A Report into Aged Care
What does the future hold for older New Zealanders?

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In conjunction with
Grey Power, New Zealand
A Report into Aged Care
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What we have discovered is an aged care sector in desperate need of a ‘revolution’ — a new approach to how we deliver care to the elderly that puts the individual first.
**1: Overview**

*A test of a people is how it behaves toward the old. It is easy to love children. Even tyrants and dictators make a point of being fond of children. But the affection and care for the old, the incurable, the helpless are the true gold mines of a culture.*

Abraham J. Heschel

When the Labour and Green parties joined forces with Grey Power to investigate the quality of our country’s rest homes and home support services, we did so because of a growing public disquiet about the quality of care provided to older New Zealanders.

Labour MP Luamanuvao Winnie Laban (Labour’s Aged Care spokesperson) and Green MP Sue Kedgley (Green Party’s Aged Care spokesperson) were disturbed by the concerns raised by Health and Disability Commissioner reports, the Auditor-General’s report in December, and a number of high profile media cases of substandard care in rest homes, and wanted to get a true picture of the industry.

What we have discovered is an aged care sector in desperate need of a ‘revolution’ or culture change – a new, less institutionalised approach to how we deliver care to older New Zealanders that puts the individual and their needs first, rather than an organisation’s.

We need to better support older New Zealanders to stay in their own homes longer with quality home-based care and, where there is a need for residential care, look beyond the current institutionalised model of care and investigate new community based and alternative models, especially for people on low incomes.

While we acknowledge that many providers offer high quality care for residents, many rest homes do not.

Worse still, many older New Zealanders desperate to stay in their own homes, are being pushed out because of inadequate home support services – or cuts to their home help.

Our older people deserve better.

From more than 450 submissions, including almost 150 written submissions and more than 300 oral submissions, as well as 20 nationwide meetings organised by Grey Power and attended by well over 1200 people, and conversations with various experts, nurses and caregivers around the country, the overwhelming feedback has been of an unregulated, desperately short staffed sector driven, in many areas, more by cost cutting and the pursuit of profit, than best care practices.

We found a sector fast reaching crisis point, struggling to meet the growing needs of an ageing population and residents’ rising acuity levels. The result is that many older New Zealanders are receiving substandard care.

While enabling and supporting people to stay in their own homes (that is, ageing in place) as long as possible is our first preference for a long-term ageing strategy, it is
clear that people going into residential aged care facilities are older, more frail, and have more complex needs than they did a generation ago – and therefore need more support on a daily basis. This is having a major impact on staff workloads. The 2008 Older Persons' Ability Level (OPAL) study showed that 56% of residents in Auckland rest homes and private hospitals had high dependency, compared with just 36% 20 years ago. About 60% have some form of dementia, and 30% are on anti-psychotic medication, according to figures from care provider Bupa.

The staff caring for these increasingly frail and dependent residents need appropriate skills and training. But, alarmingly, as the level of dependency in aged care has increased, the number of trained nurses and staff available to look after residents has declined.

As one nurse who has worked in the sector for many years summed it up: “Registered nurse workloads are so high, and the number of caregivers for each resident so low, that they do not allow consistently good care to be given”. She left the industry, disillusioned, after being “unable (even at a senior level) to ensure patients received the care they are entitled to.” (Submission).

We believe the shortage of skilled staff is the main reason behind many of the shocking stories of neglect and abuse we heard – of residents given anti-psychotic medication to sedate them and make them easier to manage; of residents being left in bed for entire weekends, or left for hours after a fall; of residents not being toileted regularly, resulting in incontinence.

We heard about residents not being walked regularly, so losing their mobility; residents being left in front of the television all day and rushed during meal times, showering or getting dressed; residents suffering from chronic dehydration or malnutrition as a result of not being assisted during meal and tea breaks; residents having their buzzers removed from their reach or being left for hours on their own, or being treated as little children and not adults with a vast life history and experience.

We heard stories of residents who were treated rudely or unkindly by staff, or who felt isolated or lonely, even in the midst of a bustling residential care home. This was especially the case for residents whose families didn’t live close by. The Eden Alternative acknowledges that loneliness, helplessness, depression and boredom account for much of the suffering experienced by residents in aged care.

We heard stories of residents who had not received proper medical treatment for common conditions such as urinary tract infections, dehydration, bed sores, skin
tears and falls. Some of these residents ended up in hospital diagnosed with necrotic pressure ulcers, resulting, in extreme cases, in amputations, or even death. We also heard stories of untrained caregivers routinely giving out medication, such as morphine; of medication and diagnosis errors; bullying of staff and residents; lack of training; low wages; a sometimes dismal service in hospital level and dementia level care; and ineffective auditing processes.

Combine this with the fact that over the coming decades, our over-65 population is set to explode – and that rates of dementia or chronic conditions such as diabetes, heart disease or chronic respiratory disease are on the rise – and it paints a rather dismal picture of the future. If the sector is already failing, how will it cope with our ageing population?

According to the recent Grant Thornton ‘Aged Residential Care Service Review’ (‘the Thornton Review’) New Zealand has a higher proportion of people in residential care than most other countries (p.86). While the use of institutional care is decreasing in most OECD countries, it remains the norm here. The Thornton Review acknowledged that older people have “a growing preference for alternative care arrangements such as informal care by family or friends, and for support provided in certain retirement villages” (p.85). Despite this, it still calls for a substantial increase in aged residential care facilities to cater for rising numbers of older New Zealanders needing care (p.156).

Already, according to New Zealand Aged Care Association figures, more than 42,000 people receive care in around 700 aged residential care facilities every year. According to recent statistics from the Health Minister, around 75,000 people receive home support at some time each year – and around 15,000 people come on, and 15,000 go off home support each year.

We have witnessed first hand how successful individualised, person-centred care can be when used in residential aged care facilities. But we have also heard numerous stories that the care provided to many vulnerable older New Zealanders is substandard. With no regulations around minimum staffing levels or training, the care provided from facility to facility is utterly inconsistent. Further, with no real transparency or accountability, and inadequate monitoring processes, it is extremely difficult for a member of the public to work out whether a facility provides good quality care – or not.

Rest homes receive more than $800 million in taxpayer funding each year, yet there is no current requirement on providers to be publicly accountable in the same way public hospitals are. Providers are not required to disclose the number of adverse events that occur in their homes. Nor is there any obligation to publicly account for how taxpayer money is spent. Yet some in the sector are making substantial profits. This lack of accountability and transparency urgently needs to be rectified.

The current problems facing the sector are acute, but they can and must be addressed. To that end, we have developed a set of comprehensive and practical recommendations which we believe will go a long way to improving the quality of care across the sector. They are the product of our investigation, which has identified the issues of concern that are facing:

1. residents,
2. the residential age care facilities,
3. the workforce,
4. the auditing process
5. home based support services and
6. family carers.

The problems facing each segment of the aged care sector need to be tackled in a comprehensive and co-ordinated fashion, if conditions across the entire sector are to improve. We find it astonishing that no one agency is tasked with ensuring the safety and wellbeing of the thousands of residents in aged care facilities. Instead, a number of disconnected agencies are involved in the provision of care, including the Ministry of
It is equally astonishing that there is no aged care strategy in New Zealand. We recommend that an Aged Care Commissioner be appointed as a matter of urgency and that a nationwide aged care strategy be developed.

While we recognise that the overwhelming number of workers in this sector are dedicated to providing excellent care to the elderly, they are severely restricted by staff shortages, low wages, lack of training, and the strict time management requirements of many providers driven by cost cutting and profit margins. As one registered nurse put it:

If I didn't know with absolute certainty that I was making a definite difference to people's lives then I couldn't do the job. Many do the job because they know it matters – but when staffing levels are squeezed, they finish their day knowing they could/should have done a better job, but didn't have the time.

An extra pair of hands makes the difference between being helped to drink the whole cup of tea or only half of it. Between a resident being 'parked' somewhere for hours on end, or someone being able to take them for a wheelchair walk outside in the sun, even if only for 10 minutes. Dozens of differences every day.

Submission

What's more, without adequate time taken for each resident, serious adverse events – including falls, pressure ulcers, infections, dehydration or medical misdiagnoses – will happen. More than 9000 residents (in subsidised care) ended up in Accident and Emergency in 2008 (questions for written answer 14577 (2010)) – putting pressure on our already stretched emergency services.

In the New Zealand Aged Care Association's written submission to our inquiry, Chief Executive Officer Martin Taylor says:

...despite everyone's best endeavours, there will always be cases of poor care, and while one case is one too many, we must accept we are dealing with people and not every one of the sector's 35,000 caregivers and nurses are going to act appropriately at all times.

New Zealand Aged Care Association submission, July 2010

We agree that one case is too many. In our view, we have a duty to ensure that all older New Zealanders are treated with dignity and respect and that no-one suffers from neglect or abuse.

Yet our investigation shows that problems in this sector are chronic and widespread, and are affecting thousands of vulnerable people now – and will affect thousands more in the coming years.

We are systematically failing some of our oldest and most vulnerable citizens. Even in the rest homes providing adequate care, many residents lose mobility, continence and mental agility not because of the effects of age and ill health– but because of the rigid, institutionalised failing of the residential facility.

Many older New Zealanders and their families said they were reluctant to complain about problems they experienced for fear of being penalised in some way. As one submitter put it:

The elderly of Mum's generation have always been brought up with a reluctance to complain or speak up. They were taught not to question 'authority' and experience genuine fear of repercussions surrounding the quality of care they receive, should they complain.

Submission

Another told us that he often found his mother, who suffered from dementia, sitting naked in a lazy boy chair, but he was afraid to complain about it, for fear that she would be victimised.
We believe a revolution in our whole approach to aged care services is needed. Instead of building ever more residential aged care facilities, we need to decrease our use of institutional care and expand alternative, community-based models of care, such as Abbeyfield.

We believe we have a duty to speak up for these people.

Similarly, some nurses and caregivers told us they had to sign a contract guaranteeing that no information about what happened inside a facility would be disclosed, and they were frightened they would lose their jobs if they spoke publicly about problems.

For this reason, we have protected the identities of most of the individuals making submissions to our inquiry.

Many people have compared the aged care sector today with the preschool sector 20 years ago. At that time, a largely unregulated, untrained workforce was the norm. We deemed the situation unacceptable for our children, and set about ensuring quality care for preschoolers. Our elders need the same protections.

We believe a revolution in our whole approach to aged care services is needed – one that puts the resident at the centre of an individualised care plan. Instead of building ever more residential aged care facilities, we need to decrease our use of institutional care and expand alternative, community-based models of care, such as Abbeyfield. While retirement villages provide an alternative model of care for New Zealanders with financial means, there is a serious shortage of supported housing for low income older New Zealanders.

Within aged care facilities, we need to move away from institutionalised, highly structured care of the elderly to a new model which provides less structured regimes; empowering residents and treating them with dignity and respect, while providing human companionship and meaningful activities.

We want to see an Aged Care Commission established, to more appropriately deal with the unique issues and needs of the Aged Care sector and to develop a long term national strategy with specific aims around establishing better systems and care across the sector.

We believe comprehensive changes are needed across the sector, including minimum staff ratios, minimum training levels, and more adequate monitoring of quality care.

We urgently need greater transparency, accountability and monitoring of residential care facilities.

We need a more integrated home support service that better cares for people in their own home. We want to see a more thorough service that allows people suffering from chronic conditions to stay at home longer – with better support.

In short, we want changes across the sector that will guarantee every elderly person in New Zealand is treated with dignity and respect.

As our population continues to age, the issues highlighted in our investigation will only get worse. We need to act now to ensure that future generations of New Zealanders receive the best care available.
2: Key Recommendations

1. Establish an independent Aged Care Commission and Commissioner.
   - The Commission to operate along similar lines to the Mental Health Commission with an advocacy service and an 0800 number.
   - The Commissioner to develop a comprehensive national Aged Care Strategy and Action Plan, along with appropriate regulations for mandatory staff-resident ratios in aged care facilities and minimum training standards.
   - A National Quality Manager, based within the Commission, to work with aged care facilities to ensure organisations carry out quality improvements and measure progress.
   - The Commissioner to develop a Quality Framework for residential aged care focused on quality improvement and the quality of care. National clinical indicators to be developed for all areas of care, including (but not limited to) restraint usage, medication incidents, use of antipsychotic medications, infection rates, falls, pressure ulcers, weight loss, and soft tissue injuries. The indicator results should be publicly available, and used to develop a star rating system for aged care facilities.
   - The Commissioner to establish clear guidelines around extra charging of residents by rest homes.
   - The Commissioner to be tasked with developing and trialling new models of care, characterised by a more person-centred care approach.
   - The Commissioner to investigate the overall funding and accountability of the sector and to explore new funding models.
   - The Commissioner to investigate appropriate remuneration and respite care for family carers and home based respite care for dementia sufferers.

2. Establish a technical working party (made up of experts from industry – including providers, the unions and consumers – and aged care specialists).
   - The working party to investigate all issues raised in our report and provide advice on the implementation of the recommendations.

3. Government funded training provided to all aged care staff – in residential and home based support services.
   - A national and portable training standard, based on NZQA, to be adopted across the sector for both home care and aged residential care workers.
   - Aged care to be a recognised career structure, with minimum qualifications and training and career progression based on levels of training and experience.
   - Aged Care workers who attain qualifications, such as NZQA level 3, to receive additional pay as an incentive to attain training.

4. Minimum staffing levels for nurses and caregivers to be mandated in regulations.
   - This will ensure that there are adequate numbers of staff in all aged care facilities.
   - Appropriate levels, including levels of trained staff, to be developed by the Technical Working Group.

5. A star rating system for aged care facilities to be developed and made publicly available on the Aged Care Commissioner’s website.
   - Facilities to be measured against the national clinical and quality of care indicators (such as staffing levels, staff qualifications, adverse events), and the quality of care and environment the residential home provides.
   - Consumers are able to check the star rating of any given aged care facility.
6. Audits.

- The Ministry of Health, or Aged Care Commissioner, to designate auditors, not the aged care facilities themselves.
- All auditors to be accredited, and on a Register held by the Commissioner for Aged Care.
- All audits to be unannounced.
- Audits to be simplified and focus on monitoring quality and care practices.

7. All residential aged care facilities and home based support service providers to operate under greater transparency and accountability.

- Facilities to advertise their fee structures and any additional charges openly.
- Facilities to measure their current organisational performance against each newly developed clinical indicator, for example, facilities must record reportable events as public hospitals do.
- Results to be freely available on an Aged Care website.
- Rest homes and home based support service providers to provide transparent information on Government contracts.
- Home based support service providers to provide a transparent pricing model to determine fair prices and fair returns.

8. Pay parity for aged care staff (including residential and home based support) with staff working in public hospitals and the community.

- This includes both nurses and aged care health care assistants (caregivers).
- The same penal rates and other working conditions should apply.


10. Greater consistency for home support services.

- Workers to be paid travel time and expenses consistently (particularly rural workers).
- Consistent quality certification and auditing of home care providers.
- District health boards, the Ministry of Health and Accident Compensation Corporation (ACC) (which all fund home health services) should behave and contract out consistently.

11. National face-to-face standardised model for home based assessments.

- No telephone assessments to be conducted.
- Standard consistent package of care provided against that assessment.

12. More integrated networks for home support services.

- GPs/pharmacists/assessment teams/caregivers etc to work together in a single integrated service. Consumers no longer confused by who to talk to and where to go for help.
- Shared information systems around care pathways and packages.
- Home health provision should be part of Integrated Family Health Networks.

13. More specialist gerontology training offered across the sector to address the desperate shortage of specialist services.

14. Consistent packages for dementia patients.

- Including respite care for dementia patients to be provided in the home.
There is a growing public concern about the quality of aged care in New Zealand.
3: Introduction

If residents received as much care as prisoners, they would receive daily showers, warm dry rooms, television, free medical and dental care, computers, good food and high staff ratio and all that would be required in addition would be the opportunity to be free to go outside the facility at will. This should not be too much to ask for those who have helped to develop this country and have also fought overseas for our freedom. It would appear that prisoners are more highly thought of than the older citizens.

Grey Power submission, July 2010

Why we decided to investigate

There is a growing public concern about the quality of aged care in New Zealand. Shocking cases of abuse and neglect have been highlighted by numerous Health and Disability Commissioner reports, including two cases in August 2009 which revealed an elderly rest home patient who had not been showered for a year and an 88-year-old man who suffered massive weight loss – 8kg in just 10 days – after he was transferred to the Christchurch facility’s hospital wing.

In some 342 complaints about rest homes to the Health and Disability Commissioner last year (up to 15% from the usual 10% of total complaints received by the office):

Issues essentially fall into the following categories: lack of appropriate knowledge and experience in specialist areas such as dementia care, communication (particularly with families and legal representatives (Enduring Powers of attorney)), wound care, falls (and fractures), nutrition and fluid management, medication, end-of-life care, and a lack of coordination of care. Concerns that there has been a failure to seek medical assessment soon enough, or that injuries have been missed, are also common.

Acting Health and Disability Commissioner’s submission, July 2010

The media have also highlighted other incidents of abuse, including the rest home worker under police investigation last November after allegations of assault against dementia patients – or the 103-year-old woman whose leg was tied to a bed.

Last December, the Auditor-General issued a critical report into the effectiveness of arrangements to monitor the quality and safety of rest homes, while the same month Wellington Coroner Garry Evans called for an overhaul of the industry after the death of a 98-year-old woman, who died in Hutt Hospital after a series of suspicious falls, caused by other patients bullying her.

Reports released to Consumer Magazine under the Official Information Act last October showed the Ministry of Health carried out 44 unannounced inspections over the previous two years, in response to complaints, and found that many of the homes it investigated were providing substandard care. One report found “serious deficits in service delivery”, and could not rule out the fact that “incidents of institutional neglect” had occurred. Other problems included a critical shortage of nursing staff, assaults by residents on other residents, inadequate assessment of residents’ needs and planning or care and inappropriate use of restraint – staff in one home used sheets to tie a resident to the bed.
A recent survey by the New Zealand Nurses Organisation (NZNO) found that caregivers are increasingly doing jobs that would normally be considered the domain of nurses, such as giving medication to residents without supervision.

Another recent report by the MidCentral District Health Board (DHB) found instances of abuse and neglect as well as many other serious wide-ranging and systemic problems that were said to pose a serious risk to patient safety, including medication errors, untrained carers administering drugs and staff shortages.

As a result of these reports, Winnie Laban recommended to the Health Select Committee on three occasions that it conduct a comprehensive cross party investigation into the state of aged care.

On three occasions, Government members refused to support a Health Select Committee Inquiry – and this prompted us to conduct our own investigation outside of the Select Committee process.

We wanted to investigate how deep seated the problems in the aged care sector were and to explore what changes could improve the quality of care provided by the sector.

We wanted to hear from the people involved to get a true picture of the state of the sector and so we travelled around New Zealand talking to people in their own communities. Grey Power organised 20 public meetings to which the elderly, their families, local health officials and non-governmental organisations and other interested parties were invited to attend.

At these meetings, we asked questions about the quality of care in the sector and listened to people’s stories about the treatment and care received by our elderly both in the home and community and in residential care facilities.

We also invited written submissions from key industry groups, including providers, unions, lobby groups and other interested parties.

We received more than 450 submissions, including almost 150 written submissions and more than 300 oral submissions. Through our investigation, we heard from a good cross-section of New Zealanders – many of whom have told us about shocking instances of the sector failing them and their families.

Our aim is to give this silent group a voice.

**Grey Power involvement**

Grey Power is an apolitical lobby group aimed at promoting the welfare and wellbeing of all over 50 year olds. As one of the country’s largest lobby groups, it “strive[s] for a provision of a quality health care to all New Zealanders, regardless of income and location.”

Grey Power helped facilitate the nationwide inquiry on behalf of its members.

*Both facets (rest homes and home help) of elder care has become increasingly urgent because the present government has refused to acknowledge the problems associated with the industry and are continually failing to recognise that the problems do, in fact, exist.*

Grey Power submission, July 2010
New Zealand has one of the highest proportions of people in residential care in the developed world and is relatively unique in its continued focus and support of residential care facilities for the aged.

Many submitters were concerned by the depressingly physical environment of many homes, as well as by the rigid institutionalised routines which often deny individual needs and preferences in favour of organisational expediency.

4: Adopting new models of care

We believe the best way to allow older New Zealanders to age with dignity and respect is by supporting and enabling people to remain in their own homes as long as possible, with better, more integrated home support services to help manage this process. As chronic conditions continue to rise, we need to provide more specialist training to our home support caregivers to better manage these conditions in the home.

This is where our recommendations for funded training for all home care staff and better remuneration and career training and options to attract homecare staff will make significant changes in the quality of care provided at home.

However, for many, who are unable to cope on their own, staying at home is no longer an option and going into some form of residential care becomes a reality.

We acknowledge there are many stories of outstanding care received by people in rest homes. The Art of Great Care: Stories from people who have experienced great care (Nationwide Health and Disability Advocacy Service, 2010) gives many examples of best practice models.

Based on our investigation, the facilities that are providing the best care are those which are offering an environment more akin to normal living patterns outside the rest home. As much as possible, residents and their families are involved with day-to-day decision making and daily cares are conducted at the residents’ own pace.

As discussed earlier, New Zealand has one of the highest proportions of people in residential care in the developed world and is relatively unique in its continued focus and support of residential care facilities for the aged (Grant Thornton New Zealand, 2010, p.86). Many submitters were concerned by the depressing physical environment of many homes, as well as by the rigid institutionalised routines which often deny individual needs and preferences in favour of organisational expediency. Many called for less institutionalised and more community based models of care.

Currently outside of residential care, there are few options for extra support for the many older New Zealanders who are no longer able, or do not wish, to remain in their own homes, but do not desire, or are not eligible, for residential care - particularly those with limited financial resources.

While retirement villages fill this gap for the relatively well off, people with low incomes are generally unable to access these options. In contrast, many European nations offer a broader range of supported accommodation outside of traditional residential care for those who do not need the full support of a residential care setting. Denmark encourages alternative housing known as ‘collective dwellings’, established by Danish councils (Grant Thornton New Zealand, 2010, p.164). As a result, health expenditure for over 80 year olds declined, and hospital bed days were reduced by 30-40% for residents in community housing (p.155).

We believe these sorts of new models of care need to be expanded in New Zealand.

The Eden Alternative

We are particularly interested in a new model of care called the Eden Alternative, which has begun to be established in New Zealand. Nine facilities are practicing...
this philosophy, which is based on 10 principles aimed at making environments in which older people are cared for much more vibrant and interactive and their lives and activities more meaningful. Some of the principles include less emphasis on structured regimes, and giving residents contact with plants, animals, children and the local community. A facility we visited which practiced the Eden Alternative had 40 volunteers from the local community who visited on a regular basis, along with school children, and people who brought in their pets. The home was bustling with people and activity, and seemed full of life and fun.

The Eden Alternative is based on normalising everyday living and incorporating a community spirit by addressing the plagues of loneliness, helplessness and boredom.

Abbeyfield

There was also strong support for the Abbeyfield model of care, a method designed to promote and establish local community-based and volunteer-led Abbeyfield Societies. They, in turn, create and manage local Abbeyfield Houses providing lonely older people a dignified way of life at a weekly housekeeping charge affordable from state sourced welfare payments or the equivalent.

According to one submission, “we desperately need Abbeyfield residences and similar accommodations. As per UK and Netherlands and other civilised countries which have wonderful models.”

As the baby boomers get older, traditional aged residential care facilities will seem less and less appropriate to meet the needs of this group.
5: Background to the report

Stop acting like hosts to patients and families and start acting like guests in their lives.

Dr Don Berwick, Institute for Healthcare Improvement, Boston

Our ageing population

New Zealand’s population is ageing, and the current problems experienced by the aged care sector are set to explode in future decades.

At the 2006 Census of Population and Dwellings, there were 495,600 New Zealand residents who were aged 65 years and over, up 45,200 on 2001 Census. This represented the largest intercensal (between censuses) growth for this group in our recorded demographic history. Over the last half a century, the 65+ group has consistently outpaced the growth of total New Zealand population. As a consequence, they now make up one in eight (12.3 percent) of all New Zealanders, compared with one in 12 (8.5 percent) in the early 1970s (Statistics New Zealand, 2007, p.1).

The 65+ population is expected to more than double to between 1.17 million (series 1) and 1.48 million (series 9) by 2051, when they will make up one-quarter or more of all New Zealand residents (Statistics New Zealand, 2007, p.1).

![Historical and Projected 65+ Population](source)

The number of people aged over 85 will also increase – almost doubling from 58,000 in 2006 to 116,500 in 2026 (Grant Thornton New Zealand, 2010, p.78). Many areas, particularly smaller towns and rural localities will see a faster shift in their age composition, including a local decrease in the number of young people. In areas like Taranaki, the number of people aged between 65-74 is predicted to rise by 69% from 2001 to 2021, 66% for people aged 75-84, and 47% for people over 85 (Healthcare of New Zealand submission, July 2010). Clearly, addressing capacity issues in secondary and aged residential care is essential.
Dementia and chronic conditions on the rise

According to the Thornton Review, in 2008, there were close to 2500 dementia beds in New Zealand (p114). Rates of dementia, including Alzheimer’s, are also rapidly rising. In 2008, 40,746 people in New Zealand had dementia, with an estimated cost to the country of $713 million (Alzheimer’s New Zealand).

By 2026, this figure is expected to almost double to 74,821 and the number of beds provided at dementia level is expected to increase by 150%. Demand for dementia care is steadily increasing with an extra 250 dementia beds needed every year (Grant Thornton New Zealand, 2010, p.91). By 2050, an estimated 146,699 people will be living with the condition.

The rate of chronic conditions – such as diabetes, heart disease or chronic respiratory disease – is also on the rise. The number of New Zealanders with type 2 diabetes is predicted to double by 2028 to almost 10% of the adult population (Healthcare of New Zealand submission, July 2010).

Residential aged care industry

New Zealand has a higher proportion of people in residential care than most other countries – and the second highest proportion in the OECD of older people receiving care or other support.

While the use of institutional care is decreasing in most OECD countries, New Zealand’s rates continue to be high with more than 42,000 people receiving care in some 700 certified aged residential care facilities every year (New Zealand Age Care Association figures). Of these, 64% of residents are subsidised by the government, while 32% of residents are not subsidised. 57% of residents are in rest homes, 31% in private hospitals and 8% in dementia units (Grant Thornton New Zealand, 2010, p.76). Thirty seven percent of rest homes are co-located with retirement villages (p.8).

According to the Thornton Review, approximately two thirds (68%) of aged residential care facilities in New Zealand are controlled by For Profit operators (p.32). This contrasts with Australia where Not for Profit providers still operate most facilities (p.31).

Many facilities are owned by major multinational companies. A Consumer magazine article put the numbers at 58 facilities for Oceania Care Group (owned by Macquarie Bank (AU)), 45 facilities run by Bupa Care Services (owned by Bupa UK), 22 facilities owned by Radius Residential Care (Kuwait Finance House), 21 owned by Ryman Healthcare (Garlow Management (Canada) and Ngai Tahu Capital), 17 owned by Metlifecare (J P Morgan Nominees, FKP, and Macquarie Investment Holdings, 16 for Ultimate Care Group and 12 for Summerset Care. According to Bupa, 33% of the beds available nationally are provided by the largest six players.

In the not-for-profit sector, the main players are Presbyterian Support, responsible for 33 facilities, the Selwyn Foundation and Christian Healthcare Trust which have eight facilities each.

More than 33,000 caregivers and nurses work in the residential aged care sector, many on a part time basis. According to Ministry of Health figures, approximately $1.3 billion was spent on targeted older people support services such as residential care, home support and rehabilitation in 2009/10. Of that, $800 million was spent on aged residential care.

Change of ownership in residential aged care industry

In the last decade, the aged care industry has undergone significant changes as ownership has shifted from mainly localised private providers and the voluntary sector to For Profit organisations. Alongside these changes in ownership has come the commercialisation and diversification of residential facilities, evidenced by the rapid rise of retirement villages, with rest home and hospital level care options available in many of these villages.
Some owners who once saw their motivation as a religious or social calling have been driven out of the sector because of lack of funding – or have been bought out.

Some submitters argue that the focus on cost cutting and securing profit margins through rationalised and uniform services (which are cheaper to provide than small scale, individually tailored services) can undermine the ethic of care.

We note the increasing devolution of the care and provision of services to older people in the sector and changing nature of those organisations providing the services. In the Residential Care sector we note the expansion of corporate and offshore ownership drawing its fiscal security from the direct subsidies paid to those businesses. We note the transition from a sector historically dominated by “faith based” and “not for profit” operators to a commercial environment has seen a parallel reduction in the capacity of the state to monitor and resource appropriate care.

Service and Food Workers Union submission, July 2010

We agree with the Thornton Review that the declining presence of Not for Profit operators in the sector is likely to have detrimental effects on the industry long-term) and that the Aged Care Commissioner should look at ways of creating incentives for them to remain in the market.

Deregulation

At the same time, the minimum staffing requirements and regulations imposed by previous legislation, such as the Old People’s Homes Regulations 1987 and the Hospital Regulations 1993, are not included in current legislation for rest homes (NZNO, 2010, p.6), and it is now left up to facilities to decide how many staff they will employ.

Prior to the introduction of certification in 2002, the registered nurse requirement for hospital level care (high dependency) was one full time registered nurse to every five hospital residents. Therefore, if a hospital had 45 beds it was required to have nine full time registered nurses or the equivalent of 360 hours per week of registered nurse hours or 1.14 hours per resident per day (Whitehead, 2010, p.19).

With the introduction of certification, facilities have been able to develop their own staffing rationale provided that they meet the requirements in the ‘Aged Related Residential Care Service Provider Agreement’ of a registered nurse on duty at all times if hospital based care is provided, 168 hours per week or 0.5 hours per resident per day for the same 45 bed high dependency facility (Whitehead, 2010, p.19).

Following concerns by a number of staff and consumer organisations the Ministry of Health published staffing recommendations in the The New Zealand Handbook: Minimum Indicators for Safe Aged-care and Dementia-care for New Zealand Consumers. It recommends a registered nurse on duty at all times if the facility provides hospital level care and a minimum of 1.14 hours per resident per day.
increasing to two hours per resident per day when levels of acuity amongst residents is high (Standards New Zealand, 2005).

The guidelines recommend that for rest home level care, 1.7 hours of caregiver time and 0.3 hours of registered nurse time per resident per day. Dementia patients should have two hours of caregiver and 0.5 hours of registered nurse time, and hospital level residents should have 2.4 hours of caregiver and one hour of registered nurse time, with a nurse to be on duty 24/7.

However, these minimum levels are voluntary guidelines only – and we were told at meetings all around New Zealand that these minimum recommended levels are not being met.

One nurse told us the rest home she worked in was “constantly” short-staffed.

Nurses are expected to do back to back shifts and sometimes work 16 hour days. We rely on lots of agency nurses so staff are constantly changing. When we are severely short staffed it becomes unsafe for residents.

A nurse in Palmerston North told us she was responsible on a routine basis for 63 residents, 30 in a residential home, and 33 in villas. A Christchurch nurse told us there were five staff at the home she worked in, looking after 80 residents. Family members told us that there were four caregivers on duty looking after 98 people in a Tauranga rest home. At nights, we were told staff levels are significantly reduced. One caregiver said she was the only staff member on duty at nights, looking after 38 residents. A Dunedin caregiver told us there were two caregivers on duty at night in the home she worked in, looking after 75 residents. A Nelson caregiver told us there was just one nurse and one carer on duty looking after 80 residents at night.

Growing inequity in the provision of aged care

According to the Thornton Review, “there is a gap in New Zealand in the provision of supported housing for the low income elderly. Retirement villages meet this need for those with the financial means” (p.11).

Forty three percent of facilities surveyed for the Thornton Review charged extra fees to some residents (including 58% of those built in the past decade) for superior accommodation standards (p.40).

The extent of part charging suggests that a growing gap in aged care is emerging between those with the income to pay for higher quality services, and those who cannot afford the expense. While this type of service model may be “financially favourable to operators” (p.40), it is creating a two tiered system of care where those people with the means to make private contributions towards their accommodation and services receive a better quality service, than those who cannot afford the expense.

This disturbing and inequitable trend needs to be addressed.

Ageing in place

The ageing process should no longer be viewed as an inevitable economic and social isolation from the rest of the community. (OECD 2003:173).

According to Judith Davey’s research paper (2006), internationally, it is increasingly accepted that traditional institutional care that keeps older people apart and ‘medicalises’ old age is no longer desirable and perpetuates a negative view of ageing (p.1). Most OECD countries are committed to reducing the number of people living in institutions (OECD 2003:11). In 1994, the health and social policy ministers of OECD countries reached an agreement on the overall objective of policies for the care of frail older people:

Elderly people, including those in need of care and support should, wherever possible, be enabled to continue living in their own homes, and where this is not possible, they should be enabled to live in a sheltered and supportive environment which is as close to their community as
Ageing in place recognises that older people will remain in the community, either in their family homes, or in supported accommodation of some type, rather than moving into aged residential care (Davey, 2006, p.2).

In New Zealand, policy statements promote ageing in place. The New Zealand Positive Ageing Strategy aims to encourage and assist older people to remain in their own homes, in order to enhance their sense of independence and self-reliance.

And the Health of Older People Strategy proposes an integrated approach to health and disability support services, which is responsive to varied and changing needs, supports older people remaining in their own homes, and reduces the need for institutional care (Davey, 2006, p.2).

In New Zealand a high proportion of people remain in their own homes until the end of their lives – though when they do go into rest homes or hospital level care, they do so with more complex healthcare needs than in the past.

Home based support services
According to recent statistics from the Health Minister around 75,000 people receive home support at some time each year – and around 15,000 people come on, and 15,000 go off home support each year. As more and more people choose to stay in their homes longer, the quality of in-home services becomes a growing and important issue where, according to the Health and Disability Commissioner, there “is no formal supervision or external regulation.”

Funding
District Health Boards fund residential care for older New Zealanders who are entitled to a subsidy. Residential aged care facilities that provide care for people who are entitled to a subsidy enter into an Age Care Contract with their local District Health Board. The contract is the same nationally, but the way it is monitored varies locally.

This year, aged care hardly featured in budget increases with just 1.73% going into residential care, following last year’s cuts to home support services.

According to the OECD Social Expenditure Database (SOCX), spending on old age in New Zealand (which comprises pensions, early retirement pensions, home-help and residential services for the elderly) has steadily reduced from 5.2% of the GDP in 1998 to 4.2% in 2005. This is below the OECD average of 7.0% for 2005, as well as Australia’s 4.4%, the UK’s 6.1% or the US’s 5.3%.

Cultural considerations
According to Age Concern New Zealand, the culture you identify with may influence your experience of ageing. As older New Zealanders become more ethnically diverse, there is a growing need to develop more culturally appropriate environments and improved language services. This also affects issues around family carers who, traditionally, are more prevalent in older Māori, Pacific Island and Chinese families than in Pakeha.

In the future, there will be greater numbers of older Māori and they will make up a larger proportion of the Māori population. The Māori population is ageing at a faster rate, but at a later time, than the non-Māori population with the number of Māori aged 65+ expected to grow by around 5% per year to 32,100 in 2011 (Age Concern website). The older Pacific population is increasing and is expected to be 11 times its current size by the middle of this century. This population is predominantly urban, with two-thirds in Auckland and the second largest concentration in Wellington (Age Concern website).

Chinese peoples began migrating to New Zealand over 130 years ago and they are currently the largest minority group after Māori and Pacific peoples. Chinese children
are expected to look after their parents (Age Concern website) – as is often the case with Māori and Pasifika families too.

**Future cultural challenges**

Many older Pacific and Chinese people experience language, transport and cost barriers in trying to access health care services. There is often a lack of information on services available. Older Pacific people may also find services culturally inappropriate. There is also a disproportionate level of chronic or degenerative diseases amongst these ethnic groups. Opportunities for positive ageing will also be restricted by lower incomes.

Not all Pacific Islands populations are eligible for retirement pensions in New Zealand and may therefore be fully dependent on family for income support.

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**Case study**

When Doug’s* beloved wife of 48 years, Joan*, started behaving out of character, he became concerned. All his worst fears were confirmed over the coming months as her health continued to deteriorate, finally being diagnosed with Alzheimer’s two years later.

“We were in the garden, it was a Saturday and I remember asking her for a cup of tea. Usually, she would say something smart, like ‘what did your last slave die of?’ or make a joke, but she didn’t say anything. She just went inside and came back with a bag of potatoes. I laughed and reminded her about the cup of tea, and she went inside and brought back another bag.”

Once diagnosed, Doug began caring for his wife at home, until the emotional and physical strain of providing around-the-clock care (as well as trying to run his own company) took its toll on his health. Doug says the home based support was inadequate, and he struggled to keep his wife safe at home as her condition worsened.

“She was incontinent by this time, so I would lift her out of bed every morning and peel off her nightgown. Then I’d roll up the bedding and do the washing, shower her – I’d have to get in with her – and it would be the same every day. The women (caregivers) who came never did any of the showering or washing.

“Our home – a house which we loved and had shared together for 16 years – suddenly was completely inappropriate. There were so many escape routes and I couldn’t keep her safe. So we moved to another house with minimal gardens and that you had to use a key to get out. But on one occasion, I was distracted for a couple of minutes and somehow she got out and had already covered a mile before I found her.

She was given no exercise or stimulation and, within months, had lost her ability to walk, talk and feed herself.

“It was hard. But it was my children who convinced me in the end. They said looking after Mum is killing you.”

After three years of caring for his wife at home, Joan went into residential care where she experienced some of the very worst levels of care available.

In the first rest home, Joan was raped by another male resident. Shocked and helpless, Doug took his wife home and reported the rape to the Health and Disability Commissioner, the DHB and the Police. While the DHB removed the resident from the facility, the Police decided they could not prosecute, because the resident was unable to give evidence in his defence. Doug was later forced to move his wife into another facility after the rest home manager decided Joan was too much “temptation” for other residents.

While rape is the most distressing on a long list of complaints, the other issues are still significant. Joan was prescribed inappropriate levels of antipsychotic medication at one facility despite Doug’s concern about the effect it was having on her, while at the second facility, she was given no exercise or stimulation and, within months, had lost her ability to walk, talk and feed herself.

Doug can also catalogue other incidents at the second rest home, where he witnessed a dementia patient left for an hour on the floor after falling, or another dementia patient shivering in a thin night dress. On both occasions, Doug called for caregiver support, but was ignored.

While he is much happier with his wife’s current facility, which he visits at least once a day, he believes current auditing practices are completely ineffective in giving a true picture of a facility – and that, as a general rule, residents are not given enough stimulation.

“If you don’t use it, you lose it. And Joan is definitely losing it.

“Somewhere between 5.30pm and 7.30pm, she’s sent to bed, and she’s usually up and dressed around 9.30am. That’s a long time to be in bed. I asked if she could stay up and finish watching her programme that she used to enjoy, but the caregiver said she was tired. But she’s not tired, she’s bloody bored.”

*Names have been changed.
Every older New Zealander deserves to be treated with dignity and respect.
6: Areas of concern

6.1: The residents

A residential care facility is a person’s home. While this may seem a very basic principle, it is one which is frequently overlooked. The individual needs and preferences of an older person are often denied in favour of organisational expediency.

Age Concern New Zealand, 2010, p.8

Overview

Older New Zealanders living in aged residential care are some of our most vulnerable citizens, and many receive substandard care. As Age Concern points out: “Older people living in residential care facilities are vulnerable to abuse and neglect. Many have nobody to protect their interests.” (Briefing to the Minister for Senior Citizens, 2010). Submissions received for this investigation reveal details about the severe deterioration of husbands, wives, mothers, fathers or friends, after they went into residential care. We were told that many go into these facilities independently mobile and continent and in a matter of months, are unable to walk, are incontinent and have all but lost the ability to make even the most basic decisions. “If you don’t use it, it’s gone,” said one family member about his wife. “They have all these posters around the rest home saying that kind of thing, and yet, they don’t let her make even the most basic decisions for herself.”

Some submitters told us it appeared that residents had no rights in many homes, and that everything was based around the organisation’s needs, not the needs of residents. “They are not allowed to have a meal in their own room, even if they request it, and they are often forced out of bed very early in the morning, even if they would like to stay in bed much longer.” (Submission).

The Acting Health and Disability Commissioner pointed out in her submission:

In my view, improving the standard of care provided to older New Zealanders will require the aged care sector more readily accepting a broader consumer-centred approach to the provision of care. Consumer-centred care requires those providing the care to offer opportunities for consumer input, where practicable, and family/whānau involvement and support so that wherever possible the care experience reflects a partnership model.

We believe the submissions we received and the complaints we heard are just the tip of the iceberg. Many meeting attendees and those providing written submissions did not want to be named for fear of retribution in either the care they received or their career progression. Frankly, it’s time we gave these individuals a voice.

Mental health of residents

Chronic loneliness is a health problem – and many older New Zealanders are chronically lonely. Despite the potential for more social interaction in residential care, many individuals find the sudden loss of independence distressing and, combined with deteriorating health, can lead to high rates of clinical depression.

1 It is widely recognised that there are high rates of depression in nursing homes, as is evidenced in several international studies.
Some spouses are amazing – visiting twice a day, every day, despite their own failing health, come rain or shine. But there are people at the other end of the spectrum. No one comes to visit them. They’re completely alone.

Registered Nurse

Some submitters were upset at the lack of kindness and sensitivity shown to their family member which, they said, contributed to the resident’s loneliness and even depression.

My father has dementia and he was told that he had to eat on his own because his eating would upset others if they had to sit at the table with him. And if he attended quiz sessions, he was told not to answer the questions – even though he had been a teacher and is a very intelligent man.

Submission

Basic cares

Many of the submissions and meeting attendees spoke about the marked deterioration of family members or friends who had gone into rest homes. Some staff spoke publicly about their concern at the rationing of continence products for residents – which sometimes meant that residents had to sit in the same pad all day. Other staff said continence products were sometimes overused because there wasn’t enough time to toilet every resident regularly.

As one Enrolled Nurse put it:

Incontinence pads are mainly used to negate the need for the staff numbers required to carry out regular toileting needed to (in some cases) restore continence. They are strapped on, and mostly, left on for hours. For some, they actually promote continued incontinence.

Submission

Lack of regular toileting, or being left in wet incontinence pads, can result in urinary tract infections.

Basic showering and washing seems to be inconsistent – submissions mentioned limited showers – two to three times each week – while a recent widely publicised Health and Disability Commissioner report revealed a resident who had not been showered for a year.

This rest home only gives me two showers a week. I sneak in for another when I can...When the staff are changing shifts nobody answers the bell for about half an hour.

Resident submission

Substandard nutrition and dehydration was also a major issue raised by many submitters, with drinks or meals, many unappetising at best, taken away untouched because staff haven’t had the time to encourage a resident to eat or drink more.

Not enough staff. Have to feed patients one at a time. One each side. Hurry patients to eat as no time to spare.

Submission

As one submitter wrote in:

We question the appropriateness and quality of much of the food that was served, especially the evening meals. Correct nutrition is essential for elderly people who suffer from many digestive disorders and swallowing difficulties. This is an incredibly basic need and could be so easily rectified.

Submission

Oral health, too, seems to be an area many rest home staff do not have the time or capacity to attend to well. Age Concern say health officials have assured them that oral care must be provided in rest homes, but that this is not always happening.
A 2004 study of rest home residents in Christchurch found that even apparently simple preventive measures such as cleaning teeth and dentures are not carried out effectively by older people or their carers. This can have serious consequences for a resident’s general health.

Overall, a major theme in the submissions was that staff are stretched to the point where they cannot provide high quality care—or in many cases, even basic care.

*The discrepancy between patient needs and available workers is very obvious everywhere. When family are available to monitor their family member’s care, it does improve. Theft can be a major problem.*

Submission

Some submitters said family members in residential care had had their bells and buzzers taken away, which was a serious safety risk, particularly for immobile residents who were unable to call for assistance in the event of an emergency. Even when bells were in reach, many complained that the delay in answering them was often prolonged. “We experienced delay times of up to 49 minutes in critical situations, even where the ringing of the bell was followed up with verbal requests for assistance.” (Submission).

One submitter said that whenever they complained about the quality of care—for example that their mother was entitled to only two showers a week—they were simply told “we are not funded to provide for more than that.”

The Health and Disability Code stipulates that all consumers are to be treated with respect and receive services in a manner that has regard for their dignity, privacy and independence. Yet many submitters complained about the lack of compassion and respect towards family members and residents. As one submitter put it:

> *We experienced at first hand an inexcusable lack of compassion and care for another human being. At a time that Mum was in a distressed and fearful state at night, she requested morphine to relieve her extreme shortness of breath. The nurse provided the morphine, watched her take it, and then walked out of the room without a single word of reassurance, care or compassion for a lady terrified of dying alone at night.*

Changes in levels of care

The 2008 OPAL study found that dependency levels of people living in rest homes and private hospitals in Auckland have increased significantly over the past 20 years. Twenty years ago 36% were assessed as high dependency. Ten years ago this figure had risen to 52%—while in 2008, 56% of residents had high dependency needs.

These rising acuity levels result in a significant increase in staff workloads and there is an urgent need for more qualified and experienced nurses across the sector. As a recent Australian study revealed (Access Economics for National Seniors Australia, 2010), there is a direct correlation between the number of nurses working in a home, and patient health, well-being and satisfaction. The evidence indicates that positive outcomes for residents in aged care facilities are directly related to the quality and quantity of care. Other studies suggest that half an hour of regular nursing care a day could dramatically decrease urinary tract infections, pressure sores and other common medical conditions. (Horn, S., Buerhaus, P., Bergstrom, N., and Smout, R., 2005)

Restraint use

Despite residents’ increasingly complex needs, nurses and caregivers are expected to perform the same duties in the same time frames. One way of coping with this heavier workload is to increase the use of restraints, which are widely used across the sector. An expert working in the industry estimates that on average 22% of residents in hospitals are tied to beds or chairs for hours on end—or are placed in beds with restraint rails so the resident cannot get out of bed.

Other studies suggest that half an hour of regular nursing care a day could dramatically decrease urinary tract infections, pressure sores and other common medical conditions.
In March 2004, Matt*, the then manager of a 180 bed retirement village began writing a letter to the Government expressing his growing concerns about the “silent epidemic” occurring in the aged care long term hospital, residential and dementia services.

Feeling demoralised by ‘certification’ and its new auditing processes that he had hoped would support his work and hold providers accountable for achieving care outcomes, Matt ended up leaving the industry.

“The historical issues that are regarded as innate and acceptable in the aged care sector are not,” he says.

“From a basic human rights perspective our older people are subjected, by care providers, to starvation (weight loss); grievous bodily harm (bed sores, wounds, skin tears); violation for convenience (use of suppositories, enemas). In any other setting these would be described as no less than deliberate criminal acts.”

The prevalence of these is not captured or reported. Matt says. “These are the areas on which audits should focus and report. These consumers do not exit the service, and so are unable to pursue accountability after the fact. The simple act of reporting on these very fundamental areas is sufficient to address them.”

Matt, who began working in the aged care industry in rehabilitation services, went into rest home management in the late 90s. He initially began work in a “dysfunctional 34-bed hospital, 20 bed dementia and 26-bed residential service,” run by a not-for-profit provider.

During the five years spent managing facilities, Matt was not required to provide care outcome information (results) to anyone. The only information ever sought was that of occupancy rates, finances and compliance.

To be skilled at shutting down complaints was viewed by the provider as essential, as was ensuring that compliance paperwork and systems were in place. However, these had no measurable impact on resident care.

“The task of identifying, addressing and being supported to improve care outcomes for clients was ultimately a lone endeavour. While the solution was very simple, the implementation was not, as this required having to address a change in culture at all levels, without the required recognition, supporting mandates and frameworks in place,” Matt says.

At the time he began, the facility suffered from a reputation typical for aged care facilities within the community, with complaints of resident neglect, as well as staffing and occupancy issues.

“The staff and care culture was of great concern. I think there was complacency in a ‘crisis mode’ of operation. The good staff left, we had a 17% staff turnover and I thought, it doesn’t need to be this way.

“This way of working is historical to the sector yet is easily fixed with a refocus. In the hospital area by doing something as simple as concentrating on toileting, nutrition and hydration and ensuring these activities happened and were measured – we made huge impacts on individual resident care outcomes. Significant financial savings were made, but by default. Staff turnover decreased to <3%. The provider built an additional 26 beds to total a 60 bed service.

“In the dementia area, I identified that a cognitive care model was required and worked on creating an environment that was calm and met the care needs of the residents. When I first arrived, the dementia unit was at half occupancy and had weekly care complaints. The staff were focused on running the area and not on the residents care needs. I changed that.

“In any other setting these would be described as no less than deliberate criminal acts.”

“This included care staff being given responsibility to run activities – there was a 700% increase in these – and every resident being involved at their level in every activity. Within a year, the dementia unit was full with a waiting list and weekly care concerns had reduced to nil. There were average resident weight gains of 10 kilograms. Based on this performance, the provider built additional beds doubling its dementia service capacity from 20 beds to 40.”

Matt says the sector needs an agreed definition of ‘care’ which is informed by the expectation of consumers and the public. Service agreements and contracts would then be required to translate this definition to that of expected ‘care outcomes’ within each service area. Additionally, these outcomes would subsequently inform any audit tool or function.

Further, Matt believes the auditing process needs an overhaul to support the focus on, and importance of, the achievement of care outcomes. This might include a centralised audit infrastructure similar to pre-2002, and a tool based on care outcomes, in sharp contrast to the current compliance focus. This would ensure that staff and providers have accountability and clearer expectations for tracking and achieving care outcomes.

He believes the governance level of provider organisations needs accountability for achieving care outcomes, in addition to that of financial outcomes. Support and mandates from the top of an organisation impact culture change, as well as results at the bedside. No model focused on staff training will change care results if they are expected to be driven and achieved by the floor staff.

“Since 2000, we have been aware the ageing demographic is coming like a tidal wave,” Matt says.

“We need the registered nursing profession to embrace its own professional first principles and preventative approach to practice. The apparent need of registered nurses to be ‘pseudo medical practitioners’ in order to feel valued is costing the sector and the country dearly.”

*Names have been changed.
Overprescribing medication

According to the Thornton Review, we are prescribing medication more often to our elderly than our overseas counterparts. In fact, prescription drug usage is 42% higher in aged care than an international benchmark (p.129).

More concerning still is that an estimated 30% of residents in aged care homes are on antipsychotic drugs, according to surveys carried out by Bupa in their own facilities.

Many submitters raised concerns about overprescribing antipsychotic medication to residents, because of the significant side effects of the drugs, including hypotension, lethargy, impotence, seizures, intense dreams or nightmares, dystonias and parkinsonism (rigidity and tremor), amongst others.

Some complained that residents are put on anti-psychotic medication to sedate residents and make them more manageable, or as a form of medical restraint.

As one concerned daughter put it:

“I feel that overprescribing of drugs to the vulnerable such as Loxapine (anti psychotic drug) to the vulnerable elderly such as in my late mother’s case should be reported to the Human Rights Commission. This incident definitely contributed at age 84 years to hastening her death in November 1993 in a rest home...overprescribing needlessly to make the already confused client more manageable for the understaffed workplaces.”

Submission

Bupa says medication safety and antipsychotic medication usage are “particular areas of concern which we are doing significant work on and we believe are sector wide issues which everyone would do well to focus on.” Bupa has moved to robotic or electronic dispensing technology to save staff time and reduce dispensing errors.

Another concern, highlighted by the Nurses Organisation, is that untrained caregivers are often giving out medication to residents. As one caregiver explained in a submission, “I give out the medication for 46 residents, including signing for and giving morphine. Why should people like me do this for $13.26 an hour. And who would look after our elderly if people like us didn’t do it?” (Submission).

Rising rates of dementia

Around 60% of residents in aged care facilities have moderate to severe dementia.

This figure, from Bupa’s surveys, is supported by international research showing the rapidly rising rates of dementia worldwide, with the Thornton Review estimating an additional 250 dementia beds needed every year (Grant Thornton New Zealand, 2010, p.91).

Currently, dementia units catering for stage three dementia patients have approximately 350 nurses and 1400 caregivers working in the area (Grant Thornton New Zealand, 2010, p.114). The units are locked to keep potentially wandering residents inside, are generally segregated from other aged residential care settings, and have specialist trained staff.

However, we have been told that these units are often not staffed appropriately – and that many staff do not have the appropriate level of training. We were told there is also a serious shortage of trained dementia staff and dementia beds around the country and that when there is a shortage of beds, patients with acute dementia are sometimes kept in residential or hospital care, rather than in the specially equipped dementia units. This can be disruptive for other residents and result in inadequate care for the dementia patient.

The appropriateness of dementia level care services, particularly for rising rates of younger adults with early onset dementia, will become a major issue in the future.
A National Dementia Strategy 2010-2015, launched earlier this year, comprising eight strategic goals, goes some way to tackling this issue. But we believe dementia level care services in New Zealand need to be overhauled and significant resource given to developing a higher quality service.

Gaps in visiting and elder abuse services

Many residents who do not have nearby family members or other visitors can be isolated and lonely in aged care facilities.

Age Concern New Zealand runs an Accredited Visiting Service to provide visitors to people who experience loneliness due to having little or no contact from family or friends. They say regular visits from people outside rest homes offer not only friendship, but also a third party supporting the older person, and may also act as a protective factor for abuse or neglect. When they surveyed people living in residential care facilities in Otago, and asked them to record their daily social contacts, one resident said “other than my visitor (from Age Concern) no one else really came to my room that was worthwhile counting.” He described the volunteer visit as the highlight of his week. (Briefing to the Minister for Senior Citizens, 2010, p. 16).

However gaps in visiting services exist throughout the country. Gaps in elder abuse and neglect prevention services also exist. Currently there are 24 specialist NGOs working in this area, but gaps in coverage exist in Northland, Rodney, Thames-Coromandel, Whakatane and Opotiki, Rotorua, Marlborough and Ashburton.

End of life care

As people are living longer with advancing disease, the numbers of elderly people with complex palliative care needs is increasing. In many parts of the country, there are no designated long term care facilities for the younger population and those under 65 with often complex palliative care needs are frequently cared for in age care facilities. This can, at times, place extra burden on the facilities which are intended for care of the elderly (Palliative Care Nurses New Zealand Society submission).

Within aged care facilities (and the community) there is a shortage of suitably trained and experienced care staff and nurses to provide adequate care for people with complex needs or who are dying. Palliative care advanced nursing roles – and clear career pathways – need to be established.

As one daughter, who was horrified by the end of life care her mother received in a rest home, puts it:

> It is about the patient being ensured adequate care and pain control, especially in cases of cancer. Towards the end stages of cancer, the agony and suffering can become unbearable for both the patient and the family if the patient is left unmedicated and unsupported.

> The level and availability of hospice care is very different from region to region. In some regions, patients over 65 may be placed in rest homes for terminal cancer care. Especially in smaller towns and rural areas, where there is no readily available back-up ‘nurse bank/agency’ support, this may leave patients without monitoring and adequate pain control.

> In a rest home, my mother (who was dying of bowel cancer) was on many occasions left in considerable pain and at times in agony because there was no nurse available, especially at night, to administer restricted medications such as morphine. Despite my best assertive efforts around quality of her care, and the level of her distress and suffering, I was unable to have the individuals and systems respond appropriately...

> For myself, while have deep gratitude towards all of those who were lovely towards my mother, I feel that much of what happened was totally inhumane and disgraceful, and my wish is to prevent others having to walk a similar path. I feel abused in two ways: the suffering at the time could have been prevented by adequate systems; and there is a legacy of pain remaining at the core of my being, despite my best efforts to heal.

Submission
6.2: The workforce

Caregivers must be trained to look beyond the face ravaged by time and care, beyond the body devastated by illness, childbearing and deprivation... Past the elderly Dutch man aggressive and angry... Past the snappy old woman... Past the stricken man who has lost control of his bowel and bladder... to the person they once were who survived all of these things by sheer fortitude.

A caregiver can be trained in a very short time to strap on a plastic brief, change a bed, thrust a spoon full of mush into a mouth and soap and shower a patient. It takes time and persistence to enlighten them to the emotional well being of a human being.

Registered Nurse

Overview

There is an acute shortage of nurses working in aged care, and, as a result, about 90% of the care in rest homes is provided by caregivers – or Health Care Assistants (HCAs). But caregivers are a completely unregulated workforce, with no regulatory professional body, and there is no minimum training or qualifications needed to work in a rest home or home based support services. Some walk straight off the street with no training or prior experience of working with older New Zealanders.

Caregivers are predominantly female, and are one of the lowest paid workforces in New Zealand. The average pay rate is $14.40 an hour, but many receive the minimum wage ($12.75 an hour) for highly demanding (physical, mental and emotional) work. We spoke to caregivers who were still on the minimum wage, even after working for 13 years in a facility.

As one caregiver wrote: “in terms of quality of care in aged care, you get what you pay for. If wages are grossly low, then the care will be of that quality.” (Submission).

The pressures and issues facing the aged care workforce have long been publicised by the sector. In addition, the Health and Disability Commissioner has highlighted many cases of substandard care and neglect at the hands of rest home staff over the past five years, while other high profile media cases and academic studies have revealed a workforce fast approaching crisis point.

Largely untrained, unregulated, overworked and underpaid, the estimated 33,000 strong residential aged care staff – along with the thousands working in home based support – face major issues every day because of a culture they believe places little value on their work.

Some caregivers in residential facilities argue that the so-called individualised care plans for residents are a “joke” – many workers have no time to give the kind of care they know the elderly deserve because of chronic staff shortages resulting in massive time pressures.

The vast majority of this workforce do the job because they are passionate about caring for their elderly residents and believe the work they do makes a difference.

Union members have... spoken of their frustration at having too little time to care for too many residents and clients. They have shared the pressures of the job, the constant demands and the extra-ordinary range of roles they undertake caring for the elderly. They have told you of their aspirations for themselves, the residents and families. And they have so often put the needs of residents and clients ahead of their own needs and those of their families.

What is extra-ordinary about those stories is that they are common place. They are the experiences of thousands of caring, undervalued and incredibly hard working women and men.

Service and Food Workers Union (SFWU) submission, July 2010
We have a duty to ensure that no one suffers from neglect or abuse.
When a rest home is acutely short staffed there is no time for the “extras” – like helping a resident finish their cup of tea or choose what to wear, cleaning teeth properly, or indeed, conducting any of the everyday cares at a resident’s pace. A number of caregivers told us they were advised by managers not to talk to residents, because it was not in their job description and anyway there was simply not enough time to carry out even the most functional chores.

As a result of staff shortages, residents are often rushed through meal times, showering or getting dressed. They are sometimes woken up before 7am, washed, dressed and given breakfast because the facility demands that night shift staff get things moving. They may be left in incontinence pads because there is no time to toilet each resident — and in some facilities there is a ration on how many products per resident are used. They may be positioned in a seat in front of the television and left there all day until bed time.

The care of older adults is a specialised area, and needs a high skill level — both in residential care facilities and in the home. Yet many of this vulnerable group are being looked after by the least qualified health care workers, many of whom are performing tasks far outside their skill or knowledge base, without adequate supervision or guidance.

Caregivers working in aged care have a much greater role in the provision of direct care and support for residents than those who work in public hospitals in District Health Boards — and yet they are paid considerably less.

Similarly, nurses working in aged care typically have greater responsibility than nurses working in public hospitals, and lack the onsite support from doctors and pharmacists. Yet they are also paid considerably less in most facilities. They do not receive the same penal rates as DHB nurses, and this has a significant impact on wage rates.

Staff, residents and family members alike are calling for an urgent regulation of the sector — with increased and specialist staff training, a logical career progression with qualifications acknowledged and remunerated appropriately, and regulations around staff-resident ratios. Many argue that there needs to be advanced nursing roles within gerontology and within palliative care, including Clinical Nurse Specialists, and Nurse Practitioners.

Health Care Assistants (HCAs) — caregivers

Lack of training

In residential care, older people are primarily cared for by healthcare assistants (nurse aides, nurse assistants, caregivers) — less than 25% of whom have vocational qualifications, thus confirming the belief...that healthcare assistants are essentially untrained personnel reliant on the employer to provide training and professional supervision.

Smith, B., Kerse, N. & Parsons, M., 2005, p.1

Currently, there are no minimum requirements around staff training levels within residential care — except for staff working in dementia care. The Food and Service Workers union (the SFWU) estimates that only about 20% of caregivers have any training or qualifications. They say that of the training and qualifications that are available (through the New Zealand Qualifications Authority (NZQA) and Careforce, the community support services industry training organisation), employer take-up is limited and “all too often, programme completion rates have been abysmal.”

As one caregiver asked: “Why is caring for the elderly with complex needs considered to be an untrained occupation?”

Bupa estimates 40% of their workers have passed or are enrolled in NZQA level three courses — and within those facilities, in-house core education training is conducted. But in many facilities the training is minimal and can amount to little more, according to some caregivers, than “a quick walk around with the nurse.”
NZNO claims that even the minimal existing requirements for staff training for staff working in dementia units are frequently not met, an omission not always picked up in audits and which can remain unresolved for extended periods, sometimes even over successive surveillance audits.

An NZNO survey of 1000 of their 5000 caregiver members assessed the training and work undertaken by caregivers, and their perceptions of the role and the issues they face. In spite of previous reports highlighting low levels of literacy and training in aged care, the survey found that many caregivers had undertaken a number of modules and courses related to their work. However, unease remained over the variable quality of training, lack of standard accreditation and, particularly, confusion around routine clinical tasks requiring the expertise of a Registered Nurse and those relating to personal care.

Both the NZNO and the SFWU want mandated minimum qualifications with at least a Level 2 National Certificate being required within six months of entering the workforce – in both residential and home based support services. They say providers should also be required to agree to provide training for support and ancillary staff.

But the New Zealand Aged Care Association, representing providers, argues that training needs to be recognised (and thus supported) by providers. It argues that the current Industry Training Organisation, Careerforce, is not employer-led and that is why it is not supported by many providers: “Once this issue is addressed, then training and support for the sector will improve.” (New Zealand Aged Care Association submission, July 2010).

However, the Nurses Organisation argues that the current training regime is recognised and supported by many large and small employers, such as Bupa and Presbyterian Support.

Unregulated

Healthcare assistants work without the obligation imposed by registration or enrolment, without a professional code of ethics, and without professional codes of practice enforced in courts of law. It is also a low-income workforce, and a significant number in the Auckland region have English as a second language.

Smith, B., Kerse, N. & Parsons, M., 2005, p.1

Currently, rest homes are not required to meet mandatory staffing levels and, according to the Nurses Union, even the minimum levels outlined in the New Zealand Standards Handbook Minimum Indicators for Safe Aged-care and Dementia -care for New Zealand Consumers (2005) are neither monitored nor universally attained. While these minimum levels are voluntary, they establish guidelines around what are appropriate staff levels.

High profile failures around inadequately trained staffing levels have featured in cases such as Winifred Clements, who bled to death at a rest home after not receiving first aid. The Coroner’s Report at the time (McElrea, 2006) highlighted the fact that there was no requirement for nurses to be present in a rest home, nor for caregivers to be formerly trained in anything other than dementia care, and specifically called on the Ministry of Health to include a requirements in the Age Related Residential Care (ARRC) Agreements (the agreement between District Health Boards and residential care facilities reviewed annually) to ensure an adequately trained caregiver was present on each shift.

While current auditing of rest homes ensures that providers meet certain standards around property compliance and managerial processes, there is an alarming lack of regulations for the 90% ² of staff who are not registered nurses.

Another concern raised by submitters was the lack of appropriate vetting of care staff. Submitters said many providers do not conduct police checks on caregivers – or indeed, vet prospective staff through other standard checks. Despite being responsible for a vulnerable group, many caregivers who have left a facility because of alleged

² According to the SFWU submission, July 2010. They say, across the wider care sector, this figure may be closer to 98%.
neglect or, even abuse, go on to work in another home.

Overworked

Many caregivers and nurses we spoke to pointed out that while workloads have increased significantly in recent years, as a result of having to care for increasingly frail residents, there hasn’t been any commensurate increase in staff hours or wages. The increase in workloads, combined with chronic staff shortages afflicting many facilities, means that most staff are overworked. As one nurse describes the situation:

The workload (especially in hospital and dementia care) is heavy and intensive. Registered nurses work loads are so high that they are unable to give caregivers the education, supervision and support necessary to maintain a good level of care for each patient. And the number of patients per caregiver simply do not allow consistently good care to be given.

Submission

According to another caregiver:

Everything boils down to the time allocated. As an experienced caregiver once told me; if you give two minutes extra time to one person and times that by 40 residents that’s one hour and 20 minutes, and we don’t have that time. Unfortunately those two minutes may be what counts in terms of decent care, and it is what many of them crave, as that is what makes them human. I try and give it as much as possible and am always late leaving work. It must break their hearts sometimes to try and engage with staff and be brushed off, sorry, I have to go.

Submission

Time pressures and high workloads often result in high stress levels, burn-out rates and mistakes. “It is almost never the fault of nurses or caregivers,” one caregiver wrote in. “We can only do the best in the time we have.” (Submission). And although owed holidays, many staff say they are unable to get the time off because there are no staff to cover their shifts. As one caregiver wrote in: “Being refused two days holidays on two occasions. I have 12 weeks holiday owing and but there is not enough staff to cover time off.” (Submission).

Further, staff can be moved (“borrowed”) between facilities – for example, a callout to a residential unit may leave the hospital short of a registered nurse – and there is no way of accounting for this.

And staffing levels are often halved at nights and at weekends, as many staff are reluctant to work during weekends because they are not paid proper penal rates.

Many caregivers told us they dread working weekend shifts because of the dangerous lack of staff. Some caregivers we spoke to told us that sometimes the only way to care for residents in weekends was to keep them in bed all day.

Some caregivers told us they are expected, in some facilities, to undertake cleaning, laundry and even kitchen work on top of their regular duties (when these jobs are cut to reduce the wage bill), and that this is an additional pressure on already overworked staff.

Staff-to-resident ratios

The Thornton Review acknowledged a “large variation in practice” for staff-resident ratios amongst providers (p.112). On average, it says nurse care for a rest home resident was just over two hours a week (p.110), with a variation from one to four hours per resident per week, while caregivers ranged from eight to 13 hours per resident per week (p.112).

But many nurses told us they were responsible for the care of as many as 60 patients on a shift, and this sometimes extended to the care of residents in retirement villas as well. Many said it was impossible to provide quality care with so few nurses and caregivers on duty, particularly on night shifts and at the weekends, when staff to
A Report into Aged Care

What does the future hold for older New Zealanders?

Patient ratios plummeted.

Age Concern says inadequate staffing is frequently cited as a cause in the cases of institutional abuse that are referred to their Elder Abuse and Neglect Prevention Services.

Caregivers performing nurses’ duties

As a rest home carer, I’m asked to perform duties which I consider to be the responsibility of a Registered Nurse ie. administering medication including insulin, taking observation of blood pressure and heart rate. All the while being paid my dismal pay just so the company don’t have to pay the Registered Nurse overtime rates to come in at night to do this task.

Caregiver

Because of the shortage of nurses working in aged care and a lack of clarity between regulated clinical staff (such as registered and enrolled nurses) and unregulated staff (healthcare assistants and caregivers), many poorly paid caregivers are asked to carry out tasks without adequate supervision, beyond their knowledge and skill.

A recent NZNO snapshot survey of caregivers working in residential aged care found that caregivers were frequently undertaking clinical tasks more appropriately performed by registered nurses, such as dispensing medication.

According to the survey, unregulated caregivers were frequently called upon to undertake nursing tasks. Medication was “very frequently” given out without clinical supervision and blood glucose monitoring and catheterisation are “frequently undertaken”.

Our investigation confirmed this. We spoke to many caregivers who were routinely giving out complex medication, such as insulin and morphine, largely because of an acute shortage of nursing staff at their facility.

Lack of career pathways

Caregivers are not only unregulated – caregiving is not recognised as a valid career profession or career path. There is no clear career pathway for caregivers, and staff are seldom given additional pay for increased qualifications or experience. Bupa and Oceania say they have put in place a career structure linked to pay, but most facilities have not. In most cases, if caregivers want to get training, they have to pay for it themselves and get little, if any, reward for their additional training. This means there is little incentive for caregivers to upskill.

As one caregiver explained:

I have my ACE badge and that entitles me to an extra 30 cents an hour which is ridiculous for all the work and knowledge that goes in to passing it. I am now doing my Nationals for another 30 cents an hour. This seems ludicrous for all the work and time that is spent achieving them.

Submission

Another caregiver said the only recognition she got for all the additional training she had undertaken was a name tag.

Wages

According to the New Zealand Aged Care Association, in the last five years, caregivers wages have gone up 25.6% (as at March 2010), while rest home level care funding has gone up 23% and “clearly, the way to improve wages is to improve funding of the aged residential care sector.”

However the Nurses Organisation disputes this. It says many caregivers have had no wage increase for more than 10 years and that, overall, wages have gone up by around 5% over the last five years.
KiwiCareers statistics show that health care assistants earned an average salary of $31,500 in rest homes in 2008 – lower than the $33,500 their counterparts earn in hospitals or $33,750 in the community. Contract wages range from $13 to $15 an hour.

As one caregiver put it:

Most of us carers get just over the minimum wage, so how are we supposed to keep up with today’s living? Everything else is going up. When I worked in retail I received a much higher wage but I decided I would like to look after the elderly. But many carers are talking of leaving because of the low wages, which is very sad as believe me it is a real art looking after our elderly. I challenge anyone in parliament to do this type of work for such little money. To me, it is like slavery, the only difference is we want the best for our elderly who have paid taxes all their lives and have paid their dues to our country.

Submission

High staff turnover

Current estimates for staff turnover across the sector are around 40-50% per annum, while the Thornton Review said just 50% of caregivers stay with an employer for more than four years (Grant Thornton New Zealand, 2010, p.108).

Add to that the high proportion of temporary staff provided by agencies that are used to cover staffing gaps, and it is clear that many facilities may have, at times, very few staff who are well informed about residents and their care plans.

Cost cutting

Many of our submissions gave examples of facilities introducing cost cutting measures – such as rationing of continence products, delaying seeking GP assistance especially outside working hours and the provision of nutritionally inadequate meals. Some expressed concern that managers sometimes overrode the decisions of nurses and caregivers for cost cutting reasons.

As one caregiver wrote in:

We are under threat from senior management that if we fail to adhere to each resident’s care plan in respect of incontinence products we will be charged for the difference in cost. We know that people have bad days and may need more products on some days. So we have to decide, do we leave Mrs Jones in wet or soiled pads because she has used her quota for the day, or not, for fear that we will have to wear the cost.

Submission

Other caregivers spoke publicly at some of our meetings about the rationing of incontinence pads, and the distress this caused them – and about their concern at the inadequacy of the meals offered at some facilities.

Migrant workforce

New Zealand does not have a formal scheme for caregiver migration. However, there has been a rapid and growing reliance on migrant caregivers in the aged care sector, particularly from the Philippines, over the last five years.

In the past, caregivers for the elderly from the Pacific formed a constant source of workers; however, in the last two years there has been a sudden rise in migrant caregivers for the elderly from the Philippines. In addition to this, while in the ten years between 1991 and 2001, overseas born caregivers for the elderly roughly made up 20% of the workforce, in 2006 the proportion increased to one quarter.

Badker, J., Callister, P., and Didham, R., 2009, p.1
According to a written submission, and discussions with migrant nurses, most are recruited by agents who may charge thousands of dollars to bring them to New Zealand. Nurses are often completely misinformed about conditions in New Zealand, and what work they will be expected to do. Many are not told that they will have to pass a difficult English language exam, and an eight week upskilling nursing course, before they will be eligible to work as a nurse in New Zealand, or that both of these are costly.

Once here, migrant nurses have little choice but to work where they are sent by their agents, as their wages are often channelled through agents, who are also the link to employers and their work permit immigration status.

Some have to work as many as 160 hours a fortnight, in order to repay the agents their initial costs.

Many nurses find the International English Language Testing System (IELTS) level 7 test difficult to pass, even after repeated attempts, so they end up working in the aged care sector, earning far less than they expected, and unable to keep up their clinical hours (necessary to maintain a valid nursing certificate). Many who have paid thousands of dollars to colleges and recruitment agencies in the hope of getting well paid jobs in public hospitals, find themselves trapped in low-paid care work.

Tiredness from working double shifts to pay onerous bonds, little knowledge about possible support systems lack of money, a feeling of hopelessness when they were hoping for a new start, all compound into a quiet human tragedy happening right in our neighbourhoods.

According to the submission, there are strong business links between recruiting agents, tertiary colleges and rest home employers. Courses in English language training and nursing upskilling have proliferated recently in polytechnics and private training enterprises. At the same time, concerns were raised that some nurses were undertaking aged care education (ACE) courses that were unnecessary for their work in rest homes (The Press, 2008).

Nurses

Recruitment and retention of staff

Recruitment and retention of good quality staff is difficult across the sector, largely due to a lack of pay parity with District Health Board employees. There is also a significant lack of advanced nursing roles within the aged care sector, meaning aged care nurses don’t have the same opportunity for career development or to progress to more advanced roles as staff working in public hospitals in District Health Boards.

The importance of advanced nursing roles – Clinical Nurse Specialists and Nurse Practitioners – within the Aged Care sector is recognised internationally and has begun to be recognised in New Zealand. However there are few pathways in place for this to occur, and funding for such positions is not readily available.

Chronic staff shortages

Poor wages, unmanageable workloads and the onus of professional responsibility under the Health Practitioners Competence Assurance (HPCA) Act keep many New Zealand nurses out of aged care. Nurses working in aged care usually practise in isolation, and there is a worrying trend for them to be over represented in the cases that are being referred to the Nursing Council for a competency review.

We were told that many nurses are reluctant to work in the sector because they know there are not enough staff to care properly for the residents they are professionally responsible for.

With the increasing acuity of residents in rest homes, more nurses need to be employed across the sector. There is also a need for more advanced roles such as Nurse Practitioners, with the ability to treat common problems such as urinary tract...
infections, or pneumonia, thus preventing hospital admissions or unnecessary distress for the frail elderly.

No time to conduct proper cares

Overwhelmingly, nurses said their work loads are so high that they are unable to give caregivers the education, supervision and support necessary to maintain the optimum level of care for each patient.

A nurse who had worked in aged care for 20 years said the time pressure and work burden routinely resulted in reduced cares such as:

- When they are lucky enough to be repositioned, residents are often hauled up by the shoulders.
- Residents get left after meals with the residue of food still on their face and hands
- Residents do not get toileted regularly, resulting in lost continence
- Dirty finger nails, crusty eyes and insufficient hydration
- Residents do not get walked regularly so lose their mobility
- Most residents lose the right to keep their own bed time simply because of staffing numbers.
- Have their tea go cold before it is taken away. (Registered Nurse).

These shortages of services were felt acutely by the family of a woman who died while in hospital level care at a residential facility.

On several occasions, it was found that Mum was alone positioned in her room with the resident call bell out of reach and the door shut. This is a serious safety issue eliminating any ability for the immobile resident to call for assistance should an emergency arise. In Mum’s condition she often needed morphine for relief of her acute episodes of shortness of breath, assistance with angina or the potential for assistance should she have a heart attack.

A Christchurch nurse told us:

I am required to do medications for 45-60 residents twice a day on my shift, as well as all the paper work. I don’t have time for anything else. There is no way I can supervise caregivers as well, because there’s just so much work to do, and there is simply no time left to do that.

Another pointed out: “We have five staff on duty looking after 80 people. How can we possibly provide a good quality of care?”

Pay parity with District Health Board staff

According to the NZNO, penal rates exist in some private aged care facilities where there is a collective agreement. However, there is enormous variation, because the aged care sector is fragmented (with over 700 facilities), and for the most part, not unionised. The variation in working conditions is compounded by the fluidity of the aged care sector. As facilities change hands, collective agreements may not persist. For the most part, registered nurses in aged care do not receive the same weekend and night shift rates as their DHB counterparts.

According to the Thornton Review, providers say they cannot compete with the total remuneration (including penal rates) offered by DHBs and have to employ a range of strategies, other than remuneration, to attract and retain nurses and caregivers. These included relying on overseas recruitment and training packages (p.117).

Night shift

Nurses and caregivers say night shifts and at weekends can be a vulnerable time for residents because there are often few staff rostered on, particularly trained nursing staff.

Many reported that staff numbers at weekends and nights are often half what they are
during weekdays, and as a result staff are even more pressured and run off their feet. We were told that staff are sometimes put straight on to night shifts immediately after they are hired, even though they had no experience or qualifications and have not even received basic orientation, such as evacuation procedures. Caregivers told us that because staff are reluctant to work at nights and on weekends (because of the lack of penal rates), some facilities rely on students, casual labour and sometimes even teenagers, to fill the gap.

**Shortages of GP services**

GP availability to aged care facilities is diminishing throughout the country, possibly a reflection of the shortage of GPs nationally. Many submitters spoke of the difficulties of getting a GP to visit a home, especially after hours. Some nurses told us they have to get permission from a manager before they are allowed to call a doctor and that some facilities delay calling GPs as a cost cutting measure.

While GPs may visit a facility for a regular time each week, many are reluctant to be called out to homes after hours and, as a result, residents are often sent to accident and emergency clinics instead. This is undoubtedly a contributing factor in the high numbers of residents from aged care facilities who end up being treated in emergency departments in hospitals each year (9,200).

Some submitters were concerned about the attitudes of some GPs to residents. One nurse described several incidents involving a GP speaking inappropriately in front of resident, unacceptable delays in responding to a patient’s needs, and the persistent refusal of a GP to reassess the pain relief provided to a cancer patient.

*The level of interest and cover after hours from GPs is highly variable. The various primary care reform processes have steadfastly ignored the vital relationship between general practise and aged residential care so there has been no policy push and no real medical professional leadership in this area nationally.*

Bupa submission, July 2010

Aged care is not integrated into the primary care strategy, which is exacerbating the problem. There is also a shortage of GPs and specialists who are trained in gerontology.

Age Concern recommend that access to medical services, including GPs, by residential facilities is reviewed and that District Health Boards be required to ensure the costs of GP access, in their agreements with rest homes.
Dianne* thinks she has seen the best and worst of residential aged care facilities.

As a Registered Nurse of more than 20 years working in rest homes here and in the United States, she has witnessed “rows and rows” of residents lined up along a long corridor and tied to wheelchairs.

That was the US – where she says it was “truly, truly bad” care, in the late 80s. But within months of people complaining about the care their family members were receiving, providers swung into action and began a rapid transformation of the sector.

“The restraints were suddenly gone and the places were totally cleaned up. Even by the early 1990s, the States were a long way ahead of where we are now in trying to develop ways to accommodate resident rights. Lip service is paid to the theory here, but a disturbing number of staff (from the manager down) don’t seem to get it.”

Dianne says the main issues here are caused by what she sees as a conflict of interest around the demands of cost cutting and driving profit with providing high quality care. This is evidenced in insufficient staffing levels and training, staff pay, and the overall institutionalised nature of facilities.

*Names have been changed.

Case study

“There is a constant conflict between individual rights and ‘greater good’ with the set, inflexible schedules of institutionalisation almost always winning out. I’m still astonished to see a 90-something-year-old whipped out of bed at 7 in the morning for breakfast – or by the night shift at 6.30am for a chosen few if they’re not able to complain.”

Dianne says the vital work conducted by aged care staff everyday needs to be appropriately recognised. Staff should be sufficiently trained and remunerated properly.

“The idea that the care needed by very frail elderly hospital-level residents can be classified as ‘unskilled’ should make anyone with ageing parents (or anyone who plans to get old themselves) worried. There are very specific skills needed to safely dress someone with severely contracted limbs without causing them harm. If more staff were trained, perhaps there wouldn’t be so many contracted in the first place. To help someone eat, when the person being fed can no longer reliably direct food to their stomach and not their lungs, needs more than just patience and a kind heart – there are techniques which should be taught.

“Training doesn’t just teach skills, it also gives recognition that the work they do is important. Some sort of certification should be mandatory. Staffing levels should be increased. When staffing levels are squeezed, they finish their day knowing they could or should have done a better job, but didn’t have the time. This is a huge cause of staff ‘burn-out’.

*Names have been changed.
As an audit is only a snapshot of a facility on any given day, we need to ensure that the audit gives a true picture of the facility.
6.3: The facilities

Everyday is the same – you have no choice but to be lined up along the wall in large chairs. The television is on, but you don’t actually have a good view from your seat in the corner. You have no control over whether or not you want to watch television let alone what programme to watch or how loud the sound is. If the television isn’t on, sometimes there is loud music coming from somewhere which you think the staff might enjoy, because you certainly don’t. Day after day...oh, until Thursdays, for bingo or crossword time. Then it is time for tea, “dear”.

Occupational Therapist describes life from a resident’s point of view.

Overview

While we were told about excellent care provided to residents or their family members, many submissions highlighted substandard care in aged care residential facilities. With no mandatory staffing levels or regulations around equipment or handling of residents, stories about inadequate staffing resulting in residents’ calls for help going unanswered, medication or diagnosis errors, and neglect, were all too common.

- Insufficient time to provide satisfactory care...left for hours with faeces on hand; left lying in wet bed; taken to dining room with wet clothing, (despite being told); not drying behind ears resulting in cracks and splits; left in bed for three hours without staff checking on him.

Submission

Submitters also raised about the lack of appropriate recreational programmes or social interaction in some facilities, and the need to create an environment in an aged care home which better reflects ordinary living patterns, rather than an institution.

- Having to wake and dress a resident at 6.30am and get another two up on to commode at 6.45. Breakfast taken out at 7.10am. A lot of 80 and 90 year olds would like to stay in bed until 8am at least. The manager arriving at work at 6.15 and following HCA (Health Care Assistance) to make sure these people were woken and got up. One resident had only slept half the night but still had to get up.

Caregiver

The Acting Health and Disability Commissioner pointed out in her submission, that improving the standard of care provided to older New Zealanders will require the aged care sector “more readily accepting a broader consumer-centred approach to the provision of care.”

By involving residents and their families/whanau in decision making, a facility would become more like the resident’s home and less like an ‘old people’s home’.

In his written submission to the inquiry, Dr Dwayne Crombie from Bupa Care Services points out that, while he believes overall the industry has improved considerably to what it was 10 to 15 years ago, it is now timely for a “national strategy on aged care, particularly for residential care.” Currently, there is no such strategy or policy on aged residential care.

The largest six providers provide around a third of the beds available nationally, but it is still a “cottage industry”, which means “there are probably more than 500 different entities in the sector and moving a large diverse group forward requires considerable energy and enthusiasm.”

Given our experience of aged residential care and in many cases also in the provision and funding of public health services, we can categorically say that the standard of aged residential care is significantly higher than it was 10 to 15 years ago. The evidence for this can be seen in the greater commitment to training of the non regulated workforce, improved gerontology skills and knowledge among nurses, much higher audit
standards, and information on a range of clinical quality indicators…

However there are still considerable opportunities to improve even further and there is still wide variability among care homes in their quality of care even though the group as a whole has improved.

There are no easy short term fixes to improving quality in the aged care sector. We have seen the sustained improvement in policy, implementation and funding that has flowed into the mental health sector from several major reviews, a commitment from the government, the establishment of the Mental Health Commission and development work by many providers over more than a decade.

While the state of aged care, and in particular aged residential care, is not as dire as mental health was, the approach adopted for mental health was a far more collaborative and enduring change. A style of approach we might at least think about in planning for the future.

Bupa submission, July 2010

Profit driven

*Human beings [are being] ‘warehoused’ often in wretched misery because they have, in effect, been ‘dumped’ in these warehouse boxes – where they sit depressed and lonely in a void of solitary meaninglessness…[it’s] ‘people farming’ for profit.*

Submission

As previously discussed, the departure of many Not for Profit organisations from the residential aged care sector and the buy up by multinational corporates has introduced what some see as a potential conflict of interest within the sector.

As a Registered Nurse said in her submission: “The aims of a rest home which is supposed to be a care based service, and a for-profit business, which is supposed to make money, are fundamentally opposed. A culture of care cannot survive in that kind of environment.”

Many submitters asked the question, how can companies striving to reduce costs and make a profit offer best practise care models?

*I frequently see cold food hurriedly being fed to some unfortunate patients, or worse, trays being removed untouched…Mealtimes should be a pleasure for patients. Rushing them is cruel and certainly not conducive to their well-being.*

Registered Nurse

Some caregivers and nurses told us they had to ‘fight for every penny’ because their manager was so focussed on trying to cut costs. A nurse said she was constantly told by management that other facilities were providing meals for $5 a resident, and asked why she couldn’t reduce the quality of meals so that they could be provided at the same price.

Age Concern says rest home proprietors need to ensure that their pursuit of profit doesn’t force managers to deprive residents of material essentials or the care they need. “This is elder abuse,” they say.

One submitter said ‘it is obscene that the elderly of New Zealand are seen as a source of profit.’

However Bupa says “whether a care home is proactive or not depends on the ethos, commitment and ability of the staff – not on whether they are part of a corporate group, a R&W or just stand alone”.

As Bupa Care Services, provide around 3060 beds – about 10% of the total occupied beds in the sector. This scale allows us to have a General Manager of Quality and Risk with a dedicated corporate team of 11 staff including a part time geriatrician and a team of mostly Registered Nurses which is exclusively dedicated to quality and clinical risk.
Funding

Some aged care providers are making substantial returns for their shareholders of 14 to 16%. Ryman posted a profit of $61 million last year. However, many submitters argued that there is a serious funding shortfall in the aged residential care sector and that providers who are making substantial profits are making them from retirement villas, not from running aged residential care facilities.

Bupa argued in its submission that current funding does not meet the current public expectation of services and facilities (and still allow providers to make a fair surplus and reinvest in capital and maintenance decisions), while the Selwyn Foundation says there are ongoing issues around under-funding in the sector. Presbyterian Support staff we spoke to said their organisation struggled financially, with about 60-70% of its budget going on wages. They said keeping high occupancy in homes was the key to financial viability, and that empty beds created funding difficulties.

We were told that some facilities lay off staff immediately, if their occupancy levels decline, and some experience difficulty hiring staff again when occupancy numbers increase.

One submitter pointed out that in a system with fixed costs for wages, lower staffing levels are one of the few options that can be used to generate profit – especially as there are no legally enforceable staff-to-resident ratios. However, the submitter said the inevitable result of reducing staffing levels will be continuously declining health outcomes for residents.

A small, independent provider who had sold her residential facility to a large provider told us that the new provider had immediately cut staff and reduced the wage bill to 50% of turnover – which she believed was too low to provide a decent quality of care.

A number of caregivers pointed out that while all facilities are funded on a per bed basis, subsidised and unsubsidised residents are all mixed together, and it was therefore not clear how providers ensured that taxpayer money going into subsidised care was not also going into the care of unsubsidised residents.

Another caregiver voiced her concern that:

> I have seen funding too often fall into the hands of the providers only to be then passed onto shareholders. What we are seeing are providers and shareholders getting higher returns and our elders getting less resources. This is happening more and more. Providers are not handing on funding and we are not getting the necessary equipment or resources to work with our frail elderly. Nor are we getting funding for education, where we often pay for our own.

Submission

However, the New Zealand Aged Care Association argues that the only way to improve staff wages is to improve funding. And it is certainly true that many smaller, often rural, rest homes have closed their doors because they cannot afford to keep running. In fact, according to the Thornton Review just 13% of homes are in rural areas (p.33).

The closure of rural facilities creates greater hardships for people living in the area, and many are forced to move away from the community they have spent their lives in, because there are no aged care homes or other facilities nearby. This area needs serious consideration.

However, we believe it is vital that there is greater accountability and monitoring of the taxpayer funding in the sector, and evidence of how public funds are currently being spent.
Many are forced to move away from the community they have spent their lives in.
The Nurses Organisation say they have been told by District Health Boards that providers are not supposed to use taxpayer funding for capital development. However, in their negotiations with providers they have frequently been told that extra money will not be spent on extra wages because the money is needed for refurbishing residential homes or for building new facilities.

**Additional charging of residents**

Many rest homes have introduced additional charging for services they provide that are over and above those covered by the Aged Residential Care agreement. However there is a lack of clarity around what extra charges are justifiable, especially for subsidised residents. Age Concern says it has received complaints from older people about this practice, and is opposed to the way it is currently applied by residential care facilities.

Some facilities charge extra for a larger room, or for one that has a view. Some charge extra (up to $100 a week) for a private toilet and bath facilities. Some impose additional charges for basic services like podiatry and even physiotherapy and doctor visits, which should be in a basic contract. Some impose these charges even on subsidised residents, and this can create financial difficulties, especially when residents haven’t been warned about these extra charges before they sign up to a home.

One family member told us her mother was told, after she had been accepted into a home, that there was an additional $100 charge for a toilet. *My mother couldn’t afford it, and she was told, well, if that’s the case, she should go elsewhere. We didn’t want to shift my mother, so it’s a burden on the whole family. What bugs us is that we weren’t told about the additional charge before we went in.*  

**Submission**

Age Concern says it appears that some facilities are not open about charging for additional services until a person is on the point of signing an admission agreement, and that this practice is not only dishonest but can lead to older people accepting admission into facilities for which they are unable to afford the additional fees. They say some residents have been forced to move because their room was ‘upgraded’ and they could not afford to pay the extra charges. They argue that greater clarity is urgently needed about what additional charges are acceptable (for example, for private toileting facilities) and that residential care facilities should be required to advertise their fee structure openly and upfront before residents are admitted to a home.

We agree with Age Concern that clarity around additional charging is urgently needed, and that the philosophy of ‘you get the care you pay for’ creates dangerous inequities, such as a two tiered level of care, and should be discouraged.

**Moving/handling of residents**

Physiotherapy New Zealand is concerned that there are currently no standards in place for training staff or minimum standards for the amount of equipment needed per resident. They say that urgent improvement in the training for staff/healthcare assistants, particular in the area of moving, handling and seating of older people, and availability of rehabilitation services, is essential if the quality of care is to improve.

**Hospital admissions**

More than 9,200 subsidised residents of aged care facilities ended up in an emergency department in 2008 (Question for written answer No 14577 (2010)) putting additional pressure on already stretched emergency services. This does not include the 32% (Grant Thornton New Zealand, 2010, p.76) of residents in 2008 who pay the full cost of care themselves.

The Thornton Review pointed out that aged care residents going into acute hospital care are 27% higher than the international benchmark in 2008 – and Emergency
Department (ED) visits are roughly twice the benchmark for aged residential care residents (p.129).

This suggests that many residents end up in hospitals as a result of problems that could have been diagnosed and treated at an earlier stage, before complications developed. A nurse working in the sector said she had witnessed many episodes of residents being inappropriately admitted to hospitals because staff were too inexperienced or too nervous to care appropriately for patients in their own setting, or because a doctor had not been called.

**Dehydration**

Many submitters said dehydration is a serious issue for many residents. For example, in the following case:

> We noticed that Dad seemed to be deteriorating [in the rest home] and one day when I went to visit him I was shocked to find that he was only semi-conscious and rambling away, and I was unable to understand anything he was saying. I went straight to the nurse's station and asked if the nurse could come and see Dad. They looked at him and said quite casually "He's not very good is he". They then told me that he had a fall that morning and he had banged his head, they found him on the floor.

> When the nurse examined Dad she discovered that he was so dehydrated that when his skin was pinched it stayed raised. I asked if he could be taken to the hospital section and go on a drip. They said no, as they didn't have qualified staff who could do this. I then asked if Dad could go to the local hospital to go on a drip, and they said that there were no beds and he would have to wait until one was available. There seemed to be no sense of urgency, despite him being seriously ill. It was very upsetting, I felt helpless. They said I should sit with Dad and get liquid into him, which I was very happy to do. This was rather difficult as he got very annoyed but I did manage to get liquid into him and it helped with his dehydration. When I left that night I asked the staff to keep trying to get liquid into Dad.

> The next morning when I returned Dad was not talking and slept most of the time but I managed to get a couple of half cups of tea into him and some soup.

> I had to return to Auckland and my sister watched over Dad.

> It was another three days before Dad was admitted to hospital and three days later my Dad died.

Submission, August 2010

All too often, staff say they don’t have time to ensure sufficient fluids are given to residents, and that residents often have their tea and other drinks go cold before it is taken away from them.

> In hospital wing and rest home care. Do not have time to give fluid… seven residents at meal time, meals get cold. Residents get up at 8.45am and may not be moved again until after dinner.

Caregiver

**Dementia units**

> All the poor performing staff were put in the dementia units and yet they are our most vulnerable people. Why? Because the residents in there wouldn’t complain.

Former rest home manager

Dementia units need well-trained staff who understand the often complex needs of this vulnerable group of society. Urgent attention needs to be paid to this group of people and units need to be better resourced, staffed and managed. Current standard practices around the institutionalised care provided to dementia patients needs to be reviewed, and clinical and institutional care practices changed to a consumer centred approach, with individualised care plans for all dementia sufferers.
There is still a huge stigma attached to this condition. While many providers are now changing their approach from a medical approach to a person centred approach, this is one of the most significant specific challenges in aged care (and indeed society). While there is considerable debate about best practice there is little in the way of a coherent national strategy and action plan and highly variable support for supporting providers to change.

Bupa submission, July 2010

Alzheimer’s New Zealand say respite care for people looking after dementia sufferers is already minimal, and is being cut further. There is a shortage of respite care beds and it is often difficult for carers to get respite care. Some submitters said it would be far more appropriate and convenient for respite care to be provided in a dementia patient’s own home – a familiar environment – rather than requiring dementia sufferers to go into the unfamiliar setting of a residential home. One submitter told us that whenever her husband came back from respite care in a home, he was even more upset, confused and demented – “and so it was no help to me.”

We understand this is what happens in countries like Australia and the United Kingdom and recommend that this option should be available here.

6.4: Audits

Overview

Many submitters said the auditing process of residential care facilities was an inappropriate and ineffective monitor of the care provided by a facility. Common issues raised by submitters included inappropriate relationships between providers and auditors – in particular, that a provider can choose an auditor to conduct the audit; the fact that providers know well in advance the date that most audits are to be carried out, and can bring in extra staff and resources especially for the audit; and that audits are focused on compliance, ticking boxes and managerial process, rather than the quality of care; and the overall ineffectiveness of the auditing process.

As the NZNO puts it:

> There are 206 audit criteria for the certification audit, for which notice is given, requiring two people for two days...The number of criteria and time frame preclude anything other than ‘paper trails’ being checked; it does not allow for qualitative assessment.

NZNO, 2010, p.9

Quality checks

The effectiveness – or lack of – of current auditing practices of residential aged care facilities has already been highlighted as an area of concern by the Auditor General’s recent report into the effectiveness of arrangements to check the standard of services provided by rest homes. We support the work and recommendations already made by the Auditor-General and believe that we need a system based on measuring and enhancing quality of care – not just ticking boxes.

We agree with the New Zealand Aged Care Association that we need to:

> Move away from a regime based on auditing, as auditing is largely about compliance and mitigating risk, not about quality of care delivery.
> Auditing may assist with ensuring a baseline level of care, but this is not the same thing as encouraging quality care.

New Zealand Aged Care Association submission, July 2010

In our view, audits should be simplified and based on measuring quality of care – not just managerial process and compliance. All audits should be unannounced audits and not pre-arranged, and accredited auditors should be designated centrally. Family members and residents should be interviewed, wherever possible.
An audit is only a snapshot of a facility on any given day, so it’s important that the audit gives a true picture of the facility. We have heard that some facilities manufacture better audit results by increasing staffing levels or recreation programmes for audit day.

Financial auditing

We believe the current practice of aged care facilities not having to account for how they spend public money is inappropriate and needs urgent attention. Currently, according to the Minister of Health, the auditing of aged care facilities does not extend to monitoring how government funding is spent (Question for written answer 11435 (2010). This means there is no way of tracking that additional funding going into the sector is used for the purpose for which it was provided – or that the money is going back into the sector in areas such as increased wages, additional staff or building maintenance, rather than into the pockets of shareholders.

More and more, providers are calling for increased funding across the sector to cope with issues such as residents’ rising acuity levels and workforce issues, even though there are no proper monitoring systems in place to measure how these public funds are used. We believe this is an area the Aged Care Commissioner needs to address urgently.

6.5: Home based support services

Overview

District Health Boards (DHBs) fund services that enable older people to be supported to live in their own homes. Home support services give older people the ability to make choices about where they want to live, and to receive the support to do so.

Support services include help with care, including showering, dressing, grooming, along with domestic assistance such as cleaning, cooking, laundry or shopping. When targeted appropriately the Thornton Review acknowledges that home support has been found to be effective in reducing the overall cost of care (Grant Thornton New Zealand, 2010, p.84).

The majority of submissions received on home care services were concerned about funding cuts to the service, which have resulted in thousands of vulnerable older New Zealanders having their home-help hours reduced or cut completely. Under the previous Labour-led Government a new model of home support was trialled in Otago, Hutt Valley and Waikato. The evaluation (ASPIRE) was very successful. The Labour-led Government also trialled a new assessment service – interRAI – which is currently being rolled out across all DHBs. The service aims to provide more systematic, consistent and comparable assessments of older New Zealanders. The assessment process uses two tools, the Contact Assessment (a screening tool which differentiates an older person’s need for a comprehensive assessment from those with less complex needs, often conducted over the phone) and the Home Care comprehensive geriatric assessment, which covers more health and support services and is always face-to-face.

Previously many short-term allocations for home help, such as cleaning, that were meant only as ‘stopgap’ measures after an operation or accident, had been continued indefinitely as clients were not reassessed. The new tools make reassessments easier to conduct.

However, many submitters said these assessments were being conducted over the phone, and that people were losing their home support without even meeting the person deciding their fate. Many people were angry at sudden changes to their own – or a family member’s or friend’s – support services:
A number of friends have told us about just a phone call telling them that their hours for homecare have been cut from two hours to one hour a month which is ridiculous – what can you do in one hour a month? In the meantime, the home is left in disarray...these people have paid tax all their working lives and treated as dirt by the government, so wake up.

Submission

Some submitters were also concerned that the standard of caregivers working in home support is unpredictable, and that the system can be confusing. If we want more people to stay in their homes longer, these issues must be addressed. Adequate provision of home support services of a consistently high standard is essential to support any long-term ageing in place strategy.

Home based support services face similar problems to caregivers working in aged care, around wages, workloads, training and career progression. Staff shortages will become more of an issue as our population ages.

If we value people remaining in their own homes, we need to ensure allied health services are given the funding required to provide a timely and safe support service.

Occupational Therapist

In her submission, the Acting Health and Disability Commissioner also raised the point that there is no formal supervision or external regulation of home based care. This is an issue, we believe, that needs to be addressed.

Need for accurate and consistent needs assessments

Submissions highlighted the need for clear, consistent and fair needs assessments of the elderly. While the introduction of the interRAI’s assessment tool may go some way to providing this, currently too many older New Zealanders are missing out on support services they need because of an inconsistent system.

One submission welcomed interRAI when “linked to nationally consistent criteria for the entry to services, based on the risk assessment, and [to] be complimented with sound support planning and client focused service delivery aimed at maximising client independence.”

We agree that if interRAI is to work, there needs to be much greater consistency, clarity and transparency about how assessments are conducted.

Telephone assessments

Many submitters were concerned that assessments were being carried out over the telephone. Submitters said this was unfair, inappropriate, and, no way to assess an individual’s needs. Many older New Zealanders have hearing difficulties, and many did not understand that they were being assessed. We were told that some assessors did not make it clear what the purpose of a telephone call was, and even used deceptive tactics, such as saying they were ‘just updating their file’ to conceal the true purpose of a telephone assessment.

We share their concerns. While we acknowledge that telephone ‘Contact Assessments’ may be faster as a screening tool, we do not agree that a person’s fate should be decided over the phone. Submitters said they ended up “saying the wrong thing” because they didn’t understand what was happening and the conversation resulted in services being cut. We believe this is utterly unacceptable.

What I would like to say is that following changes in CDHB policy, people caring for a person with dementia who already are under a lot of stress were told over the phone that their domestic help was being cut back from two hours to one hour. They were not informed how to appeal or who to appeal to. One carer’s stress had increased due to her husband having suffered another debilitating stroke. She suffered from asthma and painful arthritis on top of the demands of caring for her husband. Her supportive daughter worked. She was told how to do her housework in 15 minute lots. She had no idea how to appeal, nor did she have the energy to do so.
Another client: the woman had memory loss and had recently had bladder surgery. To the horror of her husband she was interviewed over the phone and gave all the ‘wrong’ answers regarding needs for home help. She was very polite and agreeable by nature. The woman and her 90 year old husband could only manage light dusting. He wanted to complain to the Press and the RSA about the so called phone assessment being inappropriate. Once again his energy to do so was limited...This man had been a bomber pilot in WWII and expected better treatment.

Submission

Underutilised workforce

According to a submission from Access Homehealth, a major national provider of home health services to some 13,000 older New Zealanders each day, with a workforce of 3500, the potential skill base of the home based support workforce is currently under recognised and underutilised by core funding agencies. This is “an enormous waste of both skill and economic benefit”.

New Zealand has not, and is unlikely to ever have, sufficient doctors and nurses in every location throughout New Zealand. To continue to ignore the potential of this 45,000 workforce who, with increased NZQA qualifications, and integrated into a system with appropriate clinical oversight, would be folly. This workforce could make a major contribution to the management of chronic conditions.

Access Homehealth submission, July 2010

Overworked and underpaid

Various submissions said workforce issues facing home support staff were similar to those facing residential care staff. Many are overworked and underpaid:

I have a carer that does both personal care and domestic assistance. She starts at 0700 and finishes at 10pm. She gets a half hour meal break. She does personal care from 0700-10am and then domestic assistance from 10am – 6pm then personal care from 6pm-10pm Monday to Sunday and she does extra hours for another homecare agency. Community carers need to work up to 56 hours to earn the equivalent of 40 hours paid wages. We have tried to discourage this practice but the carer just goes to the other agency and increases her hours there.

Submission

While some carers receive mileage, some companies only pay after the first 15km – and carers said they were well out of pocket before then.

In rural communities, the situation is even worse, because of the distance home care workers have to travel. In December 2009, ACC stopped covering the mileage costs of the first 20km travelled by homecare workers to visit clients. At the time, Rural Women New Zealand, who provide homecare services to rural and urban clients, estimated this represented a cut of up to 17%, and would result in a decreased ability to provide services to more remote clients (Nelson Mail, 2009).

Better continuum of care

The Government’s ‘Better, Sooner, More Convenient’ primary healthcare initiative, launched this year, aims to provide more personalised primary health care service closer to home, as a way of reducing pressures on hospitals. Removing access to home help, which enables care to be delivered in a person’s home, is completely inconsistent with this new healthcare initiative.

Further, many people are confused about how to access the services they need, and who will pay for it, and who will do the work. Many become frustrated at having to tell their story to numerous different parties including, the person referring them, the needs assessor, the service provider, and the various workers. We need to create much simpler systems for accessing services and a better continuum of care models. There is also an urgent need for a closer integration of home care health services with primary
care, and for multidisciplinary teams comprising of nurses, doctors, pharmacists, carers, nutritionists and social workers, working in the area.

### 6.6: Family carers

While the issues faced by family carers – the thousands of spouses, sons, daughters, nieces, nephews and other relatives or friends – supporting elderly loved ones in their homes fell outside the original terms of our investigation, we believe this area urgently needs to be addressed.

Countless New Zealanders are being failed by a system that does not recognise the exceptional contribution being made by the family members or friends who give up so much to look after their loved ones. As our elderly population becomes more ethnically diverse, the issues around how to better support this group of carers will increase.

At-home carers who give up an income are eligible for the Domestic Purposes Benefit – Caring for the Sick or Infirm – unless they are the spouse or partner of the elderly person, in which case, they do not qualify for the benefit. In these circumstances, the supported person and their partner may qualify for a benefit in their own right, including the Invalid's Benefit or New Zealand Superannuation, and the carer can receive financial support as a partner.

But while rest home caregivers receive at least the minimum wage, family carers provide what amounts to 24/7 care for just $278.16 (gross) for a single adult over 18.

As well as limited financial assistance, family caregivers' own health is often affected by their role. A US report conducted by the National Alliance for Caregiving (2006) found 17% of caregivers reported their health as fair or poor – compared to the national average of 9%. Fifteen per cent of the caregivers surveyed said their health had become “a lot worse” because of providing care, while 44% said it had got “moderately worse”. Common complaints included energy and sleep deprivation; stress and panic attacks: pain; depression and headaches.

I looked after mum for many years when she lived in a little flat and for extended periods in our own home. She had complex health needs - heart attacks, pneumonia, respiratory problems and hospital stays - until I felt burnt out beyond exhaustion. I feel deeply saddened that because of my own deteriorating health and other family circumstances, I could not give her loving care at home at the end of her life.

Submission, August 2010

While family carers can apply for respite care – where the family member goes into a residential care facility to give the carer a break – the quality of this care can be inadequate, as another daughter points out:

I took homecare of my demented mother from 2002-2007...during that time, she was in care to give me a break once a week for 24 hours. Everything that went wrong with her was done in the rest home respite care. I have many horror stories.

Submission

Another submitter told her story:

My husband who has Parkinson's and dementia, occasionally has time in various rest homes on respite care. He stayed in one last year that was staffed at weekends by several teenagers. He told me that the residents were bullied to hurry up getting their meals or it would be taken away from them.

Submission
They say the true test of a nation is how it behaves towards its elderly citizens.
7: Conclusion

It is time for a revolution in how we provide aged care services to the elderly.

Rigid, institutionalised care models are no longer appropriate for our older New Zealanders. We need high quality person-centred care models that better reflect the everyday lifestyles of our society.

We have seen how successful an individualised, person-centred care approach can be when used in residential facilities, like the Eden Alternative, empowering residents to enjoy a fulfilling lifestyle, and high quality, individualised care.

While better supporting and enabling our elderly to remain in their homes as long as possible is always our first choice, high quality consumer-centred residential care options should be available to all, regardless of income.

Every older New Zealander deserves to be treated with dignity and respect. We have a duty to ensure that no one suffers from abuse or neglect – and that people live in a care setting akin to their own home.

Sadly, this is not the reality for many vulnerable elderly New Zealanders.

Our investigation has found widespread problems across the sector including neglect, abuse, services cut, chronic staff shortages, overcrowding, bullying of staff and residents, lack of training, low wages, inappropriate administering of medication, overmedicated patients, a dismal service in hospital level and dementia level care, and ineffective auditing processes resulting in no true regulation or checks, which reveal an aged care industry fast approaching crisis point.

And with our rapidly ageing population, combined with rising rates of dementia and chronic conditions, these issues are set to worsen, unless they are urgently addressed.

These problems need to be tackled in a comprehensive and co-ordinated fashion, if conditions across the entire sector are to improve.
We believe our list of key recommendations go a long way to improving the quality of care across the sector.

We call for a revolution in aged care services that put the resident at the centre of an individualised care plan. We call for alternative models of care, such as community-based models of care, while within aged care facilities, an end to institutionalised care of the elderly.

We call for the establishment of an Aged Care Commission to more appropriately deal with the unique issues and needs of the Aged Care sector. We believe the establishment of an Aged Care Commission and Commissioner, alongside a Technical Working Party to investigate the issues raised in this report, will begin a journey that will make countless differences to the lives of many thousands of older New Zealanders.

We call for comprehensive changes across the sector, including minimum staff ratios, training levels, and more adequate monitoring of quality care.

We call for a long-term national strategy with specific aims around establishing better systems and care across the sector.

We call for greater transparency, accountability and monitoring of residential care facilities.

We call for a more integrated home support service that better cares for people in their own home. We call for a more thorough service that allows people suffering from chronic conditions to stay at home longer – and better supported.

We call for changes that will guarantee every elderly person in New Zealand is treated with dignity and respect.

They say the true test of a nation is how it behaves towards its elderly citizens. We need to rise to this challenge and demand better services for all.

We need to act now.
Appendix A: References

New Zealand Nurses Organisation. (2010). Submission to the Health Select Committee on the Report from the Controller and Auditor-General on the effectiveness of arrangements to check the standard of services provided by rest homes. Wellington: NZNO.


Media articles


Websites

Age Concern New Zealand. www.ageconcern.org.nz

Alzheimer’s New Zealand. www.alzheimers.org.nz
Appendix B: Original terms of reference for proposed Aged Care Inquiry

One test of the quality of a nation, it is sometimes said, is the manner in which it treats its elderly citizens.

In light of the recent Auditor General's report into the effectiveness of arrangements to monitor the quality and safety of 715 rest homes in New Zealand, which found significant problems, and the government's previous refusal on three occasions to allow an inquiry into the aged care sector in the Health Select committee, we intend to investigate, through an informal inquiry:

- whether there is evidence of significant neglect or inadequate care in the aged care sector?
- what changes are needed to improve the quality of care in the sector?
- what changes are needed to the way rest homes are monitored to ensure they provide a high quality of care to residents?
- what changes are needed to make the sector more open, accountable and transparent?
Appendix C: Meeting questionnaire

NAME: ____________________________________________________________

ADDRESS: __________________________________________________________________________________________________________

PHONE: __________________________________________________________________________________________________________

EMAIL: __________________________________________________________________________________________________________

ARE YOU AWARE OF ANY SIGNIFICANT NEGLECT OR INADEQUATE CARE IN THE AGED CARE OR HOME SUPPORT SECTORS? IF SO, CAN YOU PROVIDE ANY DETAILS:

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WHAT CHANGES DO YOU THINK COULD IMPROVE THE QUALITY OF CARE IN THE AGED CARE OR HOME SUPPORT SECTORS, IMPROVE THE WAY REST HOMES ARE MONITORED, OR MAKE THE AGED CARE SECTOR OPEN AND ACCOUNTABLE?

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ARE YOU AWARE OF ANY PRESSURES FACING THE REST HOME WORK FORCE?

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