

Submission  
No 132

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

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Partially Confidential

## **Submission to**

### **The inquiry into registered nurses in New South Wales nursing homes.**

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#### **Introduction**

I write this submission as a Registered Nurse and nurse academic who has been working in aged care since 1985. With such a large time span in the sector, I have been able to move through various roles including clinician, manager, educator and researcher. This experience has been in residential aged care, acute care and in the community in metropolitan and rural areas which has given me insight into the similarities and divergence of issues related to ageing and aged care. My commitment to enhancing quality of life for older people and those who care for them is attested to by the amount of research I have done in this area of nursing. Motivation to undertake a PhD was because I felt this level of academic achievement would give me credibility and a voice worthy of being listened to by clinicians, the aged care sector and policy writers.

Astute assessment skills, well developed communication skills, knowledge of the normal ageing process and atypical presentations of pathology in older people are essential in enabling the registered nurse to enhance the quality of life of older people residing in aged care facilities, supporting them to live fulfilling lives and preventing unnecessary admission to acute care hospitals. Being able to make a difference in an older person's life is one aspect that makes aged care exciting and rewarding but underpinning the ability to make a difference is the sophisticated knowledge and skills expected of a Registered Nurse. Unfortunately these skills are too frequently dismissed and under recognised by the aged care sector.

The removal of this level of health professional from residential aged care will subsequently impact negatively on the quality of life of the older residents and their families.

This submission will follow the headings from the terms of reference for the inquiry.

#### **The need for registered nurses in nursing homes and other aged care facilities with residents who require a high level of residential care**

There are many examples I could provide about the need for skilled Registered Nurses in residential aged care; not just any Registered Nurse but Registered Nurses with the skills and knowledge to provide patient-centred care to frail, older people with complex care needs. I will use the matter of pain and oxygen therapy as examples.

Pain is a constant issue that arises from interviews with relatives and staff in my research projects. A lack of awareness of pain and lack of assessment and treatment of pain is something that I witnessed frequently. It is terrifying for the residents and the relatives and friends of residents because they are helpless to do anything about it. The management of pain is a sophisticated skill especially when it involves a person with dementia.

To illustrate this, I am using material from my PhD research project which involves an incident I witnessed in a residential aged care facility in NSW.

While walking through a residential aged care facility my attention was drawn to a woman sitting in a restraint chair at the end of the corridor with her arms outstretched to me. She was shouting out incoherently. As I got closer I could see the terror in her eyes; she reached for my hands and I held her, stroking her face and trying to re-assure her. She had my hands held so tightly, I couldn't have let go even if I wanted to. I looked around for assistance and at a table in an adjacent room was a group of five aged care workers writing their notes. They saw me with the lady, they heard me speaking to her, they heard her distressed cries and they continued to write their notes. After several minutes, one of the workers in the group approached me. I asked what was wrong, why was the lady so distressed and why had they ignored her? The aged care worker said *"She always does this, we just ignore her, if we give her any attention, she is worse"*. On assessment, it was found that the woman was in severe pain which was only relieved with opioid medication.

This incident illustrates the attitudes of some aged care staff to pain and the ignorance of pain assessment, pain management and good palliative care strategies. The issue of pain management is not being seen by the accreditation teams because the facility can have systems in place to manage pain but these systems and strategies are not implemented if staff do not even recognise that pain is an issue. It is then exacerbated when there is no registered nurse to intervene appropriately.

### **Oxygen therapy**

The following case was shared with me in another research project and formed part of my submission to the Productivity Commission in 2011. It is an indication of how basic skills are not mastered by care staff or monitored by management. It is left to families to monitor standards of care in this instance. It shows how unsafe and how vulnerable the residents can be.

*So, Mum went from her unit into the nursing home [with oxygen] at 3 litres per minute and we took her oxygen concentrator over and did it up for her. She would go and get her hair done and they would just take the oxygen off, leave it off. She would be up there for about two hours with no oxygen. I said "You can't do that with her. The oxygen sats are low, she is living on 80% oxygen, if you take it off she is on 70, you can't do that!" They'd turn the oxygen on but they didn't take the seal off. They'd put an oxygen regulator on the bottle to move her around but the seal was still on it! Jesus! Then I'd go "Oh my God!" Then I'd go up [to management], show them this is what's happened and they'd go: "Oh, we have got to get them trained". They said, "You could show the staff how to do it". I said, "I'd do that". And then they'd employ somebody new again ... who is on, along comes the oxygen again, they'd put her on the oxygen but they don't turn it on. So she's up there with a nasal prong on, normally wearing a mask, by the way, and she is not getting oxygen. I'd come in and find her up there with the oxygen on her, waiting to have her hair done but it is not on. Then I'd come into her room when they brought her back from the hairdresser, on one occasion, and the bloody oxygen hadn't been turned off [in her room while she was away]. They had just let it pour, the whole cylinder into the room. Light a match: all over. The oxygen was just a nightmare and in the end I was changing the bottles and monitoring the oxygen for her and they were saying to me "When I took her out for a walk in the wheelchair, she'd be off the oxygen for awhile, costs us too much to have the oxygen, it's expensive". And I said "She has got to have the*

*oxygen, it's crazy". So I'd take her for walks and I'd just go into their cupboard and get the oxygen bottles myself and set them up. (2010)*

### **The impact this has on the safety of people in care**

The issue of safety was the focus of my PhD research. Through interviewing aged care workers in residential aged care, I found just how unsafe this environment is. Subsequent research projects have reinforced this fact with the following situation taken from an article I write with colleagues (Elaine Dietsch and Carmel Davies) published in *Collegian* in 2013. The full article is attached to this report as an appendix.

Even though there may be many residents present in the communal dining room of a residential aged care facility, it can be a lonely place; sitting at the table with no-one to talk to, just waiting. Residents are encouraged to be seated in their place in the dining room up to an hour prior to the meal being served. Families perceive that it is organised this way so that the few staff available can take the residents to the toilet and then prepare those who remain in bed for their meals. It was observed by some participants that when the meal is served: *There isn't anyone in there while they are eating their tea so if anything happened, there's no one around. (Participant 7). .very rare that they [care staff] were seen in the dining room because normally they disappear and you just can't find a nurse. (Participant 2).* In an understaffed dining room, it was easy for resident safety to be neglected.

One family reported that their mother's wheelchair was positioned by a staff member at the table but the brakes were not engaged: *. . I got a phone call saying Mum had a fall out of her wheelchair, sitting at the tea table. One of the residents saw it happen. She [the other resident] said your Mother just pushed the wheelchair back, the brakes weren't on. She [the other resident] was yelling out to the girls out-side, they were smoking. (Participant 3)*

As a result of falling backwards out of her wheel chair, the resident sustained extensive bruising to her face and skin tears to her legs and arms. Subsequently, the resident's family felt they had no choice but to be present for all meals to ensure their mother's safety. Staffing levels are such that there are insufficient numbers available in the dining room, especially at the evening meal when fewer staff are rostered. Inadequate staffing and unskilled staffing can result in neglect of resident care.

These are photographs taken by the family after their mother's fall from the wheelchair and are used with permission of the family. They show the bruising to her face and the skin tear she sustained to her arm.

**The following photographs are confronting.**



### **The possibility for cost-shifting onto other parts of the public health system as a result of any legislative or regulatory change to the current provisions**

Cost shifting is not a possibility, it is a reality. At a conference in 2014, there was a presentation by staff from The John Hunter Hospital related to their efforts in preventing unnecessary admission to the emergency department of that hospital. In a recent conversation with the Director of Nursing of a large rural referral hospital, it was made evident that the same experience was occurring there.

The presentation of pathology in older people differs from younger adults, their care needs are more complex and they have competing care needs. It is not reasonable to expect an unskilled care worker to be able to differentiate between a delirium and dementia or a delirium superimposed on a dementia. A care worker does not understand atypical presentations. Subsequently, when a resident of an aged care facility shows signs of deterioration, it is easier to call an ambulance than undertake a skilled assessment. Movement from the facility to an acute care hospital not only impacts on costs for the hospital and the ambulance service, it impacts on the quality of life and comfort of the older person and greatly increases the stress on family and hospital staff.

Why not provide the calibre of health professional in the residential aged care facility; a registered nurse or Nurse Practitioner, who can undertake the assessment and initiate appropriate care where the older person resides?

### **The requirement for a registered nurse to be on duty in a nursing home at all times, as compared with requirements in aged care hospital wards**

Older people being admitted to residential aged care are increasingly more frail. If they can be managed at home, they would remain there but their needs are such that it is no longer possible and they require complex care. This level of care necessitates a registered nurse skilled in aged care.

The signs of serious illness in older people can be different to those of a younger adult. Confusion may indicate infection rather than an elevated temperature; the pain of a heart attack is not as intense in an older person but carers are not educated about the unusual or atypical presentation of illness in older people. Some do not recognise even very obvious signs of pathology, delaying access to acute care and thus putting residents at risk. The following incident illustrates this fact.

Before breakfast one morning, an elderly resident of a nursing home complained of feeling weak. The carers noticed that she was perspiring and seemed a bit confused so they put her back to bed and put a fan on her to cool her. This all seems very appropriate however, the carers did not appreciate that the woman's blood sugar levels were dropping and she was going into a coma. She would have died if her Pastor had not called to see her. He knew of her diabetes and insisted she be given food.

In advocating for registered nurses in aged care, I am advocating for quality care for frail members of our community. It is not about prolonging life unnecessarily, it is about ensuring appropriate care to underpin quality of life.

### **The role of registered nurses in responding to critical incidents and preventing necessary hospital admissions**

The following incident was related to me by a family member who was visiting his mother. He heard someone in another room calling for help but no-one was responding so he went to check. He found a resident on the floor in his bathroom who could not get up unassisted. When the visitor asked care staff for assistance, he was shocked by their response.

*Part of my frustration was people got to the point, the workers, were refusing to do the work that wasn't their job. There were people who were ENs or carers on some shifts, and on other shifts they were allocated as Activity Officers (AO). So they'd be out there with people doing an activity and there'd be people [who had] fallen over in bedrooms who had been calling out for help and I've gone in and said "Do you need a hand?" and they'd say "Yes, I've fallen over". Then I'd go out and say to the AO, "There's a person who's fallen over in their room, can you go and help?" They would say to me "I am the AO today. I can't do that!"*

*How ridiculous is that!! And I'd say "Just go and do it, please. I think the bingo can wait". A person is hurt on the floor. She was furious with me. Red, flushed, threw down the bingo calling numbers and stormed off to look after the lady who was on the floor. It was disgusting!*

It should not be the responsibility of unskilled staff to be able to prioritise care, to identify which resident's needs are to be addressed in what order. This requires the skill of a registered nurse who has the knowledge to assess needs and guide the care staff.

### **The need for further regulation and minimum standards for assistants in nursing and other employees or carers with similar classifications**

The issues of regulation of care workers and the quality of education provided to this group were covered in the Productivity Report "Caring for Older Australians", 2011, p371-381. The disparity in the standards of education delivered to care staff is expressed in a number of submissions to the Commission. Without surety in standards of education and assessment of skills for care workers, there is even a stronger case for maintaining the registered nurse as the leader of care in residential aged care.

### **The adequacy of nurse to patient ratios in nursing homes and other aged care facilities with residents who require a high level of residential care**

There are no ratios for staffing in residential aged care. This issue has caused much consternation amongst the families of residents when they find that this is the case. With older people now financially contributing to their care, families and residents expect that staff who can appropriately assess their care needs and implement that care in a timely way. They are incredulous when they find there are no ratios, comparing the sector to child care where there

are ratios. This is an area that needs further discussion but if we cannot even recognise that Registered Nurses are required in residential aged care, why be concerned about ratios? More and more, it appears that the focus in residential aged care is on the fiscal not the frail older person who needs appropriate care based on their needs.

**Any other related matters.**

- Too often Registered Nurses are confined to the office of the facility undertaking documentation required for accreditation or paper based assessments to comply with the ACFI. This is not the optimal use of a skilled health professional. The Registered Nurse must work within their scope of practice determined by the registering authority and articulated in the competency standards for a Registered Nurse. The Registered Nurse must be actively involved in resident care, supporting the care workers to identify when care needs change and supporting the care worker to prioritise the care they are providing.
- There is a pervading attitude that aged care is the field of nursing where Registered Nurses go to work when they are no longer capable of the cut and thrust of the acute sector. It is deemed to be menial work and unattractive work. Recently, I had a new graduate nurse who wanted to work in residential aged care. On their behalf I approached a facility but the Director of Nursing told me that they had just filled a vacant position with a Registered Nurse from the acute hospital who was nearing retirement and they were “lucky to get her”. With this pervading attitude held by society and perpetuated by the aged care industry and the nursing profession, aged care work will remain under recognised for the sophisticated field that it is with the substantial contribution to quality of life for older people and their families. This attitude is clearly evident in the disparity in rates of pay between the acute care sector and residential aged care.
- The Registered Nurse can often be the target of bullying by the care workers and managers. The Registered Nurse can direct care and insist that care be given in a professional way determined by the assessed needs of the resident however, if the care worker does not agree, they approach management inappropriately claiming bullying by the Registered Nurse. The care worker is the most valued worker so too often managers are anxious to keep them but see the Registered Nurse as expendable.
- Ensuring appropriate standards of care in residential aged care facilities is problematic. The process for standards monitoring is unreliable and with the move to five year accreditation, even more unreliable. This is substantiated in the Productivity Commission Report (2011) and in my research projects. The Aged Care Complaints Scheme is also fraught. My research and my personal experiences as a clinician working in aged care facilities shows the fear of retribution when someone complains about poor care and the inaction when inadequate care issues are revealed. This is articulated in the article in the Journal of Business Ethics attached to this submission.



**Conclusion**

The purpose of this submission is to alert you to the vulnerability of older people in residential aged care. To indicate to you the complex nature of their care needs and argue the case for staff in our facilities who have the expertise and skills of a registered nurse. Not only does the registered nurse need to be on duty for all shifts, they need to use the full scope of their practice, not completing paper work but in being with the residents and with the care staff, providing guidance with prioritising care needs, assessing and reassessing needs as appropriate and ensuring the initiation of the most appropriate, person-centred and evidence based care for the individual.

I am willing to elaborate on this document at a hearing, if required.

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