SUBMISSION FOR INQUIRY INTO AGED CARE
By
SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

Submission prepared by:
Lucille McKenna

I have been a registered nurse since 1964 and have worked in aged care since 1969. I am enthusiastic about my work and passionate about the service I provide to the residents in my care. I am also committed to the staff for whom I have responsibility.
I am the Director of Nursing at Palm Grove Nursing Home, Narraweena on the Northern Beaches of Sydney.

(a) The adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training.

- The proposals put forward in the 2004 Budget are welcome but fall far short in addressing the real issues.
- I see the extra funding as a carrot for operators but there is no requirement for the operators to fund increased wages for staff, particularly nurses or education.
- The erosion of nursing staff will continue unless there is some form of workloads tool or a similar system to the pre 1997 CAM funding.

Nurses do not want to transfer to aged care and work for 16% less. In the current Aged Care case in the NSW Industrial Commission proprietors are saying they cannot afford to pay the nurses the same rates of pay as their acute sector colleagues.
We have the same qualifications and the same responsibilities and expect to get the same pay.
Nurses are now able to work in the acute sector fixed shifts and part time.

The rot set in when all homes were encouraged to make a profit (this includes charities and churches), often building bureaucracies at the expense of the very poorly paid care workers.
Having worked in Aged Care for the past 30 years, the period when we had SAM and CAM, prior to the current system was the most satisfactory period throughout my time in Aged Care. It was a time when adequate staffing levels were able to be maintained. Aged Care Nurses received the same wages as their acute/public sector colleagues and the CAM funding arrangement meant that nursing staffing was flexible but always appropriate.

We need quarantined funding for nursing staff positions at a level where adequate care can be provided.

Many registered nurses believe that there is an agenda to rid nursing homes of registered nurses. If this is not the case why is the Dept of Health and Ageing not demanding levels of RN participation?

(b) The performance and effectiveness of the Aged Care Standards and Accreditation agency in
(i) assessing and monitoring care, health and safety,

While most facilities are managing to remain compliant with the Standards I do not believe that this compliance can continue?
The effect of ever decreasing numbers of registered nurses, the Agency continually raising the bar, the squeeze for profits with private proprietors and "surplus" with the not for profit sector is having a huge impact on the ability of the staff at the coalface to continue to achieve these results.

The Agency is not able to monitor care. During any visit by the Agency the assessors might identify deficits in the system through the QI system, but a full visit every three years is hardly adequate to monitor care.
Support visits are brief and cannot monitor care, health and safety.

The only way to ensure good care is to have competent registered nurses who are valued by the organisation who are committed to driving a professional and progressive nursing home or hostel. These nurses need a strong conviction to the rights of the individual and management expertise. This will not be achieved while ever the governments desire is to continually improve the service without adequate safeguards for the residents and the staff who are trying to make the service work.

Staff in aged care are at their wits end. They have become demoralised by the continual erosion of their poor wages, increased workloads, limited numbers of permanent staff and emphasis on profits. One large church in Sydney is so bent on improving their bottom line that they are cutting all their AINs back to part time. Some are only reduced by ½ hour a week from 38 to 37.5 so as to make them part time and cut out the RDO. These people are earning $12.00 per hour and their wages are further cut. The staff are vulnerable and exploited by organisations that are anxious to make a surplus to spend on their other activities not related to aged care. There is a move to change AINs to other care worker categories so they can be responsible for domestic type duties as well as nursing.

Spot Support Checks by the Agency are appalling. These "inspections" often follow a complaint.
The ones that suffer from this dreadful experience are the staff. The staff are made to feel like criminals and many staff are very upset by the experience. I do not know of any other group of professionals that are subjected to such unprofessional scrutiny. It can be like an interrogation.

(ii) identifying best practice and providing information, education and training to aged care facilities

Agency staff have identified best practice in organisations where huge amounts of money have been spent to implement systems. I can give examples where wonderful results have been achieved and collapsed within months.
The nursing home which was the first nursing home to get the highest rating "Commendable" in the second round was rewarded by a restructure within weeks of the award and the CEO (a nurse) being made redundant and the DON being moved sideways. What confidence does that give in a service when the people who have driven the achievement are made redundant? Disposed of to improve the surplus!!

The Agency do not provide any education or training which is available to aged care staff. What has been provided that I am aware of has been information sessions for managers.
They did provide a series of three training workbooks in 2001 and 2002. By the time they were provided they were somewhat late and the case studies used were out of date.

I know of several homes where sanctions have been applied or where issues have been identified but the Agency has not provided any education or training.

(iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff.

The increase in paperwork since the implementation of Accreditation has been huge and it continues to grow.
When an assessor visits my nursing home, there is an expectation that she/he will be able to follow a very clear trail and this is done through minutes of meetings, records, audits, surveys, benchmarking, quality plans, procedures, policies, clinical records of residents, staff files and so it goes on.

About three years ago an assessor commented that it was too difficult to identify the improvements. This necessitated in the establishment of an Improvements Register. More paper work. The Improvements Register has been "a hit" with all subsequent assessors, as it clearly identifies the improvement and its source.

(c) The appropriateness of young people with disabilities being accommodated in residential care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements.

Firstly the level of dementia sufferers in aged care facilities is in excess of 50%, hardly a special needs group!!
Residents with dementia who have challenging behaviours or who abscond need to be accommodated in a specialist secure Dementia Unit. These residents cannot safely be kept in a regular nursing home. It is unsatisfactory for the other residents and unsatisfactory for the staff who are required to monitor the behaviour or the absconding.

At my nursing home we have a group of (5) with multiple sclerosis. One of these residents came to the nursing home at 36 at the request of the MS Society. This young woman requires total nursing care. We have successfully managed her, facilitated a reconciliation with her estranged family, accommodated her in a single room and provided appropriate activities for her age and level of disability.
While some would and sometimes do comment that her placement is inappropriate, the experts disagree. The MS Society and the family continue to compliment the staff here on their excellent care of this resident.

Nursing homes work best when there is a “mix” of residents with varying degrees of needs and disability and resident dependency.
Nursing homes which are specific to a disability e.g. Paraplegia, Multiple Sclerosis are very hard to staff due to the demands of the younger residents and they are physically heavy to nurse.
I have had considerable experience with younger residents. They are usually very dependent and can often display high levels of anger. Nursing homes specifically for younger residents often do not suit families as they want the resident to be near them, in easy access for visiting.
Some facilities are reluctant to admit younger residents as their needs are specific and often more costly e.g. Most activity programmes are geared for the aged. When there is a young person they require a completely different programme specifically for them.

(d) the adequacy of Home and Community Care programmes in meeting the current and projected needs of the elderly.

My experience with HACC services is limited. I can comment only on my experience when a resident is transferred back to the community from permanent or respite care.
If the resident has had respite only and been at home prior to the respite, with services, there are usually no problems re activating the service.
If the resident is requiring a new service on going home this is often difficult as the HACC assessment is often weeks away.
There is a wait for home care which is often vital to the return to home being possible.
Care by Community Nurses is almost always available with a day or twos notice.

(e) the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

I do not experience any problems transferring from acute care to aged care. Transferring from aged care to the community see (d) above.

Lucille McKenna