Royal Commission
into Aged Care Quality and Safety

Statement of Gaye Whitford

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1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

2. The views I express in this statement are my own based on my education, training and experience.

Background

3. I have worked in aged care since 1997, when I started as a carer at a residential aged care facility in Victoria. I did not require any formal training before I started, in those days you were thrown in the deep end. After working in the industry for two years, I commenced a Bachelor of Nursing, in 2001 I graduated as a registered nurse from Monash University.

4. Due to family reasons I relocated back to South Australia and started working in a primary care facility which had an associated aged care facility. Since 2010 I have been privileged with the position of residential aged care coordinator of a 15 bed medium residential aged care facility.

Person-centred care

5. To me, person-centred care means individual care, that is holistic and not necessarily biomedical based. I believe there is too much of a focus on the medical/clinical aspects of care, rather than emotional, spiritual journeys. It is enabling residents to be whom they wish to be.

6. It includes providing an environment conducive to companionship – not necessarily just from staff members, although that is part of it. Anyone can provide companionship to older adults, and it should be encouraged by facilities. It could come from church groups, through social outings, certain residents can connect with one another and form meaningful friendships. Friendships between residents can be misunderstood and misinterpreted by families, and depending on a person's cognitive capacity there may need to be limits, but generally they are something that should be encouraged. Families visit infrequently, but a fellow resident will be there for every meal, and activity. It can motivate people to come out of their rooms.

7. It's about making things more home like, rather than a clinical setting.

The importance of person-centred care

8. You have to know who they are before you can start caring for them holistically, taking into account cultural, social, spiritual, sexual, careers and family environments.

9. I think that a person-centred care approach is very important for residents. It motivates them to get up in the morning, gives them something to look forward to. I find that most people want to be useful, they need a purpose and a role. It might be setting the table, or watering the garden, or helping someone else. It gives them purpose in life and changes the focus to their abilities, rather than their limitations.

10. Well delivered person-centred care can have positive clinical outcomes as well. In my experience it can reduce or even eliminate the need for psychotropic medications. Keeping active assists in keeping residents mobile and prevents muscle wastage. I have found that it can even improve quality of sleep at night. We encourage our residents to keep active during the day and to keep to a routine, and we have minimal issues with insomnia.

Barriers to providing person-centred care

11. Every resident we look after has chronic conditions which the current system is focused on addressing. However, the person centred care approach philosophy is not currently being anywhere near fully implemented. Issues currently not addressed adequately are sexual identity and needs, social and cultural needs, passive elderly abuse by relatives and residents.

12. The number one barrier to providing person-centred care is staffing ratios and skill mix. Staff need time to be able to provide care that is person-centred and without pressured time constraints. Group activities are good, but not everyone likes group activities. Some people prefer to receive one on one attention.

13. I personally believe that another main barrier is a lack of staff education. Some staff members don't know what activities to provide or what to do. I think that carers should receive training similar to diversional therapy type training, so they can learn what activities might assist to address challenging behaviours and promote meaningful engagement.

14. Currently volunteers need police checks however, this continues to discourage quite a few wonderful community members from entering our doors. Although the police clearance incurs no financial cost to them it still affects volunteer numbers. Families are getting busier too, so they are not around as much to provide support. If volunteers are not left unsupervised with residents then do they really need a police clearance?

15. At our facility, we do not have a specific budget for activities. The activity coordinator role is a time consuming role that demands more attention. Activity coordinators need to have a suitable transparent budget that has the ability to employ/subcontract alternative therapists which promote holistic care. There is also great confusion on if the activity hours do they come out of the direct carers budget, which is frequently the case. It takes time to get family involvement to coordinate outings and social get together. Some families are proactive, which is great. Other families want to be, but just don't know how. They might not understand why Mum or Dad is acting the way that they are, they might take certain behaviours personally when it is just a symptom of dementia. An activities coordinator could facilitate this family involvement. Currently activity coordinators are unskilled and do not have access to support and are left to their own devices.

16. I think it is an advantage that we have a small centre as it makes it easier for staff and we know all of our residents. It does make it harder to attract volunteers though. Sometimes family members volunteer, but once their resident passes away or moves on then they don't provide ongoing help.

17. In my opinion there is a lack of understanding about aging processes, especially dementia, which is a major barrier to providing person centred care. A lot of training provided to carers is online now, but that might not be how that person learns. They might need more practical interactive education.

18. Currently mandatory education is unclear as in relation to the number of hours allocated to a staff member to complete the requirements. Ancillary and carer staff are covered by a different EB agreement there are no standardised education hours defined to promote this compliance.

19. The challenges for managers/supervisors (where I am) is the amount of administration we have to do. I am confined to my desk most of the time. I do think it is important to regularly get out and see what is happening within the facility, and I try to help at least one person get up and prepare most mornings. You can not coordinate care if you don't understand what the care needs are of the people requiring care. There needs to be more separation of administration duties and clinical duties.

20. These days the management role has increasing time constraints. I go to a lot of unproductive meetings. I don't have any dedicated administrative support.

21. All job descriptions need to be more specific so they are clear. Carers frequently cover many roles within their day e.g. kitchen hand, food preparation, cleaner, direct care attendant, laundry and administration. Currently generic role descriptions are misunderstood and open to interpretation.

22. Another barrier to providing person centred care is the limited resources we have available particularly in rural areas. For example, access to allied health we have a physio based in town once a week. Podiatrists, Speech therapists, Dietitians and Social workers visit perhaps once a month however it is very difficult to obtain appointments particularly to podiatry. There is also very limited access for orthotics support so residents can purchase appropriate footwear to minimise falls within the rural areas.

23. Lack of consultation in structural changes to the internal and external environments. Alterations are being made without reference to best practice models in an unplanned and ad hoc manner.

24. Valuing your employees is a must. We work in an environment that is constantly changing and for this we need to be more flexible and allow staff to honestly document their care hours without ramifications. Person centred care has to not have time constraints and if a staff member needs to work over their rostered hours in order to provide the desired care, we need to allow this flexibility. If staff feel valued the organisation will gain so much more support from them which, ultimately is beneficial to the residents we care for.

Person-centred care in practice

25. There are a few things that we do to try and promote person-centred care in our facility. I'm sure there is still room for improvement.

26. We always try to do different activities, and tailor those activities to what we know that our residents want to do.

27. During one of our shifts which runs from 1 pm to 9:30 pm there tends to be some downtime around the afternoons. We encourage staff to use that time for activities for the residents, and to plan in advance what they are going to do. You can't just tell staff what to do, they have to do what they're passionate about and what they think will be best for the residents at that particular time. Some residents might like gardening, or arts and crafts. We keep a record of what activities we are holding and who is attending to try and keep track of anyone who might be missing out.

28. We do what we can to encourage volunteers, who can assist with all sorts of activities. We have some who come in for bingo and sit with the residents, especially those with vision or hearing impairments, or with progressing dementia. Others do gardening with the residents, or even just read the paper. The second Wednesday of every month we hold a community lunch. For the cost of a donation residents, their friends and family and members of the community can have a two course meal together. Some residents miss out on that if they can't, or won't, go outside. It also promotes social interaction. We get a good turnout to these lunches, up to 30 people attend, including almost all of the residents.

29. Every Friday afternoon between 4 - 5 pm we hold happy hour in the main communal area for residents and public to attend. We have finger foods, music (sometimes voluntary live performances) and residents and guest supply their preferred beverage.

30. We also hold resident meetings every month. Residents come and voice any problems, feedback and suggestions. We get a lot of menu suggestions from those meetings. Unfortunately our kitchen was closed a few years ago, so we get all of our meals delivered from the hospital. We fought that move very hard; a kitchen is about more than just producing food. A kitchen promotes atmosphere and energy with sounds and smells and movement. For many of our residents, they have extraordinary practical skills. Some of our women used to live on farms and cook for shearers and workers. They know how to make a great cream puff. I think a kitchen can be used to promote person centred care, and it is disappointing that ours has gone.

31. Recently, we have commenced constructing life books for residents. A template is sent to their family member to add a few words and supply pictures. Visual cues are great conversation starters. This also assists in our cognitive assessment and social profile.

32. I find that some rules and policies seem to contradict person-centred care. They provide for blanketed rules that don't always make sense. For example, there is a policy which says that if a patient has an unwitnessed fall or hits their head with a witnessed fall, they have to undergo neurological observation in a primary care facility. Which makes sense in theory. But we don't have the capacity to provide neurological assessments, so if a resident has a fall, we have to transfer them to a hospital, which is an unfamiliar environment with nurses and carers that don't know them and their specific likes and dislikes. It can be extremely distressing. Residents can get disoriented as it is not a familiar environment and end up being a higher falls risk than before. Consequently majority of residents who sustain a fall are transferred. The patient centred care philosophy would promote care to come to them, in retrospect the majority of transfers are unnecessary.

33. We currently have a dilemma in dealing with another policy which is inconsistent with person-centred care. We have a residents who wish to utilise their own mattress from home, but in order to comply with the audit system all mattresses have to be waterproof and be light enough to be rotated by carers every month. If we comply with the residents

request, we are unlikely to pass the audit but it will provide them with some comfort and control.

34. We have found that having a resident doctor has made a difference to the personalised care that we can provide. We have used locums in the past and found that some would refuse to come out. They only get paid for the actual consult time, not for travelling back and forth. They're ok if we bring the patient to them, but they don't want to come out to us. Similarly, if we had more nurse practitioners available they would be able to so some of the more simple medical work, for example prescribing simple antibiotics for recurrent infections and assist with medication chart compliance.

Changes to current system

35. There are quite a few things that I would like to see changed, in order to improve the current system.

36. We need to complete social assessments in conjunction with clinical assessments upon admission. Currently residents are categorised by their medical conditions and limitations only. By constructing a life book during admission this enables the individual to be holistically understood.

37. I think that there needs to be a nurse rostered on for every shift. It is not enough to talk in terms of staff to resident ratios, you need to consider the appropriate skills mix.

38. I have some concerns about our current practice of only having one carer on at night. It is fine while everything is going well, but all it takes is one psychotic episode and that staff member cannot look after anyone else while they tend to that person. Sometimes a resident has decided they don't want you, it can be useful to have another staff member try a different approach. It is important that residents and staff feel secure and safe.

39. I think there is an element of risk aversion in some of the policies and procedures that are imposed. People obviously don't want residents to get hurt, so they make rules, but they're often too clinical and don't take into account dignity and autonomy. There will always be an element of risk in allowing people to have some independence, but you have to weigh that up against the potential benefits.

40. People who make the policies should be more open to communication from the people on the ground. If we can feedback to them information and suggestions they will have better understanding of the practical effect of these policies. Also it would be good to hear from them the reasons behind some of these decisions.

41. Decisions about what happens at our facility are largely driven by our budget. If something is not in the funding then we don't get it, no matter how beneficial it might be. There is downward pressure on management to cut costs, and upward pressure from care workers for more staff and activities.

42. You have to bear in mind that nursing home care is different to hospital care. In hospitals, someone comes in, you treat them and then you send them on their way. It's all about clinical care; that's all there is. In hospitals with a residential aged ward, I believe it is the case that the nurses there are asked to prioritise emergency room care, so the high care aged patients regularly get left alone. The industry is losing fantastic nurses, because they feel like they can't do a good enough job. They go home and cry and feel helpless. Until aged care is regarded and funded with the same value as acute environments these issues will continue.

43. Any alterations to aged care facilities from community funds should have to be referred to a suitably qualified authority before they are spent.

44. There needs to be adequate funding, education and the ability to obtain consultation in the activities area including alternative therapies as this is the main foundation of person centred care.

45. There is a real disregard for aged care, but in hospitals 80% of patients are aged, so you're going to come across it, whether you like it or not.

46. If we are going to redefine skill mix, generic job descriptions need to be reclassified and accurate.

Issues specific to rural areas

47. We are pretty lucky in our area that we can attract fantastic carers from the local community. We do have some difficulty attracting qualified enrolled and registered nurses.

48. We cannot receive the recommended electronic assessment and care planning system Leecare in our area. There is some issue with the network and so we are still stuck using paper. There are a number of issues with using a paper based system; it means we are not as well coordinated as we could be. It also makes it hard to have simple prescriptions updated; other places can have a doctor login externally and update prescriptions, but we have to get one to come out. If we could get Leecare up and running that would really free up some time.

49. For our residents to access the services of a geriatrician we need to arrange transport or staff to volunteer their time to enable residents to be reviewed by the visiting specialist that visits every three months for 48 hours. The town which they visit is 110 km away. These reviews are extremely beneficial however are difficult to obtain and arrange without budgets to facilitate this.

50. In my submission paper i have referred to the muted feedback up concerns. In rural areas this is accentuated in that there is limited access to a referral process which has any real consequences. Concerns and/or suggestions raised are not addressed and if they are there is no adequate feedback or resolution process.

Conclusion

51. The social aspects of one's life need to be given equal attention and support through environment, carer support, funding, activity support, education and evidence based best practices that enables the inner person to feel content particularly as they near the end stage of their journey.

Signed: G Whitford

Date: 04.06.2019

Witness: KENNETH OEAN WHITFORD

Date: 04.06.2019