SENATE COMMUNITY AFFAIRS

INQUIRY INTO AGED CARE

SUBMISSION

NAME: LORRAINE READ

Senate Community Affairs

Inquiry into Aged Care

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In response to your request for submissions to the “Inquiry into Aged Care” and after consultation with the registered nurses within the Nursing Home we present the following submission for your consideration.

1. In the past money was earmarked to address the lack of parity between the Public Hospital nurses and the Nursing Home staff. However history has shown that there is no guarantee that money given to Nursing Home proprietors and management will flow onto Nursing staff. Therefore we are proposing that there be more accountability of money spent in the area that money has been allocated for. Currently the disparity in wages is 16%
2. We are proposing that there be reasonable workload guidelines and reasonable staff to resident ratios
3. Aged care is highly specialised and requires staff to be motivated and very cognisant of the ageing process from the physical, physiological and spiritual perspective.
4. The practical “hands on” experience that is in the Certificate 111 courses is minimal. Consequently when staff with Certificate 111 applies for a position they need time and further education to gain the necessary skills to function effectively. We therefore propose that Certificate 111 courses have longer clinical component of these courses.
5. At present in Low care facilities there is no requirements for training and people can work there giving out medications including schedule 8 drugs with no qualifications. There are complicated dressings being done also with no training for staff and often not supervised.
6. There needs to be recognition that Low care facilities are becoming defacto Nursing Homes. Statistics show that there has been increasing numbers of category one, two and three residents being looked after in Low care facilities.
7. We have been asked to take young people with brain damage and other diagnoses that require many more hours care and much more technical care than Category one funding provides. See Appendix 1
8. Accreditation is virtually a sophisticated paper trail and Nursing Homes that have access to professional documentation and have policies and procedures written for them could gain accreditation with ease compared to Nursing Homes who have limited resources.
9. There needs to be support for Nursing Homes who have residents that are unsuitably placed. For example we have a man who has a history of psychiatric illness who is extremely disruptive and when we suggested that he was inappropriate for our facility we were told to manage the best way we could. Support that would help the facility would be either access to a psychiatric crisis team that could give advice, or access to suitable alternative accommodation..
10. Resident Classification Instrument is very regulated and the documentation needed to support a claim is extensive and takes nurses away from the bed side care
11. The validation of these claims is downright humiliating and something every Nursing Home dreads. Often the interpretation of a claim comes down to the individual person doing the claim. For example at our last validation we were told that in order to prove that a resident was frequently incontinent we had to allow the resident to be wet for three days which would then show that the resident had a pattern of incontinence. When this was suggested to a group of professional

nurses they all said they had never heard such nonsense. Subsequently we were downgraded with all of our incontinence programs because the residents were managed effectively and with dignity. We propose that a more professional approach be taken for validation.

In conclusion it is imperative for this inquiry to carefully address the points in the terms of reference because with the increasing aged population and also the increasing number of Australians with various forms of dementia.
The current Commonwealth plans for elderly people to remain at home and independent for as long as possible.

The effect of these two issues mean those persons who become residents in Nursing Homes are older, frailer, have poly medical problems and have various forms of dementia. This inturn means that there is an increasing high workload for staff.

If these issues are not adequately addressed within a short period of time there will not be the staff to give best practice of care.

Appendix 1

Case Histories

1. Female now aged 45 years admitted to the Nursing Home at age 39 years following anaphylactic reaction, cardiac arrest and hypoxic brain damage resulting in spastic paralysis. This young lady at the time of admission was married with two small children. She is aware of her surroundings and would benefit from more physical and recreational activities than we are able to give her. We have estimated that the time spent in looking after her is 60 hours per week and we are not funded for even half of that.

2. Female 63 years old who was first admitted to a Nursing Home aged 43 years with post operative paralysis. She has no cognitive impairment and we hope to transfer her to our new hostel being built

3. Female 68 years old who has renal failure and requires peritoneal dialysis was waiting 8 months in a public hospital before getting a bed in our facility. Many Nursing Homes refuse to take these residents due to the complex nursing and technical care needing and no extra funds to supply the care

4. Male 65 years old with psychiatric illness diagnosed with frontal lobe dementia. He is accommodated in our secure unit and is a large mobile man who us very threatening to staff and to other residents and spends his day running water from all of the taps or banging on any surface he feels like including glass surfaces. We have received no help[to manage this man.

5. Male now aged 58 years first admitted to a Nursing Home when he was 51 years old with organic brain damage.

6. Female aged 75 who has been in the Nursing Home since she was 53 years old a total of 22 years. She is intellectually handicapped and has a very young mental age.