

Experiences of nursing in older care facilities in New Zealand

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Abstract. To examine issues related to the working life of registered nurses in residential care for older people in New Zealand, 48 registered nurses completed surveys ($n = 28$) or participated in discussions ($n = 26$) regarding their work roles, continuing education and interactions with specialist nurse services when providing care for older people living with chronic illnesses. This nursing workforce is characterised by ageing, relative isolation, reduced confidence and few opportunities for induction of new graduates. Registered nurses reported their struggle to deliver the appropriate quality of care to residents as acuity increases, general practitioner availability decreases and the opportunities for increasing their knowledge and competence remain limited. The provision of nursing services in residential care for older people is an area of growing concern to many Western countries. Nurse practitioners offer opportunities to improve the quality of residential care.

What is known about the topic? The lack of registered nurses generally and the more critical shortage in residential care is well known. **What does this paper add?** This paper explains the impact on the current and future viability and the quality of registered nurse services in an area of service where acuity continues to rise and the demand for nursing services is increasing. **What are the implications for practitioners?** Nurses in older care settings often express a sense of isolation and note limited career development despite their passion for serving the frail older person. The establishment of nurse practitioner (gerontology) roles offers the potential for improved quality of clinical care for residents and clinical champions for development of nursing services.

As with other Western nations, New Zealand has an ageing population, which is expected to have a large impact on the country's health and welfare sectors, the availability and development of its workforce and future economic prosperity. The demands of older populations will be heightened as the increasing numbers of people exposed to hypertension, less physical exercise and altered diets are realised.¹ This will have a huge impact on the nature and use of the health sector and on workforce capacity.

One segment of the nursing labour market already under pressure is that of nurses who

provide the care of older people in residential settings. This paper explores the experience of working in this type of environment and the issues these nurses face.

Background

The older person in NZ

As the public health system becomes overwhelmed by the increasing acuity and chronicity of patients, so too does the need to transfer unwell older adults into the residential care setting. In 2006, 42500 older New Zealanders received

residential care subsidies,² with around 850–900 such facilities spread throughout the country.³ Full-time care is only deemed appropriate for those whom needs assessors consider require ‘high’ to ‘very high’ support. Residential care facilities provide 24-hour care, 7 days a week, and residents are either subsidised or private. Residents have to be assessed as requiring 24-hour care to be admitted. A fully subsidised resident receives approximately NZ\$88 dollars a day. Private geriatric hospitals are usually part of residential care facilities and provide hospital- level care to residents who are sick and dying.

The nursing workforce

In 2004, the New Zealand Institute of Economic Research (NZIER)⁴ quantified the demand for health services against the predicted supply of health workforce personnel. They calculated that by 2021, depending on the scenario, the excess of labour demand over supply was projected to be equivalent to between 28 and 42% of the 2001 workforce.

A nursing workforce survey commissioned by the Ministry of Health⁵ revealed a workforce with fragile capacity, characterised by an older age range in community and residential settings. There were also widespread reports of significant barriers in access to education and professional development, and minimal evidence that new graduates were able to find supported positions in residential care settings. The evidence demonstrated that the sector was not well positioned to support and sustain the demands of core policy without significant investment and development.

The Nursing Council of NZ (NCNZ), through routine data collections, reported that 8.9% of the registered nursing workforce was employed within the field of older care. The majority were NZ European, with an average age of 51 years (NCNZ data provided for 2007). Sixty-four nurses were reported as being in the 70–80 years age range and over 600 (14.5%) were older than 60 years. A survey of 919 residential care facilities in NZ⁶ found alarming turnover rates, with approximately half of the staff having moved during the previous 2 years. These authors also noted that 46% of the nursing staff within their surveyed facilities were between 46 and 60 years of age. The lack of sufficient nurses employed in the older care area was acknowledged by the New Zealand Nurses’ Organisation (NZNO) in their submission to the Ministry of Health on the Staffing Levels for Aged Residential Care document.

Short staffing is a reality in this sector. Caregivers and nurses in aged care facilities report daily that workloads are unmanageable. There is a basic entitlement for staff working in the sector to have transparent systems in place to ensure that the staffing numbers are commensurate with the type of care their profession, their employer and the residents/consumers expect. Nurses and caregivers have the right to ensure there are systems established that enable them to deliver appropriate and safe care.⁷ (p. 4)

Within the study region there are 255 registered nurses (RNs) working in 40 different older care facilities (data for 2007 supplied by the NCNZ).

The study

The aim of this study was to understand the experiences of nurses working in the residential care environment of one District Health Board (DHB) region. The specific focus was on the issues with work roles, continuing education and interactions with specialist nurse services while providing care for people living with one or more of three chronic illnesses (diabetes, cardiac and respiratory conditions). Approval for the research was received from the NZ Central Ethics Committee.

Methods

Sample

Ninety-seven questionnaires were distributed to residential care nurses through a mail-out that utilised the local Nursing Development Team's contact database. Six weeks later, a follow-up reminder postcard was mailed to those who had not yet responded. This produced a total of 28 participants, giving a response rate of 28.9%. Due to this poor response we decided to hold, in addition, a series of focus groups with nurses working within this environment. Following further ethics approval,

permission was sought from facility managers and flyers were posted in five residential care businesses in the study region. This resulted in 26 RNs volunteering to participate. Six nurses participated in both forms of data collection. All of the nurses were female and their ages ranged from 23 to 66 years with a mean age of 49.9 years. With respect to ethnicity, 92.9% were NZ European, 3.6% Maori and 3.6% 'other' non-specified.

Materials

Survey questions covered a range of topics including: sociodemographic details; nursing registration and qualifications, access to and uptake of continuing nursing education and the reciprocal receipt/provision of nursing expertise in relation to the three chronic conditions central to this research project. The focus group discussions were based on a set of questions designed to explore nurses' perceptions of their relationships with specialist nursing services, staffing adequacy, continuing nursing education and quality of care provided to residents.

Procedure

The self-report questionnaire was mailed to potential respondents with the study's background information sheet, invitation to participate, and an addressed freepost return envelope. Focus group discussions were led by the principal investigator and data were collected by independent note-taking during each group discussion. The note taker, while not recording all data verbatim, did capture statements which seemed strongly felt or which served to summarise the discussion. Notes taken were subjected to thematic analysis in which core themes were developed based on repetition, commonalities and strongly supported areas raised by participants. An inductive process was used to order the data according to recognised patterns within each focus group, and these data were then collated across the data set according to identified storylines. The storylines were then collated according to several conceptual categories. A final read cross-checked for the identified storylines and highlighted textual samples which best captured the storylines in the analytical framework.

Results

The dual recruitment and data collection procedures meant that different information was provided by each of the methods. We present in this section the themes relating to topics where there was overlap in question/discussion content, and then the themes which relate to the surveyed or focus group nurses. There are a number of ecological stresses impacting on the nurses caring for older adults in residential settings: the ageing RN workforce, lack of clinical skills and education, professional nursing support, advantages and disadvantages of residential care for chronic illness care, lower job satisfaction, accountability issues and lack of timely intervention by general practitioners.

An ageing RN workforce

The data captured the older age range of residential care nurses (mean = 49.9) in line with NZ's national data. In the focus groups, nurses spoke with concern and passion about the obvious ageing of themselves and their colleagues and the difficulty of attracting younger graduates. They described the demanding nature of the work, physically and mentally, and the challenges of remaining in such demanding bedside practice. Minimal RN staffing levels meant few, if any, opportunities to provide supervision and support of a new graduate, and therefore placements were reported as being rarely or reluctantly offered to new graduate RNs. Shrinking staffing levels have increased the workload of individual RNs and created physical and mental stress for those who remain. Nurses did not consider this a safe environment for the induction of new graduates.

Lack of clinical skills/education of RNs

Survey data revealed that only just over a quarter (28.6%) of the participants had a bachelor degree and none had a master degree. At the time of the survey, 28.5% reported being involved in further tertiary education during the previous 2 years. Surveyed nurses reported that their practice environments were on average 'moderately supportive' of their continuing nursing education (CNE). The nurses were asked about existing barriers to education, and were allowed to describe more than one. Their responses included: work/life balance (22); cost of courses (19); clinical release time (17); lack of confidence

(5 – in one case in tutors/lecturers); equitable access (3); employer (2); lack of motivation (1); and age (1).

The number of hours of paid study leave over the previous 2 years ranged from 5 to 155 with a mean of 57.2 hours. The hours for which the nurses were paid ranged from 0 to 150 (mean = 41.1) and unpaid study leave ranged from 0 to 100 (mean = 16.1). CNE workshops or seminars attended in the previous 2 years included diabetes (12), respiratory (6) and cardiac conditions (2).

We noted inconsistency between the survey findings and focus group content with respect to accessing ongoing professional development. Focus group discussions revealed that the predominantly privately owned residential settings appeared considerably disconnected from the normal processes for ongoing professional development: 'I have worked here for 12 years and I have had no paid professional development time', and 'I wouldn't know how to ask or where to start'. The situation seemed to be influenced by lowered expectations on the part of the RNs and the lack of nurse-focussed leadership in such environments. In the one setting where clear nurse leadership was present there was a noticeable difference in the awareness and uptake of supported postgraduate or short-course education.

In the survey nurses were asked whether they would like further education/experience in providing nursing care and information to patients and their caregivers, in relation to three chronic conditions. The responses of the 28 total respondents were overwhelmingly positive in that 20 indicated they would like further education/experience in diabetes care, 26 in relation to heart conditions and 27 in respiratory care.

Professional nursing support

Surveyed nurses were asked to indicate the types of nurses they had consulted during the past 2 years in planning care for

people with chronic conditions, and to rate their level of satisfaction with the expertise supplied. Results showed that 57.1% of the respondents had consulted a diabetes specialist nurse, and of these, 81.3% rated the expertise to be above-average or excellent. A cardiac specialist nurse had been consulted by only 14.3% of the respondents, all of whom rated the specialist's expertise to be above-average or excellent. Respiratory specialist nurses had been consulted by 41.2% of nurses, with the specialist's expertise being rated above-average or excellent by nearly all of them (91.7%). General practice nurses were consulted by 85.7% of respondents, half of whom rated the specialist's expertise as above-average or excellent.

When asked how often they themselves provided support for other nurses in planning patient care, only 3.6% said that they didn't; 71.3% indicated they provided support 'a good bit', 'most', or 'all' of the time. These results suggested that there were active support networks available to nurses working in the older residential care area but, not all the nurses consulted were considered expert. Although some were described as 'very supportive and encouraging – only a phone call away', 'expert' and 'knowledgeable',

others were considered to be ‘unhelpful’, to ‘know less than I do myself’ and ‘inexperienced’.

The focus group participants reported variable access to and limited professional relationships with specialist nurses. This appeared to relate back to the issues of confidence and autonomy identified earlier, but often nurses in the focus groups seemed unaware of available services. All residential care nurses reported they had contact with wound care specialist nurses, and most mentioned the Diabetes Lifestyle Centre clinicians. They reported very little contact with respiratory nurse specialists, and none with the cardiac nurse specialists. The relationship with the local hospice was reported to be excellent.

Advantages and disadvantages of residential settings for chronic illness care

The surveyed nurses were asked about their involvement with chronic illness care and the advantages and disadvantages of residential care for the provision of appropriate chronic illness care for older people. Almost all nurses indicated that they cared for people with three conditions: 25 cared for residents with diabetes, 27 for those with cardiac conditions and all 28 cared for residents with respiratory complaints. The advantages and disadvantages named were similar across all three chronic conditions and the main themes are presented in Box 1 .

The number of comments concerning barriers (153) outnumbered those concerning opportunities (94). It is evident from the themes shown in the table that the most positive aspects of the residential care environment were perceived to be access to other health professionals such as GPs, dietitians and specialist nurses and the almost constant supervision and contact with patients that the environment enables. The safe, community nature of the setting was also seen to be useful in allowing access to staff and clients for education purposes and for helping to control diet and medications. Disadvantages were

Box 1. Nurses perceptions of opportunities for, and barriers to, provision of good care for people with diabetes, aged care facilities

Frequency of response Total Diabetes Cardiac Respiratory

Opportunities
nurses/caregivers/patients/family Control over diet/medication ~~Consultation with other health professionals~~
Stable/safe environment

Barriers ~~Non~~ compliance
assessment Insufficient general practitioner support

10 5 11 5 7 4 6 5 7 3 3 1

18 9 9 11 10 4 10 4 6 7 5 9 2 4 1 4

9 24 6 22 4 15 3 14 2 12 3 7

11 38 8 28 6 20 5 19 4 17 4 18 1 7 1 6

primarily associated with some residents' and some family members' difficulties in adhering to or supporting treatment regimes, in relation to food, taking medication and lifestyle. Dementia or other forms of cognitive dysfunction were identified as a large part of the reduced adherence, as was residents' lack of understanding or interest in their own conditions. Co-morbidities served to make the treatment more complex as did the age of the residents. A number of nurses felt that they and their caregiver colleagues had an inadequate knowledge base for providing the best care, and that educational opportunities were lacking. Support from GPs was also seen as inadequate due to the shortage of GPs in New Zealand and their inability to respond promptly to calls.

Low job satisfaction

Perhaps directly related to the lack of professional development and engagement with the profession at large, nurses in the focus groups spoke of the lack of career progression in residential care and the constant lack of satisfaction resulting from their perceived inability to provide the quality of care the residents needed. Despite these concerns, we were constantly made aware of nurses' commitment to providing care in difficult circumstances as evidenced by one nurse's statement 'It is only my huge concern and affection for the residents that keeps me coming back'.

In the settings examined in this study there were few clinical leadership positions and a sense that nurses with 5 years 'experience as it was by those with 20 years' experience undertook the same role. As a useful example, in one larger residence with 40–50 hospital-level beds, the one nurse designated as a clinical leader indicated that she had such a large caseload of direct clinical care that she was hard pressed to supervise the many untrained caregivers, let alone provide any clinical supervision and teaching of other RNs. She stated that 'I can barely cope with my own clinical work load'. Another nurse noted that she was ' . . . just surviving on a day-to-day basis'.

One nurse noted that it took at least 2 hours in the morning to distribute all the breakfast medications. In addition, 20 of the 50 older adults required full feeding and 90% of the residents could only be moved with the use of a hoist. Nurses saw this as requiring much better staffing levels, but one commented:

The pay rates and conditions at work are difficult. We can't attract caregivers from [local city] who have to travel here. Some caregivers have never done it before; to give it a go they come and work with another caregiver to see what it's like.

Issues of accountability

Focus group discussions revealed that being accountable for the practice of caregivers was a source of significant stress for registered nursing staff. As one said, 'I have serious concerns about particular caregivers but I neither hire them nor can I fire them'. This nurse was referring to the fact that RNs know that where caregivers provide direct patient care the RN remains accountable for the outcome of that care. If, as this nurse noted, the RN is not involved in the recruitment of such people, does not have time or control resources to provide appropriate training, and is not involved with discipline or

performance management (as is often the case), then they have little or no opportunity to ensure that care or practice they delegate will be safely or appropriately delivered.

A recurring theme of focus group discussion was admiration for the tireless and poorly paid work of many caregivers, but there was also concern about those who were clearly unsuited for such work. Nurses commented that recruitment of such staff is often undertaken by generic management or business owners, or undertaken with need overriding judgement; consequently nurses found themselves accountable for care provided by people they were reluctant to trust. Some of the survey comments were in the same vein, for example: 'I'm working with unqualified staff who are unable to identify problems as they are arising', and another barrier identified as 'upskilling and maintaining knowledge base of caregivers'.

Lack of timely intervention by busy GPs

This theme arose directly from focus group discussions and was a source of shared concern across settings. In effect, residential settings are dependant on GP attendance to resolve medical problems. A diminishing GP workforce cannot always respond promptly to calls for visits to a local residential care setting. We heard stories of exacerbated suffering of residents because care could not be provided when needed.

I called the GP early in the morning to say that she had been in severe pain all night and we had nothing prescribed. He came at 7pm that night by which time the pharmacy was closed. An RN who works here (but was off duty) drove her own car on a 2-hour return journey to an urgent pharmacy so that she [the resident] would not have to go through another night in such pain.

Another participant noted that 'Because the GPs leave our patients to last, we feel demeaned by their lack of interest'.

Lack of timely medical intervention is, of course, highly problematic for the older residents, but it additionally increases the stress and frustration of registered nursing staff. Many nurses also spoke of preventable hospital admissions because relatively simple clinical interventions were not provided on site. This is a systems cost issue but it is also a source of increased disruption and disorientation for frail older people.

Discussion

The field of residential care varies widely, with some larger establishments having better defined levels of clinical leadership and greater involvement in professional development. However, there are numerous medium and small-sized privately owned residential settings throughout New Zealand, and the problems reported in this study are likely to be widespread. Nurses were approached via residential care managers, and it is possible that the nurses who responded to the survey were employed in organisations which support nursing leadership, as they were offered the opportunity to participate in the survey. Conversely, the focus group nurses predominantly expressed ignorance of the survey's existence, suggesting a lack of management support for the process. This may well account for some of the differences found between the survey and focus group data.

The problems experienced by the nurses in older-care settings can be understood by summarising the descriptions they provided of the people for whom they were caring. People are often not admitted to residential care until they have at least one chronic condition, which is accompanied by complex comorbidities, often including dementia. Most residents are aged 80+ years and many are not able to understand their own condition and have difficulty with respect to medication and diet adherence. Inadequate resources mean that they may need to wait to see a GP, and receive care from overworked caregivers and RNs who do not necessarily have the requisite skills and information available to provide the best possible support and are unable to attend education updates – due to lack of time, access or availability. In essence, the context of residential care requires high levels of nursing expertise but this is often absent.

All Western countries report workforce shortages in health, especially in long-term older care settings. As in all health service settings, the input of a skilled, well educated workforce is crucial to achieving and maintaining quality outcomes.⁸ Internationally, services for older people report remarkably similar problems, including the undersupply of the workforce,^{9,10} the unpopularity of the aged care sector as an industry in which to work,^{11,12} the ageing workforce populations¹³ and the lack of both a reasonably trained semi- skilled staff and a suitably qualified professional workforce.^{11,14}

Service delivery grapples with high rates of turnover and low rates of retention and this in turn is associated with the way the workforce is remunerated, the lack of training, their difficult working conditions and lack of career prospects.¹⁵ (p. 36). Virtually all residential care settings depend heavily on non- regulated caregivers for the bulk of care provision. Registered nurses know that they may delegate work to care assistants when the work does not require professional judgement, does not put the patient at any risk of harm and is in the best interests of the patient. Nurses are taught that the decision to delegate is a professional judgement and should take into account: the stability of the health status of the patient/client; the nature of the patient's/client's illness, treatment regime and wishes; the potential benefits and risks to the patient/client; the RN's ability to supervise the work and the ability of the health service assistant to do the work.¹⁶

Vicarious liability, the principle that an individual is responsible for the actions of those engaged to work on their behalf,¹⁷ is relevant to residential care settings and is significant for the findings of this study. Vicarious liability recognises the role employers play, for instance, in employing the right people, controlling the resources available to employees to practice safely and, of course, facilitating or creating barriers to ongoing education.¹⁸

Vicarious liability does not negate personal professional liability. In our discussions, we noted nurses' disempowerment and a failure to recognise that documentation and reporting concerns to management or owners are critical for both personal and professional accountability to residents, and for self-protection. This was demonstrated in a recent case heard by the Health and Disability Commissioner (HDC),¹⁹ where a nurse was found guilty of misconduct based on her failure to let her employers know that her working situation was unsafe. RNs who have worked in deeply oppressive circumstances are unlikely to have sufficient vision, courage or stamina left to protect themselves in

such a manner. In addition, many do not belong to a professional organisation and thus do not have indemnity insurance. This was to some extent supported by the nine of the 28 surveyed nurses who reported that they did not belong to any organisational source of indemnity insurance.

An additional stressor mentioned in focus group discussions was the lack of available medical response to residents with acute or chronic clinical problems needing treatment. In NZ, this response is most commonly provided by the resident's own GP or a GP contracted to the residential setting. In addition, GPs are contracted by the NZ Ministry of Health to provide monthly (or at least 3-monthly when the resident's condition is considered by the GP to be stable) 'check ups' for those in residential care.²⁰ The cost of this service is covered by the resident subsidy. A Royal New Zealand College of General Practitioners report²¹ notes that

If the decline in the number of self employed GPs (who work the longest hours), and the trend toward part time and flexible working arrangements (e.g. locums) continues, then New Zealand's FTE GP numbers would erode very quickly, leaving fewer GP hours to see more patients. This in turn would impact the changing GP workforce, causing burnout and still further retention issues. (p. 6)

In conclusion, in a similar vein to previous authors who advocate the employment of specialised gerontological nurses,²²⁻²⁴ we propose that one useful contribution to the problems identified would be the deployment of gerontological nurse practitioners (NPs). The NP is a newly established role in NZ (since 2002). Nurses holding these positions are RNs with a minimum of 4 years of work experience in their chosen clinical area, who have completed a masters degree in nursing and met NCNZ requirements to be authorised as an NP.²⁵ They are authorised to order diagnostic tests, to prescribe and have admitting privileges. The nature of their work is such that they are senior clinicians in nursing whose additional skill set enables them to provide a much fuller episode of care. NPs in older persons care can work across the boundaries of primary health care, residential care and home-based care to ensure continuity of care and management focussed on older people. In particular, such a role would work well to reduce the unnecessary admissions to hospital, caused by lack of timely intervention in residential care and which are so distressing to older residents. The use of NPs to provide intensive primary health care to older, residential care patients has been shown to decrease hospitalisations, length of hospital stay and potentially hospitalisable events.²⁶

We envisage NPs being employed across primary health care, several residential care settings and able to follow older persons through any hospital admissions. NPs could provide prompt management of pain, infection, medication adjustments and palliative care, to reduce suffering and prevent admissions to hospitals. At the same time they would be an important resource of clinical nursing expertise to upskill residential care RNs. They would increase the visibility and desirability of gerontological nursing as a career choice and provide on-site nursing leadership.

The participation of nurses from aged care settings in our research was hard to achieve.

Nurses in these settings often report feeling marginalised, and we were determined to increase their participation through the addition of focus groups. It is an irony that these nurses whose voices most need to be heard are the hardest to reach.

Competing interests

The authors declare that they have no competing interests.

1 Suhrcke M, Nugent RA, Stuckler D, Rocco L. Chronic disease: an economic perspective. London: Oxford Health Alliance, 2006.

2 Goodhew J. [National Party Associate Health Spokeswoman]. Choice not chance for older New Zealanders. Aged Care Discussion Paper. Wellington: The Office of the Leader of the Opposition; 2007. Available at www.national.org.nz/files/NZNP_Aged%20Care_Discussion%20Paper_low%20res.pdf [verified November 2009].

3 Aged Care Association of New Zealand. Questions and answers. Available at <http://nzaca.org.nz/media/questions-answers.htm> [verified November 2009].

4 NZIER. Ageing New Zealand and Health and Disability Services: Demand projections and workforce implications, 2001–2021. Discussion document. Dec 2004. Wellington: NZ Ministry of Health, 2004. Available at [http://www.moh.govt.nz/moh.nsf/0/E6EE108D0901CAD8CC256F73000F1F9A/\\$File/nzierreport-ageingnzandhealthanddisabilityservices.pdf](http://www.moh.govt.nz/moh.nsf/0/E6EE108D0901CAD8CC256F73000F1F9A/$File/nzierreport-ageingnzandhealthanddisabilityservices.pdf) [verified November 2009].

5 Ministry of Health. Primary health care and community nursing workforce survey – 2001. Wellington: Ministry of Health, 2003. Available at [http://www.moh.govt.nz/moh.nsf/0/c97842240d53447ecc256d240014917e/\\$FILE/Primary%20Health%20Care%20and%20Community%20Nursing.pdf](http://www.moh.govt.nz/moh.nsf/0/c97842240d53447ecc256d240014917e/$FILE/Primary%20Health%20Care%20and%20Community%20Nursing.pdf) [verified November 2009].

6 Kiata L, Kerse N, Dixon R. Residential care workers and residents: the New Zealand story. *N Z Med J* 2005; 118(1214): 49–59.

7 New Zealand Nurses Organisation. Submission to the Ministry of Health on the Staffing Regulations in Aged Residential Care. December 2004. Available at http://www.nzno.org.nz/activities/submissions/nzno_submissions_2002-2008_a-z [verified November 2009].

8 Wanless D. Wanless Social Care Review: Securing good care for older people: taking a long-term view. London: King's Fund, 2006.

9 Australian Institute of Health and Welfare. Nursing Labour Force, 1999. Preliminary Report. Canberra: AIHW, 2000. (AIHW cat. no. HWL18) 10 Thompson DR. Nursing in Hong Kong: issues and challenges. *Nurs Sci Q*

2006; 19: 158–62. doi:10.1177/0894318406286834
include 'role-appropriate'

11 Drugaya M, Scaletto

responsibilities. *Provider* 1991; 17: 68, 66.
care career

12 Stein I, Heinrich J, P

pathways: a successful aged care workforce strategy. *Geriatrician*

2000; 18: 5–6.

13 Senate Committee on the Health and Human Services. The health service assistant profession: time for

action. Report on the Inquiry into Nursing. Canberra: June 2002. Available at http://www.aph.gov.au/senate/committee/clac_ctte/completed_inquiries/2002-04/nursing/report/index.htm [verified November 2009].

14 Cheek J, Ballantyne A, Jones J, Roder-Allen G, Kitto S. Ensuring excellence: an investigation of the issues that impact on the registered nurse providing residential care to older Australians. *Int J Nurs Pract* 2003; 9: 103–11. doi:10.1046/j.1322-7114.2003.00408.x

15 Penny A. International trends in aged care. Palmerston North: College of Nurses, Aotearoa (NZ) Inc., 2006. Available at http://www.nurse.org.nz/te_puawai/tp_0706_penny.htm [verified November 2009].

16 Carryer JB, Harper J. The health service assistant and the registered nurse. Palmerston North: College of Nurses Aotearoa (NZ) Inc, 1999. Available at http://www.nurse.org.nz/leadership/l_s_hsa_rn.htm [verified November 2009].

17 Johnson S, editor. Health care and the law. 2nd ed. Wellington: Brookers, 2000.

18 Carryer J, Boyd M. The myth of medical liability for nursing practice. *Nurs Prax N Z* 2003; 19: 4–12.

19 New Zealand Health Practitioners Disciplinary Tribunal. Charge No. NUR05/09D. Available at <http://www.hpdt.org.nz/Default.aspx?tabid=109> [verified November 2009].

20 Ministry of Health NZ. Age related residential care services agreement 2006–2007. Available at [http://www.moh.govt.nz/moh.nsf/pagesmh/6304/\\$File/arrc-final-2009.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/6304/$File/arrc-final-2009.pdf) [verified February 2010].

21 Royal New Zealand College of General Practitioners. 2005 RNZCGP Membership Survey. General practice in New Zealand Part II. Available at <http://www.rnzcgp.org.nz/assets/Documents/research/Workforce Series2.pdf> [verified November 2009].

22 Kovner CT, Mezey M, Harrington C. Who cares for older adults? Workforce implications of an ageing society. *Health Aff (Millwood)* 2002; 21: 78–89. doi:10.1377/hlthaff.21.5.78

23 Bednash G, Fagin C, Mezey M. Geriatric content in nursing programs: a wake-up call. *Nurs Outlook* 2003; 51: 149–50. doi:10.1016/S0029-6554(03)00035-6

24 Kelly TB, Tolson D, Schofield I, Booth J. Describing gerontological nursing: an academic exercise or prerequisite for progress? *Int J Older People Nurs* 2005; 14(3a): 13–23.

25 Nurse Practitioner Advisory Committee of New Zealand. Nurse practitioners in New Zealand: the facts. 2006. Available at [http://www.moh.govt.nz/moh.nsf/pagesmh/4950/\\$File/nurse-practitioners-nz-facts.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/4950/$File/nurse-practitioners-nz-facts.pdf) [verified November 2009].

26 Kane RL, Keckhafer G, Flood S, Bershadsky B, Siadaty MS. The effect of Evercare on

hospital use. *J Am Geriatr Soc* 2003; 51: 1427–34. doi:10.1046/j.1532-5415.2003.51461.x