



HealthCare Providers
New Zealand

**The Aged Residential Care
Unregulated Workforce: A
Discussion of the Roles, Workforce
Issues and Training of Caregivers in
Aged Care**

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Introduction

This paper explores the current aged care workforce and challenges facing it in the short and long term. The paper also examines current regulations and provisions regarding training for caregivers. It concludes with a summary of issues and principles for future change regarding the skills and training of caregivers in aged residential care.

Definition of a Caregiver

The aged residential care workforce is composed of:

- **Regulated care workers** – Registered Nurses, Enrolled Nurses, Nurse Assistants
- **Unregulated care workers** - Caregivers
- **Allied support workers** – Diversional therapists, Occupational Therapists, Dieticians
- **Non-care workers** – Laundry, Kitchen, Garden, Cleaning, Office/Administration Staff

The 'unregulated' care workforce has been defined by DHBNZ as the group of workers in health care who have direct interaction with clients but do not fall under the Health Practitioners Competence Assurance Act. In the DHBNZ definition, non-care roles, or roles which do not have direct client interaction, such as food/laundry staff or administration staff, are also excluded:

*“The non-regulated workforce can be summarised as people who have direct personal care interaction with clients, patients or consumers within the health and disability sector and who are not subjected to regulatory requirements under health legislation. The non-regulated workforce spans inpatient hospital services (for example healthcare assistants and orderlies), residential care workers, community and home based services, as well as workers in the field of mental health disability and needs assessment and service coordination. The workforce includes paid and unpaid workers (for example family/whanau carers and volunteers). The workforce's focus of care is respectively restoration, recovery, rehabilitation, participation and independence across the service spectrum. Excluded from this definition are health professionals who are subject to the requirements of the Health Practitioners Competence Assurance Act 2003 and the Social Work Registration Act 2003. Also excluded are allied health workers, public health workers, hotel service personnel (for example food and laundry staff), ancillary staff (e.g. ward clerks), people who do not have direct patient, client or consumer interaction (for example medical typists, telephonists) and traditional and complementary therapists not funded by the public health sector”.*¹

Therefore, roles which meet the DHBNZ definition within the aged residential care setting include caregiver and/or healthcare assistant, or care support worker. This paper only discusses training and workforce requirements in regard to the unregulated care workforce (referred to in this paper as caregivers) working in aged care.

The Role of a Caregiver

According to the Future Workforce (September 2006)² paper on the non-regulated workforce, the scope of the Caregiver role is:

- *[To] provide and assist with the provision of nurse aid, personal care and support to residents in aged care facilities*
- *[May or may not] undertake some domestic duties*

¹ DHBNZ, *Future Workforce, The Non-Regulated Workforce in the Health and Disability Sector (Final)*, September 2006

² DHBNZ, *Future Workforce, The Non-Regulated Workforce in the Health and Disability Sector (Final)*, September 2006

- Does not necessarily work under the direct supervision of a registered nurse but a registered nurse is responsible for the delivery of care at facility

The role primarily involves assisting residents with activities of daily living and routine care, as directed by the RN and according to the resident's care plan. This can involve activities such as showering, dressing, nutritional assistance, mobilizing, toileting, and transferring.

The role includes observation and reporting responsibility, and may also require some assistance with distribution of medication and the application of wound care. Some caregivers may also carry out some house keeping and/or administrative duties.

Caregiver Demographics

The Government does not currently know the precise number of caregivers working in aged care. The Quality and Safety Workforce Survey (2004), estimated the total health and disability support workforce (including both residential and home care) to be 47,000. In the same year, an NZIER report estimated the same workforce to be 30,000.

In 2006, the HWAC 'Care and Support in the Community' paper estimated the total workforce to be anywhere between 43,000 and 50,000. With variations of up to 20,000 within two years, there is considerable confusion about the health and disability workforce, let alone the sub-set of those working in aged residential care. The most recent workforce analysis, *The Non-Regulated Workforce in the Health and Disability Sector*, produced by DHBNZ Future Workforce in 2006, didn't attempt to put numbers around the caregiver workforce in aged care.

The best source of information on caregiver numbers comes from HealthCare Providers NZ. HCPNZ survey their membership (currently 80% of aged residential care providers in NZ) annually and provide the only nationally robust data on staffing levels, salaries and retention. According to the most recent HCPNZ survey³, caregivers made up 54% of all staff in aged residential care, and 78% of all care staff.

Based on the total numbers of caregivers employed by respondents to the survey, it can be assumed that, on average⁴, a facility would employ 24 caregivers. It should be noted that the majority of caregivers (67%) were in part-time employment, so the total of 24 caregivers does not represent 24 FTE staff.

If this average number of caregivers was extrapolated across the entire aged residential care sector⁵, then the **estimated**⁶ total caregiver workforce in the aged care sector is approximately 17,400. Therefore, caregivers represent around 55% of the *total aged residential care workforce*, which is estimated at approximately 32,000.

Other key data on the caregiver workforce in aged residential care:

- The majority (67%) of caregivers work part-time (there was a 4% increase in the proportion of full-time caregivers from 2005-06)
- The majority (32%) of caregivers have between 1-4 years experience, whilst 25% have 4-7 years experience, a further 25% have more than 7 years experience, and 18% have less than one year's experience
- Caregiver vacancies at the time of survey accounted for approximately 4.3% of the caregiver workforce

³ HCPNZ Membership Survey 2006 responses represented 61% of all aged residential care beds in NZ

⁴ Non-weighted sample, average facility size 53 beds

⁵ OIA information from DHBs indicates there are 758 aged care facilities certified to operate in NZ in 2007.

⁶ $N=23 \text{ caregivers (average per facility)} \times 758 \text{ (number of aged care facilities)}$

- During 2006, providers experienced a turnover of approximately 26% of their total caregiver workforce

Caregiver Skill Shortages

Employers in the aged care industry face a dual challenge in regard to shortages of caregivers. The first is due to an absolute shortage of caregivers. This is demonstrated where employers in regions have very high vacancy levels, but have been unable to fill them, even with competitive pay and employment conditions.

Due to unemployment levels being at a historically low level, the number of workers available from the local population has greatly decreased. The most recent HCPNZ member survey (2006) indicated that turnover levels are currently around 26% a year for caregivers in aged residential care. This means, that on average, a facility will lose an equivalent of around six caregivers per year.

In addition, the member survey showed that ongoing vacancies continue to be a problem in the industry, with facilities having on average current vacancies for at least two part time and one full time staff. Respondents to the survey also reported requiring (on average) 80 caregiver hours from bureau staff per month, highlighting the inability of employers to find ongoing staff to fill vacancies.

Analysis of DOL job vacancy monitoring information produced by Careerforce illustrates the immediate skill shortages for caregivers have been increasing over the previous year:

*“Department of Labour Job Vacancy Monitor information from December 2006 shows that the 2,027 care giver vacancies for the period (Dec05-06) constituted the **third highest number of vacancies advertised in New Zealand**. The numeric growth (235) of caregiver vacancies was the 2nd highest raking [and represented growth of 103% in the period]. For most regions, care giver was ranked in the top 20 (or top 10 for smaller regions) of advertised vacancies.”*

The growing importance of the current shortage of caregivers has been the subject of a number of government strategies and planning reports which have been undertaken in the past three years. The amount of attention paid by the Government and related bodies to this workforce illustrates clearly that solutions to short term skill shortages are seen as a shared problem between industry and funder (government). The reports include:

- *Ageing New Zealand and Health and Disability Service, Demand Projections and Workforce Implications, 2001-2021, NZIER, December 2004*
- *Future Workforce 2005-2010, DHBNZ, August 2005*
- *Health Workforce Development: An Overview, MOH, April 2006*
- *The non-regulated workforce in the Health and Disability sector, DHBNZ, September 2006*
- *Care and Support in the Community Setting, HWAC, October 2006*

An important consideration in all of these reports is not only the current skill shortages facing the aged care industry, but also the projected future workforce shortages.

Future Workforce Capacity

A major challenge for the aged care sector will be developing the workforce capacity which will be to cater for the volume increases projected to hit aged care in the next twenty years. The 85+ population is *currently* increasing at the rate of 5% per annum, and will double in number within 20 years. Without a corresponding increase of people of working age, New Zealand faces inevitable chronic labour market shortages, and aged residential care will be no exception.

While current policy directions signal probable changes to the nature of aged care service delivery, in any scenario residential aged care will remain a core health service. However, the way in which services are utilised may differ, which could have differing workforce implications.

Current 'ageing in place' policy dictates that more people with chronic disease and disabling conditions are likely to live in the community for longer, which would shift the quantum of workforce need from the residential care setting to the community.

However, HCPNZ has argued that there cannot be a workforce *substitution* effect from this policy, as the frail elderly will still need care when they are unable to function safely in their homes. The workforce implications of a greater emphasis on ageing in place have never been quantified - probably due to the difficulty of modeling such a large number of variables. Also, the shift to have more people cared for in the community could worsen the workforce shortage issue as it is less efficient to deliver care to individual clients in separate locations.

The unavoidable implication is that an increasing ageing population will require additional caregivers, regardless of where, or how, care takes place. Assuming a true 'continuum of care', then it is likely that the distinction between the home and residential workforces could, or even should, blur in the future to the point that the workforce becomes interchangeable.

HCPNZ has modeled two scenarios for projecting future workforce needs. The first, a 'status quo' scenario, assumes continuation of current utilization of aged residential care usage. The second scenario, 'Diminished Rest Home', assumes decreasing rest home length of stay and rest home use, increasing hospital and dementia use, and a decrease in the length of stay in dementia and hospital. This scenario is a conservative projection of the impact of increasing acuity levels in the elderly. The assumptions for both scenarios are included in appendix one.

The table (below) illustrates that, regardless of what scenario evolves, the **aged care sector will need to find, train and retain between 11,000 and 13,000 caregivers** in the next four years by even a very conservative estimate.

Status Quo Scenario	2006 Worker No	2011 Projected No Net Increase		2021 Projected No Net Increase		2031 Projected No Net Increase	
Residential Care workforce	18,000	22,860	4,860	31,140	13,140	44,460	26,460
Homecare workforce	25,000	31,750	6,750	43,750	18,750	63,000	38,000
TOTAL SUPPORT WORKFORCE	43,000	54,610	11,610	74,890	31,890	107,460	64,460

Looking out to 2031, this means the recruitment, training and retention of an additional 65,000 workers to simply maintain status quo levels of service.

Decreased Residential Care Scenario	2006 Worker No	2011 Projected No Net Increase		2021 Projected No Net Increase		2031 Projected No Net Increase	
Residential Care workforce	18,000	18,720	720	25,560	7,560	36,540	18,540
Homecare workforce	25,000	37,000	12,000	50,500	25,500	72,750	47,750
TOTAL SUPPORT WORKFORCE	43,000	55,720	12,720	76,060	33,060	109,290	66,290

This modeling demonstrates the imperative to develop and build a strong caregiver workforce in the immediate future in order to meet the support needs of older New Zealanders, regardless of differing models of service delivery.

The Evolution of the Caregiver Role

HealthCare Providers NZ delivered a presentation to a recent DHBNZ Future Workforce Conference regarding the future of the aged care workforce in regard to the dual challenges of current and future workforce shortages.

The presentation included some fairly 'radical' suggestions including the need to change DHB contracting methods to enable providers to provide all services along continuum of care. HCPNZ argued that currently, silos of aged care services (and employment) exist in residential, home care and restorative care. HCPNZ also argued the need to promote and train workers who can deliver services across all care settings, creating a valued career pathway with a potential for upward movement.

An evolution of this idea is the HCPNZ proposal for the creation of a new role for caregivers which creates a way of bridging the need for a greater range of tasks to be undertaken by caregivers in response to increasing nursing shortages and higher client acuity levels.

Currently, the role of the caregiver is formally scoped at Level 2-3 on the National Qualifications framework. This role has limited responsibilities and it is acknowledged that caregivers work in a supervised capacity for health and safety reasons. However, HCPNZ argues that as nurses become scarcer, and consumers of aged care services have more complex health needs, the role of the caregiver will evolve and change to necessitate more complex and higher level skills in some areas.

The desire to create a 'super caregiver' role at a higher level on the NQF also emerges from a desire to broaden the career pathway for caregivers by creating more advanced roles for learners to work towards. The role is built on a 'base' set of skills which a learner would add specific sets of skills in particular areas of specialization. This would create a workforce of caregiver 'specialists' across a variety of areas, who would hopefully be able to work in a variety of aged care settings.

HCPNZ argues that the creation of such a role would be beneficial not only to learners, but also to the sector at large. It argues that a new tier of caregiver specialists would add to the quality of service for those older people receiving support by increasing the skill levels of the unregulated workforce, as well as addressing workforce shortage issues.

Currently, Careerforce is developing work on the idea of a set of pan-sector 'healthcare assistant' competencies with ability for stair casing/specialization at higher levels. However, the emphasis of this work is on first establishing the pan-sector base competencies rather than focusing on the higher level specialization roles. Simultaneously, Careerforce has developed a 'Foundation Level' qualification for caregivers at Level 2 on the framework.

Providers have expressed concern that the Level 2 qualification is fundamentally flawed because it does not meet the requirements set out in the ARRC contract. (See Appendix Two for further analysis). Therefore, providers who invest in staff training in the foundation skills certificate will not meet auditing requirements. Providers have also expressed disappointment that the emphasis of this work has been at the low end of skill development rather than looking at the higher end, which is where industry has specified training development is needed.

In both instances there seem to be a disconnect between industry and its industry training organisation. It appears that there is not, or has not been, mutual agreement and understanding regarding workforce and training development in aged care, which is of concern. Training is acknowledged by providers, policy makers and funders alike as a large part of the solution to issues facing the aged care unregulated workforce. Therefore, it is important that any development occurs in conjunction with industry, rather than being imposed on them.

Recently the Government and some sector unions have been mooting the idea of regulated, or compulsory training for the unregulated workforce, possibly linked to funding. The aged residential care industry have voiced concerns regarding the development of such a training strategy in an industrial relations context, and have also expressed concern regarding lack of consultation during the process of policy formulation. The disconnect between industry and policy makers on this issue needs to be remedied in order to create successful and sustainable workforce solutions.

Caregiver Training – Current Requirements

The caregiver workforce in aged care is, as previously discussed, defined as being an 'unregulated' workforce by DHBNZ as they do not fall under the Health Practitioners Competence

Assurance Act. In aged residential care and aged care delivered at home, there is no specific level of formal qualification required.

However, the Health and Disability Services (Safety) Act 2001 states that rest homes and hospitals are required to achieve certification against the Health and Disability Sector standards in order to receive any funding contracted by their DHB. Standards are set and reviewed by Standards New Zealand. The Ministry of Health designates audit agencies which providers can engage to conduct Certification Audits. Certification can be granted for up to 5 years, with a compulsory surveillance audit at 18 months. The Act and certification requirements mean that industry employers are required to meet all legal standards regarding employment of their staff, and include extra requirements regarding staffing levels and staffing policies. There can be no doubt that facilities meet these requirements, or else they will not be allowed to operate in the industry.

In particular, the Aged Related Residential Care contract (ARRC) sets out the relationship between the Government as funder, and providers of services, specifies various standards and requirements in regard to staffing and training. The areas stated in the ARRC contract form the basis for auditing and facilities must demonstrate they are meeting the criteria in order to continue to operate.

The conditions of the ARRC in regard to staff training are set out below, but in summary, require employers to ensure that all caregivers receive adequate orientation training, and education in regard to care of the older person, specifically in relation to seven key areas. Employers are entitled to choose the method of delivery (either external or internal, i.e. workplace training), which best suits them and meets their contractual requirements.

D17.6 Orientation and Competency of Newly Engaged Care Staff

- a. *You must ensure that all newly engaged Care Staff receive a planned orientation programme that familiarises them with your philosophy and vision, physical layout of your Facility, their job description, policies, procedures, protocols and guidelines relevant to their engagement and non-clinical and clinical emergency protocols.*
- b. *In relation to Care Staff employed, contracted, or otherwise engaged by you on a short-term basis, you will meet your obligations under clause D17.6(a) if you ensure that such Care Staff are familiar with the physical layout of your Facility, including the location of emergency exits, emergency protocols, and contact details for emergency and senior staff of your Facility.*
- c. *You shall ensure all staff who will be in direct contact with the Subsidised Residents have completed education that is related to the care of older people. Those staff who have not completed the training at the time of their appointment must complete appropriate training within six months of appointment.*

The training must address:

- i. *the ageing process, including sensory, physical, psycho-social, spiritual and cultural aspects;*
 - ii. *practical care skills;*
 - iii. *awareness of cultural issues;*
 - iv. *communication, including sensory and cognitive loss and other barriers to communication, and communication aids;*
 - v. *observation and reporting;*
 - vi. *promotion of independence and recognition of individuality; and*
 - vii. *understanding of Subsidised Residents' rights.*
- d. *You may arrange the education referred to in clause D17.6(c) at the Facility or externally. Any staff member carrying out tasks, procedures, or treatment must have demonstrated they are competent at performing the task, procedure and treatment, and follow documented policies, and protocols developed by you to ensure safe practice.*

D17.7 Staff Support and Guidance

- a. *Any Registered Nurse or Health Practitioner carrying out a delegated medical task or a specialised procedure or treatment must have demonstrated prior competency in the task, procedure or treatment, and follow documented policies and protocols you have developed to ensure safe practice.*

- b. *Where certification is required to carry out a particular task or specialised procedure (for example, an I.V. Certificate), Care Staff must have such certification.*
- c. *Tasks specified in clause D17.7(a) above shall be carried out in accordance with the relevant accepted ethical and professional standards.*
- d. *Strategies and/or protocols shall be operational to ensure that advice and/or support is available to On Duty Staff at all times, should the need arise.*
- e. *You must implement protocols to guide staff managing clinical and non-clinical emergencies.*
- f. *You must plan and undertake ongoing staff performance appraisals. Such appraisals must be documented at least annually.*

D17.8 Ongoing Programme of Staff Development

You must undertake a planned, documented programme of staff development or in-service education, with at least 8 hours of programmes being provided annually, including courses attended other than at the Facility. You must keep a written record of staff attendance at such programmes.

The ARRC also states that in Rest Homes, a Registered Nurse must be employed whose duty is to act as a resource person and fulfil an education role; monitor the competence of other nursing and Care Staff to ensure safe practice; and advise management of the staff's training needs. The implication of the ARRC is that employers can, and should, utilise more senior staff as educators to caregiving staff.

In addition, employers are required to ensure staff support and guidance (such as in regard to specialised processes), ensure ongoing staff performance appraisals, and facilitate at least 8 hours of programmes being provided annually (which may be internal or external).

In addition, there are further specific requirements for caregivers working in a dementia unit⁷. These caregivers must complete the following five NZQA unit standards within a year of starting work in a specialised dementia unit.

- **5012** - Demonstrate musculo-skeletal care and handle people safely in a health or disability setting,
- **23386** - Support a person to meet their personal care needs in a health or disability setting,
- **23387** - Demonstrate knowledge of the ageing process and its effects on individual support needs,
- **5020** - Support an older person to maintain their rights and responsibilities, and
- **17029** - Assist a person who is affected by dementia to meet daily living activities.

Therefore, in contrast to a perception that “no training exists in aged care”; there are a number of specific legal requirements and standards for the training of caregiving staff.

Provision of Training – What and Who

Like any employer seeking training for their staff, the providers of aged care have multiple choices regarding their training arrangements. Providers are required by the ARRC contract to:

- *Undertake a planned, documented programme of staff development or in-service education, with at least 8 hours of programmes being provided annually, including courses attended other than at the Facility*
- *[And] may arrange the education referred to in clause D17.6(c) at the Facility or externally*

Therefore, providers of aged care are entitled to deliver training at their facility through education courses which might, for instance, be run by a senior member of the nursing staff or a facility manager. This form of education is referred to as *informal* training, due to the fact that courses are not registered on the National Qualifications Framework and/or do not contribute to a

⁷ *Note that dementia beds made up 7.6% of all aged residential care beds in 2007, although not all facilities offer dementia services*

participant gaining any recognised credits towards a formal qualification. However, this does not mean that informal education is necessarily of lesser value or of a lower standard. It simply means that education requirements have historically been recognised and met within the workplace for caregivers, who have no *formal* qualification requirement.

The number of providers of informal training are, obviously, unlimited. Any workplace or organisation may develop and carry out its own training in this area. Currently, there are a number of individuals and groups who carry out informal training in the area of aged care. For example, HealthCare Providers NZ carries out a programme of seminars and training sessions nationwide for caregivers annually. There are many individuals, usually experts in a particular subject area, who hold training sessions and seminars across NZ which are relevant for caregivers working in aged care.

Although this training is structured and meets the requirements of the ARRC contract, it is defined as 'informal' due to the fact that learners do not receive credit from NZQA on their record of learning for completing the training. However, in addition to informal training, formal education and training also exist at caregiver level in the aged care sector. The definition of 'formal' in this context is that training is linked to the National Qualifications Framework (NQF).

The NQF is designed to provide nationally recognised standards and qualifications, with recognition and credit for a wide range of knowledge and skills. Unit standards and achievement standards, National Certificates and National Diplomas are registered on the NQF. The KiwiQuals website lists all qualifications on the New Zealand Register of Quality Assured Qualifications, Te Āhurutanga. To be included on the Register, a qualification must be quality assured. All qualifications on KiwiQuals have been approved by a recognised body and are delivered by an accredited education or training organisation.

Currently⁸ there are nine qualifications listed in the domain of older persons/aged care. These are all certificates, meaning they are registered at level 2-3⁹ on the NQF. All of these qualifications have been developed by an accredited organisation (this is the name in italics under the qualification) and have been approved by NZQA as meeting the quality standards required. All qualifications have outcome statements which illustrate that once a caregiver has completed the training, they should be able to provide safe and effective care of the older person under supervision.

National Certificate in Community Support Services (Foundation Skills) <i>Community Support Services Industry Training Organisation Limited</i>	Level 2
National Certificate in Support of the Older Person <i>Community Support Services Industry Training Organisation Limited</i>	Level 3
Ames Certificate in support of the Older Person <i>AMES Training and Resource Centre Limited</i>	Level 3
Certificate in Aged Care <i>Health Ed Trust New Zealand Incorporated</i>	Level 3
Certificate in Aged Care <i>Regent International Education Group</i>	Level 3
Certificate in Care of the Older Person <i>Wellington Institute of Technology</i>	Level 3
Certificate in Community Care Assistant <i>Corporate Academy Group</i>	Level 3
Certificate in Community Support Work <i>Nelson Marlborough Institute of Technology</i>	Level 3
Certificate in Support of the Older Person <i>Academy New Zealand - Group</i>	Level 3

⁸ Data search: 13/12/07 – <http://www.kiwiqual.govt.nz/search/Results.do>

⁹ The NQF has 10 levels - 1 is the least complex and 10 the most. Levels depend on the complexity of learning. Levels 1-3 are of approximately the same standard as senior secondary education and basic trades training. Levels 4-6 approximate to advanced trades, technical and business qualifications. Levels 7 and above approximate to advanced qualifications of graduate and postgraduate standard.

In addition, registered education providers¹⁰ can deliver training of any units or qualifications from within the NQF once approved. For example, a workplace may choose to become registered as a provider, and deliver the unit standard 16700 – clean a residential or community care facility. This would mean that a workplace had met the necessary quality standards to deliver and assess the training, and an employee who completed it would have this unit added to their personal record of learning.

Multiple providers have gained approval to deliver part, or all, of the *National Certificate in Support of the Older Person*. This particular qualification is the only one given the title of 'national' certificate, as it is developed and maintained by the Industry Training Organisation (ITO) Careerforce, which has responsibility for national skill standards for the aged care industry. There are 29 registered providers of the National Certificate in Support of the Older Person. (See Appendix Three for list). Some of these providers are private training enterprises or PTEs, some are polytechnics, or institutes of technology, and others are workplaces.

Therefore, not only do providers and staff working in aged care have many choices regarding formal education qualifications, they also have many choices regarding the provision of that education. Providers now offer a range of learning methods, such as onsite and offsite learning, online learning, and traditional 'course' format learning.

At the present time, there is no qualification which is given preference or recognition above another by either the Ministry of Health or DHBs regarding aged care. That is to say, that the legislative requirements regarding training do not currently limit provider choice by stipulating a 'preferred' education supplier or qualification.

Current Provider Utilisation of Education and Training

It is difficult to know what choices providers are making regarding education and training. A common myth regarding the aged care sector is that providers fail to provide adequate training opportunities for their caregivers¹¹, or even that 'no training system exists in aged care'.

However, in reality this is not true. An official information act request to the Tertiary Education Commission shows that, at a macro level, 1,834 STMs were allocated to CSSITO in 2006 for the disability industry and aged related industry. Furthermore, Institutes of Technology and Polytechnics were allocated 648 EFTS, Private Training establishments 332 EFTS, and Universities 1,393 EFTS for the provision of training in NZCSED codes related to training for caregivers and healthcare assistants in aged care. Altogether, it is possible to conclude that the *equivalent* of over 4,200 full time learners were engaged in formal training in the general domain of caregivers/healthcare assistants in 2006.

However, these statistics only provide a very macro-level overview of what might be going on at a formal level of training. HealthCare Providers NZ surveyed its members in late 2007 to get a better understanding of what aged care providers are doing in terms of training and education for their unregulated staff.

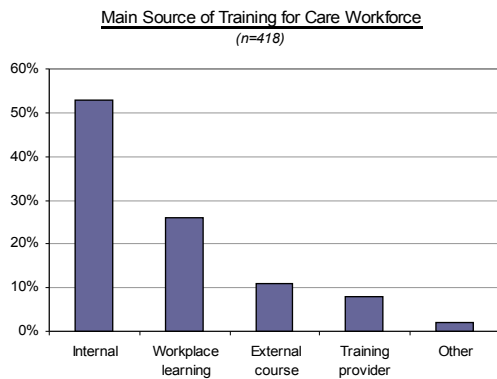
It should be noted that the survey data from which the following material represents a response rate of 56% of the entire sector, that is, providers of aged residential care in NZ. Therefore, it is possible to describe the material as representative of the sector.

¹⁰ Any education organisation can be registered to supply education, training or assessment services in New Zealand. All education organisations can be accredited to assess for National Qualifications Framework (NQF) qualifications. Before applying for accreditation, private and government training establishments must be registered with the New Zealand Qualifications Authority (NZQA). Many companies and government training establishments register their staff training operations as training establishments.

¹¹ <http://www.nzno.org.nz/Site/News/Archive/2006/agedcare.aspx>

When asked, 96% of respondents indicated that they provided **formal**¹² workplace training to their care workforce. Respondents were asked to indicate what percentage of the training their workforce received in a year would be classed as formal. On average, respondents indicated that between 32 and 37 percent of all training undertaken by their care workforce in a year would be formal.

Respondents were also asked to indicate their **main** source of training for their overall care workforce (including nursing staff). Most respondents (53%) indicated that they used internal resources, such as having a dedicated in house/internal training, or used staff with other responsibilities, as indicated by the ARRC contract.



Around a quarter (26%) used workplace learning (with the help of an external provider, such as Health Ed Trust) as their main source of training. 11% indicated they would mostly send staff to external courses, while 8% would contract an external training provider to deliver a training programme.

'Other' options included a combination of some options, or alternatives such as employing a part-time education officer. This indicates that just under half (45%) of the sector are utilising external sources for their training provision.

HCPNZ also asked where, or who, providers sourced their caregiver training from. Respondents were invited to indicate as many options as applied from a list of known providers of caregiver education in NZ.

Source	% of facilities using source
Internal	86%
HealthEd Trust	64%
HCPNZ	46%
CareerForce	36%
Wellcare	9%
Health Organisation	6%
Private/Contractor	6%
Polytechnic	5%
Community Organisation/NGO	4%
Other	4%
DHB	3%
Age Concern	3%

Once again, the majority of providers sourced their caregiver training internally; however, it is evident that this is most likely done in conjunction with the use of an external provider, who was most likely to be Health Ed Trust.

Over two-thirds of the sector used HealthEd Trust as a source of training for caregivers, while just under half used HCPNZ as a source. HealthEd Trust was the most utilised source of formal training, followed by Careerforce. The results indicate that providers utilise a range of providers to deliver both formal and informal training, but that the majority

will have an internal training component, as set out in the ARRC contract, in conjunction with utilizing other sources.

Respondents were also asked specifically whether they sourced training **resources** (such as materials, aids, etc) externally. 77% of respondents indicated that they did, which indicates that while training may be carried out internally, it may often be through the utilization of external resources. The majority of respondents (53%) indicated that they sourced their internal resources from Health Ed Trust. Respondents also identified DHBs (36%), Careerforce (22%) and a range of community and health organisations as other possible sources for training resources.

Provider views on current training and education provision

Respondents were asked whether they believed the current range of training providers met their workforce needs. The large majority (88%) of all respondents indicated that they felt the current

¹² Defined as contributing towards an NZQA qualification, such as a certificate

training providers met their needs. Of those (12%) who thought otherwise, the following reasons were given:

- *Usually all the best courses/seminars are in the main centres only, therefore making it difficult with travel/accommodation.*
- *Labour intensive. Often expensive, not held locally*
- *Doesn't meet audit standards e.g. for restraint*
- *Cannot enthuse staff to attend and participate*
- *Specialist training needed – i.e. on challenging behavior*
- *Materials provided are good but the confusion between Career Force and Health Ed Trust leads to problems*
- *Requires a greater range of clinical topics*
- *English as a 2nd language with many staff poses an issue*

The comment regarding the confusion about ITO (Careerforce) was a common theme among respondents in relation to a further question asking whether the ITO was currently meeting the industry workforce training needs.

While 30% of all respondents did not think the ITO was meeting industry needs, 43% of respondents were unsure, and only 26% believed the ITO was meeting industry needs. Respondents were invited to provide reasons for their response to this question, and the response clearly illustrates wide-spread confusion about the role of the ITO and its relationship to education providers in the aged care sector. It also indicates that some providers have had an unsuccessful relationship with the ITO in the past.

For example;

- *Unsure how it relates to Health Ed Trust*
- *Get the impression that they view ACE as competitors and enforce too many restrictions on their recognition. The beauty of ACE is that staff complete in their own time - with CSSITO, involves attendances at courses, or more time consuming*
- *Too expensive - and not available on site. Competing against their own providers*
- *Not as thorough as ACE. Not industry based. No video.*
- *Low profile - other than training agreements and funding would not be aware of them. Seem to have conflict with other providers e.g. HealthEd Trust*
- *Doesn't appear to be focused on what the sector wants - appears to have their [CSSITO] own agenda*
- *The training is too broad in terms of personal development and not specific enough with regard to care of the elderly*
- *Very unreliable, promised commitment and support but absolutely nil provided. They were experiencing difficulties with unit standards, but I felt that the support was greatly lacking.*
- *Disorganised, inaccurate material, poor internal systems*
- *HealthEd Trust is more in tune with the requirements in our sector*
- *Not sure who they are*
- *We have used them, but have found it fairly cumbersome at times, not ESOL friendly.*

Clearly, there is confusion about the role of the ITO in the aged care sector. This seems to be both in regard to the legislated role of the ITO in setting skill standards in the industry and also in regard to the ITO relationship with providers in the sector. Providers indicated clearly that they felt the provider HealthEd Trust was meeting sector needs in terms of provision, and didn't want this altered. Providers indicated a need for better clarification of the ITO role, and its relationship to the providers it contracts with. As legislation prevents ITOs from delivering training, Careerforce should not be viewed as 'competing' with education providers, and this issue is worth further investigation. However, the strong signal from providers is that they do not wish the ITO to have any role in the delivery of education.

Providers were also asked whether they thought the aged care sector requires its own ITO. This idea was proposed by the National Party in its September 2007 discussion paper 'Choice Not

*Chance for Older New Zealanders*¹³. Just under half (47%) of all respondents felt that the aged care sector should have its own ITO. 23% of respondents were unsure, and 30% of all respondents felt that there was no need for a separate ITO.

Summary of Issues

By any definition, the aged residential care unregulated workforce faces major challenges. The most pressing workforce issues are in regard to current and projected future skill shortages which threaten providers' ongoing ability to provide safe and quality care of the elderly.

The other major challenge to the workforce is the evolution of the role of the caregiver. As average acuity levels of the older elderly rise, and changes to service delivery and technology impact, the role of the caregiver must change to keep pace with industry needs.

A major part of the solution to both challenges lies in the future design and delivery of the training of the unregulated workforce. It will be necessary for the industry to address current issues regarding training in order to successfully harness training to meet its needs.

There are currently a number of tensions within the industry in regard to training. While most providers feel that the current system meets their training needs, the current system is largely dependent on provider's ability to utilise internal training systems as a major source of training. Providers have stated clearly that they wish to retain the ability to deliver flexible workplace-based training in the future.

The provider representative body, HCPNZ, has developed some interesting ideas in regard to the challenges facing the industry which are worthy of discussion. In particular, the idea of a new caregiver role is one which should be further developed. Ideally, this should be done in partnership between industry and related education and policy bodies.

In addition, specific consideration to the evolving needs of the *aged residential care* unregulated workforce need to be considered. Discussions regarding the 'health and disability' workforce are of limited value to the industry in terms of forward planning, when considering such a diverse group of professional occupations.

While there is merit in the idea of the development of (health and disability) pan-sector skill sets, at the same time, specific consideration must be given to the development of particular skills required in the evolving aged care workforce. Industry has indicated that it wishes to concentrate on the higher level of skill development, rather than the lower end. Providers have also indicated the need to carefully consider the skills and competencies which caregivers will require in the future in a true continuum of care service.

There is current speculation regarding the possible regulation of the aged care unregulated workforce, supposedly in a bid to address issues of 'quality and safety' and also wage issues. The introduction of such regulation would be an ill-considered and blunt policy response to a very complex situation.

It is clear that disconnects exist between industry, ITO and policy makers, that the real issues which exist around workforce and training have not been properly explored and that at the present time, a universally supported, sustainable solution to these challenges does not exist.

Conclusion

¹³ Released 5 September 2007, <http://www.national.org.nz/Article.aspx?ArticleId=10940>

The unregulated care workers are an occupational grouping with distinct characteristics and needs, and therefore deserve focused policy and research work. Trying to resolve their issues through a 'pan sector', 'health and disability' workforce approach will not work.

In all probability, the demand for unregulated care workers is likely to increase, whichever direction Government policy takes compounding the current skill and labour shortages. This underpins the need for a specific workforce development and planning strategy. Furthermore, any workforce development and planning strategy needs to be evidence-based and reflect the realities of current practice in the healthcare sector, rather than anecdote and assumption.

Contrary to many claims, the healthcare sector is already providing significant levels of training and staff development for unregulated care workers. Moreover, the sector is keen to develop career pathways and higher-skill development opportunities that will make care work more attractive and rewarding.

The best way of building these new pathways and opportunities is for Government to work alongside industry, recognise current practice, encourage (rather than compel) employer change, retain flexibility of choice and provision, and keep pathway and training development policies separate from industrial relations issues.

From the perspective of industry, there are four principles which must be a foundation for any future system improvement to be a success:

1. **Changes must support current practice** – contrary to myth, 96% of providers *are currently* providing formal workforce training to their employees. The system in place has been developed in conjunction with contractual requirements for health and safety, and has grown organically to meet both provider and employee needs. Most providers feel that the current system meets their training needs, and that the current system is largely dependent on their ability to utilise internal training systems as a major source of training. Providers who have well developed and successfully operating training systems should be supported to retain and enhance current best practice rather than changing for change's sake.
2. **There must be incentives for employers** – with any system change are associated costs and barriers. Employers will hesitate to move from a system which has been developed to meet their specific industry needs to a regulated system without incentives for change. These should be both a mixture of economic (i.e. cost minimization) and social (demonstrable increases in quality outcomes for staff and residents). Specific incentives to enable change should be developed in partnership with employers as part of any change recommendations.
3. **Flexibility of choice and provision** - Providers have stated clearly that they wish to retain the ability to deliver flexible workplace-based training in the future. Moving to a regulated system where provider and or qualification were mandated, and employer choice reduced, would not necessarily lead to increased quality of training outcomes for employers. Industry also believes that any future system must be low on bureaucracy, and as highly provider-led as possible.
4. **Segregation from industrial/wage relations** – Training and the issues regarding caregiver workforce development have been most frequently raised outside the industry by third parties during industrial relations in recent years. Industry feels that workforce development is a separate issue and should not be tied in with wage claims, lest it lose its importance and become a fight over money. To achieve this, Industry believes that

any change or future system development should be segregated from operational funding in both central government and DHB funding, and therefore a separate discussion from annual funding negotiations for service provision.

Any policy aimed at improving training will need to adhere to these principles in order to be successfully implemented and sustained by aged residential care providers.

Appendix One: Scenarios for Aged Care Growth and Workforce Implications

(Source: HealthCare Providers, 2007)

Scenario One assumes:

- A medium population growth;
- A continuation of present aged residential care usage at 5.55% of those aged over 65;
- Average length of stay at 262 days;
- Present percentage of homecare clients as a proportion of the total population, and
- Continuation of the current average home care usage of 3.4 hours per week

Scenario Two assumes:

- Decreasing rest home length of stay by 15% (from 262 days to 223 days) and,
- Decreasing rest home use by 15% (i.e., from 5.55% to 4.7% of the population over 65), and
- Increasing hospital and dementia care use by 10%, and
- Decrease the length of stay in dementia and hospital by 10%

Scenario ONE - Status Quo

	2004	2011	2021	2031
Aged Residential Care				
Total ARC Beds	32,544	41,187	56,380	80,539
Total ARC Bed days needed	10,393,653	13,154,174	18,006,517	25,721,987
% Growth		27%	73%	147%
Homecare				
Total Home Care Hours 65+	7,799,290	9,904,434	13,640,544	19,655,421
Total Home Care Clients 65+	45,108	57,283	78,891	113,679
% Growth		27%	75%	152%

Scenario TWO - Increased Hospital and Dementia, diminished rest home

	2004	2011	2021	2031
Aged Residential Care				
Total ARC Beds	32,544	33,738	46,252	66,091
Total ARC Bed days needed	10,393,653	10,775,125	14,771,589	21,107,766
% Growth		4%	42%	103%
Homecare				
Total Home Care Hours 65+	7,799,290	11,524,602	15,787,265	22,713,019
Total Home Care Clients 65+	45,108	59,360	81,644	117,599
% Growth		48%	102%	191%

Workforce Implications - Scenario One and Two

Status Quo Scenario	2006	2011		2021		2031	
	Worker No	Projected No	Net Increase	Projected No	Net Increase	Projected No	Net Increase
Residential Care w/force	26,190	33,261	7,071	45,309	19,119	64,689	38,499
Homecare w/force	25,000	31,750	6,750	43,750	18,750	63,000	38,000
TOTAL SUPPORT WORKFORCE	51,190	65,011	13,821	89,059	37,869	127,689	76,499
Decreased Residential Care Scenario							
Decreased Residential Care Scenario	2006	2011		2021		2031	
	Worker No	Projected No	Net Increase	Projected No	Net Increase	Projected No	Net Increase
Residential Care w/force	26,190	27,238	1,048	37,190	11,000	53,166	26,976
Homecare w/force	25,000	37,000	12,000	50,500	25,500	72,750	47,750
TOTAL SUPPORT WORKFORCE	51,190	64,238	13,048	87,690	36,500	125,916	74,726

Appendix Two (A)
Careerforce National Certificate in Community Support Services
(Foundation Skills)

Version 2, Level 2
 43 credits
 Released July 2007

Unit standard number	Title	Level	Credit
23686	Demonstrate knowledge of a consumer's rights and responsibilities in a health or disability setting	2	1
23454	Apply service delivery plan requirements to meet the needs of consumers in a health or disability setting	2	8
23451	Demonstrate knowledge of the role of a support worker in a health or disability setting	2	6
20829	Support a consumer's well-being and quality of life in a health or disability setting	2	6
20830	Maintain a safe and secure environment in a health or disability setting	2	5
23452	Demonstrate knowledge of handling equipment and people safely in a health or disability setting	2	4
23453	Describe a safe working environment for support workers in a health or disability setting	2	8
23685	Demonstrate knowledge of pre-packaged medication used in a health or disability setting	2	2
20826	Demonstrate knowledge of infection control requirements in a health or disability setting	2	3

Appendix Two (B) Foundation Level 2 and ARRC Agreement Orientation Requirements

Key Question: Does National Certificate in Community Support Services (Foundation Skills) Level 2 meet Orientation Requirements for new Staff, as outlined in the Age Related Residential Care (ARRC) Services Agreement?

The following table is based on the requirements specified in D17.6c (i to vii) of the Agreement

ARRC Agreement Orientation Requirement	Where covered
Completed education related to care of older people	Focus is on “consumers”, not specifically on older people
i. the ageing process, including sensory, physical, psycho-social, spiritual and cultural	<i>Not covered</i>
ii. practical care skills	Not specifically covered. Mentioned briefly <i>in unit standard 23454 Element 2 pc 2.2 - tasks carried out include “personal care”</i>
iii awareness of cultural issues	Covered in unit standard 20829 element 3. <i>However, talks about “people from different cultures” which suggests that people are grouped and therefore overlooks that each person has their own unique culture (which is why individualised care is so important).</i>
iv communication, including sensory, and cognitive loss, other barriers to communication, communication aids	Covered in unit standard 20829 pc 2.5 covers verbal, non verbal and listening, and pc 3.2 and 3.3 cover methods of communication and barriers to communication with people from different cultures <i>Not covered – sensory and cognitive loss, communication aids, other barriers to communication</i>
v observation and reporting	<i>Not covered – no specific mention</i> <i>May be covered</i> by the educator/education materials under unit standard 23451 pc 1.1 within Service Delivery Plan (SDP) and Job Description. Special Note 2 of the unit standards states that the SDP will outline the tasks to be performed by the support worker, but does not specify observation and reporting
vi promoting of independence and recognition of individuality	<i>Not covered specifically – no specific emphasis on these cornerstones of providing support.</i> Special Note 1 or 2 of the unit standards mentions independence and individual plans. Individuality should come through in unit 20829 about quality of life and 23454 about Service Delivery Plans.
vii understanding of Subsidised Residents rights	Covered in unit standard 23686

Note: pc = performance criteria – the part of the unit standard that states specific learning outcomes

Appendix Three

Registered Providers of National Certificate in Support of the Older Person

(Source: NZQA, January 2007)

1. [Academy New Zealand - Group \(CHRISTCHURCH\)](#) Support of the Older Person (to level 3)
2. [Access Homehealth Limited \(CHRISTCHURCH\)](#) Support of the Older Person (to level 2)
3. [Anamata \(WHAKATANE\)](#) Support of the Older Person (to level 2)
4. [Apostolic Training Centres Limited \(HAMILTON\)](#) Support of the Older Person (to level 2)
5. [ATC New Zealand](#) Support of the Older Person (to level 2)
6. [Avatar Institute of Learning \(NEW PLYMOUTH\)](#) Support of the Older Person (to level 4)
7. [Best Pacific Institute of Education Limited \(AUCKLAND\)](#) Support of the Older Person (to level 2)
8. [Business and Management Ed. & Training Services Ltd \(BMETS\) \(MANUKAU CITY\)](#) Support of the Older Person (to level 2)
9. [Community Colleges New Zealand Limited \(NORTH CANTERBURY\)](#) Support of the Older Person (to level 3)
10. [Community Support Services ITO Limited \(CHRISTCHURCH\)](#) Support of the Older Person (to level 5)
11. [Corporate Academy Group \(AUCKLAND\)](#) Support of the Older Person (to level 4)
12. [Dunedin Training Centre \(Dunedin\)](#) Support of the Older Person (to level 2)
13. [Framework Solutions Limited \(WELLINGTON\)](#) Support of the Older Person (to level 2)
14. [Haranui Marae Training Centre \(Helensville\)](#) Support of the Older Person (to level 4)
15. [Horizon Education Limited \(Palmerston North\)](#) Support of the Older Person (to level 4)
16. [Huria Management \(Tauranga\)](#) Support of the Older Person (to level 2)
17. [Insight Learning Academy \(HAMILTON\)](#) Support of the Older Person (to level 4)
18. [Institute of Applied Learning Ltd \(OTAHUHU\)](#) Support of the Older Person (to level 4)
19. [Kapiti Skills Centre \(PARAPARAUMU\)](#) Support of the Older Person (to level 4)
20. [New Zealand Career College Limited \(MANUKAU\)](#) Support of the Older Person (to level 4)
21. [Regent International Education Group \(AUCKLAND\)](#) Support of the Older Person (to level 4)
22. [Regent Training Centre Limited \(WHANGAREI\)](#) Support of the Older Person (to level 2)
23. [Taranaki Work Trust \(NEW PLYMOUTH\)](#) Support of the Older Person (to level 4)
24. [The Centre for Learning \(Division of IHC New Zealand\) \(AUCKLAND\)](#) Support of the Older Person (to level 2)
25. [The Salvation Army Employment Plus - Central \(FEILDING\)](#) Support of the Older Person (to level 2)
26. [Turanga Ararau \(GISBORNE\)](#) Support of the Older Person (to level 2)
27. [WellCare Education Limited \(NELSON\)](#) Support of the Older Person (to level 4)
28. [Wellington Institute of Technology \(WELLINGTON\)](#) Support of the Older Person (to level 4)
29. [Whakato te Matauranga \(Wairoa\)](#) Support of the Older Person (to level 4)