



2 August 2004

Mr Elton Humphery
Committee Secretary
Community Affairs Reference Committee
Parliament House
CANBERRA ACT 2600

Dear Sir

Please find attached the Health Services Union's submission to the Senate Inquiry into aged care.

The HSU is the specialist health union in Australia. HSU members work in every state in all areas of health and community care.

We are happy to supply further evidence from officials and members to hearings called by the committee as part of the inquiry.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Craig Thomson'.

Craig Thomson
National Secretary

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1. Introduction

The Health Services Union is the specialist health union in Australia. HSU members work in every state in all areas of health and community care.

The union's membership in aged care includes nurses, personal care assistants, allied health professionals, recreational activities officers, clerical, administrative, maintenance and support staff.

This Senate inquiry submission has been compiled after extensive interviews with members working in the industry in NSW, Victoria, Tasmania and Western Australia. Phone-in days have been conducted in NSW and Western Australia to gather additional information from HSU delegates, members, residents and family members.

Statements from staff, residents and family members are included in **Appendix A.**

The submission also draws on industry research undertaken by the union as well as the information produced through liaison with approved providers, other unions, the Federal Government, the Australian Labor Party and the Aged Care Standards and Accreditation Agency.

An analysis of reports produced by the Aged Care Standards and Accreditation Agency has also been undertaken.

Case studies analysing the agency's handling of individual aged care facilities are included in **Appendix B.**

The HSU (NSW) branch has also produced a submission which is included in **Appendix C.**

The HSU submission concentrates on the most critical issues for members: staffing levels, training and the performance of the Aged Care Standards and Accreditation Agency in regulating the industry.

There is also a section on the appropriateness of young people with disabilities being accommodated in residential aged care facilities.

The HSU is happy to supply further evidence from officials and members to hearings called by the committee as part of the inquiry.

2. Workforce shortages

A critical lack of staff is the greatest problem facing the aged care sector. With the rapid expansion of the industry to cope with an ageing population the shortages are becoming more acute.

There is also clear evidence both in Australia and internationally of the link between staffing levels and the quality of care delivered to the elderly.

Staffing shortfalls jeopardise the health, safety and quality of life experienced by residents in aged care facilities.

There is a greater risk they will be injured, attacked by other residents, be given the wrong medication, not get sufficient exercise or treatment from specialists, receive inadequate clinical care and not be properly supervised, even in an emergency situation.

Workforce shortages also have a clear adverse affect on the staff.

Aged care staff are committed and motivated and strongly believe in the importance of the work that they do. But for those in workplaces with inadequate staffing levels it is a demanding and stressful job.

Working in aged care for too many staff has also become more dangerous and less fulfilling.

In facilities where there are inadequate staffing levels there is a greater risk of workplace injury, of attacks by residents and intruders, and higher stress levels.

2.1 Research on Staffing and Care

The first ever detailed look at the aged care workforce released in April this year produced data which confirmed the widespread nature of staff shortages and the direct effect they were having on care.

The National Institute of Labour Studies¹ report commissioned by the Federal Government included a survey of over 6,000 care staff which found:

- Only 13 per cent of nurses and 19 per cent of staff overall believed that they had enough time to properly care for residents;
- Forty per cent of nurses and 25 per cent of allied health workers spend less than one third of their time providing direct care;
- Almost half the personal carers spend less than two thirds of their time on direct care;
- The major complaints of staff were that they did not have enough time

¹ National Institute of Labour Studies, The Care of Older Australians, a picture of the residential aged care workforce 2004

to spend with residents and the facility they worked in did not employ sufficient staff;

The results are similar to those recorded in the HSU survey of over 3,000 members¹ conducted in 2002 which found that:

- Over 50 per cent of the staff were unable to do their work in the time allotted
- 21 per cent believed the residents were in physical danger simply by being in the facility.
- 24 per cent of respondents believed their own safety was in danger working in aged care

International research confirms the link between staffing and care. The most comprehensive report completed in recent years was the report to Congress by the US Department of Health and Human Services on minimum staff ratios in nursing homes².

That report, finalised in 2001 after four years work, found “strong and compelling evidence” of a relationship between staffing ratios and the quality of nursing home care.

It found poor staffing levels had contributed significantly to an increase in the number of bedsores, to malnutrition, dehydration, weight loss and other preventable disorders and diseases.

The report also determined that there were ratios of care staff to residents that could be established which would result in vastly improved care outcomes.

2.2 Agency Findings

Recent reports by the Aged Care Standards and Accreditation Agency confirm the direct link between a lack of staff and poor care.

- At the **Kanella Aged Care facility** in Brunswick Melbourne, the agency reported that some residents had to be physically and chemically restrained because staff did not have enough time to supervise them. There was a serious risk to the health and safety of residents because there were insufficient staff to deal with resident suffering behavioural problems. There had been a series of violent incidents involving residents attacking each other and attacking staff as well as residents absconding. Relatives had to feed residents because of the lack of staff.

¹ Health Services Union, member survey 2002

² US Department of Health and Human Services, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, phase II final report, December 2001.

- At the **Sir James Terrace facility** in Queensland the agency reported residents were not being properly cared for because the facility was so short-staffed that carers did not have time to mobilise residents as per the physiotherapy plan, read clinical care plans or properly update them or complete resident documentation. They also could not adequately respond to resident requests for assistance. The report stated one care staff member had accidentally given a resident a large skin tear due to her rushing to get things done in the allocated time. There had also been repeated occasions in the 50 bed facility when only one personal carer was on duty, despite three residents being assessed as requiring two staff to mobilise.
- At the **Mount Carmel Hostel** in South Australia the agency found staffing shortages meant that there were delays in answering call bells, residents' care was rushed and some were woken at 5am to have their showers. Complaints about staffing levels had not led to sufficient improvements.
- At the **Elizabeth Lodge** facility in Sydney the agency found staff shortages and training problems affected clinical care, the management of medication, continence management, behavioural management and leisure interests. One recreational officer had to look after the needs of 129 residents (including 16 high care residents), 16 of who were located in a dementia unit.
- At the **Lewis Court Home for the Aged** in Portland Victoria the agency found the lack of staff and reduction in shift hours had was affecting the assessment, planning and delivery of resident care. "The lack of comprehensive assessments of residents' care needs means that care is inconsistent and on occasion inappropriate."
- At The **Fraternity of the Holy Cross** facility in NSW no-one was working overnight with one carer on sleepover. Low staff was hampering the care of residents with challenging behaviours with repeated instances of verbal and physical aggression towards staff and other residents and some residents repeatedly absconding. (see case studies Appendix B)
- At the **Valencia Nursing Home** in Western Australia inadequate staffing meant residents were only washed on alternate days despite all 45 residents being incontinent. Care staff were too busy to talk with residents except when they were assisting them with daily living tasks.
- At the **Richmond Community Nursing Home** in NSW a lack of staff meant delaying in responding to residents call bells, a lack of leisure activities, the non-completion of cleaning tasks and their documentation. Treatments were also being conducted but not documented, there were delays in the care and treatment of residents, some were left in bed and some received sponges instead of showers.

- At the **Armitage Manor** facility in Victoria one staff member was left alone with 60 residents overnight. Staff could not hear the buzzers of residents when they were working in the laundry, raising serious concerns about their safety in an emergency.

2.3 Experiences of HSU Members

Working in aged care as a nurse or personal carer is becoming an increasingly more demanding job, even in facilities with excellent staffing levels. Care staff can routinely be responsible for the following range of tasks and duties:

- Showering and toileting residents and assisting with their general grooming;
- Administering medication
- Simple wound dressing
- Implementation of care plans. Assisting in the development of care plans
- Attending to routine urinalysis, blood pressure, temperature and pulse checks
- Blood sugar levels checks and assisting and supporting diabetic residents in the management of their insulin and diet

In addition they may also be responsible for a range of other duties including cleaning, preparing meals, washing and delivering clothes and linen. As the National Institute of Labour Studies survey¹ found nurses and personal care staff can spend large proportions of their shift not actually engaged in caring for residents.

The statement overleaf is a list of the duties required to be carried out by a single staff member working alone overnight at the Lions Club of Sunbury home in Victoria.

It shows the staffmember is able to spend less than 20 per cent of their time caring for residents during the shift.

¹ NILS, 2004, op cit.

THE LION CLUB OF SUNBURY ELDERLY PEOPLES HOMES INC.

**DUTY LIST
NIGHTSHIFT
9.20PM – 7.10AM**

- **TIMES ALLOCATED ARE APPROXIMATE TIMES ONLY**
- **ANSWER ALL RESIDENTS PAGERS**
- **COMPLETE HOURLY ROUNDS**

- 9.20PM Changeover
- 9.30PM Check Residents
- 9.40PM Put clothes in dryer
Fold washing
- 10.00PM Medication round
Assist residents to bed
- 11.00PM Sweep dining room floor
Mop floor
Wash down tables and chairs
Set tables for breakfast
Make up 4 breakfast trays
Prepare 4 silver jugs of milk and cover (refrigerate)
Make up 4 jugs of juice and cover and refrigerate
Condiments in bowls and refrigerate
- 1.00AM Empty bins in offices and toilets and replace bags
Wipe down desks, clinical sink and fridge
Vacuum offices
Clean toilets (main building)
Including pipes under sink
Wipe down skirting boards
Wash floors
- 3.00AM Follow other duty list (cleaning) in manual and sign off when tasks are completed, **DO NOT SIGN OFF IF TASK NOT COMPLETED**
- 3.45AM Do ironing
Put residents personal washing in baskets outside residents rooms
- 4.30AM Fill supplies in each kitchenette
coffee
tea
milk (daily)
sugar
wipe down area and leave clean, remove dirty tea towel and

replace with clean tea towel

- Commence showers as per current shower list
- Take your ½ hour break when required
- Document throughout the shift
- 7.00 AM Changeover

For those staff members working in facilities which do not have sufficient staff the workloads are often enormous and care suffers as a result.

A staff member from the Yarraville Aged Care facility in Victoria, Alicia Anset said:

“The staff at this facility give 150 per cent but the fact is that the residents are not getting proper care. Some are not getting proper hydration. We are trying to feed them two at a time because we don’t have the time to do it differently. They are not getting toileted properly. There are skin tears and bruising because we are rushing to get them into lifting and standing machines.”¹

Another Victorian personal care assistant said:

“With the shortage of staff there are numerous falls. Staff are unable to give the quality of care that residents should be getting. We used to be able to spend quality time with residents on a one on one basis – nowadays it is always rushed and the residents are feeling it.”²

A NSW member who is a personal carer and works in a facility in Sydney’s eastern suburbs said:

“Hair is not being combed or washed, showers are not being done daily, teeth are not being brush – all areas of hygiene are suffering. There is no time to actually care for residents in their showering, feeding etc.”

However at a separate Victorian facility where the number of residents has recently been reduced staff have noticed a dramatic difference. According to Leanne Synan from the Regent Lodge facility:

“At the moment with the reduced number of residents the staffing levels mean our job is easier and we can give better care. The residents are happier and less agitated because we can spend more time with them. It is so important to be able to do that. We can take them for a walk or sit with them when they are upset.”³

In facilities where staffing levels are not adequate care staff often struggle to provide the required care and complete the paperwork required in the

¹ Witness Statement, Alicia Anset (Appendix A)

² Witness Statement, name withheld (Appendix A)

³ Witness Statement, Leanne Synan (Appendix A)

maintenance and updating of care plans, RCS assessments and accreditation. It can be a source of great stress for staff trying to decide whether to deliver care or document it, particularly if there is pressure from management to complete RCS assessments required for ongoing funding.

A 93 year old resident of a Western Australian low care facility, Ms Olive Mell said:

*"The documentation seems to me to be a big problem for the staff. There are too many reports that they have to write. It takes a lot of their time. They are called carers, but they don't have time to be carers because they are always writing."*¹

Ms Donna Reed who works as an enrolled nurse in Tasmania said:

*"Staff still need to spend too much time with paperwork that takes away from hands on care. Audits, surveys, claim forms, RCS assessments, the list goes on."*²

It is not only the physical care of residents that is affected by staff shortages. Residents and staff are in a stressful environment where there is little time for care outside of dealing with the basic physical requirements of residents.

A Melbourne division 2 nurse, Wendy Darrington, comments:

"Residents do not get the extras that could be provided if there was more time. It can be their emotional more than their physical wellbeing which is affected. We had one resident and her husband, who used to visit her every day, died."

*Staff didn't have enough time to sit down with her and give her that one on one support on the days that she was really down."*³

2.4 Safety of Staff and Residents

The shortages of staff are also causing serious safety problems for both residents and the staff. Higher incidences of workplace accidents involving staff and of stress leave claims are a result.

The most serious risk to the health and safety of residents and staff is caused by the common practice of only having a single staff member looking after all the residents in a facility by themselves at night. **At one facility in western Sydney a single carer is rostered on to look after 168 residents in three separate buildings, connected by external corridors.**

At least two assaults of staff who were working at night by intruders have taken place in the past six months. The first was at the RSL Veterans

¹ Witness Statement, Olive Mell (Appendix A)

² Witness Statement, Donna Reed (Appendix A)

³ Witness Statement, Wendy Darrington (Appendix A)

Retirement Village in Sydney on December 29 last year.

The second occurred on February 28 at the Garoopna UnitingCare Tanderra Lodge facility in Melbourne. The victim HSU member Shantell Barry had also previously had to evacuate 39 residents by herself after a fire broke out in a building at the facility during a night shift she was working alone. Ms Barry said of the assault:

"I was frightened to think what could have happened in this incident. I was working alone and down on the ground and there was no-one to assist me. I wonder what could have happened to the residents if someone wanted to hurt them.

I need to go back to work but I can never go back to work alone like that. Nobody should have to work alone at night. It is unsafe and how can you give the proper care if something serious happens?"¹

At a facility on the NSW Central Coast this year a single staffer had to call an ambulance after a resident had a cardiac arrest. The staff member made the call while doing CPR and then had to leave the resident alone so she could go outside and open the gate to let the ambulance in.

There is also a requirement in many facilities for staff to shower residents despite working alone on overnight shifts. At a hostel in Melbourne a HSU member has to begin showing residents at 5am due to staff cuts.

"In doing these planned showers I am neglecting my duty of care to the other 50+ residents because from the time each resident is undressed until they are re-dressed I cannot answer the emergency buzzer of another resident."

A HSU member at the Mayflower Retirement Community in East Brighton reported a similar problem.

"The practice of night staff showering makes other frail dependent residents very vulnerable and should an emergency occur elsewhere places staff in an impossible position...."²

The management of residents with dementia or challenging behaviours is particularly difficult without adequate staff. There are many examples of staff or other residents being the victims of violence because of inadequate supervision of these residents, some with tragic consequences. (See Chelsea Private Nursing Home case study in **Appendix B**)

According to HSU member Alicia Anset who works the Yarraville Aged Care facility:

"I recently had two days sick leave after being attacked by a resident. It

¹ Witness Statement, Shantell Barry (Appendix A)

² Witness Statement (Name Withheld) (Appendix A)

happened after I was left alone to look after 13 residents for over two hours. One resident was wandering around and pinching food and he went into another resident's room and they started fighting. Another one was climbing out of bed, one was incontinent and another one was waiting to be put to bed. The one who was incontinent because I couldn't get to him in time got very agitated and pinned me against the wall and was swearing and spitting. I don't blame him. He was angry. Because I didn't get to him in time this contributed to his behaviour.”¹

Bill Jacob who works at the Rosary Gardens facility in Tasmania said:

“There wouldn't be too many jobs in Tasmania where one goes to work not knowing if one is going to be punched, verbally abused, physically abused, have a cup of hot coffee, salt and pepper shakers or a bowl of cornflakes thrown over you by the residents.”²

2.5 Allied Health

Residents in aged care facilities are required to have access to a range of specialist care including speech therapy, podiatry, occupational care and physiotherapy. In reality there are huge variations in the quality and provision of these services.

Physiotherapy and activity staff can have responsibility for hundreds of residents. At the **Richmond Community Nursing Home in NSW** the Aged Care Standards and Accreditation Agency found a physiotherapist was found to be working for 10 hours a week trying to provide care for 65 residents.

At the **Elizabeth Lodge** facility in Sydney the agency found one recreational officer was assigned to look after the needs of 129 residents (including 16 high care residents), 16 of who were located in a dementia unit.

According to a Victorian carer, Jan Hamilton:

“The care staff are supposed to do the program of exercises with the residents during their shifts as well. But how do you get a dementia resident who has kicked and punched you as you try to get him into bed to then push his knees up to his chest 10 times?”³

The shift towards ageing in place has exacerbated the staffing crisis with facilities that were formerly low care taking on more acute residents but not adjusting their staffing levels to compensate.

2.6 Extent of Shortages

¹ Witness Statement Alicia Anset (Appendix A)

² Witness Statement Bill Jacob (Appendix A)

³ Witness Statement Jan Hamilton (Appendix A)

The difficulty of determining the exact changes to the size and makeup of the aged care workforce is hampered by the failure of the Federal Government to collect, until this year, any data on the number of staff working in the industry or their classification.

It has relied on the Australian Bureau of Statistics to produce information on the sector in its five yearly census.¹

The latest available ABS Census data shows that between 1996 and 2001 the aged care workforce actually decreased by 14 per cent in size from 97,086 to 83,833.²

The decrease was overwhelmingly in nursing homes (80,560 to 65,874) which reduced their number of direct carers by 15 per cent. In the low care accommodation the total workforce increased by nine per cent (16,526 to 17,959) with the number of carers up by 7 per cent.

This overall decrease came at a time the industry was significantly expanding in size. An extra 7,000 beds were allocated by the Federal Government between December 1995 and December 1999.³

In addition, the amount of taxpayer funding for residential care **rose** by 61.4 per cent between 1995/96 and 2001/2002. The average bed subsidy for high care places increased 44 per cent and the subsidy for low care places rose 96 per cent.⁴

Statistical evidence on the changes of the workforce in the last three years has not been available. The National Institute of Labour Studies report confirmed however through its survey data that there was widespread concern about staff shortages.

Evidence from HSU staff members is that staffing has decreased rather than increased. A survey carried out by the union in 2002 of over 3,000 staff found that over two-thirds believed there were not enough staff at their workplace.⁵

A Tasmanian HSU member and aged care carer Bill Jacob said:

*"From the time I commenced on this site (over 14 years ago) until now the number of staff to look after the elderly is getting fewer and fewer as the years go by and when one contemplates that if we live long enough that we could end up in a home for the aged, pity help the care we will receive if this trend keeps up."*⁶

¹ Senate Community Affairs Legislation Committee (Budget Estimates June 2003)

² Australian Bureau of Statistics, Census of Population and Housing 2001.

³ Department of Health and Ageing, Report on the Operation of the Aged Care Act 1997, 2001-2002

⁴ *ibid*

⁵ HSU member survey op. cit.

⁶ Witness Statement, Bill Jacob (Appendix A)

A phone in conducted by the Australian Nursing Federation in July 2004, which had over 1,000 calls from staff, residents and their relatives across the country, provided further evidence of the extent of staffing problems. Inadequate staffing was the number one issue raised by 86.1 per cent of callers.¹

As recently as April this year the Prime Minister John Howard also expressed his concern about staff workloads and wages. He said staff in the industry worked “well beyond the call of duty and far in excess of the remuneration that they receive...”²

2.7 Causes of Staff Shortages

There are a range of factors responsible for staff shortages, the most important being the regulation and scrutiny of aged care providers. The international shortage of nurses, low pay rates, poor working conditions and increasingly, high stress levels, have also been identified as causal factors.

In its 1997 Aged Care Act the Federal Government opened the way for aged care providers to take full control of their spending and staffing levels. No proportion of the Commonwealth funding had to be spent on providing care.

Regulations requiring nurse to resident ratios have since been removed.

The government's changes also included the establishment of vague and almost unenforceable accreditation standards. In the staffing area they require only that “appropriate” levels of staffing be employed in each facility (see section on the Aged Care Standards and Accreditation Agency).

The effect of these changes has been to allow providers the complete freedom to set the mix and number of their staffing levels.

As seen above there was a marked decline in overall numbers despite the expansion of the industry between 1996 and 2000. There has been a significant decline in nursing staff in both high and low care facilities. The Australian Institute of Health and Welfare reported an 11.1 per cent drop in the number of registered and enrolled nurses working in the aged care sector between 1996 and 2001.³

The Review of Pricing Arrangements in Aged Care carried out by Professor Warren Hogan showed the flexibility provided by the lack of regulation has allowed huge variations in the amount of money spent by providers on staffing.

Labour costs on average were found to be 66 per cent of total expenses. But

¹ Australian Nursing Federation, National Aged Care Phone-In, 2004

² Prime Minister John Howard, Opening of the Belmont Aged Care facility, April 20, 2004

³ Australian Institute of Health and Welfare, Nursing Labour Force 2002. AIHW Cat. No HWL29, 2003. Canberra

the figures spent by aged care providers varied by a huge margin between 52.7 per cent and 80.3 per cent.¹

The freedom to determine staffing levels has also coincided with a rise in the for-profit sector involvement in the aged care sector. Non-profit operators have accused this sector of exploiting the lack of accountability over staffing levels as a way to increase their profit margins.

The Aged and Community Services director Greg Mundy claimed earlier this year that the private sector ran far leaner staffing models which meant fewer hours per resident and poorer quality care.²

There is widespread evidence that the general shortage of nurses has made their recruitment into the aged care sector particularly difficult. But there are a range of other factors that influence the decision of nurses and care staff to turn away from aged care. Professor Hogan found:

“The lack of wage parity with the acute care sector, poor working conditions, lack of educational opportunities and a clear career path, the poor public image of aged care compared to acute care nursing and other workplace issues make recruitment and retention of skilled nursing staff in residential care services even more problematic than for mainstream health services.”³

Professor Hogan predicted the annual shortfall in commencing registered nurses over the next decade will be over 750.

The National Aged Care Alliance, which represents all the major stakeholders in the industry, identified in its pre-election statement that workforce problems were a critical issue that needed to be addressed.

“Nurses and care workers find heavy workloads, excessive documentation and lack of wage parity with their public hospital counterparts and their inability to achieve desired care outcomes as a deterrent to remaining in the industry. These contribute to a critical shortage of skilled staff that impacts on the delivery of quality aged care services.”⁴

For all care staff poor wages are a serious impediment to working in the industry. An experienced personal carer with a certificate III qualification in aged care in NSW earns \$13.53 an hour. The rates in other states are similar.

One NSW staffmember said:

“We can’t keep the young ones, they can earn more money stacking shelves or working in a supermarket and they don’t have to deal with the stress, the workloads or any of the unpleasant stuff that we deal with in aged care.”

¹ Review of Pricing Arrangements in Residential Aged Care, Summary of the Report, 2004.

² The Australian newspaper, February 18, 2004

³ Review of Pricing Arrangements in Residential Aged Care op. cit.

⁴ National Aged Care Alliance, Federal Election package 2004

2.8 Adequacy of Current Proposals to Address Staffing Shortages

The Federal Government has consistently refused to acknowledge the extent of the staffing and care crisis in the industry or to introduce the necessary measures to address it.

The government's major current initiative appears to be a pilot program aimed at reducing the paperwork burden on care staff. Minister for Ageing Julie Bishop said in April: "Nurses would like to spend more time with residents, of course. Providers would also join in that and the Federal Government has responded by trialling a pilot program to decrease the amount of paper work required for care needs and that's underway currently."¹

The 2004/5 Federal Budget includes \$2.2 billion in extra spending for aged care. None of that money is allocated towards addressing staffing shortages. That is not to say the money is not available for providers to act but there is no requirement for them to do so. The additional \$877.8 million over four years providers will receive in increased care subsidies includes no accountability measures that would require staff numbers to increase.

There is a vague requirement for providers to take part in a periodic workforce census but no details of how that would operate or whether it will lead to the introduction of future requirements on staffing levels.

2.9 Action Required

It is clear that the current aged care system is failing to deliver sufficient staff to provide the care and safety that residents require. The view of the Health Services Union is that the regulatory requirements for staffing, stripped away by the current government, need to be re-introduced and significantly extended.

Minimum staffing levels covering all care and ancillary staff are the only way to provide a basic guarantee of care and safety for residents and their families.

There is a clear international precedent for the introduction of such a reform. A majority of American states (37) had by 2001 established some form of care staff/resident requirement. A total of 28 had a set number of hours of nursing care per patient per day that had to be delivered.²

Minimum staffing levels should only be introduced after a process of industry consultation that involves representatives of providers, staff members and residents. They would not be a one size fits all but a regulated minimum number determined by resident needs and acuity. A mix of nurses and personal care assistants would both be required 24 hours a day to care for residents.

¹ Minister for Ageing Julie Bishop, ABC AM program, April 3, 2004

² US DHHS op. cit.

Accreditation standards need to be rewritten to incorporate minimum staffing requirements.

3. TRAINING

The need for highly skilled staff is made greater by the workforce shortages in aged care. Yet there is no minimum qualification or training required for staff before they can begin work in an aged care facility.

Providers can and do use staff who have no training in aged care on a regular basis, some even working alone at night and responsible for giving out medication. **(see witness statements Appendix A)**

There is also no minimum amount of training that providers have to give to staff over any period of time.

This lack of regulatory control again contributes to the shortfalls in care provided to the elderly and to the danger and stress faced by staff members. The need for ongoing workforce training has been made far more acute as identified in the Hogan report by the fundamental shift in the staffing model used by aged care providers.

A greater reliance on personal care assistants and less use of registered nurses has not been matched by an upgrading in the training and education required in many facilities.

As Shantell Barry from the Garoopna UnitingCare Tanderra facility said:

*"In April (2002) I started night shift. I had no qualifications, not even a first aid certificate. I was required to hand out some medications including oral morphine to one resident."*¹

Personal care assistant Bella Millar said:

*"Training was completely inadequate. We had a couple of talks from what I remember from people trying to sell things. One was on incontinence pads. Medication management training was also inadequate."*²

Providers also remain unaccountable for the training they conduct. The accreditation standards drawn up by the Federal Government in the area state that: "Management and staff have appropriate knowledge and skills to perform their roles effectively."

Enforcement of the standard requires a highly subjective judgement to be made by accreditation inspectors operating without the benefit of clear guidelines stating how to judge what is appropriate knowledge and skills.

¹ Witness Statement, Shantell Barry (Appendix A)

² Witness Statement Bella Millar (Appendix A)

The result is huge inconsistencies in the training and education programs provided by aged care providers across Australia.

At the **Kanella Aged Care Facility** in Brunswick in Melbourne the Aged Care Standards and Accreditation Agency found one staff member who had been there eight years who could not recall attending a single external training session or even one that was held in the facility. The nurse unit manager who had been there 16 years could not recall any behavioural management training. That was despite there being 17 residents with dementia, Alzheimer's or other mental illnesses.

The Federal Government also has no way of assessing or recording the level of training or expertise of staff in the industry. There has been no requirement for audited financial accounts to be submitted to allow independent scrutiny of their expenditure on training or any comparisons to be drawn. Evidence of operators misstating their training expenditure was presented in a wages case currently before the NSW Industrial Relations Commission.

Professor Robert Walker, an accounting professor from the University of NSW, said one operator, Canberra Nursing Home Pty Ltd director Michael Douglas Mooney, had passed off university fees paid for his son's degree in veterinary science as staff training expenses.¹

Professor Walker raised serious concerns about the inadequacy of financial reporting by aged care facilities.

3.1 Proposals to Address

The Pricing Review of Residential Aged Care completed by Professor Hogan made substantial recommendations on the scale of the increased training required to meet future workforce demands in the industry and improve the skills of existing staff.

His recommendations included:

- An increase in registered nurse places at Australian universities of 2,700 over the next three years. A total of 1,000 first-year places should commence in the 2005 academic year. The additional places should only be available to universities that offer specialist training for aged care nurses.
- Funding be provided to enable 12,000 enrolled nurses to complete medication management training;
- Funding be provided to enable 6,000 aged care workers to complete a Level IV aged care certificate and 24,000 to complete level III aged care certificate by 2007-08. The money should only be available to providers who are compliant with the education and staff development accreditation requirements, maintain their training expenditure at a minimum of their 2003-04 level and provide in addition at least half the

¹ Professor Robert Walker, Australian Associated Press article, July 20, 2004

cost of the training.¹

In response the Federal Government in the 2004/05 Budget allocated \$101.4 million over four years for improved training. It committed funding for:

- 400 additional undergraduate places in nursing, growing to 1094 in the fourth year.
- Up to 15,750 aged care workers to be assisted to obtain formal qualifications.
- Up to 5,250 enrolled nurses to be trained in medication management.
- Up to 8,000 aged care workers with language and literacy difficulties to be assisted with workplace English language and literacy program²

In addition the extra \$877.8 million in increased care subsidies over four years being made available to providers specifies that providers should “encourage” workplace training and make audited accounts publicly available.

There has been no explanation from the Federal Government as to why it’s budget response fall so far short of Professor Hogan’s recommendations in each area of workforce training and university education.

Senior bureaucrats from the Department of Health and Ageing were unable to say during Budget Estimates where the revised figure on university places had come from or how exactly they had been determined.

They were also unable to explain how the accountability mechanisms would operate with regards to audited financial reports, the workforce census and training or when they would be introduced. A typical response was the one provided by the secretary of the department Ms Jane Halton said: “We can never guarantee these things. You know how these things are.”³ Despite the critical need for improved training the Department of Health and Ageing’s spending on better skills in 2004/05 is \$8.9 million – less than the money allocated for selling its response to the Hogan report (\$9.3 million) in the same time period.⁴

3.2 Action Required

The Federal Government should adopt and fund in full the proposals put forward by Professor Hogan for improving the training of aged care workers and ensuring an adequate number of university places is made available to meet the future demand for aged care nurses.

In addition it should move as quickly as possible to put in place a requirement for all new staff entering the industry to be qualified to an aged care certificate III standard.

¹ Review of Pricing Arrangements in Residential Aged Care op. cit.

² Australian Government’s Response to the Review of Pricing Arrangements in Residential Aged Care, May 2004.

³ Senate Community Affairs Legislation Committee (Budget Estimates June 2, 2004)

⁴ Federal Budget 2004-2005, Health and Ageing , May 2004.

Greater accountability mechanisms should also be built into payments for providers to ensure an agreed level of workforce training is provided in each aged care facility.

Audited financial statements made available by providers should be required to detail expenditure on training and education.

Accreditation standards covering training need to reflect greater training and education requirements for providers.

4. The Performance and Effectiveness of the Aged Care Standards and Accreditation Agency

The Aged Care Standards and Accreditation is failing in its duty to ensure that an adequate standard of care and safety is provided to elderly residents in aged care facilities.

It is also failing to ensure the safety and security of staff is protected and that sufficient staff are providing care in residential facilities. The key failings of the agency are due to the accreditation standards it is supposed to enforce, the inconsistency in its decision-making and the inadequacy of its inspection regime.

The National Audit Office found in its review published in May last year the agency could not even tell whether its efforts had improved the standard of care in the industry.

“The agency has only limited information that suggests the standards of care have improved since the 1997 reforms,” the audit office report stated.¹

4.1 Standards

As outlined in the sections above relating to staffing and training the accreditation agency is hampered by the vague and almost unenforceable accreditation standards set down by the Federal Government. All of the 44 standards are subjective and open to interpretation by individual inspectors. Staffing is the most obvious example. The standard 1.6 states that there must be *“appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives”*.

This standard can and is interpreted by inspectors in endless different ways. In response to questions asked in Senate Estimates the agency refused to say whether it:

- Provided any guidelines to inspectors about what constituted

¹ Managing Residential Aged Care Accreditation, Australian National Audit Office, May, 2003.

- appropriate staffing levels
- Collected any data on staffing levels to enable comparisons to be made across the industry and best practice guidelines to be drawn up
- Whether inspectors were required to undertake analysis of staffing levels at any facility for the months and years prior to accreditation visits.¹

The HSU has been unable to find any information to suggest any of these things are actually done by the agency regarding the staffing standard.

4.2 Inconsistency in Inspections

Even the most casual analysis of the publicly available reports produced by the agency shows huge inconsistencies in the level of scrutiny applied by agency inspectors and in the reports they produce.

The vague nature of the accreditation standards combined with the lack of guidelines contributes to this problem. As the Audit Office reported there are also issues with the workforce. Up to half the assessment workforce are contractors at times of peak demand. Those contractors may be staff working in the industry who produce only two or three reports a year.

The Audit Office found: “The agency has little evidence to identify and therefore address differences in skills and interpretation between internal and contract assessors”²

Senior agency staff review the decisions of inspectors before final reports are produced but again as the Audit Office reported: “The risk for the agency is that the accuracy and quality of assessors findings and reports, upon which decision-makers base their decisions, will be inconsistent.”

The accreditation process is not transparent. Accreditation reports do not carry information on whether the inspectors are agency staffers or contractors. This prohibits any check to ensure no conflict of interest exists.

In addition no information is made available on whether the facility has successfully nominated any of the assessors (as they are entitled to do) to be part of the inspection team.

Case studies (**see Appendix B**) highlight the handling by the agency of some facilities and the inconsistencies that resulted. In the case of **Chelsea Private Nursing Home and Vincenpaul Hostel** in Victoria there are huge variations in the reports produced before and after the tragic death of residents.

Again using staffing as an example, some inspectors list the staffing levels on each shift, most don't. In the case of **Kaniva** in western Victoria the same staff levels that passed in 2000 were found to be inappropriate three years later.

¹ Senate Community Affairs Legislation Committee (Budget Estimates June 2003 Question on Notice)

² ANOA op. cit.

At the **Alroy Nursing Home** in Singleton, NSW inspectors and the agency found staffing levels were adequate despite having one staff member at night looking after 49 residents at night, 12 who were high care. On what measure could a single staff member looking after that many residents be viewed as appropriate?

Not one inspection report of the hundreds viewed by the HSU has included an analysis of staffing levels combined with resident numbers and needs over an extended period to see if they have been maintained at an adequate level.

Some reports cover an accreditation standard in a brief paragraph which shows no detailed scrutiny has been undertaken.

The **Isomer facility** in Victoria passed education and staff training despite being unable to identify the dates of training, attendances of staff at any programs. Management's explanation that the previous director of nursing had provided training to staff on an informal basis without recording the sessions was accepted.

Some reports carry detailed lists of what improvements need to be carried out. Others have nothing.

Almost every HSU member interviewed in the preparation of this submission had some concerns regarding the way accreditation visits were carried out and the level of scrutiny applied by inspectors.

Providers are given an extended period to prepare for accreditation and many facilities appear far different during the brief period of the visit than they have in the preceding three years and will be almost immediately after the visit. Staff and residents are also reluctant to speak out for fear of reprisal.

HSU member Alicia Anset works at the Yarraville aged care facility in Victoria. She said:

"Everything changes when accreditation comes around. We have division 1 nurses coming in going right through the files to make sure the paperwork and care plans are up to date. They pay for staff to stay back and do overtime and it's all a mad panic. When the inspectors are on the floor there are extra staff working.

There is extra linen brought in and the kitchen is brought up to scratch. The accreditation inspectors mainly talk to managers who paint a beautiful picture. There are meetings with family and friends of residents but only by appointment. Both the staff and the families of the residents are too scared to say what is really going on. The relatives are afraid their mother or father will be victimised or kicked out on the street.

*Once accreditation is over we go back to the bare necessities*¹

HSU member Wendy Darrington works at two aged care facilities:.

*“Working at two different facilities you see some confusion surrounding the way the accreditation system works. In one place it is ok to do something one but at the other place it is not. Things are always improved before an accreditation visit and the inspectors don’t really get to see what happens normally.”*²

HSU member Bella Millar worked at the Isomer Retirement Home in Victoria:

“At one stage we had no division one nurse, no division two nurse and no manager on site in what was becoming a high care facility during an inspection by the agency.

*I (subsequently) rang the accreditation people about this and they said it was no problem.”*³

A NSW staff member said that the facility she worked in had tried to intimidate and bully staff into working harder in the lead-up to accreditation by playing on their feelings for the residents. The comments were along the lines that: *“if we don’t get accredited and we get shut down, where will all the residents go...what will happen to them.”*

Agency inspectors appear on many occasions to be aware of the last minute scramble by providers and there are examples such as **Pineville** in Geelong where a facility passed training despite evidence there had been no proper activity except in the previous five weeks.

Kirkbrae Hostel in Victoria was deemed to have adequate staffing in April after staff numbers were boosted before the inspection and a registered nurse was appointed two weeks before to oversee care of the residents.

4.3 Inspection Regime

The current inspection regime provides two contacts including one site visit for homes in a three year accreditation period. The Audit Office found the reality was that bad homes take up a higher proportion of the agency’s resources than homes meeting accreditation standards.⁴

One visit in three years is insufficient in an industry where dramatic changes in the quality of care can take place in a much shorter period than that. The HSU has found some agency staff secretive and unhelpful when trying to access reports that should be publicly available. In addition the agency does not make clear the timetable being followed in serious cases where a review

¹ Witness Statement, Alicia Anset (Appendix A)

² Witness Statement Wendy Darrington (Appendix A)

³ Witness Statement Bella Millar (Appendix A)

⁴ ANAO op. cit.

audit has been undertaken. It is almost impossible to track the process externally despite the obvious public interest in details of a poorly performing facility being made public for residents, staff and families.

4.4 Action Required

Each facility should be subjected to at least one unannounced inspection during its accreditation period in addition to the planned visit.

The HSU also supports Professor Hogan's recommendations for increased communications with consumers and by better informing other organisations of the level of quality provided by specific services.¹

The union also strongly supports the introduction of a star rating system flagged by Professor Hogan which would allow consumers to more readily compare services and to provide incentives for providers to become more competitive in providing quality services.

Staff at each facility should also be offered the opportunity to have a union official present during accreditation to provide information to inspectors free of intimidation by management.

Accreditation standards need to be rewritten so that they are measurable and enforceable.

5. Young People in Nursing Homes

Residential aged care facilities are no place for young people with disabilities. And yet their numbers are increasing all the time. The latest estimates show that every day a young person with high or complex care needs is placed in a residential facility somewhere in Australia.

At the current rate there will be over 10,000 young people stuck in aged care facilities by 2007. There are a number of reasons why young people with disabilities should not be in aged care facilities. They include:

- Staff are not provided with appropriate training or the time to deliver the highly specialised care required by these residents. It is not that the staff don't want to care for them but they feel frustrated at not being able to deliver the full range of care required. The situation is exacerbated in homes where shortages of staff exist.
- A lack of access to the specialised therapy and rehabilitation services that are often required.
- A lack of funding to purchase the appropriate equipment and training for young people
- It is an inappropriate environment for young people to be in. Young people in aged care facilities often have little or no interaction with

¹ Review of Pricing Arrangements in Residential Aged Care op. cit.

people their own age outside of the staff. Their independence is compromised by their inability to move in and out of the facility. It is a considerable source of stress for young people to be surrounded by people in the last years of their life with no clear idea of when or if they can ever leave. It is difficult, if not impossible, for young people to make a positive contribution in the community while they are stuck in aged care facilities

- All parts of the health system are affected as a result. Aged care beds required by elderly people who may be stuck in public or private hospitals are being taken up by young people. This exacerbates the national shortage of aged care beds. Hospitals also suffer because the elderly take up the beds they need for emergency and elective surgery patients

The HSU believes that a greater effort is required by both the state, territory and federal governments to find solutions to stop young people being forced into nursing homes. The union has been working with the national organisation Young People in Nursing Homes and fully supports the recommendations about alternative accommodation and funding arrangements in its submission to this inquiry.

In cases where there is currently no alternative but to put young people in aged care facilities the HSU believes there should be:

- The establishment of a specific assessment and funding mechanism for young people with high/complex care needs
- Requirements for additional funding to be spent on the provision of extra staff and training for dealing with young people
- A mandated requirement for providers to produce an annual health check to ensure young people with complex care needs have their health needs met

Appendix A

Witness Submissions

Witness Statement – Bella Millar

1. My name is Bella Millar and I was employed for 12 months as a personal care assistant at the Isomer Retirement Home in Lysterfield, Victoria.
2. The facility has 50 beds and a mixture of high and low care residents. Up to half the residents can be high care at any time.
3. Staffing at the facility was completely inadequate. On evening shifts there would be two of us looking after 50 residents. Staff were overworked and as a result residents' care needs did not get met. Unfortunately they would often have to wait up to 20 minutes for their calls to be responded to.
4. Some residents could be left sitting for 25 minutes before their meals were delivered.
5. We were always rushing to do things, missing out on our breaks and never got to spend as much time with the residents as we would like or to give them the care they need.
6. I felt the health of staff was a risk due to the stress and the time constraints which made us have to cut corners. As well as caring for the residents we were also responsible for all meals and doing the laundry.
7. I believe the staffing levels of the facility have been reduced since my departure and there is only one staff member working at night.
8. Training was completely inadequate. We had a couple of talks from what I remember from people trying to sell things one was on incontinence pads. Medication management training was also inadequate.
9. There was also faulty equipment, broken equipment and health hazards not fixed. There was no standing machine despite this being needed. Staff were scared to claim for injuries suffered at work.
10. Despite the care needs of the residents allied health services were confined to a physiotherapist up to 6 hours a week.
11. I don't know how the facility passed accreditation. We were never given a copy of the accreditation report but I know people were scared to speak up and say what was really going on.
12. At one stage we had no division 1 nurse, no division 2 nurse and no manager on site in what was becoming a high care facility during an inspection by the agency. I rang the accreditation people about this and they said it was no problem.

Witness Statement – Jan Hamilton

1. My name is Jan Hamilton and I have worked as a personal care assistant at Noble Gardens Aged Care facility since it opened in August 2000.
2. I work shifts in a specified locked dementia unit and also in the low care section of the facility.
3. In my usual shifts we have 2 staff looking after 60 residents in the low care section on nightshift and 3.5 looking after 28 in the dementia unit during the day and two staff at night.
4. The staffing is not enough to allow us to give the proper care we would like to give. We have a lot of agency staff and that makes our job so difficult because often they don't know what they are doing. They are not trained in aged care and for example they may not know how to do a urine specimen or to take blood pressure. It is very stressful if you are in charge and you are working with people who don't know what they are doing.
5. We also have a lot of things we have to get done. Along with trying to deliver the care residents need we have to update progress notes, care plans and RCS notes all in 6.75 hours. We also have to give meals which in the dementia unit is a difficult and time-consuming job. Management also wanted night staff to fold the washing.
6. We have a Physio that comes in three times a week to do plans for the residents. The care staff are supposed to do the program of exercises with the residents during their shifts as well. But how do you get a dementia resident who has kicked and punched you as you try to get him into bed to then push his knees up to his chest 10 times?
7. A lack of equipment is also a problem and that has led to staff injuries. The lifting and standing machine is kept in the high care unit and when we need it we have to send someone over to try and get it. We should have a machine in the low care area.

Witness Statement – Leanne Synan

1. My name is Leanna Synan and I have worked as a personal care assistant at the Regent Lodge facility in Elsternwick in Victoria for nine and half years.
2. Currently we only have 17 residents in the facility which is classified as low care, although many of the residents are high care.
3. Regent Lodge has 36 beds and when they were all full we had one staff to 12 residents in the mornings plus a floating staff member and two staff members at night.
4. At the moment with the reduced number of residents the staffing levels mean our job is easier and we can give better care.
5. The residents are happier and less agitated because we can spend more time with them. It is so important to be able to do that. We can take them for a walk or sit with them when they are upset.
6. When it was full it was much harder. The staff on mornings had to give out meals and do laundry duties which made it difficult to give the proper care.
7. Regent Lodge is not accepting new residents and we do not know whether it is going to close which is quite stressful for the staff.

Witness Statement – Wendy Darrington

1. My name is Wendy Darrington and I work as a division two nurse at two aged care facilities, Marivale Community Nursing Home in Ascot Vale and the Ardeer Nursing Home in Ardeer.
2. At the Adeer Nursing Home we have one staff member to eight residents in the morning, 4 to 40 during the afternoon and three to 40 at night.
3. It is very busy especially at night if one of the staff is sick and not replaced.
4. It is disappointing to see the changes in 10 years at Mariavale. Back then the standard of care was so high. There is different management now and it can be very disappointing and disheartening. Everything is rush, rush, rush. We don't have enough time to spend with residents.
5. The paperwork we have to do for the RCS takes up a lot of time. A lot of the PCA's do not have enough training.
6. Residents do not get the extras that could be provided if there was more time. It can be their emotional more than their physical wellbeing which is affected.
7. We had one resident and her husband, who used to visit her every day, died. Staff didn't have enough time to sit with her and give her that one on one support on the days that she was really down.
8. The handover time we have between shifts is also limited. It used to be 30 minutes and now it is 15. That makes it very difficult to get all the information you need to make sure that everybody gets the proper care. There is no time to update people who may not have been working for a week what has gone on during that time it is just all about what happened on the last shift.
9. Working at two different facilities you see some confusion surrounding the way the accreditation system works. In one place it is ok to do something one way but at the other place it is not. There is an inconsistency there.
10. Things are always improved before an accreditation visit and the inspectors don't really get to see what happens normally. I don't believe that facilities should be given notice of when the inspections will take place.

Witness Statement – Alicia Anset

1. My name is Alicia Anset and I work at the Yarraville Aged Care facility in Victoria as a personal care worker. I have worked at Yarraville since it opened. It started as a hostel and high care facility but now is all high care.
2. I work day shift Monday to Friday. Staffing hours were cut in December from 91.25 hours to 79 hours of resident care per day. In a 45 bed facility that makes it impossible to do our jobs properly.
3. We look after high care residents and have the job of not only caring for them but making their breakfast, feeding them, cleaning up afterwards. We also have to do linen changes and clean the bathrooms/toilets/wardrobes/rooms.
4. The reduction in hours has had a severe impact on staff. We have had staff leaving because they can't stand it anymore, we have had staff members injuring their backs, their shoulders and their arms because they are rushing all the time.
5. The staff at this facility give 150 per cent but the fact is that the residents are not getting proper care. Some are not getting proper hydration. We are trying to feed them two at a time because we don't have time to do it differently.
6. They are not getting toileted properly.
7. There is skin tears and bruising because we are rushing to get them into lifting and standing machines.
8. They are not getting the exercise they need. Say you are trying to get everybody to lunch on time and you have somebody that has trouble walking.
9. Previously we would have walked them down to lunch but now we grab a wheelchair because it is faster. Every minute counts.
10. It becomes a vicious circle because the less they exercise the stiffer and less mobile they become.
11. We have a physiotherapist but they only come in for one day a week to assess the residents. We carry out the exercise plans during daily hygiene. It is the same with aromatherapy and podiatry. It is the care staff that have to do it.
12. I recently had two days sick leave after being attacked by a resident. It happened after I was left alone to look after 13 residents for over two hours. One resident was wandering around and pinching food and he went into another resident's room and they started fighting. Another

one was climbing out of bed, one was incontinent and another one was waiting to be put to bed.

The one who was incontinent because I couldn't get to him in time got very agitated and pinned me against the wall and was swearing and spitting.

I don't blame him. He was angry. Because I didn't get to him in time this contributed to his behaviour.

13. It is a very stressful environment to work in. The regular staff are starting to dwindle. Some of the personal carers we are getting have just got aged care certificates and are very green.
14. They fall behind in their work and we fall behind because they have to be carried. Something needs to be done to improve the training of personal care workers.
15. We have been asking for extra training. How to put someone in a standing machine or basic education like continence. If we ask for it and kick up enough of a stink we usually get it. But there is no training that is conducted as a regular basis that management organise. Staff have to initiate it.
16. Everything changes when accreditation comes around. We have division 1 nurses coming in going right through the files to make sure the paperwork and care plans are up to date. They pay for staff to stay back and do overtime and it's all a mad panic. When the inspectors are on the floor there are extra staff working. There is extra linen brought in and the kitchen is brought up to scratch.
17. The accreditation inspectors mainly talk to managers who paint a beautiful picture. There are meetings with family and friends of residents but only by appointment. Both the staff and the families of the residents are too scared to say what is really going on.
18. The relatives are afraid their mother or father will be victimised or kicked out on the street.
19. Once accreditation is over we go back to the bare necessities.

Witness Statement - Shantell Barry

1. My name is Shantell Barry and I work at Garoopna UnitingCare Tanderra Lodge in Melbourne. It is a 39 bed facility which is supposed to be low care but has 14 residents classified as high care.
2. I began work there in March 2002. After originally applying for a job as a kitchen hand I was appointed as a personal carer. I had worked before as a kitchen hand but never as a personal carer and had no qualifications in caring.
3. Initially I did a few orientation shifts and then I was told they were short of night shift staff so because it suited my hours I did that.
4. In April I started night shift. I had no qualifications, not even a first aid certificate. I was required to hand out some medication including oral morphine to one resident.
5. In June I got my first aid certificate. I also passed the medication training which involved doing a training plan with the pharmacist and you had to do a test.
6. I enjoyed working night shift although I doubted myself a few times when it came to care issues because I was not sure what to do. I don't know what happens now because some of the staff who work alone haven't even got a first aid certificate.
7. There was a problem in February 2003 when a fire broke out during my shift in a building outside the main building where the residents live. It was the old arts and crafts room and apparently it was not on the fire board because no alarm was triggered when it started.

I noticed it when I went to get a cup of tea and rang 000 straight away. It was a very difficult job getting the residents out of there rooms. If the fire had been in the building where they live I'm sure we would have lost some.

There were 20 people upstairs and at least half of them were not able to use the stairs. You can't use the lift in a fire. I had not had training in fire safety procedures prior to this incident.
8. There was another incident where I hurt my knee when I fell on the stairs. I couldn't walk and I had to get the police to come and break in through the kitchen window so that they could get me. I went to hospital after that. Working alone made it impossible to cope in a situation like that. A second person would have made all the difference.
9. On February 28 this year when I was working alone I noticed a set of keys were missing at the start of the shift which is 10.15pm. There was

no note about it in the key register which had not been filled in for a week.

The security company which is meant to come three times a night had already been for their first visit which is technically not supposed to happen because they are supposed to come after the evening staff have left and double check all the doors.

They came again about 11.30pm and rang the doorbell. They don't check every door and if you are not there they leave a card.

I was then setting the breakfast trays when my buzzer went off showing one of the doors at the front had opened. I went to check and saw a resident in the corridor and assumed she was up feeding the cat.

Not long after the door alarm went off again. I went down to the front and as I got to the end someone suddenly knocked me out of the way. I don't know who it was but I fell over a chair and hit my head. I also hurt my back, falling awkwardly. I called 000 and the police came. I don't know what happened to the intruder but an alarm went off upstairs showing that a door which leads to a fire escape had been opened.

I was taken to Box Hill but released after treatment for my back and some bruising and a grazed cheek.

10. It was frightening to think what could have happened in this incident. I was working alone and down on the ground and there was no-one to assist me. I wonder what could have happened to the residents if someone wanted to hurt them.
11. I have been off work since the incident and it has taken a big emotional toll on me and my family as well as put us under financial pressure because my employer refuses to pay the extra money to make up my wage to the same point it was before the accident.
12. I need to go back to work but I can never go back to work alone like that. Nobody should have to work alone at night. It is unsafe and how can you give proper care if something serious happens?

Witness Statement (Name withheld due to fear of management reprisal)

1. I currently work on night shift between the hours of 9.20pm and 7.10am in a small aged care facility. This shift is staffed by one person only. I am aware that staffing for the afternoon shift has been reduced.
2. This can affect the night staff PCA if all tasks have not been completed by handover. For example it could be that the staff member handing over has not been able to finish residents medication. Another example may be that laundry has not been put through the dryers. There is always a legitimate reason.
3. The effect is that the night staff PCA is needing to perform noisy tasks as the laundry is in the block where residents are trying to sleep.
4. Care for residents always comes first but the need to get domestic tasks of cleaning, laundry etc can't be ignored.
5. If all work is done at changeover it allows time to focus more on residents care. And paperwork. If there is unfinished work there is more pressure on nightshift to get the work done while also dealing with whatever issues arise during the night with residents.
6. There has been some extra demands due to staff turnover, especially night shifts during the past 12 months. This is reasonable but I sometimes feel a lack of support from management.
7. My workload has increased due to the reduction in hours of the afternoon shift and the level of staff turnover. During times of inducting new staff there is additional pressure on old staff members to ensure work is done and reassure residents etc.
8. New nightshift staff only get one night's orientation and then they're on their own. I feel that is why they leave after a month.
9. I get more stressed by the politics than the workload. Obviously due to the nature of the workplace some shifts can be hectic.
10. I am concerned about the security of the facility, particularly during night shift with one person in charge.
11. Present security arrangements allow for members of the public to work onto the property and enter the building at will. I feel this poses a risk to staff and to residents.

Witness Statement – Glenda Free, Jacqui Kendall and Ave Brophy

1. We (Glenda Free, Jacqui Kendall and Ave Brophy) are former employees of Lions Club of Sunbury aged care facility.
2. During the period of current management there have been various issues and episodes affecting both staff and residents:
 - Workplace bullying in the extreme including verbal intimidation and threats;
 - Stress due to the above and unrealistic workloads – affecting families as well;
 - Management periodically absent and working short hours;
 - Unwarranted accusations against staff – untruths etc;
 - Inability to provide quality care because of workload and frustration at lack of interest by management
 - Residents frustrated and upset at the unavailability of management and their unapproachable attitude – feeling frightened and insecure;
 - Grievance procedure ignored – staff intimidated and banned from contacting the committee of management and criticised if they contacted the union;
 - Union members ostracised – barriers put between members and non-members
3. We can expand on these details if required as one is still on Workcover, one resigned due to health issues caused by stress from management and one to further her training.

Witness Statement (Name withheld due to fear of management reprisal)

4. I work at a regional aged care facility in Victoria and have been a personal carer there since 1994. I currently work 25.75 hours a week.
5. Over the last five years and four months my hours have been cut on numerous occasions.
6. I have felt at times that I have been persuaded by the manager to change some of my shifts as she puts it that we can't have two senior staff working together.
7. I thought at the time I was doing a good turn to help out but unfortunately for me later I got told that it was my decision. When I spoke out and told the manager that I would gladly take my shifts back as she never likes to be wrong she told me it was too late. As I was struggling through a marriage breakup and bringing children up on my own. I felt it was very hard to hold my position.
8. We have a very big turnover of staff due to stress. And seeing staff go through nervous breakdowns due to management.
9. I have been through many years witnessing other colleagues being put down, victimised by the same manager.
10. We are constantly under pressure not knowing what is coming to us next as we are on the edge all the time.
11. I work 4.30 to 9pm which used to be 4pm to 9.30pm. 8.30am to 1.45pm which used to be 8.30 to 2pm. On weekends 7am to 3pm.
12. Only one staff member is on nights to look after 26 residents.
13. With the shortage of staff there are numerous falls. Staff are unable to give the quality of care that residents should be getting.
14. We have two activity staff that should be doing nails, massages, exercises or activities of any kind. Instead PCA's are doing some of it in the mornings and the evenings.
15. I do not think the care provided in the facility is enough. We used to be able to spend quality time with the residents on a one to one basis nowadays it is always rushed and the residents are feeling it.
16. Residents have left the hostel due to stress from management and other residents have been ill-treated by them as well.
17. The management refused to let me do my PCA certificate IV even though I was paying for it. There is not enough training for staff.

18. Every time we have to go through accreditation we go through a lot of stress as all responsibility is put on us because of all the changes they want to make at the last minute.
19. I have worked extra, put on the time sheet but not got paid for it, sometimes you work through our lunch break with staff carrying the pager and not get paid.
20. I thank you for giving me the opportunity to express myself as a carer and on behalf of the residents of our community to better their quality care.

Witness Statement (Name withheld due to fear of management reprisal)

1. I work at a regional aged care facility and have been a PCA there for more than 10 years. I currently work 34 and a half hours a week.
2. I look after more than 25 residents on my own from 10am to 3pm. I am doing dressings, massages, BSLS, BPS, temperatures and giving out medications. We also have to do the laundry whichever shift we do.
3. We have no kitchen hands on weekends with only two PCA's from 7am to 2pm having to do all the work.
4. Evening staff are left on their own to do medication from 9pm to 9.30pm for every room. Most of the time staff get side-tracked as residents always want you to do extra for them.
5. Night staff work almost 10 hours. They look after residents, cleaning tables, floors, toilets, vacuum, wash and iron clothes.
6. Residents will not use their buzzers as they say that staff have enough to do.
7. There is a lot of stress from management when we have not done all the work.
8. We have two people that do the therapy and activities but the PCA's do the nails, massages, exercise in the morning and night.
9. At staff meeting we never talk about the residents. The manager starts calling the staff names like big mouth, immature, cry baby etc – always putting us down, never praising us.
10. Since we have had this manager for five years there has been a lot of staff turnover due to stress management and workload.
11. When we have a resident that is on palliative care, other residents get less quality time from staff.
12. Residents have left the hostel due to stress from management.
13. When accreditation is due more work is put upon us due to the changes.
14. I was on stress leave last year but they got me to take it as a holiday.
15. This statement has given me the opportunity to express the way I feel, also on behalf of the residents.

Witness Statement (Name withheld by request)

1. I work for Mayflower Retirement Community in East Brighton.
2. The night staff in the nursing home – two staff only are expected to shower three residents every night shift between 6am and 7am leaving the other residents unattended.
3. The residents who are nominated to be showered need to be attended by two people (OH&S) and as each resident has their own room and showing takes two staff the remaining residents are left unattended.
4. Also the registered nurse division one on duty is also responsible for all the residents in the complex (another 150 residents) so she/he can be called out to attend any of the residents in the hostel or independent living area.
5. They are also responsible for replacing staff in the whole complex even if they ring in between 6am and 7am.
6. The staff member in each of the other three hostel buildings is also required to show a number of residents leaving the building unattended.
7. The practice of night staff showing makes other frail dependent residents very vulnerable and should an emergency occur elsewhere places staff in an impossible position while they are showing other residents. This policy of minimum staffing places residents at an unacceptable risk level and creates unreasonable stress for staff.
8. The knowledge of this situation would be of obvious and serious concern to resident's relatives and friends.

Witness Statement – Jane Sanderson

- 1) My name is Jane Sanderson and I live in Western Australia. My mother, Florence Mitchell is 90 years old and has recently suffered 3 successive strokes. She was recently placed at Carinya Annex after spending six weeks at Fremantle Hospital recuperating.
- 2) Carinya Annex is not an aged care facility as such, but it is a facility that elderly people can be cared for whilst waiting to be placed in a hostel or nursing home (care awaiting placement facility).
- 3) My mother had been hospitalised due to a stroke, but whilst she was at Carinya, she suffered a 3rd stroke. The standard of care that she received whilst staying at Carinya is the reason I am writing this submission.
- 4) Following discharge from Fremantle Hospital & Health Service, my mother was placed at Carinya Annex on 19 May 2004. I had visited her on Tuesday 6 June and possibly again on Wednesday 2nd June. When my friend and I visited her after work on Friday 4th June, we were shocked to see her condition. It was obvious she had incurred another stroke but I was not informed of this and did not know when it occurred until questions were raised after she was admitted to Royal Perth Hospital on Sunday 6th June 2004.
- 5) After having the stroke at Carinya, my mother insisted the hostel call a doctor, who came to see her. When my friend and I arrived at the hostel on the evening of Friday 4th June, the sister in charge was busy with medications and meals were in progress. I was given no explanation or information and told, “she had incurred another stroke and that “nothing could be done.” My friend and I got no further assistance or information, and decided to leave and come back after the meals had been served.
- 6) We returned 40 minutes later and again spoke to the sister in charge. I insisted that she phone the doctor for me so I could find out what had happened to my mother. I spoke to the doctor who advised me to leave her in the hostel for the time being and he would call again over the weekend to check on her. At this stage, the sister in charge was more approachable, but again re-iterated “nothing could be done.” My friend and I stayed with mother for a while, helping her to the toilet and getting her undressed and into bed. It took two of us to manage her.
- 7) I visited again on Saturday afternoon and found that my mother’s condition had deteriorated further. The doctor had not visited my mother. As mealtime approached and my mother could not mobilise herself, I requested a wheelchair to get her to the dining room. After quite some time, I eventually searched and found a wheel chair and got

her to the dining room myself. I stayed with her during the meal and fed her, as she was incapable of doing it herself.

- 8) After the meal, I took her back to her room, then helped her to the bathroom. I also helped her wash. At this point, my mother was quite exhausted and unsteady whilst standing. A PCW passed the bathroom and asked if I needed assistance, and the two of us managed to get her back to her room and into bed.
- 9) Later that night (Saturday 5th June) the sister in charge phoned to tell us that my mother had fallen whilst getting out of the bed trying to go to the toilet, but that she was unhurt. I was so concerned about her condition, I telephoned a neurological physiotherapist who I know, and asked for advice. She advised getting my mother to hospital as soon as possible to prevent any extension of the stroke, and further damage occurring to her shoulder and neck from her unsupported arm.
- 10) On Sunday 6th June, my son received a phone call at home telling us again that my mother had fallen a second time but fortunately, she was not hurt again. He was asked for permission to restrain her, but permission was not given. He advised the person on the phone that we would be visiting very shortly.
- 11) As soon as my son and I arrived, I could see that my mother's condition had deteriorated yet again. She had suffered an extension of the stroke and was in a much worse state than the night before. We had not been advised that her condition had deteriorated during either of the phone calls on Saturday night/Sunday morning.
- 12) I found the nurse in charge and advised her that we were taking my mother to hospital. When we were asked how we would get her there, we indicated that we would drive her there in our car. We were told that she would be our responsibility if she did not go by ambulance. I told the nurse to call an ambulance, and she replied that paperwork would have to be prepared. I told her to get it done.
- 13) Whilst waiting for the ambulance and the paperwork, the sister in charge came to inform us that my mother had been a troublesome patient overnight, and that she had been ringing the bell to go to the toilet several times, and that she had fallen out of bed. I asked if the doctor had visited my mother, and was told yes. I also asked if she had suffered an extension of the stroke, and again, was told yes. The sister in charge did not apologise or explain why my family had not been advised of this overnight, or at any time before I asked the questions.
- 14) I was also told that the doctor had given permission for my mother to be restrained, despite my son specifically not approving this earlier in the morning. My mother was restrained without my knowledge or permission. I was then given a written disclaimer to sign to this effect.

- 15) My mother was extremely disorientated and upset from the effects of the stroke. Being restrained in bed and to a chair as she was, certainly added to the trauma she experienced at Carinya.
- 16) My mother was admitted to Royal Perth Hospital on Sunday 6th June. Upon admission, it was discovered that she had aspirated on fluids due to a lack of swallowing reflex (a complication brought about by the strokes), and she subsequently developed a lung infection. I am angry and upset that the staff did not have enough time to properly attend to my mother and provide an appropriate standard of care for her. I have to ask how long would she have been left at Carinya because “nothing can be done”, and how far would her condition have deteriorated before my family was notified? The inability of staff to provide appropriate care is reflective of the level of funding that is given to aged care. The amount of paperwork that care staff have to comply with takes them away from providing direct care to those patients & residents who need it most.
- 17) The level of funding available to aged care was also reflected in the phone calls I received in the days after my mother was admitted to RPH. I received at least two phone calls from Carinya administration staff enquiring about whether or not my mother was returning to the facility. I was told that Carinya would only keep her bed open for a number of days, and that my family would incur fees to do so. Sadly, none of the staff enquired about her condition in either of the phone calls.
- 18) My mother remains in hospital at this time. My experiences to date have left me with some major concerns about what is occurring in the aged care sector.
- a) I do not believe that there are sufficient medical staff working in the aged care sector to deal with critical changes in patient/residents medical conditions;
 - b) Due to the emphasis placed on documentation and paperwork, staff do not have the time or resources to adequately care for patients/residents. Documentation demands mean that staff have to prioritise administrative tasks over advising families about serious health issues affecting their loved ones
 - c) The personal care workers that I saw working are dedicated and caring, but there are simply not enough of them - they are run off their feet balancing their workloads whilst not being able to assist patients with feeding or toileting.
 - d) I saw evening meals prepared by kitchen staff that were substandard – a kitchen hand served spaghetti from a saucepan onto a plate – using her hands. If this is the standard in the kitchen, what does that say about the standard of care delivered to the residents at Carinya? What does it say about the standard of aged care in Australia?

Witness Statement – Olive Mell

- 1) My name is Olive Mell. I am 93 years of age, and for the last four years, I have been a resident at Geneff Village, a low care facility in Innaloo WA.
- 2) There are 32 residents who live in 4, eight-bed houses each with a central kitchen and dining room. I don't believe the staff levels are adequate to provide the care
- 3) In the time that I have been a resident here, I have noticed that the residents need more care as we can't do things for ourselves that we used to be able to do, such as showering and dressing ourselves.
- 4) Each morning, I eat my breakfast in my room, and get some assistance from the carers when I have a shower and when I get dressed. On the morning shift from 7am to 1pm there are usually only 4 staff rostered on to look after all 32 residents.
- 5) Once I have been showered and dressed, it's not unusual for me to not see any carers until around lunchtime. From what I understand, they have a lot of documentation to do as part of their workload. Over the period of time that I have lived here, there has been a big increase in the amount of paperwork that the carers have to do as part of their work.
- 6) At night-time, there is only one staff member to look after all of us. If someone has a fall or otherwise needs help, it makes it very difficult for that one staff member to deal with everything. Sometimes I worry about the security of the village at night because one person can't be everywhere at once. I worry not just for the residents but for the staff member also.
- 7) The documentation seems to me to be a big problem for the staff. There are too many reports that they have to write. It takes a lot of their time. They are called carers, but they don't have time to be carers because they are always writing.
- 8) With all the documentation that the staff have to do, it takes them away from having time to spend with residents or making sure we are ok. They don't usually have the time to simply to talk to us.
- 9) I see that the staff are stressed by the amount of work that they have to do. Not only do they have to provide care to the residents, but they also have to do a lot of cleaning of the rooms and the kitchens as well. I feel that the staff are stressed all the time because they have too much to do and that there are not enough of them.
- 10) Sometimes I think it's not really a low care facility because the older I get, the more care I need. There is a big difference between needing

extra care and having to move to a nursing home. There should be enough funding from the government so that the carers can be carers.

- 11) The activities here are not that good. They are not very inspiring and not conducted often enough. A lot of the residents here are wheelchair bound, which makes it difficult to get around for many of the residents. There is a lot of craft based activities, but I have arthritis which makes using my hands very difficult so I can't participate in activities like that. Many of the residents play bingo which is popular here. Sometimes they have indoor croquet also.
- 12) We used to have regular sing-a-longs, but we don't have them very frequently any more. I know that a lot of the residents complain about the lack of activities. There is an occupational therapist here who is supposed to arrange daily activities, but we don't have any activities Friday, Saturday or Sunday.
- 13) The food here is very good. There are two chefs who work here and the food they cook is exceptional. I have no complaints about the food at all.
- 14) Maintenance at Geneff could be better. There used to be a regular window cleaner, but he hasn't been here for years. The gardens aren't what they used to be either. The maintenance man is here three days a week, and generally he is very good at fixing things, but sometimes there is a backlog in getting things fixed.
- 15) I know that the staff do the best they can do with the resources that they have, but I wish that they had more time and were better funded. The management does the best it can but is restricted by funding also. It would make life that much easier and better for all of us in aged care.

Witness Statement – Bill Jacob

1. If one looks up the dictionary, one finds the meanings to the following words.

(a) Appropriate.	Suitable, fit, proper, relevant
(b) Care.	To look after Or provide for.

2. My Name is Bill Jacob and I live and work in Tasmania. I have worked on this site for over 14 years, the site previously owned by the Government called, 51. John's Park, and now owned by Southern Cross Care, called Rosary Gardens.

3. Over a pay fortnight, the first week I work 24 hours with four days off and the second week. I work 48 hours with one day off which is a Wednesday. These are set days with other staff having different variations, e.g. they might work seven days straight and have seven days off. My position at Rosary Gardens is an Extended Care Assistant level 3.

4. From the time I commenced on this site until now the number of staff to look after the elderly is getting fewer and fewer as the years go by, and when one contemplates that if we live long enough that we too could end up in a home for the aged, pity help the care we will receive if this trend keeps up.

Back when I started on this site, then St John's Park, there were five Garden Units and at least three units on the Caruthers's Building. Each unit had the following staff to look after the 32 residents on those units. There was one Clinical Nurse Consultant, two Registered Nurses as there had to be a Registered Nurse on the unit at all times for emergencies or for when the Doctors called to see the residents. There were at least 4/5 Enrolled, or Enrolled Nurses with Pharmacy qualifications. Each unit had two Ward Assistants, two Cleaners, and one Qualified Physio, and each had an assistant.

Every so often a different unit would have a outing, which was a highlight for them and it was something for them to look forward to, with staff members coming in on their days off to help. On some Sundays because we had staff numbers, half a dozen residents were taken for a drive, mainly around the suburb where they resided. For the next week that Sunday drive was the topic of conversation.

5. Those days staff had time to attend to the residents personal hygiene and do those little extras for them. Time was spent doing their hair, applying make-up, making sure they had their stockings and shoes on that matched their dress, and also each had a handbag with them.

When I first started working there it was hard for me to distinguish between the residents and the visitors who came to see them. Many a time I had to ask the staff if a certain lady was a resident or visitor. At that time the unit I worked of/were all female.

Staff those days had time, which I feel is part of the care to talk to the Residents. I can recall a Female Resident who was very upset re her family and what was happening in her family and she was crying when I entered her room. When I inquired what was the matter, she proceeded to tell me her story. Coming from Queensland and not knowing the people she was talking about I just stayed with her and let her get it all out, which took up to at least 10 minutes. When she had finished she thanked me for taking the time to listen to her and stated that she felt a lot better.

6. Today with an average of 10 Residents to 1 staff member these days there is not the time to spend with residents like the story above. Some Units have 3 E.C.A's (Extended Care Assistants) who do all the showering, shaving, making of beds etc. There is an RN on each unit to administer medications, do dressings, attend to Doctors etc. That is if all staff turn up to work each day. With a ratio of at least 10 residents to 1 E.CA I feel that the appropriate (suitable-fit-proper-relevant), care (to look after-to provide for) falls below adequate to a great degree.
7. By the time the E.C.A's have had a handover at 7.30am, then proceed to sit the residents up in their beds, put their bed side tables across them, make sure that their teeth are in their head, so that the residents able to assist themselves are ready for their breakfast to be delivered.

For those residents not able to assist themselves, the E.C.A's have to go to the kitchen and prepare for those who cannot assist themselves, carry same to those residents and assist them with their eating. For some of these residents one can take up to 10-20 minutes. Depending how many residents need assisting depends on the time one then starts to attend to hygiene. At times you are looking at 8.30am or even 9am.

As a Carer I treat residents the way I treat myself. I arise at 6am, go to the toilet, have a shave, clean my teeth, make sure I have all my clothes ready to put on, have a shower, dress myself and I find as an able bodied person that I don't have much change out of 30 minutes. I would like to ask those responsible for this latest restructure how long it takes them to get ready for work. I would like them also to come and do the work of the Carers, as I have a saying. "That if you don't play the game, or not prepared to play the game, don't make the rules."

8. I find that to assist a Resident out of bed, remembering that they are old and frail, position them on a shower/toilet chair, transfer them to the bathroom and position them over the toilet, making sure they will not fall off the chair, make their bed, prepare towels, face washers,

toiletries, plus have all their clothes, pads, stretch pants, socks and shoes ready to put on after their shower.

After showering, drying, dressing, shaving, combing their hair, cleaning their glasses, 30 minutes is almost gone. If one has a resident who is verbally and physically aggressive the time then would increase.

Taking 30 minutes per resident and having 10 residents to care for that would take 5 hours straight work without any interruptions. Seeing there is only one other Carer on the unit, one has to help each other when a two person resident has to be attended to, or when using lifting machines on residents. Telephone has to be answered, and a lot of the time it is for the RN/ENP, who might be on another unit checking drugs or administering medications on another unit because of staff shortage. We then have to find them re the telephone call. Other calls might be for a Resident which have to be transferred to the cordless phone and taken to that Residents room.

There are some Residents who continually ring the call bell which have to be answered, only to find that they will tell you they have been to the toilet and are now back in bed, or that they have pushed the call bell, they don't want anything only to tell you that the red light which come on when the call be is pressed is glowing red. The list of interruptions that go on are too many to relay.

Then there is the morning tea for the assist residents to be given out, plus the staff are entitled to a 10 minute break for their morning tea.

With all these interruptions one is expected to have their 10 residents up with all hygiene completed before the midday meal. I find to assist these residents with their care as per the Mission Statement. I can only complete 6 maybe 7 residents before lunch, which means some have to wait until after lunch and after staff have their lunch to have their hygiene attended to. There have been times when those who already have had their hygiene attended to, have had bouts of incontinence of faeces and need to be attended to before those still in bed. There have been times when I have showered my last Resident at 3.10pm.

9. With this extra work load and the stress that is put upon the staff, some are going without breaks to complete their tasks. I feel that because of this restructure many short cuts will be taken by staff, like neglecting to clean teeth, shave the men, only use one staff when operating the lifters as it takes time to go and find another staff, or wait for them to arrive after calling them on their pagers.

Other short cuts I feel will happen more often (as I know this has happened), is that Residents will be dressed without any hygiene attended to. Also the fact that staff are working all over the complex the continuity of care will be affected. You have staff working on one unit for only one day of their shift, others rostered to two units may not

spend two days running on the same unit. Morning teas for those residents will be missed as staff will be busy showering residents and trying to get the work load completed. Fingernails will be missed, drying between their toes I feel is another area where shortcuts will be taken.

Along with teeth and shaves mentioned previously are areas where the Residents will miss out on the High Quality Care the Mission Statement states, because of the stress, heavy workload, frustration placed upon the 15 Carers who have to look after the 142 residents each day shift.

10. I cannot speak on behalf of my colleagues, but if my starting time is 7.30am, I'm always there 10 minutes before and I finish at 3.30pm. In the past there have been times when I have been the only staff member on the unit until 8am because of staff shortages, waiting for staff to arrive.
11. Management have stated that Carers will have to learn to work smarter. I would like Management to come up with some guidelines for staff in this area. I know we have some Smart Workers, they are the ones who do as little as possible, and or rush through the residents by just dressing them from the bed and telling Management it is a breeze on such and such a unit making it hard for the staff member doing the right thing with regards to residents hygiene. The stress is then put on those staff as Management will state that if so and so can get through the workload why can't they.
12. Speaking from the unit I was on over the past 12 months, we went from 3 E.C.A's in which we had 3 groups, 2 groups with 9 residents and 1 group with 8 residents. We lost 6 residents to another unit when the residents from St Bernadette's came over into the secure unit which left us with 20 residents.
13. We also lost a staff member which left us with 2 staff to 10 residents each and increase in workload.
14. One has only to speak with other staff members now after the Restructure and the very dedicated ones are now stating that they hate coming to work because of the heavy workload, that they are feel the stress, frustration and strain on their bodies. Staff morale is at its lowest I have ever known it to be, even Management find it hard to pass the time of day to their staff, as if we don't even exist. There was a day I recall in the past 3 weeks, where there were 3 E.C.A' short over the complex, leaving only 12 carers to look after the 142 residents.
15. I certainly believe there will be problems in the area of danger to both resident and staff. I feel the more one tries to hurry that is the time accidents happen.

Staff will try to take shortcuts in various ways, being frustrated when one of the staff is taken from a unit and sent to another unit leaving them short, making the workload even heavier.

Bed tables become stuck under beds and cause staff injury to backs trying to release the stuck table. I went through an injury on the 5th of June trying to release such a stuck table, and I am on Rehab. At this point in time and I move from unit to unit doing light duties and I can see what is going on with regards to staff after this restructuring.

Lifting Machines will not go under some beds and even though forms have been filled out the outcome always seems to be the fault of the staff. I believe the stress levels will increase when the R.C.S. documentation has to be completed, as the Carers on this Site have to attend to this activity. At times during the year there are on Residents on R.C.S's, and then there can be up to 10 or 11 at one time.

Management have informed us that R.C.S. documentation pays 95% of our wages. When asked at an in-service re documentation what was more important if residents were in need of attending to re. Incontinence of urine or faeces, all we received back as an answer was that the R.C.S. documentation pays 95% of our wages.

What was coming across to me from that statement was, forget the residents and make sure the documentation is completed. I find this very frustrating, when the very reason this Complex is here is for the **CARE OF THE ELDERLY**.

This in itself causes stress, as if there is enough stress as it is working in this Industry. There wouldn't be many jobs in Tasmania where one goes to work not knowing if one is going to be punched, verbally abused, physically abused, have a cup of hot coffee, salt and pepper shakers, or a bowl of cornflakes thrown over you by the residents.

16. Compared to the 1990-4. I know we have one Physio and one Assistant for the whole Complex. I do not know the hours the Physio works, but I do see the Physio Assistant walking Residents with the help of the Diversional Therapy Assistant. Before Restructure we had a Diversional Therapy Assistant for each of the Seven Units, and now on any week day there are 3. So from 1990-1994 when we had something like 5/ 7 Physio's we now have 1. The same went for Assistants, we now have one. So from those figures one can see that from those figures it is evident that the Residents are missing out on essential therapy.
17. For the first time in over 14 years, Friday the 23rd July, was the first time I have spoken with an Accreditation (inspector) Officer, and a group of staff aired their concerns with her re. the difficult times they are going through because of this Restructure in terms of Care for Residents and what it means to them in their lives. One wonders what

the outcome will be as a result of the Accreditation Officer. Over the years we have had a number of surveys to fill out, but as always we never see the results.

There were two Doctors from America here a couple of years ago with a survey that they required staff to fill out. A number of staff declined because of a no result ending. I asked these Dr's would we see the results of this survey and the answer was YES. On that basis I agreed to fill the survey out, which took ~ of an hour. To this day I have not seen any result Every year we seem to have the same survey attached to our pay slips, and as usual never do we find the results attached.

18. I find that when it is time for Accreditation, one is falling over each other as the staffing levels tend to go up in all areas of the complex and Management are going around instructing staff not to do this and not to do that while the Inspectors are here. One such practice is the use of the portable Blue Bath Tub, which will not fit into some of the rooms of the Residents. Because of this the Resident is transferred from their bed onto the Blue Bath and taken from their room and into another Residents' room because it has been built differently and allows the Bath to fit in the door. After the Accreditation is over it is back to what was being done before.

Witness Statement – Jason Suggett

1. My name is Jason Suggett. I am a level 3 extended care assistant at Pleasant Pines nursing hostel. I have been a Carer for 5 ½ years and at my current employer since April 2003. I am employed as a holiday relief permanent part time. My duties include Carer, Diversional Therapist, Cleaner and Maintenance Person on an average of 30 hours per week.
2. We are a forty-one bed facility including two respite beds. Our staffing levels consist of one RN (director of care), one enrolled nurse and twelve carers. Our shifts consists of 0700-1500, 0700-1030, 0830-1330, 1500-2300, 1500-2000, 1615-2015 and 2300-0700hrs. Our full shifts give out the medications via Webster packs and attend to dressings if the enrolled nurse isn't on duty.
3. From 1330hrs there is only one carer on duty until 1500hrs (the director of care is normally there during the week) but on weekends they are in charge. It's the same after 2015 hrs there is nobody on site to help if there is a problem, you have to ring the D.O.N to come down. On night shift the carer that is on has to clean, do washing, set tables, empty rubbish as well as answer bells and do the regular checks.
4. Our staff to resident ratio (when there are three carers on) is one staff member to fourteen residents but that changes of course when there is only one. The amount of time for wash resident when three careers are on is about 41 minutes and when only one carer is on it drops down to 11.7 minutes...
5. When all staff and all residents are well and there aren't any problems, there is enough staff to cope. There is never a time when all staff and all residents are well and there are no problems and this is where we run into trouble. There isn't enough money to pay extra people to come in to cover for the people that are sick. This usually means that some of us have to work a double or do a short shift and then come back a couple of hours later to do a night shift.
6. I feel that the safety of the staff and residents is at risk. If there is a fire, an intruder, the staff member hurts themselves on the stairs or one of the residents fall out of bed (depending which one it was), even a lifting machine with one staff member could not get them up off the floor.
7. When it comes to Diversional Therapy for the residents we can only afford twenty hours a week. This is split up over three days, so that on the weekends the residents have to entertain themselves or rely on family to take them out or just visit.
8. When it comes to accreditation there is too much emphasis on paper work and forms, if there were less paper work there would be more money for the actual care of the residents e.g. more staff and money

for improvements etc. I feel the way that accreditation is conducted puts to much pressure on management and staff which creates unnecessary stress and lowers your job performance which the residents suffer from.

Witness Statement – Glen Hunt

1. My name is Glen Hunt an Extended Care Assistant who has worked for Southern Cross Care (TAS) at their aged care facility Rosary Gardens I currently work 64 hrs per fortnight. Since entering the industry I have seen a significant decline in the care given to those who live at the facility. Commencement of my employment in 1994 I was directly the primary care giver to maximum of 6 residents with an average of 74 minutes available to single resident in my 8 hr day shift.
2. Now 2004 I now find myself giving direct care to 10 residents with an average of 44 minutes per resident. Within that 44 minutes I'm expected to wash, dress and groom complete R.C.S. documentation so funds can be obtained from the federal government for these people's care. This process robs the resident of direct care because I'm unable to deliver care while attending unnecessary paper work in my experience of 10 years I have not yet seen a resident leave the facility recovered from the ageing process in fact it's a decline. People entering aged care facilities in 2004 are more frail than ever before on average and their health and mental statues is well documented before entering the aged care facility. If that status is agreed why do I find myself completing repetitive paper work when we all know these people require high care when entering the facility?
3. The 44 minutes I talk about is an 8hr shift average. The 44 minutes is significantly reduced if you think it's a fair expectation to have your mother, father or relative washed dressed and groomed by midday - 44 min now becomes 21 minutes per resident - an imposable task. This now has created stress in the work place to all who are there the resident wanting to be attended the care staff attending the resident, the relative who expects their family member to be attended prior to midday, not an unreasonable expectation.
4. I now see staff taking sick leave who are mostly not replaced on the day adding even more stress to those in the work place. It's a fact some residents are not able to be attended by midday quality care is compromised due to inadequate staffing levels which is a direct result of insufficient funding being available to care facilities to provide adequate staffing levels.
5. In my opinion the industry is in crisis, those in the industry are leaving and those entering have not seen quality care delivered, the care given today is a far cry from what was even delivered 5 years ago, the industry needs to now address
 - Better ways of obtaining funds
 - Bench mark staffing ratios
 - Provide training to those in the industry to increase skills
 - Competency checks for all in the industry

- Unannounced accreditation checks
6. In closing this is what's happening in my facility with out a genuine look in to the problems in the aged care industry we all risk even further decline

Witness Statement – Donna Reed

1. My name is Donna Reed and I work at Pleasant Pines, a small 41 bed facility. I am employed as an Enrolled Nurse, but I started at Pleasant Pines as an Extended Care Assistant.
2. Pleasant Pines has an excellent reputation and the residents are very happy and satisfied with the care they receive. They particularly like the fact that it is a small facility and they know the staff and the other residents very well. The staff turnover is very small as the staff like working there and getting to know the residents and their families well.
3. Unfortunately, the small size leads to its own problems and the facility faces financial difficulties. The Commonwealth subsidies do not cover the cost of staff wages, insurance, utilities etc. The Government believes residents requiring low level care (particularly Level 8) do not warrant subsidies or only very small subsidies, but these residents still require assistance, they still need their rooms cleaned, their laundry done and their meals served. Because the residents are not as frail as high care residents they expect more. They want to be entertained with outings and activities. The residents want to manage their own finances, but need to get to the bank or to the post office. They want to attend community activities. They often need supervision by staff, they may need checking at night, or just to be able to see someone to feel secure - but not enough to warrant a subsidy.
4. Just because Pleasant Pines is small does not mean that there can be less staff. In fact, small, generally low care facilities, often need more staff per resident than the larger facilities, but this is not recognised by the Government. There still needs to be Carers, Kitchen staff, Maintenance, Diversional Therapy, Accounts staff etc.
5. Accreditation and the Government's demands that aged care facilities are top class is great, but this has led to more demanding residents and families whose expectations are much higher than before, but the subsidies do not reflect this change in attitude or expectation.
6. Documentation in aged care continues to be problematic. Staff still needs to spend too much time with paperwork that takes away from hands on care. Audits, surveys, claim forms, RCS assessments, the list goes on. Again in low care facilities, the subsidies do not pay for many trained staff such as registered nurses or enrolled nurses. Therefore documentation must be handled to a great extent by untrained staff such as carers. This can lead to stress for carers and high expectations by management that untrained staff document at least as well as trained staff. In turn, subsidies may be lost as carers cannot be expected to document their care as well as trained staff. Smaller subsidies lead to poorer financial viability that lead to less trained staff and therefore smaller subsidies.

7. Pleasant Pines Management has tried to age in place when possible, so that the residents don't have to move to a different facility as the resident needs more care. However, if the resident needs more nursing care, Pleasant Pines cannot afford to have nurses on every shift because the majority of residents are still low care and the subsidies cannot cover the cost of trained staff for just a few high care residents.
8. The same problem occurs with night shift. Although a large number of residents do not need care at night, they still like to know they are secure and being checked on by staff. However, being checked on regularly does not count when claiming subsidies, so the subsidies are low and the cost of staffing at night is high.
9. That's why a number of facilities, including Pleasant Pines only has one staff member at night. There often is not enough work for one staff member, let alone two, but of course it would be safer to have two staff in case something happens, such as a resident falling.
10. All of these problems have not been adequately dealt with by the Government. Despite lots of talk, aged care is still not funded enough. Small, community based facilities are disappearing as they are swallowed up by the larger facilities. This may be easier for the Government as they will only have to deal with a smaller number of aged care providers, but it does not answer the community's needs or wishes. Ask any resident in a small facility and they will tell you that they like the fact they know the staff well and the staff know them. The staff knows their families, their likes and dislikes and their wishes for care. I doubt if residents in large facilities can say the same.
11. Despite Pleasant Pines being an excellent facility with very satisfied residents and families, content and hard working staff and a three year Accreditation, Pleasant Pines is now up for sale. The owners cannot afford to continue due to the small size of the facility, the lack of Capital funds for building, increased care needs and expectations, the need for increased staffing levels to meet the resident's needs and demands, and the poor Commonwealth funding.

Appendix B

Case Studies

Chelsea Private Nursing Home, Edithvale, Victoria

This case is the most serious example of the agency's failure to properly carry out its duties. Its inadequate scrutiny and lack of action in the facility led to the maintenance of a dangerous environment in which a serious assault of a resident by another resident took place less than one month after it was found to be in breach of the behavioural management standard and granted two years accreditation.

The resident, Mrs Alice Woolcock, died shortly after the incident. A further review audit by the agency a month after her death resulted in serious risk to the health and safety of residents being identified and the home failing 19 accreditation standards. Six months later it had still not reached a standard where it passed all accreditation standards.

The question which remains unanswered is why was tougher action not taken against the facility after its September 2003 inspection which may have prevented the death of Mrs Woolcock. In addition how can the agency explain the fact that the home was found in breach of a further 18 standards less than two months later?

Accreditation April 2000

Chelsea Private which is a 124 bed facility in Melbourne was the subject of a review audit conducted in April 2000.

The team reported that:

- The approved provider was not providing specific resources to enable staff to provide residents with appropriate clinical care.
- Health and personal care was rated unacceptable. Units at the facility were regularly understaffed. Residents medical records were inaccurate.
- Skin care and continence management were not properly managed
- Behavioural management was inadequate with care strategies incomplete or limited. "The team observed six residents wandering the units continually over the two days of the audit and that little was done to engage them in meaningful activities. Three residents commented to the team that wandering residents entered their rooms and interfered with their own activities on occasions."
- Staff indicated they did not have enough time to interact with residents, particularly those with challenging behaviours.

Accreditation October/November 2000

Chelsea Private was again inspected on October 31/November 1 2000 and passed all 44 accreditation standards without a single criticism from inspectors. The facility was granted three years accreditation

Accreditation September 2003

Chelsea Private was the subject of a site audit on 17/18 September 2003 which subsequently led to it being found to have failed one accreditation standard. It was granted two years accreditation. The inspectors found:

- Non-compliance with the behavioural management standard with the needs of residents with challenging behaviours not always being managed effectively. As in 2000 residents were “observed by the team to be wandering into other residents rooms and other areas of the building. Three residents and seven representatives stated concerns regarding wandering residents being intrusive, impacting on residents privacy and dignity, removing personal items. One resident informed the team that another resident had physically threatened their resident on more than one occasion.” The team further reported that two residents had complained about residents entering their rooms overnight.
- Five requests for action by staff and residents to deal with the problems had not been addressed by management. They included requests for extra staff, a door lock on a resident’s room and segregation of residents with challenging behaviours.
- One resident had 49 falls since May that year and another 20 falls since July.

The accreditation teams recommendation was that there should be two contacts with the home over the next two years, including at least one visit.

Serious Assault October 25, 2003

On October 25 at 6.30pm Mrs Alice Woolcock a resident of Chelsea, was found lying on the floor of her room. According to the incident report filled in by staff, visitors observed a female resident from another section of the facility pulling Mrs Woolcock from her bed and kicking her and hitting her while she was on the ground. Mrs Woolcock died on November 7.

Review Audit

On November 14 a serious risk to the health and safety of residents was identified at Chelsea and sanctions imposed by the Department of Health. A review audit was conducted on November 17 and 18.

A different accreditation team found the home in breach of **19** accreditation standards. Their findings included:

- Internal audits dating back to 2002 had not been properly followed up despite inadequate findings in occupational health and safety, emergency procedures, medication management
- Education and staff development was inadequate. There was a high use of agency staff, some who lacked experience or were unqualified.

- Staffing was inadequate to meet residents care needs. Over-reliance on agency staff including 62 shifts in a fortnight. Out of 112 shifts per fortnight for a division one nurse only 73 were permanently filled. Some agency staff sent had no personal care training, incapable of feeding residents and had no knowledge of infection control, manual handling or maintaining resident dignity.
- Management and staff had not conducted audits against the accreditation standards and “were not aware of significant non-compliance in standard two, for example behavioural management”.
- Management and staff did not have the skills and knowledge to perform their roles effectively.
- Clinical care was inadequate.
- Behavioural management rated non-compliant with serious risk. “Residents continue to wander, fall and intrude on others’ personal space and exhibit aggressive behaviours towards other residents and staff.” One resident had 45 separate documented examples of aggressive incidents towards staff between July and November. Many of the incidents happened in the evening when agency division one nurses were in charge. “Residents who wander continue to do so within the units and around the service generally.” Care plans were inadequate. Not all incidents properly reported.
- Four extra evening staff had been employed after the attack on Mrs Woolcock.
- The physiotherapist had 20 hours a week to provide physiotherapy to 124 residents. “Care staff said they are not able to assist residents to do their exercise or walking programs other than the exercise of hygiene and toileting due to the number of residents that they are allocated to care for.

Vincenpaul Hostel, Mont Albert North, Victoria

In this case the hostel was granted three years accreditation after an inspection which found all standards were met. The subsequent death of a resident prompted a recommendation 12 months later that the facility was so bad it should be shut. The contrast between the scale of the investigation mounted by the two inspection teams is dramatic. The question remains whether there was such a dramatic drop in the standards of the facility in 12 months or whether the first inspection was not rigorous enough..

Accreditation 2002

Vincenpaul, a 53 bed facility, was granted three years accreditation in November 2002 after passing all 44 accreditation standards. The report is uncritical, includes no details of staffing levels. No details of when medication management training was conducted are listed or how many staff attended. The accreditation team recommends two contacts in the next three years including at least one visit.

Serious Incident

On October 27 a resident Mrs Olive Barns was given the wrong medication at 8.30am. Her GP was alerted at 11am. She collapsed four hours after getting the medication and was taken to hospital where she died on November 1.

Accreditation 2003

The agency conducted a review audit in November 2003 which found the home was in breach of 17 accreditation standards (later reduced to 13 by the agency). A serious risk to residents health and safety was identified during the visit. The agency decided to revoke the home's accreditation (later reversed). Inspectors conducted a much more far-reaching investigation and found:

- Staff did not have the knowledge and skills to perform their roles effectively with no system in place to properly rectify identified deficiencies
- The staff education plan only commenced two months before accreditation. Medication incident reports from July 2003 had indicated the need for education regarding medication administration
- Staffing was inadequate. Three PCA's looking after 40 residents in the morning, two in the afternoon and one overnight. The single night shift staffer worked 9.45pm to 7am. "During the review audit, the team noted two residents in distress, one who had been incontinent of urine and another who was distressed by the state of a bathroom and needed staff assistance. However, neither resident was able to find any assistance during this time despite the team assisting in searching for a staffmember to help."
- Medication management was rated non compliant with serious risk to the health and safety of residents. "None of the personal care staff have been assessed for competency in relation to medication administration to ensure that they have sufficient knowledge and skills to safely administer medications." Only after the death of Mrs Barns was a process put in place to identify gaps in the medication management competency of PCA's.
- Since July 2003 there had been at least one incident a month of residents being given either the wrong medication or an incorrect dosage. In June 2003 there were six instances where residents did not receive their medication as prescribed
- Another resident administered the wrong medication including a medication to lower blood pressure. Doctor not notified until two and a half hours later.
- Clinical care standards inappropriate. Care plans inadequate. Care documentation training undertaken two months before assessment.
- A residents family member provided specialized nursing care including repeatedly flushing her catheter with coca cola. A topical anesthetic was found to be nine years out of date

Fraternity of the Holy Cross Kentlyn NSW.

This case shows the agency approved a sub-standard facility in 2000 and applied inadequate scrutiny to it in the subsequent three years with the standard dropping further to the point residents and staff were both at risk.

Fraternity of the Holy Cross is a 29 bed facility that was first accredited for three years in November 2000.

It was granted a three year accreditation despite the fact it was rated unsatisfactory in each of the three major categories management systems, staffing and organisational development.

- Inspectors found staff education was “incidental rather than planned”
- It was also rated unacceptable in health and personal care with the finding staff had no qualifications, had not undertaken any clinical care courses and had “little understanding of the clinical care processes”. The home had advised it was planning to appoint a registered nurse on a sessional basis to oversee the clinical care processes.
- The facility was rated unacceptable in the category of resident lifestyle with concerns raised about the lack of activities.
- The physical environment and safe systems rating was unacceptable. Chemical and physical restraint was in use to stop residents absconding.

Inspection 2003

On their return three years later agency inspectors found that conditions were significantly worse with the facility failing seven accreditation standards including education and staff development (1.3 and 2.3), clinical care and behavioural management (serious risk identified).

- The same training and education issues were identified with management failing to evaluate staff training needs and provide training that met those needs.
- A single staff member for 29 residents from midday. No-one worked overnight in the facility with the evening carer doing a sleepover shift before handing out medication and finishing at 8pm.
- Staff had only seen a registered nurse in attendance twice in six months;
- Care plans are not always updated and some do not contain information about carer provision current to the residents needs
- Concerns about a lack of time and skill to manage residents had not been acted upon
- Residents were absconding, threatening staff with knives, being verbally and physically aggressive to other residents
- The needs of those residents with challenging behaviours were not being effectively identified or met.

Albury Private Nursing Home

This case again raises questions about the approach of the agency when it grants full accreditation to a facility in January 2003 only to return six months later to find widespread and serious non-compliance, including systemic failures.. The difference in the results has not been explained by the agency.

Accreditation History

The Albury facility had a chequered history of accreditation including failing 21 out of 44 standards in June 2001. But in January 2003 it appeared to have finally lifted its standards when it was found to have passed 44 standards and was granted three years accreditation.

Review Audit July 2003

Inspectors failed the facility on 11 standards (later reduced to nine) including education and staff development, medication management, staffing levels and the living environment. Inspectors found:

- Claims by the director of nursing that medication incidents had decreased over the last nine months were supported by a graph which had been altered to artificially show a decrease;
- Education sessions dating back to September 2002 had not been properly evaluated. No staff had attended all the required competency assessments
- Nursing staff 10 times between January and May signing that medication had been delivered when it had not;
- 205 incidents in a month where nursing staff had not signed the medication chart to indicate medication had been administered;
- Breaching its own performance appraisal system going back to July 2002.
- Systemic failures including the failure of the service to ensure all registered nurses who administer medications were competent to do so and the failure of the service to take appropriate action when multiple breaches of its medication policy occurred. Provisions of the service's medication management policy (signing charts retrospectively) which did not facilitate the safe and correct administration of medication.

Kaniva Hostel, Kaniva, Victoria

This case shows the agency granted three years accreditation in 2000 to a facility which was left un-staffed overnight and during lunch breaks and had inadequate emergency procedures. The same situation was discovered three years later and ruled to be totally unsatisfactory.

Kaniva a 10 bed low care hostel which caters for people with dementia or

related disorders was granted three years accreditation in November 2000. The facility was rated satisfactory despite having:

- No staff on duty at the facility between 8.30pm and 7.45am or during lunch hours
- Inadequate assessment of the risk to residents in an emergency

In 2003 the facility failed 11 accreditation standards and receiving only one year's accreditation.

Inspectors found:

- The service did not actively pursue continuous improvement. Improvement logs were available but had never been used by management residents or families;
- The service was failed on human resource management because like in 2000 no staff were on duty during the lunch break and overnight.
- Residents were asked to pay for their own furnishing and bedding in breach of the Aged Care Act
- Residents files are stored in the wardrobe of an onsite caravan. A garage was the office for the staff with no toilet or hand-washing facility. The garage roof leaked and the walls were covered in mould.
- As discovered in 2000 there were not the systems to minimize fire, security and emergency risks. Fire extinguishers in residents rooms had not been checked since October 2000. Inadequate emergency procedures were in place. Some of the alarms in residents rooms had flat batteries and others not registering on the nearby hospital's computers.
- There was no secure perimeter fence and the facility had a history of prowlers

Alroy House, Singleton NSW

In this case the agency approved staffing levels at a facility which had a single staff member caring for 49 residents (12 high care) despite evidence the workload was too high.

Accreditation June 2003

The facility was granted three years accreditation after inspectors found it complied with all 44 of the accreditation standards. This was despite the facility having one personal care assistant looking after 49 residents alone at night (12 who required high care). The facility passed this standard despite being told by relatives the workload was too high for the PCA and by residents that they had to wait to receive care.

The response of management to concerns of understaffing had been to take away the catering duties of the nightshift staff member.

St Lawrence Nursing Home in Victoria.

Unacceptable storage of food, poor kitchen hygiene, a lack of labeling of chemicals and clothes delivered by wheelbarrow did not stop this facility passing the standard covering catering and cleaning

Inspectors found during the May 2004 audit potatoes, pumpkin and loose cabbages were being stored in a maintenance shed beside paint, chemicals and other equipment. Chopping boards for food were in poor condition and staff said that management was slow to respond to requests for new or replacement equipment.

There had also been no preventative maintenance on the washer or dryers for two years and some cleaning chemicals did not have proper labels. Clothes were distributed to residents in a wheelbarrow or supermarket shopping trolley.

Appendix C

HSU (NSW) Branch Submission



Health Services Union

**Submission to the Senate Community Affairs
and References Committee**

More time to care...

Authorised by Michael Williamson, General Secretary, Health Services Union
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AGED CARE INQUIRY

TERMS OF REFERENCE

The following matter be referred to the 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 & 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

The Health Services Union is a registered trade union, representing over 37 000 health and aged care workers in NSW. In the aged care sector, the HSU represents members

working in both the charitable and the for-profit sector. We represent care workers (personal carers and care service employees), and support staff such as cleaners, cooks, recreational activities officers, diversional therapists, administrative staff and maintenance and outdoor staff.

This submission will focus on points (a), (b) and (e) from the terms of reference for this Inquiry. This submission is the result of extensive consultation with HSU members in the Aged Care Sector including a 'Members Phone-In' conducted on 17 July and a survey of members carried out during July. We have drawn on the input of over 100 aged care workers in the preparation of this submission. The HSU would welcome an opportunity to discuss this submission at a Senate Inquiry Hearing and to facilitate the appearance of some of our members also.

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

From extensive consultation with our members, the two most pressing issues facing the aged care sector are;

- Poor wages; and
- Inadequate staffing levels and excessive workloads.

These are both factors which contribute significantly to the aged care workforce shortages.

Wages

It comes as a surprise to many that an experienced personal carer with a Certificate III in Aged Care earns a paltry \$13.53 an hour. For this rate of pay, a personal carer would commonly care for between 15 and 50 residents and would routinely undertake the following range of tasks and duties in any given shift:

- *Provide a wide range of personal care services to residents, under limited supervision, in accordance with Commonwealth and State Legislative requirements, and in accordance with the resident's Care Plan, including:*
- *Showering and toileting residents and assisting with dressing and general grooming;*
- *Assist and Support residents with medication utilising medication compliance aids;*
- *Simple wound dressing;*
- *Implementation of continence programs as identified in the Care Plan;*
- ***Attend to routine urinalysis, blood pressure, temperature and pulse checks;***
- *Blood sugar level checks etc and assist and support diabetic residents in the management of their insulin and diet, recognising the signs of both Hyper and Hypo-Glycemia;*

- *Recognise, report and respond appropriately to changes in the condition of residents, within the skills and competence of the employee and the policies and procedures of the organisation;*
- *Assist in the development and implementation of resident care plans.*
- *Assist in the development and implementation of programs of activities for residents, under the supervision of a Care Service Employee Grade 3 or above, or a Diversional Therapist.*

One of the most common complaints from members is that the rates of pay for carers are too low given the responsibility and complexity of tasks performed.

Members get extremely frustrated and angry at the lack of interest by employers in negotiating better wages and conditions for workers in this industry. Members find it grossly unfair that they receive \$13.53 an hour for the complex, emotionally and physically demanding work they perform, many of them with TAFE certificate qualifications in aged care, when their children if they worked as a checkout operator for Bi-Lo or Coles could earn \$14.13 an hour, or at Hungry Jacks for \$14.86 an hour. Further, members get very frustrated that they receive substantially lower pay than workers doing similar or equivalent work in a public hospital setting. It is a real indictment that the lowest pay for carers, cooks and cleaners is in fact in the for-profit sector, as opposed to the charitable sector, who pay slightly more.

One member from the North Coast of NSW said, “people in the

community assume that because we're carers and we work in nursing homes and hostels, that we're paid as Nurses. When we explain what we're paid as carers, most people just can't believe it."

Research shows that qualified and experienced carers in Aged Care earn less than unskilled workers in fast food outlets, and retail checkout operators. One member from the Hunter said "we can't keep the young ones, they can earn more money stacking shelves or working in a supermarket and they don't have to deal with the stress, the workloads or any of the unpleasant stuff that we deal with in aged care."

One member from the Southern Highlands wrote in her survey that "young people don't seem to be attracted to working in aged care for whatever reason ... who will look after the baby boomers in the years to come?"

Staffing Levels

Whilst the poor wages in aged care is a source of anger and frustration to workers, what they get most upset about are the inadequate staffing levels.

Members have explained how staffing shortages impact on them and on the level of care received by the residents.

A member from Albury explained that "we are constantly losing care hours. When someone resigns, they cannot be replaced, so everyone else picks up the extra workload. Then we all burn out and before you know it, someone else has left, it's just a vicious circle."

Members get upset about the low staffing because of the impact it has on the residents quality of life. Consistently, members state that because of understaffing they only have time to provide “basic care” to residents and regret that the feeding and showering of residents is too often “like a production line”. Members hate that they don’t have time to spend quality “one on one time with residents.”

Many members commented on the busy morning shift when they are trying to get the residents showered and groomed. One member from Albury said, “We’re not able to take reasonable time on residents showers, particularly with dementia patients who need more time to work through their behaviours. Too often we skip our breaks provided for by the award, we just don’t have time to stop and take them.”

Another consistent theme was that residents were reluctant to ask for help as they know how stretched and overworked the staff are, as one member from Tuncurry put it, “Residents do not wish to call staff when they know there is only 1 staff member on ie. Night duty. Night staff are unable to shower incontinent residents because they are unable to spend unlimited time one to one and need to be available to respond to other residents.”

A Carer from Merimbula said, “Due to lack of time, some residents will shower or dress themselves but require staff to check in on them due to frailness, unsteadiness etc.”

A Carer from Gosford said, “I feel the residents are often rushed through showers and wound dressing with medication delivery also rushed which causes stress and anxiety for both residents and staff.”

A Carer with six years experience and working in the eastern suburbs of Sydney explained how staff cuts have impacted on residents; “Hair is not being combed or washed, showers are not being done daily, teeth are not being brushed – all areas of hygiene are suffering. There is no time to actually *care* for residents in their showering, feeding etc.”

A Diversional Therapist from Bowral with 8 years in the industry lamented the incapacity of staff to attend to individual residents, explaining that “usually a number of residents are fed at the same time with one staff member sitting in the middle and spooning food out one at a time.”

Many members expressed grave concerns about understaffing on the night shift and the safety issues associated with this.

It is not uncommon for one carer to be rostered on alone overnight in a hostel, looking after up to 50 residents. Members feel a huge weight of responsibility in these circumstances. An awful incident occurred in a facility on the Central Coast this year when a resident had a cardiac arrest and the sole carer had to call the ambulance whilst also trying to give CPR and then actually had to leave the resident alone so that she could go outside and open the gate to let the ambulance in. Clearly, this is an unacceptable arrangement. The union believes that there is a very strong argument for minimum staffing levels, especially at night. It is not safe or appropriate that one carer should be rostered on alone at night.

Other concerns about single carers working at night involve patient falls. If a patient falls at night, either from their bed, or has a mishap on

the way to or from the bathroom, the single carer is often physically unable to assist them off the floor and back into bed. Most times when this occurs, the carer will have to call an ambulance so that the ambulance crew can assist to return the patient to bed. Alternatively, some facilities instruct carers to place whatever bedding they can on the floor and make the resident as comfortable as possible so that they can be lifted in the morning. Clearly, neither of these scenarios are satisfactory.

Another obvious concern about short staffing at night is in terms of the carers capacity to respond to a fire or other emergency. Clearly, one carer with 50 odd residents in a facility would have no hope of getting those residents to safety in the event of a serious fire.

In one western Sydney facility, there is one carer rostered at night to care for 168 residents, in three separate buildings, connected by external corridors. This is clearly a safety issue and one that the union has raised with the WorkCover authority.

A relatively common practice in the industry is to roster a single carer overnight on a sleepover. This arrangement sees the staff member paid \$32.20 for the night and provided with a bed to sleep in. The staff member is expected to rise and attend to buzzer calls and is paid in addition to the \$32.20 for all time worked during the night at the normal hourly rate. Members advise that many use a substantial part of the sleepover shift to catch up on paperwork. Others advise that they very rarely get any sleep as it's a strange bed and they're constantly expecting the buzzer to go off. The union believes that sleepovers are being misused and do not provide a satisfactory level of care.

A final issue raised over the lack of staff is that of staff fatigue. Members report that they are often required to work double shifts and that this, combined with the constant running and rushing in the job, causes burnout. As one member from Unanderra says, “staff are always doing extra shifts or doublers which causes them to burn out and sometimes to be short with residents.”

Clearly, there needs to be better funding of aged care services so that the salary of staff can be improved and more staff can be employed. Whilst staff are currently giving 150%, residents are still not getting the quality of care that the staff would like to be able to give. Many members said they wished they had “more time to care” and that is the name we have given to this submission. Our elderly have already given a life time of service to the community and they deserve care and dignity in their twilight years. Aged Care funding must be increased so that this can be achieved.

Accreditation and Paperwork

- 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;*

Members consistently expressed concern about the amount of

documentation required of them now. One member from Henty said, "Accreditation can help keep you on target, but the amount of time spent on paperwork is time away from giving care."

Many members stated that they regularly work unpaid overtime, sometimes regularly 30 mins at the end of each shift to complete paperwork obligations. As one member from Sydney put it, "it's a vicious cycle, you need to do the paperwork or you don't get the funding, but you don't have enough funding to get the staff to do the paperwork."

As one member from the North Coast put it, "I believe there should be some other type of monitoring system. What I don't agree with is the paperwork etc that we have to provide to prove we are doing our jobs."

Members were strongly and consistently of the view that the current accreditation model is inadequate. Scheduled accreditation gives management the opportunity to roster extra staff on, adjust menus and activities, and generally have everything looking ship shape for the accreditors. However, members argue that the standards shown off at accreditation are rarely maintained outside of accreditation periods.

As one Carer with 7 years experience said, "because management know they are coming, they can put on extra staff, and make sure everything looks good. Why don't they turn up without management knowing, that could make things very interesting."

As a member from Bowral said, "Random inspections might lead to more continuous quality care, rather than the focus being on one visit every three years."

Members said that considerable pressure is placed on staff in the lead-up to accreditation in order to 'get things right'. One member even said that their facility tried to intimidate and bully staff into working harder in the lead-up to accreditation by playing on their emotions towards the residents by saying things to the effect of, "if we don't get accredited and we get shut down, where will all the residents go...what will happen to them."

A member from the Illawarra said, "it seems when accreditation is coming up management put on extra staff and give or get you what is needed. Once it is over, it goes back to less staff and less things getting done."

A member from Ballina said, "there are far too many dollars and hours spent on the lead-up to the desk audit and the site audit. Standards of quality improvement need to be investigated more closely."

Transitional Care

- 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*

The union is acutely aware of the impact of the increasing number of public hospital beds being occupied by the elderly. In a report released by the NSW Auditor-General yesterday, it is estimated that "up to 900 inpatient beds are occupied by patients who should be in nursing

homes or, with appropriate support, back in their own homes.”¹

The HSU has initiated discussions with the NSW government about the possibility of creating ‘transitional aged care beds’ as recommended in the Auditor-General’s report, as opposed to having these patients in acute care beds.

With the current chronic nursing shortage, the creation of transitional beds in hospitals for the elderly would potentially enable the engagement of ‘personal carers’ to attend to the needs of these patients as opposed to nurses. This would enable nurses to be allocated to acute beds and the needs of these patients to be looked after, as they would if they were in a hostel or nursing home setting, by carers.

The Union will continue to pursue this with the NSW government and sees great potential for the introduction of a new ‘personal carer’ classification into the public hospital setting to assist in caring for the increasing number of aged care admissions in that transitional period between requiring acute care in hospital and being able to either return home, or access nursing home care.

Conclusion

The HSU is pleased to have the opportunity to submit our views and those of our members on the important public policy area of aged care. It is the view of the HSU that there must be immediate and significant enhancements to aged care funding and that such enhancements must be targeted towards improving staff pay and conditions and also

¹ Sendt, R.J., Auditor-General’s Report – Performance Audit – Transporting and Treating Emergency Patients, NSW Audit Office, July 2004, p. 3.

increasing staffing levels. The staff in aged care do a very important job in caring for the aged and frail in our community. Their job is a physically and emotionally demanding one and they deserve to have better recognition for the skills they have and the important work they perform. They must be remunerated better for their work. The HSU supports the introduction of staff to resident ratios to ensure that all providers meet an agreed standard of service provision to their residents.

The HSU also urges reform to the accreditation process to ensure a more continuous quality focus. Finally, the HSU supports the introduction of transitional beds into public hospitals and would welcome an opportunity to further explore the use of a 'personal carer' in the public hospital setting.

As stated at the outset, the HSU (NSW) would welcome the opportunity to attend and give evidence at the Committee's hearings and have several members who would also like to attend to give their first hand perspectives on the industry.

29 July 2004