www.agedcarecrisis.com

"where little voices can be heard"

20 June 2005

The Secretary
Senate Community Affairs References Committee
Suite S1 59
Parliament House
Canberra ACT 2600

email: community.affairs.sen@aph.gov.au

Inquiry into Aged Care

The Aged Care Crisis Team appreciates the opportunity to present this submission to the Senate Community Affairs References Committee Inquiry into Aged Care and thanks you for your willingness to accept late submissions.

Our new website www.agedcarecrisis.com is now receiving an increased number of responses and we therefore wish to make the Committee aware of the issues raised by our respondents. The tenor of much of our feed back indicates a high level of community concern relating to aged care issues. Our submission aims to accurately reflect these concerns.

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Submission

Senate Community Affairs References Committee
Inquiry into Aged Care
Terms of Reference

On 23 June 2004 the Senate referred the following matters to the Senate Community Affairs References Committee for inquiry and report by 30 September 2004:

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

(b) the performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

(i) assessing and monitoring care, health and safety,

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

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

(c) the appropriateness of young people with disabilities being accommodated in residential aged 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;

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

(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.

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Introduction

The Aged Care Crisis Team welcomes the opportunity to provide a response to the Senate Community Affairs References Committee Inquiry into Aged Care.

Our response covers all areas identified in the Terms of Reference, with particular emphasis on staffing and accreditation issues.

This submission supports that of the Aged Care Lobby Group in South Australia.

Who we are

The Aged Care Crisis Team is an independent group of Australian citizens. We are deeply concerned about issues relating to the provision of aged care in Australia. All members of our group have experienced the current aged care system first hand - as primary carers for family members. While each of us has encountered individual dedicated and skilled professionals within the aged care system, we feel that the system failed us, and our aged relatives, in many ways. Most of us are also engaged with the aged care sector generally, in either a professional or voluntary capacity.

Why we exist

In each instance, we felt we had nowhere to go for support in a fragmented, incoherent system. Thus, we saw the urgent need to provide easy access to the full range of aged care information. Our website, www.agedcarecrisis.com aims to do this. It provides ready access to information and issues relating to the care of frail older people. Its purpose is to support and educate family members and carers.

Already www.agedcarecrisis.com is a much used web site, and has a growing user base. We have had considerable feedback on a range of issues relating to the quality of care provided to older residents of health and aged care facilities. Sadly, most webpage correspondents, and those who follow up with personal contact, indicate that fear of retribution prevents them from using the established complaints procedures. Others who have inquired about the complaints process, or attempted to use the complaints process, have found it frustrating and inadequate.

In Summary

The Aged Care Crisis Team draws attention to the vulnerability of people at the end of their life journey. The overwhelming response to our new website confirms our own experiences and indicates a high level of community support for reforms to the current aged care system.

In particular:

- we urge that critical issues relating to the shortage, low morale and inadequate training of aged care staff be addressed as a matter of urgency;
- we stress the need for a transparent and rigorous monitoring process which protects the safety and dignity of elderly, frail, and vulnerable people, who mostly cannot speak for themselves;
- we urge that consumers (residents, family members and carers) of the system should have ready and complete access to information about the system, and the facility, to which they have entrusted the care of their loved one;
- we stress the need for a transparent and totally independent complaints collection and management process.

1 Workforce Shortages and Training

> *"… I felt that I had to go every day to supervise her care. So many things happened, little things and big things in the end I became so exhausted just trying to keep on top of all the problems that would arise. Most of the staff are wonderful, but understaffing is a real problem and there is often only one trained sister in the evening to up to 100 or more residents…*
>
> *But what of the souls who have no one and there are many of those. I used to feed residents who had no visitors at all…"*

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

Nearly everyone agrees that Australia's 'ageing population' will place extraordinary demands on the health care system. Initially most of this demand will be in the acute care sector, but as the 'Baby Boomer' cohort continues to age, unprecedented demands will occur in the aged care sector.

There appears to be increasing recognition of this reality, and the magnitude of the changes that will be required are finally being acknowledged by those who administer and finance the system.

Key recommendations of the *Investing in Australia's Aged Care: More Places, Better Care* package, released earlier this year were:

- Provision of additional undergraduate higher education places in aged care.
- More opportunity for aged care workers to obtain and upgrade their qualifications up to Enrolled Nurse level.
- Provision of funds for more certificates of attainment in Medication Management for Enrolled Nurses.
- Assistance for aged care workers to improve their literacy and language skills.

Whilst clearly supportive of these measures, which should go at least some of the way towards addressing the existing deficiencies in the aged care sector, the Aged Care Crisis Team would like to expand further, and draw attention to what we feel are the crucial workforce issues for the future.

1.1 Adequately Trained Staff

No one would dispute that were you to find yourself in a Coronary Care or Intensive Care Unit that the availability of staff specially trained in that area would ensure the highest standards of care. The same principle should apply in aged care. There is an urgent need for more specialty trained staff in the aged care sector[1], and this commitment to training must encompass continuing education and ongoing professional development.

1.2 Staff/Resident Ratios

In consultation with the appropriate nursing and medical representative's, agreement must be reached on acceptable minimum staff to resident ratios. This must include the minimum number of specialist trained staff per shift based upon both number of residents, and their assessed level of care[2]. Once these staffing levels are agreed upon adequate funding must be forthcoming, preferably to ensure average staffing levels that are greater than the stated minimums.

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[1] Feedback to date sent to www.agedcarecrisis.com from carers and family members, believe that providing sufficient trained staff is the critical issue in ensuring that their vulnerable relative is cared for properly. In addition, education and the on-going geriatric based training of staff, staff attitudes and values, are all seen as factors affecting quality of care.

[2] A high proportion of feedback submitted to www.agedcarecrisis.com relates to aged care staffing. (Appendix of this submission, clearly supports and reflects this).

1.3 Availability of Regular Staff

One important benefit of addressing the existing shortages in aged care will be reducing the reliance on 'agency' or 'bank' staff. Staff shortages due to illness can, of course, create demand for temporary replacements, but by building up a larger core of committed trained staff, we can significantly reduce the number of times relatives will hear 'I can't really help, I'm just agency', in response to an inquiry about their loved one. If agency staff is used, all efforts should be made to access staff with aged care training and/or clinical experience.

1.4 Aged Care/Acute Care Pay Parity

Caring for the elderly should not be viewed as some kind of 'second class' occupation. Appropriately trained aged care staff should be paid at the same level as their colleagues in areas such as Coronary Care, Intensive Care and Renal Dialysis.

1.5 Access to Allied Health Services

Currently we seem to feel that once someone is admitted to an aged care facility, particularly a nursing home, they are no longer 'deserving' of efforts to achieve further functional gains. It is time we acknowledged that for many older persons a small functional gain can mean a significant improvement in quality of life. Greater access to services such as physiotherapy, speech pathology, and occupational therapy is mandatory if we are serious about providing high level holistic care.

1.6 Support for Relatives

Having a loved one admitted to an aged care facility is a traumatic experience for families at a number of levels. Very few facilities offer supportive counselling and too many relatives who are in fact experiencing grief, anxiety and depression come to be seen by aged care staff as 'demanding' or 'trouble makers'. We must acknowledge the needs of relatives, and provide more resources to assist them to cope with what their loved one is going through, and also to assist them to understand the necessary limitations of institutionalised aged care.

1.7 In Summary

Additional benefits of the above measures will include improvement in staff morale, and care delivered to the aged in a manner that better reflects the care and respect that this special group deserves. Many staff in aged care report a significant increase in non-clinical workload, including the now almost clichéd 'mountain of paperwork'.

> ***What an indictment of the system if we allow this non-clinical load to take staff away from the bedside. Surely we are not going to banish to the history books sitting with someone and providing comfort if they are scared, or in pain?***

Residents in our aged care facilities are getting older, and this means their care needs are increasing in complexity. Taking the time now to ensure we have a system that meets these needs will reflect not only the type of health care we value, but also the type of society we want to live in.

2 Accreditation

> *"… When accreditation was introduced, I thought at last the residents would have the quality of care they deserved and were entitled to. How wrong could I have been - it was a total farce:*
>
> - *the nursing home hired an expert to bring them up to standard so they'd pass;*
> - *equipment was hired for the duration of the inspection;*
> - *the medical trolley was fully equipped with new bandages, gloves, etc, (but most of these were for show – we were under strict instructions not to use them and if so, only sparingly otherwise we were lectured severely).*
>
> *This was all so appalling. Accreditation was going to change nothing and we were basically lying. Having worked there for 18 months I had to quit for I couldn't be a part of this charade."*

(b) the performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

(i) assessing and monitoring care, health and safety,

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

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

The Aged Care Crisis Team is particularly concerned about the inadequate integration in residential aged care of compliance activities, the complaints resolution scheme and the accreditation process. The Agency currently accredits facilities against a series of accreditation-related criteria (44 points) — an approach that many prospective residents find neither intuitive nor helpful.

Feedback (refer to the *Appendix – page 14* of this submission) to www.agedcarecrisis.com indicates the many ways the current accreditation process fails residents. Many family members and carers believe that accreditation teams often miss critical health and care issues, and are deeply concerned about the standard of care for their elderly relatives in nursing homes. Secrecy, power and control appears to be predominant features of a system which purports to care for one of the most vulnerable groups within society, but instead seeks to protect itself against any attempt to dilute that power.

Role Model: www.myziva.net

Innovative in its infrastructure, this overseas website captures and presents useful and easy to understand information that is consumer and facility focus based. Australia currently lacks any resemblance of useful or informative information for residents in nursing facilities. The MyZiva.net format offers basic information about every licensed nursing home in the country and, in our view, makes the complicated investigation process easier. Consumers and healthcare professionals can get sufficient information to make an initial evaluation by not only being able to compare nursing homes, but also to understand the various services and payment options.

MyZiva.net is easy to navigate, and as participating nursing facilities can "tell their stories" in pictures and words, valuable facility-specific information is available. Through a user-friendly search engine, you can find nursing homes in various localities throughout the country. You can even delineate your search according to facility name, type of ownership, number of beds, number of residents, percentage of occupancy, zip code, city, county and state. Through a Comparison Tool, you can perform an analysis of nursing homes, including a side-by-side comparison of the inspection reports, quality rankings, and the all-important staffing ratios (the number of staff members per resident).

In addition, MyZiva.net maintains current governmental data and reports gathered and maintained by the relevant government departments. The Survey section of the Web site provides a detailed listing of governmental performance surveys and records of previous surveys so that you can track a facility's progress over time.

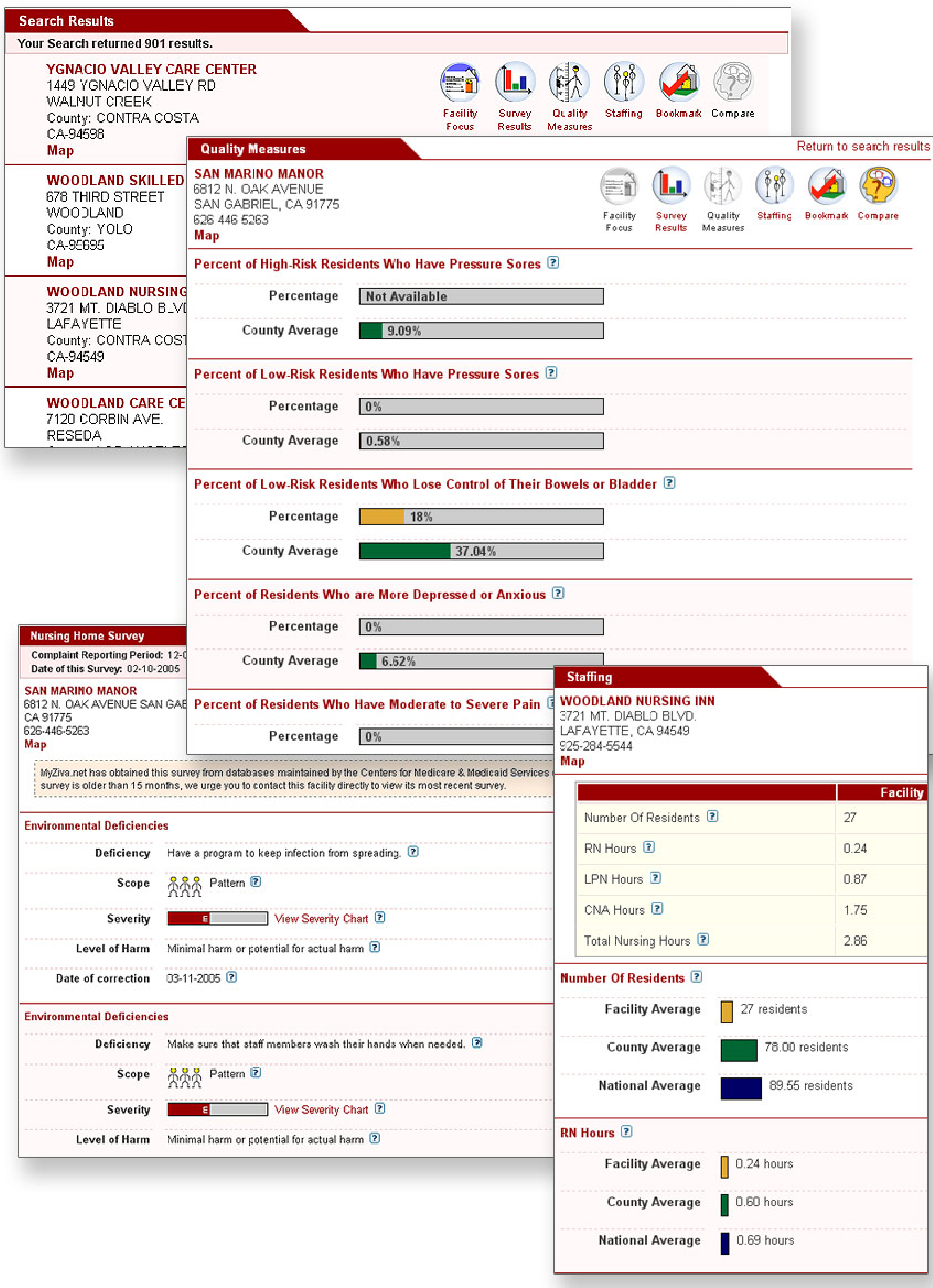
2.1 Recommendation: Accreditation

The Aged Care Standards and Accreditation Agency should significantly improve its focus on supporting informed consumer choice and consumer input to monitoring standards by providing useful and relevant information for residents of aged care facilities, as well as their families.

Mandatory (on the spot) electronic data capture for all nursing facilities; (one online system could be easily setup to allow data entry, data capture and online reporting, thereby providing consistent and timely information at all times, for all facilities). Capturing data on the spot, would also facilitate with the following points below:

- exploring with consumers input, a rating system to assist consumers to more readily compare quality of care and services *(which in turn would provide incentives for providers to become more competitive in providing quality care.)*
- the need for a consumer focus and consumer involvement in the accreditation processes;
- the need for transparency of information regarding the accreditation process whereby consumers can readily acquire information about accreditation results, including the disclosure of all reports and surveys, and in a timely manner
- an urgent need for more spot checks and unannounced visits
- the need for totally independent auditing
- the need for monitoring processes which do not take staff away from caring responsibilities in order to complete bureaucratic paperwork
- the need for inspections to be held over 24 hour periods (include meal times in the evening, right through to overnight
- the need for a totally independent complaints process *(feedback we receive indicates that there are no guarantees that the nursing facility will record complaints, also a reluctance to utilise the existing complaints process as it is looked upon as "too difficult")*
- better informing relatives (and hospitals) on the occupancy of facilities (*this would greatly facilitate already stressed relatives looking for nursing home placement, as well as facilitate hospital transition)*
- providing useful information in the areas of **Quality Measures** for residents, for example: environment, mistreatment, hydration, nutrition and diet, percentage of facility residents with physical restraints; percentage of infections; pain management; pressure sore prevalence; pharmacy service, quality care, resident assessment and resident rights; (again, electronic data capture "on the spot" would be able to be monitored easily – re www.myziva.net for examples of this and the following point).
- **Staffing Section** online data should be captured, with supporting data detailing information on hours spent by staff members caring for each resident, on a facility, state, and national level.

Figure 1: Consumer focus - sample of online nursing home data www.myziva.net



3 Young People with Special Needs in Nursing Homes

> *"I have a brain Injured son in a nursing home who requires 24 hour care. He has no short term memory and is confined to a wheelchair. He has been in the current home for 6 years, and I can relay to you the times they have left him sitting on the toilet (forgotten about him), and he got impatient and tried to get up himself, and finished up on the floor…."*

(c) the appropriateness of young people with disabilities being accommodated in residential aged 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;

The Aged Care Crisis Team is greatly concerned about inappropriate groupings of people in some aged care facilities. In particular, the practice of placing young people with high care needs in aged care homes means that it is almost impossible to provide age-appropriate care and therapy for these residents.

Issues of concern:

- the need for specific accommodation for young people with high care needs
- the need for additional low care accommodation for aged people who have a mental illness
- the need for additional low care accommodation for marginalised people who do not readily fit in to the majority of existing facilities

4 Home and Community Care Programs

"My aunt and uncle, in their late eighties, both experienced serious health issues at the same time. We were lucky to be able to obtain CACPs packages to support them at home. However, the hours of care were not really enough to ensure their safety and well-being. Additional, extensive family support (including one relative sleeping over most nights) was required. This proved unsustainable on a long term basis. My uncle died unexpectedly and my aunt reluctantly moved into an aged care facility. She was distressed by the move – more hours of home support would have enabled her to remain at home. This, of course, would be much less expensive, than residential care…"

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

The Aged Care Crisis Team supports current programs (provided through HACC[3] and CACPs[4] packages) which aim to keep individuals supported in their own home[5]. However, we also believe that many of the staffing issues raised in *Section 1* of this submission also applies to aged care workers who support frail older people at home.

In particular, we raise the issue of the need for quality control and monitoring of care workers who support vulnerable people within the relative isolation of the suburban home. We draw attention to recent incidents where vulnerable older people have suffered abuse at the hands of people charged with their care.

Feedback from www.agedcarecrisis.com alerts us to the considerable stressors placed on Councils of most municipalities within Australia, as they strive to meet the demands of elder care support. Additionally, the hours provided by both HACC[6] programs and CACPs are often insufficient to maintain people adequately within their home[7].

[3] **HACC**: Home and Community Care program

[4] **CACPs**: Community Aged Care Packages

[5] "Helping the aged for 51 minutes a day" (Source: The Australian, 6 May 2004)

[6] "Strain grows on community care" (Source: The Mercury - Tasmanian, 27 February 2005)

[7] "Home care crisis" (Source: Central Western Daily – NSW, 20 July 2004)

5 Hospital Transition for Frail Older Patients

"I have heard from numerous people now that bedsores often occur in hospitals and in the case of my mother-in-law, she was not moved from bed much in her three month stay, therefore wasting her leg muscles and creating a clot behind her knee. After her knee being operated on to bypass the blocked vein, she has not walked again because her muscles have worn away and will no longer support her.

She recently went into hospital for 4 1/2 weeks for pneumonia and once again arrived back at the nursing home with a bedsore on her ankle. One has to wonder that she's spent 8 months in the home and had a very nasty bedsore (from her previous hospital stay) cleared up with no more occurring to have another one reoccur in hospital once again…"

(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.

Currently, older people take up a considerable proportion of acute care beds in our hospitals. Feedback provided via www.agedcarecrisis.com reveals the extreme pressure placed on families to locate aged care facility places at a time when they are extremely vulnerable. Relatives are given impossible ultimatums to provide the names of facilities within extremely short time frames that are often impossible to meet

Feedback to www.agedcarecrisis.com highlights the following problems with hospital transition for frail, older patients:

a) quality of care delivered to frail and older patients in hospitals often does not meet acceptable community standards;

b) facilities were not accepting any new residents (some facilities had lists that were closed for months, some up to years)

c) few beds were available for men – the beds were "allocated" to either male or female, and there simply were not enough "allocations" for male residents.

d) other facilities unable to provide any timeframe **at all**. *We realise that it would be difficult to 'calculate' when a bed became available, but one would reasonably expect that a facility could provide an indication on how many people were on their waiting lists.*

e) hospitals un-cooperative with providing information, often citing it is "not hospital policy" to advise families of homes that their lists were closed, regardless of furnishing relatives with a seemingly endless supply of facilities. Once the search in earnest began, it was very obvious and apparent that the hospital has provided these lists to relatives, with the knowledge that some of these lists are already "closed", adding more anxiety and stress on relatives;

f) there is no choice – if your relative's health degrades to a point of requiring full "high level care", and they are in the hospital system, the aged care system is extremely unsupportive of these cases;

g) there just aren't enough nursing home places fullstop;

h) the need for inclusion of married couples to be accommodated together, through no fault of their own, are unfortunately forced to separate and live away from each other – this is particularly heartbreaking, and we have heard from several elderly people who have written in to us that have been separated;

i) the resident's own long-term physician is often unable to continue to treat their patients if located outside their "jurisdiction"

j) despite ridiculous time frames imposed on relatives, most are forced within an unrealistic time frame to locate a suitable "list" of nursing homes (it can often take up to approximately three weeks for the facility to book an inspection appointment).

The theory and stated intentions of aged care publications (particularly with government related publications) could not have been more contradictory. Despite the best intentions that are well documented in aged care publications, when it comes to practice lip service is paid to the practice side.

For example:

- Government publications available on the Australian Government Department of Health and Ageing web site, list "additional services" for high level residents - which should be supplied by nursing homes – for example water and air mattresses, and wheelchairs.
- Supply of "additional services" should be accurate. Most facilities respond that the patient's relatives paid for the hire/supply of these items. (equipment is usually acquired by a facility after relatives residents had died, with the equipment being donated to the facility).
- Despite recent efforts to attempt to "streamline" paperwork for patients needing to apply for a nursing facility, in practice, this has not managed to occur, most of the facilities insisted on additionally filling out their own application forms.

6 Appendix

6.1 Feedback sent to www.agedcarecrisis.com

The following are a small collection only, of extracts of emails and letters sent to the Aged Care Crisis Team (names and addresses supplied) from:

- Staff training, working, or who have been disillusioned with aged care within Australia and since left;
- Staff working in nursing facilities across Australia, concerned with the Accreditation process of nursing facilities in Australia;
- Daughters, Sons and relatives, who have personal experiences with aged care nursing facilities in Australia

Feedback 1.

"...As a PCA[8] *or Nurse's Aid, one doesn't have a voice. You are considered quite lowly and no respect is given. So I decided to go to Uni and study to become an Enrolled Nurse (Div 2). I only lasted for half the course due to my disillusionment of the industry.*

The class was supposed to consist of 22 students, but had 39. You were taught some things once and then considered qualified in that area. When we were sent to placement at a Nursing Home/Hostel, they were understaffed so us, the students, were left to shower, bandage and feed with no assistance or supervision. Because I'd had some experience, the other students would come to me for help and advice.

This is what they called training...

The government have a lot to answer for..."

Feedback 2.

"...there seems to be an influx of untrained and unsuitable staff who, because of the unemployment rules, take on any job because Centrelink tell them they have to.

Companies want to take on Division 2 Trainee[9] *to make money, then ask them to leave when their traineeship is over, causing loss of trained staff.*

Many of the PCA[10] *trainees have come into aged care because they are not able to find employment elsewhere and companies are desperate for staff take them on with very limited skills putting the residents and other staff at risk..."*

Feedback 3.

"... Mum is in her mid fifties, yet it is not unusual for her to work double shifts and she routinely stays back two and three hours after her shift ends to catch up on documentation. In fact, although her official working hours have been cut back recently, the hours she actually spends at work have not. She is a highly dedicated nurse and does everything she can to give the residents the best care possible under very poor conditions..."

[8] Personal Care Attendant (PCA)

[9] Division (Div) 2 Trainee is a student nurse not yet completed training and not yet registered with the Nurses Board. The facility is given special funding to employ under contract the student nurse until they have completed their training. Students take a lower rate of pay and a set number of working hours and they have their fees paid for them. They come under the Traineeship board.

[10] Personal Care Worker (PCA) - there are no specific educational requirements to become a personal care worker.

Feedback 4.

"… it is difficult to "care" for residents with the present staffing levels. I burnt out within twelve months of commencing work in a Nursing Home, because of what I saw and as a result of not having the time to spend with people who so desperately needed me to just be there for them.

As a Nursing Home employee I treasure the time when I can speak to a resident, and listen to what they have to say. That only happens when they are naked on a chair, in a shower. This is their quality, one to one time.

I have 15 minutes maximum to get that person out of bed, often with a lifter, get them to the bathroom, shower them, dress them and transfer them into another chair. I also should have the bed made in that time. If someone needs to use a pan while I am in the shower, they have to wait. I can't leave the person I am with. Then we wonder why the majority of residents are incontinent. Most aren't when they are first admitted.

I am going to university to study so I can escape the tragedy of our nursing homes. They are a huge indictment on our society.

I challenge anyone, who knows the reality of life in a Nursing Home, to say that they would like to spend the last years of their life in one.

We couldn't come up with a better way to strip aged people of all their dignity and humanity…"

Feedback 5.

"… I am now in my mid 40s (a baby boomer) and for most of my working life have worked as a trained nurse (now no longer). During my initial years as a nurse, I worked as an untrained nursing assistant in the area of aged care, and I must say I found it difficult and depressing to say the least.

I witnessed many acts of brutality and cruelty from more senior registered nursing staff and doctors alike, but due to my low rank at that time (felt) I wasn't able to do anything about it.

The thought of me having to rely on strangers to take care of my personal needs (like bathing and toileting), for me, is simply out of the question. My feelings would be the same if I were to ever need the services of a nursing home…"

Feedback 6.

"As a nurse in an aged care facility, it is very frustrating to have a resident returned from a hospital visit of only a few days, return to us with pressure sores that did not exist before the hospital admission. Let me tell you - the hospital nurse/patient ratios are FAR less than what we nurses in aged care deal with. I was in hospital myself recently and the ratio was 1 nurse to 4 or 5 patients, compared with the ratios I work with at present 1 carer/nurse to a minimum of 12 residents on an afternoon shift. Sometimes it is more, if you are short staffed. Morning shift is worse because the workload is even heavier, and the night shift is 2 carers for 45 high care residents, with one RN Div 1 for almost 100 residents - this is a lot of responsibility for the RN Div 1. Not only is the RN responsible for the residents, but the care staff as well, and including the building itself.

Based on the hospital nurse ratio's one has to wonder how they cannot give adequate pressure area care required to avoid pressure sores…"

Feedback 7.

"… I work in an aged care facility as a nurse/carer. It is a lovely facility but it has many problems. I specifically see problems in the delivery of quality and best practice care to residents.

I get very frustrated working along side people who call themselves carers who do not have experience, and some have no formal training/skills. Unfortunately, the government let aged care facilities employ such people. I believe the elderly deserve to be looked after respectfully and with dignity, but the delivery of care falls short by most facilities when employing staff who basically 'do not know what they are doing' and do not have the passion and dedication to perform and deliver quality care…"

Feedback 8.

"… I have been a personal carer for several years now, and for the last few months working in nursing homes.

I care deeply for my residents and treat every one of them as I would my own grandparent and I am disappointed that many people believe that Personal Carers (PC's) are careless or abusive. I guess there are people like that out there, but given that where I work I am pressured to carry out the ADL's with speed... (aim for 15 minutes/ resident), I am not surprised that residents are injured at times.

I have been instructed through communications (at my work) that if we cannot fulfil our tasks in the allotted time, then maybe we should not be working here (place of employment). We are short staffed and apparently 'under funded'.. something I find very hard to believe, but that is what I am told.

On average, each employee would stay on the shift (unpaid) for up to half an hour just to complete tasks and make sure that the residents are comfortable. All my work colleagues are compassionate and caring individuals. It is the management and owners of the nursing homes that need to be accountable for the funding they receive.

My understanding is that as long as a nursing home meets the accreditation standard, they continue to get funding to be spent in whatever way they choose. As with the 'serfs' of Russia, we personal carers form the foundation of aged care, we bear the brunt of abuse, a career that very few others would choose to pursue and get paid very little for a job very few of us would swap for another career. We don't work for the money.... we work for the love of our elderly citizens.

Would someone please help us, to help our elderly live out their remaining years with dignity and comfort?"

Feedback 9.

"… I have in the past had expressed concerns about the level of aged care but have not been heard. I worked in a large aged care facility for the best part of a decade many years ago and not a great deal has changed. In the industries where accreditation is implemented I see fundamental flaws. I see agencies given accreditation status in aged care and child care facilities and I often wonder how they achieved this standard. The only way accreditation will work is if spot accreditation is applied. A set schedule for the process only provides the organisation the opportunity to dress up the "facade" for the occasion. It is a farce and always has been. I could tell you many a story about accreditation!"

Feedback 10.

"… have just left employment with a categorised Low Care Hostel employed as a PCA. Over the 6 months I was there, I was a silent partner in out and out deception regarding accreditation:

- *I was told to complete 18 months worth of bowel assessments before (accreditation);*
- *the staff were hand-picked for the day the on spot review happened (the roster was changed to accommodate this);*
- *the residents who may of spoke of concerns where sent on a bus trip to local RSL for the day (a first I might add), unbeknown to them the accreditation team were coming in;*
- *the ratio of staff was upped for the day; and*
- *the menu changed to something very palatable the residents did not normally receive.*

Of course, the home passed with flying colours. I was lucky in the respect I was not stopped and asked any questions, saving me an ethical dilemma, due to the fact 3 weeks earlier, had been rushed through my medication competency - to the extent I arrived for a shift at 6am and found I was giving medication out, and at 9.00am the R.N arrived and then signed me off for 3 previous supervised medication rounds that had not happened.

I was working that day with one other carer who had no experience in aged care and had only worked one shift the evening before. She (no buddy shift/no competency passed) walked in and had to shower 9 residents before 8.00am and burst into tears when faced with a colostomy bag. (The poor woman had called 2 days previously on the off chance looking for domestic work and had been employed on spot as a carer.)

I was lucky that day, as no incidents/accidents occurred. When I queried the fact I was not conversant with the medication I was giving to the cognitively impaired (as per regulations), and (asked) 'when would education happen for that', I was told 'you have a MIMS[11] in the clinic, read that'.

My next shift as the Carer giving out medication was over the long weekend, no R.N is rostered on for 4 days, and unfortunately for me she also was not answering her phone or mobile so I had to make my own judgement calls re PRN medication[12]. When I brought my concerns up, I found they were not addressed - leaving me no choice but to leave before they fabricated a reason to get rid of me as happened to previous staff members."

Feedback 11.

"…Speaking with other relatives today, there are still ongoing issues. One resident asked to go to the toilet and was told to wait until after she had finished her breakfast. Staff did not return and she soiled the bed. It seems they are still not adequately staffed, either quantity or quality…"

Feedback 12.

"… A nurse wheeled Mum into the disabled toilet and went away. The nurse then went off duty. Unable to see any buttons (blind) Mum called out until her voice was gone. She was found 3 hours later at meal time by a staff member searching for her.."

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[11] **MIMS** – A handbook containing medicine information from Australian pharmaceutical companies

[12] **PRN Medication** - the name given to'when required' medications. PRN medications are defined by the Australian Pharmaceutical Advisory Council (APAC) as being those which are ordered by a medical practitioner for a specific person on that person's medicine records and when the registered nurse, using clinical judgment, initiates, or delegates to an authorised enrolled nurse, when necessary. The administration of PRN medicines must be recorded on the person's medicine record (APAC 2002). *Staff should record the times and dosage for which that medication is administered on the resident's medication chart and record why the medication is given and the outcome (for example, pain relieved, resident settled) in the progress notes.*

Feedback 13.

"… Lack of surprise inspections: I worked in a Nursing Home, which was privately owned for nearly two years. In this time the proprietor sacked over 18 D.O.N's (Directors). Food for residents was locked with a padlock in a fridge because the owner felt we might steal her milk or margarine or jam. So, hungry residents couldn't get a snack after 7.30pm when kitchen staff went off duty. We once had two chickens to feed to 30 residents because she wouldn't purchase more food. If we ran out of stuff, we had to buy milk or bread for the people. Sure, we complained, and complained about so many things you could never believe. Nothing ever was done. All in a very affluent Melbourne suburb too!"

Feedback 14.

"… Self regulation is a joke. Why would a proprietor, who most often is an absentee landlord with no emotional bonds with the patients, expend extra money if he does not have to? Philosophically how many people invest in aged care homes to provide good quality care as the first objective? Surely the main objective is to make a profit. The two are contradictory.

How many inspections take place at "dinner time" at 4pm when the bread and butter and cup of tea are handed out with nothing else until 7am the following morning?"

Feedback 15.

"… This home has had sanctions placed since and one of the biggest flaws was that they have one qualified RN on each shift and sometimes none at night time. When my husband spoke with the RN on Sunday, the RN had no idea that MIL[13] had been sick. The report on the accreditation stated that often care assistants were in charge of residents and did not report illnesses back to the RN's[14]. She was showing signs of flu and maybe the assistants didn't think it was bad enough - who knows.

The doctor had not been called for her. My MIL was just under the impression that that was the case as she had commented on her unwell feeling to the staff. When we bought it to the RN's attention, a Dr was arranged for the next day. Unfortunately, the infection had already hit the brain causing hallucinations and 4 days later, despite antibiotics, she had deteriorated enough to be admitted to hospital with pneumonia.

The poor RN's have way too much responsibility - medication records, changes in resident's health/appetite, etc and often don't get to actually spend time with the residents. If they had, they might have picked up her illness and acted upon it earlier."

Feedback 16.

"… Due to staff shortages my mother (totally blind and with dementia) had several bad falls, one when she fell out of bed suffering bruising, cuts, and a broken collar bone and resulting in extensive hospital treatment. The relieving staff member was unaware my mother was blind and forgot to put the restraining sides up on her bed"."

Feedback 17.

"…Are you aware, to reach Accreditation nursing homes have to tender an application, at the cost of thousands. Nursing Homes have to be accountable for care given, we have to prove we do what we say we do. Hospitals do not have to do this…"

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[13] Mother In Law (MIL)

[14] Registered Nurses (RN's)

Feedback 18.

"… My grandmother, a dementia sufferer was often put in the humiliating position of being left on a commode chair in full view of other patients and their families.

She was harnessed into the chair by a piece of cloth tied around her waist to the arms of the chair. One day she wriggled down and was trapped by the cloth around her neck. Had it not been for one of the other residents, she would have choked.

She was admitted to hospital, bruised and very ill. She was left too long without supervision…"

Feedback 19.

"… My mother was in a nightmare of a nursing home....a broken walker that no-one knows how that came about; items that go missing never to be returned; a lady that empties her bowels in my mother's room - faeces all over her things.

I complained to staff and management. I was told they don't have enough staff or money to look after them properly. If it was the RSPCA, they would have closed them up!"

Feedback 20.

"… My mother in law had lots of falls and was often there for some time as the nurses rounds are only every few house through the evening and she seemed to manage to fall between checks. One morning I found her on the floor at 8am. Never knew how long she had been there. She had a dislocated shoulder. The ambulance took hours to come as she was not an 'urgent case'.

I do really feel for the staff though the good ones are just run off their feet. and most do care it is just the insufficient funds for good care and supervision…"

Feedback 21.

"… The domestic staff were doing most of the caring with only one qualified nurse for 65 patients. My mother was often left to sit for hours, on a vinyl chair, not properly clothed or covered. One day she fell off this chair and broke her hip. She was sent home from hospital 48 hours after her hip replacement and untrained domestic staff were used to bathe and move her. Within two days .her hip had dislocated. This happened again - twice. Once it was dislocated for nearly a week but the doctor had not been called.

A physiotherapist was supposed to train staff, but the one nurse there told me 'she didn't have the time'."

Feedback 22.

"…We actually verbally discussed our concerns regarding the medication with both the DON[15] in January (2005) and the Managers/Owners on several occasions during February and March. They were meant to "look into it" and get back to us and we heard nothing. After several discussions with the pharmacy, we informed the Compliance part of the Department who after investigating our comments, strongly advised us to place a formal complaint. It was only after this that something was done by the nursing home. The fact that we had not put our concerns in writing, gave the owners a chance to claim that we went straight to the department. The home does have a written communication book to write concerns but part of the assessment found that none of these were being followed up…(we are concerned that there is no) proof that they have received the complaint…"

[15] DON: Director of Nursing

Feedback 23.

"…I'm more concerned about their "sneakiness" in not providing information when requested and lying about what is going on in the facility (missing medication) and only supplying information and admitting the truth when the Department became involved upon our complaint. This leads me to wonder what will happen after their sanctions are lifted and the department is no longer watching…"

Feedback 24.

"…Nurses in a hospital setting have little or no understanding of aged care and how to manage any person over 70 years of age.. We hate sending our folk to hospital, they return with pressure sores (very little are known in a nursing home setting) their behaviours have usually exacerbated and are out of control, they are malnourished and to put it bluntly - are worse than when they were transferred for a said 'acute illness'... It just makes me sad, angry and quite disgusted that elderly people nearing the end of a good life are enforced to go through this debilitating treatment…"

Feedback 25.

"…Where I used to live, Graham Kennedy is in care at a local nursing home, he is protected, he is treated as high priority, and confidentiality is paramount. He also is ?special? he is still old, with dementia and needs total care in his twilight years, your Dad, my Dad are every bit as important, the 96 residents in my nursing home are important, every person deserves the best care there is. Let's get out there and be heard. The media reports that "Every resident received a Government grant of $3.500," we had 90 residents at the time, big money - but it did not go toward extra staffing or equipment, it was given to meet the legislation of no more than two residents to one room. Nursing Homes were forced to extend, spending the money on bricks and mortar to meet the 2008 deadline for accommodation ruling and Accreditation…"

7 References

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Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings
Purpose: The purpose of this report is to provide a critical review of issues surrounding nursing education and training in aged care, and the current nursing shortages faced in the Australian aged care sector.
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National Review of Nursing Education 2002 [ISBN 0642 77313 0, ISBN 0642 77314 9 (Internet copy)]
Chair: Mrs Patricia Heath AM BEM FRCNA(HON)
Purpose: This Review was established by the Commonwealth Government to examine the future nursing educational needs of the health, community and aged care system and to advise on appropriate education policy and funding frameworks. Its role is not to define 'nursing', nor to enter into debates about the discipline or profession of nursing. It is for nurses themselves to resolve their concepts of professionalism and to develop their discipline.
http://www.dest.gov.au/archive/highered/nursing/pubs/duty_of_care/default.html

[16] **Inquiry into the Funding of Aged Care Institutions:** Four month inquiry, with a report presented: June 19, 1997 after 118 public submissions and three public hearings in Sydney and Canberra. Witnesses: more than 60. The report said: "The major concern for the Parliament should be the quality of care government can deliver." There were 28 recommendations, one of which called for the Government to ensure equality of access to aged care facilities for all aged people.

[17] **The Patient Profession: Time for Action - Report on the Inquiry into Nursing:** Duration: 14 months. Report tabled: June 26, 2002 after more than 970 public submissions and eight public hearings. Witnesses: More than 150. What the report said: "The shortages of nursing staff, especially in hospitals and aged care that has been threatening for years, have now reached crisis point."

[18] **National and State Skill Shortage Lists – Explanatory Notes**: The Department of Employment and Workplace Relations (DEWR) is the Australian Government agency with prime portfolio responsibility for monitoring skill shortages. DEWR assesses skill shortages by a number of means including contact with employers, industry, employer and employee organisations and education and training providers.