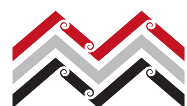
CARE IN CRISIS
MANAAKI I TE RARU

A Call for Culturally & Clinically Safe Staffing in Aged Care
He Karanga mō te Kaimahi Haumaru ā-Ahurea, ā-Haumanu hoki i te Manaaki Kaumātua



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He karakia timatanga

Kia tau ngā manaakitanga
a te mea ngaro

ki runga ki tēnā, ki tēnā o tātou

Kia mahea te hua mākihikihi

kia toi te kupu, toi te mana,
toi te aroha, toi te Reo Māori

kia tūturu, ka whakamaua kia tīna!
Tīna!

Hui e, Tāiki e!

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Foreword | Kupu Whakataki

Paul Goulter, Chief Executive Tōpūtanga Tapuhi Kaitiaki o Aotearoa, NZNO

The aged residential care sector is at a crossroads. Despite imminent challenges of an ageing population, this Government has choked funding to the health system, scrapped pay equity for nurses and care and support workers and begun steps to deregulate the health workforce. This report, *Care in Crisis: Manaaki i te Raru*, lays bare the consequences of a funding model that is fundamentally failing older people and the workers who care for them. It is not safe. It is not sustainable.

It can be shocking to read some of the quotes and statistics in this report. However, they speak to the daily experience of the experts – the nurses and kaiāwhina who are dedicated to caring for kaumātua in ARC facilities while holding together a broken system. The scale of the crisis demands systemic change. This means more than a one-off cash injection for surface level modifications. We need to reset the sector. We need to reset the approach to health funding so that it corresponds to the level of need and the workforce requirements to meet those needs, safely and with dignity. We need to do it now.

Tracey Morgan, Māori co-chair Age Safe Committee

> *Ma te huruhuru ka rere te manu* | Adorn the bird with feathers so it may soar (with the right support and encouragement anyone can rise.)

As the Māori researcher for this report, I have listened closely to the voices of kaimahi caring for our kaumātua. Their stories are moving and often heartbreaking: missed care, unsafe staffing, and cultural needs left unmet. Māori residents are often separated from their communities, and Māori staff are left to carry cultural responsibilities without support. Cultural and clinical safety cannot be separated. Our kaumātua are not just residents. They are parents, grandparents, and knowledge holders who deserve dignity and respect. This report calls for aged care that honours Te Tiriti o Waitangi and ensures older people are cared for in ways that uphold their mana and wellbeing. We owe our kaumātua more than survival, we owe them the opportunity to live their final years with care, respect, and compassion.

Brianna Dynes, co-chair Age Safe Committee

This report reflects the voices of aged care workers from across Aotearoa. Their message is confronting but consistent: aged care is underfunded, understaffed, and unsafe. Workers describe impossible choices, which essential care to deliver and which to leave undone, and the toll of being unable to give residents the dignity they deserve. Yet there is hope. The solutions outlined here are practical, evidence based, and achievable. When they are implemented, they will be life changing for my colleagues and I, and for every worker who wants to deliver safe, quality care. Most importantly, they will transform aged care into a system that honours our parents, grandparents, and future selves with the respect and care they deserve. We must act now to create aged care that is safe, equitable, and person centred.

Acknowledgements | He Mihi

To the health care workers who have generously shared their kōrero about working in aged care, and who have offered visions for a better future – this report is the culmination of your voices. We are deeply grateful for your time, insight and the trust you placed in us to tell this story. We also acknowledge all our kaumātua who live in aged residential care, their whānau, and the incredible kaimahi who care for them every day. Ngā mihi nui ki a koutou katoa.

This report has been strengthened by the expertise and guidance of many individuals. In particular, we would like to acknowledge:

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Julie Reeves, Australia Nursing & Midwifery Federation

Arvid Muller, UNI Care

Jess Sanders, United Workers Union

Max Harris

Age Safe Oversight Committee: **Tracey Morgan, Brianna Dynes, Ruth Te Rangi, Bridget Richards, Rajni Lata, Merit Quiray, Deepika Kumar, Melisa Peat, Azbeen Nisha, Sushil Devkota, Lindsay Warren, Maree Ross.**

Section One

Executive Summary

Whakarāpopototanga

Headline Findings | Ngā Kōrero Matua

Underfunding, chronic understaffing and system-wide failures have left the aged residential care (ARC) sector unable to provide culturally and clinically safe care for kaumātua. This research draws on 80 in-depth interviews with ARC workers in nursing and kaiāwhina (healthcare assistant) roles. Further findings come from sector-wide surveying of 415 kaimahi in direct care roles and 156 health and safety report forms relating to unsafe staffing in ARC facilities.

The collective worker voice presented here speaks to a sector in crisis. Frontline staff are left to carry the burden of systemic under-resourcing, despite their clinical insistence that delivering high-acuity care without adequate staffing is putting kaumātua living in ARC at risk. The sector is characterised by shortfalls in essential clinical and personal care, neglect and preventable harm to residents resulting from time and budget constraints, and the overall erosion of residents' dignity and mana. Workers described the toll of working in a broken system where they are set up to fail.

Our vision demands a culturally and clinically safe aged residential care system. Building on the care minutes model from Australia and the case-mix model developed in Aotearoa, we are calling for a care minutes framework that builds a safe staffing system around the needs of residents. This model unites comprehensive assessment of residents' clinical and hauora needs with the funding and staffing commitments to meet them.

Unsafe Care | Manaaki Kore Haumaru

- Missed care is the discrepancy between the expected level of care, in terms of best practice and resident/whānau expectations, and the care that is ultimately delivered. One quarter of kaiāwhina reported that residents are going without showers, receiving meals cold or late, and being left anxious, distressed or lonely almost every shift.
- Staffing levels have a direct and demonstrable impact on the quality and safety of care provided to our kaumātua. Nurses and kaiāwhina we surveyed strongly agreed (87%) that staffing levels have affected their ability to provide high-quality care to residents.
- Toileting and continence care in ARC fall well below clinical baselines for meeting kaumātua needs with dignity. 43% of kaiāwhina surveyed don't have time to support kaumātua who require assistance to the toilet almost every shift or often. Workers described overuse of incontinence products, residents left in soaking pads and supply restrictions leading to pad-rationing.
- Cost-cutting regularly overrides clinical best practice in wound care, putting residents at extreme risk. Nursing staff reported limited access to high-quality wound products, lengthy approval processes and even situations of cutting products in half to save money. Nearly 40% of surveyed nurses reported that almost every shift or often they do not have time to dress residents' wounds.

- Staffing shortages put pressure on workers to rush, increasing the risk of shortcuts and decisions to deviate from safe practice or company policy. Frontline workers described serious health and safety failures such as unsafe hoisting, unsupervised residents and rushed care.

Cultural Safety | Kawa Whakaruruhau

- All kaumātua in care are entitled to both clinically and culturally safe care. Cultural safety is inextricable from clinical safety. Our research found that policies and practices relating to cultural safety in ARC were minimal, inconsistent and unenforceable. The design and delivery of aged care services must be mana-enhancing, culturally responsive and safe.
- Residents who are Māori, Pasifika and culturally diverse often need access to additional services and direct care time to ensure the care they receive is safe. Kaimahi highlighted the risk of sidelining high-needs and vulnerable residents who could not effectively advocate for themselves to care staff, especially residents with dementia or those who are not native English speakers.
- Māori kaimahi have additional cultural work delegated to them, they are asked to run whānau hui, lead karakia, interpret in te reo Māori or mediate cultural misunderstandings – all while carrying full clinical or personal care workloads.
- One barrier for Māori accessing ARC is that the systems, processes and design are not Māori-centred. Māori kaimahi described low levels of Māori working in ARC, widespread tokenism, explicit anti-Māori behaviours, inadequate knowledge of Te Tiriti o Waitangi and failures to follow through with cultural care plans.

Unsafe Staffing | Kaimahi Kore Haumaru

- Systemic underfunding manifests as chronically understaffed ARC facilities. Over half (53.4%) of nurses and kaiāwhina surveyed reported their shifts were understaffed most of the time or often.
- Kaimahi emphasised that even with a full roster, they were under extreme pressure – routinely forced to ration care, work unpaid overtime and forgo breaks. 43.9% of workers felt they didn't have enough time to do everything required most days; only 5.8% of respondents always had sufficient time.
- Amid ongoing understaffing, health workers report facing excessive workloads, burnout, moral injury and a growing fear of the professional consequences for providing clinically unsafe care. This leads many to leave ARC, with 39.8% of kaimahi surveyed reporting frequently thinking about leaving the sector.
- From 1 January – 30 August 2025, workers lodged 156 individual staffing concern reports on understaffing as a health and safety matter in ARC. 96% reported that in their professional judgement the workplace was unsafe during the shift.
- Substituting Registered and Enrolled Nurses with lower-paid medication competent Healthcare Assistants (HCAs) was widespread and largely driven by budget constraints. These HCAs are often left unsupported, unsupervised and asked to work beyond their training. Only 7.8% of nursing staff reported always having time to provide active supervision and leadership for HCAs.
- Staffing policies and practices compromise interRAI assessment data quality, with 30.9% of nurses lacking time to complete care plans and interRAI almost every shift.

System Failings | Ngā Hapa o te Pūnaha

- Aged residential care cannot meet the level of need for care in the community at current bed capacity. Rural areas with a high Māori population are particularly impacted by limited ARC bed availability within the community.
- Survey respondents almost unanimously agreed (95.2%) that aged care residents have more complex health needs and require more support. Inevitably in the context of increasing acuity, 82.9% of respondents agreed or strongly agreed that the tasks they do at work have become more complex.
- Assessment is a critical component of a functional and safe aged care system. The current four service levels do not have mechanisms for addressing the diverse needs of residents, or accounting for the spectrum of physical and cognitive capacities across residents within the same classification.
- Workers repeatedly raised concerns about delays and inaccuracies in assessing residents' care needs – both at admission and during reassessment when their condition deteriorates. As a result, some residents are entering facilities without accurate assessments of the physical mobility and cognitive capacities. This means residents may not have access to the level of care, equipment and staffing they require.
- For residents with dementia, delayed or incorrect assessments pose serious safety risks, including being placed in unsecured facilities where they may wander unsupervised. Reassessments are often only triggered by serious incidents, rather than early warning signs routinely reported by kaimahi.
- Residents' access to allied health care is unequal and inconsistent across facilities, with care staff highlighting increased rates of falls, choking, weight loss and reduced mobility due to a lack of specialised support services.

Culturally and Clinically Safe Staffing | Te Kaimahi Haumaru ā-Ahurea, ā-Haumanu hoki

Everyday nurses, kaiāwhina and all health kaimahi demonstrate that good aged care is possible, if we are prepared to ensure there is staffing, resourcing and funding to guarantee it.

Our vision demands a culturally and clinically safe aged residential care system. Building on the care minutes model from Australia and the case-mix model developed in Aotearoa, we are calling for a care minutes framework that builds a safe staffing system around the needs of residents. This model unites comprehensive assessment of residents' clinical and hauora needs with the funding and staffing commitments to meet them. This framework shows how we can achieve a safe staffing system that is enforceable, equity-based and world-leading. It ensures that kaumātua are safe, whānau are respected, staff are supported and gives practical effect to Te Tiriti o Waitangi.

We conclude with a series of recommendations. These ten recommendations emerge from the voices and expertise of kaimahi as clinical, cultural and industrial leaders of their sector. These are described in the final section of the report and are summarised here.

Recommendations | Ngā Tūtohi

1. **RN Coverage:** All aged residential care facilities must have a Registered Nurse on site and on duty 24/7 to ensure safe care for kaumātua. This precludes the use of virtual or remote nursing services and is in addition to mandated nursing staffing ratios.
2. **Case-mix:** A case-mix model of assessment that reflects the acuity and complexity of residents coming into ARC facilities now and those projected to enter in the future is essential for identifying residents care needs and corresponding funding requirements.
3. **Care Minutes:** The Government must establish legislated evidence-based safe staffing minimums that ARC providers are legally obliged and funded to meet. In conjunction with interRAI (LTCF) assessments, care minutes provide an evidenced baseline for what is needed for individual residents in terms of their clinical, cultural and personal care needs 24 hours a day. Each category of resident must have fixed minutes, and entitlements are resident-held, daily and non-transferable.
4. **Cultural Safety:** A care minutes model in Aotearoa must embed cultural safety within clinical assessment by quantifying and embedding cultural care time and culturally safe practice in the form of Hauora care minutes. This means that the staff time to provide direct care, both clinical and personal, accounts for the hauora needs of residents by providing additional time to deliver care in a mana-enhancing and culturally safe manner. Hauora care time also accounts for meeting the cultural, social and spiritual needs of residents beyond immediate clinical or domestic routines.
5. **Ratios:** Care minutes calculations should be converted into safe patient ratios for both nursing staff and kaiāwhina to ensure safe staffing on every shift. Ratios indicate the number of residents one staff member can safely look after per shift, or conversely, the number of staff a facility of a given size must roster for every shift. Ratios make care minutes legible and enforceable. This would translate the evidence-based clinical and Hauora calculation of care minutes into minimum staff to resident ratios.
6. **Workforce capacity:** There must be a robust training pipeline and full pay parity with Te Whatu Ora HNZ to ensure there are enough appropriately trained staff to meet the needs of residents now and in the future. This includes workforce planning, capacity and cultural competencies.
7. **Funding:** Funding must be linked to the provision of care time based on case-mix modelling and accompany a clear legal requirement to fulfil care time. Funding levels should be determined by independent evidence-based costings of care delivery, including workforce and operational costs.
8. **Building Capacity:** The Government needs to fund additional capacity in the ARC sector to address bed shortages nationally and fill service gaps that compromise equitable access to ARC services in local communities.
9. **Transparency:** The Government must legislate mandatory reporting on planned staffing levels to meet minimum requirements, actual care time delivery, compliance with targets and provider financial information at the level of each ARC facility, provider and parent company receiving public funding for ARC service provision.
10. **Accountability:** Every facility must have a Workers' Voice Committee, comprising elected staff representatives and union delegates, with access to rosters, compliance data and Registered Nurse 24/7 logs.

Section Two

Introduction

Kupu Arataki

Introduction | Kupu Arataki

From the outside, it is not obvious that the aged care system in Aotearoa is broken. But for the residents, workers and whānau who see the inside of aged residential care (ARC), it is undeniable. Kaumātua (older persons) across the motu depend on a system that is entirely unable to meet their essential clinical and personal care needs on a daily basis. Staffing below safe levels is widespread and a poorly funded system is ill-equipped to provide culturally and clinically safe care. Aged care is in crisis.

The complexity and depth of needs among ARC residents are not being met due to a failing and underfunded health system. As funding fails to keep pace with the growing complexity and need among kaumātua, health kaimahi (workers) are overwhelmed by chronic understaffing and increasing workloads. The monumental shortfalls in care capacity due to budget constraints and unsafe staffing levels manifests as unmet needs, missed or delayed care and in some cases, outright neglect. While underfunding the health care system may superficially appear to save the government money in the short term, the true cost is borne instead by residents, their whānau and the health kaimahi who care for them.

A steady stream of evidence has been building about the funding and capacity crisis in the ARC sector. However, these have failed to address the workforce component and the direct impact on care for kaumātua. The Te Whatu Ora commissioned Sapere report[1] on aged care funding and service models and the Aged Care Commissioner's report *Amplifying the voices of older people across Aotearoa New Zealand*[2] highlight supply shortfalls, underfunded facilities and limited access for older people. These reports have lacked the political conviction to admit the root of the crisis. An overly simplistic and inadequate funding model and system design leads to unsafe staffing and unsafe care.

The findings in *Care in Crisis: Manaaki i te Raru* are based on the most extensive primary research conducted to date in the aged residential care sector. It documents the voices, insights and experiences of workers from the frontline who provide direct care to kaumātua and witness daily the myriad ways in which the system fails them. Our research draws on 80 in-depth, in-person interviews with aged residential care workers in nursing and kaiāwhina (this term refers to non-regulated caregivers / health care assistants) roles. Further findings come from sector-wide surveying of 415 kaimahi in direct care roles in ARC and 156 health and safety report forms relating to unsafe staffing on specific shifts in ARC facilities. The collective worker voice presented here encompasses various direct care roles across all facility and provider types, with geographical coverage across the motu. This is the most comprehensive research into worker expertise and experience in the ARC sector to date.

The challenges facing aged residential care are not confined to a few areas, select roles, or certain types of facilities. They traverse the aged care sector in its entirety. Large for-profit chains, community providers, religious organisations, urban centres, rural enclaves, migrant workers, nursing staff, clinical managers, kaiāwhina (health care assistants) – we find the same story at every turn. The aged care sector is underfunded and understaffed – and this has a direct and demonstrable impact on the quality and safety of care provided to our kaumātua.

In the section **Unsafe Care, Unsafe Staffing | Manaaki Kore Haumaru, Kaimahi Kore Haumaru**, we present workers' stories of unsafe care, the inadequacy of cultural safety processes, the experience and consequences of unsafe staffing and the system failings of ARC. Workers reported daily shortfalls in essential clinical and personal care, witnessing neglect and preventable harm to residents resulting from time and budget constraints, and the overall erosion of residents' dignity and mana. Workers described the toll of working in a broken system where they are set up to fail. This includes working excessive overtime, missing breaks, being buried under overdue paperwork and documentation, and suffering moral injury because they do not have enough time or capacity to provide the kind of care they are trained to deliver. The ARC system architecture is structurally faulty – there is an overall lack of beds, residents have higher acuity levels and complex needs, assessments are often delayed or inaccurate. Budget constraints ultimately determine the poor-conditions of care. The lack of enforceable standards leaves regulators without clear levers, while providers under-deliver on care without consequence. The current approach to ARC is neither safe nor sustainable.

However, the point is not to simply document the crisis. Kaimahi in ARC do not want to be perennial experts in the problem. This report exposes the scale and depth of unsafe care and unsafe staffing in ARC to highlight the unequivocal urgency of reform. We must begin the work of building an alternative ARC model that is uncompromising in its commitment to the safety and wellbeing of kaumātua and their kaimahi. The scale of change is significant – no degree of modification at the margins will fix the deep-seated issues in the capability of the aged care system to meet the needs of kaumātua safely. Significant new investment is needed to transform aged residential care into an accessible, equitable, culturally and clinically safe, and te Tiriti consistent system.

The framework outlined in **Culturally and Clinically Safe Staffing | Te Kaimahi Haumaru ā-Ahurea, ā-Haumanu hoki** builds on the ambition of Australia's care minutes model in ARC for uniting comprehensive assessment of residents' health needs with the funding and staffing commitments to meet them. However, the Aotearoa model must correct for structural weaknesses and learnings from the Australian experience since the implementation of their aged care reforms in 2023. The resident must be at the centre of the ARC system. The design and planning of ARC funding and staffing models must also account for the cultural context of Aotearoa. It must recognise that good care is not just clinical – it is equitable, cultural, relational, and mana-enhancing.

Government budget constraints have driven decisions to erode the capacity and quality of ARC to the brink of collapse. The pursuit of affordability has been the governing principle of health funding in Aotearoa for decades. The real question should be: what is the cost of doing nothing? Jasmine[1], a kaiāwhina in Te Waipounamu, shared her personal experience with the failing aged care system. Jasmine's mother entered aged residential care in her mid-thirties after being diagnosed with Huntington's disease. She passed away in an aged care facility after falling from bed and hitting her head. Jasmine told us that because Huntington's disease has a 50% inheritance rate, she herself could need to be a resident of the same care facility where she currently works in the next five to ten years. Her words are a powerful reminder of the urgency of reform:

> I have seen the quality of life that these residents experience. That could be mine. I immediately fear what this could mean for my future. I want to be able to expect more from a care facility than the bare minimum, where care is given in terms of 'which essential care is less essential and can wait?' I want to be able to expect a quality of life where no matter my cognitive or physical ability, I have higher expectations than a relatively quick and clean death like my mum. I want to hope for this future now, not 10 years from now. Because for me, 10 years could be too late.
>
> Often, we see this as something in terms of someone else, or our loved ones. It's easy to put it off and say 'things will get better by the time this becomes relevant to me personally,' or 'I would be in a financial, physical, or emotional place where I could care for my loved one at home, so this wouldn't apply to anyone I care about.' But this isn't something that should be pushed off to a distant future. The aged care sector is an immediate problem. We need solutions now. Because while it might not be YOUR future, it could be MINE.

1 To protect participant confidentiality, pseudonyms have been given to all participants and identifying demographic information has been withheld or generalised.

Section Three

Unsafe Care, Unsafe Staffing

Manaaki Kore Haumaru, Kaimahi Kore Haumaru

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Unsafe Care | Manaaki Kore Haumaru

Unsafe care is the product of unsafe staffing, which stems from an aged care system that is failing to keep up with the growing complexity in clinical and care needs of kaumātua.

High-level decisions about ARC system funding and design are not just abstract policy and funding settings. These decisions manifest in chronically understaffed ARC facilities ultimately leading to the compromised quality of care that residents receive. Despite the tireless efforts of kaimahi to care for kaumātua in a safe and dignified way, no amount of personal sacrifice can rectify a system designed to erode and undermine their ability to deliver the high-quality care they have been trained to deliver. This chapter exposes the day-to-day reality of missed and unsafe care in ARC and the impact on the safety, well-being and mana of kaumātua.

Missed care

We use the term missed care to describe the discrepancy between the expected level of care, in terms of best practice and resident/whānau expectations, and the care that is ultimately delivered. In other literature, this is sometimes called substandard care or neglect. However, this framing does not accurately reflect that often the care that health workers are able to provide is excellent, they simply do not have enough time, capacity or resources to deliver enough of it. In these understaffed and under-resourced conditions, even the basic clinical and personal care for residents get missed. Nurses and kaiāwhina we surveyed strongly agreed (87%) that staffing levels have affected their ability to provide high-quality care to residents. Kaimahi told us that time pressures, caused by budget-driven staffing decisions alongside increasing acuity and care needs of residents, ultimately results in kaumātua missing out on essential and dignified care.

Our sector survey revealed the daily prevalence of essential cares being missed. One quarter of kaiāwhina reported that almost every shift residents are going without showers, not being supported to toilet themselves, receiving meals cold or behind schedule, or going without reassurance when anxious or lonely. Similarly, nearly one quarter (23.4%) of nurses reported being unable to administer medications on time almost every shift and almost one third (31.9%) cannot respond to call bells in a timely manner when residents need them urgently.

Laura, a Clinical Nurse Manager at an Enliven facility told us this simple equation:

> **"The quality of care is always correlated to the time that the staff can give to them."**

Health workers described daily compromises where cares are rushed, delayed or missed entirely. Workloads prioritised meeting bare minimums for residents. Compromised care was evident across all regions, provider types, and service levels.

> Back 20 years ago we had more staff and more time with the residents, whereas now we don't get that quality time. Some days it honestly feels like a milking shed, you know, line them up, hose them down. Some days you're running from one resident to the next (Tina, Kaiāwhina, Summerset, Central).

> They really deserve to be looked after, they deserve to have respect, they deserve dignity. And what I'm seeing, they get nothing. They're lucky if they get showers. They don't get the time spent on them that they should be getting. Things are being skipped, missed. It's heartbreaking. And all because they want to make a dollar. Upstairs, it's a bum in a bed (Angela, Kaiāwhina, Bupa, Canterbury).

Feeding and hydration

There is undeniable evidence that staffing levels in aged care are not adequate to provide kaumātua with appropriate feeding and hydration assistance. Health workers frequently cited time constraints forcing them to rush residents' meals, failing to feed them complete meals, often contributing to avoidable weight loss. The prevalence of feeding issues is evidenced by 41% of surveyed kaiāwhina reporting that they are unable to provide meals on time and while still warm often or almost every shift. Nurses report that when rushed, residents requiring assistance may only be fed a quarter of their meal before kaiāwhina move onto another resident. The risks of dehydration also carry significant clinical consequences such as urinary tract infections. Kaimahi report that residents often go without fluids for prolonged periods due to staffing levels and time pressure. Kaimahi noted a significant drop in food quality, as well as nutritionally insufficient portions and a lack of alternatives for residents who would not eat planned meals or had specific dietary needs.

> Staff do tend to miss people that are in their rooms, so dinners get missed out, and that's the same with feeding people as well. Some residents don't get fed at all (Logan, Kaiāwhina, Bupa, Central).

> Also, with short staffing, you can tell there's more UTI incidences because residents don't have fluids. People are losing weight because no staff can sit with them for that long to feed them. Or they miss out on breakfast because by the time they get to them, it's already like 10 o'clock and then there's morning tea (Florence, Registered Nurse, Oceania).

I've got a patient who's a really bad diabetic. His HBA1C is like 180 something, and yet they can't even put him on a diabetic diet because the facility doesn't provide special diets (Gina, Nurse Practitioner).

And another thing with the way that they're budgeting things is they're not buying as much food for the residents... To make up for the reduction of food, they're increasing the number of residents on Ensure and Diasip, which is meant to be a last resort. But it's being used as a substitute for the food that they're not getting. It's being used to make up for the fact that they don't want to buy as much food for the residents, basically, all around the budget (Cameron, Registered Nurse, Presbyterian Support Services).

Showers and hygiene care

Residents' basic hygiene needs are directly compromised by staffing shortages. Showers and essential personal care tasks are frequently missed due to time pressures and inadequate staffing.

Only 7.9% of surveyed kaiāwhina reported always being able to shower and bathe all residents requiring assistance.

In contrast, one quarter reported that residents miss being showered and bathed almost every shift. Interviews with kaimahi confirmed that missed hygiene care is widespread. Consequences of compromised hygiene vary from neglected oral care to serious infections caused by prolonged lack of bathing. Again, this was evident across a wide range of facilities.

Showers and baths will be dropped and will be scheduled to another day or sometimes the week after. And now rampant in our healthcare facility is itchy rashes (Hazel, Registered Nurse, Summerset, Central).

We've got a couple of residents that were full assist that hadn't had a shower for about two weeks. They got a fungal infection, quite bad and in multiple different areas. And all in all, the documentation was very clear. Showers missed due to poor staffing (Renee, Registered Nurse, Bupa, Central).

Underarms didn't get washed. Under breasts only got washed if they had to do it for certain residents. And then sometimes just forget about the teeth and dentures which would be dirty and not cleaned. It was missed more often than not (Ava, Kaiāwhina, Presbyterian Support Services, Te Waipounamu).

Continence care and toileting

Toileting and continence care fall well below clinical baselines for meeting kaumātua needs with dignity and respect across the ARC sector. The evidence indicates that time constraints and understaffing result in residents losing this essential right. 47.3% of kaiāwhina we surveyed reported that they don't have time to support residents who require assistance to the toilet almost every shift or often. Core issues related to continence and toileting include the overuse or inappropriate use of incontinence products where residents could otherwise be supported to toilet themselves, residents left in soaked pads for prolonged periods and facility budget constraints leading to pad-rationing.

Overuse of incontinence products

Many workers described residents who are capable of toileting themselves with assistance from care staff. In practice, however, there are not enough staff members on shift or time allocated for resident care to support independent toilet use. That leads instead to the overuse of incontinence products as a substitute toilet. Violet, an RN at a Summerset facility in Central region, reported that residents are frequently told, "*just go in your pad and we'll come and change you.*" Kaimahi frequently described pre-emptively putting residents in pads in anticipation of being unavailable when they may need the toilet.

> Three out of five residents do not need incontinence products. If someone took the time to help them get to the toilet, they could absolutely do that. Because they weren't actually incontinent, right? (Rebecca, Clinical Nurse Manager, Arvida).

Residents left in soaking pads

Incontinence products are not changed as frequently as required resulting in residents being left in soaking pads. As a comfort and hygiene issue, this can lead to further clinical consequences such as rashes and infections. Beyond this, it also diminishes the mana and dignity of residents left in soiled products for prolonged periods.

> It needs to be full, from end to end, of urine before you change it and if the moisture is faecal, too bad. Keep it on until the end. It must last seven hours. But when the afternoon staff is short, what doesn't get done? And by that stage, they're swimming in it. That's what's happening and of course they're getting red groins because of it. And then they go, 'oh, why is it so red?' And it's like, what do you think? The product's meant to last seven hours, but when the afternoon staff have short staffing, that person doesn't get changed for so many hours afterwards. By then, they're drenched (Angela, Kaiāwhina, Bupa, Canterbury).

> The pads are absolutely soaking, and you can tell with the fungal infections and red groins, that people aren't being dried properly and definitely hygiene is an issue (Gina, Nurse Practitioner, multiple facilities).

Supply restrictions and pad-rationing

Incontinence products in ARC facilities are commonly kept in locked cupboards. Many facilities reduce the quality and ration incontinence products for residents. Residents are put into products that are lower quality or absorbency than required or the wrong size product. This results in skin issues, pressure injuries and residents wetting through their products, clothes and beds. Kaimahi explained having to request and justify why they need additional pads.

> They say, 'who asked for the key around here?' I say, 'I need it for such and such.' And they'll say, 'they've been allocated.' So, what do you want me to do? Just leave them sitting there? I asked for a pull up, but that was gold. I feel sorry for him because he gets embarrassed when he wets and it's only because the pad slipped between his trousers and his leg (Ruby, Kaiāwhina, Ryman, Auckland).

> So, for example, if they purchase the wrong continence product, they will ask you to finish those first before they purchase the right one because they don't want to waste those products. They're trying to save money. Sometimes we have to adjust our care, and it does give us a lot of extra work. If they're wearing a small pad, we have to change them more frequently and sometimes it leaks and it wets the whole bed (Chelsea, Registered Nurse, small not-for-profit, Auckland).

> Each of our residents have their allocated pads for the morning and the afternoon or nighttime. But, for example, if they need to change in between, we need to offer them a cheaper pad. But residents really suffer because they're prone to pressure injuries and rashes. So, yeah, you can see it from them that some of them get pressure injuries or wounds because of the pads (Courtney, Unit Coordinator, Ryman, Auckland).

Wound care

Wound care is critically compromised by chronic understaffing, time pressure and budget-driven cuts in product quality. Nearly 40% of nurses surveyed reported that almost every shift or often they do not have time to dress residents' wounds. As a result, essential care is delayed or missed altogether, leading to preventable infections and prolonged healing. In May 2025, the coroner criticised the care provided at a Heritage Lifecare facility in Gisborne, where a 71-year-old man died after an infected pressure wound was left for months without proper treatment.[3]

Frontline nursing staff said that cost-cutting regularly overrides clinical best practice in wound care, putting residents at extreme risk.

Nursing staff reported limited access to high-quality wound products, lengthy approval processes and even situations of cutting products in half to save money. Many nursing staff felt constrained by a one-size-fits-all approach to wounds. Chelsea, an RN based in Auckland, explains, "*I can't use whatever I want based on my clinical judgement. I have to compromise because of the money.*"

> When you go for wound training, they said the best wound product that you need to use would be Allevyn. But if we use Allevyn, we get told off because it's expensive. Then our stock of it would be locked in the office. So, they ask us to use those cheap ones like the PrimaPore or the QT Plus because it's cheaper. But sometimes when you take it off, residents' skin would come off as well, especially for those frail residents (Lucas, Registered Nurse, CHT, Northern).

> When we're already short-staffed, if someone happens to get a skin tear, some of the caregivers don't say anything. They leave it because they don't want to have to do all the paperwork because they're already falling behind. And then that kind of gets missed, and then it gets picked up a couple of days later once it's infected (Renee, Registered Nurse, Bupa, Central).

> We started getting really budget dressings that would disintegrate into the wound. And I was lucky because I have a friend that works in the community. So, she could go into the district nurse's cupboard at public health and nick me some dressings. Before, if we needed medical supplies, we could order them. Not anymore (Sarah, Clinical Nurse Manager, Arvida).

Te Whatu Ora provide funding for high-cost wound dressings, but kaimahi report that the funding application is complex and the payment is delayed– in some cases facilities wait six months to receive payment for these products. When adequate funding for essential wound products is not available, some facilities have resorted to alternative funding mechanisms, transferring the financial burden to other governmental organisations. A senior nurse at Oceania told us "*Oceania I know in particular are claiming a lot of ACC so if it's skin tears and wounds and they need dressings they will claim through ACC and get some money in to fund the dressings that way.*"

Turning and repositioning residents

Pressure injuries are a preventable harm affecting people receiving care. Aged care residents, especially those who require hospital-level care, are exposed to risk factors for developing a pressure injury, such as sitting or lying down for long periods of time, damp skin from sweating or incontinence and dehydration.[4] Thus, pressure injury prevention and management protocols (PIPM) such as turning and repositioning residents is essential. However, only 13.1% of nursing staff surveyed responded that their team always have time to roll or reposition residents.

> Those two hourly moments where you're supposed to go and shift residents on their chair, move them about or make sure that they don't get any pressure injury - when they're short staffed, those will be missed (Radhika, Registered Nurse, Oceania, Auckland).

Sometimes they'll be sitting in chairs for long periods of time without being repositioned or moved or whatever, and that's frustrating, but you generally can't move them by yourself (Harriet, Registered Nurse, Arvida, Te Manawa Taki).

Sadly, I know people don't get turned. I don't care how many times they tick the box to say they do; the evidence is on the residents (Grace, Unit Coordinator, Bupa, Te Manawa Taki).

Health and safety risks

Kaumātua are being put at real and avoidable risk due to unsafe staffing levels. Across nearly all interviews, frontline workers described patterns of serious health and safety failures, which in many cases led to preventable injuries for residents. Far from a rare occurrence, such failings were characterised as routine components of daily care across facilities. Breaches of health and safety were most evident when it came to hoisting, unsupervised residents, and rushed care.

Unsafe hoisting

Staffing shortages put pressure on workers to rush, increasing the risk of shortcuts and decisions to deviate from safe practice or company policy. Interview participants felt complicit in the compromised quality of care and fearful that if they admit the prevalence of these breaches of policy or best practice, they will be subject to disciplinary action and risk their job.

Kaimahi report insufficient staffing levels to ensure safe hoisting practices. Health workers across major providers – including Ryman, Arvida, Summerset, Oceania, Metlife Care, Bupa, Radius, Presbyterian Support Services, and Heritage – shared experiences of being left to hoist residents alone despite requiring two staff members, particularly during high-demand periods. Due to extreme anxiety displayed by kaiāwhina about reprisal from their employer for admission of single person hoisting practices, potentially identifying details have been withheld in the worker quotes below. This is demonstrative of the regulatory conditions where workers are pressured to make unsafe decisions due to unsafe staffing and subsequently punished individually for what is ultimately a structural problem.

When I started, there were a lot less residents that needed constant observation and a lot less that needed two assists for cares. Things like hoisting - our policy is to use two caregivers always, but there's no accounting for that in the safe staffing policy. They don't give you any extra staff depending on how many residents you've got that need those two assists. I find that if you're physically able, you might have to do the rolling on the bed yourself. You can't do it with two caregivers if you don't have a second person available. I don't think it's safe for the residents. But sometimes you've got no choice (Kaiāwhina, Summerset).

There's been so many skin tears. And it's because the girls are using the sling hoists on their own instead of two people and the manager said if I catch you doing a sling hoist on your own and there's a skin tear involved, there will be a disciplinary. But what are they supposed to do when there's nobody there to help them? (Registered Nurse, New Zealand Aged Care Services).

Unsupervised residents

Significant health and safety risks arise from the inadequate supervision of residents. Kaimahi report that inadequate supervision in communal areas leads to serious and preventable incidents including falls, injuries, and unsafe behaviours. This is particularly acute in dementia-level and psychogeriatric facilities. Staffing shortages and competing care demands limit kaimahi ability to supervise residents, exposing kaumātua to undue risk and preventable harm. Participants frequently described being forced to leave large groups of residents unsupervised while they attended to other essential care tasks. In some cases, when an unsupervised fall occurred, other residents would attempt to help them up, causing them to also fall and suffer an injury. Some examples of the risks and injury to residents from inadequate supervision are outlined below.

> Recently one of our dementia-level residents swallowed a glove. If we have enough staff to observe our patients, to support our patients, this kind of problem decreases (Jenna, Registered Nurse, Bupa, Te Waipounamu).

> A dementia patient was left in the garden by a care staff to toilet someone else and when he came back the resident had a massive cut and a fracture. That fall could have been avoided if there was someone looking after them (Vince, Registered Nurse, Bupa, Northern).

> We don't get to see the residents for a while after we've helped them, because we're helping the six other people. If anything happened to them while they're in the room, we wouldn't know until hours later unless they've rung the bell. But if there's an emergency, if they've fallen over, we wouldn't know unless someone was going into their room for a reason (Brooke, Kaiāwhina, Heritage, Te Waipounamu).

> So, you've got maybe six people to do personal cares for per caregiver, and you're left prioritising the ones that are immediately unsafe. And you can't do all of those all at once when you've got two or three people on your list that are technically immediately unsafe. So, it's which one is least unsafe? Then you've got someone else who is physically safe being left alone, she is banging on furniture, and it's disruptive to everybody around her that can hear her. She's obviously mentally in distress, but I cannot leave the person I'm currently helping because she's immediately at risk of harm if she climbs out of bed. So, you're stuck choosing between which is the more immediate concern and which has the worst consequences (Jasmine, Kaiāwhina, Summerset, Te Waipounamu).

Rushed care

Kaimahi consistently reported that time pressures forced them to rush care, creating significant health and safety risks for kaumātua. This was not limited to isolated incidents but described as a routine feature of daily care across all facility types. Rushed care was directly linked to preventable harm, including falls, skin tears, and bruising. Participants gave numerous examples, such as dressing residents too quickly or urging them to walk faster than was safe or comfortable for their level of mobility. Stories from kaimahi on the frontlines highlight the systemic nature of rushed care and the ongoing threat it poses to resident safety.

> Our residents have falls and injuries. I've had some residents who got burned. Some residents have bruises everywhere, all because we are rushing (Courtney, Unit Coordinator, Ryman, Auckland).

> That's how a lot more accidents happen, you're trying to make them walk a little bit faster to the bathroom, trying to run and change their bed while they're on the toilet, so you know, you're giving them slightly less time because you have to get things done (Brooke, Kaiāwhina, Heritage, Te Waipounamu).

> If the workload increases, the staff try to rush and finish the work and then if they are rushing, the bruises, skin tears, all these things happen (Annie, Registered Nurse, Radius, Te Manawa Taki).

> And I've noticed in the last few years too, the incidence of residents having falls has increased massively over the national average and I think that too is reflective of staffing, and equipment (Jacki, Kaiāwhina, small not-for-profit, Wellington).

Missed Cares: Kaiāwhina

In the last year, how often have you not had enough time or staff on to complete the following cares?

Missed Cares	Almost Every Shift	Often	Sometimes	Rarely	Never
Shower and bath all my residents that need assistance	25.20%	32.28%	24.41%	10.24%	7.87%
Support residents to toilet themselves	25.20%	22.05%	24.41%	10.24%	18.11%
Provide meals while still warm or on schedule	25.20%	15.75%	20.47%	15.75%	22.83%
Assist residents to eat	21.26%	19.69%	22.83%	14.17%	22.05%
Provide reassurance to distressed, anxious or lonely residents	25.20%	25.20%	26.77%	8.66%	14.17%
Support residents to participate in planned activities	21.26%	16.54%	39.37%	13.39%	9.45%

Missed Cares: Nursing staff

In the last year how often have you not had enough time or staff on to complete the following cares?

Missed Cares	Almost every shift	Often	Sometimes	Rarely	Never
Complete care plans and interRAI	30.85%	29.08%	23.05%	12.06%	4.96%
Complete all documentation required for residents	30.14%	27.30%	22.34%	10.64%	9.57%
Respond to call bells in a timely manner	31.91%	25.53%	21.63%	13.48%	7.45%
Roll or reposition patients	18.44%	20.57%	26.95%	20.92%	13.12%
Dress wounds	19.86%	19.86%	28.72%	16.67%	14.89%
Administer medications on time	23.40%	14.54%	23.05%	16.31%	22.70%
Converse with or otherwise spend time with residents	31.56%	26.24%	25.53%	10.64%	6.03%
Provide reassurance to distressed, anxious or lonely residents	22.70%	28.72%	23.40%	15.60%	9.57%
Provide active supervision and support to HCA team	27.30%	24.82%	26.95%	13.12%	7.80%

Cultural Safety | Kawa Whakaruruhau

Policies regarding culturally safe care in ARC are not effectively implemented in practice. Cultural safety requires healthcare professionals to examine their own biases, attitudes and stereotypes.

Kaimahi must engage in ongoing self-reflection to ensure the care they provide is responsive to the clinical, emotional, mental and social needs of the resident.[5] While the concept of cultural safety is well established in the health sector, its implementation has largely focused on individual behaviour and education, rather than being embedded as an organisational responsibility.[6] The Age-Related Residential Care (ARRC) Agreement, which is negotiated annually between Te Whatu Ora and Aged Residential Care providers to outline the standards and service obligations for publicly funded aged care, requires facilities to have a policy on providing culturally safe care. Despite this requirement, kaimahi report that cultural safety has been reduced to a compliance mechanism, existing in policy documents and audit checklists, but not in the day-to-day care provided to kaumātua. Kaimahi point to wider system issues that undermine the provision of culturally safe, mana-enhancing care. Unsafe staffing levels, expanding workloads, insufficient orientation and a lack of training are eroding their ability to deliver the care that kaumātua deserve.

Aged care is failing to meet the needs of Māori

Upholding Te Tiriti o Waitangi is a professional, ethical, and legal obligation for all nurses in Aotearoa. This involves actively supporting Māori self-determination, advocating for equity, and working in genuine partnership with tāngata whenua across all areas of nursing care, policy, education, and leadership.

Te Tiriti o Waitangi is a living covenant that underpins equity-focused, kawa whakaruruhau and culturally safe nursing practice.

We found several ways the aged care system is failing Māori as both residents and kaimahi. This relates to limited or non-existent access to residential care in their community, limited ability to maintain connection to their whānau, hapū and whenua, a lack of Kaupapa Māori services, and failure to provide culturally safe care in practice, including explicit breaches of local tikanga. Māori health care workers frequently carry the burden of cultural responsibility, with assumptions that they will perform tikanga solely based on their identity – without adequate support, recognition, or preparation. This creates an additional cultural workload delegated to them without compensation. Māori health workers are asked to run whānau hui, lead karakia, interpret in te reo Māori, or mediate cultural misunderstandings – all while carrying full clinical or personal care workloads.

The extent to which ethnic inequities seen in the wider health system exist in ARC is largely unstudied. Academic research defines older Māori as 45 years and older to acknowledge that disease and disabilities commonly associated with old age start earlier for Māori than non-Māori.[7] Life expectancy for Māori was 75.8 years in 2022-2024. For non-Māori life expectancy was 82.8 years.[8] The demographic ageing of the Māori population is happening faster than for non- Māori and even with underrepresentation, the number of Māori accommodated in ARC is expected to increase four-fold over the next two decades.

Māori access to local ARC services

Private, profit-driven aged care models pose significant risks to Māori health equity. There is little commercial incentive to deliver care in high-needs or rural Māori communities, where services are often least accessible. As a result, further privatisation is likely to exacerbate already entrenched inequities in access and service delivery, particularly in rural areas where fragmentation and service gaps are common.[9] Rural communities are chronically underserved by aged care services, forcing Māori previously living in rural communities on their whenua to move to urban centres to access care.[10]

Māori kaumātua face another forced displacement, severing them from their whenua, hapū and their tūrangawaewae.

This erects additional barriers to accessing care and disconnects kaumātua from their whānau and support systems while in care.

Delayed access to beds in rural communities leaves whānau caregivers making choices to keep their kaumātua at home until a bed opens in their community. However, lengthy waitlists for extremely limited local bed supply ultimately force those with advanced care needs or those for whom waiting is not a viable option to abandon their community and move into residential care away from home. Severely restricted rural bed capacity and the specific staffing challenges at facilities that are meeting the needs of rural Māori require urgent attention. Gina, a Nurse Practitioner supporting

iwi providers of aged care, described the distinct struggles that characterise rural Kaupapa Māori aged care services:

> So over there, a lot of the residents speak te reo and that's really important for them. Being cared for by Māori, mostly Māori caregivers, is good because they're conversing in a way that they're used to, which builds a lot of trust... Some of them are whānau, they are related. It's quite a happy place. I get happy feelings when I walk in there. The staff, with nursing, there's still the same struggles. You know, the nurse manager is frequently on the floor or doing night shifts or whatever. And I don't see that in the other facilities in town, the nurse managers having to do that. But they've got no other choice up there, because if you've got no nurses, you've got no nurses, that's it. So, it's on her, which is really hard. And I think holding onto the nurses up there is really difficult. Because if you've got a family, the schools up there, I think they're all te reo schools so they will have a mix of language, but straight away that puts a halt on a lot of town kids, or overseas especially. Housing - there's no housing for them. There's a nurse's house on the premises, the nurse's flat, and if you've got a family, that's not gonna work. So, they've had two nurses leave when I first started within a few months because they've both got families and no houses. They didn't have a vehicle. They didn't realise how far away it was.

Mātauranga Māori in care

Māori kaumātua are hesitant to enter ARC due to a lack of Kaupapa Māori services – they need to see, feel and hear the presence of mātauranga Māori to thrive in aged care.[11] However, kaimahi were adamant that facilities had to go further than just presenting a Māori façade. Cassie, a Māori kaiāwhina working for a not-for-profit provider, described the disconnect between the Māori façade of their facility and the actual care delivered to residents saying, "*If you go out the front and all that, you see all the stuff that makes it look like it's culturally safe, but then all of the detailed stuff, that's just not there.*" Māori kaimahi described low levels of Māori working in ARC, widespread tokenism, explicit anti-Māori behaviours, inadequate knowledge of te Tiriti, and failures to follow through with cultural care plans. One barrier for Māori accessing ARC is that the systems, processes and design are not Māori-centred.[12] Māori kaimahi agreed that aged care is not built to support the needs of Māori in care. Instead, whānau, other Māori residents and Māori kaimahi are left to address these service gaps through informal support and advocacy.[13]

> Everything in te ao Māori world is missing in aged care. Te Tiriti is missing, and they don't have an understanding of te Tiriti and they can't expect that the Māori staff in aged care do all that mahi (V, Māori Kaiāwhina, Heritage).

Cultural safety training and equity approaches to care are not often present in facilities. Older Māori require a sustainable Māori workforce in ARC that is well-resourced in a way that acknowledges both clinical and cultural expertise. To develop an appropriate workforce that contributes to achieving health equity, there should be explicit training relating to health equity, te Tiriti o Waitangi, cultural safety, Māori health and anti-racism.

Policies without practice

Under the ARRC agreement, providers are contractually obliged to develop a Māori health plan which includes eliminating care barriers, supporting cultural practices, including whānau and consulting with Tāngata Whenua in order to meet the needs of Māori residents during the provision of care.[14] Māori kaimahi we interviewed had never seen these policies enacted in practice. Workers highlighted a lack of accountability or structural support to embed these principles into actual care delivery. In most instances, this was at best reduced to a tick-box exercise for audit purposes. Even for practical day-to-day care delivery, workers described breaches of tikanga around food handling, hygiene and grooming practices, such as placing used pads on bedside table surfaces or cutting hair and nails at night while residents slept.

> It's very hard there, culturally, being Māori in aged care. A lot of tokenism. We have policies written up for our Māori pathways, health pathways, and there were no macrons. I mean, I don't know it well, but even I know the spelling was wrong. It was very copied and pasted. That's how I've seen it. And then we started getting signs in, and there was no education given as to why we had the Māori names for things. It was just like, oh, we're one country, blah, blah, blah. So, the staff didn't like it, because they felt like we were forcing it on them. Where, in that space, there should have been some education about why we're using this, and why it's important to our country to use both names (Tori, Māori senior nurse, Arvida).

Cultural care passed to Māori kaimahi

When staff are forced to prioritise basic physical tasks under pressure, there is no capacity left to engage meaningfully with residents, build trust, or uphold tikanga. This creates a situation where both staff and residents are placed at risk – culturally, emotionally, and physically.

Māori kaimahi are left to uphold cultural safety within a system that does not support it.

They are often expected to perform cultural leadership roles within aged care facilities, taking sole responsibility for ensuring compliance with tikanga and cultural duties with no reduction in their full clinical or personal care load.

When asked if te Tiriti was upheld in aged care, Māori kaimahi unanimously agreed that it was not a priority. One participant remarked that the only time tikanga *"comes in is when someone has passed,"* at which point a Māori staff member may be called upon to perform a karakia. They added, *"So they honour that time of the resident's life, but not the present."* Once again, the cultural labour of observing appropriate tikanga around death was disproportionately shouldered by Māori kaimahi. Many Māori care staff described taking responsibility for cleaning and dressing residents who had passed,

setting up a personal lamp in their room, sitting and talking with them. They described anxiety about what death might look like for residents when there were no Māori staff on shift and whether appropriate tikanga is followed by staff who have not been trained and supported to understand its significance.

Māori workers are often going above and beyond to bring te ao Māori into their daily practice – walking the corridors during night shifts to perform karakia or taking it upon themselves to educate others on tikanga. Workers described situations where staff touched residents' heads without consent or were expected to go directly from toileting someone to preparing food. One kaiāwhina shared a story where she was required to hover an iPad over a deceased resident so a virtual RN could verify death. Many described their motivation to work in aged care stemming from te ao Māori and their reverence for kaumātua, which translated into their daily delivery of care.

> We're great believers that we do not rush them into bed while you sit down and do nothing. Māori, for us, is we do what they want. Because at the end of the day, if you're very fortunate to still have your grandparents with you, you have well over 100 years of knowledge between them, and you don't want to shove them in bed, you want to kōrero with them (Cassie, Māori Kaiāwhina, small not-for-profit, Northern).

> My passion is with our people. And whether it's a Pākehā that wants to do it the Māori way, kā pai. You know, and there's lots of them that like the way that we roll. And that's what I want to implement. I want us to be able to be us and not have to justify that to anyone. You know? I have our residents in the same category as my mokopuna. You know, they deserve nothing but the best. And it's really important that we give them that. Because they've lived their life. They've provided for their whānau. And why shouldn't they get the best? (Delia, Māori Enrolled Nurse, Not-for-profit provider).

Inequitable access to safe care

Culturally safe care for all residents in aged care requires equitable access to health care. This involves challenging systemic inequities and unsafe practices to ensure that aged care is both a safe and mana-enhancing environment for all residents. Our research highlights that all residents living in aged care facilities do not have equitable access to safe care.

Māori, Pasifika and culturally diverse residents in care

Residents who are Māori, Pasifika and culturally diverse often need access to additional services and direct care time to ensure the care they receive is safe. Kaimahi shared stories of working with residents who did not speak any English, or dementia residents who had reverted back to only speaking their first language. However, kaimahi did not have the resources or time required to ensure that communication was clear and meaningfully understood, conduct whānau meetings and ensure that residents remained informed and safe. One worker told us about a picture chart she had produced to overcome communication barriers – it included standing, sitting, bed and toilet to address baseline communication needs but was inadequate for more complex or social interactions.

Care disparities based on visibility and voice

In many facilities, care and attention are allocated relative to resident or whānau complaints. This situation is a direct consequence of the business-driven care model where minimising formal complaints and maintaining a positive brand image take precedence over consistent and equitable delivery of care to all residents. This approach creates disparities where care is not always distributed based on clinical need but on an individual resident's ability to speak up. Kaimahi highlighted the risk of sidelining high-needs and vulnerable residents who could not effectively advocate for themselves to care staff, especially residents with dementia or those who are not native English speakers.

> You tend to find that the squeaky wheels, the ones that make the most complaints, will be the ones that get the most attention. And that has a huge impact, actually. That can take care away from the quieter ones, the ones that are kicking up a fuss and then the managers don't want to upset them (Bonnie, Nurse Practitioner, Oceania).

> If there were more staff, we wouldn't have these issues where the relatives that bark the loudest will probably get a bit better care than those that aren't barking at all because they're bringing attention to the need. Some relatives, they will sing out and go, 'I want this done by this time', so, of course, they get prioritised, don't they? But then somebody else might miss out because they have to wait because nobody's barked for them (Paula, Registered Nurse, Ryman, Te Manawa Taki).

Kaimahi also addressed the role chronic understaffing plays in residents' self-silencing, where repeated failures to address their needs cause them to stop voicing their needs altogether. In practice, kaimahi told us that residents don't ring their call bells for essential needs when they can tell the staff are busy. It was felt that residents didn't want to feel like a burden on already overworked and stressed care staff.

> They tell me, you know, 'I didn't want to be a nuisance to you. I didn't want to ring because you're already so busy.' Their call bell is their lifeline. When they need something, they're supposed to call us. That's our whole job, to care for them and help them with things (Brooke, Kaiāwhina, Heritage, Te Waipounamu).

> They are holding themselves back from asking for help. Maybe because they already know the situation of the place, thinking 'I can't be asking for a bit extra because they're already short. They're always busy' (Radhika, Registered Nurse, Oceania, Auckland).

Person-centred care

Person-centred care is a fundamental component of culturally safe care by acknowledging that all residents are individuals who have unique care needs. This approach is diametrically opposed to budget-driven care decisions. While almost all aged care facilities tout a person-centred approach, the research reveals that these claims are hollow. On this, kaimahi were unequivocal: it is impossible to provide individualised care within current staffing levels. Courtney, a Unit Coordinator at a Ryman facility explained that her kaiāwhina work at a ratio of 1:10 for dementia residents:

> I've found that caregivers know what person-centered care is. They're being taught how to render person-centered care, but it's the institution that limits them, the staffing is not enough.

Over half (50.4%) of surveyed kaiāwhina responded that they do not have time to provide reassurance to distressed, lonely or anxious residents often or almost every shift.

Shockingly, only 6% of surveyed nursing staff responded that they had time every shift to converse or spend time with residents. Kaimahi reiterated that they are unable to spend meaningful time with residents. Sarah, a Clinical Nurse Manager at an Arvida facility, described the dehumanising admissions process, where the full and rich personal history of each resident is discarded and replaced with a checklist of standardised care routines:

> When they admit people, they admit them, and what's your care? What's this? What's that? No one addresses the impact it has on them mentally. They've just lost their independence. They've lost their homes. They've lost everything. But all they want to know is how many times a week you want to shower. And then that's it. You're in your room. That's it. You're there. Done. We're not mentioning it again. It's not right. We should be supporting their mental health. Because they mourn. They definitely mourn.

Kaimahi consistently highlighted that time constraints resulted in residents being robbed of choice and self-determination. One kaimahi described residents as "prisoners of times and allocations." In practice, this looks like stripping kaumātua of daily decisions about clothing, toileting, showers, wake up and bedtimes, and meals. Participants were unanimous that aged residential care is not sufficiently staffed to ensure that residents' independence and autonomy is protected.

> Once they come into a rest home the less time that we have, the less independence that they're getting. To make things go a bit faster, we're doing a lot more for them. So, you know, instead of letting people brush their teeth and their hair by themselves, you do it. Instead of letting them make their bed, you do it, because it's faster. Instead of letting them wash themselves, you do it, because it's faster (Brooke, Kaiāwhina, Heritage, Te Waipounamu).

> We are taking away a lot of the independence at the moment because of time restraints. It is hard, but we don't have time to socialise with the residents, discuss what they want. It's 'we're having a shower today because we need to have a shower.' Not 'when would you like to have a shower? I'll come back after morning tea because that suits you better' (Renee, Registered Nurse, Bupa, Central).

Whanaungatanga

Whanaungatanga emphasises the importance of building and maintaining respectful, authentic relationships with patients, whānau, and communities. It extends care beyond task-based interactions toward enduring relational care embedded in trust, reciprocity, and collective wellbeing. Aged care facilities are residents' homes; hence, whanaungatanga is essential to challenge the inherent power imbalances often present in clinical relationships.[15] Relationships between kaumātua and kaimahi that are grounded in trust and consistency ensure residents feel safe. Theresa, a Registered Nurse who works at a NZ Aged Care Services facility, captures the importance of this relationship:

> **If I don't build that relationship and that trust and rapport with residents, they're not going to open up to me. They'll sit there and the issues and their concerns and their health and wellbeing will deteriorate because they won't come forward with it.**

All kaimahi agreed that knowing their residents well led to better care outcomes, yet they consistently expressed deep concern over the lack of time they had to talk to residents. Staffing is increasingly volatile due to restructures, redeployment and high turnover. This led to some kaiāwhina turning up to a shift and doing full unassisted cares for residents they had never met or whose care plans they had not read. Over-reliance on agency staff to plug roster gaps compounds this problem. Extensive staff restructuring in the last year has produced inconsistency in shift patterns, which meant residents could have different carers every day of the week. It was noted that this is particularly disruptive for residents with dementia, for whom the consistency of routine and personnel delivering their care is clinically vital. Workers felt that the drive to maintain profit levels or operate within a constrained funding environment compromised the focus on person-centred care. As one survey respondent told us when describing their ideal vision for aged care:

> **We need people who are dedicated and able to provide individualised care for all, including the owners and shareholders of residential care facilities. It reads: He tāngata, he tāngata, he tāngata [It is people, it is people, it is people]. It does not read: He pūtea, he pūtea, he pūtea [it is profit, it is profit, it is profit].**

Unsafe Staffing | Kaimahi Kore Haumaru

Unsafe staffing levels are a defining feature of aged residential care in Aotearoa. In this chapter, kaimahi describe the toll of working in a broken system where they are set up to fail.

It details findings from an online self-reporting tool for shifts with unsafe staffing levels. The prevalence and consequences of unsafe staffing includes working excessive overtime, missing breaks, becoming buried under overdue paperwork and documentation, and suffering moral injury because they do not have enough time or capacity to provide the kind of care they are trained to deliver.

Sector surveying revealed that 39.8% of ARC workers had frequently thought about leaving the sector and a further 22.7% reported occasionally thinking about leaving the sector. These thoughts are perhaps explained by responses to questions about increasing workload and time pressures. In response to the question, ‘In the past month, how often have you felt like you didn’t have enough time to complete everything required of your role?’ 43.9% responded that they felt like this most days and a further 22.7% responded they felt like this a few times a week. Only 5.8% of respondents stated that they always had enough time to get everything done.

Perhaps the greatest condemnation of the conditions in the sector is that

only 11.8% of survey respondents strongly agreed that they would want their own whānau members to live in the workplace as a resident.

By contrast, 40.7% of respondents disagreed or strongly disagreed with wanting their own whānau living as residents in their place of work.

Staffing levels at aged care facilities routinely fall short of their contractual obligations as set out in the Age-Related Residential Care (ARRC) Services Agreement. Nursing staff described dangerously inadequate staffing levels that fail to meet the complex health needs of residents or ensure their personal care needs could be met.

Clause D17.3(b) of the ARRC Agreement states:

> **Despite clause D17.3(a), where (having regard to the layout of the Facility, the health and personal care needs of Residents and the ease with which the Residents can be supervised) the Registered Nurse or Manager at any time considers that additional staff are required to meet the needs of all Residents, you shall ensure that those extra staff are On Duty for the period of time that the Registered Nurse or Manager recommends.**[16]

However, none of the 46 nurses we interviewed had ever seen the requirements in this clause actively promoted or enforced. Despite repeatedly raising understaffing concerns with management, they felt ignored and dismissed. The unenforceability of regulatory frameworks outlined in the ARRC undermines the stated intention of ensuring staffing levels are directly responsive to facility layouts and resident care needs. Instead, frontline staff are left to carry the burden of systemic under-resourcing, despite their clinical insistence that delivering high-acuity care without adequate staffing is putting kaumātua living in ARC at risk.

Reporting

HealthCERT is the team within Manatū Hauora (Ministry of Health) that is responsible for regulating healthcare providers as required under the Health and Disability Services (Safety) Act 2001 (the HDSS Act). ARC providers are required to report incidents under section 31(5) of the HDSS Act to the Director-General of Health about any health and safety risks to residents or other people. From 1 January 2023 to 30 April 2024 registered nurse shortages account for 62% of all section 31 notifications made to HealthCERT.[17] Our research found that these external reporting mechanisms are underused and insufficient.

> **A lack of an RN on shift was sometimes reported through Section 31s, but at one point I was told not to bother submitting them because no one would be reviewing them. Same goes for falls. They were sometimes reported through Section 31s, but not always. Understaffing (other than RNs) and safety concerns were never reported externally (Rebecca, Clinical Nurse Manager, Arvida).**

However, internal reporting processes alone are insufficient. Many kaimahi were fearful that reporting incidents, injuries, and bruising could result in being blamed and disciplined by management. Eden, a Registered Nurse working at a Bupa facility, described being pressured to reclassify an incident to a lower level when working both an afternoon and night shift as the sole staff member responsible for over 30 hospital level residents:

> **So, I decided to rate it as Level 5, because I felt that all those residents were at risk already, having one medical person on duty. And I was told that I must downgrade it to a Level 2. And nothing came out of it. Nothing. I was never even contacted to find out what the situation was.**

Unsafe staffing reporting findings

Our research clearly exposed the inadequacies of formal reporting tools at an organisational and broader system level. This includes the consistency and quality of reporting data, inaction in response to unsafe staffing reports, and fear and cynicism

among staff regarding the efficacy and employment consequences of internal reporting procedures. In response, Tōpūtanga Tapuhi Kaitiaki o Aotearoa NZNO has developed an Aged Care Staffing Concerns Reporting Tool. This supports aged care workers to report instances of understaffing as a health and safety matter confidentially and directly to NZNO.

The reporting form asks for information regarding staffing shortfalls, impact on care, missed breaks, skill mix and staff mix concerns, unfilled shifts, care rationing and professional judgement. This last factor asks whether the staff member deems the workplace unsafe due to workloads, environment and/or teamwork. It then asks for further explanatory detail about what happened during the shift, whether a manager or supervisor was notified, and their response to the notification.

Based on the shift detail information given, a shift score is determined relative to the identified care capacity deficit. This assessment employs a traffic light system of escalating care capacity deficit. The shift scores are categorised as follows:

Score -1: Excess care capacity

The facility currently has spare capacity (e.g., can accommodate more residents, allow staff to share shifts, or offer short-notice leave).

Score: 0-4: Care capacity meets demand

The facility is well-resourced with staffing levels matching the care needs of resident’s care and cultural requirements.

Score 5-11: Early signs of strain

The facility is stretched, with early signs of pressure on care delivery, such as longer response times and staff fatigue.

Score 12-17: Significant care capacity deficit

The facility is operating beyond its optimal capacity, leading to compromised care delivery. Staff may need to make difficult decisions, and there is a heightened risk of negative outcomes for residents.

Score 18-23: Critical care capacity deficit

The facility is in a severely compromised state, with care quality affected and evident negative consequences for residents’ well-being and staff.

From 1 January – 30 August 2025, 156 individual staffing concern reports were received from workers in ARC facilities. Kaiāwhina roles accounted for 65% of reports, and Registered Nurses accounted for 28% of reports. The median shift score was 18 – within range of the critical care capacity deficit, the highest category of understaffing.

57% of reports had a shift score between 18 and 23, indicating the facility has a critical care capacity deficit and evidence of negative consequences for residents' and staff wellbeing.

A further 31% of reports received shift scores between 12–17, indicating a significant care capacity deficit where there is evidence of compromised care and staff needing to make difficult decisions regarding care rationing.

Reports routinely described inadequate staff numbers and mix to meet the clinical and personal care needs of residents safely. In some cases, this was due to short-notice leave and the inability or management decision not to fill the roster with existing staff or agency staff. However, many reports described baseline rosters and conditions that were not sufficiently staffed which impacted resident and staff wellbeing. Of the 156 reports received:

- 56% stated staff were unable to take meal breaks and/or tea breaks during the reported shift.
- 41% stated staff on duty did not have the skillsets required to safely complete tasks.
- 77% reported there was a problem with the mix of available RN/EN/Kaiāwhina and other staff.
- 71% stated care rationing had taken place as a result of understaffing.
- 96% reported that in their professional judgement, the workplace was unsafe during the shift.

Reports described compromised care for residents such as missed care, delayed care, or an inability to safely manage challenging behaviours among residents. Understaffing impacted staff in the form of missing breaks or working unpaid overtime, providing supervision for untrained staff, and feeling pressured to undertake risky behaviour such as dispensing medications unsafely or single person hoist-use. Some examples of reported shifts are below.

> Only one HCA was assigned to the other wing, which has 27 residents requiring both hospital and rest home level care. The staff member reported feeling unwell before her shift but was informed that three caregivers had already called in sick, despite not feeling well, she agreed to come in (Registered Nurse, small facility).

> Only 1 RN was on duty. 2 RN shifts were vacant. Total 120 residents were looked after by a single RN. In the PM shift, 2 falls and 1 hospital transfer occurred. I was not able to take my break in an 8 hour shift. I was running all 5 wings during the shift (Registered Nurse, Bupa).

> **2 rostered were 2 RNs and a med comp HCA each of us having 30 residents each. Clinical coordinator was supposed to overlook medcom but this was not done. Medcom kept saying that she could not find Clinical Coordinator. So out of good heart I helped medcom, leaving me to take care of 60 residents. I have emailed my unit manager. But the outcome would be same. They will find ways to tell me how I should have handled the situation, how I should have managed my time making me feel worthless rather than tackling the main concern**
> **(Registered Nurse, CHT Healthcare Trust).**

> **Two inexperienced caregivers managing cares of 19 advanced challenging dementia residents plus a med Com caregiver doing medication in an area she had never been in before. An RN overseeing 3 communities a total of 56 people (Registered Nurse, Bupa).**

Short staffing

Reductions in staffing levels beyond safe and sustainable limits are a widespread feature of the industry. Enforceable minimum staffing standards in the aged residential care sector are absent and combined with conditions of systemic underfunding and financial constraints at a facility-level, staffing hours and wages are often the first choice for cost-cutting. Over half, 53.4%, of survey respondents reported their shifts were understaffed most of the time or often. By contrast, only 13.5% stated that their shifts were understaffed rarely or never.

There is no standardised staffing level seen throughout aged care providers in Aotearoa, and no evidence to suggest that private providers have better staffing levels than not-for-profit organisations. According to the NZACA's 2023 member survey, 83% of provider respondents to their member survey said their facility was not fully staffed with RNs in 2023 (up from 59% in 2021).[18] Based on Ministry of Health data, there were 676 certified rest home facilities across New Zealand in 2025.[19] If the 83% figure were applied to all 676 facilities in the sector, 561 facilities were not fully staffed with RNs. Research clearly shows that staffing decisions are driven by financial constraints rather than the clinical needs of residents. Kaimahi emphasised that even with a fully staffed roster, they were under extreme pressure – forced to ration care, work unpaid overtime and forgo breaks. Gina, a Nurse Practitioner highlights the state of the staffing crisis:

> **Call bells don't get answered at all, and you hear people screaming out to come and help and it's heartbreaking when you walk around there. It's not because the staff don't want to help, it's just because they are so busy and it's a big facility and there's just no one there and it's really unsafe.**

Robin, a kaiāwhina at a small private provider in Te Waipounamu, reflected on how rare it is to be fully staffed calling it a 'novelty', further sharing "*it could be even three to four staff down. So normally it's meant to be a staff of 10, but you could be working with six or seven staff in the morning.*" In seeming direct contradiction with the material experience of workers on the frontline, aged care facilities have undertaken financially motivated restructures on base rosters and staffing levels in the past year, resulting in significant further reduction in care capacity for residents. In 2025, there have been over

37 facility restructures that resulted in an overall reduction in direct care hours. Nurses and kaiāwhina reported a decline in staffing and conditions resulting from restructures. Many described staff to resident ratios creeping higher and higher in their tenure at a given facility. For example, at a Bupa facility, a kaiāwhina described the increased ratios from 8 carers for 53 residents to 5 or 6 carers for 60 residents. Here we see an effective ratio increase from 1:6 to 1:10.

Staffing has reached a crisis point, where the demands placed on workers now exceed their capacity to deliver safe care.

Jasmine, kaiāwhina at a Summerset facility in Te Waipounamu, highlights how chronic staffing shortages prevents residents from having even their most basic needs met:

> They want to get up, they want to get dressed, they want to go to the toilet, they want to talk, they want to be able to eat. And we can't do it. The tools, the resources, everything exists to help them, but we can't give them that care because we aren't there to help them with it. We have a hoist to physically move somebody, we have the continence products to change them, but we don't have the staff to do that task.

Impact on workforce

Working in aged care can be incredibly challenging and often stressful. Nurses and kaiāwhina face many demands daily, including providing physical assistance with daily activities, managing complex medical needs, and addressing the emotional and psychological well-being of elderly individuals. The emotional toll can be hefty, as the care team often build deep connections with their residents and may experience grief and loss as they witness the decline of health or the passing of those in their care. Additionally, long hours, high staff-to-patient ratios, and the need to navigate family dynamics can add further stress. Amid ongoing budget-driven understaffing, health workers report facing excessive workloads, burnout, moral injury and a growing fear of the professional consequences for providing clinically unsafe care.

Excessive workload

Higher resident-to-carer and resident-to-nurse ratios undeniably impacts care outcomes and experiences for kaumātua. Excessive workloads are compounded by understaffing service roles such as kitchen hands, laundry workers, cleaners and administrators. These responsibilities are then passed onto an already overstretched care and nursing team. In practice, nursing staff adopt management related tasks such as rostering, finding sick leave cover, performing audits or doing the daily cares for residents. Kaiāwhina shared that they are routinely expected to do dishes,

cooking, cleaning, laundry, drive residents to appointments and even undertake facility maintenance. Collectively they expressed that extra duties directly take away from care time for kaumātua.

Burnout

Excessive and prolonged stress causes burnout. Extreme time pressures during shifts lead kaimahi to forgo their own essential needs, such as bathroom breaks, drinking water, eating and taking legally entitled breaks in an effort to meet the needs of kaumātua under their care. As Theresa, a Registered Nurse at a NZ Aged Care Services facility, explains, "*we'll put ourselves second, because we have to look after the people we are caring for, they're paramount.*" Chronic understaffing results in unsustainable and unachievable workloads. The system functions, in large part because of workers' compassion and willingness prioritise the needs of kaumātua. However, interview participants explained this ethic of care is routinely exploited by facility management. Denise, a Registered Nurse working on the West Coast told us "*the more you give, the more they take, and that is the problem.*"

Persistent understaffing results in nurses and kaiāwhina filling in roster gaps at short notice or working excessive overtime to ensure residents receive essential care. 30.84% of survey respondents stated they have to cover other people's work with short notice most of the time and a further 22.41% reported this was often the case. While this demonstrates the self-sacrifice and dedication of the aged care workforce, it is a key contribution to both burnout and health workers permanently exiting the aged care sector.

Moral injury

Chronic understaffing results in conditions where workers often feel set up to fail as the clinical, physical, social and emotional needs of residents far exceed the capacity of rostered care staff to meet them, sometimes termed 'moral injury.'[20] We asked survey respondents about their mental distress resulting from the inability to provide adequate care to residents, nearly one third (30.84%) reported they experienced mental distress most of the time.

Moral injury has become a cornerstone of the aged care sector, with almost all interview participants expressing some degree of guilt, shame, or distress that erodes their mana as healthcare professionals. Jenna, a Registered Nurse at a Bupa facility in Te Waipounamu told us, "*I feel I did my best to support them, but I feel ashamed.*" The profound depths of moral injury is powerfully captured in the words of Eden, a Registered Nurse at a Bupa facility who felt that without the ability to provide decent care, health kaimahi become facilitators of residents' declining condition and hastened death:

> **That's what worked on my mental state – that we're here just for them to die. If you're not providing the care that you're supposed to provide, you're actually enabling this death to happen rapidly, you're part of the people that are killing.**

Fear of professional consequences

Nursing staff expressed their growing concerns that working in aged care put their professional registration at risk amid increasingly unsafe staffing and higher whānau expectations. Kaimahi surveyed almost unanimously agreed (94.2%) that whānau expectations of nurses and kaiāwhina in aged care have increased. A reduction in staffing has increased the discrepancy between the care that residents and their whānau expect, and the care that health workers are able to provide.

Many described the weight of being the sole-charge RN on site. Nina, a Registered Nurse at a Summerset facility in Auckland explains, "*we don't have doctors on site. If anything would happen, it's our license.*" This sentiment was echoed by all RNs who had experienced working as the sole RN on duty. Many describing that even two people falling over at the same time would put undue pressure on their ability to properly care for residents. Jaya, an internationally qualified nurse (IQN) working in Te Waipounamu, explains "*when I came, I thought it will be safe practicing, but what I experienced is different. There is no safety for us. We're taking risks.*"

Workplace injury

Care work is inherently hard and physical work, but physical risks of injury are significantly heightened by understaffing. Kaiāwhina frequently spoke of staff on ACC covered leave from work due to back injuries linked the physical strain of the job or from failure to adhere to health and safety protocols in an understaffed environment. Injury results from incorrect equipment, facility design flaws, and inadequate processes to keep staff safe, particularly in high-level dementia facilities. Kaimahi in dementia and psychogeriatric facilities consistently reported that unsafe staffing levels put them and other residents at risk. Many health workers described situations where residents slapped, grabbed or punched kaimahi due to inadequate de-escalation processes or no available staff to help redirect unsettled or aggressive residents. They stressed that ARC facilities do not do enough to ensure kaimahi are safe at work, nor are there sufficient changes made to prevent incidents from happening again.

Breaks and overtime

Missing entitled breaks is commonplace for workers in aged care. The prevailing sentiment was that the demands of the workload made taking breaks impractical or unsafe for residents. As Grace, a Unit Coordinator at a Bupa site in Te Manawa Taki, explains: "*if you do have a break, it just delays your day for half an hour at the other end. So, I would rather work through and then try to go home on time.*" Even when staff do manage to take a break, there are frequent interruptions from call bells or other staff requiring assistance. As a result, breaks are often cut short or abandoned altogether. One kaiāwhina described eating their lunch in the resident lounge, a prohibited practice, in order to both supervise residents and manage to eat during their shift. Participants who reported regularly taking their breaks typically described the presence of protective factors such as supportive management or RNs, manageable workloads, or long-term experience in the sector.

Kaimahi are routinely working unpaid overtime. Due to the demands of the workload, kaimahi often arrived early to their shifts or stayed late to complete their duties. Harriet, a Registered Nurse, working at Arvida in Te Manawa Taki described arriving at work up to an hour before she was due to start and often finishing at least an hour late because the workload was so heavy. Kaimahi felt they were expected to work beyond their scheduled hours to complete mandatory tasks, especially paperwork and documentation. Hillary, a Registered Nurse working at a MetLife Care facility stated that she was told, "If you can't volunteer your time, you're not wanted."

The problem of unpaid overtime is not exclusive to the nursing workforce. Sita, a kaiāwhina working at a not-for-profit, described her colleagues beginning an hour before their official start time to ensure they could complete residents' cares and showers that would otherwise go undone. However, this meant that they were completed in ways that fell below what is reasonable for residents. For example, multiple kaiāwhina described residents being woken up at 4–5am for showers or cares in an attempt to get through the workload by the end of their shift.

Nursing and care teams frequently reported that they had been put in a position of doing unsafe overtime or placed on unsafe rostering patterns. Vince, a night shift nurse at a Bupa facility, reported staying on until 11am and being required to administer medications. He states: "*I think it's quite dangerous. Not just for you, but for the patients as well. Because you might mess up with medications.*"

Rebecca, a Clinical Nurse Manager at an Arvida facility, described a difficult situation where some staff developed a reliable reputation for picking up extra shifts at short notice. This created an over-reliance on a small number of kaiāwhina who would frequently work double (16 hours) and triple shifts (24 hours). Courtney, who worked as a Unit Coordinator at an Auckland Ryman facility, reported some kaiāwhina worked 160 hours in a fortnight, the equivalent of over 10 eight-hour shifts in one week. Courtney escalated her safety concerns to the clinical manager and HR, but they were unconcerned. In rural areas, where staffing challenges are particularly acute, Clinical Nurse Managers and senior RNs reported being "always on-call."

One senior RN recalled working 22 consecutive days to cover critical nurse shortages.

Workforce challenges

Since the Covid pandemic, there has been a significant shift in the workforce demographics for aged care workers. The aged care sector employs a significant number of recent migrants, with 71% of staff in ARC on visas.[21] New Zealand has a disproportionately high reliance on migrant nurses compared to other OECD nations.[22] This dependency on internationally qualified nurses (IQN), while filling critical gaps in the health workforce, must coincide with developing a culturally competent and Te-Tiriti responsive workforce.[23]

Almost all interview participants remarked on the increased reliance on IQNs and migrant workers in the aged care sector. Health workers identified that while IQNs had excellent clinical skills, some faced significant language barriers that made communicating with residents, whānau and colleagues challenging. An unintended consequence of these communication issues was that residents could feel unheard. This means nurses with better English language skills find they need to pick up certain duties that some IQNs are not well supported to perform, such as speak with a resident's whānau, write letters to GPs, or call an ambulance. This sentiment was echoed by many RNs who participated in the research explaining that this adds more unplanned work for them, but it's often required to keep residents safe.

At an organisational level, participants reported migrant staff being bullied, taken advantage of and set up to fail with inadequate training and support for working in aged care in the Aotearoa context. IQNs arrive highly trained, many with backgrounds in acute hospital, surgical, or community health settings but without structured orientation or peer support, they are not trained to excel in an aged care setting. IQNs told us they feel professionally adrift and socially isolated, which compounds existing language and cultural barriers. Multiple participants explained that newly registered nurses, who complete the Competency Assessment Programme (CAP), often start working in sole-charge roles, such as on night shifts, to fill long-term roster vacancies. Rebecca, a Clinical Nurse Manager at an Arvida explains the implications:

> **They were always started on night shift because that was always the gap. No one wanted to work night shifts and they would be willing to, which was super dangerous because while we always had another RN like myself on call, there wasn't anyone there to teach them. And being a new nurse, I would say you need a solid six months of side-by-side training with another nurse.**

Other participants described that nurses who did not have good English language skills often got 'stuck on the night shift.' This dynamic exposes how chronic understaffing means a sector that relies on IQNs to deliver essential care does not support them with appropriate rostering, mentorship, training or orientation.

Paperwork and documentation

The transition from paper-based records to electronic documentation systems in ARC has been a necessary upgrade. However, while these systems are designed to support high-quality, timely, and person-centred care, they cannot achieve their purpose if kaimahi are not given the time and resources to use them effectively. Nursing staff consistently reported that feel they are pulled away from the residents to do documentation, which they also struggle to complete.

57.4% of nurses don't have enough time to complete documentation required from residents almost every shift or often.

Surveying further revealed that nearly one third (30.9%) of nurses reported they did not have enough time to complete care plans and interRAI almost every shift, a further 29.1% reported they often did not have enough time. The central role that interRAI serves in categorising, caring for and funding aged care residents is not reflected in the staffing policies and practices, compromising the integrity of assessment data.

Susan, a Registered Nurse at a Presbyterian Support Services facility in Te Waipounamu expressed "*they place so much importance on the interRAI in terms of that it's a contractual agreement between the facility and the DHB, and how it's so important, and there isn't that much commitment to supporting staff to actually get them done.*" Many participants described frequent interruptions when they try to carve out dedicated space to complete interRAI assessments. In some facilities, paperwork was shifted to night shift staff which compromises the validity of the assessment. Florence, a permanent night shift RN at an Oceania facility in Te Waipounamu shared her reaction:

> **If you want me to do permanent nights, then I can't do paperwork because they're asleep. I cannot do a lot of assessments because they're sleeping, and I don't want to fake an assessment. Or just for the sake of compliance with audits and paperwork, you know, make up stuff on the care plan.**

Many nurses also described feeling pressured to complete their interRAI assessments outside of work time as they were past deadlines. Rochelle, a Registered Nurse who works part time at a not-for-profit in Otago, is responsible for the interRAI assessments of all 30+ residents at her facility and explained that the initial assessments could take between 4-6 hours. Increased time constraints and completing the assessments outside of work hours may impact the quality and accuracy of the assessments. This means care plans and interRAIs don't always reflect the needs and abilities of the residents.

Many kaimahi shared the sentiment that paperwork is done for the sake of audits, not for the sake of resident care. Bonnie, a Nurse Practitioner at an Oceania facility illustrates this issue clearly.

> **Then we have audits. How many times do they get audited? Audits are another bane of my life. All they're interested in is the paperwork. They are not interested in going to see a resident. Because a lot of the auditors are nurses, so why can't they go and deliver the care to somebody and check that their skin is intact, that they're being given the right sort of food, that they've done an assessment, and the care plan that's in place is actually appropriate for that person, rather than it being, 'oh, your documentation and your interRAI and everything else has all been done and your MediMap's up to date.' I don't get it… The month before an audit is known to be taking place, the whole nursing staff are just spending time making sure care plans are up to date. They're not focused on delivering care, and that really pisses me off.**

Kaiāwhina are not spared from the increase in documentation requirements, often citing tablets and phones required for online programs, such as V-Care – software for streamlining care and support plans with resident records. Tina a Kaiāwhina at

a Central Summerset facility describes not having enough time to input resident records: "*It's got the interventions, which is the cares, toileting, everything you need to know, the care plans are on there, but even though it's in your pocket, you're still not getting time to input it, which should only take a couple of minutes, but that's how full-on it is.*" Kaiāwhina reported being told to input notes while they have the residents on the toilet, during cares or between residents. Again, time-pressure leads to records that are minimal and in some cases inaccurate. Jackie, a kaiāwhina at a small not-for-profit in Wellington describes a scenario that leads to poor-quality record keeping:

> **You're signing off at 1, you'd have to have all your notes and paperwork and bowel cares and everything all done before then, as well as the rest. Which becomes quite a pressure, because a lot of people, in order to get it finished on time, minimise what they put in their notes. So, they're not accurately recording what's happened to that patient. They'll put the generic eating and drinking well, assisted with cares, BNO, bowels not open, that sort of stuff. And it doesn't truly reflect the full picture... So a piece of the jigsaw gets missed, because you're trying to get your notes done quickly.**

Skill mix

The skill mix of health workers on the floor in ARC directly impacts the safety and care of the residents in the facility. However, shifts often lack experienced staff or the planned ratio of nursing and care workers, thereby putting significant pressure on senior staff on the floor. Lucas, a Registered Nurse working at a Northern CHT Healthcare Trust facility, explains "*If they are new or they are from agency, they don't know what they're doing, so you have to micromanage them. 'Oh, you have to wash. When you wash, you have to start from here and then finish it from there.' You know, you have to tell them step by step.*" Monica, a Registered Nurse at a New Zealand Aged Care Services facility described a common scenario where despite requirements to have at least one medication-competent health care assistant on the shift to assist with signing off controlled drugs, she often has to pull one from another wing because one has not been rostered on.

The aged care sector relies heavily on medication competent health care assistants (HCAs). Med-comp HCAs, who have completed the New Zealand Certificate in Health and Wellbeing (Level 4b), can support registered health professionals by carrying out delegated clinical tasks, such as dispensing medication. However, our interviewing shows that no provisions or safety measures are in place at an organisational level to ensure that nursing staff can safely oversee and support med-comp HCAs. This is further evidenced by surveyed nursing staff, with only 7.8% responding that they always have time to provide active supervision and leadership for HCAs. Annie, a Registered Nurse working at a Radius site in Te Manawa Taki, had three shifts the week she was interviewed where she was the sole RN on duty with two med-comp HCAs filling the other two RN gaps. Annie was left with responsibility over 70-80 residents across 3 wings. The result is that nursing and care staff are operating with significantly higher care loads and responsibilities, which directly impacted resident health and care outcomes.

Med-comp HCAs interviewed consistently expressed concern over their workloads, stating increased responsibility with no change in their care load results in rushed and missed care for residents and increased risk of medication errors. Many are also not notified that they are rostered on medications until they have arrived for their shift, reducing their ability to prepare. The role of a medication-competent HCA varied significantly depending on where they worked highlighting how the role is shaped by the demands caused by RN understaffing in their facilities. Ria, a med-comp HCA at a Te Manawa Taki Bupa facility feels that facilities "*put a lot of work on the level four caregivers. We all do medications, some of us do the wound cares, we do everything here.*"

Substituting Registered and Enrolled Nurses with lower-paid med-comp HCA staff was widespread and most attributed it directly to budget constraints. They are often left unsupported and unsupervised and typically asked to step outside of what they were trained to do. Multiple RNs claimed they have been unable to pick up extra shifts that were reserved for med-comp HCAs. Some HCAs also felt they were signed off on medication competency without appropriate training and oversight due to workplace pressures. As Jackie, a kaiāwhina at a small not-for-profit facility in Wellington, explains: "*I wasn't signed off to do medications. I had seen them being done, and I was given the paperwork and basically signed in on that day to start, because they were so short-staffed and they were relying on my experience to do it, which was quite overwhelming as well, because the weight of the responsibility of that.*"

Orientation and training

Effective orientation is a critical component of workforce development in aged care, providing new employees with the opportunity to become familiarised with the facility, the residents, and their roles and responsibilities. However, almost all kaimahi reported either personally experiencing or observing inadequate orientation processes. It is evident that the length and quality of orientations are severely impacted by staffing shortages.

In many instances, orientation only lasted 2-4 shifts and commonly did not take place in the wing or shift where a new staff member would ultimately work. Kaimahi described turning up for their first shift having not met the residents or read their care plans leaving them completely unprepared to ensure safe care. Several participants shared that they felt so overwhelmed during their initial weeks they cried during their shifts. Participants also raised concerns about being asked to orient new staff while managing their own full care load. This dual responsibility significantly increased pressure and reduced the limited time they had to engage meaningfully with residents. High staff turnover contributed to a continuous stream of new employees requiring orientation, compounding the strain on existing staff. Julia, a Registered Nurse at an Arvida facility in Te Manawa Taki, was tasked with orienting new staff despite having only two weeks of experience in aged care herself.

Training in aged care has been diminished to a 'tick-box exercise'

Most interview participants reported that training was primarily online courses or a paper to read, ostensibly to be completed during work shifts. This is divorced from the practical training needs of aged care staff, such as wound care, hoist and manual handling or specific techniques such as best practice for fitting continence products for residents. Seini, who works as an kaiāwhina at a Northern Radius facility explained that training used to be delivered in person, it is now exclusively online. She reports, "*there's no time to do the training online because something comes up to do especially when short staffed, and we have short staffing most days.*" Lenora, a Nurse Practitioner at Oceania and former nurse educator in aged care, recounts a similar experience. Despite efforts to deliver in-person training, "*the nurses couldn't get out of the facilities to attend the education I was running, although they desperately needed it.*" Short staffing was consistently reported as a barrier to adequate training. Even informal training is compromised where senior staff struggle to pass on institutional knowledge and practices to junior staff.

Significant gaps in training include dementia care, and complex medical and mental health needs. Participants consistently reported working with residents with dementia without having received the mandatory training. Marcia, a Te Waipounamu based Registered Nurse working in dementia care highlighted the disconnect between organisational messaging and reality: "*Bupa are trying to promote what they call, person first, dementia second. So, you're trying to provide care that is related to an individual. I've been trained to be a tutor for it, but we can't get staff off the ward to do the training. So, they're promoting themselves as this kind of a company, but actually the staff aren't being trained to do it.*" Eden, a Registered Nurse, provided further testimony for staff failing to meet training requirements for dementia care: "*I never attended a refresher course, neither did any of the support workers, carers, because for dealing with dementia, you have to have a certain qualification to deal with dementia, which none of us had.*"

System Failings | Ngā Hapa o te Pūnaha

Unsafe care and unsafe staffing are a result of an underfunded system that is failing to address the growing needs of kaumātua in our communities. Kaumātua in ARC are stripped of quality care and choice due to Government failings to both fund and regulate this part of the health system.

In this chapter, kaimahi draw attention to a flawed system and how insufficient beds and delayed assessments create unsafe care by design. It outlines the tension between increasing acuity, care needs and insufficient budgets.

Budget constraints

Clinical managers responsible for aligning meeting care needs with insufficient budgets are forced to make zero sum calculations between staffing capacity, clinical resources and equipment in delivering care. Clinical nurse managers we interviewed highlighted the conflict between the budget constraints and safe care. Rory, a clinical nurse manager at a Presbyterian Support Services facility described that despite seeing an increase in acuity and complexity of residents' care needs, "*we operate probably the same base roster that we would five years ago. And that's solely a funding thing and a budget thing.*"

Rebecca, a Clinical Nurse Manager at an Arvida facility starkly explains the daily trade-offs operating with inadequate funding levels:

> **As a clinical manager, it's just having like 12 things, 12 really important safety concerning things on your plate, all of which you want to improve. And trying to decide which few to focus on, because you know that if you put more energy and money into one, you're going to lose out on another. And they're all important, right? They all go together for holistic care of a patient. But there's no way that you can get all of them together. And if I were to go to my manager and say, 'Hey, we really need more incontinence products,' if somehow I got her to agree to that, then it would be – OK, then we can't afford the wound care, or we can't afford to get someone to come in for a certain training to train the staff, like on feeding, perhaps. It's always a give and take. And it's just an impossible position.**

Many health workers expressed frustration that aged care has become driven by profit. They described a system where financial priorities overshadowed resident care, and where maintaining the appearance of quality took precedence over delivering quality care. There is a distinct tension between occupancy targets and a facility's capacity to provide adequate care.

Lack of beds

Aged residential care cannot meet the level of need for care in the community. There are not enough beds in total or at the required level of care. ARC beds operate across four levels of care: Rest home (entry level care), hospital (continuing care), dementia and psychogeriatric. For those that are already residents in ARC, the Long-Term Care Facilities Assessment (LTCF) is required to be completed at least once every six months. The LTCF is administered to residents in ARC to evaluate their needs, strengths, and preferences. However, changes in acuity can often be swift and put significant strain on care staff who are not resourced or funded to provide care at the level required for miscategorised residents.

Limited access to beds in rural areas and shortages at the required level, especially psychogeriatric beds, was a recurrent concern. ARC beds in rural communities are scarce leading to lengthy wait-times for an available bed. Lack of access is further compounded by difficulties in retaining staff in rural areas, often resulting in unutilised beds. Participants noted that the lack of access to beds results in residents remaining in facilities ill-equipped to provide the level of care they need.

Rural areas with a high Māori population are particularly impacted by limited ARC bed availability within the community. As a result, kaumātua often have no choice but to accept a bed in an urban centre to access urgently needed care. For example, Gina, a Nurse Practitioner, discussed the bed shortage in rural coastal areas surrounding Gisborne. Rurally based kaumātua are often left with no option but to accept an ARC bed in Gisborne with the hope of moving into one of only 12 aged residential care beds in their community once available. However, once they enter care their priority level for local community admission drops compared to others still waiting in the community. They are then never able to move back to their community, whānau and whenua.

Across Aotearoa there are currently 859 psychogeriatric beds, concentrated in large cities. Most participants working in dementia-level care reported issues with limited access to psychogeriatric beds, resulting in residents staying or being moved into a lower-level dementia facility. Zoe, RN at a Central Enliven site, explained,

> **This resident should have really been in a level 5 psychogeriatric level dementia facility right from the beginning. But obviously because of the lack of beds, they got signed off as level 3 and they came to us. And they were in our facility for nearly a year before they were moved.**

Increasing acuity

Survey respondents almost unanimously agreed (95.2%) that aged care residents have more complex health needs and require more support. Inevitably in the context of increasing acuity, 82.9% of respondents agreed or strongly agreed that the tasks they do at work have become more complex. When asked about what has changed in ARC over time, the health workers we interviewed pointed to significantly higher acuity and needs of residents who are now entering residential care. One nurse described the change in acuity as follows, "*So when they're coming into us, it's usually via ambulance. Nobody's walking into us anymore.*"

Residents move into care sicker and with more complex needs

The baseline for determining rest home and hospital level care has changed significantly over time. Grace, a Unit Coordinator at a Bupa facility in Te Manawa Taki described a time when rest home level residents were "*still going out shopping, still going to the supermarket. They would drive their cars. Where now people are so sick when they come into care.*" Many workers explained that residents in rest home level care now require two-person assists for daily cares. They highlighted persistent shortages in both equipment and staffing to safely meet these demands. Additionally, hospital-level residents were described as having increasingly complex needs and multiple comorbidities. Rochelle, RN at a Presbyterian Support Services facility in Te Waipounamu explains that now "*residents need a lot more nursing and medical input. It's no longer just about age. It's about managing all the medical diagnoses.*"

Increased levels of dementia presenting in rest-home and hospital-level facilities

Kaimahi working in rest home and hospital-level facilities described a growing number of residents with dementia being placed in environments that are not designed to meet their specific needs – most notably in an unlocked facility. Jasmine, a kaiāwhina working at a Summerset facility in Te Waipounamu explains that having residents with dementia in a hospital-level facility "*is very hard to provide care for because we're not actually a dementia facility. We don't have the staffing for it, we don't have all the resources that otherwise might be available.*" This puts patients at risk and places further strain on workers, who are responsible for keeping them safe and secure in facilities that lack the necessary infrastructure, resources and appropriately staffing levels and training to support them.

Increasingly diverse and complex needs among residents

For those 65 years and over, 38% will die in ARC in Aotearoa, one of the highest rates in the OECD.[24] Yet many staff working in ARC feel ill-equipped to adequately provide end-of-life care.[25] In addition to higher rates of palliative care need, participants reported an increase in bariatric residents, which represents a further level of need requiring more care time from nursing and care staff. The four service levels do not have mechanisms for addressing the diverse needs of residents, or accounting for the spectrum of physical and cognitive capacities across residents within the same classification. Many staff also reported that ARC beds were often used for people who require full time care and rehabilitation such as people with spinal cord or brain injuries, or significant mental health needs. In one case a young prisoner was admitted to an ARC facility to recuperate from surgery and remained permanently handcuffed to their bed under the supervision of two security guards. Interviewees stressed that in these cases there is usually no change to staffing levels or adequate supplementary training to reflect the increased clinical and domestic care needs of the residents.

Assessment issues

Assessment is a critical component of a functional and safe aged care system. Delayed assessments result from a limited needs assessor workforce capacity to qualify for entry into and movement within the aged care system, in conjunction with supply shortages due to lack of beds, lack of staff and low bed turnover. The Sapere report into aged care funding and design found that high needs dementia and psychogeriatric care residents were left waiting, on average, nearly six months to be admitted to an ARC facility after being assessed as high priority for moving out of a home setting. Waiting times for high priority individuals being admitted to an ARC facility ranged from 82 days in MidCentral region to 219 days in West Coast region.[26]

Workers repeatedly raised concerns about delays and inaccuracies in assessing residents' care needs – both at admission and during reassessment when their condition deteriorates. As a result, some residents are entering facilities without accurate assessments of their physical mobility and cognitive capacities. This means residents may not have access to the level of care, equipment and staffing they require. The bed-level for high-needs residents varies geographically and is dependent on local assessment and bed capacity – for example, in Taranaki 46% of high-needs residents are in rest-home level care, while in South Canterbury only 5% of high-needs residents are in rest-home level, the rest supported in higher-level facilities.[27]

For residents with dementia, delayed or incorrect assessments can lead to serious safety risks, such as being placed in unsecured facilities where they may wander unsupervised. Kaimahi shared that residents in dementia-level care who develop challenging behaviours often need to be transferred to psychogeriatric care. However, workers described significant delays between the onset of these behaviours and their eventual transfer – delays that place the resident, other residents and kaimahi at risk. These delays result from facility management dismissing nursing and care staff concerns and are further exacerbated by lengthy wait-times in accessing the small pool of assessors nationwide.

Reassessments are often only triggered by a serious incident occurring, rather than the warning signs of challenging behaviours routinely reported by staff.

The rates of home care assessment carried out by Needs Assessment and Service Coordination (NASC) assessors has decreased in almost all regions nationally between 2016 and 2023, most notably in Taranaki and Capital and Coast.[28] Our research similarly highlights a lack of capacity, with health workers in the Wairarapa, central Otago, and Taranaki experiencing extreme delays in accessing needs assessors. This forces nursing staff to find workarounds via other parts of the health system. Zoe, an RN working at a Enliven facility in Central, explains the challenges to initiate reassessment:

Our only option is to send them to the DHB, where things can be investigated. And that's usually where they're signed off as Level 5. But then we always get backlash from the hospital, the DHB, you know, 'why did you send them to us? They're not medically unwell.' But then we don't have the option either, you know? It's like we're stuck between a rock and a hard place because we can't keep them here because they might hurt themselves or hurt another resident or another staff member. But then the DHB is like, well, they're not unwell.

Interactions with primary health and hospital services

Allied health services and access to General Practitioners (GP) and Nurse Practitioners (NP) ensure that residents are kept safe, well and mobile. Access to high quality allied health care is contingent on the willingness of independent providers to pay for these services. Therefore, residents' access is unequal and inconsistent across facilities. Routine access to primary care is minimal due to costs of bringing in practitioners and the ballooning level of need for assessment, monitoring, intervention and follow-up care for residents.

And at the end of the week when the doctor comes, maybe there's about 15 to 20 residents that need to be seen. There's no way the doctor is seeing all those. So now you have to choose whose life is more important than the other one.
(Eden, Registered Nurse, Bupa, Te Manawa Taki)

One of the facilities didn't want to do the same contract with the doctors for the two hours every fortnight because of the cost, so they do one hour a month, and that I struggle with, because for me to go in once a month, it doesn't work
(Gina, Nurse Practitioner).

Another prominent issue is a lack of access to physiotherapists, occupational therapists, dietitians or speech language therapists. Kaimahi described residents being advised to pay privately for physiotherapy services due to excess demand for the facility physiotherapist who only visits weekly. Alternatively, facilities would draw on ACC funding for physiotherapy services. However, the value of these services is undermined by the inability of permanent care staff to support residents to complete prescribed care plans and exercises due to workload and staffing levels. Care staff were clear in describing the direct consequences in failing to provide specialised support services to residents. This increased incidence rates of falls, choking, weight loss and reduced mobility. Some workers advised they have never seen a physiotherapist in their facility. Bonnie, a Nurse Practitioner at an Oceania facility describes the discrepancy in accessing rehabilitation services across facilities.

And then we have the post-hospital hip fractures as well. And they need rehabilitation, but they quite often get discharged from hospital really, really fast because, 'oh, you're in a hospital level care facility, so you can go back there.' But they miss out on an element of rehabilitation because there's a perception that because it's called hospital level of care that we have OTs, physios, dieticians, you know, this facility has a physiotherapist that comes in three times a week.

> The other facility I work in has no physiotherapists at all... Occupational therapists, who the hell are they? Wouldn't know what one looked like. And referring and trying to get those services through the DHB is almost impossible... So again, the nursing staff are expected to be able to direct rehabilitation, but they don't have the knowledge base to be able to do that... Even getting a physiotherapist to come in and do physio, it should happen but it doesn't. So, we're let down by everybody everywhere.

In response to the cost burden of aged care residents in public hospitals, residents are frequently discharged from hospital before all their medical issues have been addressed. Kaimahi described residents being transferred back to aged residential care in the middle of the night, when facilities are not adequately staffed or prepared to receive them. One nurse recounted a particularly distressing incident where a vulnerable resident was sent back from hospital alone in a taxi. Poor hospital to ARC transitions have a direct impact on vulnerable kaumātua.

> We had about five of our people going to hospital, all come back with stage two or three pressure injuries, they don't have time either. The communication between staff in the hospital and the rest home is poor. You often don't get a correct handover from the hospital back to you. We were finding pressure injuries, or we were finding that medications have been changed. In aged care, you can't give anything unless it's charted. And they will send them back with prescriptions. And we'll be like 'we can't give them this medication.' There's a lot of barriers; they just don't get it. (Sarah, Clinical Nurse Manager, Arvida).

> There are instances that the resident is still really unwell, but they're already transferring them back to us with oral antibiotics. Even though, those residents really need a week of IV antibiotics, but they just wanted them out of the public hospital. We have a lot of residents who are coming back to us still unwell. After two or three days, we have to send them back. And then after two days, they will send them back again. And then the resident will just give up and we'll just put them into end of life care. Eventually they will just pass away in the facility instead of them being treated in the hospital (Lucas, Registered Nurse, CHT, Northern).

Section Four

Culturally and Clinically Safe Staffing

Te Kaimahi Haumaru ā-Ahurea, ā-Haumanu hoki

Chapters

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Our vision demands a culturally and clinically safe aged residential care system in Aotearoa. Building on the care minutes model from Australia and the case-mix model developed in Aotearoa, we are calling for a care minutes framework that builds a safe staffing system around the needs of residents.

This model unites comprehensive assessment of residents' clinical and hauora needs with the funding and staffing commitments to meet them. The design and planning of ARC funding and staffing models must also account for the cultural context of Aotearoa. It must recognise that good care is not just clinical – it is equitable, cultural, relational and mana-enhancing. This framework shows how Aotearoa can achieve a safe staffing system that is enforceable, culturally safe and world leading.

What Good Care Looks Like | He Āhua o te Manaaki Pai

Despite the immense pressures of an aged care system in crisis, good care continues to happen every day due the unwavering commitment, compassion and manaakitanga of kaimahi working in the sector. We repeatedly heard stories from workers about their dream to provide mana-enhancing, person-centred care to all kaumātua. Equitable, accessible, culturally safe, mana-enhancing aged care is not unrealistic or unattainable. Everyday nurses, kaiāwhina and all health kaimahi demonstrate that good aged care is possible, if we are prepared to ensure there is staffing, resourcing and funding to guarantee it. What this tells us is that the problem with aged care is not the competencies and vocational drive of the workforce, it is that the system sets them up to fail by precluding the possibility of culturally and clinically safe care through underfunding and understaffing. Here we provide a vision of aged care in Aotearoa derived from the collective voice of kaimahi through our interviews and sector surveying.

Good for kaumātua

Kaimahi described a future for aged care where all basic care needs for residents are met without fail. In this future, missed cares become an exceptional incident that prompts interventions and increased staffing, not a daily occurrence and defining feature of the sector. Residents personal care routines are not rushed, their autonomy and independence are encouraged, they receive balanced and nutritious meals and can interact freely with kaimahi. Workers described conditions for being able to provide person-centred care in a relaxed way, in ways that accommodate the personal and cultural preferences of residents, at their own pace and crucially in ways that meet their individual needs with respect, dignity and compassion. It was a call to remember that kaimahi are working *"in the residents' home, not them living in our workplace."*

A flourishing resident in aged care is someone who is thriving physically, emotionally, and socially despite the challenges of ageing. This could look like a resident who is:

> **assisted to be as independent as possible and supported to take as much time as needed to complete a task themselves. They are happy, have made friends with other residents and have an active social life both within the facility and outside it if that is their wish. Family feel their family member is well cared for and they are free to visit at any time and find their loved one looking dignified and respected.**

Kaimahi described the joy in being able to genuinely spend time with residents, time to make them smile, sing to them, read to them, or take them for walks. They envisioned being able to meaningfully spend time with residents, to provide emotional and social support, address any concerns they have and being able to follow up with their whānau directly, so they feel secure and happy. Through this expression of whanaungatanga, nurses identified the opportunity to develop better clinical care plans and decisions. More time with residents enables assessments to be done regularly and thoroughly, where any deterioration or changes in residents is nuanced and detected early by care staff with established communication and trust. When care staff have in-depth experience of residents, they can quickly recognise differences, monitor, modify or escalate their care plans to improve a resident's quality of life and level of care.

When residents are accurately assessed for their required level of care, they can be supported to thrive. One nurse described a resident in rest home-level care, who was struggling with his mental health, poor appetite and losing weight. After suffering a fall resulting in a hospital stay, he was reassessed as hospital-level care. The resultant extra support and assistance allowed him to flourish, he began eating again, regained weight, began enthusiastically participating in activities and life withing the facility. This shows the personal toll of incorrect or delayed needs assessment, and by contrast the changes we can see when people who need more support can access it.

Good for kaimahi

In describing their ideal vision of aged care, health workers initially described the most basic enforcement of their already legally mandated employment rights – being able to drink water and use the toilet on shift, taking their tea breaks and lunch breaks, and working only their rostered hours to get home on time. They described having enough staff to ensure that direct cares can be completed, and paperwork and documentation could be completed within their shift, rather than in their own time. One nurse described the desire for a workday that would leave them "*Feeling productive without being overwhelmed.*"

The crux of the solution for good care is safe staffing. Implementing evidence-based nurse-to-patient and carer-to-patient ratios was seen as key safeguard for ensuring adequate care time. Every facility needs RNs on the floor. Workers described feeling valued and supported in their work, receiving fair pay, and adequate training to deliver care safely.

This requires an enforceable system for matching the number of direct care staff dedicated to the needs of each resident. For one survey respondent, this means:

> ensuring that nurses and caregivers can provide personalised attention and meaningful interactions, allowing them to understand each resident's unique preferences, histories, and care requirements. I envision a supportive environment where staff are not overwhelmed, enabling them to foster genuine relationships with residents, which enhances both the quality of care and the overall well-being of individuals in our care. In this ideal scenario, communication flows freely among staff members, residents, and families, creating a community that values compassion, dignity, and respect for every aging individual.

Or in the words of another worker,

> Aged care needs to be valued as part of the community's health care continuum, and staff recognised as palliative care nurses as well as ARC nurses. Funding needs to be urgently addressed so quality aged care is available to everyone, not just those who can afford it.

Actualising Te Tiriti in Aged Care | Te Whakatutuki i Te Tiriti i te Manaaki Kaumātua

Health care in Aotearoa must reflect our constitutional tuāpapa (foundation) in Te Tiriti o Waitangi. The health system must give full effect to te Tiriti o Waitangi by translating its guarantees into the structure, culture and daily practice of the health system. It centres values such as whanaungatanga (relational care), wairuatanga (spiritual wellbeing), and pono (integrity and accountability) as foundational to how care is both conceptualised and delivered.[29] This means centring Māori knowledge, enabling shared decision making, embedding Māori-led accountability and prioritising a mana-enhancing and te Tiriti-based partnership. A health system grounded in te Tiriti o Waitangi is one where Māori exercise tino rangatiratanga in health, manaakitanga underpins all relationships and health services, and all people experience equitable access, outcomes, and care – free from racism, bias, and marginalisation.

All kaumātua in care are entitled to both clinically and culturally safe care.

Cultural safety is inextricable from clinical safety.

Although the concept of cultural safety has become a cornerstone of health discourse in Aotearoa, its implementation has been ineffective in addressing structural racism and power imbalances, this is reinforced by ongoing poor Māori health outcomes. Our research found that policies and practices relating to cultural safety in aged residential care were minimal, inconsistent and unenforceable.

A Te Tiriti-centred health system rejects models rooted in individualism and competition. Instead, it prioritises collective wellbeing, drawing from Te Ao Māori, which emphasises interdependence, whānau-centred approaches, and healing that embraces the spiritual, cultural, and social dimensions of ōranga (wellbeing). This values-based model is counter to the priorities of the private sector, where profit incentives necessarily override commitments to culturally responsive, mana-enhancing care. Publicly funded health services, whether delivered by public or private entities, must be accountable to these principles and values.

Redressing the determinants of Māori health inequities include dismantling institutionalised racism and ensuring a health care system that delivers accessible, appropriate and equitable care. The design and delivery of aged care services throughout the health system must be mana-enhancing, culturally responsive, and safe. Culturally safe care centres the mana of the patient and their whānau at all points of interaction through the health system. These relational models of care are embedded in principles of manaakitanga, whanaungatanga (relationships), tiakitanga (guardianship) and wairuatanga (spirituality) which provide the ethical and cultural grounding for a te Tiriti-based aged care system that serves both Māori and tangata Tiriti (non-Māori). These values are foundational to the nursing profession in Aotearoa and align with both Te Ao Māori ethics and the New Zealand Nursing Council's regulatory standards for cultural safety.[30]

Te Tiriti o Waitangi establishes a constitutional relationship between Māori and the Crown, informed by the principles of kawanatanga (governance), tino rangatiratanga (self-determination), ōritetanga (equity) and wairuatanga (spiritual freedom). This necessitates binding co-governance arrangements between the Crown and tāngata whenua at all levels of health system governance and decision making. The aged residential care system must be Tiriti-based, affirming Māori rights and Crown obligations. Article 2 of te Tiriti guarantees tino rangatiratanga. This means Māori need control and the capacity to steer aged care facilities. This could look like funding for iwi, hapū, urban Māori authorities, and other Māori health providers to develop or bolster aged care facilities.

The principles underpinning the Crown's obligations under te Tiriti o Waitangi in health are:

Tino rangatiratanga: Providing for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.

Equity: Committing to achieving equitable health outcomes for Māori, requiring a focus on addressing disparities and ensuring fair access to services.

Active Protection: The Crown has a duty to actively protect Māori interests, including their right to health and well-being, and ensure they are not disadvantaged.

Options: The Crown must provide and properly resource kaupapa Māori health services, allowing Māori to develop and manage services in ways that reflect their own values and priorities.

Partnership: The Crown and Māori must work together in a strong and enduring relationship for the governance, design, delivery and monitoring of health services.

Australia Care Minutes Model | Care Minutes Model o Ahitereiria

In response to similar widespread neglect, elder abuse, and substandard and delayed care for older residents, the Australian Royal Commission into Aged Care Quality and Safety was established in 2018 and its final report was published in 2021.[31] The report laid bare similar conditions: chronic understaffing, widespread neglect, opacity in reporting, and no enforceable minimums. The Commission concluded that without enforceable staffing standards, aged care could not be safe. It made 148 recommendations to form the foundations of a new aged care system that would uphold the universal right to high quality, safe and timely care for older people with dignity. In response, the Australian Government amended the Aged Care Act to introduce a new residential aged care funding model and enshrined the rights of people who access publicly funded aged care services to be treated with respect and have the quality of life they deserve.[32] It puts the rights of older people at the centre of the aged care system.

In response to the Royal Commission's findings, safe staffing mechanisms were designed, implemented and fully funded by the federal government in the form of care minutes to guarantee the right to receive safe, high-quality aged care with dignity and respect.

Care minutes encompass the total amount of direct, hands-on time that nurses and caregivers spend providing care to support residents each day based on their differing levels of acuity and need.

Approved providers of residential care are legally obligated to deliver a certain number of care minutes to each resident across 13 levels of assessed care needs. This system ensures that older people in aged residential care facilities receive the dedicated care time they need, and that providers are funded to deliver.

Mandatory direct care minutes in Australian aged residential care facilities were introduced on October 1, 2023. Residential care homes were required to deliver a sector-wide average of 200 care minutes per resident per day, including 40 minutes provided by a RN. Additionally, all facilities are required to have an RN on site and on duty 24 hours a day. The 200 minutes of care could be provided by RNs, ENs, personal care workers or assistants in nursing. From 1 October 2024, the care minutes responsibility increased to an average of 215 minutes of care per resident per day, including 44 minutes of direct RN care.

In addition to the Australian sector-wide average, care minutes are mandated for each type of resident. The Australian National Aged Care Classification (AN-ACC) funding model that was introduced in October 2022 is an assessment tool that assigns resident to one of thirteen classes based on the variable needs.[33] The AN-ACC accesses the degree of care required by each aged care resident and allocated funding to the facility providing their care. It accounts for physical ability, cognitive ability, behaviour and mental health. Categories range from Class 2 (independent mobility without compounding factors) to Class 13 (Not mobile, lower function and higher pressure injury risk with compounding factors). Class 1 is for those admitted for palliative care and has the same weighting and funding level as Class 13 residents. Each Class carries a case weight that translates into staffing minutes.

This evidence-based safe staffing approach was a watershed moment in the design and delivery of aged care. It ensured that staffing was grounded in residents' needs rather than provider convenience.

Between the September quarter 2023 (the quarter prior to the implementation of mandated care minutes) and the March quarter 2025, total care minutes per resident rose 11.9% from 194 minutes to 217 minutes – above the 215 minute requirement. Over the same time period, care minutes by RNs rose 27% from 37 minutes to 47 minutes – above the 44 minute requirement.[34] The introduction of care minutes in Australia fundamentally changed their national conversation on staffing. The model has placed minimum staffing requirements on a measurable foundation for the first time, thereby lifting transparency, accountability, and expectations across the sector.

Concerns with Australian care minutes

Care minutes have proven themselves to be a transformative mechanism to institute benchmarks for safe staffing and safe care in Australian aged residential care. In the intervening years, experience with this new model has identified some shortcomings and opportunities for further refinement. These primarily relate to the lack of consideration of cultural safety as a component of clinically safe care, enforcement and transparency gaps that allow for provider non-compliance, complexity in design and delivery, and a lack of worker voice in care planning. While care minutes can lift staffing levels and account for task-based workloads, without mandated cultural safety, embedded transparency and accountability processes, and legislated worker voice the gains are fragile and uneven.

Cultural safety

The evidence base used for quantifying clinical need in the form of care minutes exclusively indexes staffing workload with respect to direct care tasks and duties. However, this makes no account for culturally safe practice of nurses and carers in their discharge of these tasks. Cultural recognition is not built into the Australian minimum standards. Te Tiriti obligations mean that simply replicating the Australian system in Aotearoa will not work. Te Tiriti must be upheld within the design and service delivery of the health system. Further, health agencies are responsible for ensuring cultural competencies in workforce and practice, and nurses have a professional requirement for cultural competency as part of the registration with the New Zealand Nursing Council.

Compliance

Non-compliance with care minutes is widespread. Australian union representatives described large corporate providers gaming the care-minute mandates to report compliance within quarterly averages but non-compliance on individual shifts. For example, large providers were found to front load rosters at the start of each quarter, then cut back on staffing levels once quarterly averages were met. Staff experienced inconsistent and unreliable shift patterns, often being sent home mid-shift once a day's minutes were achieved or reassigning care staff into non-direct care roles, such as laundry or kitchen duties, while still claiming their allocated care minutes for residents. Some staff reported to their union representatives that records were falsified to cover gaps.

Despite the sector-wide average exceeding the required minimum, in the March quarter 2025, 43% of services did not meet the total care minutes mandate and 64% did not meet both the total care minutes and RN minutes mandate. Services in rural areas were more likely than services in metro areas to exceed minimum care minutes, despite workforce constraints being generally lower in metro areas. Not-for-profit services were more likely than for-profit services to exceed minimum care minutes.[35]

In October 2024, the Australian Minister for Aged Care, wrote an open letter to ARC providers outlining the extent of non-compliance and highlighting the 58% increase in funding they had received since 2022. The Australian Government is continuing to explore options to boost care minutes compliance, including funding options, supporting providers that are actively working towards compliance, and using the full range of regulatory powers to enforce compliance where providers are not making genuine attempts to increase their staffing levels.[36]

Complexity

Compliance issues are a product of the complexity in translating the clinical currency of care minutes into the daily provision of care and rostering practices. The value of care minutes is precision in assessment and funding tools. However, it is difficult to assess compliance in real-time in a ward or facility. The average of 215 minutes per day does not reflect residents' real-time needs and smooths over acuity differences. Providers average care minutes across a whole facility each quarter, which can obscure daily under-staffing.

Worker voice

The absence of a legislated worker voice clause compounds the problems with non-compliance and weak enforcement protocols. Early drafts of the Aged Care Act included provisions requiring providers to consult workers, protect them from reprisal when raising concerns, and give union delegates access to rosters and compliance data. These were stripped from the final Act to secure its passage. As a result, unions argue, the system lacks real time accountability and remedies for unsafe staffing levels. Weak enforcement mechanisms result in ongoing complaints, workplace disharmony and poor outcomes for residents. Without robust avenues for workers' voice, providers can continue to take public money with less accountability for quality of care.

An Aotearoa Care Minutes Model | Care Minutes Model o Aotearoa

Our vision demands a culturally and clinically safe aged residential care system in Aotearoa. Drawing from the Australian experience, a care minutes approach in Aotearoa must be culturally safe, person-centred, accountable and sustainable. This framework shows how Aotearoa can achieve a safe staffing system that is enforceable, equity-based, and world-leading. It ensures that kaumātua are safe, whānau are respected, staff are supported and gives practical effect to Te Tiriti o Waitangi.

Infometrics data shows that New Zealand is already operating far below safe care thresholds. Analysis of the aged care sector and workforce requirements to meet Australian mandated care minutes finds that applying minimum care standards in Aotearoa would require an estimated additional **8,232 carer (RN, EN caregiver/kaiāwhina) FTEs** overall, of which **1,550 FTE** would need to be RNs. This is a 34% increase on current RN workforce levels and a 38% increase in the overall aged residential care workforce.[37] Adopting a care minutes model will not only lift staffing standards but also make visible and quantifiable the exact worker FTEs that must be funded to provide culturally and clinically safe patient care.

interRAI and case-mix model

The Ministry of Health mandates that all existing and newly entering residents in an ARC facility undergo a comprehensive assessment with the interRAI Long Term Care Facility (LTCF) tool. This tool is used for clinical needs assessment and for developing resident-specific care plans. Assessments must be undertaken at least every six months for all residents. It is used to support care planning, reporting of quality indicators, measuring outcomes and Resource Utilisation Groups (RUG). However, currently, the bulk funding model in ARC only separates residents into four crude levels of need (rest home, hospital, dementia and psychogeriatric) and stems from a time when residential care assumed low to moderate care needs. The current system does not account for high variability between residents within the same level of care band depending on their physical, cognitive and behavioural ability, nor does it factor in rehabilitative or complex needs. These calls for greater funding that is responsive to both higher levels of resident acuity and individualised need are widespread across the sector.

Extensive research and modelling have been carried out by clinical and academic experts to develop a case-mix model that categorises individuals into groups of similar needs.[38] This Aotearoa case-mix approach uses the RUG-III-15 system, an adapted and validated version of the interRAI LTCF tool, to place individuals into groups of similar needs. It classifies residents into fifteen categories across five lead domains: physical function, behavioural problems, cognitive impairment, clinical complexity, and rehabilitation. Each domain is further stratified into Low, Medium, and High need levels. This would determine the level of funding and the type and quantity of care. Implementing this case-mix model would mean moving from four levels of care to fifteen levels of care, an even more granulated patient classification system than the thirteen categories of care developed for the AN-ACC funding tool in Australia ARC.

Case-mix is integral for instituting person-centred care because it allows for more careful assessment of individual need and triggers the care plans and funding to meet this need. However, greater accuracy in assessment is ultimately ineffective if it does not accompany mandated staffing minimums to meet this need in a clinically and culturally safe manner.

Care minutes in Aotearoa

Care minutes are not aspirational targets; they must be legislated minimums that providers are legally obliged and funded to meet. Building on the care minutes model from Australia and the case-mix model developed in Aotearoa,

we are calling for a care minutes framework that builds a safe staffing system around the needs of residents.

Nurses and kaiāwhina are the crux of delivering day-to-day care for residents. Care minutes will establish a rigorous and evidenced baseline for what is needed for individual residents in terms of their clinical, cultural and personal care needs 24 hours a day.

Aged residential care is a nurse-led model of care. While the needs of residents are always met by multidisciplinary care teams, nurses are the predominant clinical leaders in the overall monitoring, assessment and clinical delivery of care. For this reason, it is essential that care minutes for baseline 24/7 resident care is secured in nursing and kaiāwhina care minutes. Each category of resident would have fixed minutes – entitlements would be resident-held, daily and non-transferable.

Where residents require two-person tasks such as hoist transfers, additional minutes are allocated to cover both staff. These paired task minutes are calculated from the resident's interRAI LTCF assessment (which records transfer needs), multiplied by the average time per hoist episode and daily frequency, and doubled to account for two staff being engaged simultaneously. These minutes are added on top of baseline entitlements and must be rostered in overlapping blocks so that two trained staff are always present for the transfer. Examples of paired tasks that need to be built into the needs assessment process are hoisting, turning and repositioning, dispensing controlled drugs and medications, or the use of syringe drivers for palliative care.

Given the proposed case-mix model in Aotearoa would contain 15 categories of resident, greater than the 13 categories in Australia, the specific detail of each category's care minutes calculation will differ from the Australian model. This level of detail is beyond the scope of this report and requires extensive clinical research.

Hauora minutes in care minutes

Another reason the Australian care minutes model is inadequate is its lack of enforceable cultural safety measures, required in Aotearoa to uphold the Crown's obligations under te Tiriti o Waitangi in designing, funding and delivering health care. As the Waitangi Tribunal identified in the WAI2575 report, "cultural safety recognises not just that services need to be culturally appropriate but that, if services are delivered inadequately, then the delivery method of those services can become a negative determinant of health outcomes."[39]

> A care minutes model in Aotearoa must embed cultural safety within clinical assessment by quantifying and embedding cultural care time and culturally safe practice in the form of Hauora care minutes. This means the staff time to provide direct care, both clinical and personal, accounts for the Hauora needs of residents by providing additional time to deliver care in a mana-enhancing, culturally safe manner and further additional time to meet the cultural, social, spiritual needs of residents beyond immediate clinical or domestic routines.

Although interRAI has incorporated a Culturally Appropriate Assessment Model (CAAM)[40] to promote cultural responsiveness, person-centred care, and partnership (including a te Tiriti view), it is apparent these aspirations are not being meaningfully realised in practice for Māori. It is ultimately up to the cultural competencies of the nurse making the assessment and there are often gaps in the assessment process. The intent of interRAI CAAM framework is to embed cultural safety, whānau-centred care, and partnership. However, despite these formal commitments, implementation gaps persist, and Māori cultural needs remain largely unmet at the coalface.

As outlined above, Māori continue to experience disproportionate health inequities across all indicators, shorter life expectancy, higher morbidity, racism and bias in health care. Quantifying and funding Hauora care minutes is a necessary equity response to this shortfall and should be explicitly resourced within the care-minutes funding model. This would give concrete expression to the interRAI's government endorsed position on equity and te Tiriti by embedding culturally responsive models of aged care and resourcing them appropriately. When cultural safety is severed from clinical practice, unsafe care ensues.

Hauora care minutes are grounded in Māori aspirations for mana-enhancing care and whānau-centred service delivery. This means not only providing direct care time to enact values such as manaakitanga, whanaungatanga and tiakitanga as discussed above.

It also means that daily care is person-centred and mana-enhancing at every interaction.

Care time must accommodate the personal and cultural preferences of residents, at their own pace and crucially in ways that meet their individual needs with respect, dignity and compassion. Additionally, embedding cultural safety in care minutes goes beyond just the numbers, but demands that cultural competency is a core part of the workforce skillset in making assessment decisions and providing care.[41]

Skill mix and a Registered Nurse on site and on duty 24/7

Not having enough staff with the right skills to care for kaumātua is unsafe. In addition to a case-mix approach that classifies residents, it is important to ensure facilities are staffed with an appropriate skill mix.

> **This refers to the specific combination of nursing staff with different educational levels (Registered Nurses, Enrolled Nurses) and experience within a healthcare team to match patient needs, with a strong emphasis on ensuring the right skills are available to provide safe, high-quality care.**

With a recently expanded scope of practice, ENs are positioned to make greater contributions to the clinical delivery of care in ARC. The Australian care minutes model assigns care minutes to a ratio of 30% RN: 20% EN: 50% Caregiver. If there are insufficient ENs in a facility to undertake the 20% care minutes, then this work needs to sit with RNs as regulated colleagues. It is not appropriate to substitute an unregulated workforce for a regulated one.

ARC facilities in Aotearoa are increasingly making use of virtual RNs who are available for caregivers to contact for clinical advice when there are no nurses rostered or available for any given shift – this practice is unsafe for both residents and clinically unsupported kaiāwhina. One of the key findings of the Royal Commission into Aged Care Quality and Safety was to have a Registered Nurse on site and on duty 24/7 to guarantee safe care. This reinforces the critical role RNs play in ensuring quality care, managing medical issues and responding to emergencies.

> **Having RNs on site and available enhances resident safety, allows for appropriate intervention and escalation of care needs and prevents unnecessary hospitalisations. It is essential for clinical safety of residents and staff to have nurses working in ARC facilities at all times.**

Infometrics modelling shows that **3,976 Registered Nurse FTEs** are required to meet this requirement in Aotearoa.[42]

Staff to resident ratios

In response to the complexity and weak enforcement mechanisms of the care minutes system for determining appropriate staffing levels in real-time, care minutes should be converted into safe patient ratios for both nursing staff and kaiāwhina.

> **Ratios indicate the number of residents one staff member can safely look after per shift, or conversely, the number of staff a facility of a given size must roster for every shift. Ratios make care minutes legible and enforceable. This would translate the evidence-based clinical and Hauora calculation of care minutes into minimum staff ratios.**

Ratios enable staffing to reflect the different requirements and weightings for different shifts. Where Australian providers could average care minutes across shifts by over-staffing and under-staffing at their discretion, ratios ensure each shift has an enforceable staffing baseline. For example, night shifts generally require less personal care or assistance with meals; however, there may be specific wards with residents who need direct support 24 hours a day or dementia units where wakeful nights are common.

In the Australian state of Victoria, nurse-to-patient ratios are in effect for aged high care residential wards mandated by the Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015. This legislation sets out nurse-to-resident ratios between 1:7 and 1:8 for morning and afternoon shifts, and 1:15 residents for the night shift. Once Aotearoa care minutes are determined with the use of case-mix needs assessment combined with Hauora minutes to ensure culturally and clinically safe care, these minutes can be translated into clear and accessible ratios for nurses and kaiāwhina.

Funding, Transparency and Accountability | Te Pūtea, te Pono me te Haepapa

The current funding model for ARC sets arbitrary and inadequate funding envelopes for the delivery of care. This then necessarily limits the staffing capacity and skill mix of facilities, and therefore, is a direct contributor to unsafe care. The system of annual "uplifts" is ad hoc, vulnerable to political manipulation and contrary to sound policy. The funding model and the inadequate staffing levels it incurs is the architecture of neglect and unmet need in ARC. In contrast, we propose turning this model on its head. ARC must be designed around a needs-driven model, rather than a supply or demand-driven one.

When we begin with the resident and place their needs – clinical, cultural and personal – at the centre of ARC, we can then implement a staffing and funding system that concretely guarantees their right to culturally and clinically safe care.

Aotearoa has employed an overly simplistic funding model in ARC. There are four levels of assessed need that crudely fall into rest home, hospital (continuing care), dementia and psychogeriatric. These are each accompanied by a fixed weekly subsidy paid directly to care providers. The Sapere review of aged care funding and service models confirmed that the current funding rates are insufficient and inflexible for meeting the individual needs and acuity of a diverse spectrum of residents.[43] Despite 84% of residents falling into two categories of assessed need, rest home and hospital, there is no recognition of how those in the same funding band can have entirely different care needs and individual capacities. Providers thus have limited ability or incentive to adjust the level of care relative to resident need. In contrast, this creates a perverse incentive to ration care or refuse to admit high needs residents, amplifying existing inequities in access to care.

If service delivery for older people remains as it is now in Aotearoa, 9 out of 10 hospital beds will be filled by someone aged 65 or over by 2043.[44] Safe staffing levels, skill mix, and bed availability are direct contributors to preventable hospital admissions of elderly residents. The cost of understaffing and subsequently unsafe care is already being displaced to the tertiary hospital sector. Investing in culturally and clinically safe aged care will reduce the ballooning cost and capacity burden of residential care patients transferred into the public hospital system for acute care.

In response to the findings of the Australian Royal Commission into Aged Care, the Australian Government invested $17.7 billion (AUD) in its 2021/22 Federal Budget into aged care reform to deliver sustainable quality and safety in home and residential aged care services.[45] While this direct investment into the promise and delivery of safe aged care was significant, it is less than estimates of the existing cost of avoidable hospital admissions of elderly patients in residential care. The Australian Medical Association estimated these savings could be up to $21 billion (AUD).[46]

Within a case-mix funding framework, funding follows the resident.

Care minutes needs to be embedded into the funding framework to ensure residents get the care they need. A care minutes methodology ensures staffing requirements to provide care reflect the assessed needs of residents and are fully funded. It is essential that public funding received by ARC providers for the purpose of meeting residents' direct care needs makes its way to the workers who provide that care.

There are currently no mechanisms to demarcate operational funding from workforce funding. This is why a case-mix based financing system that adopts a more granular assessment methodology for residents must be inextricably bound with the mandatory and enforceable safe staffing requirements to provide the care that any given assessment dictates. With no obligation to ensure safe staffing minimums, the case-mix model is just a more nuanced assessment of the kinds of care that will continue to be missed. Funding should be conditional on providing care time and accompany a clear legal requirement to fulfil care time. Consistent breaches in meeting staffing and care time obligations should attract penalties, including mechanisms for funding being recouped by the Government if care time requirements are repeatedly unmet by providers.

Independent pricing authority

Calculating funding levels for ARC is rife with political distortions, where stakeholders are competing for limited funding to the detriment of residents. This tension was clearly illustrated in 2023 when the Government announced a 5% uplift to funded sector providers of health services intended to address wage disparities between public sector nurses and kaiāwhina and their funded sector counterparts. However, due to

unbudgeted cost increases across all business variables, providers refused to pass on the full value of the uplift to their workers. Employers eventually relented and passed on 3% of this uplift to kaimahi. Where there is a high level of reliance on a funding model in which government or statutory bodies effectively set the price for labour, collective bargaining is functionally precluded or seriously limited. There is no available funding to reflect the market value of labour costs, or all other fixed and variable capital costs in providing ARC services.

Independent pricing and funding advice is therefore essential in Aotearoa. The Australian model employs the Independent Health and Aged Care Pricing Authority (IHACPA) to provide pricing advice that ensures funding is directly informed by the actual costs of delivering care.[47]

> **Drawing on the evidence-based advice of IHACPA, the Government can then determine the prices for aged residential care subsidies that reflect the cost of care and develop policy settings to ensure this funding makes its way to the resident via direct care time. Independent, evidence-based costings are critical to securing the delivery of culturally and clinically safe care in Aotearoa.**

Transparency and reporting

Increased funding for care time will not work without oversight, accountability and enforcement mechanisms. To make providers accountable for their use of public funding and delivery of care, mandatory reporting on planned staffing levels to meet minimum requirements, actual care time delivery, compliance with targets and transparent financial reporting is essential.

Since July 2022, Australian aged care providers are required to submit quarterly financial reports to the Government as a condition to receive operational approval and public funding.[48] Mandatory financial reporting must detail the financial performance and position of ARC providers and their parent organisations. Financial reporting on parent organisations will reverse the tide of private equity's increasing involvement in ARC. Private equity firms harvest public funding via ARC contracts and seek to leverage gains from property speculation, risk shifting tax burdens, cost-cutting in reducing staffing and supplies, and levying management fees from the operational costs of facilities. This should also address the reluctance to provide further public funding to large multinational corporations that report healthy profits outside of their ARC divisions and activities.

Mandatory quarterly financial reporting allows oversight and more timely analysis of the sector's financial performance and viability – reducing the risk of bed closures or facility closures.

> **These reports must detail income and expenses for care services and other activities for each facility, including labour costs and hours. Funding should be linked to providing care time and it should be clear and accessible where providers are failing to provide mandated care time or monies have been redirected to other lines of expenditure. Where providers repeatedly fail to fulfil staffing and care time obligations, there should be clearly defined regulatory mechanisms, including penalties and public notification of residents, whānau and staff.**

Workers' voice committees

Nurses and kaiāwhina are in ARC facilities 24 hours a day, 7 days a week with the residents – they are the best placed to monitor and enforce real-time accountability mechanisms. Compliance with mandatory staffing requirements is the crux of ensuring safe, high-quality care for residents. Workers must be empowered to proactively enforce facility compliance with delivering funded care time. It should be a legislative requirement for every ARC facility to have a Workers' Voice Committee. Members of this Committee would adopt a recognised representative role, nominated by staff to represent the interests of direct care workers in the planning, monitoring and implementation of safe staffing ratios in their facility. Worker voice ensures that the people who see risk first are empowered to act. It creates a feedback loop between the floor, the regulator, and the public. Without it, as Australia has shown, care minutes can be gamed. With it, care minutes become enforceable.

> **Every facility must have a Workers' Voice Committee, comprising elected staff representatives and union delegates, with access to rosters, compliance data, and RN 24/7 logs. These representatives may raise issues on rosters, appropriate models of care, skill mix, care plans and related task allocations, work classified as direct care activities, implementation issues of care minutes and safe staffing ratios or any other issues they believe impact the quality of care and the implementation of culturally and clinically safe staffing minimums.**

The law will:

1. Protect workers who raise concerns from reprisal.
2. Provide access to information, including rosters and compliance data.
3. Require providers to consult openly and transparently.
4. Ensure clear pathways for resolving issues.
5. Oblige regulators to respond within fixed timeframes.
6. Reinforce existing rights under the Employment Relations Act 2000 and Health and Safety at Work Act 2015.

Section Five

Recommendations

Ngā Tūtohi

1. **RN Coverage:** All aged residential care facilities must have a Registered Nurse on site and on duty 24/7 to ensure safe care for kaumātua. This precludes the use of virtual or remote nursing services and is in addition to mandated nursing staffing ratios.
2. **Case-mix:** A case-mix model of assessment that reflects the acuity and complexity of residents coming into ARC facilities now and those projected to enter in the future is essential for identifying residents care needs and corresponding funding requirements.
3. **Care Minutes:** The Government must establish legislated evidence-based safe staffing minimums that ARC providers are legally obliged and funded to meet. In conjunction with interRAI (LTCF) assessments, care minutes provide an evidenced baseline for what is needed for individual residents in terms of their clinical, cultural and personal care needs 24 hours a day. Each category of resident must have fixed minutes, and entitlements are resident-held, daily and non-transferable.
4. **Cultural Safety:** A care minutes model in Aotearoa must embed cultural safety within clinical assessment by quantifying and embedding cultural care time and culturally safe practice in the form of Hauora care minutes. This means that the staff time to provide direct care, both clinical and personal, accounts for the hauora needs of residents by providing additional time to deliver care in a mana-enhancing and culturally safe manner. Hauora care time also accounts for meeting the cultural, social and spiritual needs of residents beyond immediate clinical or domestic routines.
5. **Ratios:** Care minutes calculations should be converted into safe patient ratios for both nursing staff and kaiāwhina to ensure safe staffing on every shift. Ratios indicate the number of residents one staff member can safely look after per shift, or conversely, the number of staff a facility of a given size must roster for every shift. Ratios make care minutes legible and enforceable. This would translate the evidence-based clinical and Hauora calculation of care minutes into minimum staff to resident ratios.
6. **Workforce capacity:** There must be a robust training pipeline and full pay parity with Te Whatu Ora HNZ to ensure there are enough appropriately trained staff to meet the needs of residents now and in the future. This includes workforce planning, capacity and cultural competencies.
7. **Funding:** Funding must be linked to the provision of care time based on case-mix modelling and accompany a clear legal requirement to fulfil care time. Funding levels should be determined by independent evidence-based costings of care delivery, including workforce and operational costs.
8. **Building Capacity:** The Government needs to fund additional capacity in the ARC sector to address bed shortages nationally and fill service gaps that compromise equitable access to ARC services in local communities.
9. **Transparency:** The Government must legislate mandatory reporting on planned staffing levels to meet minimum requirements, actual care time delivery, compliance with targets and provider financial information at the level of each ARC facility, provider and parent company receiving public funding for ARC service provision.
10. **Accountability:** Every facility must have a Workers' Voice Committee, comprising elected staff representatives and union delegates, with access to rosters, compliance data and Registered Nurse 24/7 logs.

Section Six

Research Methodology

Kaupapa Rangahau

Research Methodology | Kaupapa Rangahau

The ARC member survey sample

The survey was distributed in April 2024 via local aged residential care facility networks. Over the eight weeks it was open, it was completed by 415 aged residential care workers in nursing and health care assistant / kaiāwhina roles. The majority of respondents were Registered Nurses (54.2%), and kaiāwhina comprised just under one third of respondents (30.6%).

Reflective of trends in the sector, the vast majority of respondents identified as female (89.64%). Reported ethnicities were predominantly Pākehā (35.8%), Filipino (22.5%) and Indian (15.5%), and 6.1% of respondents whakapapa Māori.

A significant proportion of respondents were working at the top of their scope and salary scale, and had been working in the sector for some time. For example, of the 127 health care assistants surveyed, 44.9% were employed at Step 4b (medication-competent) – the top of the step range for this role. Of the 225 registered nurses surveyed, 38.2% were employed at the top of the nursing scale, Step 7. Of all respondents, 20.2% had been working in aged residential care between eight and 14 years, 10.6% had been working in the sector for between 14 and 20 years, and 12.3% had been working in the sector for more than 20 years. Cumulatively, 43.1% of respondents had worked in aged residential care for more than eight years. Most respondents were in permanent full-time positions at 65.8%. Those in permanent part-time positions made up 18.1% of the sample. The remaining 16.1% worked in casual or fixed term positions.

Interviews

Interviews were conducted between December 2024 and May 2025 with 80 health workers in aged residential care across Aotearoa. Health workers in ARC were identified through Tōpūtanga Tapuhi Kaitiaki o Aotearoa NZNO membership and participants were selected based on geographic region, provider type, role, ethnicity and employer, to reflect trends in the sector. Interviews were 45-90 minutes, semi-structured and the majority kanohi ki te kanohi (face to face). Interviews were participant-led, included time for whakawhanaungatanga and covered worker experiences in aged care, staffing, missed and unsafe care and the biggest challenges in ARC for kaimahi and kaumātua.

In line with Te Tiriti o Waitangi, the research gave greater representation to kaimahi who whakapapa Māori, (25%), redressing consistent underrepresentation across health sector research and to address distinct challenges that Māori kaimahi and kaumātua face in ARC. Interviews with Māori kaimahi were undertaken by a Māori researcher and reflected Kaupapa Māori research practice.

Interviews with kaimahi were transcribed and coded using both inductive and deductive thematic analysis through two coding cycles. The first involved organising the data set by deductive analysis based on previous reports and literature, identifying challenges in the sector. The second cycle of inductive analysis identified patterns. To protect participant confidentiality, pseudonyms have been given to all participants.

Interview sample

Interviews were conducted across Aotearoa, slightly overrepresenting Te Waipounamu, 33%, due to the distinct challenges of rural and regional ARC facilities. Participants worked across 36 different employers, representing both smaller facilities and all major providers of aged care in Aotearoa. This includes Arvida, Bupa, CHT, Heritage, Metlife Care, NZ Aged Care Services, Oceania, Presbyterian Support Services, Ryman and Summerset.

Health district	Count
Te Waipounamu	27
Northern	19
Central	18
Te Manawa Taki	16
Total	80

Provider type	Count
Large Chain	42
Not for Profit	23
Small private	9
Other	4
Iwi provider	2
Total	80

Ethnicity	Count
Pākeha	27
Māori	20
Filipino	10
Indian	4
Fijian	4
Tongan	3
South African	2
Samoan	2
Nepali	2
African	2
Other European	2
Chinese	1
Korean	1
Total	80

Role	Count
Registered Nurse	37
Health Care Assistant	28
Clinical Nurse Manager	7
Nurse Practitioner	3
Other	3
Enrolled Nurse	2
Total	80

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Karakia whakamutunga

Unuhia, unuhia

Unuhia ki te uru tapu nui

Kia wātea, kia māmā, te ngākau,
te tinana, te wairua i te ara takatā

Koia rā e Rongo, whakairia ake ki runga

Kia tina! TINA! Hui e! TĀIKI E!

Tōpūtanga Tapuhi Kaitiaki o Aotearoa

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