NEW ZEALAND NURSES ORGANISATION

2009

NZNO Aged Care Survey

An examination of the perceptions, tasks, responsibilities & training needs of Care Givers in New Zealand's Aged Care facilities.

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Executive Summary

As with the general population, New Zealand's aged care sector is staffed by care givers who are themselves ageing: workers in aged care are older than the average across all health sectors. Many recent reports highlight both rising demand for aged care (especially for those with high care needs), and increasing concern that, without significant reform, there will not be enough carers to meet the demand. Public disquiet about standards in care, along with the necessity of promoting care giving as a viable career choice, are among the drivers for an examination of the training and regulation requirements of this vital workforce.

This snapshot survey of the whole aged care sector in New Zealand has shown that moves to increase the levels of training in the sector may be starting to take effect. Many care givers have undertaken a number of modules and courses related to their work. More research is required to compare the training levels and access to training in different employment settings. Neither increased training, nor years of experience gained on the job have resulted in increased levels of pay to reflect these changes.

It must be acknowledged that respondent bias may exist: issues of literacy may be linked with likelihood to respond to a paper survey, and self reported qualifications are often higher than audited qualifications. Additionally, "training" can mean different things to different people: anything from being shown once how to do something, to a detailed, accredited and competency assured programme. The survey answers appear to reflect a general confidence in abilities to perform tasks – whether competence is assured by formal qualifications or not. More detailed work needs to be undertaken to rigorously determine the systems in place by which employers, and Registered Nurses, can demonstrate the competence of those to whom these tasks are delegated.

Provision of orientation, and of in-service mandatory training was reported by the vast majority of respondents. Access to, support from, and relationships with RNs was also reported very positively, with only one out of 280 having a poor relationship with one of the RNs that they came into contact with, and only 2 reporting a lack of respect for their work from RNs.

A number of tasks more commonly thought of as RN tasks are frequently undertaken by unregulated care givers. Specifically: medication is very frequently administered by Care Givers without the supervision of RNs, and blood glucose monitoring and catheterisation are frequently undertaken. These findings have important implications for recent consultations related to the regulation of specific nursing and care tasks, the Enrolled Nurse scope of practice and wider use of ENs in the aged care sector, and for the training and skills required to perform these tasks with or without direct supervision by Registered Nurses.

There was overwhelming support by the participants for proposed compulsory standards and regulation of care givers, along with the expectation that such moves would lead to increased pay and recognition for the role.

Despite poor pay and many challenges related to funding, resources and understaffing, many working within the sector love their work.

Throughout the report, the term care giver refers to unregulated workers, and covers a range of different titles such as Health Care Assistant, Care Assistant, Hospital Aide. A previous study by NZNO found that there was overwhelming support for the use of the title Health Care Assistant (as found in the DHB sector). Despite this, and perhaps because of the large pay gaps between the sectors, most employers in aged care still choose the title Care Giver.

Background:

While regulated nurses work to prescribed scopes of practice, and have very detailed guidance related to the tasks and activities for which they are legally and professionally responsible, unregulated care givers work under the guidance, direction, supervision and delegation of Registered Nurses, and to job descriptions and training competencies that vary from employer to employer. In the light of proposed changes to the training and regulation of Care Givers, and to further inform the debates, a project was undertaken to explore in detail:

- The tasks currently undertaken by Care Givers
- The training Care Givers have received related to each of these tasks
- The supervision and support that is available (immediately and remotely) for Care Givers from Registered Nurses
- The attitudes of Care Givers to proposed changes to training and regulation

Introduction:

Several recent studies have highlighted the issues presented by the combination of an ageing population, and ageing workforce, and the rising need for increasingly complex care and support services that will allow "ageing in place" and end of life care. Estimates of the size of the workforce vary considerably, from around 18 thousand (Callister, 2009) to around 65 thousand unregulated care givers identified in 2004 by NZIER. The variation may be partially due to the many different employment codes that represent workers in the sector, and to the inclusion in some data sets of unpaid and informal carers, many of whom are family members.

Formally, care workers assist and support regulated health professionals (Registered and Enrolled Nurses/Nurse Assistants) increasingly however, tasks previously ascribed to nurses are being undertaken by unregulated care givers, and the lines of responsibility for the competency assurance, and the delegation and oversight are far from clear or consistent. The nature of the work, ranging from provision of basic personal care to assisting with the management of people with dementia and other challenging behaviours, combined with at or near minimum wage, makes this vital work unattractive to many. The resulting workforce is predominantly female and has an over-representation of new migrants. The workforce is thought of by many employers and policy makers as fluid, transitory, and low skilled. As was highlighted by MoH / DHBNZ in 2007 in their report: *Future Workforce: a career framework for the health workforce In New Zealand,* until pay and career pathways more accurately reflect the increasing need for paid care givers, New Zealand will struggle to provide adequate care for it's rapidly ageing society.

A recent study by Careerforce (Ryan, 2009) evaluating their Embedded training courses, reported that "few current trainees hold formal qualifications" and the NZEI –funded Employer Survey of 2004 identified low levels of language, literacy and numeracy skills.

The current NZNO survey was undertaken to examine the generalisability of these assumptions, and to investigate the actual tasks being undertaken by unregulated care givers in aged care.

Methodology:

This snapshot survey used:

1) Examination of a range of secondary sources (job descriptions, DHB guidance documentation)

2) Discussion with educators of courses for care givers, and academics in the Aged care field.

3) Group discussions with NZNO Aged care sector colleagues

to develop a detailed questionnaire to capture the full range of tasks, issues, attitudes and feelings about their work of a large sample of Care Givers.

The anonymous questionnaire was sent to 1000 NZNO non-RN members (chosen from the data base to ensure workers from all sites were invited to take part) along with free-post envelopes. This represents around 1/3 of all NZNO care giver members. Returned survey forms were scanned, and data checked manually using Re-Mark survey software. Free text answers were also recorded. Analysis used the programme Statistica and standard descriptive statistical methodology.

Results:

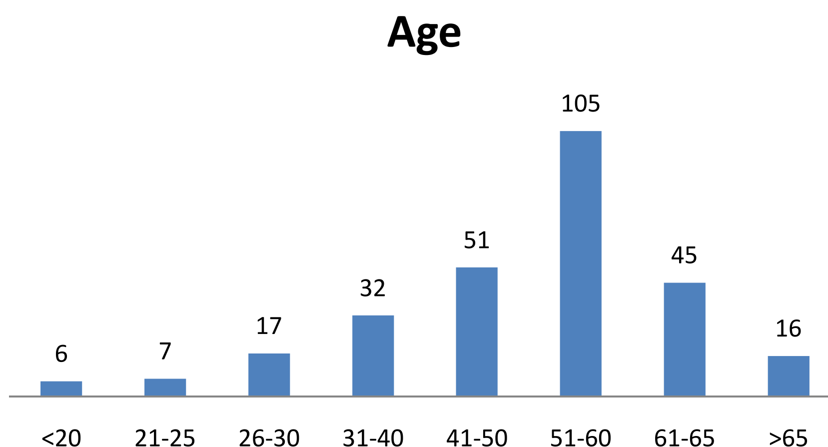
Within the 3 week return period, 284 survey forms were returned, representing a 28.4% response rate. The demographics of the respondents are shown below, and are representative of the Care Giver membership.

1) Sex

94% were female, 6% male. This compares to the 92% and 8%reported by Callister, 2009, and the 93% seen in the NZNO female membership data base.

2) Age

The full range of ages from under 20 to over 65 were seen, with the **modal** age being 51-60. This is slightly older than the average age of RNs across the Nursing Council register, which is currently around 48. This also replicated the demographics reported by Callister.



3) Ethnicity

Ethnicity	Percentage	Ethnicity	Percentage
NZ European	67.79	**Fijian**	2.50
NZ Maori	11.79	**Other Pacific**	1.70
Other European	4.29	**South East Asian**	2.86
Samoan	2.86	**Chinese**	1.07
Cook Island Maori	0	**Indian**	2.86
Tongan	1.79	**Other Asian**	3.57
Nuiean	0.36	**Other**	0.78
Tokelauan	0.71		

Total Pacific Island respondents made up 9% of the sample. Most who specified South East Asian also specified Filipino. In total, 22% of all respondents were migrants to New Zealand, 50 % of these had lived in New Zealand for over 5 years, 31% 1-5 years, and 19 % had arrived here within the previous year. 60% of all migrants had passed an IELTS test, many of the longer established migrants commenting that it had not previously been required. This also correlates well with the NZIER and Callister analyses, which show higher than average proportions of migrant workers and Pacific Island workers

4) Job title

The majority (68.42%) have Care Giver / Aged or disabled carer (CG) as their job title. A further 26 % were Health Care Assistants (HCA), the rest having other titles, including Senior Care Giver. There were many comments to the effect that the title Health Care Assistant carries more kudos, and better reflects the value and training of workers in the sector.

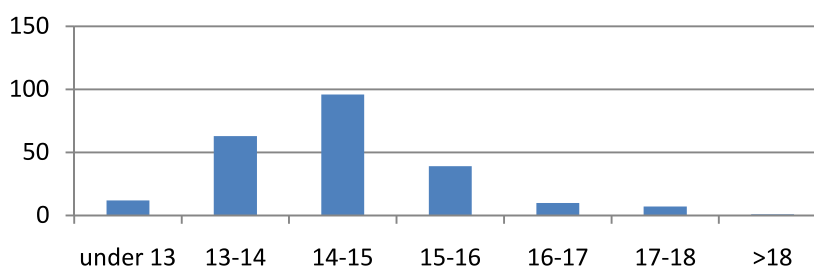
5) Other Employers

11 % regularly work for more than one employer. This is much lower than the 20% of RNs who reported additional employment in the 2008 NZNO Employment survey. The majority of those who reported working for more than one employer were on casual contracts, and did not have the number of fixed hours they wished to be guaranteed.

Mean number of hours guaranteed was 30.8 hours per week. Mean hours worked was 33.3, and mean hours wanted was 34.8 hours. There was large variation in the number of hours worked, but there was generally a good match between hours wanted and hours guaranteed. The desire to work less than full time might also reflect the age profile of the workforce, and the nature of the work.

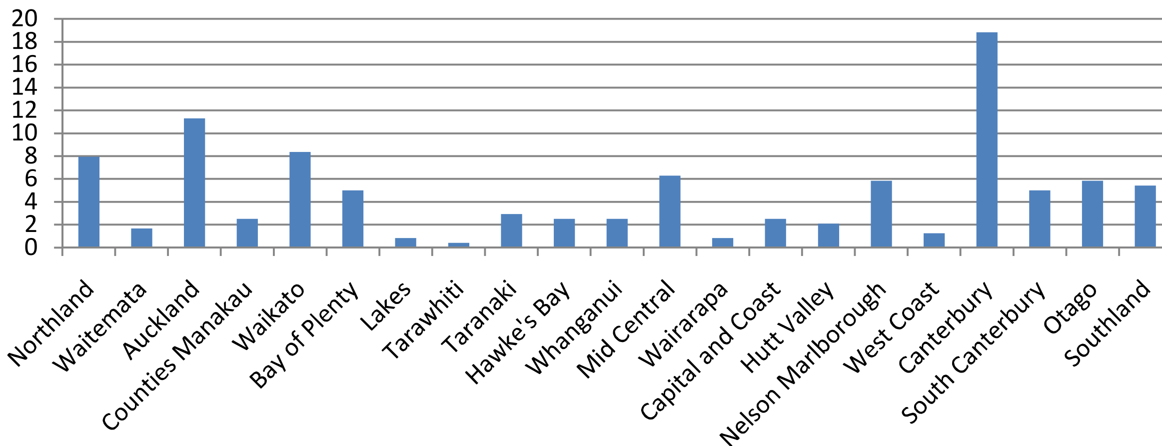
6) Wages

Of the 240 respondents who answered this question, the mean wage per hour was $ 14.40, ranging from $12.55 to one respondent who earned $19 while senior CG on night shift. What was also apparent from the responses was the nature of pay scales in the sector being both a short range, and being made up of very tiny increments.



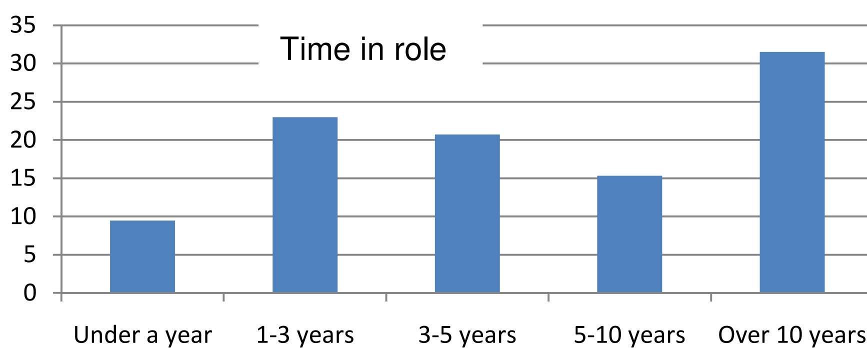
7) DHB

A spread of respondents from all DHB regions was returned, with the numbers largely corresponding to the relative sizes of the populations, with a possible over-representation of respondents from Canterbury.



Time in role

There were differences in the time staff had been in their current roles between the different DHB regions, with Mid Central and the South of the South Island having worked for markedly fewer years on average in their current role than those in the North of the North Island, though the numbers are small. There was no pattern seen between the answers given to this question and working in urban versus rural DHB regions. In hindsight, and if the survey was repeated, the question "how long have you worked in your current role?" should be changed to 2 questions, "how long have you worked as a Care Giver/ HCA?" and "how long have you worked for your current employer?" to be able to be confident how this question was perceived. The answer given is shown below, and reflects NZNO delegate perceptions that employees stay with their employers for long periods.

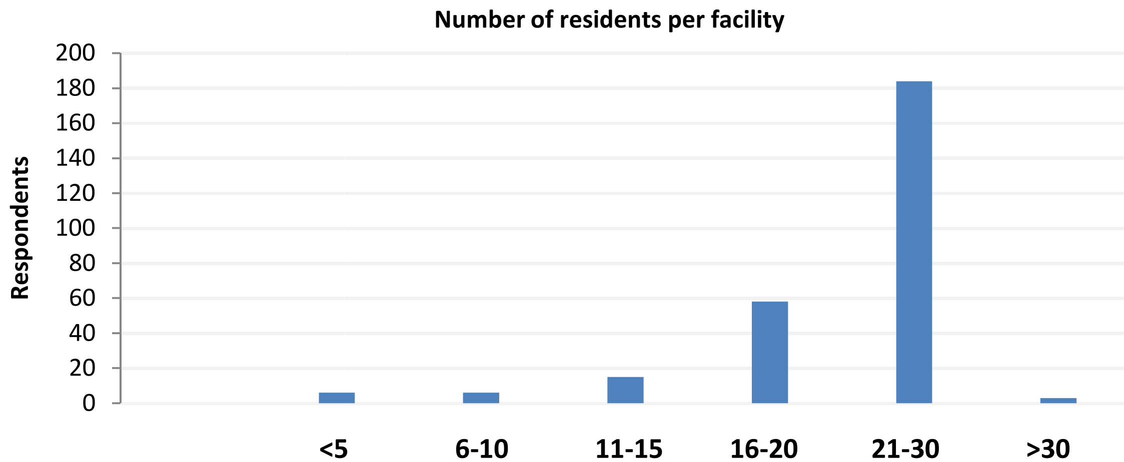


8. Type of Facility

Percentages are misleading, as many facilities are of multiple type. The actual frequency is therefore shown in the table below. For comparison, figures from the OPAL study across Auckland (Boyd 2009) are shown. NZNO has fewer members who work in solely rest homes.

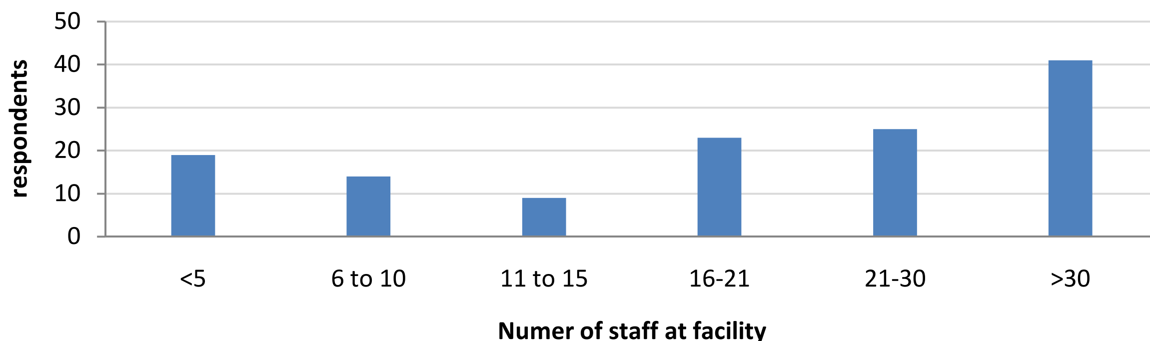
Response	Frequency	Percentage	% Boyd
Rest home only	83	29%	46%
Hospital only	38	13%	11%
Dementia care only	11	4%	5%
Mix not including Dementia care	97	34%	23%
Mix including Dementia care	51	18%	9%
Blank	4	2%	-

Most work in units with 21- 30 **residents:**



Numbers of staff

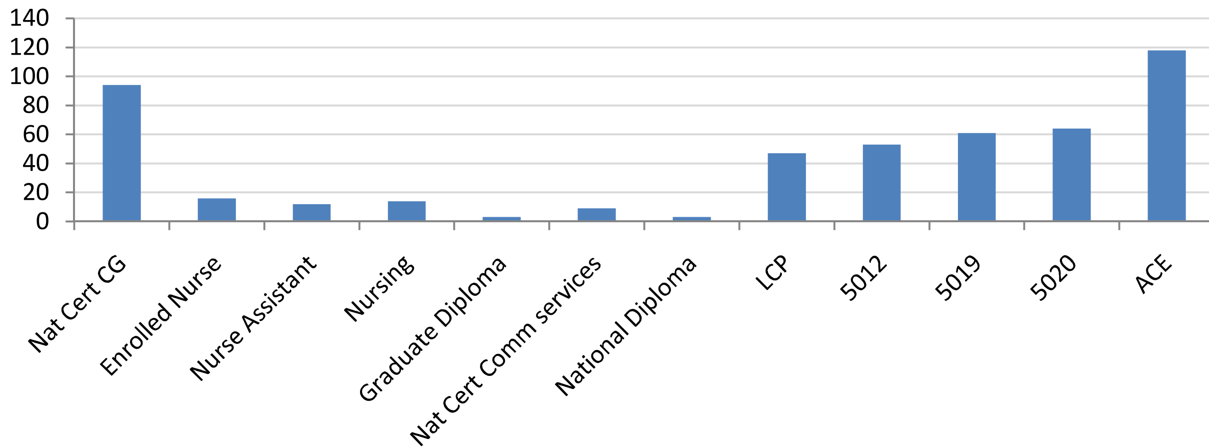
The question related to the number of full time equivalent staff may have been interpreted in many ways – for example, how many people work full time, how many people were on the roster at any one time, or how many people are "on the books" as available to work. Many also did not answer this question, or answered "don't know" and there were no patterns between types of home, number of residents and how this question was answered, so caution is advised with interpretation.



9. Qualifications

The results of the questions relating to qualifications showed a depth and breadth in the levels of qualification and training amongst care givers that explain the resentment that many care givers express at both their levels of pay, and the description of care giving as "unskilled "work. While 40, (8%), have no formal NZ- recognised nursing or care giving qualifications, nearly 80 % have either nursing or care giving qualifications. Sixteen who had nursing qualifications had either qualified in New Zealand but had not got current practicing certificates (8) or qualified as nurses overseas and were not registered as nurses with the Nursing Council (8). Of those with care giving qualifications, ACE was the most common, with all other qualifications on the questionnaire list represented. Very many had multiple qualifications: {Nat cert, CG, LCP, 5012, 5019, 5020} was a common set of qualifications. Additional qualifications mentioned were dementia-specific, mental health specific, or other qualifications not directly related to aged care, including a social worker, and a medical doctor from the Philippines.

Of those with no formal qualifications, many had been in post for more than 10 years, and 8 were in the process of doing ACE, or were awaiting their certification. Many commented that the possession of recognised qualifications made very little difference to the salaries that they were paid. It would appear that the training requirements for care givers involved in the care of Subsidised Residents (as in the DHB contract for age related residential care) are largely being met. It should also be remembered that those motivated to return questionnaires might be disproportionately qualified, and literate than those who do not return questionnaires.



(The qualifications shown above are detailed more fully in the Appendix.)

10. Support and orientation

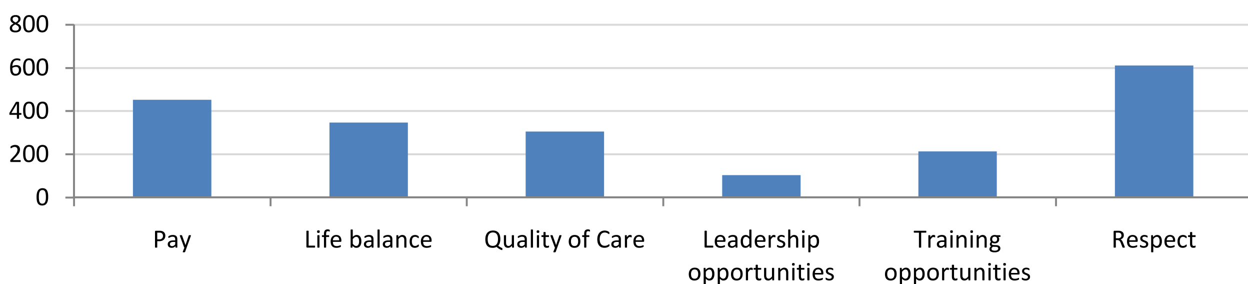
The overwhelming majority (90%) had access to a registered nurse at all times, appraisals, and managers they could talk to. Ninety four percent had received formal orientations to their roles. Those that had not had a formal orientation, had mostly been in post for over 10 years. (In 2001, the Health and Disability Service Standards Act required that DHB service contracts included the requirement for staff orientation)

Of the eight elements of orientation listed in the DHB contract as essential, most elements rated at over 95% covered in orientation. The least commonly covered were those covering information about ageing and cultural awareness.

There was also evidence of high levels of in-service training covering the mandatory topics of OSH, Fire safety, Lifting and handling, Infection control, cultural safety and CPR, with 57-90% having attended these different elements during the past year, and with 83% having received this training while at work. Where people had not been paid for training, many said this was because they were not working at the time the particular sessions were run. The evidence of high access to updates on these essential components, especially delivered in-service, is encouraging.

11. Priorities

A list of priorities related to employment were presented to generate the three most important. The question was answered variably, making analysis complex. A weighted score was therefore generated, and these are shown below. The total possible score for an item, if it had been a first choice for all respondents was 1000. The minimum possible score was zero.



While pay was very important, work-life balance and providing quality of care were also very important. The most frequently cited first priority though was to be respected and valued for the work they did. There is an obvious linkage between respect and levels of pay.

12. RN Presence and relationship between RN and respondent

71% of respondents answered than an RN was present all of the time, 18% most of the time, and 11 % part of the time. There was a significant difference between type of facility and the presence all of the time of RN. As might be expected, more hospitals had RNs present all of the time than rest homes did. 94% reported having access to an RN at all times. Of those who did not have access to an RN at all times, all but two were of the rest home only type.

Home type	number	RN present all of the time	Access to an RN at all times
Rest home	N=83	57%	91%
Hospital	N=38	87%	95%

60% reported getting on very well with the RNs at their facility, and 39% quite well. There were two comments from care givers who did not feel respected by an RN, but correlations between all questions related to this relationship were robust, and the relationships are viewed very positively.

13. Job dissatisfaction items

The items related to causes of poor job satisfaction scored infrequently on the whole. The most frequent causes of dissatisfaction were staff turnover and co-worker absence. The least frequently experienced was lack of proper supervision by a Registered Nurse.

14. Key tasks and training for tasks

The percentage answers, rounded to nearest 0.5 % are shown for each item.

Task	Very frequent %	Frequent %	Sometimes %	Never %
Washing	**78**	12	8.5	1.5
Skin care	**72**	18	7	3
Observing skin condition	**80**	13	6	2
Mouth care	**75**	12	8	4
Pressure area care	**60**	21	14	5
Food & fluid monitoring	**72**	14	11	2
Toileting	**71.5**	15.5	11	2
Incontinence management	**70.5**	18.5	7	4
Use of aids	**70**	19	18.5	2.5
Preparation for sleep	**67**	16	14	3
Feeding	**64**	12	16	9
Giving medication with RN supervision	19	12	**36**	33
Giving medication no RN supervision	26	11	16	**47**
Observing social changes	**50**	22	22	6
Blood glucose monitoring	26	14	**30**	30
Catheterisation	4	3	11	**82**

The list of tasks not in italics was generated from care giver job descriptions. The items in italics are often deemed nursing tasks, or tasks to be performed under delegation of an RN. Correspondingly, it is not surprising to see that the first group were very frequently undertaken by care givers, and the latter group much less so. There was a clear group who never gave out medication without RN supervision, these tended to be more likely to work in hospital or mixed settings. Though "never" was the most common answer to catheterisation, 50 care giver respondents (18%) **did** catheterise, and 11, (or 4%) of these did so very frequently. Of those who reported catheterising, the majority reported having had training to do this, while 9 people out of the 50 who do catheterise reported needing training to do so.

For the most part, respondents reported having received training to carry out the vast majority of all the tasks they undertook. Tasks such as giving out medication without RN supervision, and catheterisation were usually marked as Not Applicable in the corresponding questions about training requirement.

It must be acknowledged that "training" can mean different things to different people: anything from being shown once, to a detailed, accredited and competency assured programme. The answers appear to reflect a general confidence in abilities to perform tasks – whether competence is assured by formal qualifications or not. More detailed work needs to be undertaken to rigorously determine the systems in place by which employers, and RNs, can demonstrate the competence of those to whom these tasks are delegated.

15. Support for changes to training and regulation

There was overwhelming support for the introduction of compulsory standards and regulation of care givers (97%) with many commenting that this should lead to better recognition of the role, and to better pay. Only 13% would consider leaving care giving if training became compulsory. Some however commented that they were too old to consider more training at this stage in their careers, and others that experience should be recognised alongside qualifications. Nearly 10% might consider leaving the profession if regulation became compulsory. More detailed examination of the understandings and fears related to the practical implications for care givers if regulation became compulsory, particularly as has happened in other industries protection of the employment rights and conditions of established workers while qualifications required change might be required if de-stabilisation is not to occur.

16. Other comments

Most comments were related either to the need for better pay and recognition of the work undertaken by care givers, or to the support for more (especially paid) training. Many also commented on enjoying their job, and working with the elderly.

Conclusions

In order to ensure care giving remains a viable career option, especially for younger care givers, appropriate pay, recognition, training and regulation are warranted. Care Givers are prepared for the increased need for accredited qualifications, and would accept this if training is provided during the time they are paid to be at work, and provided it leads to better pay and recognition of their role. Improved training and career pathways for Care Givers would ensure the availability of this vital workforce into the future, and lead to improved quality of care for vulnerable elderly people.

Recommendations

- **NZNO is currently developing and consulting on recommendations for nationally accredited, transferrable training and career pathways for care givers.**
- ***Ongoing* training & appropriate pay progression should be in place for trained care givers.**
- **Detailed, consistent guidelines on the roles and tasks of RN, EN and Care Givers in aged care should be agreed across the sector.**
- **Registered Nurses working in the aged care sector must be supported by adequate numbers of appropriately trained and competent staff, if the difficulties recruiting RNs to the sector are to be reversed. Mandatory staffing levels are the most robust mechanism to ensure this.**

Appendix

A myriad of qualifications / modules for working in the sector exist. A few of the more commonly required modules are shown below.

Qualification	Description
LCP	Liverpool Care Pathway for the dying patient
5012	Level 3 NZQA Lift and position people safely
5019	Level 4 NZQA Assist an older person to meet their needs
5020	Level 4 NZQA Support an older person to maintain their rights & responsibilities
ACE	Aged Care Education

The ACE series can be cross-credited for NZQA qualifications: for example ACE dementia series is judged equivalent to the National Certificate in Support of the Older person.

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