so did not require RNs 234/7. But, now, with aging in place and changes to legislation, about half the residents could be considered “high care”. Evenings, nights, weekends and Public Holidays are without RN support. The RN told me of how, one day, she came on duty in the morning and the care staff that greeted her, told her to “do something” with a lady who they perceived was just attention seeking and annoying. The RN went in to see this lady and immediately called an ambulance – she was transferred to hospital where she was diagnosed with pulmonary embolism. This leads to another very real concern about neglect in aged care facilities – when the staff on hand do not recognise the implications of a resident’s symptoms. The condition of the elderly can change extremely 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? With more and more “high care” residents in what used to be “low care” facilities, where will this problem end?

Psychological/Emotional Abuse:

Due to lack of staff, small numbers of diversional therapists, many resident are left alone in their room. It is easier. If they were brought together, someone would have to be there to intervene and supervise, as they would act and react inappropriately with each other. Boredom exacerbates other problems the aged may have. Depression becomes more common.

The diversional therapists are too busy doing the paperwork needed to justify their existence, and responding to the needs of those who can interact and relate to each other in groups.

In about April 2014, a group of staff members at [redacted] formed a branch of the NSWNMA within the facility. We did this due to our growing concerns about resident care and issues with staffing. During my time at [redacted] I had seen many staff leave once they had tried to negotiate for change or to improve anything – the very long standing management team would not allow it, and were very intimidating. We thought, with a united voice, we would be able to work and negotiate with management. One of the concerns we initially thought to raise with management was cluttered residents rooms which made manoeuvring lifters and other equipment dangerous for staff.

When the management [redacted] heard of this, she went to the room of one particular resident whose room was the most cluttered. She yelled at this mentally competent but physically dependent woman, reducing her to tears. She was threatened with having to find another place to live. The resident was too scared to raise the matter further, did not want to report it to Aged Care Complaints, and would not allow staff or her family to report it on her behalf.

The resident who first requested a refund of the cost of putting medications in Webster packs, was also intimidated. She has received letters from management accusing her of breaching residency agreement by feeding a cat and birds – management had no evidence. But again, the resident was intimidated into inaction.

At a residents and relatives meeting, the management took over the chair and would not allow residents to discuss the issues they wanted to discuss.

Part of management's response to the formation of the union branch and our concerns seemed very reactionary and very punitive: They started moving staff around the facility. Staff did not like this. **But, residents liked it even less.** When you are frail aged, forgetful, it is comforting to have a familiar face – someone who knows how to handle you, what you need, how you like things done.

While I respect the facility's right to move staff around the facility, I accuse them of emotional abuse of residents when they move so many staff at once, and do not allow new staff time to get to know residents before moving them again. Also they did not train and support the staff in the new work environment.

While staff are so busy, and not encouraged to participate in resident case conferences and the development of care plans, there is potential for more subtle abuse, or failure to provide quality care. Some staff will say that every time they go to shower a particular resident, that resident refuses. Another staff member may say they never have a problem, the resident always co-operates for them. If there was

proper staff discussion staff might find out more about what works for that particular resident. Leading to better person-centred-care planning.

Often, while on my medication round at _____, I would go into a resident's room to give medications, and all they wanted to do was talk. I just didn't have time.

A hierarchical management, with punishment the main form of staff management, does not promote staff pride in their work. Unreasonable workloads make working conditions stressful, ***but knowing that staff do not have the support of management and cannot go to management with concerns make it unbearable and unreasonable.***

I know that as the stresses at _____ increased, and the lack of support or intervention from management became more apparent, my job satisfaction greatly declined. I could only see how things should be done better, I no longer felt as if I was making a difference, helping improve the quality of life of those I "cared" for. It became extremely hard to keep even trying to care.

When staff in aged care stop caring, there is a huge potential for abuse. But it is so hard for them to keep caring when there is no support given and no respect from management!

Something needs to be done. The average age of a worker in aged care is 48, well above other industries. There is often high staff turnover, as the job satisfaction and rewards are not there when there is no support for staff and no time to care!

<http://www.australianageingagenda.com.au/2015/10/23/government-blind-to-urgent-workforce-issues-expert/>

A registered nurse who used to work at _____, now works at the local supermarket. The pay is less, but so is the stress, the workloads are more reasonable, ***and there is no heartache watching those you are supposed to care for suffer.*** At present I am working only casual at _____, (better staffed than the previously mentioned facilities), but, I am contemplating the same move.