Feedback to inquiry of Green Party/ Grey Power into "Quality of care for older New Zealanders"

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Submission to:
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This submission is on behalf of the College of Nurses, Aotearoa (NZ) Inc. The College is a professional body of New Zealand nurses from all regions and specialities. It provides a voice for the nursing profession and professional commentary on issues which affect nurses, and also the health of the whole community. Its aim is to support excellence in clinical practice, research and education and to work with consumers to influence health policy. The College is committed to the Treaty of Waitangi and the improvement of Maori health. This commitment is reflected in the bicultural structure of the organisation.

Thank you for the opportunity to make a submission to the Green Party / Grey Power inquiry into "Quality of care for older New Zealanders.

We wish to make the following comments:

Key points

1. There needs to be a greater number of RNs employed in aged care. The increasing acuity of residents makes this urgent.

2. The role of the nurse as specialist in aged care, skills in assessment and treatment of complications of aging processes need to be recognized as a source of humane and cost effective care.

3. There is an urgent place for Nurse Practitioners in aged care. NPs have specialised skills to review the current management, treat new problems such as urinary tract infection, pneumonia etc thus preventing hospital admissions and unnecessary distress for the frail elderly.

4. There is urgent need for research into the cost effectiveness of RN, and NP in aged care so that decision making takes a whole of system view rather than simply measuring the profit margin for ARRC owners.

5. There must be an increase in salary for the care assistants – who are there to assist with, not provide the care.

6. Funding for supporting people in the home and in aged care needs to be reviewed to make sure that rationalisation is based on reason, not emotion.

Following is a collation of nurses' responses: (in no particular order of importance):

- Care facilities that have a good reputation usually align with 'Magnet Principles' where good HR practices, good communication with staff and clients, staff and client involvement and ample education opportunities create motivated staff and lower staff turnover. These organisations manage to get a critical mass of well-educated motivated leaders who will emphasize quality care and best practice. What occurs on the ground is not what is in the Strategic Documents.

- The health sector appears to be in reactive mode, not putting any finances or support into long term planning. It appears that due to public and political pressure, whatever the topic of concern is at any given time, is the area of the greatest action.

- Both unregulated as well as registered nurses are not paid equally to hospital settings.

- The Green party and Grey Power instigated this inquiry. Feedback from Age Concern would also be beneficial as they deal with a large number of abuse issues. This may not fit directly into quality and health care but elder abuse closely links to how people access services and view and voice their rights when it comes to quality. How people feel empowered to stand up to ask for quality care as well as recognising what should be quality care.

- Although financial support and reimbursement for care is challenging and pay is low, there is no excuse not to look at other ways of working: for instance in a more co-ordinated manner, where older people have one point of contact rather than DN, caregivers, wound care nurses and the diabetes nurse visit all within the same week. Often these health professionals come from a slightly different paradigm and provide older people with confusing and conflicting information. This is a fragmented delivery and does not promote a continuum of care. Some elderly who live closer to the tertiary hospitals seem to get better care as they generally have more GP or District nurse or Clinical Specialist Nurse Visits.

- Care facilities could look at their staffing and care routines and better reflect ordinary living patterns. Corporate organisations could lead by example.

  Whilst Private Hospitals are required to have Registered Nurses on duty 24hrs/day, Rest Homes are not. Unregulated staff can have significantly varying levels of skills and knowledge relevant to their work. We now know from the OPAL study that the complexity of people entering Rest Homes has increased. There is evidence that shows there are improved outcomes for

older people in Rest Homes with increased Registered Nurse hours and direct input into care planning and supervision of staff.
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- Specifically to Rest home and Care facilities: Clients admitted to these facilities have increasingly complex needs. It is my opinion that there is a false sense of security in this. Clients who have to go 'into care' have less access to community services. For instance, while living in the community they have access to the Diabetes nurse, the diabetes podiatrist etc. while in care, they have an RN overseeing the care, but this is not necessarily an RN with knowledge about every person's complex need. Another example is access to Falls Prevention (Such as the Otago falls prevention that is no longer funded through ACC). This was available in the community but not accessible to care facilities). Tai Chi is identified as good falls prevention, but not funded in care facilities. Generally, RNs in care facilities have over the last few years improved their knowledge and a number is studying postgraduate clinical papers. Access to CTA funding is largely still with hospitals and increasingly into PHOs, but the work of RNs in care facilities is largely going under the radar. RNs in care facilities are seldom recognized as knowledgeable and often DHBs and PHOs are progressing to assist, but in such a manner that NGO/organisations view their own knowledge as inferior, and postpone asking for assistance.

- The GP availability to care facilities is diminishing throughout the country

- There is now a clause in the aged care contract, which allows Nurse Practitioners to do GP assessments. Although one step forward, further work is to be completed as this brings the risk of employers having NPs working in isolation, just for those parts of care organisations see as important and not having NPs taking a leadership role and be involved in quality assurance and general strategic planning. NPs could provide co-ordinated services if they are acknowledged for their skills and not viewed as an inexpensive solution to address GP accessibility. NPs working with older people do not have access to the same funding streams as GPs, reducing the incentive to employ NPs. It is now being recognized that care of older adults (particularly those >80 that may require Rest Home care) is a specialized area and needs a high skill level.

- With an ageing population we are likely to see an older workforce caring for the very old. Different support may be required. Technology if used in the right manner will be very advantageous in the future and will help to reduce some of the issues generated in an ageing population.

- Good staffing levels are important, this will avoid staff taking shortcuts in care delivery, prevents staff burnout and staff turn over.

- Care facilities are to be encouraged to look for well-qualified managers; qualified in a practical as well as theoretical sense. Not all owners and managers have a clinical background and at times their decision-making in these areas is inadequately supported. Clinicians are vital in senior roles within the organisations and should have the ability to direct clinical care services. As care is the core business for care facilities, it is encouraging to see that there is more of an emphasis to have a nurse as a manager. This aligns with the core values and prevents discord between nurses and non-nurse managers who may have trouble understanding why certain clinical or quality actions have to be taken. Unfortunately, there are still organisations of the opinion that nurses are not leaders or cannot be managers: there are plenty of nurses who have management degrees and are well able to manage a care facility. In essence and in view of the contract, nurses are what make the business legal.

- Caregivers are a non-regulated workforce and therefore less supported. There are organisations supporting staff well, resulting in better quality care, however, a more stringent regulation would assist in equivalent care throughout the country. Of note is that older people in care facilities, consequently unable to live independently at home, are looked after by the least qualified health care providers, not sure how we can justify this. The hiring of care staff without relevant education and without any prior experience is a dismal practice. When education becomes an expectation, facilities will be expected to allocate a wage in accordance with this.

- The re-instatement of Enrolled Nurses needs to be carefully monitored and implementation of E/N roles into care and community well supported and co-ordinated. There is a risk for organisations working with older people, such as care facilities to have one RN overseeing a number of E/Ns and professing this is quality. This compromises the care and the role of RN, unless there is a well-explained clinical framework, identifying responsibilities and scope. The staff as well as management should understand this. Literature addressing staffing levels and better quality care outcome consistently refer to higher RN staffing levels providing better quality care.

- Auditing is one way of addressing quality, as long as the audit results are analysed and issues addressed. Internal audits are basically just a gap analysis. Benchmarking with other similar organisation provide a wider result, however, it is important to ensure the same issues are benchmarked, so the

same items are compared. Thereafter it is important to have dialogue about how to improve, otherwise it is just box ticking. Ministry of Health audits are just a window in time and are no guarantee that good care will continue. They appear to be punitive and generally considered by care facilities as unhelpful, as MoH, DHBs and Retirement village audits often audit different criteria and standards, it would be more helpful if these would align.

- Relationships between primary and secondary services need to be improved. There is often a lack of understanding of the different focus of the 2 services and clinicians can be quick to form conclusions that may well be erroneous. This can lead to adverse outcomes for older adults and facilities with clinicians seldom being aware of the impact. Barriers to effective communication need to be broken down via collaboration and a willingness to work together in the best interests of the people served.

- The media is quick to express people's concerns about poor care in Aged Care Facilities but the outcome of investigations is not always followed with the same enthusiasm. The public receives a slanted view that is not representative of the majority of Aged Care providers. This can be very damaging to the relationships between families and care staff that are based on trust and open communication. Poor outcomes are seen across the continuum of care.

- A Nurse's response specifically to community care: The work force in the community are very lowly paid. This then impacts on the quality of the people in the workforce, which can then put elderly and vulnerable people at risk. This, coupled with the fact that DHBs are reducing the amount of the help people get also makes it very hard to retain good staff when their hours and income fluctuate so dramatically at times. Support workers are now doing a lot of the tasks that were done in the past by RNs and their low rate of pay means a work force that is undervalued and with the potential to be exploited. There is a lot of emotion regarding the provision of household management. Household management is not a health issue, rather it is a social issue and should be moved under the auspices of the Ministry of Social Development and people can then apply for a disability allowance to help fund the costs. Many countries overseas do not fund household management and there is the expectation in NZ that when you retire you are entitled to have someone clean your house. This attitude needs to be changed, as there is there are a lot of people that are taking advantage of this and abuse the system. A lot of the stress in the community support sector has been around household management and it is not cost effective for home support agencies to provide it. At the moment the provision of supports in the home are very task orientated. However management of chronic long-term conditions can make a difference to an elderly persons dependence on others for their basic needs.