From: Nick White <nwhite@gordonlegal.com.au>
Sent: Thursday, 19 May 2022 5:05 PM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Subject: RE: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Witness Statement of Mr Voogt

Dear Associate

Please find attached amended statement of Stephen Voogt in PDF and Word format.

Kind regards

Nick White
Principal Lawyer
Accredited Specialist (Workplace Relations)

Gordon Legal
IT'S PERSONAL

Level 22, 181 William Street
Melbourne VIC 3000
T: +61 (3) 9603 3035
F: +61 (3) 9603 3050
DX: 39315 Port Melbourne
E: nwhite@gordonlegal.com.au
W: www.gordonlegal.com.au

From: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>
Sent: Thursday, 19 May 2022 2:40 PM
To: Nick White <nwhite@gordonlegal.com.au>
Cc: Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value - Witness Statement of Mr Voogt

Good afternoon Mr White,

We understand from the hearings of evidence that some amendments needed to be made to Mr Voogt's witness statement.

Could you please provide an amended version of Mr Voogt's witness statement?

Kind regards,

Madeleine Castles (she/her)

Associate to the Hon. Justice IJK Ross, President

Fair Work Commission

Australia's national workplace relations tribunal

T 03 8656 4645

E madeleine.castles@fwc.gov.au

Level 4, 11 Exhibition Street, Melbourne, VIC, 3000
PO Box 1994, Melbourne, Vic, 3001

The Fair Work Commission acknowledges that our business is conducted on the traditional lands of Aboriginal and Torres Strait Islander people. We acknowledge their continuing connection to country and pay our respects to their Elders past, present and emerging.

This email was sent from Wurundjeri Woi Wurrung Country.

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 STEPHEN ANDREW VOOGT

I, Stephen Andrew Voogt of [redacted] in the State of Victoria say:

1. I am a member of the Australian Nursing and Midwifery Federation.
2. Where I refer to a conversation in this statement and I cannot remember the exact words used, I have stated my best memory of the words spoken, or the effect of what was said.

Personal Details, work history and qualifications

3. My date of birth is [redacted].
4. I live in [redacted] but work consistently in Wangaratta and across the north-east of Victoria in a range of aged care facilities looking after certain residents. I also provide consultancy services across the public and aged care sector around Victoria.
5. I am a Nurse Practitioner (**NP**) in Gerontology (since 2010). Much of my work involves mental health and dementia/psycho-geriatric behaviours. I have worked in private aged care since 2013.
6. I currently work as a consultant Nurse Practitioner. For example, on 6 September 2021, I commenced an eight week contract to review the care and systems in several aged care facilities for a major Melbourne public health provider. This involves:
    a. performing comprehensive geriatric assessments on most of the residents which includes investigations. This has involved a lot of prescribing and deprescribing.
    b. Advising on the current model of practice.
    c. Advising on how care is delivered.
    d. Advising on the new standards and how this affects care at the bed side.
    e. My colleague is advising on compliance and quality etc.
7. However, a large part of my on-going work is with a group of about 10 GPs in Wangaratta. I look after their residents in several private aged care facilities in Wangaratta – St Catherines

Lodged by:	Telephone:	03 9603 3035
The ANMF		
Address for Service:	Fax:	03 9603 3050
Level 22, 181 William St	Email:	nwhite@gordonlegal.com.au
Melbourne VIC 3000		

(72 beds) where I look after about 40 residents and Rangeview (about 60 beds)where I look after about 20 residents.

8. I have a Collaborative Agreement (CA) arrangement with each of the participating GPs which is a condition for me prescribing medications, ordering diagnostics and charging consultations against the MBS items available to Nurse Practitioners.
9. I did my Registered Nurse training at Mercy Private in East Melbourne from 1986 to 1988. After I finished my training, I moved around Victoria and Australia undertaking nursing work. I worked at St Vincent's public hospital and then worked in the Northern Territory at Tennant Creek hospital in around 1990. I was there six to eight months and then moved back to Victoria to Warrnambool Base Hospital for six to 12 months. I then moved back to Melbourne to worked at the Epworth Hospital for about a year.
10. From about 1992 to 1997, I worked at the Austin Hospital. I was Nurse Unit Manager in the Surgical Ward at the end of my time there. In that role I managed about 30 staff and was responsible for the staffing of the busy ward, relationships with surgeons and visiting medical officers and ensuring that the ward complied with policies and standards.
11. In late 1997, I moved to South Eastern Private Hospital. In about 2000, I moved to Knox Private Hospital for 18 months where I did my Post Graduate certificate in Critical Care.
12. In about 2001 I moved to Canada and worked in a major hospital in Edmonton for one year doing critical care nursing and developed specialty skills in neuro-trauma in an ICU environment.
13. I returned to Australia in April 2002 and was employed at Northeast Health Wangaratta (**NHW**) in critical care. In the years that followed I performed a number of different roles with NHW as discussed below.
14. I had an interest in mental health issues so started working at the Kerferd Psychiatric Unit at NHW where I completed my Graduate Certificate in Mental health Nursing from RMIT.
15. In 2007, I commenced my Nurse Practitioner candidacy in gerontology. I completed all of the practical and theoretical components over the next three years. This involved advanced work during placements in aged care as well as completion of a Masters Degree. This included Pharmacology component for the Masters as well as Advanced Clinical Decision Making. I was endorsed as a Nurse practitioner in 2010 by the Nurses Board of Victoria. I'm proud to say that I was the first aged care Nurse Practitioner endorsed in Victoria. A copy of all of the qualifications mentioned are in **Annexure SAV 1.**
16. From 2010 until about 2012 I worked as a NP at Illoura, public health aged care facility in Wangaratta as an employee of NHW. My work as an NP at Illoura and in public health aged

care facilities is essentially the same as the work I do now as a NP consultant discussed below. Illoura is a residential aged care facility that is part of public hospital system. Around this time and as part of my employment with NHW, I also worked:

a. on the Geriatric Evaluation and Management (**GEM**) Unit in Wangaratta;
b. at the Kerford Acute Psychiatric Unit; and
c. with the Older Persons Community Mental Health (**OPMH**) which involved providing psycho-geriatric services to older people in the community. These services were provided to older people who had chronic mental health issues or who developed acute mental health issues such as depression/anxiety. Patients became involved with OPMH based on a referral from a GP. The work of OPHM involved a team including a psychiatrist, mental health nurses and allied health professionals such as occupational therapists and social workers. In this work I provided direct care to older people in their homes, in aged care facility and in the acute hospital setting. Much of this work involved working in residential aged care facilities assisting in the management of behavioural/psychological symptoms of dementia (**BPSD**) and general psychiatry including depression/anxiety. OPMH also use to be deliver the Dementia Behaviour Management Advisory Service (**DBMAS**), a service run out of St Vincent's Hospital. Part of my work was with this service.

17. In about 2015 or 2016, OPMH was taken over by Albury Wodonga Health, another public sector health provider. I continued to work in the OPMH program after it transferred to Albury Wodonga Health for a short period.
18. The DBMAS program was dismantled and terminated. A similar service is now delivered through a Commonwealth Program, contracted to Hammond Care called Dementia Support Australia or DSA.
19. As a NP I am able to obtain and use a Medicare Australia provider number and a PBS prescriber number. However, when working with NHW (and Albury Wodonga Health) I did not use need either a provider number or prescriber number. In the public health system I was able to order and prescribe without provider number or prescriber number.
20. In about 2011, the Deputy Director of Nursing at Illoura moved over to become the Director of Nursing (**DoN**) at St Catherines in Wangaratta. St Catherines in Wangaratta is a non-for-profit residential aged care facility but is outside the public health system. In about 2013 I was first contracted by the DoN of St Catherines to do a couple of sessions a week with some of the residents as a NP. At that time, I continued to work at NWH in the units described above on a part-time basis.

21. From 2013 I slowly built a consulting business.
22. In 2014 I was contracted to do some work as a NP at St John's Wangaratta. At that time, St John's Wangaratta was a large 120 bed facility as well as retirement village operated by from the Anglican Diocese. That work was initially for a year or so. After a tragic influenza episode in 2017 that killed about 10 residents, the Aged Care Quality and Safety Commission (**ACQSC**) investigated St John's, and after this I was contracted to come back for a couple of years to assist with care of residents. My work at St John's then revolved around the unmet standards identified by the ACQSC which included acute deterioration and host of clinical issues that were identified as non-compliant. Examples included chronic pain and BPSD. I continued my work with St Johns until 2019 when Respect, a Tasmanian NGO, took over the facility.
23. In about 2017, I started performing NP work for Omeo Hospital in small public run aged care facility of 15 beds.
24. Also in 2017, I also started doing some work at Bentley Wood, a private aged care provider, at the Myrtleford Lodge. Later in 2018 I was engaged to also perform work at the Bentley Wood facility in Woods Point, Yarrawonga. I have also worked at Yackandandah Health Service which is a community based private aged care service as well as Tallangatta Health Service in their public aged care.
25. In September 2021 I was invited to work at Yallambee Aged Care, a 120-bed community facility in Traralgon. [redacted] (Harcourt Aged care Advisers), who I work with on occasions, had been engaged by Yallambee as the nurse advisor following a serious incident at the facility. She was engaged to evaluate and investigate an incident where a 78 year-old male resident had attacked and brutally bashed 13 residents and staff. She asked me to come and assess a few of the residents involved in the incident. I did this and several had ended up in hospital with significant injuries. I had to assess one particular resident for post-traumatic stress and I was worried about whether this resident would survive. Many of the other residents were lucky in a sense because they had dementia and could not remember the trauma – you could see the battle scars however.
26. As a NP working outside the public health system, I need to enter into Collaborative Agreements (**CAs**) with GPs in order to utilise my Medicare provider number and PBS prescriber number. As a Nurse Practitioners I am an autonomous practitioner – I can diagnose, order therapeutic interventions, order diagnostics and refer patients and residents to specialists. However, under the regulations this needs to be in the context of a

CA when I work outside the public health sector. Without a CA, I could see patients but couldn't order pathology without the patient paying the full cost, or prescribe via the PBS

27. I have a group of GPs – 10 in Wangaratta – with whom I have CAs and who are happy for me to look after their residents collaboratively. I take on their residents in each facility. I manage most of the medical clinical needs of the residents. I will contact the GPs if there are particularly complex issues. I monitor the medical issues and geriatric syndromes which usually requires assessment, investigations, and pharmacological intervention. I look after about 40 residents at St Catherines. About 6 months ago I also started at Rangeview and look after about 20 residents. What I do that usual RN in aged care can't revolves around the extended scope of practice with prescribing/diagnostic and referral rights. Ultimately RN staff may identify a clinical issue and refer it to me as the NP. I would then diagnose and manage the issue.
28. From working in and with a number of residential aged care facilities, I am aware that some GPs aren't providing adequate services into aged care facilities. I have noticed that this has become worse over the years. In Wangaratta there is one GP practice which is now refusing to provide care to residents in the aged care facilities. I understand that a second practice may soon also withdraw from working in aged care facilities. The GPs who continue to provide services to residential aged care facilities have less time to service residents in those facilities. These GPs may come in for a lunch time session for an hour once or twice a week. As a result, individual resident are more heavily reliant on NPs like me and otherwise fall back on the RNs in the facility to try and monitor, observe and treat. RNs in residential aged care facilities have the added problem that they are trying to deal with every resident, deal with crises as they arise, manage other staff and they don't have the capacity to order diagnostics or prescribe medications.
29. To my knowledge, Yallambee had, and still only has, two GPs from one GP clinic who will work with the residents there. These two GPs do a total of two sessions per week at Yallambee and there is effectively no GP coverage after hours. Like a lot of regional and outer metro facilities they can call My Emergency Doctor, a national on call service.
30. I consider that residents of aged care facilities are the most complicated group of people to look after in our community. It takes time to properly assess and treat these people. Based on my observations, I consider that some GPs are not spending the necessary time to do this.
31. The reduction in GP availability, the lack of support and changes to resident acuity (as discussed below) means that the nurses on site have to be more skilled, observant and

responsible. This is all occurring in the context of recommendations from the Royal Commission about using fewer drugs and fewer restraints – both chemical and environmental.

32. In relation to chemical restraints, Recommendation 65 of the Aged Care Royal Commission Final Report included that by 1 November 2021, the Australian Government should amend the PBS Schedule so that only a psychiatrist or a geriatrician can initially prescribe antipsychotics as a pharmaceutical benefit for people receiving residential aged care.
33. The Australian Medical Association (**AMA**) recently published a submission to the Pharmaceutical Benefits Advisory Committee on the restricted prescription of antipsychotics in residential aged care. Whilst I do not agree with all aspects of this submission, I do agree that limiting prescribing to geriatricians and psychiatrists wOULD severely impact health services in rural and remote areas. I agree with the AMA that the proposal is "attempting to deal with the symptoms of a broken aged care system while ignoring the causes".
34. A copy of the AMA submission to the Pharmaceutical Benefits Advisory Committee – Restricted prescription of antipsychotics in residential aged care, dated 20 October 2021, is **Annexure SAV 2**.
35. The ACQSC has picked this up the need to limit the use of chemical and environmental restraints and has made a real focus in audits and communications on pressuring providers to cut or eliminate restraints and interventions. I support that focus and the right of residents not to be chemically or physically restrained. However, the problem is that once you go down that path a lot more resources are required to ensure harm minimisation and keep risk at an acceptable level. This is the minefield that direct care staff in most facilities face daily. There is a new philosophy, but as yet, no additional resources to implement it.
36. Unless someone like myself comes in, Dementia Support Australia (**DSA**) and the GP are the only source of external support and advice that staff and residents of facilities have in private aged care when dealing with issues related to dementia. Originally, DBMAS provided support for BPSD in the community and in aged care facilities but now this has been replaced with DSA (run by Hammond Care). GP's and facilities are able to refer behavioural problems to DSA. DSA may then send a worker in to the aged care facility and they are focussed on non-pharmacological interventions. They work out the triggers that precipitate BPSD and then develop strategies and non-pharmacological interventions. The worker can refer to their specialist, usually a psychiatrist or geriatrician, for complicated cases and pharmacological advice.

37. However, DSA are based/co-ordinated in Melbourne, they visit infrequently, and facilities really needs someone on the ground several times a week (reviewing and reassessing). So, unfortunately, DSA is not able to provide enough support. The system is pretty much busted and the nurses and carers are left to pick up the pieces. They are under pressure because of the short staffing. In my work in aged care facilities I observe that nurses and carers can't sit with people with behavioural issues when it is needed. They are under pressure to get all their other tasks and reporting done.
38. I am all in favour of non-pharmacological interventions. I never want to use psychoactive substances if this is not necessary. But when it comes to residents with psychotic symptoms which can result in moderate to severe aggression, there are simply not the resources in these facilities to manage many of these residents totally non-pharmacologically. Many of them require one on one care for a period of the day and that is what the family expect. They are a lot of work and are complex and ACFI doesn't provide the necessary funds to provide adequate care. I don't see that changing any time soon. I understand the new funding system to be introduced next year rewards immobility – the less mobile someone is the higher the funding. In my view the immobile are often actually easier to look after. Mobile residents have greater risks of falls, they present a greater risk to themselves/others and, because they are less cognitively impaired, they often have greater expectations.
39. I've witnessed a number of assaults in residential aged care facilities. I am aware of incidents where males who are sexually disinhibited have presented a threat to vulnerable female residents. On some occasions where this has arisen, I have advised of the need to intervene pharmacologically but on several occasions the families have said "no" and a sexual or physical assault has followed. It's got to the point where major providers won't take moderately to severely behaviourally disturbed patients and many end up in public facilities after being sent to emergency. I'm not sure if it is a growing problem or it has simply been hidden. Mandatory and serious incident reporting now means it is being reported more often to the ACQSC and the Department.
40. Compounding the problem for staff are several factors. I have noticed that families - and even the residents themselves – have very high expectations of the care that can be delivered. Often those expectations, which reflect the marketing and the promise of "choice", are well above what can actually be provided by the facility or sustained over a period of time.
41. Another issue I have noticed is the consequence of the difficulty getting some GPs to provide appropriate levels of care as discussed above. One result of this, is that facilities are

left with the RNs and ENs trying to diagnose and manage behaviour. For example, RNs and ENs are required to figure out if behavioural issues have their genesis in an acute physical issue or pain. This occurs where the RNs may have three or four other residents in the same boat. This takes significant time and still the RN may have to manage the needs of another 60 or 70 residents as well as manage the staff around them.

42. I have observed RNs working on their own, especially on PM shifts, nights and weekends. They have no doctors around them like a hospital and can't order diagnostics like blood tests, urine tests etc. The GPs around Wangaratta share or take turns to operate on-call service for the local aged car facilities, but this service is variable depending on the GP. As of May 2022, a further three GP practices now do not offer on-call services. The GP on call may be up in Beechworth 35 kms away and it will not be practical for them to visit the resident.
43. Another factor in adding to the stresses for staff which I've seen is reductions in overall numbers of staff and in the skill mix: steering away from RNs/ENs towards more carers. Carers do a terrific job, but they do not have the education and training of a RN or EN. They are less able to evaluate and make decisions around complex information or situations.
44. A major change in the last decade has been the new Aged Care Quality Standards introduced from July 2019. They really make the providers a lot more accountable which puts more pressure on nurses and carers because of limited funding and increasing regulation.
45. From working in residential aged care facilities, I have noticed that the ACQSC is cracking down on a few things – dementia and behaviours and the use of chemical and environmental restraint. This is a problem without adequate resources to fund non-pharmacological strategies. The management of acutely deteriorating residents is also another focus and the battle is to keep the residents at the facility and manage them there with limited resources and medical backup. The dynamic I have observed in aged care is that residents are now kept at home a lot longer and they are a lot frailer and more complex to look after when they get to the facility. Since 2010 I have observed a trend of residents being admitted from acute hospital or from the community where they have been on home care packages when they can no longer cope with that level of care. Previously, those being admitted to aged care included a mix, some reasonably well residents and some complex or dependent cases. Now all new residents are complex and there are higher levels of dementia.

46. The negative media has also raised the bar. I have noticed that residents and their families are now more aware of their rights. An example is the standard which requires the recognition and provision of culturally diverse services. For example, at Bentley Wood in Myrtleford there are a lot of people of Italian heritage, so they look to cater for their needs through Italian cuisine and language. At Monash Health where I'm working on a short-term contract there are over 10 nationalities, and the standard says there is a need to recognise each of them. It is extremely difficult to do that for staff, especially given the resource envelope they have.
47. In my work in aged care facilities, I have noticed a steady increase in bariatric residents who require two and three person lifts. I notice that in facilities all the time. And there is more complex palliative care – the residents have been unwell for quite a while and there can be significant distress and pain. It is a real struggle for nurses and carers to provide psychological support for them and their families – often with absolutely no extra resources. The ACQSC has promoted advanced care planning (**ACP**) and most residents choose to stay in the facility for their final weeks – it falls back on the facility to do all of this. The nurses are the ones on PM and night shift who have to make a call on what to do. Many of the GPs simply aren't available to attend the facility or provide an adequate resource for out of hours care.
48. The Advanced Care Plan may say that the resident is not for hospital transfer but at 2am when the resident takes a turn for the worse what does the RN do? If they keep them in the facility the family may complain because there aren't the staff or resources to manage the resident effectively. If they send them to hospital, it is a breach of the ACP and the family may complain. Where an ACP says that the resident is not for transfer to an acute hospital that this may be further complicated where family members are consulted about this and give a direction that is contrary to the ACP. It is not black and white and involves difficult choices between what is best clinically for the resident and what the resident says they wanted at the time they completed the advanced care plan.
49. I have seen that in facilities dealing with residents is much more complex than it was a decade ago. Staff have to deal with all the diseases and geriatric syndromes - falls, incontinence, polypharmacy, dementia, depression to name a few. They are often very interconnected and not easy to unravel. Changing expectations of residents and their families has also magnified this.
50. I am starting to see a lot more acute treatment in aged care – things like intramuscular anti-biotics, increasing the level of observations and vital signs, more in-dwelling catheters,

subcutaneous fluids are becoming more common (which for older people is a better alternative to intravenous). In my view, especially if nurses had access to a few more machines, there is not a lot of difference between aged care and hospital, especially the GEM wards I have been used to. That is a recent development the last five to ten years.

51. The government has funded in-reach expertise to stop transfers to hospital, but it isn't that effective – there simply aren't enough resources provided. At NHW we have one Nurse Practitioner employed on a full-time basis who works 11am-7:30pm Monday to Friday and she covers the whole of north east Victoria. I may deal with that NP if a facility in which I am working has a resident who is unwell. If I can't get to a facility I will call her and speak about specific residents. If there is a resident with chest pains, I may ask her to attend and perform an ECG. Unfortunately, this isn't an adequate resource and often isn't on hand when those RNs and carers need it most. What they need is after-hours residential in-reach.
52. I have also noticed increased expectations of PCAs around their observation of residents. PCAs are now expected to observe residents, recognise and report deterioration and be able to articulate it to the RN/EN. They are expected to be involved in giving out medications. They are no longer there just to do personal care "tasks". More and more they are expected to make judgements.
53. With ENs I have noticed that they are now expected to be quasi-RNs.
54. In my view and based on my observations and experience, RNs and ENs in aged care have to be more accountable and responsible than RNs and ENs in acute care. RNs and ENs in aged care don't have the medical and peer support. They don't have the RN down the corridor to come and have a look. They can't just escalate a difficult issue up to the medical staff – even private hospitals have resident medical officers. RNs in a hospital environment who suspect some deterioration can usually get an order for diagnostics or medications at any time of the day or night.
55. I have also noticed barriers to RNs sending residents to hospital. In my work, I have observed ageism in the acute health system. For example, there is often resistance from ambulance paramedics and hospital staff to admitting aged care residents to hospital. I have also observed that residents of aged care are often discharged back to the facility after very short periods of time and well before the cause of their admission is adequately resolved. In that case, it falls to the facility to provide that clinical care.
56. Most providers have moved over to online IT for medical records, which is a good thing, and I would expect that technology implementation will speed up in the private aged care

sector over the next few years. However, this does add to the necessary skills for those providing care in the facility.

57. There has been a lot of pressure from the ACQSC on aged care facilities to review medications. There is a lot of pressure to de-prescribe. Now, as a part of the assessments conducted by the ACQSC facilities are held accountable for polypharmacy. The ACQSC encourages facilities to intervene and manage polypharmacy with the GPs. This pressure comes in a number of ways. First there is anti-biotic (**AB**) stewardship. The ACQSC is targeting the facilities for overuse of ABs – it is now part of the standards. Second, there is now additional focus on reducing or eliminating several classes of drugs. These include psychoactive drugs and other drugs such as statins, Protein Pump Inhibitors. It is the RNs in the facility who have to now prompt the GPs about these issues.
58. The time, resources and skills associated with managing residents with complex behaviours and to provide high level quality of life for residents in aged care has dramatically increased over recent years. Staff are expected to be highly skilled in management of behaviour complexities. Deprescribing has compounded issues to the point that on some occasions I have witnessed GP's who are reluctant to prescribe when it may be relevant to do so. Residents with clear thought disorder, perceptual disturbance and behavioural disturbance are being untreated at times. This would not happen to younger persons with similar symptoms.
59. I have also observed a focus by the ACQSC on reducing environmental restraint (no cot sides, more open doors). All of this comes back on the staff who have to manage the implementation and consequences of these initiatives. Because of the change in expectations more people are allowed to wander unrestrained now. That is a real change. The aged care facility is the resident's home and I agree with that they should get a say in their care – what they like and don't like. But with that comes a cost and you the need to have the resources to implement it properly. However positive, the focus on restraint free environments has increased demand on staff. High falls risk residents are requiring high level supervision and one-to-one attention that we just do not have resources to provide in many cases. Staff resources to minimise risk of falls have not increased in correlation with the decrease in restraint.
60. I have also noticed that communication with cognitively impaired residents is a growing problem. Understanding what residents want and need is crucial to preventing behaviours that may be a risk to them or others or which simply make them distressed. That is added stress for staff in not being able to understand clearly what a resident wants or how much

pain they are in. I've also witnessed a lot of racism from the residents towards staff which those staff members have to deal with without much support in many cases.

61. With pain management there are similar issues to that above. I have observed an increasing expectation from the ACQSC that RN's will prompt and guide GPs. A massive amount of time and resources of ENs, RNs and GPs are involved in assessment, pain management and review, especially for residents with dementia. Expectations on the provider have escalated to the point that the evidence required to support effective pain management is well in excess of what would have been required 10 years ago. The resources to provide the level of evidence required is tremendous.
62. There is an increased complexity of wounds with residents coming from hospital system. The RNs and ENs lack access to wound consultants (unlike the public system) leaving aged care nurses to manage complex wounds.
63. The pandemic has resulted in a lot more isolation of residents from families and social supports. The increased need for psychological support of residents particularly during COVID pandemic has fallen onto all levels of staff within the facility.
64. Because of the difficulties in private aged care, a lot of good nurses have told me that they don't want to manage a facility as the Director of Nursing or Care Manager. I am aware that there is difficulty attracting RNs to act as Care Managers. I have been approached on a number of occasions and asked to act the Care Manager of a facility. One of the reasons I would not take on such a role is that it is just too hard to negotiate external factors (families, public health) as well as the multitude of internal management and clinical pressures. When I compare the requirements and demands of those roles today against those of aged care facilities 10 years ago, it is just chalk and cheese. The funding and wages have not kept pace with the increase in skill and responsibility.
65. I have been involved in the management of COVID outbreaks within residential aged care facilities twice now.
66. The first occasion was in August 2020 when I worked within a facility in Glenroy for a 7 week period. The second was in October 2021 at a facility in Noble Park.
67. Some aspects of these experiences have been identical, namely:
    a. the working environment is extremely stressful, being the most stressful I have experienced;
    b. there has been severe human resource depletion and availability; and
    c. the outcomes have been heart breaking for residents, family and staff.
68. Despite this I have walked away from these experiences with positives.

69. At the forefront of this is my admiration for the nursing and care staff who worked in these conditions. They endured much more than what the public are aware of, including:
    a. the stress of having to look after acutely/severely unwell residents with limited resources;
    b. continual lack of/short staffing, working 12 hours days in full PPE with minimal breaks;
    c. Some of the RNs working 5 days straight 12 hours. I am aware of staff sometimes having to work a 16 hour day and then return to work the next day at 0700 hrs for a 12 hours shift;
    d. staff have had to endure the negativity from government departments, the media and the public about COVID and criticism of residential aged care facilities;
    e. in the 2020 outbreak there were no vaccines and still little known about COVID. Staff put themselves in harm's way, risking their own health for the residents; and
    f. staff in residential aged care facilities are less well resourced than the acute public health sector.
70. From these experiences I am filled with admiration for the RNs, ENs and PCAs working in aged care. I'm not sure any other profession would endure this.

STEPHEN ANDREW VOOGT

9 May 2022