The role of caregivers and their interaction with rest home residents, particularly noting their preparedness to respond to needs of a spiritual nature.

1. Roots of research

My research stems from questions raised in years of pastoral work as a parish priest. When visiting in rest homes I became aware of the often unspoken need of some residents who, nearing the end of life had begun to wrestle with questions of existence, of what life as lived by them had meant, of what if anything faced them at death. I talked with older people who in earlier years had followed the teachings of a particular religion but for one reason or another, had left religious practices behind. Now ageing, they sought reassurance in regard to the effect past actions might have on whatever, for them, lay beyond the end of life in this world. Such need was often perceived from unspoken signs that occurred within conversation—a long pause triggered by a passing comment, the dropping of eye contact, tears welling for what appeared to be no particular reason.

It took time to build a sense of trust with the man or woman who was experiencing what was a deep need for inner peace. Further visits were made before the resident found the courage to develop a conversation focussed on the misgivings or doubts that were at the heart of a disturbed peace of mind. In most cases, the conversations then centred on the spiritual needs of the individual whose life was now in transition from previously held concepts to new understandings of a possible spiritual dimension of existence.

From observations made over the years, I noticed that the official chaplain or trained pastoral visitor was not always the person to whom the resident felt confident to speak. Visits were sometimes seen as perfunctory. There was the unspoken fear of being judged. The formation of a trusting relationship remained unrealised. I began to notice that the person to whom the resident was most likely to turn was the caregiver; a person met almost daily, someone who had built a personal relationship with the ageing resident. It may have been a nurse from the medical team; it may have been a therapist whose regular attentions built an atmosphere of trust and concern; but most likely it was the daily caregiver who had built that ongoing, caring relationship with the resident.

On occasions a familiar, trusted and sympathetic listening ear was all that was required by the resident who needed to verbally express inner feelings. Yet more often, a reassuring response was demanded. From such situations, I found questions arising. Was the caregiver aware of what were essentially the spiritual needs of the resident? Did the caregiver have the ability to respond to the spiritual dilemmas of the ageing persons in their care?

Questions such as these led to the focus of my thesis: Are Caregivers in New Zealand rest homes adequately prepared to respond to the spiritual needs of the frail elderly?
I believe this question is important for the wholistic well-being of the ageing population of New Zealand who are now living in or in the future will choose to live in rest homes.

I base my comments now from research recently conducted in two rest homes in the greater Wellington region.

2. What are the spiritual needs of residents?

Firstly, I'm not merely referring to religious needs. The word *Religion* has generated many definitions which include the systematic ordering of beliefs in supernatural powers, rituals in which those spiritual beliefs are expressed, sacred symbols and writings, and sets of values which may differ from those of a particular community. Religion is important to some rest home residents but these needs are usually met by pastoral workers of the particular faith to which the resident belongs. Residents interviewed were clear about the importance or otherwise of their religious affiliations and how associated beliefs and ethics had been integrated into or discarded from their lives.

The sense of a spiritual dimension to life is different. It is one which I believe deepens and becomes important to residents as they age. MacKinlay posits the spiritual dimension of ageing as part of the essential spiritual journey that is necessarily a part of being human, seeing it as a search for ultimate meaning in life, one individually undertaken if and when spiritual tasks are recognised during the process of ageing.[1] There is a connection between loss of relationships which gave meaning to life and the search for spiritual meaning in life. Spiritual needs become focussed by the move into institutional care away from the significant relationships on which their lives were previously centred.

I'm not referring to the particular culture which formed the background of the individual resident's life, although culture frequently embodies particular religious or spiritual understandings and needs. When each resident's Care Plan was drawn up on admission to the rest home most cultural needs were identified. Caregivers I interviewed were aware of the cultural responses that were appropriate for their 'cares' and cultural mores were often referred to when we discussed religion and spirituality. However, difficulties in understanding residents' spirituality apart from culture arose particularly with the migrant caregivers. Referring to one of her 'cares' a caregiver said: "Spiritual person—I think it's like that—we have one of our residents here who doesn't eat pork." And a Hindu caregiver for whom English was her second language noted "I don't understand. Maori religions? Maori culture? Kiwi Culture?—so many different cultures—I'm still learning you see."

[1] Elizabeth MacKinlay, *The Spiritual Dimension of Ageing* (London and New York: Jessica Kingsley Publishers , 2001), 223-224.

Ten residents from two rest homes were interviewed to gain a deeper understanding of whether or not they felt they had unexpressed spiritual needs. I tried to tease out from their responses what was for them the existential reality of their present lives and the spiritual issues that might be raised by the frailty of ageing, by the loss of supportive relationships, by the loss of independence or those specific spiritual issues raised by the fear of death. Yet in the course of the interviews it was difficult for five out of the ten to separate spirituality from the practices and social activities of their particular religious backgrounds. Another resident had rejected any involvement with the church of his childhood, yet continued to wear a silver cross on a chain around his neck. He kept offering reasons for breaking away from his faith but I had the impression that spiritual issues of life and death were concerning him. Some of these we discussed but the necessary brevity of the interview left much unsaid. A woman expressed her longing to understand her own spirituality. The richness of spirituality that might have brought her comfort in her ageing years had always been supplied to her through the deep faith of her husband. His death had brought this to an end and left her with a sense of emptiness and futility. The remaining three residents had spent their lives immersed in their particular denominational teachings. They spoke of a perceived new wisdom that accompanied their ageing and expressed confidence in a wide, spiritual dimension to their lives—one which brought a sense of self-worth and peace. Their only spiritual need seemed to be the desire to share their increasingly free visions of the enormity of an existential spirit of love abroad in the world. Two of these residents liked nothing better than to share their new understandings with their caregivers enjoying the opportunity to develop in others the sense of a fulfilled life.

So who is going to help residents, such as those in this sample, to find meaning and purpose in life which ageing renders finite?

3. Who are the caregivers?

For the purposes of this address I define *caregivers* as members of the paid workforce who provide care for older people in residential facilities. Public demand is for the provision of wholistic care for the ageing. Wholistic care will respond to the necessary physical, mental, social, and spiritual needs of residents. The task of caregivers is to be part of a team which contributes to the daily wellbeing of each resident assigned to their care. Their focus is primarily on physical care but the nature of the work often brings wider care challenges.

The group of such workers, nationally, is large. In *Caring Counts,* The New Zealand Human Rights Commission's 2012 report into employment in the aged care sector, it is noted that 'As many as 48,000 workers in New Zealand …undertake indispensable but largely invisible employment every day. They care for older people either in their homes, in residential aged

care facilities, or in hospitals.'[2] According to the report the sector is staffed by an ageing and largely female workforce, many of whom work part time. It is a workforce which embodies a significant gender imbalance and the report signals the desirability of overcoming this as demographic trends indicate increasing male longevity is likely to result in an increase in male residents.

The rest home sector is marked by an ethnically diverse workforce, a trend which is reflected in the sample of caregivers I interviewed. This is not matched to the ethnic diversity of residents. Possibly, in time as the national migrant population ages, rest home residents may reflect the diversity of caregivers.

Of the caregivers interviewed five in one rest home were from a migrant background—some were obviously struggling with the English language. Three were Indo-Fijians, two of whom were Hindus and one Moslem. The fourth was a Hindu Malaysian, and the fifth—a male—was a Christian Filipino. Of the four women interviewed in the second rest home, two were Pakeha, a third was part Maori, the fourth Maori and the fifth caregiver, a male, was Pakeha. As may be deduced from this, the cultural differences between caregivers and residents were significant.

The migrant caregivers presented a cultural and language challenge to residents, their effective interaction and communication being limited by these factors. MacKinlay, in her seminal work on ageing and spirituality, picked up on this point and wrote, "The onus is always on the staff to effectively communicate with residents, never the other way, as these elderly people may often have impaired communication abilities, and need sensitive support from the staff."[3] Migrant caregivers interviewed were alert and bright as they addressed the residents but it was apparent that their comments or questions were often not understood.

Training of the interviewed caregivers varied. The Health Education Trust New Zealand (Inc.) has developed courses for support workers to achieve National Certificates in Health and Disability Care at levels 2, 3, and 4. The similar ACE courses used in the two institutions I studied, follow a pattern of modular teaching through four programmes and are used as a pathway to attaining the certificates. Training for caregivers was experienced in two basic forms. Some attended community classes to study the Foundational Skills modules and undertake placement training in institutions. Later, when employed, they went on to complete credits for required unit standards. Others, who although untrained, were employed by rest homes, worked through an induction course which includes these

[2] The New Zealand Human Rights Commission, *Caring Counts, Tautiaki tika* (Wellington, New Zealand, 2012), 13.

[3] Elizabeth MacKinlay, *Spiritual Growth and Care in the Fourth Age of Life* (London and Philadelphia: Jessica Kingsley Publishers, 2006), 238.

modules. They too are continuing on as individuals to gain unit standard credits and attain knowledge and skills necessary in their daily work with residents.

I move now to consider the nature of their work.

4. Caregiver duties

The individual caregiver is the person upon whom the resident relies daily for the most intimate care. In the homes studied caregivers noted with some sense of pride the ways in which they coped with a heavy daily work load. Their 'cares', as they referred to those for whom they had responsibility, were not always cooperative. I was impressed by anecdotes which told of ways in which caregivers recognised and enabled residents to retain personal dignity while assigned tasks were accomplished.

One caregiver commented, "I do about four or five showers a day, so you start a shower with one person and then you check on another having a wash. In this sort of work you have to become really friendly with your resident. Ask them nicely to help with the assistance—like start getting dressed for the day—you put out the clean clothes and so on." She went on, "I encourage the residents to do a bit for themselves…the main thing is to try and maintain independence and feel wanted. Stuff like that—you know."

Intimate contact was fostered by the concerned attitude of the caregivers. In the course of my interviews it became obvious that caring was understood as more than a concern for their physical necessities. Another caregiver recognised the loneliness felt by residents who no longer have partners or families whose presence once formed the nucleus of their lives: "It's a really good experience working with the people—their special needs and all that… most of them are alone. They have a niece or nephew or something like that but they get lonely, they want to talk."

Through the very private conversations that arose while care duties were undertaken, another found herself the recipient of residents' stories that previously may never have been told. Many of the caregivers spoke of listening to similar experiences of past incidents in the lives of residents. Listening was part of their caregiving experience—stories of pain, hardships or regretted actions possibly never expressed before but now were shared with the person who was showing a personal concern for their well-being. They were stories which embodied the vital questions, hopes, and fears engendered by residents in this fourth stage of their lives; stories which contributed to their spiritual struggle to find life-meaning in past, present and future events. The question arises from this as to the way in which caregivers respond to these conversations. Are they aware of the search for meaning and spiritual peace that lies behind some of these exchanges?

5. Are the caregivers prepared to recognise and understand the spiritual needs of residents?

As was observed, caregivers brought their individuality and personhood to their roles. The intensely personal nature of the relationships that developed between caregiver and resident was the background to the conversations which were part of daily encounters. They were genuinely caring people, but I did not find they were prepared in their training to recognise and understand the spiritual needs of residents.

When asked if the residents ever spoke to them about spiritual matters most caregivers responded that spiritual questions appeared to revolve around the residents' wish to die. They found residents expressed their recognisable spiritual doubts or concerns at times of suffering or distress—when loneliness, deterioration in health, hopelessness or seeming alienation from loved ones became too much to bear. Caregivers working the night shift were particularly familiar with the dark times, the 3 o'clock in the morning questions of self worth or identity that were distressing to wakeful or pain-filled residents. Such residents wanted to talk their doubts and fears through there and then – particularly with this person they trusted.

These caregivers were sympathetic yet they didn't think they knew how to respond to the residents. I questioned them about any training they might have received on this aspect of caregiving. One responded, "We had lectures on different cultures –like the Maori culture, the Jewish culture, and Indian culture as well. One thing I learnt is if the patient talks about their spirituality or their culture openly I learnt not to push my beliefs on them. It took a lot of time for me to understand because I thought I was being helpful but in fact I wasn't."

Looking at the content of the ACE modules that had been studied by the caregivers I found that the spiritual components of caregiving were developed as core competences. A section of Module one outlines the wholistic nature of caregiving and broadly defines spiritual information as being "about how people find meaning in life and a sense of connection with people and important things in their life." Cultural information is defined as "a person's culture is what they do and why they do it, what is important to them."[4] In Module Two: *The Ageing Process*, a section encourages caregivers to look at the spiritual effects of ageing together with cultural changes which may arise from life experiences. The content comments "that as we get older, we may think more about spirituality and what it means to us" noting that spirituality means different things to different people. In this it includes reference to seeking meaning in life through religion or ideas about life, expressing spirituality in love for other people or love of nature, linking spirituality to special places such as the marae or beach or forest, and spirituality as it involves the idea of the soul which

[4] The ACE Programme, Module 1, (Health Ed Trust New Zealand Inc., 2008), 23.

may continue after the death of the body.[5] Reference is made to culture in relationship to the aged, the module noting "our culture does change as we age. It is always important to find out about the culture of each person you support and be aware that their culture may change."[6] Module Four: *Effective Communication* also attends to the changes in spiritual and cultural awareness in residents from the perspective of experiences of grief, noting this is a time when religious beliefs or spiritual values may be questioned. It is in the comprehensive treatment of grief based issues that the module notes the caregiver might recognise the resident's need for more specialised support beyond the boundaries of the caregiver's own abilities in compliance with the rest homes policies and procedures.[7] The common response of caregivers in this situation was to suggest the resident might talk to the chaplain about their concerns. Yet while this might be helpful, I believe that more could be done to prepare the caregiver to interact supportively with the resident at the time the need was most pressing.

6. Conclusion

As the number of rest homes in New Zealand is expanding, so too is the caregiving work force. Public recognition of the importance of the practical aspects of caregiving for the frail elderly of the nation is increasing together with high expectations of the care offered. On becoming a resident in a rest home facility the frail elderly face a major transition from independent living to being dependent on others. This is a significant factor which may trigger a search for spiritual understanding of life.

The work of the caregivers studied showed that their personal involvement in the life and concerns of those for whom they cared was a positive factor in promoting residents' well-being. There is little doubt about the presence of some form of understanding of the spiritual needs of residents being present in the attitudes of those interviewed. For them, spirituality, religion and cultural practices often blended, being understood and appreciated through their own religious and cultural backgrounds. However, I believe that their spiritual care of the elderly falls somewhat short of what is needed.

The spiritual component of the observed caregivers' training was embedded in four modules of the ACE programme which formed the basis of instruction. The modules, while attending to recognition of the spiritual needs of residents, need further development to help caregivers understand more fully the significant role of spiritual well-being in the lives of their 'cares'. I believe more could be done to give them the skills needed and so to be better prepared to respond with confidence to residents' spiritual needs.

[5] The ACE Programme, Module 2, (Health Ed Trust New Zealand Inc., 2008), 48.
[6] Ibid, 50.
[7] The ACE Programme, Module 4, (Health Ed Trust New Zealand Inc., 2008), 81.