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Residential care workers and residents: the New Zealand story

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Abstract

Aims To describe the nature and size of long-term residential care homes in New Zealand; funding of facilities; and the ethnic and gender composition of residents and residential care workers nationwide.

Methods A postal, fax, and email survey of all long-term residential care homes in New Zealand.

Results Completed surveys were received from an eligible 845 facilities (response rate: 55%). The majority of these (54%) facilities housed less than 30 residents. Of the 438 (94%) facilities completing the questions about residents' ethnicity, 432 (99%) housed residents from New Zealand European (Pakeha) descent, 156 (33%) housed at least 1 Maori resident, 71 (15%) at least 1 Pacific (Islands) resident, and 61 (13%) housed at least 1 Asian resident. Facilities employed a range of ethnically diverse staff, with 66% reporting Maori staff. Less than half of all facilities employed Pacific staff (43%) and Asian staff (33%). Registered nursing staff were mainly between 46 and 60 years (47%), and healthcare assistant staff were mostly between 25 and 45 years old (52%). Wide regional variation in the ethnic make up of staff was reported. About half of all staff were reported to have moved within the previous 2 years.

Conclusions The age and turnover of the residential care workforce suggests the industry continues to be under threat from staffing shortages. While few ethnic minority residents live in long-term care facilities, staff come from diverse backgrounds, especially in certain regions.

The ageing of the population, with a projected six-fold increase in those persons over age 85 in the next decades,[1] will ensure that health and care of older people remains an important issue for New Zealand health planners. Currently, 28% of people over age 85 years live in long-term residential care. Even with an emphasis on community care and 'ageing in place'[2] such an increase in the absolute numbers of frail older people will ensure that residential care will be needed, and will probably increase in the decades to come.

Although Maori and Pacific (Islands) older peoples are under-represented in long-term care[3,4] the demographic projections show the potential for considerable increase in the proportion over age 75 years in the next half century,[4] and it is likely that there will be increased need for culturally appropriate residential care to assist aging minority groups.

Debate about whether ethnic matching in caregiving enhances quality may be academic if ethnically appropriate caregivers are not available in the workforce. Differing models of residential care are being developed to better meet the needs of

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ethnically diverse older people, however little is known about the available workforce to support such developments.

Quality of long-term care has been questioned in the United Kingdom (UK);[5] and another study in the United States (US) suggests poorer quality in privately funded facilities compared with not for profit facilities.[6] Over the last three decades, there has been a general shifting of funding of residential care from publicly-run facilities to publicly subsidised, privately-run facilities. The effects of these large policy shifts have not been studied. Previous work established profiles of residents in care,[7] but staffing arrangements have not been described.

Currently the main source of information about working and living in residential care has come from ethnographic studies, based mainly in the US.[8–12] A first step in finding out who it is that lives and works in long-term residential care in New Zealand is to survey long-term care facilities New Zealand-wide.

This paper reports the results of a study aiming to establish the characteristics of staff and residents, particularly looking at regional variations in ethnicity and workforce stability.

Methods

Clinical directors and managers of long-term care facilities were asked to complete a survey about the characteristics of their workforce and residents. One survey per home was sent with a letter of explanation.

Questionnaire development—Key informant interviews with managers of long-term care facilities in Auckland informed ways of asking about ethnic and age make up of residents and staff. A two-page survey questionnaire was designed and pilot-tested in long-term care facilities in the greater Auckland area with group discussions and feedback to researchers. The resulting nine-question survey entitled *Who Cares for Older People?* was used in the survey.

The questionnaire enquired about the following:

- Type of residence (privately owned, religious and welfare, publicly funded, charity trust, or combination of these sources).
- Numbers of residential care beds, private hospital beds, rest homes beds, respite beds, secure unit beds at the residence.
- Numbers and ethnicity of residents living at the residence.
- Age-range of the residents.
- Numbers, ethnicity, and job designation of facilities' employees.
- Age-range and formal qualifications of facilities' employees.
- English as a second language among facilities' employees.
- Numbers and ethnicity of employees working part and full-time at the residence.
- Length of time employees had worked at residence.

Sample—A national list of the residential care facilities providing long-term care (including rest homes and private hospitals) was compiled from the Ministry of Health's listings of licensed 'hospitals and old people's homes' in New Zealand and a commercial list used for marketing purposes (Personal Communication with Meg Butler, 2002). Assurances from the sources of both lists indicated that they were updated regularly. Private hospitals care for very frail, high-needs older people requiring daily nursing care. Rest homes cater for the frail mobile aged with dependencies in one or two aspects of daily living. These long-term care facilities are hereafter referred to as 'facilities' in this paper. The final list comprised 919 facilities.

Data collection—Questionnaires were sent and returned between March and May 2002 to 919 facilities on the list. 679 surveys (74%) were posted out, and 240 (26%) were emailed. Two follow-up telephone calls were made, and mail-out reminder letters were sent to facilities that had not responded

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within 2 weeks. Respondents either mailed or faxed their completed surveys back to the research centre.

Data analysis—Descriptive statistics of age, gender, ethnicity, and stability of the workforce were generated using SPSS (v. 10.0) software. Cross tabulations were used to investigate the degree of ethnic 'match' between workers and residents in facilities where Maori, Pacific, and Asian older people lived.

Approval for this study was obtained from the University of Auckland Human Subjects Ethics Committee.

Results

The data from 845 of 919 facilities were eligible to be included in the study. Of the remainder, 27 were not long-term care facilities (they were private surgical hospitals), and 47 were no longer in business.

468 facilities (55%) chose to respond to the survey. The majority (78%) of these responses were returned by postal mail, 14% were faxed, 7% emailed, and 1% were completed by telephone survey.

Of the 468 facilities (for which completed surveys were received), the majority (65%) were privately owned. The remaining facilities were run using a variety of funding sources: religious and welfare organisations (18%), public funding through health funding agencies (4%), or a mixture of funding sources (7%). Three percent of facilities were run by a charitable trust.

Tables 1 and 2 show regional and population density breakdown of facilities and the regional variation in response rates. A quarter (26%) of all facilities were located in the greater Auckland area. There were 33% of all facilities in mainly rural areas (with populations less than 25,000), with the remainder being located in small and large towns and cities of greater than 400,000 people.

Table 1. Total respondents and response rate of New Zealand long-term care facilities by population (n=845)

Size of population where facility was located	Number of facilities sent surveys N (% of total)		Number of returned surveys N (% of regions)	
<25,000	283	(33)	170	(60)
25,000 to 250,000	222	(26)	112	(50)
250,000 to 400,000	149	(18)	75	(50)
>400,000	191	(23)	111	(58)
Total	**845**	**(100)**	**468**	**(55)**

Size of facility

Facilities size ranged from 3 beds to 222 beds (mean=37, standard deviation [SD]=32). Fifty-four percent of facilities had fewer than 30 residents and only 10% had more than 70 beds.

Private Hospital beds

158 (34%) facilities accounted for a total of 3,899 private hospital beds (mean=25, SD=16). The majority of these facilities (63%) had 25 or fewer private hospital beds,

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while 25% reported 14 or fewer private hospital beds. Eight facilities had only 1 private hospital bed, and 1 large residence had 89 private hospital beds.

Table 2. Number of surveys sent and returned by regional location of residence

Number of facilities			Number of returned surveys	
Region	**N**	**(% of total)**	**N**	**(% of regions)**
Northland	45	(5)	26	(58)
Auckland	209	(25)	120	(57)
Waikato	63	(7)	31	(49)
Hawke's Bay	185	(22)	100	(54)
Wellington	85	(10)	50	(59)
Marlborough	26	(3)	15	(58)
West Coast	7	(1)	6	(85)
Canterbury	145	(17)	75	(51)
Otago	80	(10)	45	(56)
Total	**845**	**(100)**	**468**	**(55)**

Rest Home beds

Rest homes ranged in size from 1 to 150 beds—accounting in total for 11,243 rest home beds (mean=29, SD=18). Fifty percent of rest homes had 25 or fewer beds, and 90% of all respondents reported that their facility had fewer than 50 rest home beds. The largest complexes (10%) had between 50 and 150 rest home beds.

Respite beds

171 facilities had respite beds that were used for short stays. Over half (59%) of these facilities had beds specifically designated for respite care, while 41% of facilities used regular beds (as and when available). Over half (52%) of those facilities with regular beds had 1 bed held only for short stay residents, while 30% of residential care management reported that they had 2 beds ready. The remaining facilities (18%) had between 3 and 8 beds available for respite care.

Secure Unit beds

A small number (n=65; 14%) of facilities had dementia care units where 1,270 secure unit beds were located. Approximately half (49%) of the 65 facilities had 16 or fewer secure unit beds, and the other half (49%) had between 16 and 100 secure unit beds. Only 5% (n=3) of the facilities offered more than 50 secure beds.

Residents

Ninety-three percent (n=437) of respondents offered information about the ethnic make-up of their residents. Information was provided on 16,092 residents, most (95%) of whom were of European and/or New Zealand European (Pakeha) descent. Minority ethnic groups were indeed in the minority, with 392 Maori (2%) and Pacific accounting for less than 1% (n=81) of the total number of residents. Asian (including Indian) residents accounted for less than 1% (n=55) of residents. Other non-European residents (including African and Middle Eastern people) comprised the remaining 1% (n=145).

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Table 3. Ethnic diversity of *residents* in long-term care facilities by region in New Zealand

Facilities by region			Ethnic composition of facilities housing one or more…									
			Maori residents		New Zealand European (Pakeha) resident s		Pacific Islands residents		Asian (including Indian) residents		Other non-European residents	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Northland	24	(5)	12	(50)	24	(100)	3	(11)	1	(–)	0	(–)
Auckland	117	(26)	38	(32)	115	(98)	41	(34)	37	(31)	19	(16)
Waikato	30	(7)	19	(63)	30	(100)	3	(1)	3	(1)	0	(–)
Hawke's Bay	92	(21)	47	(51)	92	(100)	5	(5)	5	(5)	4	(4)
Wellington	47	(11)	16	(34)	46	(98)	15	(3)	9	(18)	2	(–)
Marlborough	14	(3)	4	(29)	14	(100)	0	(–)	1	(1)	0	(–)
West Coast	6	(1)	0	(–)	6	(100)	0	(–)	0	(–)	0	(–)
Canterbury	68	(16)	10	(15)	66	(97)	1	(–)	4	(1)	6	(1)
Otago	39	(10)	10	(26)	38	(97)	3	(1)	1	(–)	2	(–)
Total*	**437**	**(100)**	**156**	**(36)**	**431**	**(98)**	**71**	**(15)**	**61**	**(13)**	**33**	**(7)**

*Totals do not reconcile with the values above them due to missing values.

Table 3 shows how many facilities in each region housed ethnically diverse residents. Thirty six percent of facilities (n=156) housed Maori residents. Half of these (51%) had only 1 Maori resident (mean 2.3), with a maximum of 10 Maori residents being housed. Fifteen percent *(*n=71) of facilities had at least 1 (but no more than 10) Pacific Islands resident (mean 1.3).

Similarly, 61 (13%) facilities housed Asian (including Indian) residents. Seven percent of facilities housed other non-European residents (n=33). Over 50% of facilities in Northland, Waikato, and Hawke's Bay reported having Maori residents, while one-third of Auckland facilities had Pacific residents. However, overall there was considerable regional variation in the ethnic distribution of facilities with non-Pakeha residents.

Age range of residents

Although the study focused on residential care for the elderly, 31 (7%) of the facilities reported that they also catered for younger residents, with 114 residents being aged 45 years of age and under. The majority of these facilities (75%) had no more than four of these younger residents. Seventy percent of managers (n=329) reported catering for residents aged between 45 and 75 years (total residents 2,146) while the majority of residents were over 75 years of age (n=4656). Almost all facilities had residents over 75 years of age (92%).

Staff

Qualifications/Training—Managers reported that a total of 1,990 registered and enrolled nurses worked in their facilities. The age range of employees in specific roles in residential care varied. The majority of registered and enrolled nurses were between 46 and 60 years of age (47%). Forty-four percent were aged between 25 and 45 years, while only 2% were less than 25 years of age. An important minority of registered and enrolled nurses were over 60 years of age (8%).

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Healthcare assistants—A total of 8,184 healthcare assistants worked in the facilities surveyed. The healthcare assistants' age-range differed from registered and enrolled nurses, with the majority (52%) being between 25 and 45 years of age; 36% being between 46 and 60 years of age, and 2% being 60 years and older. Nine percent were less than 25 years of age.

Other employees—12% of maintenance, kitchen, cleaning, laundry, and administration staff were aged 25 years and under. One-third (38%) of these staff were aged between 25 and 45 years. The majority of staff doing these jobs were aged between 46 and 60 years of age (42%), and 8% were 60 years of age and older.

Ethnic composition of staff

Enrolled and registered nurses—Of those facilities who provided information about ethnic composition of staff, 15% (n=70) had Maori enrolled and registered nurses on their staff. Nine percent of facilities employed Pacific nurses and 13% employed Asian (including Indian) nurses respectively.

Healthcare assistants—63% (n=295) of facilities employed Maori healthcare assistants. Even fewer facilities (n=198; 42%) employed Pacific healthcare assistants, and less than one-third (29%) employed Asian (including Indian) healthcare assistants.

Other employees—Non-clinical roles including administrators, maintenance workers, gardeners, cooks, cleaners, and activities performers (such as piano players) were also predominantly New Zealand European (Pakeha) employees. Thirty-five percent of facilities employed Maori, 16% percent of facilities employed Pacific people, and 15% employed Asians (including Indian) in these roles.

Table 4 shows how many facilities in each region employed ethnically diverse staff.

Table 4. Ethnic diversity of *staff* in long-term care facilities by region in New Zealand

Facilities by region			Ethnic composition of facilities staffed by one or more…									
			Maori employees		New Zealand European (Pakeha) employees		Pacific Islands employees		Asian (including Indian) employees		Other non-European employees	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Northland	24	(5)	20	(83)	24	(100)	5	(21)	7	(29)	3	(12)
Auckland	117	(27)	84	(72)	116	(99)	97	(83)	76	(65)	39	(33)
Waikato	30	(7)	29	(97)	30	(100)	12	(40)	13	(43)	5	(17)
Hawke's Bay	93	(21)	77	(84)	93	(100)	29	(32)	15	(16)	7	(75)
Wellington	47	(11)	36	(76)	47	(100)	25	(53)	20	(42)	8	(17)
Marlborough	14	(3)	9	(64)	14	(100)	4	(44)	1	(7)	0	(–)
West Coast	6	(1)	3	(50)	6	(100)	2	(33)	1	(16)	0	(–)
Canterbury	69	(16)	30	(44)	69	(100)	20	(29)	14	(20)	10	(30)
Otago	41	(9)	21	(54)	41	(100)	9	(22)	8	(19)	3	(73)
Total*	**441**	**(100)**	**309**	**(70)**	**440**	**(100)**	**203**	**(46)**	**155**	**(35)**	**75**	**(17)**

*Totals do not reconcile with the values above them due to missing values.

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Language

Management was also asked about employees who spoke English as a second language. One-quarter (25%) of the respondents stated that they had employees who were speakers of Maori as a first language at the residence. Seventy-five percent of these respondents said that they had one or two Maori first-language speakers at their facility. Another 35% of respondents had employees who spoke a Pacific language (not specified), and nearly half (49%) of these facilities had at least 1 Pacific employee who spoke English as a second language. One-third (33%) of the 154 facilities with Asian (including Indian) employees had 1 or 2 workers who spoke English as a second language.

Work time

In response to question *How many of the staff work at the facility more than 20 hours per week?*, 53% of facilities who employed Maori had at least 1 Maori staff member who worked more than 20 hours per week. Forty-eight percent of respondents who employed Pacific staff said that 1 or 2 of their Pacific staff worked more than 20 hours per week, and 43% of those who employed Asian staff had at least 1 Asian (including Indian) employee working more than 20 hours a week.

Of the 194 long-term care facilities answering this question about New Zealand European (Pakeha) and overseas European staff working more than 20 hours per week, 52% had up to 13 staff working full time (over 20 hours per week).

Employers were asked about the length of time employees had worked at the facility. There was an even spread, with employees who had worked at the facility for less than 12 months totalling 22%, while 21% had worked at the facility between 1 and 2 years. Long-term employees (particularly those who had been working between 2 and 5 years) comprised 29% of the workforce; 28% having worked 5 years or more. Table 5 shows breakdown of length of employment.

Table 5. Length of employment of New Zealand long-term care facility employees

Length of employment	Employees in long-term care facilities	
	n	(%)
Under 12 months	3187	(22)
Between 1–2 years	3048	(21)
Between 2–5 years	4138	(29)
Over 5 years	4003	(28)
Total	**14376**	**(100)**

*Totals do not reconcile with the values above them due to missing values.

Discussion

Overview— This study adds to our understanding of the nature of the residents and workforce in long-term residential care facilities in New Zealand. Most facilities are small, housing mainly New Zealand European (Pakeha) residents and staffed by an older workforce. Staff turnover in these facilities was as high as 43% over 2 years. Profiles of residents over a decade ago were similar[7] and, although the current study

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was unable to describe disability levels, workforce information will form a baseline for future evaluations.

It is concerning that most facilities are currently small, as contemporary thinking suggests that larger facilities may be more financially viable. It is also interesting that such a small number of facilities were offering respite beds. The *Health of Older People Strategy*[13] emphasises 'ageing in place' and support for informal caregiving. Respite is a vital part of caregiver support, and one would therefore hope for an increase in available beds in line with that policy.

There are currently very few ethnic minority elders in long-term residential care. The reasons for under-representation of ethnic minorities are complex and related to cultural concepts of elder care.[14] As Maori, Pacific, and Asian populations are living longer, increased numbers of ethnically diverse older people will potentially require long-term care in the future.

The ethnic make-up of the workforce is currently more diverse than those housed in residential care. There is, however, considerable regional variation in the distribution of facilities employing ethnically diverse staff. At present, there appears to be at least one staff member of Maori or Pacific ethnicity available in facilities that house ethnic minority elders. However, whether these staff are available round the clock could not be established by this survey.

Other research suggests that intercultural care may create difficulties due to ethnic and cultural misunderstandings between carer and care recipient.[14,15] This current study suggests that the most common mismatch is between ethnic minority workers and majority New Zealand European (Pakeha) elders. It is also interesting that elders from new immigrant groups are as frequently housed as Maori and Pacific residents. This diversity will add complexity to the workplace in the future.

The residential care workforce is ageing, with the majority of registered and enrolled nursing staff being over 45 years of age. The implications are that there may be shortages as this workforce retires. This will affect the trained staff first, so younger registered and enrolled nursing staff need to be encouraged into the residential care workforce.[16]

Availability of residential care staff is at critically low levels in the US, with reports of very high staff turnover. While acknowledging the difficulty of measuring staff turnover, one recent report from the US estimated that the average nursing assistant turnover rate is between 38% and 143% a year.[16] High turnover rates compromise continuity of care for the older residents and continuity of carer is closely linked with quality of care.

The situation in New Zealand is not ideal, as we found that the staff turnover in responding facilities was 22% annually and greater continuity is desirable. In comparison to the US it seems New Zealand is relatively fortunate in maintaining a reasonably stable workforce to staff residential care.

Reasons for staff dissatisfaction with residential care work include low rates of pay, no involvement in care planning, and low job security.[15,16] Moreover, some of these issues, along with conflict related to intercultural caring, have been identified in New Zealand.[14]

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Redress of these issues may include a career structure for healthcare assistants within the industry associated with training, increased involvement with care planning for residents, increased involvement in therapeutic care for older residents, and flexibility of working times for workers with families. There are some moves towards these changes in the industry, however more work is needed. Current work supports this suggesting that residential care management style dictates levels of nursing staff turnover.[16]

The list used for sampling for this study was the most up-to-date possible (as it was a combination of a commercial list and the Ministry of Health list). It is possible, however, that newer homes were not included in the available information.

Limitations of this study—The low response rate to this survey means the results must be interpreted with caution. The composition of non-responding facilities is not known, although the regional distribution of non-responding facilities is similar to those who responded.

Ascertainment of ethnicity for this survey was left to the judgement of the clinical managers completing the survey instrument. In some instances, respondents reported they kept records of staff and resident ethnicity, but there was no systematic enquiry about the validity of the reported data about ethnicity, and self-reported ascertainment of ethnicity (from those reported on) was beyond the scope of this study.

Facilities were asked how many New Zealand registered nurses they employed. This question was the cause of some confusion due to the inconsistency of terms used to identify specific roles in elder care facilities. Enrolled nurses were in some cases placed under caregivers/care assistants/nurses, while other facilities placed enrolled nurses along with registered nurses.

The perceived lack of clearly defined roles in facilities has also arisen in other countries. This study follows the US's lead, where caution has been advised against positioning all 'nursing assistants' together in statistical analyses because of vast differences found in their skill bases.[16]

Future implications—The New Zealand population is undergoing a major demographic transformation. New Zealand's older population is expected to live longer, and in increasing numbers, over the next decades. It is estimated that, by 2024, for the first time in New Zealand history, the population of those over 65 years of age will be greater than the number of children aged 0–14 years.[3] Indeed, the population aged 65 years and over totalled nearly half a million at the time of the 2001 Census, and will double over the next 50 years. Of those people, 12.5% will be 75 years of age and over, and it has been projected that those aged 85 years and older will quadruple in the next two decades.[4] This will result in growth in the absolute number of older people requiring long-term residential care.

The New Zealand Government has identified older adults as a high priority group likely to become increasingly reliant on health, disability, and social services. The trend for long-term care facilities moving away from the public sector (and into the private sector) is likely to continue. However, our knowledge about the people who live and work in long-term care facilities in New Zealand is scant. What little we do know is based mainly on overseas ethnographies, particularly those in the US and UK.

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This paper aimed to establish the characteristics of long-term care residents, and the people that care for them. Results from the study provide an overview about the people living and working in long-term residential care in New Zealand. However, ongoing research is necessary to follow population changes in residential care and better understand this evolving 'carer/care recipient' population for effective policy development and implementation.

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