
A snapshot of staffing levels in aged care services

A report to the New Zealand Nurses Organisation
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Table of Contents

Summary of findings	1
Introduction	3
Rest Homes	4
Hospital care	6
Mixed care and dementia	9
Overall situation	11

Summary of findings

1. The Ministry of Health and sector groups have produced a booklet outlining indicators for safe aged care for patients, which include staffing level indicators for a variety of settings.
2. The report notes that “most providers already work within the recommended staffing levels”, and thus there is no need for enforcement of the indicators.
3. The NZNO has carried out a snapshot of a variety of aged care sites to examine whether they work within the indicators for staffing levels of nursing staff and caregivers.
4. In rest homes, actual caregiver hours per week were at only 56% of levels expected by the indicators. Caregivers also undertake a range of non-care activities, such as laundry and cleaning. Some sites reported high use of temporary staff.
5. The situation was similar for nursing staff within rest homes, where staffing levels were at only 53% of those expected by the indicators.
6. The data collection process did not distinguish between level of care required in the hospital settings, so nursing hours had to be compared against all three indicators of ‘low’, ‘mid’ and ‘high’ levels of care requirement. The main finding is that nursing numbers in aged care hospitals fell significantly below even the lowest level of staffing calculation, and even though some work in high needs areas. RN hours were at only 66% of the ‘low’ calculation. Even when EN hours are factored in, nurse hours are 10% short of the ‘low’ indicator.
7. It also appears that ENs are being used to substitute for RNs. The indicators report notes that ENs may undertake RN tasks, but only under supervision and only for 15 or 20% of the time, depending on the task. There is heavier use of ENs than this in the aged care hospitals.
8. In the hospitals, caregiver hours came close to indicator levels across all sites, and exceeded them in 7. In total, they are at 95% of indicator levels. Given the noted imbalance in the two workforce populations, this must lead to concerns that caregivers are undertaking roles more properly done by nurses, and this should be followed up.
9. The third sector examined including mixed care sites (usually hospital/rest home combinations) and dementia units. In the hospital/rest homes, staffing levels are similar to those reported above, Nursing staff numbers were at 62% of indicator levels, and, despite the requirement to have an RN on duty at all times, there were shifts where none was rostered. On one morning shift, an RN was substituted by an EN, in a clear breach of guidelines.

10. The one area where nursing hours were up to or exceeded indicators was in dementia care. The three units examined here all showed either RN, or RN plus EN, staffing in excess of indicator levels.
11. In the five sites which were dementia, rest home and hospitals, nursing staff levels come within 5% of indicator levels, but only when the significant use of ENs is factored in. EN number are at about 50% of RN numbers, which is much higher than the guidelines and indicates substitution of more-qualified staff for less-qualified ones.
12. Over the mixed care sector, staffing levels of caregivers are low, at 62% of expected levels. In this sector, there was evidence of staff shortages and some care tasks were not completed.
13. Across the sector, nursing numbers, whether including ENs or not, was below the lowest indicator levels. If EN are not counted as RN substitutes, nursing numbers are at two-thirds of the 'low' indicator.
14. Caregiver hours across all sites represent a shortfall of 5,888 hours, or 24%. The total actual weekly care hours at the sites investigated were 26,707 compared to a 'low' indicator requiring 33,367. At best, then, the sites were only staffed at 80% of the lowest indicator level outlined in the report.
15. The findings of this study are important, and offer an important series of findings about staffing trends. But if it is to be used to argue for change, a more substantial study is needed, conducted professionally, and focussing equally on both quantity and quality issues in staffing of the aged care sector.

Introduction

Earlier this year, the Ministry of Health published a handbook on safe aged care and dementia care staffing levels and standards of care¹. The booklet was put together by a sector group representing employers, community organisations, government agencies, education sector representatives and the NZNO. It developed and published a series of indicators on safe care, including staffing levels. These indicators were based on the New Zealand Standard 8134, which notes that:

... all consumers accessing health services in New Zealand have the right to the provision of safe, quality care. Organisations without the appropriate skill mix and number of staff would be unlikely to comply with NZS 8134².

The report goes on to note that a survey carried out within the sector appeared to demonstrate that “most providers already work within the recommended staffing levels”, and that therefore there should be no attempt to enforce the use of the indicators. The assumption that the indicators are already widely adhered to was of concern to the NZNO, who decided to carry out its own small study to check the validity of this assumption.

During August and September, NZNO delegates at a range of aged care sites undertook a snapshot study of actual staffing on a single day. The survey form included information on patient numbers, shifts worked during the day, staffing levels of Registered Nurses (RN), Enrolled Nurses (EN) and caregivers (CG), other staff involvement, casual and temporary staff on that day, incomplete care procedures, unpaid time spent by staff and non-care tasks undertaken by nurses and caregivers.

This report outlines the findings of that study and analyses them according to the indicators.

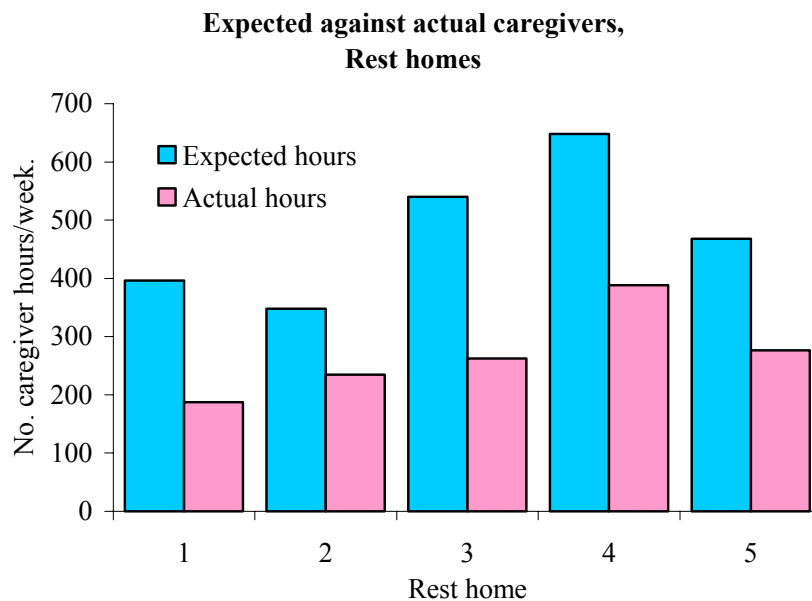
¹ Ministry of Health (2005) Indicators for safe aged care and dementia care for consumers. New Zealand Handbook. Wellington: Ministry of Health.

² Ibid p. 8.

Rest Homes

There were five sites in the study that were solely rest homes. The indicators for care hours in rest homes are 12 hours of caregivers and 2 hours of RN per patient per week, a total of 14 hours. The actual hours in both staffing categories were significantly below the guidelines.

Caregiving hours fell well short in each of the rest homes. The expected weekly hours for the five homes, using the indicators, would be 2,400 hours. Actual weekly hours are around 1350, or only 56% of the expected level. The actual shortfall at each site is demonstrated in the following graph:



There is significant evidence of under-staffing in all these sites, even though the snapshot was taken over only one day. In addition to their care duties, caregivers undertake a wide range of other activities, a lot of which are domestic or administrative in nature.

These activities included: serving morning tea and doing the dishes, running Housie for the residents, serving meals, doing laundry and returning it to patients and cleaning tasks.

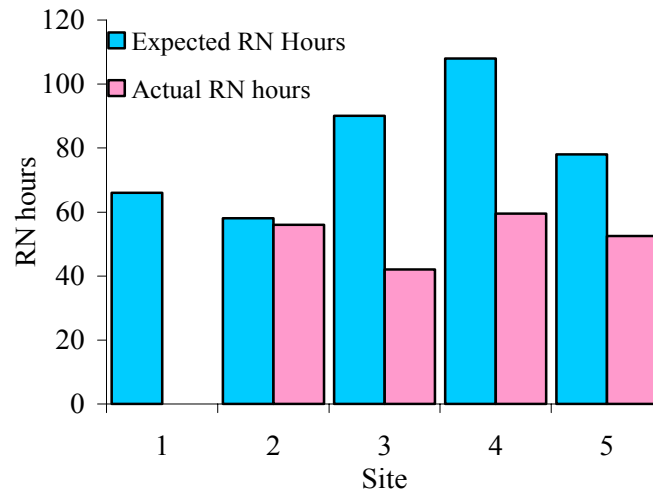
On the other hand, staff get help from external sources at times. Household staff may come in and help residents get dressed, one Nurse Manager prepares breakfast trays Monday-Friday and, in one rest home, an Enrolled Nurse (EN) from the adjoining hospital helped rest home staff with meals.

Caregiver staffing problems can also be made worse by high use of temporary staff, and this was an issue mentioned in three of the five rest home sites.

Figures for RN staffing in rest homes show similar trends. In one of the sites, there was no RN and no EN on duty during the whole period. Only site two showed staffing

levels up to expected levels. Expected RN hours for a week were 400, and actual were 210, or 53% of the indicator level.

Expected against actual Registered Nurse hours (weekly), Rest Homes



However, sites 3 and 5 also had EN employed on some shifts, and these totalled 126 hours over the week. This put both these sites over the indicator levels. This does, however, raise further questions, because EN are supposed to substitute for RN only under narrow circumstances, when:

- ◆ There is an RN on duty,
- ◆ There is more than 56 hours of workload per week, and
- ◆ For no more than 15% or 20% of the time (p. 22).

In summary, among the five rest homes, the indicators noted that there should be an average of 14 care hours per week per patient, a total of 2800 across the five sites. The snapshot study demonstrated that a total of 1686 hours were actually provided, or 70% of the expected.

The systematic staffing shortfalls were exacerbated by the need for care staff to undertake a wide range of non-care activities, although at times they received support for their work from non-care staff. The shortfalls showed up also in the high rate of temporary staff that needed to be employed on a daily basis.

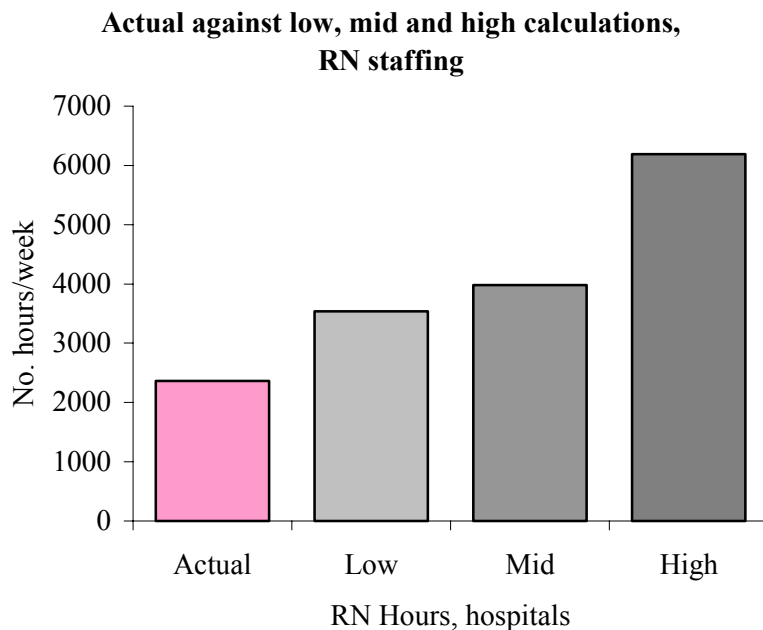
Staff reported that, in general, care activities associated with patients were completed. When staff are short, it is patient showers that are the first to be sacrificed, and in one site (5) this occurred on the day of the snapshot. Finally, in site two the RN engaged in 20 minutes of unpaid work at changeover of shift.

Hospital care

One of the key indicators of safe aged care in hospitals is that there should always be a RN on duty. There may be an EN, but she must be under the supervision of a RN. The requirement for there always to be a RN on duty in hospitals appears to have been met. In the hospitals, there was always either a Registered Nurse or, at times, an Enrolled Nurse on Duty. It was rare, however, even in large complexes, for there to be more than one. As can be seen from the following table, actual nurse hours (recalculated into weekly hours) mostly did not meet the hours in the indicator report.

The main problem with the snapshot survey was that it did not distinguish between low, medium and high RN staffing categories for hospitals. The Expert Advisory Panel noted that there should be three different levels of RN staffing, dependent on need and nursing tasks. These were, respectively, 8, 9 and 14 hours per patient per week. ENs could substitute for RNs under some circumstances, but only when under the supervision of an RN and only for between 15 and 20% of RN time.

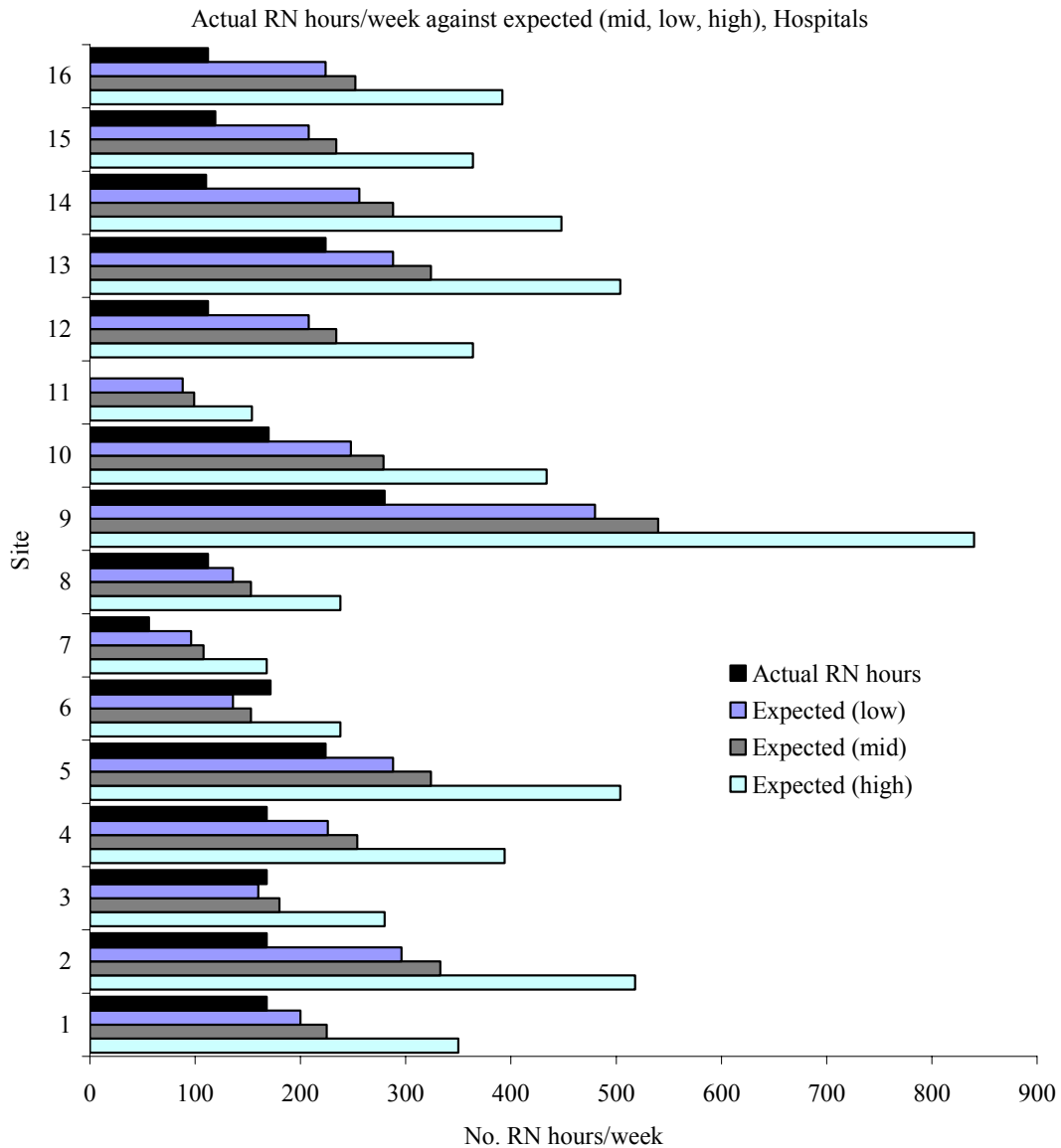
The first main finding of the snapshot survey is that hospitals fall very short of the indicators for RN care.



Even when EN hours are factored in, the actual nursing hours still fall below the 'low' indicator levels, as can be seen in the following table.

Category	Hours/week
Total RN hours	2306
Total EN hours	838
Total nurse hours	3144
Low indicator	3512
Medium indicator	3951
High indicator	6146

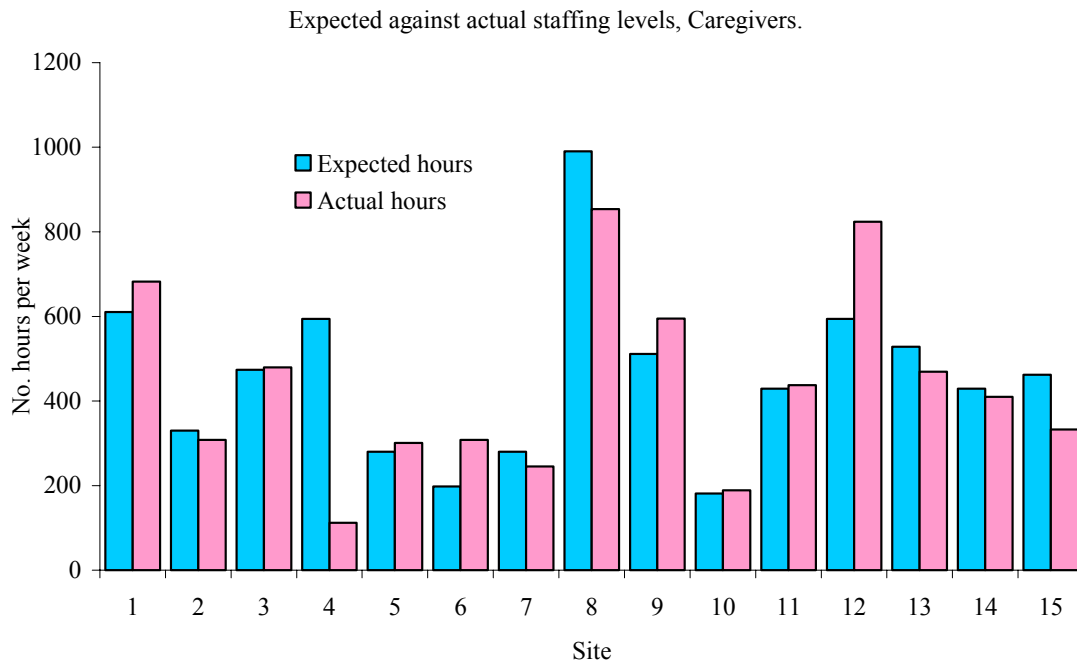
In 12 out of the 48 shifts observed in 16 sites, there was no RN on duty. In six of these 12 shifts, there was an EN on duty. Information on Nurse Managers was not collected, and it is possible that, in some cases, the EN was under the supervision of a Nurse Manager. In some cases, staff were shared between, for example, a rest home and a small hospital. The overall picture is of very sparse staffing levels. Only two of the hospitals (see chart below) reached the lowest indicator level for safe aged care.



There are indicators of stress on the nursing staff in these sites. One RN came in to update care plans on her day off. Others undertake other forms of unpaid work, are forced to do non-care tasks such as preparing teas and trays, cleaning and laundry. In most of these sites there is never more than one RN on at a given time, and so if there are new or temporary staff members (and this is most of the time), the RN must supervise orientation for that person in addition to care tasks.

While nursing staff levels fell well below indicator levels overall, caregiver levels came quite close to indicator levels. Overall, caregivers exceeded indicator hours in 7 of 15 sites (the 16th could not be counted), and totalled 6903 however, which was 95% of the expected hours of 7305. While this is by far the closest of any category to

indicator levels, it is still 400 hours per week, or 10+ full time staff, short of expectations. The following chart outlines the situation at the 15 sites. The result shown below regarding site 4 may indicate reporting problems rather than a major shortage of staff, in which case the overall figure may approximate 100% of expected levels.



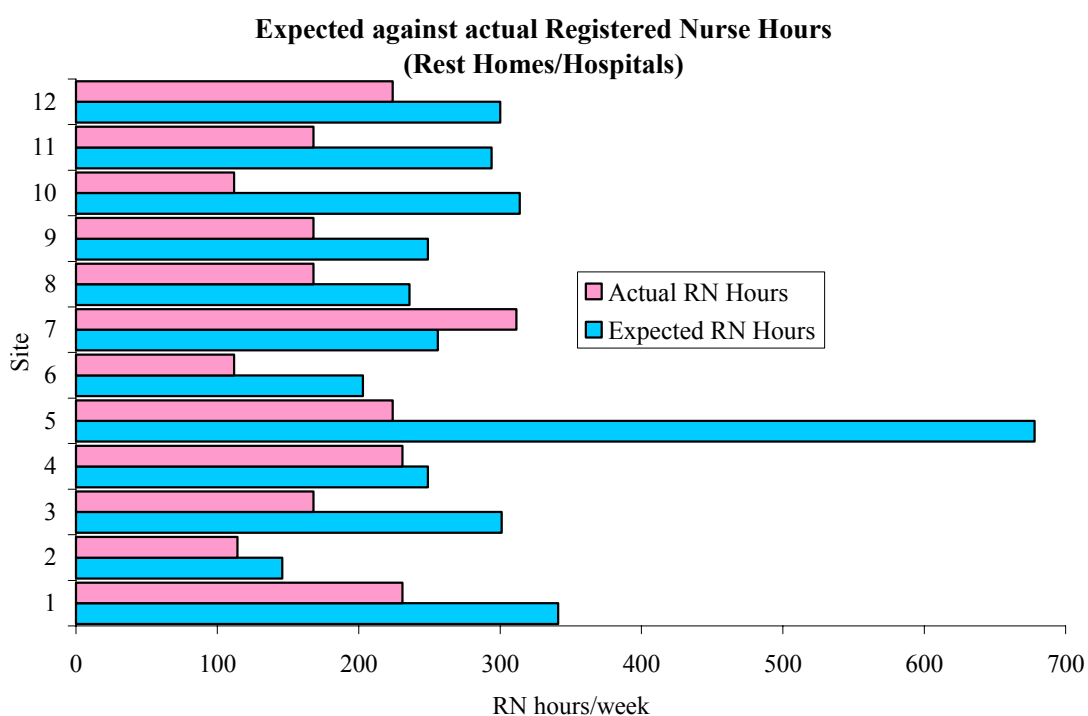
Caregivers also undertake many tasks aside from their caring duties. Outside of office hours, they are expected to act as receptionist and telephonist for the site. Many of them are required to undertake laundry and cleaning tasks. They act as out-of-hours occupational therapists and in a multitude of other roles.

They may also undertake many roles that would otherwise be done by nursing staff. It can be argued, although further evidence is needed, that the aged care sector has chosen to substitute lower-paid caregivers for higher-paid nurses. The indicators report notes that care staffing is not enough, there is also a need to ensure quality staffing. This point is returned to in the last section of this report.

Mixed care and dementia

Around a third of the sites canvassed are both rest homes and hospitals, and a further eight are either stand-alone dementia units or a mix of hospital, rest home and dementia unit. It has been possible to calculate expected hours according to the indicators for each sub-group (e.g. dementia patients, rest home etc). To simplify matters, however, all ‘hospital’ patients have been assumed to be at the middle level of care need (RN hours 9 per week, whereas low is 8 and high is 14).

As with hospitals and rest homes separately, the overall staffing by RNs in mixed rest homes/hospitals is far lower than indicator levels, at 62% of the expected level. Three of the sites had one shift each with no RN on duty. In one such case, a morning shift, an EN was in charge.



Indicators for dementia patients are that there should be 3.5 hours per patient per week of RN care. Only three dedicated dementia units were included in this snapshot survey, and they all exceeded indicator levels of nursing staff, if EN staff are taken into account:

Expected RN hours	Actual RN hours	Actual EN hours
91	94.5	115.5
70	220.5	0
80.5	56	56

A small number of surveys examined sites (5) which offered all three types of care: rest home, dementia and hospital. In analysing nursing returns from these multiple sites, we calculated expected RN hours at 3.5 per week for dementia patients, 2 for

rest home patients and 9 for hospital patients. Expected RN numbers, compared with actual numbers and number of ENs, are outlined in the following table:

Expected RN hours	Actual RN hours	Actual EN hours
244	168	0
198	168	98
475.5	210	112
372	168	168
433	168	56

The RN and EN total added together come to 95% of the indicator levels for safe RN staffing for these units. The indicators state that EN levels should not exceed 15-20% of RN levels, when they are replacing RN staff. In this case, EN staffing levels are at just under 50 percent (434/882) of RN staff. This is clear evidence of substitution of roles in these sites.

Caregiver staffing levels in mixed units is once again low, at 62 percent of expected totals. In the mixed sector particularly, complaints about unfilled caregiver shifts and understaffing were common. There was some use of agency staff to fill gaps, but often staff just had to cope with the shortages. This meant that certain care activities (in particular showers, shaving and bedmaking) were not completed. Some responses noted that staff completed all tasks, but did so in a rushed manner, which patients often did not appreciate.

Overall situation

The overall situation showing from this snapshot survey of just over 40 sites is that staffing levels fall significantly below the indicators issues by the Ministry of Health earlier in 2005. The view expressed in the report that the indicators are already largely adhered to, and therefore no action is needed to enforce them, was not borne out by the snapshot. While there were problems in the data collection process, the use of a ‘typical day’ of staffing is a good method that should stand up to scrutiny. Such typical data captures problems due to understaffing, to non-replacement of staff who are sick, difficulties in recruitment and retention and a lot of other factors.

The overall findings can be summarised as follows:

Requirements for RN staffing on a weekly basis range from 2 hours per week for rest home patients to 14 hours for high need hospital patients. The following table lists the actual hours (weekly) in the total sites reviewed here, against low, mid and high calculations for hospital patients (*NB each rest home patient is scored at 2 hours per week, each dementia patient at 3.5 hours per week, and each hospital patient at, in turn, 8, 9 and 14 hours per week*).

Actual RN hours	6255
RN hours indicator: Low	9134
RN hours indicator: Mid	9911
RN hours indicator: High	14600

- ◆ The actual EN hours for the group were 2,107, so even if RN and EN hours are added, they still total less than the lowest indicator level for nursing staff across the sector.
- ◆ The actual number of caregiver hours across all sectors was 18,345 hours, which the expected rate was 24,233. This represents a shortfall of 5,888 hours, or 24 percent.
- ◆ The total actual care hours at the sites was 26,707 per week, while expected hours range from 33,367 to 38,833, depending on required care levels in the hospitals. The actual staffing level represents between 69% and 80% of expected levels.

The belief outlined in the report that actual staffing levels are close to the indicators outlined by the Ministry of Health appears false, according to the evidence outlined in this snapshot study. There is clear and consistent evidence of under-staffing across nearly all sectors and groups.

If the NZNO wishes to begin to campaign around these findings, however, this study does not, by itself, provide an adequate basis for that. A slightly more systematic approach is needed, with consistent data collection, a verification process and a more

professional research format. What this study does do is confirm your beliefs that there are real staffing issues in this sector.

The indicators report outlines (p. 25) a series of quality indicators for staffing, which include turnover, supervision, absenteeism, staff satisfaction, education and competency and a number of other factors. The surveys were full of examples of poor quality indicators: absent staff, temporary staff, staff having to undertake non-care activities and possibly high turnover rates. The questions of quality sit alongside and inform the issues of quantity dealt with in this study, and each affects the other. There is therefore a need to collect systematic quality data as well.