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A Construct of Nursing Practice in an Australian Residential Aged Care Facility

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GLOSSARY

ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
BP	Blood Pressure
CAM	Care Aggregated Module (Obsolete Funding Regulation)
CofA	Commonwealth of Australia
CEO	Chief Executive Officer
CN	Clinical Nurse
CNC	Clinical Nurse Consultant
CRS	Complaints Resolution Scheme (Aged Care Act 1997)
CW	Careworker (also known as personal carer, nursing home aid, personal care assistant, assistant in nursing, nursing assistant, personal care worker, unlicensed healthcare worker, and 'non-nurse')
DOC	Documentation
DON	Director of Nursing
DVT	Deep Vein Thrombosis
EN	Enrolled Nurse
GP	General Practitioner
Int	Interviewer
NPO	Non-Participant Observation
Non-nurse	Careworker (CW) doing nursing work
Nursing Staff	RNs, ENs, and CWs
Nurses	RNs and ENs
MN	Medical Notes
OH&S	Occupational Health & Safety
PCAI	Personal Care Assistance Instrument
PN	Progress Notes
RACF	Residential Aged Care Facility
RCI	Resident Classification Instrument
RCS	Resident Classification Scale
Rel	Relative
RN	Registered Nurse
ROM	Range of Movement (exercises)
Staff	Nursing staff including RNs, ENs and CWs
TV	Television
UTI	Urinary Tract Infection

ABSTRACT

This thesis explored the relationship between the discourses of nursing care, the nursing care provision, and the perceived nursing care needs of three highly dependent residents in a residential aged care facility in Australia. Residential aged care in this country has undergone major reforms since 1987 and the nursing profession has struggled with these changes because of the documentation, validation, and accreditation requirements; the inadequate determination of dependency on nursing care for funding; the Registered Nurse (RN) being removed from the bedside to a role of scribe and delegator; the increasing acuity and complexity of the residents' needs; an increase in the turnover of residents; a rise in the nursing staff attrition rate; the delivery of care by untrained and unqualified persons; the RN being accountable and responsible for the care given by 'non-nurses' from a distance; and, the inadequate skill mix and staff to resident ratios provided in these institutions. The interest of this thesis was to research gerontological nursing practice in the context of residential aged care.

Residential Aged Care Facilities (RACFs) in Australia that care for the highly dependent elderly were identified in the thesis as disciplinary institutions that used 'subjectivation' as a means to control the efficiency and effectiveness of the labour force and the 'docile' bodies of the residents, whilst at the same time the government rhetoric is that of the quality of life standards and the rights of residents in these institutions. As well as the discourse analysis, an historical overview of the aged care reforms in Australia was undertaken for the period from 1975 to 2006 that demonstrated the effects the reforms have had on the voice of nurses and nursing care in these institutions. This analysis highlighted where nurses have been silenced and found the federal government determining what is nursing care and what is not nursing care, and also who is providing this nursing care.

Using a case study approach and discourse analysis each of the three residents was studied using data from five sources namely the resident or relative, a RN, a careworker (CW), the current documentation pertaining to the resident's nursing care, and the non-participant observation of the nursing care provided. These discourses on the nursing care and perceived residents' nursing care needs were analysed using the theoretical base developed from the philosophy and research interest of Michel Foucault (1926-1984), who questioned the apparatus and institutions of Western cultures and searched for discontinuities in the practices of what he termed 'disciplines'.

The results of the discourse analysis found nursing care practices that were alarming around the residents' perceived nursing care needs, the documentation of the nursing care provision, and the observed 'actual' nursing care provided. A questionable standard of nursing care was evidenced even though this facility had recently been accredited. A custodial level of mechanistic care was provided to residents in an extremely noisy and public environment within a culture of haste and bustle by unknowledgeable CWs, under the distant gaze of a RN, and the direction of the government documentation requirements. This resulted in unsafe,

unethical, unprofessional, and negligent practices, as well as fraudulent, illegal, and dangerously out of date documentation practices. This was ultimately affecting each resident's quality of life, nursing care, and wellbeing and was an added burden on the residents' relatives. Many discontinuities, dissonances, conflicts, and contradictions in nursing practice were uncovered for these three highly dependent residents that may be transferable and similar to other highly dependent residents in this and other institutions. Indeed it may mirror other disciplines that provide care services, such as mental health care, acute care, and disability care provision.

The concerns for the nursing profession have epistemological, ethical, and political ramifications for the residents and their relatives, the nurses, the non-nurses doing nursing work, the government, and the industry. Epistemologically new nursing 'knowledges' were being developed that were not resident focussed or based on evidence. Ethically, the legislated rights of residents were not being supported, despite the accreditation, funding, and complaint mechanisms in place - and this has the potential to have punitive ramifications for the industry. Professionally and politically, CWs were identified as non-nurses doing nursing work of a poor standard. This care was not based on accepted nursing practice, but developed through the documentation requirements of the federal government department, the applied constraints, and the CWs themselves. Furthermore, the documentation requirements were found to be a pretence in regard to funding through validation and accreditation, as well as a charade in nursing practice.

There is presently a substantial third level of nurses who are identified legally and political as non-nurses doing non-nursing work (known as 'personal' care); but these non-nurses *are* doing nursing work and are identified by the nursing profession and the public as 'nurses' doing nursing work. These non-nurses who provided nursing care are not educated, licensed, or regulated, and are not accountable professionally to nurses or legally to the public. It is proposed that CWs are in need of licensing under nurses' boards requiring at the very least a minimum of training and education. It is further proposed that documentation requirements resort back to professional nursing documentation; funding be dependent on an predetermined minimum skill mix and staff/resident ratio; and the funding of residents be based on a minimum data set and untied from nursing practice. The professional nursing practice of assessment, planning, implementation, and evaluation of nursing care needs resorting to a nursing domain of knowledge, practice, accountability, responsibility, and documentation.

If an acceptable quality of life is to be realised for residents in the residential aged care system, given that highly dependent residents are reliant on quality nursing care that is fundamentally imperative to their very quantity and quality of life, then changes in the residential aged care system and the nursing profession will be necessary. This thesis will contribute to opening up such dialogue between the government, the industry, and the nursing profession in Australia, and it also highlights areas of aged care nursing practice in need of further research.

DECLARATION

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

A.M. De Bellis **Date**

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This thesis is dedicated to my father and mother, my husband, and my children because of their support. It is also dedicated to nursing and nurses.

PREFACE

I am an RN of 31 years experience in nursing practice, education, research, and health services. As such, I care about my profession and the quality of nursing care provided by nurses. My research interest was founded on a strong belief that nursing, at its essence, is needs based and through my practice and research my interest focussed on gerontological and palliative nursing care. My master's research studied nursing theory and epistemology as it related to the nursing care needs of patients. It was a natural progression to research the perceived nursing care needs and nursing practices for aged care recipients, as well as the knowledge underpinning the nursing care.

The Aged Care Reform Strategy of 1987 and Aged Care Structural Reform of 1997 were implemented as economically rationalised policies as part of the regulation, standardisation, and commodification of aged care provision. The industry was repeatedly thrown into chaos whilst reforms were implemented. The protestations, research, and anecdotal evidence suggested the system was unfair. It became extremely frustrating for nurses who were being silenced and under extreme pressure, and as a result, were leaving the industry. I was disappointed that with the implementation of the reforms 'nurses' and 'nursing' were taken out of the dominant discourse of aged care provision. The 'discipline' of residential aged care was based on the accommodation of elderly persons and quality of life indicators, rather than the residents' need for nursing care and the quality of that nursing care.

From a nursing perspective the fiscal tools used did not match the dependency of the individuals receiving nursing care and the punitive nature of the system was evident. Added to this was the enforcement of documentation supporting the funding that was at odds with what was expected in professional nursing documentation, was excessive, and had become demeaning to residents. The aged care system and the documentation requirements had also removed the RN from the bedside and rendered them essentially scribes and medication administrators. The nursing profession believed nursing and personal care needs were not being met at the bedside, but government rhetoric was embedded in the legislated right of each and every resident to 'quality care' based on their needs. According to the government, quality was assured through the legislation, the funding mechanism, the accreditation process, and the complaint agency established from 1987 to the present. This rhetoric silenced the nursing profession and the problems being experienced in providing nursing care.

A fundamental point of difference between the nursing profession and the federal government was the dependency and nursing care needs of residents. I wanted to study the 'mismatch' of resident nursing care needs from a number of different perspectives or discourses, with comparisons to the tool and the documentation that determined the funding, and hence the nursing care provision and the quality of that nursing care provision. All CWs do nursing work but this was not recognised and there was no requirement that CWs be trained, licensed, or regulated. The supervision by an RN had become distant and problematic being one of indirect supervision, as well as delegation and then eventually

credentialing; but the RN was accountable and responsible for the nursing care provided by the CWs (non-nurses). My aim was to identify and compare the 'perceived' nursing care needs in the discourses, the actual nursing practices, and the rationales for nursing around highly dependent residents. The direction of the thesis was to make comparisons between the different discourses of those who received the nursing care, those who provided the nursing care, those who directed the nursing care, myself who observed the nursing care, and the documentation of that nursing care.

The nursing home that allowed me access was a 'good' nursing home on the surface, and it was well meaning in its philosophy and management. The nursing management believed the nursing care the residents received to be of a satisfactory to high standard. It was a totally random circumstance that this nursing home consented and it was not targeted for any particular reason, other than the willingness of management to participate. The nursing staff and management were confident in the nursing care provision and the organisation was recently accredited. The nursing staff appeared to be 'good' people and they were friendly, welcoming, and caring in their attitude.

This thesis did not aim to discover poor or dangerous practices and discourses, but because of what was revealed, I began to question the construct of nursing practice. My aim became one of opening up dialogue about the ethos set up by an aged care system that has many problems for residents residing in and nurses working in the aged care sector. I did not set out to uncover what I found and my purpose was not to criticise nursing care, but this is what I have been compelled to do. I make no apology for the nursing care discourses and observations I heard, read, saw, and consequently analysed that were truly represented objectively and subjectively from the data.

The federal government, however, has much to answer for in what was essentially the demise of aged care nursing and competent nursing practice in this facility. Although the findings cannot be generalised, they may be recognisable and transferable to other facilities and other highly dependent residents. The problem of this standard of nursing care happening *at all* in the residential aged care system in Australia is of concern given the government rhetoric. What was revealed has many serious implications for the nursing profession, the residents and their relatives, the industry, and the federal government. I commend the nursing staff of many organisations for the quality of care they provide under the constraints, but nursing has become complicit in allowing the system to dictate the nursing care for residents - to the detriment of the residents themselves and the quality of nursing care able to be provided.