ARTICLE : CASE REPORT

Doing aged residential care better – the view from the trenches

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ABSTRACT

In this article, we explore issues within the aged residential care sector from the perspectives of representatives of the workforce and the residents themselves. Qualitative interviews were conducted with residents, nurses and care workers at one residential care facility in Dunedin, New Zealand. Care workers expressed a strong vocational ethic of care but also raised concerns in the areas of wages, career progression, training, resources and workload management. They offered opinions on how the sector could improve on these issues and better support its carework employees. These included increased wages, training programmes, in-house management of equipment and allowing experienced care workers to have a stronger voice in the sector. Opinions expressed by the participating residents supported those made by the staff; they voiced concern on behalf of the care workers in regard to wages, training and workload.

INTRODUCTION

Like many other developed countries New Zealand has an ageing population which is expected to result in increased demand for residential care facilities. In 2011 there were approximately 32,000 older people that were cared for by such services. This number is projected to increase to approximately 38,000 in 2016 and to 52,000 in 2026.[1] The 85 and above age group is the largest user of residential care facilities and their numbers are projected to double between the years 2006 and 2016. Concerns have been expressed about the potential impact upon demand for care.[1,2] On top of anticipated increasing demand, those in care have become more dependent. A recent Auckland based study conducted by Boyd et al found that over a two decade period from 1988 there was a decrease in the number of residents who were apparently independent (from 16% to 4%) and an increase of those highly dependent (from 12% to 21%). Dependency was quantified by considering factors such as mobility, toileting and continence, orientation, memory and behaviour.[3] An overall increase in the dependency of residents puts more pressure on those who are providing care.

These are worrying statistics in light of the current concerns around the quality of aged care in New Zealand. 'A Report into Aged Care' commissioned out by the Labour and Green parties in conjunction with Grey Power New Zealand[4] uncovered some serious shortcomings in how older people are cared for. These authors described aged care as an "unregulated, desperately short staffed sector… [They] found a sector fast reaching crisis point, struggling to meet the growing needs of an ageing population and residents' rising acuity levels. The result is that many older New Zealanders are receiving substandard care."[4] This report, together with the Aged Residential Care Service Review (ARCSR) uncovered many fundamental issues and made a series of recommendations.[1] These included 14 recommendations put forward by the 'Report into Aged Care' and 15 by the ARCSR which ranged from establishing an aged care commissioner to having pay parity for the staff.[1,4]

Many studies have aimed to quantify the quality of life (QOL) of residents in aged care. Important factors such as leisure activities, family, relationships and independence along with the quality of life of co-residents and physical ability have strong correlations with QOL.[5,6] Marquis advocated that the quality of care in rest homes should be focused on resident outcomes, such as QOL, and not service outcomes, such as profit. Residential care facilities in New Zealand are audited on a framework of standards set out by the Ministry of Health.[7] The standards included in the audit are: consumer rights, organisation management, continuum of service delivery, safe and appropriate environment, restraint use and infection prevention, and control.[8,9] Facilities are given a score ranging from major shortfalls through to commendable.[8,9] While all the factors included in the audit will affect QOL there is no direct analysis on how the residents of that facility perceive their own quality of life. A limitation to this is that currently there is no standardised way of assessing one's QOL.[10] Some researchers have developed their own measures based on other literature or based on trends that emerged while interviewing participants.[11,12] More common methods of assessing QOL are the Schedule for the Evaluation of Individual Quality of Life (SEIQoL) or the simplified SEIQoL-Direct Weighting approach.[13,14] Both methods have been used widely and utilised in many different international settings but have not been universally adapted for New Zealand.[15,16,17]

A recent study conducted in Spain by Rodríguez-Martín et al examined what quality of care meant for residents of a care facility by conducting a series of interviews.[18] All participants considered the care staff to be a vital aspect. Specifically, staff should be affectionate, kind, good mannered, qualified and able to show personalised attention to detail when assisting with care. Resident independence was also regarded highly. In particular there should be no strict rules to living.[18]

As well as the aforementioned research regarding residents there has been some exploration into the challenges that health care assistants and nurses face in regards to working conditions and rates of pay in aged care. According to a recent survey by the New Zealand Nurses Organisation the most frequent source of dissatisfaction from the current staff was the high staff turnover rate and co-worker absence.[19] Factors that contribute to staff absence and the high turnover, which in some facilities has been

found to be as high as 43% over two years, may relate to the nature of the work.[19, 20] The challenge of providing basic personal care and managing people with dementia combined with receiving near minimum wage, feelings of under appreciation and limited job progression render the sector unappealing to the labour market.[19] In this article, we present findings from a small qualitative research project exploring the perspectives of long term residents and careworkers in one aged care facility on how to sustain quality of care to the highest possible standards.

METHODS

Setting

This research was conducted in a hospital-care wing of a retirement village complex in Dunedin. The participating retirement village is a modern facility with specialist aged care for up to 120 residents.

Participants and recruitment

Consent processes were negotiated between the research team, retirement village management and the University of Otago Human Ethics Committee (HE13/08). All participants were asked to give consent. Furthermore, it was requested by retirement village management that the residents required consent from their next of kin. The facility manager and clinical nurse leader were responsible for recruiting of participants. Despite the negative attention the sector has received we entered the facility with the assumption that there was nothing hidden to be uncovered as the participating home had passed all audits. Five residents, five care workers and three registered nurses (RNs) from the care facility were invited to participate. To participate the residents had to be over 65 years old, lived in the facility for over six months, could speak English, and without deficits in cognitive function. Cognitive function was not formally assessed, instead the nursing staff made judgements relating to the residents ability to participate. The care workers and nurses had to be over 18 years old, worked in the care facility for more than 6 months and could speak English.

Qualitative interviews

The interviews were semi-structured qualitative interviews based around predetermined open-ended questions.[21] Semi-structured interviews were used as they afford the interviewer the freedom to explore unanticipated and de novo responses while not constricting to a set interview schedule. The interviews were audio recorded. They took place in a private room at the care facility and were conducted one-on-one. Family members of the residents were free to attend as support and one resident chose to have their family member present during the interview. The questions asked focused on identifying issues in the provision of quality care and exploring possible solutions from the perspective of the interviewee. Examples of the questions included, "what are the challenges in providing good care?" and "how could these challenges be overcome?"

Analysis

A general inductive approach, as described by David R. Thomas, was employed to identify and code recurrent themes within the audio recordings.[22, 23] An innovative method of analysis was utilised so that the audio files themselves formed the basis of analysis. After the interviews were completed, recordings were listened to multiple times. Only selected quotations were transcribed verbatim.[22, 24] Quotations were selected if the subject content could be categorised by a definable idea or related to an emerging theme. Once the raw data had been converted to text, quotations were read through multiple times and categories of emerging themes were created. The text was broken up and coded into each category. If the text segment reflected more than one common theme this method allowed it to be coded into more than one category. Categories were then refined to reduce overlap and reveal overarching themes that would be included in discussion.

RESULTS

The mean age of the residents was 76. They all identified as NZ European, three were females and two were males. All the staff interviewed were female with a mean age of 35. All the care workers identified as NZ European while there were different ethnicities amongst the RNs.

Care Ethic

A key theme that emerged from the analysis was that participating staff held a very strong ethic of care. All the staff interviewed asserted that the primary reason they remained in aged care work was the enjoyment they get out of their work.

> *"And the care that we do for the residents means a lot; that is why we are here anyway… For me nursing is who I am. I am passionate about my work. It's not really about the money it's what I do."*
>
> *"I think it's just my nature to give and care for people. It's something I've always enjoyed - helping people and feeling like you're actually valued for what you are doing."*

Against the obvious satisfaction that participating staff gained from their work, they identified wages, training, workload, appreciation and access to equipment as the primary challenges for careworkers and the aged care sector.

Wages

Staff considered that the wage they received did not adequately reflect the demands of the job and the effort they put into their care work. This is a well-documented issue and a strong theme in all of the interviews. The low wage contributed to feelings of lack of value and low job satisfaction and a critical factor contributing to the high turnover of staff. Furthermore, experienced more senior care workers were unsatisfied with the pay increments they have received after such long service.

> *"They could pay us more; we are quite underpaid for what we do. Sometimes you do wonder why you do it. I could get more money standing out on the street holding a lollypop sign."*

A related concern expressed by some participants was that unsuitable people were being employed within the sector. They suggested that increasing the rates of pay would resolve many of the issues in aged care via a follow on effect.

> *"If you put the wage up higher you'd get more people applying for the jobs. That way you could be picky with the staff you want… when you pay peanuts sometimes you get monkeys… Then it would make a huge difference to patient care, you would just be working with top-notch people who knew what they were doing. "*
>
> *"The big thing to improve a lot of the places would be to pay more. That would bring a lot more experienced people into homes and the more experience that you have the more efficiently the place is run... We do have a lot of experience and we leave and go elsewhere because we are underpaid."*

Participating residents were also critical of the low wages paid by the sector to care workers. One resident said:

> *"Pay, it is very poor… It's almost like a voluntary job for the money they get. It's incredible what they do, they are off their own back… It's a shame really they just couldn't get more pay."*

Training

Staff members expressed a need for more accessible training and a more educated workforce. As with the low wage there was a concern that the low level of education required to enter the sector was attracting a cohort of unsuitable individuals into caring roles.

> *"I do think that the [lack of] qualification is a big [issue] because anybody could walk off the street into here. And the people we get! …There are people who work here that shouldn't be. They are lovely people but they don't know how to care for the elderly. There's a lot to learn about different ways of dealing with residents in different situations. I think it needs to be more education based."*

Many of the staff held the view that increasing the amount of training and making training more accessible would improve the quality of care residents receive.

> *"A lot of the training they have here is through meetings and lectures and we haven't been able to attend. They have been when we are working and we have to go out for all the bells. I know you can't get everybody all the time but try to vary the timetable a little bit so you can go when your shift is over or your day off. You have to be educated on some of the protocols, [on the] different cares, [such as] aged care and dementia. Just make it easier for people to attend."*

Residents were unanimous that care workers should have a higher level of competency before they enter the job and are given responsibility.

> *"Well they do teach them but perhaps a bit more attention to that… You don't feel very good with someone new because you have to explain to them and that takes a bit of time. I suppose they have to learn but you'd expect them to be taught what to do."*

Workload

The workload pressure experienced by care workers was a key concern for most participants. Aged care facilities can be busy and stressful working environments. Our participants felt it was often a struggle to meet the diverse needs of high demand residents.

> *"This is one of the busiest jobs I've had, there is no down time. We are on the go as soon as you walk in the door to when you leave."*
>
> *"Sometimes we don't have time to do the little things like finger nails, cleaning out their drawers or making sure their wardrobe is nice and tidy. The little things behind the scenes that need to be done but that get neglected as we don't have time."*
>
> *"I think that even when we do have full staff we don't have enough. Even when we have what we are supposed to it is not enough."*

Some of the residents interviewed also expressed their opinion that the facility was short staffed and that the workers had an unrealistic workload.

> *"Not enough staff… More staff will solve a lot of the problems."*

Appreciation

Care workers viewed care work as a skilled vocation and reported that it is easy to feel unappreciated and inadequately recognized by the sector. They expressed the desire to have a stronger voice in local decisions made about equipment requisitions, social events and resident care plans. They considered that this perceived lack of value also contributes to the high turnover of staff and a high absence rate.

> *"I don't think staff are appreciated. I believe [the care workers] are the back-bone of the entire industry and our opinion matters. If there is an issue we are not asked our opinion, [as if] we're not really here, we just do the hard work and that's it."*
>
> *"We do have a lot of experience but we leave and go elsewhere because we are underpaid and undervalued. We have a lot to offer."*
>
> *"I think appreciating staff [is a solution]. People are not going to come in and work extra shifts if they are not appreciated."*

Equipment and resources

An issue identified by many of the staff was the need for facilities to invest adequately in the specialised equipment required in aged care facilities.

> *"Here we spend an awful lot of our time looking for things such as shower chairs. It would make it easier if those things were more readily available and we were able to find them easily. Then our job will go more smoothly."*

Solutions

Many of the staff interviewed offered solutions on how to make care workers' workload more manageable and how to improve the care received by residents.

> *"I think perhaps working in pairs, because you get through the residents a little bit quicker and it makes your workload easier. Bedding, bathing and things like that, it would be easier with two people as some [of the residents] can be quite heavy."*
>
> *"This morning I had to answer the phone as well as train somebody, plus do my cares. They could take [a responsibility] off or lessen my group so I don't have so many people to get up. So I have more time to train somebody."*
>
> *"We [the care workers] don't have meetings with the nurses to discuss our residents fully. We don't have a lot of contribution to their care plans. I think sometimes an RN should actually [carry out a care routine with] a resident before they are doing their care plan to know what their resident would like. They don't actually do the person but they write the paper work up and tell us what to do."*

One nurse participant suggested the scope of practice for registered nurses was too narrowly defined in the aged residential care sector. She considered that registered nurses' professional competencies were not being well utilised resulting in delays for residents who required medical attention. She suggested that if nurses had a wider scope of practice residents would receive more prompt resolution to some of their health and clinical concerns.

> *"Even up until now I still have that funny feeling that I am not doing my level best when I see things and I can't do anything about them, because somebody else is supposed to do it. That makes it difficult for me but I am learning to let go. So that's one of the constraints that I have… I'm not allowed to fly."*

RESULTS

The issues in aged care are well publicized because of the attention the sector receives from the media. Absent from the body of literature are the opinions of those on working on the front line of the sector and the opinions of those living in care facilities. Our findings suggest that care workers, nurses and residents can make a contribution on how to improve working conditions of staff and quality of care received by residents. Their key message to the sector concerns the provision of a better wage and a recognised training pathway for care workers. They also identified a need for greater recognition of the value of care working to the sector and input in decision making, better access to resources, notably equipment, and an improved, better managed work load.

The Waitemata District Health Board (DHB) has recently established a dedicated Gerontology Nurse Specialist (GNS) team to try and address some of the issues of aged care in their region.[25] The GNS team collaborates with residential care facilities to help them build a functional relationship with the DHB and to offer extra support for the aged care workers. One such initiative the team has established is a clinical hotline that nurses can ring for extra guidance. Since the establishment of the GNS team there have been lower rates of hospital admissions from the care facilities and a lower turnover of staff.[25] As well as establishing their own GNS team, the Canterbury DHB has started a Gerontology Acceleration Program (GAP).26 GAP is aimed at mid- to senior-level Canterbury nurses and provides them with a framework of clinical skills relevant to aged care. The aim of this initiative is to develop aged care nursing as a career choice and to strengthen the competency of the workforce.[26] Similar initiatives have been started by the Taranaki and Midcentral DHBs aimed at supporting and strengthening the nurses' role in aged care.[27, 28] Such programmes would address one of the issues raised by an RN interviewed in this study. That extra support and training may widen RNs' scope of practice and allow them to resolve more health concerns without the need for a GP visit or hospital admission. The reduction in staff turnover that resulted from the implementation of the GNS team would also address issues raised in this study, including the inconsistency of care.

Care workers expressed the greatest dissatisfaction with the work conditions of care work, more so than the RNs. Residents expressed satisfaction with the care they received and were appreciative of the staff. They particularly complimented the staff on their attentiveness towards their carers and the friendly, cheerful manner in which they go about their tasks. It is a testament to care workers' vocational ethic that the residents reported such a high standard of care. It also suggests that personal dissatisfaction with the sector is not reflected in the care they provide. All residents were aware of the challenges that their care workers face and many expressed solidarity with care workers. We found that the RNs were more content in their role than the care workers. Overall, they did not raise the same concerns regarding pay and working conditions. Perhaps this reflects the positive societal value associated with the nursing profession and the gains made for the nursing sector over the previous decade by the New Zealand Nurses Organisation.

While some aged care organisations offer training programmes for care workers, these do not have the recognition that a nursing degree carries, nor is there a career path associated with current training options. The competencies of care work are not formally recognized in a national tertiary qualification. The nature of care work means care workers are able to develop a familiarity or intimacy with their residents that surpasses that of nurses and managers and this represents a wealth of knowledge that can contribute greatly to the resident care plans and the running of a facility. The initiatives described above to improve aged care target registered and enrolled nurses.[26, 27, 28] Experienced care workers represent an untapped resource for the organization of care work.

The solutions offered by our participants echo those put forward in the Report into Aged Care, such as pay parity with other 'unskilled' professions, minimum staffing levels mandated in regulation and government funded training to all aged care staff.[4] In addition, our interviewees suggested that morning and evening care routines could be run more efficiently by rostering the use of equipment and sharing responsibilities. These are achievable ways in which to address some of the issues raised.

LIMITATIONS

Sample size was a limitation in this study. Due to time constraints 13 people from the same facility were interviewed. We argue that these findings are likely to be generalizable to the sector within New Zealand. The issues and solutions that emerged are consistent with the existing literature and there was strong internal concordance among our relatively small sample but further research is required in order to claim that saturation was reached.[1, 4, 19, 20] In addition, the majority of questions asked were designed to elicit responses in relation to the industry as a whole.

The retirement village manager hand-picked the residents and staff to be interviewed potentially introducing selection bias. Those that were interviewed may have been selected due to their contentment or high level of satisfaction with working or living in the facility and those who were vocally discontent may have been avoided, although the responses would tend not support this claim.

It is possible that the results were influenced by social desirability. Studies have shown that older people have the highest degree of social desirability and acquiescence which may have influenced the answers to some of the research questions.[29] Furthermore, social desirability may have influenced the answers the staff gave resulting in responses that intended to please the interviewer or protect colleagues and the image of the facility.

CONCLUSION

It is the care workers who are largely responsible for the residents' quality of life, yet it seems there is little infrastructure in place to assure their own quality of work life. They remain in the sector because of a strong vocational ethic of care towards their residents which renders them vulnerable to potential exploitation by the aged care sector. From the interviews it was apparent that all the staff and many residents could identify issues and contributed ideas on how to improve on the shortcomings of the industry. Perhaps the most important finding of this study is the need to strengthen the voice of care workers on the front line so that we can future proof quality care of the current aging cohort.

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REFERENCES

1. Thornton G.
Aged Residential Care Service Review.
Wellington (NZ): New Zealand District Health Boards and Aged Care Association. 2010.

2. Health Workforce New Zealand.
Workforce for the care of older people Phase 1 REPORT.
2010. Accessed 04 December 2013. http://otago.hosted.exlibrisgroup.com/primo_library/libweb/action/openurl;jsessionid=C9

3. Boyd M, Broad JB, Kerse N et al.
Twenty-Year Trends in Dependency in Residential Aged Care in Auckland, New Zealand: A Descriptive Study.
J Am Med Dir Assoc 2011;7(12):535-40

4. Labour, Green Party, Grey Power.
A Report into Aged Care: What does the future hold for older New Zealanders?
2010. Accessed 13 August 2013. http://www.nzdoctor.co.nz/media/337671/aged%20care%20report%20for%20email.pdf

5. Hall S, Opio D, Dodd RH, Higginson IJ.
Assessing quality-of-life in older people in care homes.
Age Aging 2011;40:507-12

6. Wilkinson T, Kiata LJ, Peri K, et al.
Quality of life for older people in residential care is related to connectedness, willingness to enter care, and co-residents.
AJA,2012;31(1):52-5

7. Marquis R.
Quality in aged care; a question of relational ethics?
AJA,2002;21(1): 25-9.

8. Standards New Zealand.
Health and Disability Services (Core) Standards.
2008. Retrieved: http://www.health.govt.nz/system/files/documents/pages/81341-2008-nzs-health-and-disability-services-core.pdf

9. NZ Ministry of Health NZ.
Rest home certification and audits.
2013. Retrieved November http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/residential-care/rest-home-certification-and-audits

10. O'Boyle CA.
Measuring the quality of later life.
Philos Trans R Soc Lond B Biol Sci 1997;352:1871-9. doi: 10.1098/rstb.1997.0173

11. Kane RA, Kling KC, Bershadsky B, et al.
Quality of Life Measures for Nursing Home Residents.
J Gerontol A Biol Sci Med Sci 2003;58A(3):240-8. doi:10.1093/gerona/58.3.M240

12. Byrne H, MacLean D.
Quality of life: Perceptions of residential care.
Int J Nurs Pract,1997;3:21-8. doi: 10.1111/j.1440-172X.1997.00021.pp.x

13. Joyce CRB, Hickey A, McGee HM, et al.
A theory-based method for the evaluation of individual quality of life: The SEIQoL.
Qual Life Res 2003;12:275-280. doi:10.1023/A:1023273117040

14. Ciarán A, O'Boyle JB.
The Schedule for the Evaluation of Individual Quality of Life (SEIQoL): a Direct Weighting procedure for Quality of Life Domains (SEIQoL-DW): Administration Manual.
Department of Psychology, Medical School, Royal College of Surgeons, Dublin, Ireland. 1993. Accessed 06 November 2013. http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCUQ

15. Abdel-Kader K, Myaskovsky L, Karpov I, et al.
Individual Quality of Life in Chronic Kidney Disease: Influence of Age and Dialysis Modality.
Clin J Am Soc Nephr 2009;4(4):711-718. doi: 10.2215/CJN.05191008

16. Durner J, Reinecker H, Csef H.
Individual quality of life in patients with multiple myeloma.
myeloma. SpingerPlus 2013;2(397):1-8. doi: 10.1186/2193-1801-2-397

17. Hickey AM, Bury G, O'Boyle, CA.
A new short form individual quality of life measure (SEIQoL-DW): application in a cohort of individuals with HIV/AIDS.
BMJ,1996;313:29-33

18. Rodriguez-Martin B, Martínez-Andrés M, Cervera-Monteagudo B, et al.
Perception of quality of care among residents of public nursing-homes in Spain: a grounded theory study.
theory study. BMC Geriatr 2013;13(65):1-9. doi:10.1186/1471-2318-13-65

19. Walker L.
NZNO Aged Care Survey.
New Zealand Nurses Organisation. 2009. Accessed 06 November 2013. http://www.nzno.org.nz/resources/research

20. Kiata L, Kerse N, Dixon R.
Residential care workers and residents: the New Zealand story.
N Z Med J,2005;118(1214):1-11

21. Crabtree BF, Miller WL.
Depth Interviewing.
In: Crabtree BF, Miller WL, eds. Doing quantitative research. California: Sage Publications, Inc, 1999: 89-108

22. Thomas DR.
A General Inductive Approach for Analyzing Qualitative Evaluation Data.
American Journal of Evaluation 2006;27(2):237-46. doi:10.1177/1098214005283748

23. Meert KL, Eggly S, Pollack M, *et al.*
Parents' perspectives regarding a physician-parent conference after their child's death in the pediatric intensive care unit.
Journal of Pediatrics 2007;151(1):50-5

24. Halcomb EJ, Davidson PM.
Is verbatim transcription of interview data always necessary?
Appl Nurs Res 2006;19(1):38-42. Accessed 29 November 2013 http://ac.els-cdn.com/S0897189705000893/1-s2.0-S0897189705000893-main.pdf

25. Ministry of Health NZ.
Waitemata aged-care nursing.
2013. Accessed 15 November 2013. http://www.health.govt.nz/our-work/nursing/showcasing-aged-care-nursing/waitemata-aged-care-nursing

26. Ministry of Health NZ.
Canterbury aged-care nursing.
2013. Accessed 15 November 2013. http://www.health.govt.nz/our-work/nursing/showcasing-aged-care-nursing/canterbury-aged-care-nursing

27. Ministry of Health NZ.
Taranaki aged-care nursing.
2013. Accessed 15 November 2013. http://www.health.govt.nz/our-work/nursing/showcasing-aged-care-nursing/taranaki-aged-care-nursing

28. Castaneda R.
Award winning NP scheme gives elders better access to care.
New Zealand Doctor Magazine 2013;6 Nov 6. Accessed 06 December 2013. nzDoctor.co.nz

29. Vigil-Colet A, Morales-Vives F, Lorenzo-Seva U.
How social desirability and acquiescence affect the age-personality relationship.
Psicothema 2013; 25(3): 342-48. doi: 10.7334/psicothema2012.297