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**Sent:** Tuesday, 10 May 2022 2:11 PM
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**Subject:** AM2020/99, AM2021/63 & AM2021/65 – Work value case – Aged Care Industry

Dear Associates

Please find attached amended statements (excluding annexures) of Ms McInerney and Ms Bucher in PDF and Word format.

Regards

**Nick White**
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IT'S PERSONAL

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**IN THE FAIR WORK COMMISSION**

**Matter No.:** **AM2020/99, AM2021/63 & AM2021/65**

**Re Applications by:** **Australian Nursing and Midwifery Federation and others**

**AMENDED STATEMENT OF IRENE McINERNEY**

I, Irene McInerney of [redacted] in the State of Tasmania say:

1. I am a member of the Australian Nursing and Midwifery Federation.

**Personal Details**

2. My date of birth is [redacted].
3. I live alone and have a high weekly rental of $470. [redacted] cost of living is high and the demand for housing is much higher and rents are not cheap. I totally rely on my sole income and cannot afford the risk of leaving Tasmania during the current COVID climate .I cannot risk becoming stranded nor can afford two or more weeks of self-isolating. I need to be able to meet my rent and regular fixed requirements.
4. I work at least eight shifts a fortnight across the board, that is nights, days and afternoons. I often pickup extras hours to help make ends meet.
5. My income in Aged Care is less than it would be in the acute public sector. 10 years ago I tried working back in the acute sector, having been encouraged by a partner at that time. However, I gravitated toward caring for the aged people in hospital who were needing a lot of care. I came to realise that despite the trial back in acute care, my skills and passion lay only in aged care nursing.
6. I make my income stretch to cover my living expenses as I am on my own, but I can only do so because of shift penalty rates. However, penalty rates in my new role are less than my employer from a year ago but I needed to leave that employment; it was a high risk working environment. By that, I mean I was concerned that under what I felt was an unpopular manager, that it was a matter of time I would feel discouraged about aged care altogether. I needed to leave and have a fresh start elsewhere.


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7. I am on a lower wage than nurses in other sectors and as a result employer super contributions are also less. At [redacted] years of age, I will definitely need to work beyond a retirement age of 67. I do not have enough Super and retirement savings to leave nursing for quite some years yet.
8. I now hold one nursing role. I work for one employer doing a range of weekday hours and night shifts to ensure I earn enough income to make ends meet.

**Work history and qualifications**

9. I started my first nursing qualification as an Enrolled Nurse (EN) in 1981. Since that time the majority of my roles have been in the aged care space as an EN and later a registered nurse (RN). I raised a family of two and worked part time when my children were small. I now have several decades of experience in Aged Care.
10. I obtained my qualification as a registered nurse in 1996 and then I continued with the 120 extra credits required to ensure a Bachelor of Nursing. I achieved my Degree while solo parenting. I have also achieved a Cert IV course in Workplace Management and Safety. It is during the latter in particular that I gained valuable leadership skills which I use on the working floor to this day.
11. I regularly participate in mandatory training and professional development (which is required to maintain my registration as a nurse). As an example, and on a day off, I recently participated in a day long course to keep current with changes in aged care. My employer does not provide me with professional development opportunities in paid time.
12. My previous role in Tasmania was 7 years with Southern Cross Care (SCC) I worked across two different SCC facilities.
13. I originally came to Tasmania from Queensland 8 years ago. At first I considered SCC as very well resourced with nurses compared to my experience in Queensland. However, the residents in the Tasmanian facility were older, more frail and required higher levels of care. But over the 7 years with SCC, the staffing had eroded at SCC from a nurse on each of five wings to only two for the whole building. Yet care needs have increased and continue to increase. It is now exhausting work.
14. Prior to working in Tasmania I worked for 13 years in Queensland. I worked for 8 years with Blue Care at their aged care facility in Caloundra on the Sunshine Coast. I also worked, a year as an agency nurse in aged care and then four years at the Tantula Rise aged care facility at Alexandra Headland, the Sunshine Coast.

**Description of role and work**

15. I work in Tasmania's only Salvation Army aged care facility, "Barrington Lodge Aged Care Centre", here in Hobart. I am RN Supervisor for at least half of my shifts i.e. RNIC (RN In Charge), with little extra dollars for this senior role, receiving $30.60 for the whole shift when the role is RN in charge. Barrington Lodge is a 77 bed home, and if the shift if fully staffed, there two other nurses (often Enrolled Nurses (ENs)), on duty during the day and afternoon shifts. I am the only nurse at night and work with three carers.
16. I work permanent part-time and have worked at Barrington Lodge for one year. I am paid an hourly base rate of $40.74 Barrington Lodge has an Enterprise Agreement in place only for nurses, not care staff yet.
17. Barrington Lodge has some clients with other needs who happen to be aged. For example, there are several residents on high alcohol intake, there is a NDIS client with challenging behavior, and there are several with mental health illnesses like schizophrenia. Many others live with a mixture of these issues and have dementia type processes. The mental health space of many residents can be rather challenging. It is a secure facility, yet residents at times use emergency buttons and abscond. We provide palliative care and have residents aged from 53 to 102 years of age. The residents have multiple and complex health issues including mental health concerns.
18. The layout of the facility with its several wings and some built on, require fit and able staff. I am responsible for the whole facility when I am on afternoons and nights, and for half the building in my morning shifts. I go home totally exhausted after most shifts.
19. I once also worked in the community sector in aged care to learn how the packages worked for aging in their own homes. It was a good experience. However, I wasn't paid as a registered nurse so that role could not sustain me.
20. I work across all shifts on a four week roster rotation; no two weeks are alike. True shift work. I am at least adaptable but I often feel I am not rewarded for the hard effort.
21. Barrington Lodge prefers to restrict permanent accommodation to residents with the most complex needs. The Aged Care Funding Instrument (ACFI) is the tool used as the basis for Government funding of residents by reference to their needs. Where the needs are not high care nursing homes earn less government funding. The staffing at both SCC and more recently at Barrington Lodge has not increased to keep up with higher care demands on the registered nurse.

22. Only one RN is rostered for the first hour of a morning shift. Nurses receive handover, do several Schedule 8 medication administrations which needs two people by law. It takes minimum of two hours to do the 0800 medication round which includes eye drops, inhalers, and creams . I do drug administration for 35 residents as well as answering the phone, organizing the replacement of sick workers, wound management, vital observations, responding to doctors and other allied health requirements, along with all the documentation expected each and every shift.
23. If there are any incidents with residents such as falls, appointments, pathology requirements or acute ill health, then I have to prioritise workload. I have to decide on care needs and alone decide whether it is necessary to call family, doctor or an ambulance. We triage care needs, and at times I feel like I am working in a mini hospital but without the resources and support available in other settings. Other settings have doctors and other support people on site at all times.
24. The requirement for monitoring the whereabouts of wandering residents with cognitive problems can take a half to one hour. Diversions are needed and we do not have sufficient staff resources to consistently prevent absconding situations.
25. To reiterate aged care residents nowadays have more than one illness or infirmity. While it may be their ''home'' in residential aged care, there are residents entering the facilities already in the palliative care space. Recently a lady died who only entered the facility five days prior; she was palliative on admission. Residents have complex high care needs. In aged care facilities there are no longer any "hostel" type residents with modest care needs. There are higher numbers of residents with cognitive decline than there was 10 or 15 years ago.
26. We do not have doctors' onsite nor all too often no other Registered nurses to summon. I find the workload stressful, and am using the work iPad during some lunch breaks to catch up with documentation so I do not have to go home too late. I often find it difficult to get a drink or even a toilet break. It is like I have to have all the answers.
27. 'Agency' nurses who do not know the residents are employed to cover staff shortages. This adds to my workload and stress levels. The use of agency staff means there is a lack in continuity of care, communication break down and tasks are sometimes incomplete. Regular staff need to follow up with doctors' matters or an appointment for a resident. The RN workload is heavier during the day as we have medication rounds x2 to complete, a lot of wound dressings and observations. If there is an acutely ill resident or a fall the workload is more strained. One must follow facility policy with all incidents and we are questioned if

we deviate. You have to manage workloads and prioritise what is more important alone. It is difficult, and at times not possible to complete the workload in a timely fashion. I do not like keeping residents waiting, for example for pain relief, but in aged care it is a symptom of inadequate staffing. I have to wait on others to be available to sign out medications and it frustrates me; the lack of staff further contributes to delays.

28. I chose to work in this industry (aged care), as it is the most rewarding nursing role I know. It is not rewarding monetarily but I certainly know I make a difference each and every shift I work. There is the feedback from appreciative co-workers and residents who so often acknowledge the difficulty having time for everything, especially with short staffing. The latter frustrates me as it is then the residents missing out on my time they need.
29. I really enjoy engaging with our older people and improving their day. They are in their vulnerable later years and deserve to be truly cared for well. I take music to the facility and I see smiles on the faces of dementia clients and I attempt to cheer up the hallways with well-chosen music. Weekend shifts, when management and administration are not on duty, can sometimes be more relaxing. I will endeavor to have lunch and sit and engage with residents and put on my record player. There are not enough diversional activities and if I can do my little bit, I certainly take an opportunity. I enjoy working with other like-minded workers who care for the aged. I feel a friendly professional respectful approach to our work is paramount.
30. I enjoy the palliative caring aspect in aged care. On my watch I endeavor to ensure a dying person and their family will want for nothing and have all comfort needs met. I feel it is vital to provide high quality professional palliative care, it should be done well and with total dignity and respect. I have been involved in many 'good deaths' in my decades of aged care nursing.

31. **Nature of work**
32. Resident's care needs are changing all the time; the residents are more sick and they need more time and lots of support. There are more calls to doctors yet RNs are way fewer. Nowadays there is not even half the number of RNs rostered compared to ten years ago.
33. Even residents are now heard to be saying, "It is not like it used to be". On elaborating they say the staffing is down, and that they feel hurried and cannot understand the language of the 'international workers'. The latter possibly make up two thirds of the workforce with English as a second language to many workers

34. There are 77 residents that need to get out of bed,showered or washed, toilet assisted, with many people now need full assistance to be fed, to be hoisted to toilets, to be kept safe and in cases, monitoring their whereabouts. There are many challenges with the cognitively declining residents that take time. There can be paranoia and delusions to deal with.. Listening time is therefore needed for those individuals, and time can be tight.
35. Residents have many different diagnoses so the skills of carers need to meet the needs but carers are not paid nearly enough for effort. Unfortunately, where there is a skill mix with more training required, those staff interventions can exacerbate the behaviour of resident because staff do not have the necessary skills and knowledge (or time) to interact with them appropriately.
36. As I have noted, the RN numbers have reduced, and more than ever we need to communicate well to get the work done. We often have to pass on requirements to other staff, so we do rely on team effort and support. With so many agency nurses providing different staff, we cannot guarantee continuity of good care for the residents. There is more fragmentation to the care now.
37. I remain accountable for the care delivered while I am on duty. This means that I need to work with and rely on the nursing team and the carers. This includes identifying at handover and at the start of the shift those residents with particular issues or needs. The carers need to tell RNs anything that is out of the ordinary with any residents. The RNs then need to assess and address issues. Reporting, things as in bruising, an escalation in behavior, skin changes, changes in presentation or condition so the RN can monitor for health changes and make a plan of care.. As the RN I monitor resident condition, additionally watching for changes such as confusion or agitation, possible pain management issues, and swallowing issues at meal times. There is need for trust and support for the full team I work with.
38. As above the residents have a lot of problems now, both physical and mental. It is not unusual for them to have a dozen different diagnoses and also the same high number of tablets. Care plans often reflect the care that is needed but staffing does not necessarily allow for the care to be given in accordance with that care plan.
39. The needs of residents have become increasingly complex, and I have addressed those under some specific headings:
    a) **wound care**; Complex wounds, can develop and require outside services.
    b) **medication**; Many of the residents require multiple medications throughout the day. These can be in tablet form, injection, as eye/ear drops. Along with

checking the drug chart, ensuring the right medication, right resident, right time, there are other tasks that are time consuming including crushing tablets (mixing them in something to make palatable), and trying tocajole resistive people to take the medications they are ordered. If residents are 'wanderers', we need to track them down to administer the medication; it all takes time.

c) **pain management**; Doing this in a timely fashion requires considerable effort. I try but with staffing one cannot always get another person to sign out drugs timely.. In my opinion, pain management in residential aged care, is not often well handled.

d) **infection control and prevention**; We dread an outbreak of COVID. While we have actual protective resources (PPE), current staffing would not be adequate to deal with any outbreak, particularly when residents are inclined to wander. Further, care staff have limited understanding of infection control and this coupled with low staff numbers is one reason to prevent outbreaks of gastroenteritis type illnesses too. This is an area of on-going concern for RNs given the need for supervision and training.

e) **food, nutrition, and hydration**; I try to provide fluids to people at night as I see dehydration in those who are fully dependent for care. There is a demand on staff to feed those who are more dependent. Mealtimes should not be hurried but the number of people requiring assistance and the number of staff available is grossly mismatched. Dehydration also increases the risk of urinary tract infection (which can also result in increased confusion, agitation and wandering behaviors).

f) **continence care**; There should be regular toileting of residents who need assistance but poor staffing means this is impossible and so there is a reliance on pads which are regularly full and cannot be changed on time. This in turn causes problems with excoriation and skin breakdown. It takes staffing and time to hoist people onto a toilet and there generally needs to be more than one staff member to assist each resident. The inability to toilet residents as the need arises, means call bells are answered late, and residents are trying to take themselves to the toilet. This can result in falls.

g) **dementia care**; There are not enough diversional workers. Residents can become bored and this is exhibited with unfavorable behavior e.g. residents trying to get out, turning up at the nurses door over and over again. Attention and interaction is wanted. It is not enough to 'park' someone in front of a television, there needs to

be a program where residents can be assisted to do something meaningful such as drawing, arts and crafts and structured outings.

h) **mobility and falls**; There are many residents that could be assisted to take walks staffing permitting. 20 years ago, the care requirements I have outlined in this part of document could easily occur. This is no longer possible and I dread a bad incident occurring on my shift; it is difficult enough keeping up with regular things, but we can only try to do the best we can and keep people safe.

i) **social supports**; The families complain that residents have long fingernails or dirty dentures. These things are basic and shouldn't be happening but it is a symptom of inadequate staffing. Unfortunately, and again this is due to poor staffing, with the louder residents (and those who are likely to fall) getting earlier attention. No excuses are justifiable, but there are priority differences.

j) **quality of life**; We strive to give vital meaning to residents. Some sit all day without much human interaction. It is truly sad, and residents deserve so much better. I do remember the 'old days' having time to sit and talk with residents, find out about their lives, their likes/dislikes. Now, all I can do is race between residents trying to make sure the basic care needs are attended best (hygiene, food, drink and toileting).

k) **end of life / palliative care**; Palliative care needs to be done well. Those of us who are 'old school nurses' will do our best to see the high priority comfort needs. However, time constraints and management expectations (especially for the completion of extensive documentation) has meant good palliative care can be difficult to achieve as well.. Again, there are too few staff (especially qualified staff) to provide the care a dying resident and their family should have a right to expect.

l) **greater and/or increased co-morbidity and acuity**: There is an increase in comorbidities. The focus on aging at home has meant that by the time people can no longer cope (with support in the community) they are really frail and in need of considerable care support. They often have multiple illnesses – heart disease, diabetes, peripheral vascular disease, arthritis etc. Hence feeling like the facility is sometimes like a hospital but with staffing a lot less than in the public sector. Aged Care facilities all over lack the resources to do care well.

40. These changes impact on the work and demands of the RN in a variety of different ways. There is a concern about missed care; there is need to consistently re-evaluate priorities in

care delivery. Our education demands are substantial in order to maintain currency of the range of significant and complex health issues affecting residents as well as regulatory requirements. The health setting is dynamic and lacks the stability and predictability there had been 10 years ago. The existence of co-morbidities, greater psycho-social needs, poly-pharmacology and complex disease processes demand increased complexity in nursing assessment and sophistication in identifying changes and illness.

41. I have observed that the changes in both resident and staff profiles and composition have meant that the work of each of RNs, ENs and carers have been transformed over the last 15 to 20 years. Carers are substantially more engaged in the delivery of direct nursing care, ENs have taken on more supervisory and clinical responsibility such as medication endorsement, and RNs work has become focused on accountability for the overall delivery of care, supervision, and mentoring while still providing hands on care.
42. Any diversion from the 'normal' status of a resident needs to be documented. The mantra is: if it is not documented, it didn't happen. If our efforts are not documented, or heaven forbid a coroners case occurs, we need to be able to demonstrate things were thoroughly recorded. A lot of this is done in our own time, after handover to the next shift. There is never ending updating of care plans and incident forms to be completed on a regular basis (often because of falls). Some days I feel like I am reacting to the next incident presented rather than having the time to address things proactively to stop problems occurring in the first place.
43. Management often put out memos and messages to ensure we complete funding documents. I sometime feel like it is more important to management to prioritize documentation where hands on caring ought to be the priority. There is so much to do and so little time. Accreditation demands a thoroughness of documentation, and there are unannounced visits where interviewing staff comprehensively is occurring. I know of this from 1.5 hours this winter with the onsite accreditors; no lunch break offered.
44. We have more on our job description than ever before, yet staffing has not kept up. Staffing numbers have eroded, and this in itself is affecting the mental health of many residents and staff. Staff are known to take mental health days off to get a recovery break and increase change coming back better for the next shift. I find myself supporting those who are under the pump. If we talk about our feelings together, we feel supported and not alone.
45. The work day leaves me feeling there isn't enough of me to go around; it is that simple. But I do get the reward from achieving a difference in the residents' day. Many staff decide it is

too hard on them mentally (as well as physically) and they leave the Aged Care sector. They leave as the pay isn't attractive enough for a difficult of work environment.

46. There is little time to assist with basic activities of daily living and providing time for emotional or psychological support to residents consistently. It is too difficult and we aren't remunerated for all this pressure and demand.

**Skills and responsibility**

47. When I am RN in charge, I have to find replacement staff (which is very time consuming) and contact management by phone to advise of serious incidents. I am responsible for supervising and assisting care workers and enrolled nurses to make sure the best possible care. I do medication rounds, wound care, trouble shoot where people are unwell. I contact other health care professionals (including ambulance and medical staff) and I am regularly required to contact family members to keep them up to date with what is happening with their loved one. I have chosen to not move to Care Manager or further senior levels, though I have a lot of great skills. I enjoy interacting with and delivering care to the residents on the floor. I am more able to advocate for staff and residents on floor level as an experienced RN and ANMF workplace representative.
48. We need more skills in the workforce. We need to continue to grow in our role. It is complex now with the multiple disease and mental health processes we are dealing with.
49. There has been a huge change in the use of computers in the workplace. Paper based wasn't that long ago, now I am using an iPad type device giving out the medication. We are also required to complete our progress notes electronically. It is change for the better but insufficient education can see staff floundering to grasp new concepts. We have an aging workforce that are often pre digital era workers. Employers rarely seem to understand that you need time to develop these new skills, and some workers find it harder to adapt to using computer-based technology yet are supposed to learn these new skills 'on the job' while still trying to do complete their enormous workloads.
50. The number of registered nurses in Aged Care has dropped dramatically. When we were working in 'Nursing Homes' as when I was in Queensland there was usually a Director of Nursing or other senior nurse who could be approached for professional advice, direction or merely an opinion. Often an RN cannot access sick leave or other leave because there is no one to replace them. The RN role is more complex yet there are fewer of us. More than ever there is the need for skilled registered nurses. Management are rarely available (and sometimes are not able) to give professional advice.

51. Interactions with allied health people is needed to take care of needs of residents. Every day we deal with outside professionals too and we often need to send the residents to appointments rather than having in home care. The increasing complexity of residential clinical needs means that there is more interaction with other clinicians. Unfortunately, it is not always possible to fully implement the care plans they develop because of poor staffing and poor skill mix. There is also the need to organise transport for residents to and from these appointments. Sometimes family members can assist but this is not always the case.

**Work Conditions**

52. There is always the potential for violence from unpredictable residents who have mixed mental health diagnoses (including dementia). We need to know what triggers residents toward unexpected and potentially dangerous behaviours (and these triggers can vary between residents). All staff need to have good communication skills; we need to judge when to press and when to back off. Judging well comes of years of caring and nursing experience. The language from some residents is profane related to their high alcohol consumption. We have to have skills and time enough to divert and best manage any variation best we can. Residents can also pose a risk to other residents and this needs to be monitored and interventions implemented. Increasingly, the lack of time to deliver the care that residents should be getting, can see verbal and aggressive behaviours arise.
53. I have outlined the staffing profile at Barrington Lodge above. However, it is not unusual to have people call in sick at short notice. As a result, short staffing often occurs. The casuals are already rostered (sometimes replacing annual or other projected leave) meaning there is no one to call in. We can sometimes access agency RN's but the agency does not always have someone to cover If short, we all try to give a hand but registered nurses struggle to oversee and/or support the care staff due to their own workloads.
54. I have had a lot of years of experience and can often see a need before an escalation occurs. Where possible, it is good to be preventative. This includes recognising triggers which can mean toileting a person so they don't fall, or taking time for a quick 1:1 chat so to divert the resident from absconding, or providing a shoulder to cry on because another resident died who was their friend. There is no end of emotional and psychological needs of our residents, and sometimes for their family members. These are situations where the Leisure and Lifestyle staff (if available) can be very helpful. A resident running out of cigarettes or beer can create huge problems and for them any waiting may not be an option.

**Additional comments**

55. Residents appreciate care particularly when they know staff genuinely try. I feel sad when I have to apologise for lateness, for example in the delivery of medication, but to generate a good relationship means maintaining their trust. Trust is huge and I do my best to maintain that. Good communication is the key. Residents sometimes understand the pressures we work under and some can be reluctant to ask for help. I always worry that the 'quiet ones' do not get the attention they need. I feel my work is valuable to the resident, to the families and to other floor staff, but unfortunately, we do not feel adequately remunerated for the huge complexities of the job we face each and every shift. We often feel underappreciated (or even misunderstood) by management.
56. I intend to work in Aged Care until I retire which could more than ten years yet. I wouldn't be able to afford to retire for a time.
57. I hope to see the wages increase in my time. For all the talk about residents 'rights' the reality is that staff are trying to do their utmost to honor requests and demands, for example, for a shower at a certain time of the day. It can be difficult to accomplish.
58. What I do not like about working in aged care is the lack of time to deliver consistent and safe care. The result being there is consistent pressure and the need to prioritize between often equally urgent and significant resident needs. Residents are not getting the care that they deserve and need timely. There needs to be better recognition that looking after our frail elderly well takes a definite and diverse skill set involving a high level of responsibility.

**IRENE McINERNEY**

10 May 2022

**IN THE FAIR WORK COMMISSION**

**Matter No.:** **AM2020/99, AM2021/63 & AM2021/65**

**Re Applications by:** **Australian Nursing and Midwifery Federation and others**

# AMENDED STATEMENT OF HAZEL BUCHER

I, Hazel Bucher of [redacted] in the State of Tasmania, say:

1. I am a member of the Australian Nursing and Midwifery Federation.

## Personal details

2. My date of birth is [redacted].

3. I live in [redacted] and work across the North and South of Tasmania.

4. I live with my husband, and we rely on my income to contribute to our daily expenses and save for life when I finish full time work.

## Work history and qualifications

5. I am qualified as a Nurse Practitioner (**NP**). I was employed full time in my role as General Manager Clinical Services Nurse Practitioner by Southern Cross Care Tasmania Inc., until 22 April 2022. My hourly rate of pay was slightly higher than the rate paid to a Nurse Practitioner employed by the Tasmanian Government. I am now engaged as an NP by Access Aged Care to provide consulting services to residents in residential aged care facilities in Tasmania in co-operation with local "virtual" medical specialists. These residents generally have specialist care needs.


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6. I commenced working for Southern Cross Care in November 2020. Southern Cross Care is an aged care provider operating nine Residential Aged Care Facilities (**RACFs**) throughout Tasmania. It is the biggest provider of residential aged care in Tasmania.
7. I also have two of part time/casual jobs. I am employed by the University of Tasmania as a Casual Tutor in the role of Unit Coordinator for Mental Health Wellbeing and Dementia Care Post Graduate Unit in Tasmania University's nursing programme. In this role I offer support, advice and grade papers for the post graduate student nurses from Tasmania and the University's NSW campus. My second part time work is in a private memory clinic I run. In this role I receive self-referrals and referrals from GP practices in Hobart to assess and advise the patients referred on their cognitive status and on approaches to care. I am a health practitioner member of the Tasmanian Nursing and Midwifery Board.

8. My work in the aged care sector in Tasmania spans about 40 years. In the 1980s after graduation I was employed at the Medea Park Nursing Home in St Helens and the small nursing home in St Mary's for about year. In the 1990s I was employed at Bishop Davies Court another nursing home for about two years.

9. In 2006 I began employment at the Royal Hobart Hospital (**RHH**) in its Aged Care Service (ACS). The Service predominately provided in-reach services to the RHH aged patient cohort. The service developed with the establishment of the RHH Older Persons Unit and provided outreach services to RACFs. During this period I undertook study to become a NP in Aged Care.

10. Upon qualifying as a NP Aged Care in June 2010 I was employed by the Tasmanian Mental Health Service in its Older Persons Mental Health Service (OPMHS)/Dementia Behaviour and Management Advisory Service (DBMAS), providing an out-reach consultation service to RACF's as a Nurse Practitioner Aged Care/Mental Health. OPMHS and DBMAS integrated in 2008, I was in this role in the period 2010 - 2017. During this time, I completed a graduate nursing diploma – mental health. The OPMHS team received referrals from GP's managing older people in RACFs and the community who were developing dementia or mental health issues, behavioural issues, delirium and the end stage of life for some residents. In that role I worked closely with staff, GP's and specialist and residents at RACFs in assisting and advising on their management and care.

11. In 2017 the DBMAS service then became Dementia Support Australia (DSA)conducted by Hammond Care in 2018 and I was employed by them for 6 months as a Dementia Consultant. However the NP role was not developed in that setting.

12. From 2017 to 2020 I undertook independent NP work with a GP. As part of this GP's RACF specific work I worked in a shared care model, managing infections, geriatric syndromes, palliative care, behavioural challenges, depression and anxiety. I left this work after 3 years to join the Community Rapid Response Service for 6 months until I started working with Southern Cross Care.

13. In addition to basic qualifications for registration I hold the following qualifications:
    - Master of Nursing Science ( Nurse Practitioner);
    - Graduate Diploma Nursing Aged Care & Graduate Diploma Mental Health;
    - Graduate Certificate (Geriatric Rehabilitation).

14. My qualifications for registration as a Nurse Practitioner in Aged Care/Mental Health require two graduate diplomas' (Aged Care & Mental Health) in addition to the Master's degree – Nurse Practitioner. A NP has Medicare billing and PBS rebatable rights subject to a verbal or written collaboration with a medical practitioner. My authorisation enabled me to order pathology, prescribe and treat conditions within my scope of practice independently without a collaborative agreement in place, however, my patients or employer pay privately.

15. My curriculum vitae and current position description are **Annexures HB 1** and **HB 2**. The Tasmanian Department of Health publishes Guidelines for Nurse Practitioner Authorisation to Prescribe Scheduled Substances (see **ANMF 106**).

16. As a result of my employment and roles since 2010 I have visited in a professional capacity almost every RACF in Tasmania. In the course of that work I have observed the residents and staff and worked closely with many of the facilities. While working with the GP in 2017 to 2020 I worked at six facilities in Southern Tasmania whilst OPMHS, DBMAS and DSA were state wide services involving outreach to RACFs.

**Description of my current role and work**

17. I work across each of Southern Cross Care Tasmania's (SCC Tas) nine RACFs in Tasmania which have a total of 728 beds and three Memory Support Units (known elsewhere as dementia units) located in Rivulet, Fairway Rise and Glenara Lakes. The RACFs are named

    Rivulet, South Hobart:
    Rosary Gardens, New Town:
    Fairway Rise Aged Care Home, Lindisfarne:
    Guilford Young Grove, Sandy Bay
    Sandown Apartments, Sandy Bay
    Glenara Lakes, Youngtown
    Mt Esk, St Leonards
    Ainslie Low Head, Low Head
    Yaraandoo, Somerset

18. I also provide clinical support to SCC Tas regarding home care packages by attending monthly meetings. As the home care packages expand to include more clinical duties, I will provide further support as required.

19. A key objective of my role with SCC Tas is to contribute to and further develop my own and their nurses' palliative expertise. I generally spent one day a week at each of SCC Tas's RACFs to embed the use of the Palliative Care Outcome Collaborative tools, improve our palliative care outcomes and generally provide clinical advice. I have commenced a research project with University of Tasmania to research current gaps in palliative care knowledge and confidence of SCC Tas nursing and care staff. I am also mentoring a NP student for the next 2 years who is specialising in Palliative Care/Aged Care.

20. When I visit a RACF my work entails responding to RN/EN queries in relation to issues such as:
    a. updating medication charts as appropriate
    b. management of venous leg ulcers
    c. behavioural management
    d. infection control
    e. referral processes.

21. For example a RN may have concerns about a resident with a wound and the way it is tracking. I will review the resident's overall health status in collaboration with the RN looking at such matters as diet, oxygen levels, and options for dressings. In the event of an infection I will advise in relation to contacting the GP and advice to the resident's family. If I have a collaborative agreement in place I will manage the infection informing the GP, providing timely health outcomes for the resident. The role is to act as a resource for the resident's clinical needs as well as a mentor and resource for the RNs involved in the care. Medication charts sometimes require updating in circumstances where GPs have prescribed but not attended or accessed the relevant digital system. Under a shared care model the GP will authorise me as NP to update the medication chart on their behalf. This ensures timely access by the resident to the changed medication regime, rather than delay pending the GPs attendance.

22. For the last 2 months I have been appointed by SCC Tas as an advisor to one of our RACF's – Rivulet, which has a Notice to Agree from the Aged Care Quality and Safety Commission (ACQSC). Such a notice obliges a RACF to agree to take steps to address a failure to meet standards. This arose due to some unmet Quality and Safety Standards following a visit in January this year 6 weeks after SCC assumed responsibility for the RACF and then again when revisited in August. These standards were unmet in January as SCC Tas were initiating the move from paper based notes to a new digital platform only 6 weeks into the transition. Additionally in August Rivulet had just employed 3 – 4 graduate RN's with little clinical confidence.

23. Matters of special emphasis in my role are ensuring communication is clear and consistent when introducing new programs such as Palliative Care Outcomes Collaborative (PCOC) and that clinical care is of a good standard. Many younger RN's from Non-English speaking backgrounds require further education both theory and practice for the aged care setting. I have been developing a SCC Graduation Program with the Clinical Nurse Educator (CNE) and Pharmacists which will support the new Graduates and provide them with clinical experience whilst supporting their transition into practice. The program is a 6-month program which includes elements addressing wound care, pain management, skin care, deliriums and governance. The plan is these RN's then provide the teaching to the next intake of new nurses with the support of myself and the CNE and they then commenced the next block with different topics. By teaching what they have just learnt and in which they have become

competent, they become leaders for the next intake of RN's and the 'referring out to specialists' approach is a reduced as they see expertise is evident within the organisation.

24. As General Manager of Clinical Services – Nurse Practitioner I have oversight across 9 RACF's and home packages supporting Clinical Care Co-ordinators (CCC) and RN's across these sites. I generally hold monthly Clinical Committee meetings which the Facility Managers and Clinical Care Co-ordinators attend. With a current shortage of experience RN's the focus is maintained on the education and support of these new nurses. The meeting minutes are then reviewed by the governance committee of SCC.

25. The Clinical Nurse Educator' role is a new role developed by SCC this year in response to the trend for Graduate nurses employment, with associated need to develop clinical confidence and expertise. The CNE who has 10 years clinical experience in aged care and acute care, with a specialty in palliative care currently works 4 days a week and will then become a state wide role in March 2022.

26. The Clinical Care Co-ordinators role is to support the Facility Manager (usually an experienced RN) with staffing allocations and support, whilst primarily providing clinical support to the RN and EN working on the floor. The CCC's are generally new nurses with only a couple of years of experience but who have settled into a career in Aged Care. To date the nurses in the CCC roles have no post graduate specialist qualifications and often only a few years experience. There is a trend for non-clinical Facility Managers developing, which places the CCC role as more clinically important.

27. My role generally supports the development of resident care plans and programs, I am not directly involved in the creation of these plans. In my experience it is more beneficial for the RN's on the floor to develop and review the residents care plan so they learn about the care needs of the resident, liaising directly with the families. Additionally, providing supervision to the EN's and carers becomes more fluid and the care more meaningful. I work with the CNE to develop assessment forms such as the wound care assessment and to mentor clinical reasoning, clinical decision making and clinical leadership.

28. The skills I use in my work day to day are predominantly highly developed communication skills, assessment skills, critical reasoning and mentoring skills. I provide informal education most of the time by encouraging clinical reasoning and critical thinking whilst mentoring.

29. In my role I consistently engage with other health professionals via emails, telephone calls and meetings face to face.

30. In residential aged care, residents enter RACF's for the nursing care and oversight provided for their chronic illnesses and often due to carer fatigue. It is a huge and difficult step, generally not taken by choice, but driven by illness. There is an adjustment period for the residents and their families. Kindness from staff is key and skilled clinical leadership important. I enjoy working with elderly people, learning about their lives and understanding what makes them who they are, hearing their stories and by listening informing them that their lives mattered and their contribution to this world valued. I have a strengths-based approach to the care and advice I provide, and acknowledge that although frail, the residents I work with are generally resilient. With the chronic/terminal disease of dementia being an increasing cause of RACF placement, there are different challenges but nevertheless I see the strength and good nature of the resident's shine through as they face the difficulties of their declining cognition. I feel working with people as they enter the palliative stages of life a humbling experience and knowing a resident is comfortable and their families well supported at this vulnerable time is important to me.

**The work of RNs, ENs and Carers in aged care**

31. The nature of work within RACFs has become more stressful over the approximately ten years in which I have been engaged in the sector. There are many competing priorities – creating a home like environment but providing clinical grade service is challenging. Navigating the fine line between allowing the resident to steer the course of their day versus what is clinically better resulting in a healthier outcomes and improved quality of life is challenging. When the motivation to get up and have a shower is lost, and seeing the need for one less evident as dementia progresses, staying as engaged as possible to maintain strength and communication skills requires gentle persistence and energy from nursing and care staff. Supervising the staff and understanding the resident has become more important whilst attending to clinical tasks takes time with increased documentation to evidence the care being provided.

32. The current public scrutiny on the sector although very needed, results in further external pressures and attracting experienced nurses to the sector more difficult, particularly as the nursing work has historically been viewed as less important than nursing in acute care. Aged care work is often the second choice for graduate nurses if they are unable to gain a graduate position in a acute hospital, and is also evidenced by the lower pay rate for nurses in this sector. Aged care bodies such as Aged & Community Services Australia (ACSA) provide a transition to practice program to support graduate nurses working in Aged Care, however, attendance to the sessions are generally low due to clinical shortages on the day and resident needs take priority over learning. This trend contributes to a task orientated focus of care in Aged Care of 'Doing the right thing' versus developing clinical reasoning skills which result in 'doing things right' as does the public media surrounding RACF care. See Sturmberg J, (2019) *'False accountability' – The harmful consequences of bureaucratic rigour for aged care residents* (**ANMF 107**).

33. Supporting very new and clinically inexperienced RN's to develop and become empowered and productive isn't easy particularly with language barriers and cultural differences of overseas staff. This responsibility falls on a daily basis to more senior RNs.

34. Due to the historic over prescribing of antipsychotic medications, the onus of responsibility imposed by the Aged Care Quality and Safety Commission (ACQSC) for the management of this prescribing now rests more and more on the RACF staff not the prescriber. Insufficient acknowledgement is given to the clinical confidence required to manage external GP's directions in respect of medications. For instance, a GP may commence an antipsychotic medication and when the review of this medication is required, the RACF RN's are often faxing and calling multiple times for the GP to attend to complete the task.

35. When transferring residents between RACFs and hospitals there is often a lack of clear communication from Hospitals, for example, discharge summaries often only go to the treating GP not the RACF staff and copies of pathology results to RACF are also often provided in an ad hoc manner. The effect of this is disempowering for the RN on the floor, which means they are often working clinically blind for a couple of days before the GP provides a copy of the discharge summary.

36. The unannounced visits from the ACQSC to assess our adherence to the Aged Care Standards are important albeit stressful for staff especially junior staff. Due to the transient nature of the work force, it is rare to have staff on the floor who have previous experience with the ACQSC visits.

37. Often in my experience new graduate nurses move after a few months working in Aged Care to the Acute sector or see Aged Care as a second job with a likely contract in acute care their preferred focus.

38. The care plans that are required to be written are lengthy, and whilst evidencing resident choice they are also directed to ACFI requirements. Resident care plans provide evidence to the ACQSC that we know our residents well however, day to day care staff rely on verbal reports and knowing the resident and needs are communicated through mentoring for new staff . Thus generally, care staff rely on verbal instructions and asking questions/mentoring. The care plans are important in documenting care needs both for care provision for new staff and to ensure an understanding of the care needs of the resident.

39. The needs of the residents have increased in complexity since 2010. The prevalence of depression and dementia in RACF living is high, requires energy and insight from nursing staff to draw the resident into attending activities which once engaged, they will likely enjoy whilst also monitoring for increased risks of falls and choking episodes. Official data supports my own observation of these changes. See:
    a. Australian Institute of Health and Welfare, (2021) *Dementia in Australia 2021 Summary Report* (**ANMF 108**) at page 13.
    b. Australian Institute of Health and Welfare, (2018) *Older Australia at a Glance* (**ANMF 94**).
    c. Gibson D, (2020) *Who uses residential aged care now, how has it changed and what does it mean for the future?* (**ANMF 109**).
    d. Reierson F, (2021) *Trends in Medication Use 2016-2021* (**ANMF 110**).

40. In the SCC Tas RACFs we have a mix of Australian, English and Culturally and Linguistically Diverse (**CALD**) residents mostly from European backgrounds, having moved to Australia after the Second World War – Hungarian, Greek; there are a few Asian residents who are younger with health issues. Equally there are substantial numbers of staff for whom English is a

second language. Communication difficulties between residents and staff are not infrequently a source of frustration for both.

41. Family members with pre-existing mental health illnesses such as anxiety can be challenging to manage for the RNs as at times phone calls can be abusive and difficult to end. Over time interactions with families has become more frequent, with expectations and a need to provide feed back to and consultation with families increasing.

42. There are a range of challenging areas of care provision in aged care and many of these areas have involved changes over the last ten years including :
    a. wound care complexity with increased documentation required for each wound;
    b. medication administration becoming more challenging with multiple medications (polypharmacy) to manage co-morbidities and prn medications;
    c. pain management and particularly the delivery of timely prn pain relief, monitoring for increased risks of falls;
    d. antimicrobial stewardship, infection control and prevention needing a high level of vigilance and supervision;
    e. ensuring appropriate food, nutrition, and hydration attending to referrals to dieticians, prescribing high protein diets and supplemental drinks;
    f. continence care: diagnosing and managing incontinence, managing constipation and loose bowels;
    g. dementia care: assisting with development of behavioural plans, diagnosing depression, delirium and management of same – non-pharmacological and pharmacological treatments;
    h. mobility and falls risk prevention and assessments post fall, history taking and risk reduction;
    i. social supports: providing support to families, often complex with guilt issues or high expectations of what is possible;
    j. quality of life: partnering with residents to elicit what is important to them for their quality of life;
    k. end of life / palliative care: is a specialty and I am establishing ‘palliative care needs rounds’, which will provide education for palliative care support, build collaborative relationships with Palliative Care specialists and their teams, completing thorough pain assessments mentoring new graduate nurse into this specialist care.

and

l. dealing with increased co-morbidity and higher levels of acuity, substantially due to the ageing population and people staying at home understandably as long as possible, often and the decision to move into aged care a result of a presentation to hospital.

43. The work of aged care RNs, ENs and nursing Assistants/PCWs has in my experience been profoundly influenced by changes in the following areas since I resumed work in the sector in 2010:

    a. Changes in the staffing levels and staffing profile or skills mix. There are fewer RNs and ENs and an increased proportion of carers. Further there has been a reduction in the hours of care staff available;
    b. There has been an increase in the complexity and acuity of residents at the time of admission and ongoing. This has been reflected in such matters as levels of frailty, co-morbidities, poly-pharmacology, falls risks and the number and severity of cognitive and dementia related conditions;
    c. The regulation of the sector ranging from the abolition of the "Low care/high care" distinction, the introduction of ageing in place, the application of Care Standards and the introduction of the Aged Care Quality Standards, regulation in respect of restraint, increased documentation and reporting and the demands of the Aged Care Funding Instrument;
    d. The expectations of residents, families and the community generally have changed such as to require, rightly, greater levels of accountability and reporting and communication about the delivery of care; and
    e. Increasing need for good palliative care provision.

    There are many other changes, but these areas summarise the major influences on change I have observed.

44. These influences have had a direct impact on the work of RNs, ENs and carers in the RACFs. This has been evident in such matters as:

    a. The devolution of responsibilities and tasks from senior and experienced RNs to less experienced (and fewer) RNs, an increased role for ENs, especially in the area of medication, and a substantial change in the role of carers in delivering direct care;

b. An increase in the intensity and complexity of the work performed. Each item in the list of care work required in paragraph 37 above has been changed as a result of the changes imposing greater demands on staff in their daily work. Further, there is a sense of rushed care with the potential for missed care; and
c. The difficulty of the physical settings in which care is provided. A home like environment and older facilities present difficulty and dangers in delivering care to frail, obese or cognitively impaired residents.

45. My ideal RACF would consist of all carers who have completed additional qualifications in dementia care and all senior nurses would hold post graduate qualifications in aged care. The two areas in which I consider RACFs should do better are in dementia and palliative care. I have observed high levels of burn out of inexperienced staff in a complex clinical field, with associated high turnover of staff where the attraction to the acute sector and better wages draws nurses away. My ideal is a long way from being realised.

46. New graduate RN's from Australia and other countries need time to develop and build their clinical experience, and confidence, in order work to the full scope of practice in the practice setting. The transition to practice programs currently offered and paid for by employers are often poorly attended due to the demands of providing nursing hours on shift.

47. Interaction with other health providers within the RACF is robust where the team work regularly with the provided, for examples, collaborating with the team of physiotherapists is regular and productive. Interaction with external providers such as dieticians, speech pathologists and GP's can be problematic when their visits are ad hoc, notes can be buried in the electronic system and if they are not proactive, communication with nursing staff can be unsatisfactory.

48. Palliative care takes time, experience and skill. It requires calm unhurried discussions with families and the residents to work through expectations, fears and desires, so death can be peaceful and grief uncomplicated. Both formal learnt and informal skills and experience are required. In my experience there is a significant increase in palliative care provided in RACFs compared to ten years ago, when more frequent transfer to hospital occurred for palliative care and pain relief.

49. This year, beginning in the memory support unit at Rivulet, SCC Tas has begun to train our care and nursing staff in the Montessori model of care. The memory support unit is a closed unit for residents with dementia or dementia related disease. This model of dementia care is primarily about providing purposeful tasks for residents living with dementia, targeted at their level of engagement and cognitive ability, improving their sense of self, quality of life and thereby reducing boredom and likely aggressive incidents. The Montessori program was first developed for people living with dementia by Dr Cameron Camp 20 – 30 years ago.

50. Covid 19 has increased the isolation of residents and the wearing of masks challenging for residents with dementia (and staff) who rely heavily on facial expressions for communication.

**Additional comments**

51. I do not feel my NP role or experience is as yet valued very well by health professions who generally don't understand it. What I bring to the sector is focussed experience and expertise plus a desire to provide timely interventions and improve the quality of life of older Australians and thus their families.

52. I feel there is a lot of social rhetoric about the value of older people, but when it comes to spending money to better their world, there is less commitment from the Federal Government. The need for improvement to aged care was identified after the Royal Commission and the many commissions prior to that, however, the response is delayed.

53. I aim to work for around 2 more years in aged care before I leave full time work. I will likely continue with my part time memory clinic and supporting new students with their post graduate studies for a couple of years more.

54. I hope to see the sector better funded and supported, with Nurses and Nurse Practitioners empowered to be less dependent on external medical services.

55. An increase in the minimum wage would hopefully encourage carers and nurses to prioritise their work, we would have better retention and therefore provide improved care.

**HAZEL BUCHER**
10 May 2022