After reading this chapter, you should be able to:

- define the key terms listed in this chapter
- briefly describe the Australian and New Zealand healthcare systems
- describe the healthcare services available in Australia and New Zealand
- describe the types, purpose and organisation of aged care in Australia and New Zealand
- describe the make-up of the healthcare team
- define ‘quality care’ and explain how it is provided
- know how to promote quality of life.

Key terms

**acute illness**: A sudden illness from which the person is expected to recover

**aged care facility**: A facility that provides healthcare services to residents who require regular or continuous care; licensed nursing care is required

**Alzheimer’s disease**: A disease that affects brain tissue; the person suffers from increasing memory loss and confusion until they cannot meet their simplest personal needs

**chronic illness**: An illness, slow or gradual in onset, for which there is no known cure; the illness can be controlled and complications prevented

**community care packages**: Coordinated care that enables older people to continue living at home, who might otherwise require low-level residential services

**deconditioning**: The process of becoming weak from illness or lack of exercise

**enrolled nurse (EN)**: An individual who has studied nursing and is registered with a state/territory authority to practise as an EN; also called a registered nurse (Division 2) in some states of Australia. Also called a nursing assistant in New Zealand

**functional care**: A method of organising nursing care; nursing staff perform specific tasks for all assigned residents

**HACC**: Home and Community Care Program, an Australian Government program aimed at providing aged care services in the community

**healthcare assistant**: Staff member who provides basic task-oriented care under a nurse’s supervision

**hospice**: A healthcare agency or program for people who are dying

**hostel accommodation**: Provides housing, personal care, supportive services, healthcare and social activities in a home-like setting

**Medicare**: The Australian federal health insurance program for Australian citizens, New Zealand citizens and permanent visa holders

**multidisciplinary healthcare team**: The many healthcare workers whose skills and knowledge focus on the person’s total care

**nursing/caring team**: The individuals involved in providing nursing care: registered nurses, enrolled nurses and personal carers

**personal care assistant**: A person who gives basic personal care under the supervision of a nurse; also called personal care worker, personal carer or personal care attendant

**primary care**: A method of organising nursing care; a nurse is responsible for the total care of specific residents on a 24-hour basis

**private hospital**: A facility owned by a for-profit, not-for-profit or charitable organisation

**private insurance**: Insurance bought by individuals and families

**public hospital**: A facility owned, operated or funded by the state/territory/country

**registered nurse (RN)**: An individual who has studied nursing for a minimum of three years and is registered with a state/territory/national licensing authority to practise as an RN

**residential care facility**: A facility that provides aged care services

**retirement village**: A complex made up of self-care accommodation; this may or may not include hostel-type accommodation and an aged care facility

**team care**: A method of organising nursing care; a nurse serves as a team leader; the team leader assigns other nurses and nursing assistants to care for certain residents
It is important for those working in any aspect of healthcare to understand the basics of the Australian and New Zealand healthcare systems, in order to recognise how employers, employees, their work process and clients are affected by these arrangements. Healthcare systems operate within the broader social and economic environments of each country. The differences between how Australia and New Zealand have approached healthcare delivery is a result of the way in which the government systems of each country are organised. In Australia, there is a federal–state split in healthcare service provision, while in New Zealand, one national government organises healthcare services for the entire country.

AUSTRALIA

Settlement of Australia occurred tens of thousands of years ago by groups of people now referred to as Aboriginal and Torres Strait Islander people, or Indigenous Australians. White settlement commenced in 1788 with convicts from Great Britain, and people of other nationalities followed. As a result, Australia's current population (around 22 million people) has a wide ethnic diversity.

In 1901, Australia became an independent, federated nation comprising six states and two territories. With Federation, the Constitution established a Commonwealth (federal) government. Each state or territory retains its own parliament, and also has local governments, such as municipal or shire councils.

Governments, the private sector and health

The major role of the Commonwealth in healthcare is to provide leadership in policymaking, particularly on national issues such as public health, research and national information management. The Commonwealth funds most medical services out of hospitals, and most health research.

The states and territories are primarily responsible for the delivery and management of public hospitals and services, and the regulation of health professionals. The states and territories deliver public acute and psychiatric hospital services, and a wide range of community and public health services, including school health, dental health, maternal and child health and environmental health programs.

The Commonwealth, states and territories jointly fund public hospitals and community care for aged and disabled persons.

Residential aged care is financed and regulated by the Commonwealth government and provided mainly by the non-government sector (by religious, charitable and for-profit providers). The Commonwealth, states and territories jointly fund and administer community care (such as meals on wheels, home help and transport). Some state, territory or local governments provide some community services.

There is a large private sector in health services. Private health insurance can cover private and public hospital charges (public hospitals charge only patients who elect to be private patients in order to be treated by the doctors of their choice), and a portion of medical fees for inpatient services. Private insurance can also cover allied health and paramedical services (such as physiotherapists and podiatrists’ services) and some aids and appliances (such as spectacles).

Non-government religious and charitable organisations play a significant role in health services, public health and health insurance.

Health status

The Australian population generally has a good health status, with life expectancy at birth of 75.2 years for boys born in 1994–96 and 81 years for girls born in that period. The health status of some groups, such as Aboriginal and Torres Strait Islander people, is poor, however. Otherwise, the pattern of disease is similar to that of other developed countries.

Health services delivery

Australia has a mix of public and private sector providers of health services. Most doctors are self-employed, although some are salaried employees of Commonwealth, state or local governments. Salaried specialist doctors in public hospitals often have rights to treat some patients in these hospitals as private patients. In some allied health/paramedical professions, a significant proportion are self-employed. Others are employed by state and local government health organisations.

Public hospitals include hospitals established by governments and some initially established by religious or charitable bodies but now directly funded by government. There are a small number of hospitals built and managed by private firms providing public hospital services under arrangements with state governments. Most acute-care beds and emergency outpatient clinics are in public hospitals. Large urban public hospitals provide most of the more complex hospital care, such as intensive care, major surgery, organ transplants, renal dialysis and specialist outpatient clinics.

Private hospitals are owned by for-profit or not-for-profit organisations, such as large corporate operators, religious operators and private health insurance funds. In the past, private hospitals tended to provide less complex non-emergency care, such as simple elective surgery. However, in the past decade, some private hospitals have become increasingly complex, providing high-technology services.

Specialised mental healthcare in the public sector is provided in separate psychiatric hospitals, general
hospitals and community-based settings. Historically, mental health services have operated separately from mainstream health services, but the Commonwealth, state and territory governments are currently working under the National Mental Health Strategy to incorporate mental health services into mainstream health. Other key reforms are focusing on replacing separate psychiatric hospitals with community-based and general hospital services, and integrating mental healthcare provided in different settings.

Australia's aged care system focuses on two main forms of care delivery: residential and community care (ranging from meals on wheels, home help and transport to care for people who otherwise would need residential care). Residential services are mainly in the non-government sector; about half of those are operated by religious and charitable organisations.

Both government and non-government organisations, under the Home and Community Care (HACC) Program, provide community care services.

Medicines or pharmaceuticals prescribed by doctors and dispensed by pharmacies are directly subsidised by the Commonwealth Pharmaceutical Benefits Scheme (PBS).

Australia provides a number of specific services based on its unique geographical and population needs. They include:

- the Royal Flying Doctor Service, which delivers care to remote areas by aircraft
- the Aboriginal and Torres Strait Islander peoples’ community-controlled health services, which aim to meet the special needs of Indigenous Australians
- Regional Health Services, through which community-identified priorities for health and aged care services in rural and remote areas are met through a flexible mix of Commonwealth- and state-funded services.

The national healthcare funding system

The aim of the national healthcare funding system is to give all citizens access to healthcare while allowing choice for individuals. The major part of the national healthcare system is called Medicare. Medicare was established to provide healthcare to all Australians. It is financed largely from general taxation, which includes a Medicare levy based on a person's taxable income. Commonwealth funding for Medicare is mainly provided as:

- subsidies for prescribed medicines (with a safety net providing free medicines for the chronically ill) and free or subsidised treatment by practitioners, such as doctors, participating optometrists or dentists
- grants to state and territory governments to help cover the costs of providing access to public hospitals at no cost to patients
- specific-purpose grants to state/territory governments and other bodies.

The Commonwealth also funds some special categories, such as members of the armed forces and veterans, who have additional arrangements while remaining eligible for mainstream Medicare coverage. Some injuries and illnesses are covered by compulsory workers’ compensation insurance, and injuries from motor vehicle accidents may be covered by compulsory third person motor vehicle insurance.

Residential aged care is financed by the Commonwealth government by means of subsidies paid to service providers, based on the level and type of care needed by the individual. Residents may pay daily care fees and accommodation payments related to the level of care, with special provisions for residents who have difficulty paying these charges.

The Commonwealth, state and territory governments jointly fund community care services for the frail aged and the disabled. Clients pay different fees for community care services depending on the type of service and the client's capacity to pay. The Commonwealth funds intensive community care packages of coordinated care to enable older people to continue living at home, who might otherwise require low-level residential services.

Healthcare settings

The healthcare industry includes a multitude of services provided by many different health professionals and agencies. Services can be broadly classified as those that provide (Fig. 1-1):

- preventive care—health promotion and illness prevention in settings such as community clinics, schools, industries and doctor’s surgeries
- primary care—diagnosis and treatment of disease and illness, usually in a doctor’s surgery, hospital, clinic or outpatient service
- tertiary care—rehabilitation or long-term care provided by rehabilitation centres, hospitals and aged care facilities.

Factors affecting healthcare delivery

In recent decades, there has been a shift in healthcare away from the diagnosis and treatment of disease towards a health promotion and disease prevention approach. People within the community are now more knowledgeable about health and preventing illness, and are prepared to accept some responsibility for their own health. As a result, healthcare providers have developed and initiated a number of health promotion programs.

Aged care facilities

The number of aged care facilities in Australia has grown in the past few decades. This has been partly due to the ageing population, improving technologies, better treatment strategies and an increasing emphasis on healthy lifestyles. Many aged people are able to remain...
in their own homes for longer periods than those in previous generations, or until they die. A relatively small percentage of the aged population requires care in an aged care facility. These facilities include hostel accommodation and self-care accommodation within an aged care facility.

People living in aged care facilities are called ‘residents’. They are not called ‘patients’. The facility is their permanent or temporary home. Aged care facilities are designed to meet the special needs of people who are older or disabled. They provide services to those who cannot care for themselves at home but do not need hospital care. Services range from supportive care to very complex care. Medical, nursing, personal care, dietary, recreational, rehabilitative and social services are provided. Housekeeping and laundry are included.

**Hostel accommodation** is a safe setting, and supervision is provided with support but not 24-hour nursing care for residents who are assessed as requiring low levels of care. Residents can usually dress themselves, and usually tend to their grooming and bathroom needs with little help. Services include three meals a day, housekeeping, laundry and transportation. There is a 24-hour caregiver and an emergency call system. Residents receive help with personal care and medication reminders. The caregiver may be a personal care worker. Historically, hostels had residents who were largely independent; however, with the increase in availability of community care services, residents are accessing hostel accommodation at a time when they may need supervision with many of their care needs.

**Self-care accommodation** within an aged care facility allows the person to be totally independent. The resident has his or her own apartment or unit, and is independent with all care while living in a community environment.

A **retirement village** is often a complex made up of self-care accommodation and may or may not have a complex that includes an aged care facility.

**PURPOSE AND GOALS**

Aged care facilities are there to provide a supportive, caring home where the individual needs of the residents are catered for and where families and the community are welcome to interact. The purpose of aged care facilities is to promote physical and mental health. Most residents have one or more chronic illnesses, and all are helped and encouraged to:

- accept the limits of their diseases
- function within those limits
- focus on abilities, not disabilities
- do as much for themselves as possible
- change habits that can make their illnesses worse
- eat properly and exercise.

The goals of aged care facilities include the following:

- **to promote understanding of changes**—it is important for the resident and their family to accept and understand the physical and mental changes that occur, and families are taught how to assist their loved ones to maintain the highest possible level of functioning. They are also taught how to accept the limits of chronic illness.

- **to prevent communicable diseases**—a communicable disease is one that can spread from one person to another.
another. Colds and influenza (flu), for example, can cause major health problems for older and disabled people. The care assistant may be the first person to detect signs and symptoms of a communicable disease.

- **to treat chronic illness**—a **chronic illness** is slow or gradual in onset, and has no cure. Chronic illness can be controlled, and complications can be prevented with proper treatment. An **acute illness**, on the other hand, begins suddenly and the person should recover, but may require hospital care.

- **to provide rehabilitation or restorative care**—people are helped to return to their highest possible level of physical and mental functioning, to become or remain as independent as possible. This includes those who need nursing centre care until death. Rehabilitation starts when a person is admitted to the centre. Often residents are deconditioned after an acute illness. **Deconditioning** is the process of becoming weak from illness or lack of exercise. Disabilities can result from strokes, fractures or surgery. All staff follow the rehabilitation program.

**OTHER SERVICES**

Some aged care facilities provide learning experiences for students who are studying to become nurses, carers, doctors or other health team members. All students focus on the centre’s purposes and goals, and assist in promoting health, treating illness and preventing communicable disease, and rehabilitation. Many facilities have special care units, including hospice and dementia care units.

**Hospices**

A **hospice** is an agency or program for people who are dying. The person’s physical, emotional, social and spiritual needs are met in a setting that allows a great deal of freedom. The family’s needs are met, too. Children and pets can visit, and family and friends can assist with care. Hospice care is provided by hospitals, aged care facilities and home care agencies.

**Dementia care units**

A dementia care unit (also referred to as a **special care wing**) is for people with Alzheimer’s disease and other dementias. Dementias affect brain tissue, causing memory loss and confusion to increase until the person cannot attend even to simple personal needs. Over time, the person may forget his or her name. They may also wander and become agitated or combative.

The unit is usually closed off from the rest of the facility. This provides a safe setting in which these residents can wander freely. Dementia worsens over time, and those affected may not wander during the middle and end stages of the disease. In this case they will no longer need a closed unit, and will be cared for in other units in the aged care facility. Due to the increased and special needs of residents who have dementia, staffing levels are generally higher. Staff are trained to recognise and identify the possible cause of any agitation and combative behaviour and to implement strategies to minimise their occurrence.

**Rehabilitation and respite care**

Some aged care facilities and hospitals provide respite care or rehabilitation. This care may be provided in special units. Often the length of stay is short—a few weeks or months. If problems occur, the person may need long-term care.

**Quality improvement and accreditation**

Healthcare facilities have a responsibility to provide quality care to clients and their families. Providers are responsible and held accountable for the care and services they provide. Quality-control systems are used to ensure that specified levels of care are met. The Commonwealth Standards and Accreditation Agency is the accrediting agency. It has standards and practices for hospitals, aged care facilities and home care agencies. It serves to improve the quality of care to the public.

To become accredited, the facility must meet certain standards of care. Some levels of government funding depend on the facility becoming accredited. Accreditation is also a way for a facility to show that it provides quality care. If an organisation does not meet a significant proportion of the accreditation standards, accreditation is not awarded. The public are regularly informed of accredited organisations.

**The multidisciplinary team**

The **multidisciplinary healthcare team** consists of many different health professionals working to provide quality, coordinated care for the client (Table 1-1). The team provides services that support the overall goal of quality resident care.

Team members work together to meet the needs of residents. Many healthcare workers are involved in the care of individual residents and, therefore, coordinated care is needed. A registered nurse serves in the key leadership position.

The **nursing/caring team** are the individuals involved in the daily care—registered nurses, enrolled nurses, and personal care assistants—and each has a different role and responsibilities. All focus on the needs of residents and their families.

**REGISTERED NURSE**

To become a **registered nurse** (RN), the student completes a three-year university program and registers with the Nursing and Midwifery Board of Australia.
## TABLE 1-1 Members of the multidisciplinary healthcare team

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversional therapist</td>
<td>Works in nursing centres; assesses recreational needs of residents, and plans and implements programs accordingly</td>
<td>Required training varies with state and/or centre policies; ranges from no required training to Bachelor degree</td>
</tr>
<tr>
<td>Audiologist</td>
<td>Tests hearing; prescribes hearing aids; works with hearing-impaired persons</td>
<td>Bachelor degree and registration with professional body</td>
</tr>
<tr>
<td>Cleric</td>
<td>Works in all types of healthcare settings to assist persons with their spiritual needs</td>
<td>Priest, minister, rabbi, sister, deacon or other pastoral training</td>
</tr>
<tr>
<td>Dentist</td>
<td>Prevents and treats disorders and diseases of the teeth, gums and oral structures</td>
<td>Bachelor of Dentistry and registration with state/territory licensing authority</td>
</tr>
<tr>
<td>Dietitian</td>
<td>Assesses and plans for the person’s nutritional needs; teaches individuals and families about good nutrition, food selection and preparation</td>
<td>Bachelor degree</td>
</tr>
<tr>
<td>Enrolled nurse (EN)</td>
<td>Provides direct patient/resident care, including administering medications, under the direction of an RN</td>
<td>Graduate of state-approved program (12 months to 2 years duration) and enrolled with state authority</td>
</tr>
<tr>
<td>Personal care worker</td>
<td>Assists RNs and ENs; gives direct bedside resident care; must be supervised by a nurse</td>
<td>Completion of Certificate III level program</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>Assists individuals to learn or regain the skills needed to perform activities of daily living; designs adaptive equipment for activities of daily living</td>
<td>Bachelor of Science in occupational therapy and registration with state/territory authority</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>Fills medication and prescription orders written by doctor; monitors and evaluates medication interactions; consults with doctors and nurses regarding medication actions and interactions</td>
<td>Bachelor of Pharmacy and state licensure</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>Assists persons with musculoskeletal problems; focuses on restoring function and preventing disability from illness or injury</td>
<td>Bachelor of Science in physiotherapy and registration with state/territory authority</td>
</tr>
<tr>
<td>Doctor</td>
<td>Diagnoses and treats diseases and injuries</td>
<td>Medical school graduation, residency and registration with state/territory authority</td>
</tr>
<tr>
<td>Podiatrist</td>
<td>Prevents, diagnoses and treats foot disorders</td>
<td>Bachelor degree and registration with state/territory authority</td>
</tr>
<tr>
<td>Radiographer</td>
<td>Takes X-rays ordered by doctor and processes film for viewing</td>
<td>Bachelor degree and registration with state/territory authority</td>
</tr>
<tr>
<td>Registered nurse (RN)</td>
<td>Assesses, makes nursing diagnoses, plans, implements and evaluates nursing care; supervises ENs and personal care attendants</td>
<td>Bachelor degree and registration with Nursing and Midwifery Board of Australia</td>
</tr>
<tr>
<td>Social worker</td>
<td>Helps residents and families deal with social, emotional and environmental issues affecting illness and recovery; coordinates community agencies to assist patient/resident and family</td>
<td>Bachelor of Social Work and registration with state/territory authority</td>
</tr>
<tr>
<td>Speech pathologist</td>
<td>Evaluates speech and language, and treats voice, hearing and communication disorders; evaluates and treats swallowing disorders</td>
<td>Bachelor degree and registration with state/territory authority</td>
</tr>
</tbody>
</table>
Registered nurses assess, make nursing diagnoses, plan, implement and evaluate all care. A registered nurse develops a care plan for the person and makes sure that the team follows the plan. The registered nurse also delegates care and tasks to team members. The registered nurse then evaluates how the care plan and care are affecting the person. The person is taught ways to maintain or improve their health and independence, and family teaching is also provided.

The registered nurse carries out the doctor’s orders. He or she may delegate the order to a member of the team. Registered nurses do not diagnose diseases or illnesses, and do not prescribe treatments or medications.

ENROLLED NURSE
The scope of practice for enrolled nurses (ENs) comes under the Nursing and Midwifery Board of Australia. Duties are performed under the direction and supervision of a registered nurse. To be entered on to the roll, the student completes a program of 12 months to two years duration, for an advanced certificate or diploma from a TAFE (Technical and Further Education) college. ENs are able to give medications on completion of additional study.

PERSONAL CARE WORKER
Personal care workers provide basic personal care under a nurse’s supervision. Personal care attendant, care worker and healthcare assistant are other titles. Personal care workers provide much of the care in aged care facilities. To work in an aged care facility, they must have formal training (Certificate III level) and pass a competency evaluation.

Care patterns
Care is given in different ways. The care pattern depends on how many people need care, the available staff and the cost.

- Functional care focuses on tasks and jobs. Each team member does certain tasks or functions. For example, one nurse gives all medications, another nurse gives all treatments. Carers give baths, make beds and serve meals.
- Team care involves a team led by a registered nurse. The team leader delegates the care of certain persons to other nurses. Delegation is based on the person’s needs and the abilities of the team members. Team members report to the team leader about observations made and the care given.
- Primary care involves total care. The primary nurse (a registered nurse) is responsible for the person’s total care, and other team members assist as needed. The registered nurse gives nursing care and makes discharge plans, and also teaches and counsels the person and their family.

NEW ZEALAND
New Zealand has a system of public and private health services. Public healthcare is subsidised by the New Zealand Government, while private healthcare is paid for by the individual consumer. There are both public and private hospitals. Public hospitals are available to any New Zealand citizen or resident; private hospitals are available to anyone who holds appropriate health insurance.

Health status
The New Zealand population generally enjoys good health. However, the health status of the Māori and Pacific Islander people is poorer than that of other New Zealanders. The life expectancy for European New Zealanders is on average 10 years longer than Māori and six to seven years longer than Pacific Islander people. Factors that affect the health of New Zealanders include smoking, exercise and alcohol consumption.

Health of Older People Strategy
The primary aim of the Health of Older People Strategy was to develop an integrated and responsive approach to the varied and changing needs of older people in New Zealand. The strategy identified the importance of specialist health services that would provide an integrated continuum of care.

Assessment, treatment and rehabilitation services
The aim of assessment, treatment and rehabilitation (AT&R) services is to identify and treat potentially reversible conditions, manage symptoms and restore clients to their maximum level of function. Any person over the age of 65 years who requires assistance with activities of daily living (ADLs) is referred to a gerontology specialist team in order to undergo a comprehensive assessment of their needs. These specialist units are attached to District Health Boards (DHBs) and are interdisciplinary. Referrals to the unit may be made by general practitioners who might have concerns about the safety of a client, or by the medical team in a public hospital where an older person has been receiving care. The assessment process may be carried out in a hospital setting or in the individual’s home. The latter is often desirable because it allows the specialist team to assess how well the individual is managing at home. Furthermore, older people often become disoriented when taken out of their home environment, making it difficult to assess their cognitive
abilities. Following the assessment, the gerontology specialist team recommends the type and level of care required. This may include:

- a rehabilitation program
- ageing in place with support
- sheltered housing
- continuing care in a rest home, hospital or dementia unit.

**REHABILITATION PROGRAMS**

Rehabilitation programs take place in specialist units in public hospitals and are interdisciplinary. The focus is on assisting clients to regain sufficient functional ability to return to their own homes.

**AGEING IN PLACE**

Most people prefer to remain in their own homes as they age. Following a rehabilitation program, some people may be able to live independently in their own homes, while others may require some assistance to do so. Support (information and financial) is available for home modification and funding for equipment that will allow people with disabilities to return to or remain in their own homes. Funding for this assistance is managed on a contractual basis from the Ministry of Health by Enable New Zealand. Some people may require ongoing daily assistance in order to remain at home. The success of this option depends on the availability of and access to support services. Subsidies are available on a scale of need determined by the Support Needs Assessment Unit. Services available in New Zealand include assistance with activities of daily living, meals on wheels, cleaning and laundry. Most older people in New Zealand do remain in their own homes, with or without support.

**SHELTERED HOUSING**

The concept of sheltered housing has not been well developed in New Zealand. However, some religious, welfare and voluntary groups, trusts and local authorities provide low-cost accommodation in supportive environments. Some of this accommodation is simply group housing (known in the United States and Canada as congregate housing), where the support comes from living in close proximity to other people. However, in some cases 24-hour on-call care is available in emergency situations.

**CONTINUING CARE REST HOMES AND HOSPITALS**

New Zealand’s public health system does not provide age-related residential care services in public hospitals. Under section 10 of the *New Zealand Public Health and Disability Act 2000*, District Health Boards enter into agreements with private providers, from whom they purchase services on behalf of consumers. A residential care subsidy is available to those who:

- are eligible for publicly funded health or disability services
- are aged 65 or older, or are aged 50–64 and single with no dependent children
- have undergone a needs assessment that has determined their need for continuing care
- have undergone a means assessment that has determined that their income and assets are within the applicable thresholds
- receive contracted care services provided by a rest home or hospital that is certified under the *Health and Disability Services (Safety) Act 2001* and has a contract with a District Health Board.

**BOX 1-1  Gerontology specialist teams**

Gerontology specialist teams include:

- geriatricians
- gerontology nurse specialists
- physiotherapists
- occupational therapists
- continence nurse specialists
- speech therapists.

**BOX 1-2  Providing care at home**

Healthcare assistants provide hands-on care for those individuals who are able to remain at home with support. Typically, support includes assistance with bathing or showering, dressing, undressing, housekeeping and shopping. Healthcare assistants are expected to be aware of and report significant changes in an individual’s status. The gerontology specialist team visits each individual at frequent intervals to assess and monitor progress. They will rely heavily on observations made by the healthcare assistant.

**BOX 1-3  Healthcare assistants and continuing care**

Healthcare assistants make up the majority of staff in continuing care facilities. Although they work under the direction of a registered nurse, they are expected to take responsibility for much of the resident’s care. It is usual for each healthcare assistant to be assigned a group of residents. They are responsible for ensuring that the daily needs of these residents are met. In order to do this they will need to be aware of their residents’ care plans. Care planning is carried out in partnership with residents and their families, predominantly by registered nurses, but may include interdisciplinary collaboration with physiotherapists, social workers and speech therapists. Senior healthcare assistants may be asked to provide input into both the planning and the evaluation stages of this process.
A person assessed as having very high needs is likely to have significant safety issues staying at home, even with support. In this case, they would probably require continuing care in a rest home or hospital. New Zealand is probably the only country that has rest homes. There are many similarities in the way continuing care rest homes and hospitals operate. When people become very dependent it is often difficult to decide whether they should remain in a rest home or transfer to a hospital. When a rest home is no longer able to manage the care of a resident, it remains up to the management to request a needs assessment. It is likely that a decision will be made to transfer the person to a hospital where there is 24-hour coverage by skilled registered nurses. However, the appropriateness of yet another late-life move for these people is still being debated. Whereas ‘ageing in place’ refers to remaining in one’s own home, older people who have relocated to rest homes and have lived in them for many years are likely to refer to them as ‘home’.

Rest home management
Some rest homes are on the same site or are attached to a continuing care hospital. This ensures the availability of a registered nurse at all times. Stand-alone rest homes are not legally obliged to have a registered nurse on site at all times. The ratio of registered nurses is determined by the number of residents in the rest home. District Health Boards are responsible for ensuring that the needs of older adults are met and that they are appropriately cared for. Gerontology Nurse Specialists, employed by District Health Boards, consistently monitor the care provided by continuing care facilities.

Quality improvement
All health and disability providers in New Zealand, including continuing care rest homes and hospitals, must be certified by the Ministry of Health under the Health and Disability Services (Safety) Act 2001. In order to be certified, facilities must comply with the Health and Disability Sector Standards (2001). These standards are designed to establish consistent, safe and acceptable levels of care for all consumers of health and disability services in New Zealand and provide the framework for each facility to develop a continuous quality improvement program. Quality audits are conducted within a specified period (maximum of three years), with surveillance audits taking place halfway through certification. Whereas meeting sector standards may be open to individual interpretation, the District Health Board contracts are more specific about the standards that providers are expected to meet. The most definitive difference between rest homes and hospitals is staffing levels and staff qualifications. Table 1-2 summarises the requirements for each as specified in health fund contracts.

It should be noted that the standards in Table 1-2 are minimum standards and will be exceeded by many facilities.

Health and Disability Sector Standards
Health and Disability Sector Standards (Standards New Zealand 2001) comprise six outcomes to be achieved. Each outcome is expanded into several standards and includes criteria required to achieve the outcome. District Health Boards base their service specifications on these standards. The six outcomes and the standards they encompass are summarised below.

CONSUMER RIGHTS
This outcome recognises the right of clients to receive safe services that demonstrate respect for their cultural and individual values and beliefs. The standards for achieving this outcome include: providing services in accordance with consumer rights legislation; recognition of Māori values and beliefs; recognition of individual values and beliefs; maintaining consumer confidentiality; advocacy and consumer support; assistance to maintain contact with family/whanau and community; respect for and maintenance of privacy and dignity at all times; and informed consent.

ORGANISATIONAL MANAGEMENT
This outcome recognises clients’ right to efficient, effective and well-managed services that comply with legislation. The standards for achieving this include: efficient management that ensures appropriate and well-planned services; a documented and maintained quality and risk management system that reflects continuous quality improvement principles; recording of adverse events and operating problems, and notification to statutory agencies where applicable; a complaints management system that is accessible and complies with legislation; efficient and effective management of the facility, ensuring the provision of safe and appropriate services to clients; human resource management processes that are conducive to good employment practice and meet current legislative requirements; and the provision of timely, appropriate and safe services from sufficient suitably qualified, skilled and experienced healthcare staff.

PRE-ENTRY AND ENTRY TO SERVICES
The outcome for pre-entry and entry to the facility concerns equity and timing. The facility has an obligation to ensure that assessment agencies are aware of the level of care and the service they provide. Assessment agencies can then advise clients and families on which facilities are appropriate for the level of care needed. The standards for achieving this outcome focus on the provision of accurate and adequate information to Needs Assessment and Service Coordination.
(NASC) teams and to prospective residents and their families. Information will include entry criteria, such as the suitability of the facility for prospective residents, and the suitability of prospective residents for the facility. It will also include the level of care provided and the possibility of relocation in the event of any change in functional status.

**SERVICE DELIVERY**

The outcome for this standard is that clients receive coordinated services that meet their individual assessed needs and reflect desired goals and outcomes. The standards for achieving this outcome encompass each stage of service provision (assessment, planning, service provision, evaluation and review), including: care that is timely, competent and appropriate to the client’s assessed needs, goals and desired outcomes; assessment of needs that is comprehensive and timely; care planning that is client-focused, integrates services and promotes continuity of care; regular evaluation of care plans; and the maintenance of planned activities and interests appropriate to the client’s needs and age.

**MANAGING SERVICE DELIVERY**

The outcome for this standard is to provide a service that is planned and coordinated, complies with current legislation and meets the needs of clients. The standards for achieving this outcome include: compilation of information for each client that is identifiable, accurate, current, confidential and accessible when required; maintenance of client records that are accurate, reliable, authorised and comply with current legislative and regulatory requirements; safe and timely administration of medication in accordance

<table>
<thead>
<tr>
<th>TABLE 1-2 Management and healthcare staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manager qualifications</strong></td>
</tr>
<tr>
<td><strong>Rest home</strong></td>
</tr>
<tr>
<td>Must hold a current qualification or have experience relevant to management and care of older people. Evidence of at least eight hours annually of relevant professional development.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>Must be either a general practitioner or a registered general or comprehensive nurse. Must hold a qualification or have experience relevant to both management and the care of older people. Evidence of at least eight hours annually of relevant professional development.</td>
</tr>
<tr>
<td><strong>Staff qualifications</strong></td>
</tr>
<tr>
<td><strong>Rest home</strong></td>
</tr>
<tr>
<td>Registered nurse for a specified number of hours each week, depending on numbers and dependency of residents.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>Must be at least one registered general or comprehensive nurse on duty at all times. The prescribed formula for nurse hours per week is for one full-time equivalent for every five patients. A 30-bed hospital would then have 240 RN hours per week.</td>
</tr>
<tr>
<td><strong>Care staff numbers</strong></td>
</tr>
<tr>
<td><strong>Rest home</strong></td>
</tr>
<tr>
<td>For 10 or fewer residents: one care staff on duty at all times. Up to 29 residents: one care staff on duty at all times and one on call at all times. More than 30 residents: at least two care staff at all times. More than 60 residents: at least three care staff at all times.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>A minimum of two care staff at all times. The registered nurse determines the number and distribution of care staff required according to the needs of residents.</td>
</tr>
<tr>
<td><strong>Medical officers</strong></td>
</tr>
<tr>
<td><strong>Rest home</strong></td>
</tr>
<tr>
<td>24-hour, seven days a week on-call cover. It is usual for a doctor to be contracted to provide a service to a rest home. All residents must be visited and medications reviewed at least three-monthly.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td>24-hour, seven days a week on-call cover. Service is usually contracted to a doctor or group of doctors. Doctors visit the facility weekly and see each patient fortnightly or as required. Medications must be reviewed three-monthly.</td>
</tr>
<tr>
<td><strong>Physiotherapist</strong></td>
</tr>
<tr>
<td><strong>Rest home</strong></td>
</tr>
<tr>
<td>Registered physiotherapist contracted to provide required services.</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
</tr>
<tr>
<td><strong>Dietitian</strong></td>
</tr>
<tr>
<td>Food service planned and audited by a registered dietitian.</td>
</tr>
</tbody>
</table>
with legislative and regulatory requirements; provision of food and nutrition according to individual needs (including special diets); infection control management that protects clients, visitors, staff and the community from exposure to infection; and management systems that protect clients, visitors and staff from exposure to hazardous substances.

SAFE AND APPROPRIATE ENVIRONMENT
The outcome for this standard is service provision in a safe environment that ensures physical privacy, safety, adequate space and amenities to facilitate independence, is in an appropriate setting and meets the needs of people with disabilities. The standards for achieving this outcome include: respect for the client’s physical privacy when delivering care; adequate space to promote safe mobility and freedom of movement; provision of habitable, appropriately furnished areas; provision of adequate personal hygiene facilities that take account of physical privacy; adequate personal living space; accessible areas for relaxation, activity and dining needs; appropriate and efficient emergency and security systems; safe and appropriate external areas; adequate light and ventilation; and an environment that is maintained at a safe and comfortable temperature.

QUALITY ASSURANCE PLANS
In order to demonstrate compliance with the Health and Disability Sector Standards, each facility develops its own quality plan. It is well recognised that staff need to have a sense of ownership of their facility’s plan and it is, therefore, usual for management to involve all staff in the process. Typically, a facility will have a committee dedicated to continuous quality improvement. Each of the criteria for meeting the standards will be scrutinised by the committee and appropriate policies and procedures to meet each of the criteria will be developed.

The care teams in continuing care facilities
The direct care staff in a continuing care facility consist of registered nurses, enrolled nurses and healthcare assistants (also known as caregivers or support workers). In New Zealand, healthcare assistants are the predominant direct care staff in both rest homes and hospitals. However, in rest homes they may be the only direct care staff on duty. In both rest homes and hospitals, the registered nurse is responsible for the planning of care and for ensuring that quality assurance activities are maintained. The roles of registered and enrolled nurses and healthcare assistants are as follows:
- **Registered nurses**—assess, make nursing diagnoses, plan, implement and evaluate nursing care. The registered nurse develops the care plan and ensures that it is implemented. The registered nurse is also responsible for delegation and evaluation of

<table>
<thead>
<tr>
<th>BOX 1-4 Actions to promote dignity and privacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For courteous and dignified interactions:</strong></td>
</tr>
<tr>
<td>• Use the right tone of voice.</td>
</tr>
<tr>
<td>• Use good eye contact.</td>
</tr>
<tr>
<td>• Stand or sit close enough as needed.</td>
</tr>
<tr>
<td>• Use the person’s proper name and title.</td>
</tr>
<tr>
<td>• Gain the person’s attention before interacting with him or her.</td>
</tr>
<tr>
<td>• Use touch if the person approves.</td>
</tr>
<tr>
<td>• Respect the person’s social status.</td>
</tr>
<tr>
<td>• Listen with interest to what the person is saying.</td>
</tr>
<tr>
<td>• Do not yell, scold or embarrass the person.</td>
</tr>
<tr>
<td><strong>For courteous and dignified care:</strong></td>
</tr>
<tr>
<td>• Groom the person’s hair, beard and nails as they wish.</td>
</tr>
<tr>
<td>• Assist with dressing the person in appropriate clothing for the time of day and in accordance with their personal choice.</td>
</tr>
<tr>
<td>• Promote independence and dignity in dining.</td>
</tr>
<tr>
<td>• Respect the person’s private space and property.</td>
</tr>
<tr>
<td>• Assist with walking and transfer without interfering with the person’s independence.</td>
</tr>
<tr>
<td>• Assist with bathing and hygiene preferences without interfering with the person’s independence.</td>
</tr>
</tbody>
</table>
| • Provide a neat and clean appearance:
  - clean-shaven or groomed beard
  - nails trimmed and clean
  - dentures, hearing aid, glasses and other prostheses used correctly
  - clean clothing
  - clothing properly fitted and fastened
  - shoes, hose and socks properly applied and fastened. |
| • Provide extra clothing for warmth as needed, such as a sweater or a lap blanket. |
| **For privacy and self-determination:** |
| • Drape the person properly during care and procedures to avoid exposure and embarrassment. |
| • Drape the person properly when in a chair. |
| • Use curtains or screens during care and procedures. |
| • Close the room door during care and procedures or as the person desires. |
| • Knock on the door before entering. Wait to be asked in. |
| • Close the bathroom door when the person uses the bathroom. |
| **To maintain personal choice and independence:** |
| • The person smokes in designated areas. |
| • The person takes part in activities according to their interests. |
| • The person is involved in scheduling their activities and care. |
In both Australia and New Zealand, systematic and thorough healthcare systems are in place to ensure a mix of both public and privately funded healthcare facilities for the general population to choose from. Care of the elderly is high on the agenda for both countries and there are a number of choices available for the older person once they require assistance. These choices range from being assisted to stay within their own homes, to low care, and high care.

The care provided in aged care facilities is always focused on the resident. The multidisciplinary healthcare team helps all residents to become or remain as independent as possible. Aged care facilities must care for residents in a manner that promotes dignity and self-esteem, and must also promote residents’ physical, psychological and emotional wellbeing. Residents are shown respect, are spoken to in a polite and courteous manner, and are provided with good, honest and thoughtful care. (Box 1–4 lists actions that show concern for the person’s dignity and privacy.)

Activities
To promote quality of life, aged care facilities must provide activity programs that allow personal choice. They must promote physical, intellectual, social, spiritual and emotional wellbeing. Many centres provide religious services for spiritual health. Residents may need to be assisted to and from activity programs, and assistance with the activities.

Environment
To promote quality of life, the centre’s environment must be clean, safe and as home-like as possible, and this includes allowing residents to have personal items.
## Review Questions

**Circle **T if the statement is true or F if the statement is false.

1. T F A person in a long-term care facility can refuse a treatment or procedure.

2. T F In New Zealand, the concept of sheltered housing has been well developed.

3. T F Personal care workers provide basic care under supervision.

4. T F A small percentage of older people live in aged care facilities.

5. T F Residents can be restrained in order to prevent them from leaving the centre.

6. T F Personal choice is important for quality of life.

7. T F In New Zealand, all health and disability providers, including continuing care rest homes and hospitals, must be certified.

8. T F In Australia, aged care facilities must be accredited by the Standards and Accreditation Agency.

9. T F It is important for those working in any aspect of healthcare to understand the basics of the Australian and New Zealand healthcare system.

10. T F An aged care facility provides healthcare services to residents who require continuous care.

11. T F Both government and non-government organisations provide community care.

**Circle the BEST answer.**

12. Helping people return to their highest physical and mental functioning is called:
   - A Detecting and treating disease
   - B Promoting health
   - C Rehabilitation
   - D Preventing disease

13. Which of the following provides 24-hour care in Australia?
   - A Self-care accommodation
   - B Hostel
   - C Aged care facility
   - D Senior citizen housing

14. Which of the following is not an aged care facility goal or purpose?
   - A Treating acute illness
   - B Preventing communicable disease
   - C Promoting physical and mental health
   - D Providing restorative care

15. In New Zealand, the direct care staff in rest homes are predominantly:
   - A Registered nurses
   - B Healthcare assistants
   - C Doctors
   - D Enrolled nurses

16. Which of the following statements about Australian personal care workers is false?
   - A They assist nurses in giving care.
   - B They are required to complete a training program.
   - C They supervise others.
   - D They are supervised by registered nurses and enrolled nurses.

17. A method of organising nursing care, in which a nurse is responsible for the total care of specific residents on a 24-hour basis:
   - A Team care
   - B Functional care
   - C Primary care
   - D Operational care

18. Which of the following actions does not promote dignity and privacy?
   - A Assisting with bathing and personal hygiene
   - B Calling the person ‘sweetie’ or ‘honey’
   - C Covering the person during personal care
   - D Knocking on the door before entering the person’s room

19. Which of the following describes the healthcare industry?
   - A Preventive care
   - B Primary care
   - C Tertiary care
   - D All of the above

20. A hospice is:
   - A A facility that provides rehabilitation
   - B A dementia care unit
   - C An agency or program for people who are dying
   - D None of the above

**Answers to these questions are on p 531.**