Royal Commission
into Aged Care Quality and Safety

Statement of Emma-Kaitlin Murphy

Name: Emma-Kaitlin Murphy

Date of birth: [redacted]

Address: [redacted]

Date: 7/06/2019

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 graduated from a Bachelor of Nursing in December 2017 and went immediately into aged care. I have not completed a graduate program and I am currently in my second year as a Registered Nurse. I work for a nursing agency that subcontracts me to various facilities around Brisbane, and I also work on a casual basis at a residential facility.

4. The aged care facility I work at on a casual basis has the capacity for approximately 130 residents, this is about average in my experience. Some of the smaller facilities I have worked at have a 60 – 90 resident capacity. Aged care facilities are not always full to capacity and therefore the number of residents fluctuate accordingly.

Person-centred care

5. To me, person-centred care is individual or tailored care, having regard to a person's individual requirements – clinical, functional, social, religious, and emotional. Person-centred care, quite simply, means that the person for whom we are caring is at the centre of the care. Therefore, they are at the centre of every decision that is made. This includes exercising the person's right to be involved in the decision-making process regarding the care they receive and the delivery of care. It is important to note that for the long-term care of a person this process will be ongoing as their needs change.

6. In the setting of residential aged care person-centred care should focus on the emotional, social and mental wellbeing of the person. For example, it could involve sitting and chatting with someone, finding time to share memories. Or taking the time to find a resident her favourite pair of pink pants. Or actually passing on a message that you promised to pass on.

7. When I first started working in aged care I was told that "this is their home, not our workplace". Think about how you behave when you are a guest in someone's home, you fit in with their lifestyle and habits. You would engage with them, give them your time

and attention. This should be reflected in aged care, our focus should not be going to work and ticking tasks off a list. Our focus should be on the people who we are there to care for and whose home we are in.

The importance of person-centred care

8. Neglecting the social, emotional and cultural needs of a patient can have direct clinical outcomes, and can result in an unsafe environment. We can, by our actions, make residents feel undervalued and neglected, or exacerbate those existing feelings.

9. Older people love to chat about their history, their families and things that remind them of happy times, but they are not blind to how busy nursing staff are. They know that we cannot always find time to sit and chat with them. It is challenging to have someone say to you "I know you don't have time, but can I just quickly ask...." or "I know you are too busy, but I am worried about...". More often than not, the only real time we spend with each resident is during medication rounds, during hygiene cares, or to do a wound dressing.

10. This has a real effect on clinical outcomes. Most families cannot visit all the time, and therefore we are their daily social interaction. Older people often feel a burden to their families, they are unable to do things they used to be able to do for themselves. They need assistance with the most basic of tasks. If staff do not have time to spend and make these visits enjoyable then these basic tasks such as showering can become monotonous. Hence, why I believe it is imperative that staff have the time to spend with them, rather than just completing tasks. It's a basic human requirement to engage and socialise with others, to have people who take time to talk with you.

11. If someone doesn't feel loved, worthwhile or cared for it impinges on quality of life. What is the purpose to their life? Why get out of bed in the morning? Why participate in activities? We frequently see that people who express feelings of isolation or loneliness are less likely to engage in activities or come out of their room, due to low mood or depression. So how are we caring for their mental and emotional health by telling them that we do not have time?

12. I find it challenging that these are the last years of their lives, and they spend most of their day sitting alone in their rooms. Waiting for meals, waiting for their showers, waiting for visitors and not really partaking in anything. I believe this also has a significant impact on their mental and emotional wellbeing and in turn negatively affects their quality of life.

13. If residents feel undervalued or feel we are too busy for them, they may not raise issues with us. I once found that an 85 year old man had a fall, but he didn't tell anyone about it because he didn't want to be 'a hassle'. He told me that we are too busy for trivial problems. This is a dangerous mindset to cultivate in a person receiving care. It has the potential to directly and negatively affect clinical outcomes. There may not have been visible injuries, but he could have hit his head suffering neurological damage. Regardless of injuries or lack thereof, this man felt frightened and alone.

14. Residential aged care is, or should be, purpose built to protect and care for people and to prevent the elderly feeling this way. While improving or maintaining quality of life.

15. I believe an approach to care that focuses on the whole person, and emphasises getting to know a person is better for the care recipient, but also better for facilities in terms of management of risk. For example, if a resident has swallowing difficulties, we can thicken fluids to prevent them from aspirating (water or food entering the airway). For people with

difficulty chewing, we can modify their diet. A care worker or nurse who knows all of their residents will know this information. This would be achievable if there were legislative ratios for staffing, resulting in staff satisfaction and the inclination to remain in the industry. Yet, for most staff, especially contracted staff, we must check a resident's paperwork before complying with any and every simple request. Sometimes resulting in a resident's basic request being unattended.

16. The longer that staff work in a facility, and the longer that a resident lives in a facility, the better they get to know each other. It stands to reason, if you are familiar with someone you can provide a higher standard of care, because you know more than what is written in their clinical notes. I believe this is a vital part of aged care, yet it doesn't happen as much as it should, because of the high staff turnover. Nursing is a stressful and demanding job, and aged care is losing passionate and experienced staff due to the frustration and exhaustion related to the unsustainable staffing conditions.

17. Another risk it mitigates is medication administration. In hospitals patients wear identification wristbands. This is not an option in aged care, as it is their home, so we identify residents by using 5cm x 5cm pictures, which may not always be up to date. This is how we identify who to give medication to, or who needs a particular treatment. It can be unsafe if you don't have staff that are familiar with each resident. Or for staff who are feeling the pressure of time and may be rushing. This can ultimately lead to unsafe administration of food, water or medication or the absence of administration.

Barriers to providing person-centred care

18. A huge barrier to providing high quality person-centred care is time constraints. A key issue that I have identified is the lack of staffing ratios in aged care facilities. In hospitals there are patient to nurse ratios of about 1 to 4 (in general wards). In aged care facilities there is no legislative guidance on adequate staffing levels.

19. During a standard shift there are allocated tasks (eg. wound dressings, medication rounds, doctors rounds, communicating with families, appointment follow-ups etc) for approximately 30 people per nurse. That is 8 hours to complete all tasks, plus handle any additional complaints or problems that arise.

20. It is important to me that I make each resident feel valued and safe. It is important to me that I continue to strengthen my relationship with each resident. Unfortunately, I often do not have time to provide additional personal or emotional care to those who seek it. I simply do not believe it's possible for anyone to provide safe, holistic, person-centred care to upwards of 30 people within the time constraints. Let alone ensuring every resident feels they are much more than a task to complete in a workplace.

21. For example, a common complaint may be "I do not feel well." To properly engage with this, I need time to sit down and investigate why. Frequently this feeling of general unease and lack of wellness stems from loneliness or lack of self-worth. Unfortunately, there is no 'quick fix' for this feeling and frequently time just does not permit a therapeutic conversation. Time is a huge barrier to providing quality care.

22. Another barrier is the lack of motivation for qualified nurses to enter aged care. A common assumption is that aged care lacks clinical care and consists predominantly of showering the elderly and administering medications. This perception leads to aged care being an underappreciated and misunderstood industry. Nursing in aged care provides the opportunity to care for the person behind the medical condition and form relationships with

them and their families. Not only is the acuity of our elderly increasing, but social and emotional care form a pivotal component of holistic care and I believe these aspects are a privilege to provide.

23. Another challenge for delivery of comprehensive care in residential aged care is the lack doctor presence. Doctors usually visit once a week, or only if you call. Therefore, the nurse on shift is making clinical decisions and consulting with doctors via email or phone. Sometimes you cannot contact them at all and must call an afterhours doctor - yet another unfamiliar face to our elderly. Working without the provision of a doctor can be overwhelming and can often lead to unnecessary hospital admission and invasive treatment. To maintain quality of life we need comprehensive clinical care which is managed by regular nursing staff and doctors. This allows for internal incident management and timely commencement of end of life cares.

24. I believe a lot of the identified issues stem from funding, although I am not too sure how that works. I am aware of how the high cost of care affects residents. The elderly experience a lot of stress associated with giving up their family home and moving into a room with someone they don't know, it is rare to get a single room.

Examples of good person-centred care

25. When the residents are well-known to staff I have seen a lot of good social activities, bus trips and games implemented. The level of engagement increases when the activities are tailored to specific groups of people within the facility.

Examples of poor person-centred care

26. A stand-out example of poor person-centred care is one of a married couple, who entered residential care together. A reasonably common situation, however no one ages at the same rate or in the same way. The wife has late stage dementia and has the tendency to abscond, so she needs to reside in the secure wing, where a pin code is required to enter that wing. Her husband has not deteriorated to this point but is cognitively impaired and at times, confused, therefore needing supervision by staff. He wants to spend as much time with her as he can. However, due to time constraints of staff he is only allocated one hour, twice a day to see her.

27. It honestly breaks my heart when he comes to ask, countless times a day, if he can visit his wife and we have to say "it isn't your scheduled time, you can't go for another two hours", or "you have already seen her today, you will have to wait until tomorrow".

28. This is his home. This is his life. He wants to be with his wife in her last years or months or weeks and we cannot currently facilitate this.

Changes to the current system

29. I would love to see staffing ratios implemented in aged care facilities. Although, it is difficult to imagine what that would look like, however I would expect; nurses, care staff, administrative staff and leisure staff at a minimum.

30. I would also love to see more social activities and day outings, especially on weekends and even after hours. In my opinion this is dependent on funding, and providing sufficient staff for activities to occur. I believe social activities are vital ingredient to the resident health, effective person-centred care and maintaining quality of life.

Choice and control

31. I believe resident choice is imperative to the delivery of quality care. Everyone has the right to freedom of choice. As people grow old and become confused it can be challenging to differentiate a person's choice from confusion. Despite this, everyone has the right to exercise their choices, even if there is a cognitive impairment. Often confused residents may refuse care that is deemed essential to their overall health. As a nurse it is our responsibility to manage this behaviour and communicate with family, implement strategies to overcome and assist in providing a high standard of quality care.

32. A great example of resident choice in care is on admission to most aged care facilities there is a questionnaire they, along with their families are asked to complete. This questionnaire asks about how the person lived, when they like to eat, dietary preferences, shower preferences (time and frequency). These preferences form a guide for us to deliver the most individual care possible.

33. This however poses its own challenges, as most people's preference is for a shower is in the morning. And the morning is when medication rounds occur, and breakfast is served. A standard morning shift sees two care staff showering, toileting and setting up meals for 15 people. Due to time constraints and understaffing people's preference for these little comforts are often compromised. Ultimately a resident's most basic preference is altered to suit staff, due to lack of staff.

34. Habits are comforting and provide a sense of familiarity but can also trigger memory and help to orientate a person. A routine is a simple yet paramount part of life, something that just about everyone has and probably takes for granted. It the little things that I believe are essential for providing quality care, yet often overlooked.

Conclusion

35. The experiences I have shared are my reality, yet they are not unique to me. Our staff are overworked, and our residents feel undervalued. They are not blind to the crisis of our current aged care system, they deserve better and they are paying for better.

36. Staff in aged care are exhausted and frustrated by the conditions in which we currently work. We are confronted by the workload which often impinges on the quality and safety of care that we provide. We want to provide a higher standard of care, our residents want to receive a higher standard of care. So let's make that happen.

Signed: Emmakaitlin

Date: 7/6/19

Witness: [signature]

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