Report on the Dysfunctional Provision of

Rest Home Care and Funding

in New Zealand

By Geoffrey M Harper

Tauranga

January 2011

Contents

1. Foreword

The provision of care and funding for the aged in rest homes in New Zealand is in urgent need of review and reform.

There are currently many significant problems which are causing suffering to our New Zealand rest home residents, these include:

- a vagueness in, scope for misinterpretation and exploitation, of the General Standards;
- a lack of appropriate supervision and regulation of rest home providers;
- Agencies dealing with issues involving aged health care are disconnected, and unnecessarily bureaucratic.
- a disconnect between the contractual relationships of our District Health Boards (DHB's), the rest home providers and residents;
- an ineffective level of supervision by the Health and Disability Commissioners;
- a lack of proper focus in the audit function;

It has been 9 years since New Zealand adopted the General Standards designed to ensure the safety and effective functions of our rest home health sector under the Health and Disability (safety) Act 2001.

The move away from **specific General Standards has had disastrous consequences** and the risk to residents is considerable.

A lack of political will to promote the interests of residents against the interests of industry and its shareholders is unacceptable.

Demographically New Zealand's population is aging. Within 15 years the bed numbers will have to double to meet demand. Some observers predict that the current government qualifying subsidy, if the Grant Thornton recommendations are accepted, will have to increase from **$1 billion currently** to **$2 billion per annum in 2011.** My estimate, at the lower end of the increase in projected numbers (without allowing for inflation), is somewhere over **$3.3 billion by 2026**.

Not only is there urgency required to resolve existing shortcomings in the industry, but there must be a way to ensure the required growth is effectively managed and the end result offers New Zealanders requiring aged care, an appropriate quality of life.

It is time that regulators acknowledged that the industry demand estimates indicate that sector bed numbers need to adjust to accommodate an extra 26,000 to 37,000 residents by 2026. The direction and lack of speed of the government led review, is denying proper protections for a population that is vulnerable and increasingly exploited.

I call on the Government to urgently address the issues raised in this report.

2. Introduction

This report aims to provide a clear set of objectives that should be adopted immediately to ensure our rest home residents are safe, and that New Zealander aged care consumers are protected. It is intended to stimulate public debate on the dysfunctions observed and to start the process of reform of the unnecessarily complex, costly and bureaucratic structures which surround this industry.

The body of this report includes critical evaluation of the current policies, structure and provision of aged care services to the residents of rest homes in New Zealand.

Commentaries are provided by sector participants, in New Zealand and overseas jurisdictions, on the observed systemic failure of the existing methods and operational practices of providers, funders and Government Agencies. These commentaries illustrate the lack of safe - guards for the 34,000 residents of residential care homes in New Zealand and overseas.

The report is designed to collate and provide comment on these submissions by various stakeholders, many of whom highlight specific deficiencies in the application of the General Standards.

This report includes website references and a full appendices section including summary copies to these representations.

G. M. Harper, BCA

Director Global Business Examiners Ltd

January 2011

3. Executive Summary

Below are summaries of each of the sections of this report.

General Standards

The "General Standards" are the rest home regulations of the Health and Disability Service (Core) Standard: NZS8134.
These General Standards must meet any legislative requirements under the Health and Disability Services (Safety) Act 2001 (the Act). These requirements are aspirational not specific.
The Controller and Auditor General, Lyn Provost, in 2009, issued a damning report on Rest Home care.
She singled out the Ministry of Health for failing to provide adequate assurance that Rest Homes are meeting required standards.

Comment

My belief was that emphasis was placed on providers having no additional compliance costs, to the significant disadvantage of not making the standards measurable, auditable, and open to misinterpretation, and not having clear and concise technical content and means of expression and not providing a safe outcome for consumers.

The decision was to "move away from extensively detailing specific outputs, instead concentrating on the outcome to be achieved" This in my view, created loopholes that providers (especially multi-nationals) could exploit to lower staffing ratios and services. (See section on staffing ratios pages 15-16)

Changes can easily be made by the Governor-General by order in Council (s53 of the Act) – (See Appendix C, page 31)

Recommendation:

The Standards should specify the minimum provision of services.

Voluntary opt out clauses by the resident could cater for variations.

Experience overseas

Alternatives methods of care delivery and funding;

The **Australian Productivity Commission** in 2009 has undertaken a major review of Aged Care provision in Australia, titled "caring for Australians". The Commission requested suggestions on alternative models of service delivery. The draft report is expected to be released on the 21st of January 2011. Details of the inquiry can be accessed at http://www.pc.gov.au/projects/inquiry/aged-care
Submissions can be viewed at http://www.pc.gov.au/projects/inquiry/aged-care/submissions

This report could be a valuable tool as a basis of reform in New Zealand. The desire of most aged people is to receive assistance in their own home when possible (be it the family home or in a retirement village). Because of this, and shifts in government policy, there has been a trend away from residential care towards community care. In 1995, community care places (in Australia) made up less than 2 per cent of all aged care places. By June 2009, this had

increased to around 22 per cent. An important part of this growth was the expansion of funding to support flexible care places.

Reforms could include:

1) **Individualised Funding** as currently successfully applied to the Disability Sector. Potential consumers could decide what services they assess they need, when they want them, and how they will be delivered. This means that if consumers so choose they are responsible for the funding of their care entitlements and recruiting/purchasing care according to their own needs and expectations. Consumers will shape the service delivery and actively participate in service delivery and evaluation.

2) **Not for profit Cooperatives or Incorporated Societies** where residents pool their resources, purchase or build a facility, appoint a shared professional manager and set standards of service. They would be subject to Specific Standards and audited. *The evidence suggests that, on average, not-for-profit nursing homes deliver higher quality care than do for-profit nursing homes. (see page 26)*
There are models in the USA that operate on this basis. Preliminary costings indicate these are viable models. There would be a fiscal advantage to the Government as it would not have to fund the Cost of Capital as required in the Grant Thornton model (See Financials Section pages 17-18)

3) Greater funded support for **Assisted Living.**

4) Government provided supervised facilities and increased funding for **end of life palliative care.**

Recommendation:

Alternative structures to established Rest Homes should be investigated for the delivery of Aged care services and funding.

Financials

Comment

Interpretation of the costing models from the Grant Thornton Report (see page 17) appear to show that this report ,commissioned as a joint project by the DHBs and the Aged Care Association, is requesting an average increase of **$79.00** per resident per day or **96%.**

If you extrapolate this increase over the 34,000 residential care residents x365, the amount requested would increase by **$980 million** for residential care home Residents in New Zealand.

Analysis of the above report also shows that on average the providers are suggesting that their capital return and interest should be **$73.12** per resident per day. **Return on Capital would range from 14.8% to 17%.**

Recommendation:

It is in the New Zealand Governments fiscal interests to investigate alternative models of funding and delivery of services.

Staffing Levels in New Zealand and overseas

Current staffing ratios 2010
NZS-HB 8163:2005
Recommends the ratio of Staffing Levels in New Zealand
The recommended Contractual Staffing Ratios (Rest Homes) for subsidised Residents in New Zealand are as follows

Up to 10 Residents	**one care staff per 10 residents on** duty at all times
Up to 30 Residents	**one care staff** on duty at all times and **one on call**.

The above code replaces the **Old Peoples Homes Regulations 1987** which specified

Number of residents	minimum aggregate number of hours to be worked per week by staff	
3-5	60	1.5 FTE
6-10	120	3 FTE
11-15	160	4 FTE

Recommendation:

Increase the minimum staffing levels in Rest Homes in New Zealand

Agencies with input into residential care

There are 23 Government agencies, NGO's and associations involved in setting regulations and providing advice to Rest Homes. (See page 19 for diagramme)
This results in duplication and unnecessary bureaucratic structures.

Recommendation:

The multitude of Agencies should be more simply structured with possible amalgamation of government funded functions.

Complaints procedure

Comment
No agencies are tasked specifically with the protection of the interests of individual residents. Even after numerous complaints there is no mechanism for physical investigation unless there is a gross breach of safety or criminal activity. Experience has shown that even when a gross breach has been established in the provision of services by the providers, remedies available to the Health and Disability Commissioner are narrow and no monetary penalty can be imposed. This in effect can mean time consuming, endless communications and cost to the complainant, with the providers quite comfortable in the knowledge that remedies are limited and the Accident and Compensation Act limits liability.

Recommendation

A specific agency should be tasked with the responsibility for aged Care and substantial monetary penalties are available for breaches of the Act.

Audit Functions

The Auditor General in her report 2009 has issued a damning report on Rest Home care.
"Auditing by Designated Auditing Agencies has been inconsistent and sometimes of poor quality".
Consumer New Zealand has stated "our research uncovered cases where Rest Home auditors failed to pick up serious shortcomings in care. Our investigations have also found current auditing of the sector is failing consumers"

Recommendation:

The audit function should be rationalised to one agency tasked with auditing, certification, and training.

Auditors should also focus on the physical provision (or lack thereof) by the providers of services to Residents of Rest Homes, not administrative only as is currently the main focus of auditing performed.
This should include onsite auditing to ensure service provision complies with specific responsibilities under the Standards and the contractual conditions with the DHB.

Audits should include unscheduled, non-notified audits, at regular intervals. Surveillance Audits should be conducted yearly.

The Auditors should be appointed by Government agencies (not the provider) and conduct on the spot physical audits.

Other Recommendations

The Age Related Residential Care Services Agreement

This Document establishes the contractual relationship between the DHB and the provider. It covers rest home, dementia and geriatric hospital level care delivered in a residential care setting. The wording in the Residential Care contract is non-prescriptive and in my view is un-enforceable unless there is a clear breach of the Health Act 1956 or the New Zealand Public Health and Disability Act (Safety) 2001 or criminal activity.

Recommendation:

When a Residential Care contract is let by the DHB to a Provider, Consumer Representatives should have an input into the terms and conditions of service. Clauses in the contract should give DHB's greater enforceability over breaches.

Recommendation:

The Department of Labour should have jurisdiction over safety issues affecting residents in Rest Homes.

Recommendation:

Advocates (or relatives of the residents) **should be present at the assessments of residents in rest homes**, and **assessments should be conducted by an independent body, not internally assessed**.

Recommendation:

Before contracts are let, the financial capacity of the provider should be more stringently assessed.

General Standard's availability:

It is incredible that a copy of the **General Standards** is only available to the general public from the Standards Association at a cost of **$206**.
Care Standards (which set the Ratios for the numbers of Carers per residents) are only available at a cost of $60.
Even the DHB, Advocacy and the Health and Disability Commissioner were not allowed to provide a copy

Recommendation:

A copy of the Standards should be freely available (without cost) to the consumers of aged care, perhaps with a current copy having to be available at the rest homes themselves.

4. Rest Home Statistics in New Zealand

Source statistics Grant Thornton Aged Residential Care Service Review
http://www.grantthornton.co.nz/Assets/documents/home/Aged-Residential-Care-Service-Review.pdf

- 34,000 aged residential care beds in New Zealand and 715 certified rest homes in 2009.
- 84% increase in population aged over 65 (from 512,000 to 944,000), between 2006 and 2026.
- 26,500-37,500 new residential care beds needed between 2009 and 2026

- $785 million paid by the government to aged residential care providers for long term residential care in 2008/09. (Includes rest home, dementia units, continuing care hospital and psycho-geriatric level care.)
- $112.93 to $123.06 per resident per day (depending on the district / DHB) - current average government subsidy paid to providers for rest home care.
- $151.82 per resident per day - average government subsidy providers are asking for to cover increased costs.

- 64% of residents are subsidised by the government, while 32% of residents are not subsidised.
- 57% of residents are in rest homes, 31% in hospitals and 8% in dementia units.

- 68% of aged residential care facilities in New Zealand are controlled by "for profit" operators.
- 33,000 people currently employed in the aged residential care sector.

- 27% higher "acute hospital days of aged residential care residents" in New Zealand compared to international benchmark in 2008.

- Twice the level of "emergency department visits of aged residential care residents" in New Zealand compared to an international benchmark in 2008.

- 42% higher prescription drug usage of aged residential care residents in New Zealand compared to an international benchmark in 2008.

The publication by Susan St John/Ashton; *"Financing of Long Term Residential Care in New Zealand: Swimming Against the Tide"2005 states*
"Expenditure on government subsidies for residential care is projected to more than double from around $843m per annum in 2005 to almost $2000m by 2021." This report is available
http://homes.eco.auckland.ac.nz/sstj003/AshtonSt%20John%20paper%20final.doc
Increases in the subsidy rates in 2005 and 2010 (and including payments by unsubsidized residents) have increased the estimated cost of Rest Home care in total to 1.4.billion in 2011

5 Detailed Analysis

5.0 General Standards

5.0.1) The Health and Disability (safety) Act 2001 requires the Minister of Health to regularly review the existing standards (s24 of the Act).

In 2007 an expert committee was appointed by the Ministry of Health and Standards and met to review these standards. (A full list of the committee membership is available in Appendix A, pages 28)

Some of the key goals of this review included

The standards are measurable and auditable
The standards are not open to misinterpretation
The technical content and means of expression are clear and concise
The standards ensures a safe (including culturally safe) outcomes for consumers of the services

The revision was designed to ensure the standards were to be "in the public interest having regard to the extent to which compliance would be likely to ensure the safe provision of services of that kind to the public and the likely costs to providers of compliance. No additional compliance should be placed on the providers unless agreed to by the expert committee."

The Committee of 22 persons formulated the General Standards, and these were adopted in 2008. **Of the 22 committee members, only 3 represented the interests of rest homes residents** and mental health advocates.

2 out of the 3 advocate representatives on the committee resigned in protest at the lack of recognition of their requirements. They issued a Minority Report which criticised the other participants for their self serving interests and failure to reveal their vested interests. (See Minority Report, Mental Health Consumer Committee Representatives, Appendix B, pages 29-30)

Comment

The committee membership in my view was not widely and impartially selected to give a balanced view and outcomes for consumers, as its membership was heavily skewed towards the representatives of commercial providers and Government agencies.

The adoption of the new General Standards took the regulations from prescriptive / specific to aspirational, I believe this was because of the lack of consumer advocate representation.

5.0.2) Below is an extract from the British Medical Journal (BMJ), which talks about "replace legally enforceable regulations with less effective accreditation schemes, **this has had disastrous consequences" and "the result is continuously declining health outcomes for residents**"
The full article is available from the BMJ website
http://www.bmj.com/content/323/7312/566

"Experiences in the United States and Australia have shown the lack of political will to promote the interests of residents against the interests of the industry and its shareholders.

In Australia the industry successfully lobbied to replace legally enforceable regulations with less effective accreditation schemes; this has had disastrous consequences.

In the United States the industry successfully opposed the introduction of robust standards for minimum numbers of staff, and the result is continuously declining health outcomes for residents.

The risks to residents of nursing homes in the United Kingdom are considerable as subsidiaries of large US multinationals enter the United Kingdom; some of these companies have come under scrutiny in the United States for fraud and embezzlement of government funds and for abusing patients.

5.0.3) below is an extract from the paper titled Staffing Regulations for Aged Residential Care Facilities: Consultation Document published by the Ministry of Health (MOH) in 2004.

It appears at that time that there was an acknowledgement from the MOH that more specific directives be prescribed. Unfortunately exclusion of specific recommendations on minimum staffing levels continues to be a weakness in the Standard.

This extract is available from the MOH website.
http://www.moh.govt.nz/notebook/nbbooks.nsf/0/b9019d55a6d7079ecc257702007ee13c/$FILE/staffingregulations.pdf

"The Old People's Homes Regulations 1987 and the Hospitals Regulations 1993 were revoked on 1 October 2004 when section 59 and Schedule 5 of the Health and Disability Services (Safety) Act 2001 (HDSS Act) came into effect.

It is proposed that new regulations be developed to maintain existing minimum staffing levels for aged residential care facilities and support the provision of quality and safe care under the HDSS Act.

Before 1 October 2004 licensed aged residential care providers had to comply with the minimum staffing level requirements set by the Old People's Homes Regulations 1987 and the Hospital Regulations 1993.

From 1 October 2004 providers who have attained certification under the HDSS Act do not have to comply with these two regulations, but need to meet all service standards.

A standard 2.7, Service Provider Availability, of the Health & Disability Sector Standards (NZS 8134:2001) sets out service providers' staffing responsibilities. It is proposed that the standard be supplemented with specific staff requirements in regulations.

In addition, the national Age Related Residential Care Contract (ARRC) sets staffing requirements for the provision of aged residential care by providers who have a contract with a District Health Board (DHB)."

5.0.4) Extract from the Decisions of the Technical Committee P8134 for the Standards Council established under the Standards Act 1988, Section 9, and Outcome-Focused Standards.

"Previous Standards, particularly NZS 8143:2001 National mental health sector Standard, explicitly specified how they would apply to a population range. In the development of NZS 8134, there was a decision to move away from extensively specific inputs, instead concentrating on the outcome to be achieved."

5.0.5) an extract of the General Standards shown below illustrate the vagueness and unenforceable nature of these Standards.

NZS8134.1.4	Safe and appropriate environment		
NZS 8134.1.4.2	Safe and appropriate environment	Facility specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose
NZS 8134.1.4.3	Safe and appropriate environment	Toilets, showers and bathing facilities	Consumers are provided with an adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements

Comment

5.0.6) Note the terminology **"appropriate", "adequate"** in Standards 8134.1.4.2 and 8134.1.4.3. **These are almost legally indefinable.**

Requests from residents for basic hygiene, such as to be provided with a shower a day, are denied by rest-homes with reference to 3 showers a week as an "industry standard" - NZS 8134.1.4.3 only states "**consumers are provided with adequate toilet/shower/bathing facilities",** and this wording provides no recourse for residents.

Providers can and do interpret the standards as they feel appropriate, and historic levels of care are being steadily reduced as cost cutting measures. It is often the case that residents are not aware of rest homes specific interpretations as brochures and other marketing material from providers doesn't include any specific schedules of the standard base level of care.

Even if there is a complaint, providers (even the Health and Disability Commissioner) are not capable or obliged to produce a copy of these standards.

5.0.7) Media Release of the New Zealand Nurses Organisation 2010. The referenced document is available from the NZ Nurses Organisation website
http://www.nzno.org.nz/activities/media_releases/articletype/articleview/articleid/523/rest-home-horror-stories-will-continue
"

Rest home "horror stories" will continue

While "horror stories" of inadequate care and neglect of elderly residents in rest-homes come under the media spotlight from time to time, the sad reality is that such cases are not rare, according to aged care industrial adviser with the New Zealand Nurses' Organisation (NZNO), Rob Haultain.

Two just-released reports by the Deputy Health and Disability Commissioner (HDC), Rae Lamb, detail inadequate care at Villa Gardens rest-home in Christchurch. One details the inadequacies of care of an 88 year-old man who suffered massive weight loss – eight kilograms in ten days – after he transferred to the hospital wing of the rest-home. The other details the care of a woman with dementia, who was not showered for a year.

Commenting on these reports, Haultain said they painted an appalling, but all too common picture, of too few registered nurses with too much work, untrained caregivers and an unsupportive management. "These two cases are a powerful illustration of the conflict between caring and profit. And it is not just within Villa Gardens or the Oceania Group that such conflict is evident. We hear daily from nurses and caregivers working in rest-homes of inadequate care and sometimes outright neglect of elderly residents because there are not enough trained staff to provide even basic care."

NZNO had been campaigning for years for more funding, better pay and working conditions, more training for rest-home staff and legally enforcable staffing ratios. "But our pleas have largely fallen on deaf ears. There seems little political will to tackle the systemic issues that afflict this sector. All our large rest-home chains are overseas owned and their bottom line is a return to shareholders and that can and does mean, too often, there are not enough staff to provide quality care to residents," Haultain said.

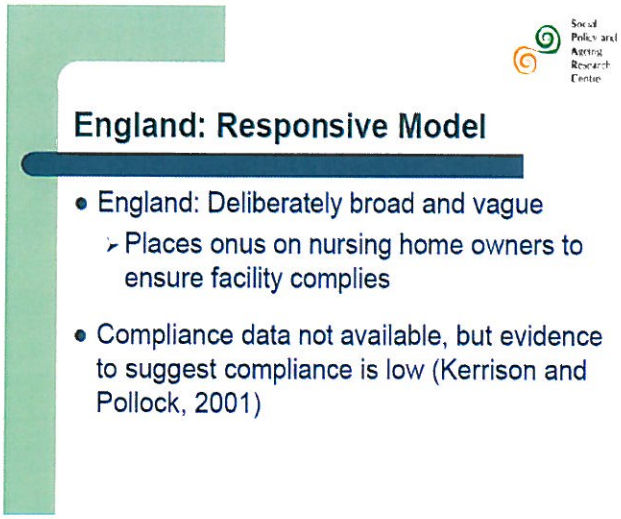
She questioned just how much difference HDC reports actually made. "It is hard to read what those two elderly residents endured at the end of their lives. The deputy HDC can make recommendations and Oceania can apologise profusely to the residents' families for the short falls in care but unless and until the systemic failures that lead to these horror stories are addressed, then there will be more of them."

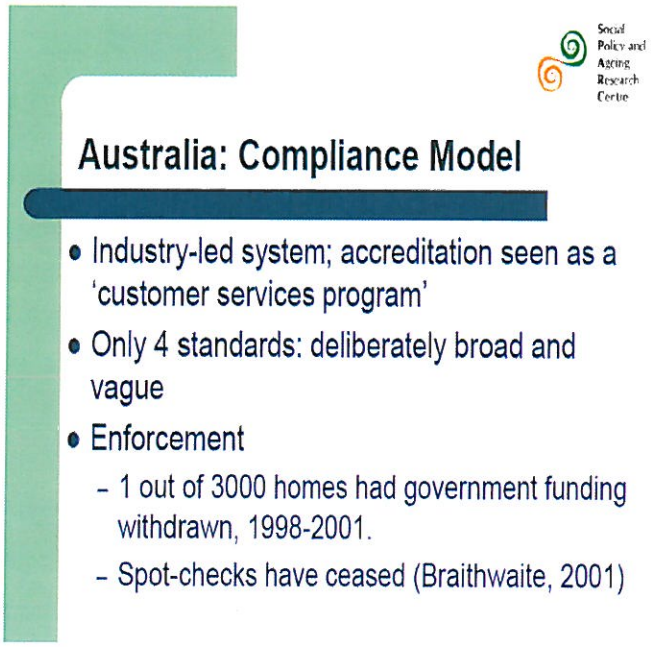
Haultain also said many families found it difficult to complain about the lack of care for their loved ones. "Too often families are silenced, out of fear that if they do raise their concerns, their loved ones will suffer even more, or they simply haven't the wherewithal to complain or the knowledge of how complain to the HDC. *While these two recent reports have highlighted gross inadequacies at one rest-home, sadly there are many similar cases in rest-homes throughout the country which are never exposed to public scrutiny."*

Note the above statement "for years NZNO has been calling for mandated staffing levels in the Sector".

5.1 Experience Overseas

5.1.1) The Social Policy and Ageing Research Centre has published the following conclusions on different models that are aspirational in adoption of there relative general standards. As can be seen no specific industry guidelines has meant low standard of care.





5.2 Numbers of Staff in New Zealand and Overseas Rest Home Care Facilities

5.2.1) Staffing Ratios as they used to apply

1987 Old Peoples Homes regulations
Code for staffing levels Rest Homes

Number of residents	minimum aggregate number of hours to be worked per week by staff	
3-5	60	1.5 FTE
6-10	120	3 FTE
11-15	160	4 FTE

5.2.2) Staffing ratios now recommended in New Zealand

NZS-HB 8163:2005
The recommended Contractual Staffing Ratios (Rest Homes) for subsidised Residents in New Zealand are as follows:
Two staff must be on duty at all times where RN or Manager determines that this is to be required to meet the needs of residents
>30 residents two care staff on duty at all times.
> 60 residents –three care staff on duty at all times
Nb each new care staff is considered "on trial" until competency & fit with the position are established

5.2.3) The below referenced document is available from the Canadian Medical Journal website:
http://www.cmaj.ca/cgi/content/full/172/5/645

"The nursing homes in our study represented 76% (167/221) of the facilities in British Columbia with a level-of-care designation of IC, IC & EC, or multilevel (Fig. 1). Of the 167 nursing homes examined, 109 (65%) were not-for-profit and 58 (35%) were for-profit facilities (Fig. 1). Of the 58 for-profit facilities, 14 (24%) were part of a chain.

The mean number (and SD) of hours per resident-day provided by direct-care staff differed significantly by facility level of care: it was 2.46 (0.33) in IC facilities, 3.06 (0.64) in IC & EC facilities, and 3.18 (0.64) in multilevel facilities ($p < 0.001$). The corresponding numbers for hours per resident-day provided by support staff were 1.05 (0.22), 1.11 (0.28) and 1.17 (0.26) ($p = 0.08$). There was no significant association between facility size and direct-care or support staff hours in the univariate analysis ($p = 0.43$ and $p = 0.36$ respectively)."

It is noted that the mean number of staff hours per resident day in multilevel facilities in British Colombia is **3.18**
In New Zealand the Industry Standard is 1.65 hours per resident day.

In the abstract of this research paper the following conclusion is drawn:
"Interpretation: *Not-for-profit facility ownership is associated with higher staffing levels. This finding suggests that public money used to provide care to frail eldery people purchases significantly fewer direct-cares and support staff hours per resident-day in for-profit long-term care facilities than in not-for-profit facilities."*

5.2.4) The below referenced document is available from the New Zealand Nurses Organisation website:
http://www.nzno.org.nz/activities/media_releases/articletype/articleview/articleid/585/mandatory-staffing-levels-needed-in-resthomes

"Mandatory Staffing Levels Needed in Rest homes

"The New Zealand Nurses Organisation (NZNO) believes the concerns raised by the Auditor-General, in her report on Wednesday, could be partially addressed through requiring residential facilities to have minimum staffing levels.
"Currently there is no requirement on providers to have a certain number of staff working at any one time. Our members frequently report being short staffed and unable to meet patient needs," NZNO Organiser, David Wait said.
"Aged care workers are working with the most vulnerable elderly in our community, caring for their most intimate needs. These elderly have increasingly complex health requirements and there simply needs to be more trained people working in the sector," said Wait.
"The average hourly rate for caregiving is $14 – the same as for people working in petrol stations, or stacking shelves in supermarkets. Caregivers are the majority of the workforce in the aged care sector with a much smaller number of Registered Nurses to support their work. These workers are undervalued by both the government and employers," said Wait.
"Our elderly in resthomes and aged care hospitals deserve better treatment and the government can choose to do something about the current crisis. Legislating for minimum staffing levels to care for our elderly is surely a good first step," said Wait."

5.3 Financials

5.3.1) Grant Thornton Aged Residential Care Service Review, September 2010

http://www.grantthornton.co.nz/Assets/documents/home/Aged-Residential-Care-Service-Review.pdf

Notable items in this report are as follows:

"To achieve the objectives of the costing component, the Review project team:
- Designed the Review Survey instrument
- Promoted the survey initiative to aged residential care providers
- Designed and built survey models
- Reviewed and vetted the provider data submitted
- Developed Greenfield models from combined data sets and consultation with providers
- Established a fair rate of return and capital costs for the provision of aged residential care services."

Table 13
Rest home facility operating costs

Cost component	Greenfield site costs per resident per day	Review Survey average historical costs per resident per day
Care costs	$45.70	$46.19
Catering	$9.10	$10.70
Cleaning	$3.20	$3.21
Laundry	$1.90	$1.97
Property/maintenance	$8.30	$8.30
Administration	$10.50	$11.53
TOTAL	**$78.70**	**$81.90**

Total costs of aged residential care services for an efficient and effective provider

The total costs of delivering aged residential care services on a per resident/day basis under the methodology and assumptions described above, with the varying land value assumptions shown, are presented in **Tables 21-23**:

Table 21
Summary of total costs per resident/day (land price $200/m²)

Facility type	Operating costs	Capital costs	Total costs
Rest homes	$78.70	$69.63	$148.33
Hospitals	$126.60	$69.63	$196.23
Dementia units	$104.25	$69.63	$173.88

Table 22
Summary of total costs per resident/day (land price $350/m²)

Facility type	Operating costs	Capital costs	Total costs
Rest homes	$78.70	$76.61	$155.31
Hospitals	$126.60	$76.61	$203.21
Dementia units	$104.25	$76.61	$180.86

Interpretation of the costing models above appear to show that this report commissioned as a joint project by the DHBs and the Aged Care Association is requesting an average increase of **$79.00** per resident per day or **96%.**

If you extrapolate this increase over the current 34,000 residential care residents x365, the amount requested would increase by **$980 million** for residential care home Residents in New Zealand.
Some observers predict that the current government qualifying subsidy, if the Grant Thornton recommendations are accepted, will have to increase from **$1 billion currently** to **$2 billion per annum** in 2011.
My estimate, at the lower end of the increase in projected numbers (without allowing for inflation), is somewhere over **$3.3 billion by 2026**.

5.3.2) **Capital return:**

Table 21
Summary of total costs per resident/day (land price $200/m²)

Facility type	Operating costs	Capital costs	Total costs
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Dementia units	$104.25	$76.61	$180.86

"Finally, it is generally accepted that investors dealing in non-publicly traded investments demand higher rates of return than indicated by CAPM due to the relative illiquidity of their investment compared to shares in publicly listed companies (such as those that comprise the bulk of the global sample). Applying the above formulae and inputs results in a cost of equity estimate in the range of 14.8% to 17.0%."
Analysis of the above figures shows that on average the providers are suggesting that their capital return and interest should be **$73.12** per resident per day. **Return on capital would range from 14.8% to 17%.**

Contrast this with the rates of pay for the caregivers who are on average paid $14.00 per hour. Also notable is the estimation shown in the Grant Thornton report of the likely annual increase for caregivers over the next 18 years or 0.4% real on $14.00 per hour.

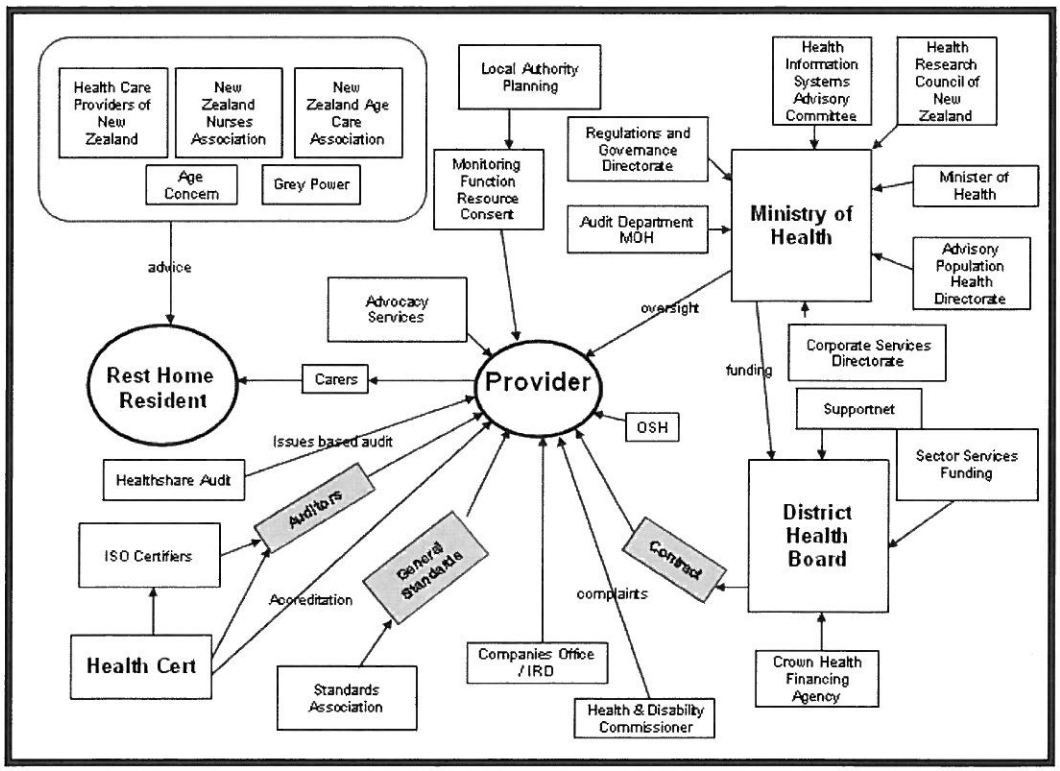
Table 44
Summary results – alternative assumptions

Demand and supply of labour		Scenario A				Scenario B			
		2008	2026	%pa		2008	2026	%pa	
Underlying demand	Bed days	11,189,000	18,132,000	2.7%		11,189,000	15,902,000	1.8%	
	Residents	32,500	52,500	2.7%		32,500	44,500	1.8%	
Realised demand	Bed days	11,189,500	17,842,500	2.6%		11,189,500	14,489,500	1.4%	
	Residents	32,500	51,500	2.6%		32,500	42,000	1.4%	
Labour requirements									
Nurses & managers	Labour required	4,750	7,850	2.8%		4,050	5,900	2.1%	
	Realised Supply	4,750	7,100	2.3%		4,050	5,300	1.5%	
Caregivers & others		19,250	31,350	2.7%		16,850	23,250	1.8%	
Total		24,000	38,450	2.7%		20,900	28,550	1.7%	
			-750						
Average wage									
Nurses & managers		$23	$75	4.1%	Real	$23	$51	1.9%	Real
Caregivers & others		$14	$23	0.4%	Real	$14	$23	0.4%	Real
Gap nurses and managers: demand vs supply %			-10%				-10%		
Gap level			-750				-600		

5.4 Agencies with Input into Residential Care

5.4.1) Diagram of the 23 Government Agencies, NGOs and Residents Representative Associations in New Zealand

As shown below



Comment

The above is an example of a Bureaucratic morass.

It should be noted that the critical component of the delivery of services to the resident, namely the caregiver, is paid on average only $14.00 an hour. With this low remuneration these primary caregivers tend to be transitory and poorly trained.

5.5 Complaints Procedure

5.5.1) **Ineffective complaints process and supervision by the Health and Disability Commissioner**

Comment

If there is a complaint to the Health and Disability Commissioner, the commissioner can, through the DHB, have recourse to an "issues based audit". As shown below this is a policy and documentation audit, not a physical audit .This approach has proven not to be robust enough nor appropriate for the investigation of a specific complaint.

5.5.2) Example of an issues Based audit work-form below

GENERAL SERVICE SPECIFICATIONS			
⇩		**Does the attainment level impact on consumer safety?**	**Performance Indicators**
	✓	**Risk - ☐ Critical ☐ High ☐ Moderate ☐ Low ☐ Neg**	
CI		**Actions required to ensure consumer safety:**	(a) View documented policy/procedure to ensure it meets all Health and Disability Commissioner requirements: (i) All complaints are documented (ii) Complainants are informed of their right to have an independent advocate (iii) Handled in a professional manner by an appropriately designated person (iv) Complaints are fully reviewed in an objective and professional manner (v) Complainants will receive a response within 2 weeks (vi) Clear and accurate records of complaints and subsequent action taken are maintained (vii) Complaints to be handled sensitively with consideration for cultural and other values (viii) The policy offers alternative agencies which complainants can be referred to (b) Complaints procedure is able to be accessed anonymously i.e. the resident, carer or visitors should not have to request a "Complaints form" etc. - Provision of a complaints form to residents/families on admission will not ensure availability when required (c) View a complaint received, does it comply with HDC requirements to substantially respond within two weeks of receiving the complaint (d) Monthly updates if the resolution of the complaint or concern is drawn out. (e) There is evidence of complaints coming to a mutually acceptable resolution (f) Monitoring of complaints and identification of trends if they exist.
FA			
PA			
UA		**By when:** **By whom:**	
	✓		

Comment

Results of issues based audits often result in clear audits that providers have fulfilled all contractual and legislative requirements, even when death has occurred.

5.5.1) The below referenced document is available from the New Zealand Nurses Organisation website:

http://www.nzno.org.nz/activities/media_releases/articletype/articleview/articleid/523/resl-home-horror-stories-will-continue

She questioned just how much difference HDC reports actually made. "It is hard to read what those two elderly residents endured at the end of their lives. The deputy HDC can make recommendations and Oceania can apologise profusely to the residents' families for the short falls in care but unless and until the systemic failures that lead to these horror stories are addressed, then there will be more of them.""

5.4.4) Extract of a Report by the NZ College of Nurses 2010, available from the College of Nurses website.
http://old.nurse.org.nz/elder_person/ep_nurse_strategy_age_care.html

"Current concerns

The Health and Disability Commissioner reported that the second largest group of health care related complaints in New Zealand related to rest homes (Patterson, 2004). The level of complaints has increased from 10 percent to 15 percent of the total number of complaints in 2008 and 2009. This and the resulting media interest in the sector have provided a negative image of the care provided. With the level of complaints increasing so is the exposure to risk for nurses who work in the sector. The New Zealand Nurses Organisation continues to express concern about staffing levels, skill mix and the quality of care."

Comment:

Even if the complainant was capable of proving negligence and neglect the end result would be a letter of apology. Recourse to the Courts is both costly and prolonged and there is doubt of the relative's legal capacity when the complainant is dead.

5.6 Audit Functions

5.6.1) **Consumer report 2009**

Rest home audits failing consumers

22 Dec 2009

Auditor-General Lyn Provost has issued a damning report on rest home care.

The report singles out the Ministry of Health for failing to provide adequate assurance that rest homes are meeting required standards.

The Auditor-General's findings back-up our research on rest home care. Our investigations have found current auditing of the sector is failing consumers. The Ministry of Health received a "Worst" award in our annual Best and Worst Awards for this very reason.

Our research uncovered cases where rest home auditors failed to pick up serious shortcomings in care. We also found that rest homes not meeting required standards can still be certified by the Health Ministry. These findings are echoed in the Auditor-General's report.

The quality of rest home care is a major issue for consumers. We believe rest home regulations need to be strengthened. We want homes to report on key indicators of care such as staffing ratios and infections. Facilities providing a high standard of care have nothing to fear from the release of this information.

There are numerous audit entities and functions with oversight of this industry.

5.6.2) **DAAS**

Designated Audit Agency Scheme

The Designated Audit Agency scheme has been developed by the New Zealand Ministry of Health to ensure that hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001.

The document quoted below is available from the Health Audit NZ Ltd website.(one of the Designated Audit Agencies)
http://www.haudit.co.nz/Auditing/Auditing+Process.html

"Auditing process involves an audit team assessing how effectively a management system is working. In essence the audit process will determine the extent to which the organization is managed in accordance with the chosen audit criteria contained in standards.

***It is important to recognise that an audit is not an inspection**. The auditor is not trying to "catch-out" personnel doing the wrong thing. Rather, the audit process will see if problems – real and potential – are being identified and managed effectively.*

For the audit to be successful, your management team should ensure that all personnel know when the audit is scheduled to take place, the purpose of the audit and what is expected of them.

There are 9 accredited DAA's performing Surveillance Audits on an 18 month and 3 yearly timetables.
The Provider (rest home) appoints and pays for the Audit by these agencies.

5.6.3) The Office of the Auditor-General comments about this as a risk, in the document Performance audit report - Effectiveness of arrangements to check the standard of services provided by rest homes
http://www.oag.govt.nz/2009/rest-homes/docs/rest-homes.pdf
Section 4.3 of this report states"
"General risk management

4.3 The design of the system for certification has some inherent risks. In 2008, the Ministry acknowledged that the risks in rest homes choosing their DAA, and the competition between DAAs for business, had the potential to create a "moral hazard". Managing the performance of the different DAAs is also a challenge for the Ministry, particularly because most of the auditors who work for DAAs are self-employed contractors. In September 2009, the Ministry developed a risk register for managing these and other risks. In our view, this should have been introduced sooner, given the level of risk that the Ministry had known about and acknowledged in Cabinet papers written in 2008."

5.6.4) **Healthcert** - http://www.moh.govt.nz/moh.nsf/indexmh/certification-contactus

Healthcert is responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001.

Healthcert s role is to administer and enforce the legislation, issue certifications, review audit reports and manage legal issues.

5.6.5) **HealthShare Ltd**

HealthShare Limited is designated to audit the provision of the following health care services:

- hospital care (as defined in section 4(1) of the Act);
- rest home care (as defined in section 6(2) of the Act); and
- residential disability care (as defined in section 4(1) of the Act).

5.6.6) **JAS –ANZ** - http://www.jas-anz.com.au/

JAS-ANZ is the government-appointed accreditation body for Australia and New Zealand responsible for providing accreditation of conformity assessment bodies (CABs) in the fields of certification and inspection. Accreditation by JAS-ANZ demonstrates the competence and independence of these CABs.

JAS-ANZ accredits 80 CABs who in turn certify some 60,000 organisations. Including accreditations and technical assistance projects JAS-ANZ provides services in over 20 countries.

5.6.7) **HDANZ** Training and certification –
http://www.healthaudit.co.nz/auditor_competencies/nzqa_training_courses

NZQA Training Courses

Health and Disability Auditing New Zealand Limited (HDANZ) is accredited by the New Zealand Qualifications Authority under the provisions of the Education Act 1989 to provide education and training based on

a) Unit 8086 Demonstrate quality management systems (level 4) and
b) 8084 Audit quality management systems for compliance with quality standards (level 6).

Auditor Training Course (Whakatere Tikanga Kaute)
This is a 5 day course intended for persons who wish to be quality auditors (internal and/or external). People credited with this NZQA Unit Standard 8086 (level 4, credit 4) are able to demonstrate knowledge of:

- quality auditing,
- preparation for auditing,
- quality standards,
- auditor behaviour,
- registration of auditors, and
- Accreditation of certifying bodies.

Commentaries by

5.6.8) **NZ Nurses Organisation**

http://www.nzno.org.nz/activities/media_releases/articletype/archiveview/month/10/year/2009

"Our members have long called for spot auditing and we are well aware of some shocking incidences which have been discovered by spot audits in the past", NZNO industrial adviser Rob Haultain said.

"But are concerned the audits the Minister has announced are not genuine spot audits. The audits will be carried out in workplaces where the owners have volunteered to be "spot audited" so they know they will be audited sometime in the next couple of months," Haultain said.

"The purpose of spot auditing is to create a culture shift towards provision of high quality care. Providers who are not providing such care should be able to be found out through a variety of mechanisms, including spot audits,"

"Our members tell us that they are intensely frustrated that their employers are able to turn on a good show for auditors but once the audit is completed things can return to how they were before."

"We call on the government to extend the spot audits to all residential aged care facilities where concerns about the care have been raised by families, friends and workers," Haultain said.

5.6.9) The Auditor-General of New Zealand, in the document Performance audit report – "Effectiveness of arrangements to check the standard of services provided by rest homes"

http://www.oag.govt.nz/2009/rest-homes/docs/rest-homes.pdf

Stated in the overview section:

"Auditing by designated auditing agencies has been inconsistent and sometimes of poor quality. Audits of rest homes can never eliminate the risk of poor care. Audits can only establish whether, at a particular point in time, rest homes have the systems and processes in place to minimise that risk."
"There are examples from 2008 and 2009 where DAAs have failed to find or report instances where rest homes have not met the criteria in the Standards. Serious failures in the care of residents have been identified later by other regulatory bodies. The frequency of these events may have been low, but they are significant because the failings are serious."
" Most (65%) DHBs do not consider certification to be reliable. Fourteen DHBs carry out their own auditing of rest homes (usually through their shared service agency), which largely duplicates the auditing carried out by DAAs. This diverts scarce resources from other monitoring work that could focus more on improving the quality of care in those rest homes where the risk to rest home residents is greatest."

5.7 Age Related Residential Care Services

5.7.1) Available from the MOH website
http://www.moh.govt.nz/moh.nsf/indexmh/hop-longtermresidentialcare-arrcaqreement

Comment

The terms and conditions for service provision, audit access and process are specified in this bi-lateral agreement. There is no input from the residents or representatives of residents for the provision of services under this contract.

Notable in this contract is the section dealing with service specifications (section D of the contract).

> ***SECTION D: SERVICE SPECIFICATIONS – GENERAL***
>
> **D1. COMPLIANCE WITH LEGISLATION AND STANDARDS**
>
> D1.1 You must comply with all relevant legislation, including, but not limited to:
>
> a. Food Hygiene Regulations 1974;
>
> b. Health Act 1956;
>
> c. Health and Disability Commissioner Act 1994;
>
> d. Health and Disability Services (Safety) Act 2001;
>
> e. Health and Safety in Employment Act 1992;
>
> f. Health Practitioners Competence Assurance Act 2003;
>
> g. Medicines Act 1981;
>
> h. New Zealand Public Health and Disability Act 2000;
>
> i. Privacy Act 1993;
>
> j. Social Security Act 1964.
>
> D1.2 You must comply with any legislation that supersedes, substitutes or amends the legislation listed in clause D1.1 above.
>
> D1.3 You must comply with all Approved Service Standards.

Compliance with relevant legislation is noted and D1.3 "you must comply with all approved service standards." As discussed earlier in this report these standards are so aspirational as to be almost meaningless, and compliance not measurable.

5.8 Not for Profit vs. For Profit

There has been a large body of Research on the two models of care delivery. Below are some views

5.8.1) From a Canadian Medical Journal Association research article:

http://www.cmaj.ca/cgi/content/abstract/172/5/645?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=%22for-profit+health+care+delivery%22&searchid=1&FIRSTINDEX=0&sortspec=date&resourcetype=HWCIT

*"**Background:** Currently there is a lot of debate about the advantages and disadvantages of **for-profit health care delivery.** We examined staffing ratios for direct-care and support staff in publicly funded not-for-profit and for-profit nursing homes in British Columbia.*
***Methods:** We obtained staffing data for 167 long-term care facilities and linked these to the type of facility and ownership of the facility. All staff were members of the same bargaining association and received identical wages in both not-for-profit and for-profit facilities. Similar public funding is provided to both types of facilities, although the amounts vary by the level of functional dependence of the residents. We compared the mean number of hours per resident-day provided by direct-care staff (registered nurses, licensed practical nurses and resident care aides) and support staff (housekeeping, dietary and laundry staff) in not-for-profit versus for-profit facilities, after adjusting for facility size (number of beds) and level of care.*
***Results:** The nursing homes included in our study comprised 76% of all such facilities in the province. Of the 167 nursing homes examined, 109 (65%) were not-for-profit and 58 (35%) were for-profit; 24% of the for-profit homes were part of a chain, and the remaining homes were owned by a single operator. The mean number of hours per resident-day was higher in the not-for-profit facilities than in the for-profit facilities for both direct-care and support staff and for all facility levels of care. Compared with for-profit ownership, not-for-profit status was associated with an estimated 0.34 more hours per resident-day (95% confidence interval [CI] 0.18–0.49, $p < 0.001$) provided by direct-care staff and 0.23 more hours per resident-day (95% CI 0.15–0.30, $p < 0.001$) provided by support staff.*
***Interpretation:** Not-for-profit facility ownership is associated with higher staffing levels. This finding suggests that public money used to provide care to frail eldery people purchases significantly fewer direct-care and support staff hours per resident-day in for-profit long-term care facilities than in not-for-profit facilities."*

5.8.2) From the British Medical Journal

http://www.bmj.com/content/339/bmj.b2732.full.pdf

"Concerns about quality of care in nursing homes are widespread among academic investigators, the lay press, and policy makers. Whether a facility is owned by a for-profit or a not-for-profit organisation may affect structure, process, and outcome determinants of quality of care. In the United States, for example, two thirds of nursing homes are investor owned, for-profit institutions; in the United Kingdom, more than half of healthcare beds belong to independent nursing homes for older people, most of which are operated by for-profit institutions. The type of ownership of nursing homes in Europe varies; countries with previously dominant public healthcare systems (such as Poland) now seek privatisation. In Canada, 52% of nursing homes are in for-profit ownership, and not-for-profit care is evenly split between charitable or privately owned not-for-profit facilities and government or publicly owned not-for-profit facilities. Both for-profit and not-for-profit nursing homes may have both public and private funding.

Conclusions: This systematic review and meta-analysis of the evidence suggests that, on average, not-for-profit nursing homes deliver higher quality care than do for-profit nursing homes. Many factors may, however, influence this relation in the case of individual institutions."

6.0 Appendices List

COMMITTEE REPRESENTATION

This Standard was prepared by Technical Committee P 8134 for the Standards Council established under the Standards Act 1988.

Committee Member	Nominating Organisation
Frances Acey	Disabled Persons Assembly (New Zealand) Inc.
Victoria Brown	Association of Residential Care Homes (New Zealand) Ltd
Trudi Bryant	National Division of Infection Control, New Zealand Nurses Organisation (NZNO)
Lee Cordell-Smith	South Island Shared Service Agency Ltd
Cathy Cummings	New Zealand Association of Designated Audit Agencies
Elaine Elbe	Accident Compensation Corporation (ACC)
Robyn Fraser-Craw	Platform
Jaime Greaves	Mental Health Commission
Gillian Grew	Ministry of Health
Joanne Hayes	NGO Working Group
Judy Hindrup	New Zealand Council of Christian Social Services
Anna Hutchinson	Canterbury District Health Board
Judith Johnson	Healthcare Providers New Zealand
Dr Mark Jones	Australasian Society for Infectious Diseases (New Zealand Branch)
Dr Don Mackie	Council of Medical Colleges in New Zealand
Carole Maraku	Te Upoko O Nga Oranga O Te Rae
Fiona Parrant	National Residential Intellectual Disability Providers (NRID)
Elizabeth Powell	Pacific Health Advisory Committee
Catherine Rae	District Health Boards
Rosaleen Robertson and Barbara Fox	New Zealand Private Surgical Hospitals' Association
Dick Stark	Grey Power Federation
Suzy Stevens	KITES Trust (resigned from the committee on 28 March 2008)
Judi Strid	Office of the Health and Disability Commissioner
Renee Torrington	Wellink Trust (resigned from the committee on 28 March 2008)

Mental Health Consumer Committee Representatives Report on

The Ministry of Health and Standards New Zealand

Review of the Health and Disability Service (Core) Standard: NZS8134

Minority Report

January 2008

Introduction

This report is presented by 2 mental health consumers employed by Wellink and Kites Trusts who were members of the Expert Committee (2007) during part of the review. It is solely in relation to the Health and Disability Service (Core) Standard NZ8134 (draft version for ballot).

The Health and Disability suite of Standards were approved by the Minister of Health under Section 13 of the Health and Disability Services (Safety) Act 2001. The Minister decided to amend these Standards in line with feedback received during the stakeholder consultation.[1]

The Health and Disability Services (Safety) Act was under review during 2007 by the Ministry of Health (MOH) to include Public as well as Private Hospitals. This has commenced the introduction of a new licensing regime by the MOH. This new regime created the need for a review of the Standards and a revised Standards process.

Background

Expert Committee (2007)

Standards New Zealand's role was to "work with the Expert Committee to revise the amended Standards with a view to ensure:

- The content is in line with the results of stakeholder consultation;
- The revised Standards meet any legislative requirements, including the requirements of the Health and Disability Services (Safety) Act 2001;
- The amended Standards are in the public interest, having regard to the extent to which compliance would be likely to ensure the safe provision of services of that kind to the public, and the likely costs to providers of compliance, in accordance with section 19 of the Health and Disability Services (Safety) Act 2001.
- No additional compliance requirements should be placed on providers unless agreed to by the Expert Committee and Ministry Representative; and
- Minimal duplication within and between the four Standards."

Standards New Zealand states that the principles guiding the work of the each Expert Committee member are to:

- Ensure nominating organisations and key interest group views are considered
- Have a commitment to working openly and collaboratively with the Committee and Standards NZ
- Gain widespread support from providers and consumers for the standard being developed
- Ensure evidence based criteria are applied to the Standard, as much as possible.
- The Committee shall ensure:
  - The standards are measurable and auditable
  - The standards are not open to misinterpretation
  - The technical content and the means of expression are clear and concise

[1] Cited in Standards New Zealand - P8134 Terms of Reference - Version 0.3

- The standard ensures a safe (including culturally safe) outcome for consumers of the services.

Issues

1. Conflicts of Interest

The Committee included representatives from a range of (nominating) organisations. Some of them were providers of health and disability services with a commercial interest as either owners or managers of private, fee for service organisations. To our knowledge no conflict of interest was ever declared or recorded by these members.

We are of the opinion that people on the Committee from private, fee for service organisations held a conflict of interest in relation to the development of a consumer focused standard.

2. Representation

The Health & Disability (Core) Standards legislate how services must be provided to consumers of those services. It is legitimate to have a range of perspectives available however there was an imbalance of providers to consumers. The Terms of Reference for the review process states that "Committees are representative and balanced and consensus decision making principles are employed". Of the 23 listed Committee members a mere 3 specifically provided a 'consumer' rather than a 'provider', 'governmental' or 'organisational' perspective. These were: Frances Acey (Disabled Person's Assembly), Renee Torrington - mental health consumer (Wellink Trust) and Dick Stark (Grey Power). Later, in August 2007 a second mental health consumer was allowed onto the Committee but the 2 consumers had to share the one ballot vote.

We argue that as the National Mental Health Standard was being incorporated into the Core Standard that from the outset of the meetings in April 2007 there should have been significantly more mental health and addiction service consumers represented on the Committee.

4. Public Comment

The public 'consultation' process for the draft was in the form of written 'public comment' versions being sent out to stakeholders. It was not known how these stakeholders were identified for inclusion.

.

5. Presentation and Quality of the draft Core Standard

The draft Core Standard that was circulated for ballot vote is fragmented and poorly drafted. In some areas it does not flow well which indicates that there may have been multiple writers and varied influences from different parties during the drafting.

The ballot draft is not a document that we feel could be formatted into a standard that would be easy to follow, or clear and straight forward for consumers of mental health and addiction services to pick up and use. While we appreciate that the audience for the standard includes auditors and service providers, we contend that it should be written so that consumers can easily use it to advocate for and receive quality health and disability services.

(Abridged)

Submitted on: 22nd January 2008

Signed:
Renee Torrington
Wellink Trust

Signed:
Suzy Stevens
Kites Trust

Health and Disability Services (Safety) Act 2001 No 93 (as at 01 October 2008), Public Act

Part 4 Miscellaneous
53 Regulations

- (1) The Governor-General may, by Order in Council, make regulations for any or all of the following purposes:

o (a) prescribing in respect of services that are rest home care, or geriatric services that are hospital care, a means by which there can be ascertained—

- (i) minimum numbers of nursing and other care staff who must be on duty (at any time, or at different times) in premises in which the care is being provided; and
- (ii) any minimum qualifications any of them must have:

o (b) prescribing fees for the purposes of this Act, or a means by which fees for the purposes of this Act may be calculated or ascertained:

o (c) providing for any other matters contemplated by this Act, necessary for its administration, or necessary for giving it full effect.

(2) While there are in force service standards for providing health care services of any kind that state minimum levels of staffing in premises in which services of that kind are being provided, regulations under subsection (1)(a) do not apply in respect of services of that kind.

6.4 Appendix D

Old Peoples Homes Regulations 1987
Staffing Ratios Levels

"

36. Staff –

(1) Subject to sub-clauses (2) to (5) of this regulation, and except as may be permitted by the Director-General in any particular case if the Director-General is satisfied on reasonable grounds that it would not be harmful to the welfare of residents, the minimum aggregate number of hours to be worked per week by the staff (including the manager) employed in a home (whether for payment or otherwise) shall be as follows:

Number of residents	minimum aggregate number of hours to be worked per week by staff
3-5	60
6-10	120
11-15	160
16-20	200
21 or more	200, plus 40 additional hours for every four additional residents or part of that number

6.5 Appendix E Audit Tool for measuring compliance with the Agreement for Health and Disability Services (Aged Care Residential Services)

http://www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/92a4ff3c093bbe18cc256b9c000d84ee/$FILE/aged-care-contract-audit-tool-generic-final.doc

6.6 Appendix F Tony Ryalls response

Office of Hon Tony Ryall
Minister of Health
Minister of State Services

19 January 2011

Mr G Harper
RD3
Ohauiti Road
TAURANGA

Dear Mr Harper

Re: Report on the Dysfunctional Provision of Rest Home Care and Funding in New Zealand.

Thank you for your letter of 22 December 2010 and the enclosed copy of your above report. I appreciate the opportunity to read and comment on the report before the planned release to the public on 21 January 2011.

I want to emphasize that this Government is committed to continue working to ensure older people in aged residential care receive safe and appropriate care.

My replies to your correspondence of May 2010 and July 2010 cover many of the issues you have raised in your report.

I have responded to each of the recommendations made in your report below.

(1) The Health and Disability Sector Standards: NZS 8134 should specify the minimum provision of services.

In 2001, a move was made from a regulatory regime that was "input" focused to a quality and safety approach that provided opportunity for providers to identify and assess safety risks and take steps to address those risks. This move was made following considered review of overseas research.

The emphasis is on improving the safety of services for consumers' health and disability services. The intent of the standards is to guide the provision of safe and reasonable quality services. The standards are outcome focused and contain general statements, service outcomes, procedures or techniques to guide providers in offering services safely and at a reasonable cost.

The Health and Disability Services (Safety) Act 2001 (The Act) requires the Minister of Health of regularly review the existing standards (s24 of the Act). A review was undertaken in 2006 which included consideration of the views of key stakeholders. This process resulted in revised Standards being issued in 2008. In 2012 I will consider whether a further review of the Standards is required.

(2) Alternative structures to established Rest Homes should be investigated for the delivery of aged care services and funding; and

(3) It is in the New Zealand Government's fiscal interest to investigate alternative models of funding and delivery of services.

You will be aware of the report on the Aged Residential Care Service Review published in September 2010. This review was commissioned by the aged residential care sector and the District Health Boards to comprehensively assess the cost, capacity and service delivery implications of the increasing numbers of older New Zealanders likely to require residential care in the future.

The fifteen key recommendations from the report include consideration of alternative models of care and provision of sufficient number of beds to meet the need for residential care including the funding requirements to enable this to happen.

A working group has been established to consider all the recommendations of this report. This work is ongoing.

(4) Increase the minimum staffing levels in Rest Homes in New Zealand.

In your report you draw comparisons between the current minimum staffing requirement and the 1987 standard. The problem with the 1987 standard was that providers took that ratio as all that was necessary rather than as a minimum. Moreover the 1987 standard was lower than the current minimum recommendation. Using your example of 1 staff member to 10 residents, 1 staff member at all times is 168 hours per week (24 hours times 7 days) which is greater than the 120 hours you quote from the 1987 standard.

You also make a comparison between the NZ industry standard and staff hours in British Columbia. However, the Ministry of Health advise me that New Zealand facilities have higher staffing ratios than the industry standard and are similar to British Columbia.

The Health and Disability Sector Standards and the DHB Aged Related Residential Care contract require aged residential care providers to provide sufficient staff, of appropriate skill mix, in an aged care facility at all times to ensure that the assessed needs of the residents are safely met. Provides are required to have a mechanism in place that ensures the overall level of resident need is assessed and staffing adjusted accordingly.

The Standards New Zealand Handbook: *"Indicators for Safe Aged-care and Dementia – care for consumers"* (2005), includes an indicator on safe staffing. This is available to all providers and is used by many providers as a quality improvement tool.

(5) The multitude of Agencies should be more simply structure with possible amalgamation of government funded functions.
(6) A specific agency should be tasked with the responsibility for Aged Care and substantial monetary penalties are available for breaches of the Act.

The matter of possible amalgamation of agencies involved and a specific agency tasked with the oversight of aged care was covered in my correspondence to you in July 2010. My thoughts on this matter remain unchanged. Within the aged care system each agency has specific roles and responsibilities. In practice HealthCERT, DHBs, and the Health and Disability Commissioner are in regular contact and work collectively on matters relating to aged care.

Section 54 of The Act allows for monetary penalties for breaches of the Act.

(7) The audit function should be rationalized to one agency tasked with auditing, certification, and training.

While the Ministry has not gone as far as appointing auditors, providers are required to select a Designated Audit Agency (DAA) from a group of organisations that have achieved accreditation with an approved accreditation body.

Your criticism of the audit programme is noted, however, your report has not taken into account the improvements made since the release of the Office of the Attorney General's report *"Effectiveness of arrangements to check the standard of services provided by rest homes"* (2009).

In April 2009 the Ministry established a project to improve the effectiveness of aged residential care provider audits. The project included enhancing designated audit agency quality to improve the consistency and reliability of audits, the introduction of spot audits and arranging for audit reports to be made available on the Ministry of Health web site. This work is ongoing.

(8) When a residential care contract is let by the DHB to a Provider, Consumer Representatives should have an input into the terms and conditions of service. Clauses in the contract should give DHBs greater enforceability over breaches.

The Aged Related Residential Care (ARRC) contract is reviewed each year. Issues for review are sought from all providers and from all DHBs. The issues put forward are based on many factors but often relate to occurrences within residential care facilities that have arisen throughout the year which may be a national issue that can be addressed by way of a change to the contract.

These occurrences are often resident driven i.e. complaints received from individuals or family members, from an association such as Age Concern or Grey Power or from a support agency such as the residential care line.

So whilst consumer representatives have no role in the negotiation process between the DHBs and Providers over the contract they do have many ways that they can input into issues to be negotiated and can even suggest wording that they consider should be included.

In regard to breaches the ARRC contract includes actions that can be taken. Generally a DHB will commence dialogue with parties concerned around a breach and depending on the severity or materiality of the breach determine the timeline for rectification prior to next steps which could involve actions ranging from withholding of payments, commencement of a disputes resolution process through to immediate termination of contract and removal of residents. Each breach will be treated on its merits and its impact on the safety and quality of care that residents are receiving.

The following recommendations were covered in previous correspondence and my comment remains unchanged.

(9) The Department of Labour should have jurisdiction over safety issues affecting residents in Rest Homes.

The Department of Labour responsibility is to work to ensure safe work practices and work environment6s for workers rather than residents. Resident safety rests more appropriately with health agencies.

(10) Advocates (or relatives of the residents) should be present at the assessments of residents in rest homes, and assessments should be conducted by an independent body, not internally assessed.

Section D16.3 Care Planning, of the DHB ARRC contract, requires providers to offer the resident and their family the opportunity to have input into a resident's care planning process. The resident has a right to refuse to have anyone else present. As previously discussed the responsibility for ongoing assessment of a resident's needs sits more appropriately with the facility staff as they are better able to identify any change in a resident's condition and act quickly to review the resident's need and adapt the care plan accordingly.

(11) Before contracts are let, the financial capacity of the provider should be more stringently assessed.

I am advised that DHBs have a mechanism for assessing the financial capacity of prospective providers before a new contract is let. This evaluation process considers their capacity to deliver the proposed services, including their financial capacity. DHBs also run reference checks and examine information held at the Companies Office.

When an actual failure occurs the DHB facilitates the transfer of residents to other facilities.

(11) A copy of the Standards should be freely available (without cost) to the consumers of aged care, perhaps with a current copy having to be available at the rest home themselves.

I am advised that the Standards are available on line on the Ministry of Health's web site (http://www.moh.govt.nz/moh.nsf/indexmh/certification-standards), however, these are in read only format and cannot be printed.

It would be expected that all aged residential care facilities will have a copy of the Standards and it should be possible for the facility copy to be made available to residents, or their families, on request.

I believe there has been measurable improvement in the audit process over the past year. I have been advised that a comparative analysis to identify the level of improvement in DAA performance will be possible within the next year.

I give you my assurance that the needs of our vulnerable population of older people, especially those who reside in aged care facilities, will remain a priority for this government.

Yours sincerely

Hon Tony Ryall
Minister of Health