WHAT I FOUND IN 40 YEARS OF AGED CARE NURSING

Submission to the Royal Commission into aged care quality and safety.

My experiences with aged care go back to the 1970s. Since the 1990s I have worked part time in many age care facilities [ACF] retiring about four years ago.

In this submission I have given some personal experiences and some recommendations to improve situations.

When nursing people in hospitals one usually gets the satisfaction of seeing their health improve and then they go home. This is not the case in aged care where the norm is to nurse residents to heaven. Therefore there is little job satisfaction, but a great desire from most staff to make that last journey as pleasant as possible.

Over the years, despite some improvements with electric beds, hoists for lifting, and other technical advances the demands on fewer staff have increased the workload dramatically.

Staffing

In the 1970s I worked night duty as the only registered nurse with two nurses aids as they were then called. We were looking after about 100 residents, all of whom were to be changed, sat out of bed for breakfast, medicated etc. The aids started getting people out of bed at 2:30 am. When I questioned this practice they stated, we have to get them out of bed for breakfast and anyway they don't know if it is the day or night.

Nurses aids in those days were trained on the job and were poorly paid but mostly very dedicated. In the early 1990s pre-work education was required. Unfortunately many of those nurses aids couldn't read or write, so they would never get their certificate and left their jobs. Aged care facilities were left with a big staffing problem. Some were recruited from overseas, that is the Philippines, India, and China but were usually only able to work a few days a week. There was no continuity of care and definitely no ladder of progress for the nurses unless one went to university to become a registered nurse. So commitment to the work faded.

It is very important to note that the elderly need to get to know a face, to be truly trusting of that person. It usually takes about six weeks for residents to settle into an age care facility.

The pay now for assistants in nursing [AIN] remains low and many work double shift in the same or another age care facility just to maintain a reasonable lifestyle. They are often very tired. Apart from working they are expected to attend many extra activities, for example staff meetings, fire drill, lifting and use of equipment sessions. Over the years many kitchen duties have also landed in their laps, for example giving out meals, collecting trays etc which interfere with the resident-to- staff time.

Recommendations

Staff ratios need to be implemented in aged care facilities - for example –
in the morning:

- one registered nurse to 24 residents,
- one enrolled nurse [EN] to assist the registered nurse with medications and dressings and as an extra for the AINs to call on,

- 4 AINs to 24 residents - that is six residents each AIN.

evenings.

- one registered nurse to 24 residents,
- 1 EN to assist the RN and AINs,
- 3 AINs to 24 residents .

Night duty

- 1 RN and 2 AINs for each floor

Meals And Drinks

In one ACF I found a kitchen staff member putting cups of sugar in a teapot. When I asked "why?" she stated that nearly everyone has sugar and this way is quicker. It was revolting.

Meal quality in nursing homes is generally poor . Meals are often made on Friday for the following week end.

Drinks include cordial for lunch, tepid tea or coffee and tiny pieces of cake or a plain biscuit for afternoon tea. Ice cream if offered, is usually melted. Very rarely does anyone make a cup of tea for a resident in between mealtimes.

Menus do not often correspond to the meal delivered. Pureed meals are boring and are not always the meal of the day. Porridge is popular for breakfast but there may only be about 3 tablespoons in the bowl. Hotel style condiments are impossible for residents with arthritis to open eg jam

MEALTIMES are a problem. Breakfast is generally at 8 am followed by morning tea which can be as late as 10:45 am, then the main meal at 12 midday, which is often wasted as residents are generally not hungry after such a late morning tea.

Immediately after lunch, tea or coffee is served for afternoon tea which can be as early as 2 pm. Then a light tea is served at 5 pm which generally includes a bowl of watery soup and some small sandwiches.

This means that 4 meals are had between 8 am and 2 pm then dinner at five and nothing until 8 am the next day. Staff are not allowed to enter kitchens and food is locked away.

Many people to feed, means that some residents may not get fed at all or have a cold meal.

Water jugs are often inaccessible or left in bedrooms when residents sit in the lounge room all day.

Recommendations

Meal times need to be changed. For example:
Breakfast 745am
Morning tea 10am
Lunch 1 pm
Afternoon tea 3pm

Tea 530pm
Staff meal times should occur before resident's mealtimes so that all staff are available to feed residents at their mealtimes.

Old fashioned water jugs could be replaced with individual personalised plastic bottles with a straw top and which residents can easily access. Food should be available at anytime for residents when they want it. Fruit should be more available. Milo or hot milk should be available at night.

Continence and toileting .

Dementia does not necessarily mean that a person becomes incontinent, it often means that they have lost the ability to find a toilet. Incontinence pads, now used and limited to 3 or 4 a day, [because of the cost], were never meant to be a substitute for toileting.

I have witnessed a carer remove the faeces from a soiled pad only to then put the soiled pad back on the resident. Pads did not come in to use until the mid 1990s. Before that old towels or pillowcases and draw sheets were used. Unfortunately that meant the aged care facility often smelt of urine and faeces. Pads now seem to be used on everyone.

Residents will ask to go to the toilet, only to be told they can pee in their pad. Incontinent residents get more funding from ACFI.

Toileting should be an integral part of caring for the aged . Some dementia sufferers become very agitated and after toileting are more relaxed. Bathrooms need redesigning urgently and I have added some suggestions at the end of this submission.

There is no point in asking a resident with dementia if they want to go to the toilet. They must be taken and shown the toilet.

Restraints

I arrived at work one afternoon for a PM shift to find a lady resident, tied to a chair with a seatbelt and was walking with the chair on her back ,a lounge chair. She looked like a tortoise .

No one really understands what a restraint is and whether or not they can be used. Staff insist residents sit down for fear of them falling and the consequences of what happens when they do fall.

Unfortunately physiotherapists do not have time to spend with every resident in a nursing home.They therefore encourage as much walking as possible. Staff today do not have the time to walk residents so they will take them from the bed to the bathroom or where ever they wish to sit for the day in a wheelchair or shower chair to get them there more quickly. As a consequence of this residents get very little physical activity and are therefore prone to not being able to walk at all ,or get sick.

Psychotropic drugs are often used on wanderers without the consent of relatives and these drugs have dreadful side-effects including the inability of a resident to walk, they may dribble constantly and are often very agitated, made worse in my opinion by the drugs. A lot of restlessness could be alleviated by some simple nursing care.

Medication and Medical Management

Residents in age care facilities need to be cared for, not overmedicated. Pain relief, bowel tablets, asthmatic and diabetic medications are probably all they require. Almost all are on eyedrops of sorts, require skin treatments for skin tears and dry skin and dressings for other wounds.

In my observation there are excessive amounts of natural herbal medications given out, especially in private age care facilities. Polypharmacy is the norm.

It can take eight hours when you are new staff member to give out medication by the book. You need to find residents who are often out of the room, have no name bands which is apparently an issue with privacy, and they may not even know their own name.

At one ACF I was giving out 36 tablets to 2 people in the morning. One of these residents had had a stroke and could not swallow whole tablets, so they had to be taken apart or crushed and mixed with jam and fed to him .This is not uncommon. Some Medication is not meant to be crushed but is still ordered for residents who can't swallow whole tablets.

These days there are many patches especially schedule 8 drugs patches, need to be checked by two registered nurses and supplied together, to the residents and this takes a considerable amount of staff time. The checking of S.8 drugs between shifts is also very time consuming and could be reduced to weekly checking.

General practitioners are often chosen by the nursing home for residents because their own GP may live or work too far away and it is not worth time to visit. However, an aged care facility is supposed to be the resident's home. So I don't understand why general practitioners can just pop in at their will without being called by one of the registered nurses or a family member to see their relative.

If the resident were in their own home, a doctor would only come to the house if he were called. There tends to be some over servicing and some under servicing. Sometimes it's very hard to get a doctor to see a resident when it's an emergency. These days, nobody seems to want to take responsibility for a sick resident, and will prefer to send them straight to a hospital emergency.

Recommendations

Apart from the absolutely essential need for more staffing in nursing homes or aged care facilities to improve the life of the residents, there are a number of physical things that could be improved as well and I will list them below.

Bathrooms

- Bathrooms should be big enough for a large wheelchairs, shower chairs or hoists to be used
- no shower curtain's flat floor and well drained.
- An area should be available to put dry clothes and soiled clothes.
- Bins for incontinence pads.
- Handheld shower that extend a fair distance.
- Toilets should be placed in the middle of the wall so the aid can attend to a resident from both sides.
- There needs to be a device, not seen as a restraint which comes down from behind the toilet and it becomes the armrest and headrest, so a resident can be left on the toilet without risk of falling. It could be padded with rubber or a washable soft material . This would allow staff

to leave residents in safety and privacy on the toilet for longer and staff should be able to go away and make beds, get forgotten clothing or other such items.

Bedrooms

- Bed privacy screens should not just be around the bed but far enough away from the bed that allows for hoist to be used, wheelchairs moved and visitors chairs to be accommodated.
- Bedside tables should be on wheels and wide enough to hold water jugs or glasses and easy enough to clean underneath.
- Wardrobe should be big enough to be close easily.
- All beds should be electric and height adjustable cot sides should be optional and not regarded as a restraint.

Lounge areas

- Should be large enough with chairs arranged socially in small groups.
- Large TV screens should be in a separate area at a distance so residents who do not wish to watch television can do so without constant background noise.

Outdoor areas

- Walking paths with railings and safe nonslip pathways, with lots of colour, trees, flowers and seating areas with umbrellas.
- They should be enclosed and safe for all residents.

Thank you for taking the time to read my submission and hopefully it will contribute to a better future in age care for all residents

yours faithfully

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