Letter from an Australian nursing home worker

4 April 2000

Below is a letter sent to the WSWS *from a nursing home worker in New South Wales, Australia on the recent article,* "Kerosene baths reveal systemic aged care crisis in Australia."

Dear *WSWS,*

I read the recent article on Australian nursing homes and would like to offer some comments drawn from my experience in the industry. Firstly I'd like to congratulate the authors for their honest assessment of the industry. It was cut-throat and penny pinching before the change from Residential Classification Index (RCI) to Residential Classification Scale (RCS). Minutes were counted; so long for a shower, so long for a meal, so long on the toilet, and so on. Grams of food, mls of water, every sliver of soap, was accounted for. Even the amount of breathable air, per room, was calculated. Since the RCS, conditions for both residents and workers have dropped sharply.

Your article addressed the conditions of the elderly. I would like to talk about some of the problems of workers in the industry. Most of the staff in nursing homes are either Assistants in Nursing (AIN's) or Residential Care workers (RCW's). They are drawn from widely different sources. Some are with qualifications unrecognised by Australians laws, some are students, some farm girls, some refugees. Most are married and have a family, even sometimes a sick parent at home. Some have another two jobs.

The training they receive is always inadequate—maybe a week, more often less. Their hours are long and dislocated with poor conditions. Added to this is the frustration of working with people in need and being unable to help, assist or comfort them. If you work in a factory or an office you don't have to talk or empathise with the product of your labours. Computers don't cry or call out in pain when you turn them over, tools and dies don't grab at your sleeve and think you are their long lost grandchild. No one likes to see distress in others and the constant clutching at the heart can, and does, wear out all.

In nursing homes the relationship between the needs of capital and the needs of humanity are graphically revealed. The elderly are a commodity, exploited and utilised to reach the rate of profit as efficiently as in any other enterprise. They resemble "battery hen" complexes more than anything else. (The final aim in both *is* death.) Room after room, crammed with elderly workers whose only "crime" has been to grow old in a period of savage societal relations. (It is noteworthy the per year funding of the elderly is about a quarter of a maximum security prisoner.)

From the front, nursing homes usually look nice and homey; flowers along the path, kept lawns and cheerful residents. Inside, near the front door there's two comfy chairs. There's a chandelier (usually plastic) on the ceiling, bright happy paintings and flowers. Proprietors like to have a good entrance; it creates a favourable impression on new relatives. It's when you get out the back and upstairs you see the true picture.

As most of the nursing homes have two storeys, all the residents who can walk and smile are put downstairs and nearer the front. The "problem children"; who can't walk, have "behavioural" problems or are too poor to have clean clothes go upstairs and towards the back. Without physio and exercise they get sicker quicker and need to go to hospital more.

As a lot of the buildings are old and without lifts to get the resident down is a problem. The ambulance drivers used to carry them but had so many work related injuries they banned the practise. So the nurses have to carry the resident down and back up on return from hospital. When two or three small woman are expected to carry a 110 kg. man up 20-30 steps, it is obvious injuries will occur and they will be severe.

In one nursing home, each of us had to lift eight residents onto chairs, shower chairs and trolleys before breakfast every day. With all the manoeuvring it came to 5.2 tonnes per head. It was the tip of the iceberg. We'd make 20-30 beds, push trolleys, stack linen and position the patients in bed every two hours. All these actions are "ergonomically wrong" for the spine. The tiny spinae erecta muscles at the bottom of the back aren't built for it. The big muscles that should be doing the work are the quadriceps in the thighs, but the rooms are so small, with too much furniture jammed in, the nurses end up having to use their back muscles.

It's no surprise then that AINs lead the Workcover statistics in back and back related injuries. *They share the same percentile of damage as coal mining does for men.* As a lot of them—over 45 percent—can't speak English, most do not receive compensation or even treatment. They are thrown out the door and told to come back when well. Even if nurses do know their rights they still find themselves victimised mercilessly on return to duties. A lot of women, working a second job (even a third sometimes), do not let on if they are injured for fear of losing their jobs. Permanent and severe damage results from any further trauma.

Damage done psychologically can be no less crippling. Walking along any corridor causes an instinctive feeling of sadness. The things people like to do don't cease at the age of retirement. They still need to talk, chat, be cuddled, be cajoled, laugh, smile, show pictures of the grand kids and all those social aspects. They reach out to try and keep as much of themselves—the pre-nursing home self—as alive as possible. But there's never enough time. Workers feel this and feel guilty themselves, often, adopting brusqueness as a cover.

Giving intimate care has problems also. Most people only wash themselves, wipe their own bums, or one of their children's. Touching a person whom you don't know is stressful. It takes time to learn how to touch "neutrally". Doing so under speed-up is impossible. It becomes an assembly line, a cattle crush. You focus on the leg or the

arm, wash it or dress it then move on, usually feeling as if you haven't been able to do the job in the right way. The leg or wound has become a “thing in itself”, separate from the whole. It becomes “care” without “caring” and feels hollow and false.

Then there are the residents with “difficult behaviours”, i.e., a euphemism to cover everything from schizophrenia, brain damage, dementia, personality disorders, etc. Many spend their day in a chemical fog; alive without living. Likewise emotional reactions, are often interpreted as mental illness. The resident who shows sadness by crying is diagnosed with depression and given anti-depressants. One who angers at being hurried and responds with aggression is given tranquillisers. One wanting to go home is a wanderer and will probably be tied to a chair and get drugs as well. The solution is always to drug the residents down to the level of their surrounds.

Yet it is well known that most of the behaviours which relate to sedation orders are easier and more humanly managed with environmental measures. One example is the dementia patients, many of whom prefer circular paths. They experience less frustration with a circle and do not get as irritable. If they walk all day in a hallway, only to meet wall at either end they become confused and frustrated at not being able to proceed. Sooner or later they will lash out and have sedation ordered. This only increases the chance of falling, thus a fractured hip, then so on and on.

Sometimes if they're feeling useless, old or rejected by family or staff, or so they don't have to face the daily pain, residents will stay sedated all day. I have heard old ladies ask, almost in tears, for sleeping pills at 5 p.m. This puts the nurse between the needs of the market and the needs of humanity. What do you do? The pills will last 4-5 hours, take them now and the resident might wake in the night. The skeleton crew on nights won't be happy. But here's someone old enough to be your grandmother, in real extremis, sick to death of the whole “slow dying” business, asking for help. What do you do? Either way you lose; you either gripe with your colleagues or the resident.

It becomes clear at times like this, there is no answer and no way to solve the problem on the job. But where do you go to get something done about it? Well, not last year's Annual Conference of the New South Wales Nurses Association (NSWNA), where the dominant feeling was, yep, sure, there were a few “issues and concerns”, but nothing worth cancelling the ball for.

A feature was the unusually large turnover of delegates—131 out of 400. What this represented was hard to establish. There was the annual blooding of apprentice bureaucrats and the usual number of “tourists” down for the free trip, etc. Among the others were some who were curious and some who came to see if anything could be done. For many it was their first time so close to the union bureaucracy and so by the end of the conference—no matter how wide-eyed at the beginning—most were outraged. They had expected a certain amount of cynicism and horse-trading. But never the sheer indifference and remoteness of the top table to staffing, conditions and cutbacks—the everyday working life of the membership.

That their number was a concern to the leadership was seen by the special “Branch Official Training” courses that ran leading up to the conference. The aim being to prevent any unseemly displays of independence or democracy. At the conference they were put in their place, by being referred to as “virgins”. A type of initiation or “bastardisation” into the hurly burly of unionism. If one put forward a resolution or spoke, the delegate or someone else, would say: “I'm/here's a virgin delegate ... ” Self-conscious and mocking laughter would follow.

The last day was the “Professional” day, the conference theme had been “Psychedelia”. Purple and orange lights flashed and turned and streamers and balloons flopped in the air conditioning, while we listened to the spokesmen for Aged Care. He was thorough and scrupulous. His presentation listed each and every Government cut made to staff, food, medicines and diversional activities. He compared it to the OECD countries and to the USA. Everywhere, he said, had problems. At the end he went through what was the motor cause of it all. It wasn't the economy or the attitudes of society, none of that sort of thing. It was the discourse, he said. If only they had of called them Nursing Care Facilities the funding wouldn't have been withdrawn. The fact they were called Aged Care Facilities had doomed them.

Gerald Durrell had a story concerning the toilet habits of a breed of rat. In the wild it buried its faeces under trees. In captivity it would defecate in a corner of its cage and start burying motions. When it finished scrabbling, the rat would believe the faeces to be buried. The rat could still see them and smell them. On occasions—its cage being too small—unavoidably stumble over them. Even then, with faeces matted and dripping from its paws and whiskers, there was still part of the rat's brain insisting, its faeces lay buried.

It seemed the same at the Conference. Here's the health system—a shambles—waiting lists, infection rates, nursing home scandals, hospital deaths, etc. Add in massive anger and discontent among both health workers and patients—and you have abundant evidence, right under your nose—of “something rotten in the state” of New South Wales. But at the NSWNA Conference, to the top table at least—it was all dug and buried. We were to ignore the evidence of our senses and reduce ourselves to the perspective of a soiled rat.

By this time, it was clear that the problems of nurses, the elderly and the health system were not going to be solved here. For some of the delegates—maybe even most—this might have meant nothing. But there were others for whom it was a revelation, and they were going to start to do some thinking on the way home.

Regards,

A health worker

Auburn, Australia