59. I Jones

**Submission to the Elder Abuse Inquiry**

Dear Sirs

The following submission contains some of the experiences gained in 10 years of working as a Registered Nurse in Aged Care; the views expressed are the result of personal experience.

**Introduction**

Private Aged Care is an industry with the goal of generating income, requiring strategies that maximize profits and minimize expenditure.

Expenditure related to employment of staff, accommodation and maintenance, catering and meals management, safety and security, climate control, and ongoing improvement and staff education are just examples of allocated funding. Prudent financial management by the facility manager may be rewarded with a yearly bonus in some facilities.

**Common problems arising in “for-profit” aged care facilities**

1.     **Staff shortages** (no staff-resident ratio enforced in privately owned aged care) affect ability to ensure high standards of person-centred care and cause increased staff absenteeism and turnover, staff sickness and burnout.

2.     **Employment of suitable staff, and male-female staff ratio**. Care workers need to be suitably trained and motivated to care for elderly residents. They must be competent in the use of the English language. Residents are not generally aware that male care staff shower and apply continence aids to female as well as male residents. This is particularly important in the care of persons living with dementia, who may not understand or be able to give consent, and relatives may not be aware or be consulted.

3.     **Supplying suitable food and beverages**. Pre-packed and frozen foods are not uncommon and little attention is paid to reduction of sugar and salt in the diet. Many residents pay for food supplements (they are prescribed by the GP and supplied by pharmacy). Residents with swallowing difficulties may or may not receive suitable diets and assistance with eating.

4.     **Mobility and exercise**. When there is a shortage of staff residents may not have the required assistance with getting out of bed, sitting up and walking, affecting physical as well as mental wellbeing. In addition, residents may remain in their chairs for many hours, without a period of lying down in their bed, until it is time to retire for the night, and the time for this varies with staff availability.

5.     **Assistance with eating**. This activity may be time-consuming, and not be done well or done at all. It is not uncommon to find uneaten meals in a resident’s room, as the individual was unable to reach the meal or eat it unaided.

6.     **Continence management**. This may require frequent assistance with toileting and/or changing continence aids. Changing aids requires washing the area and applying a new pad, all time-consuming activities. Some facilities use large continence aids, said to last up to 12 hours, reducing time required to attend to the resident’s personal hygiene.

7.     **Restraints.** Although restraints are not encouraged, facilities are able to seat residents in “Princess Chairs” with a table attached to the front and a non-slip mat to sit on. If a book or glass is placed on the table, it is not categorized as a restraint. Wrapping a resident in sheets or towels to restrict movement still occurs unfortunately, and is said to ensure resident safety.

**Other important issues in Aged Care**

**Facility managers** have a critical role in ensuring high standards of resident care. It is regrettable that many do not have qualifications in Aged and Dementia care, affecting the standards of care offered by the facility. A qualification such as the Bachelor of Dementia Care, offered by the University of Tasmania, should be a requirement for appointments to the position of manager in Registered Aged Care Facilities (RACF).

**Clinical Care managers** have been appointed by the larger care facilities. It appears that they rarely work with staff and residents to ensure high standards of care. They are generally found in their offices, working on their computer to complete paperwork required as evidence of the required standards of care for accreditation. A qualification in Aged and Dementia Care and involvement in clinical care should be a requirement for this level of staff.

**Staff education** in clinical as well as legal/ethical issues in the care of older residents and those living with dementia is desirable, and newly acquired skills should be encouraged and supported by management. Too often staff attend training, then continue as before, because no support is offered to them by management. Written evidence of staff training is always available to the inspectors for the purpose of facility accreditation.

**Locked wards.** These are still a common feature of dementia care, as many facilities do not have the type of purpose built accommodation that is suitable for residents and the staff caring for them.

**Facility inspection for accreditation**. Inspections occur on a schedule that is known to the facilities. Staff numbers increase on those days, food quality improves, cleaning and gardening standards are high, and table cloths and vases with flowers appear on tables. Staff may be given a talk by the facility manager prior to the inspection regarding loyalty and being aware of the impact of what is said to inspectors.

Inspectors have been known to spend more time in the offices with documentation than with staff and residents receiving care. Inspectors do not as a rule appear on night shift to assess the care given, and the number of staff available to give that care.

**Palliative and Terminal Care**

There is frequently a lack of staff skilled in palliative and end-of-life care. A “Palliative Care Box” is often presented as evidence that the facility is aware of obligations to provide care that ensures the comfort of the resident.

**Examples of incidents that have caused concern**

Staff were instructed not to intervene when 2 residents with dementia wanted to enter a room to engage in sexual activity. Staff were told that they were consenting adults and that relatives had agreed that they would benefit from experiencing affection. It was ignored that these adults were living in a locked unit, had advanced dementia, lacked insight and emotional control, and that their behavior was unpredictable.

 A male resident was wrapped in a large bath towel and then tucked in tightly with a sheet, with arms outside the wrapping, severely restricting movement. The reason for this was stated as preventing “playing with faeces”. His wife was persuaded to agree with this treatment.

 A female resident, who had had a stroke and was paralised on one side of her body, was left to struggle with her breakfast porridge unaided until lunch time. The nurse in charge said she could manage if she wanted to, staff should “leave her to it”. The resident was crying, but nobody helped her with her meal. The student who reported the incident was criticized for interfering, and following this incident, walked out. She no longer wants to work in Aged Care, and is now following a different career path.

As can be seen, there are a number of issues in Aged and Dementia Care that would benefit from close scrutiny and proposals for alternative approaches.

**Attachment**

Glass, A. P. (2014). Innovative Seniors Housing and Care Models: What We Can Learn from the Netherlands. *Seniors Housing & Care Journal*, 74-81

**Abstract**

This brief report highlights some innovative seniors housing and care practices from the Netherlands. The first is the Humanitas Apartments for Life, where if and when residents need assisted living or nursing facility level care, it is brought to them, thereby eliminating stigma and relocation issues. Second is the unique dementia village of De Hogeweyk. Both models have specific physical design elements and philosophies that support them and use “small houses” for severe dementia care. Finally, the general approach of community integration that seems to naturally permeate senior living facilities is discussed. This integration takes the form of offering services, such as home care, to the wider community as well as having businesses in the facility that make neighbors feel welcome.

Ingrid E. Jones RN, FCNA.