Caring for the Carers

Aged Care Industry Benchmark Report

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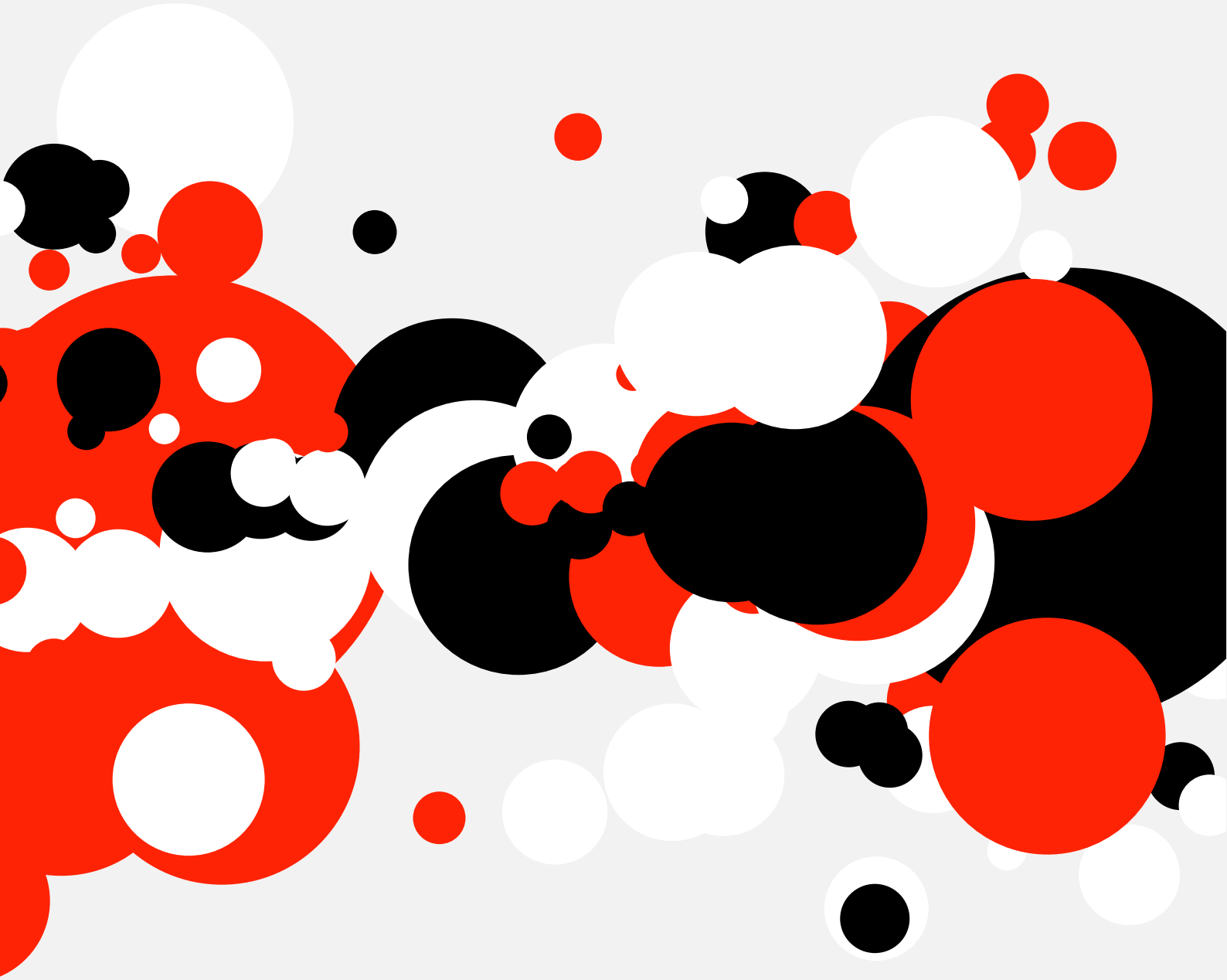

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Executive Summary

The Caring for the Carers project incorporated a substantial benchmarking process of aged care organisations, and their employees, examining the state of management support, employee well-being, the provision of proactive care, and on the reporting of the aged care quality indicators – pressure injuries, sudden weight loss and the use of restraints. The project collected survey data from eight aged care organisations across two states (New South Wales and Queensland). In all, data was collected from 26 separate sites, and from 410 individual employees. The sample includes employees from private and not-for-profit aged care providers, from both regional and urban centres.

This benchmarking report provides participating organisations with an overview and comparison of the distribution of results for each of the variables examined through this project. Key findings from the project include:

Provision of Care Findings

- Proactive Care – a self-report measures that accounts for the ability of an aged care employee to prevent and/or recognise and respond to health issues facing residents - was generally strong across all sites.
- Higher levels of Proactive Care were associated with supportive supervisors, higher individual well-being, teamwork and work autonomy.
- Across all of the sampled respondents, instances of pressure injuries, sudden, unexplained weight loss and the use of physical restraints were infrequently observed by all sampled aged care employees. Aged care employees typically observed these clinical challenges in less than 30% of the residents they cared for.

Management Support Findings

- Positive perceptions of support from supervisors was higher for aged care workers in urban facilities.
- Support from managers was associated with a range of positive work behaviours, including higher levels of safety participation, proactive care, teamwork, wellbeing, and a lower intention to leave
- Employee autonomy, a crucial consideration for advancing employee work morale, was higher in for-for-profit organisations, while instances of managerialism (negative micro-management of employees) was lower in these firms.

Human Resource Considerations

- The average age of surveyed staff at regional aged care facilities was 48, in contrast to 42 years of age for their urban equivalents.
- Migrant workers were more commonly found in the sampled urban, and for-profit, facilities; and not difference was found the approach of this cohort towards proactive care.

- The overall turnover intention of staff was high, with approximately one quarter of sampled aged care workers indicating an intention to leave their organisation. This was significantly lower for those in not-for-profit organisations.
- Lower perceptions of turnover intention were associated with higher levels of well-being, supportive management and lower levels of managerialism (micro-managing).

Implications for Aged Care Organisations

- Substantial differences in average staff responses to the survey were noted from different organisational types (private and not-for-profit) and in different locations (regional and urban). While previous research indicates that aged care organisations are a homogenous group facing universal challenges associated with quality of care and human resources, the results from this study indicate that this is not necessarily the case. Rather, the challenges facing aged care organisations can be unique from one facility to the next, and from one organisation to the next. Accordingly, management initiatives and responses to address challenges may best be designed and implemented at the local level.
- There is evidence that management influence the work-oriented behaviours of staff, and staff in turn play a significant role in shaping the quality of care experienced by residents. Managers can improve work-oriented behaviours through enhancing the level of work autonomy, employee psychological capital, and supervisor support provided to all staff, as these considerations were associated with higher levels of proactive care. There also is a need to stamp out managerialism (micro-management practices), in an effort to improve staff well-being and reduce turnover.

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Study Overview

Australia's population is ageing and demand for residential aged care is rapidly increasing, despite significant growth in home care. At the same time, residential aged care workers face a number of unique challenges, including emotionally draining work, lower pay levels and limited career opportunities. As researchers, we lack a thorough evidence-base regarding how aged care organisations and managers can more adequately support their care staff, in order to advance quality care for elderly residents. Equally, a limited understanding regarding the impact of management support on the quality of care outcomes provided by aged care employees pervades.

The overall objective of this project is to establish a robust evidence-base, within the context of aged care organisations, regarding the state of management support, employee well-being, the provision of proactive care, and on the reporting of the aged care quality indicators – pressure injuries, sudden weight loss and the use of restraints. In doing so, the results of this study seek to equip managers of aged care organisations with insight and tools to more adequately negotiate the challenges associated with residential aged care.

The challenges facing the aged care sector

The aged care sector faces a number of significant challenges. As a sector, policy trends and funding models that impact on the day-to-day operation of aged care facilities have undergone significant changes over the last fifteen years. The sector receives a significant amount government funding, and services are predominantly administered by third sector (not-for-profit and charity-based) and private (for-profit) firms. As with the provision of other social and health services that exist to generate a public good, but receive some or all funding through complex and compliance based government-administered systems, significant challenges associated with organisational resourcing and human resource management considerations are ever-present challenges for aged care organisations. In aged care organisations, one central challenges is having access to highly engaged and committed staff, who remain active at an organisation long enough to provide a continuity of quality care (Kaine 2012, King, Mayromaras et al. 2012). The work of carers, while rewarding, is also emotionally and physically draining. Carers are expected to provide services ranging from basic clinical and hygienic care, to hospitality, cognitive stimulation and wellbeing activities for those under their care. This breadth of these work duties is complicated by the context of aged care, where carers are regularly exposed to stressful, end of life situations involving those who they care for (including challenging behaviours, chronic and acute ailments, and death). While the mandatory level of certificate training (Cert. III and IV) provides carers with competencies required to deliver on work tasks, the broader emotional robustness and energy levels required to stay active and engaged in care work is difficult to acquire in simulated environments (Baldwin, Kelly et al. 2015). Furthermore, those who manage aged care employees, are also confronted with the challenges of resource constraints, competing demands, and managerial inexperience – with only 8.3% of all aged care managers having post-graduate management education (Baldwin et al., 2014).

Care staff who are overburdened with the personal strain associated with the provision of emotionally draining work can quickly become disengaged, reducing their alertness and attention to changes in the health and wellbeing of those under their care. This is complicated by the fact that the average pay received by aged care workers is not sufficient as a primary motivating factor to stay within an organization (Kaine 2012). The combined effect of disengagement and staff turnover on resident care can be profound, as continuity and quality of care suffers and the relationship formed between caregiver and recipient becomes transactional and underdeveloped. In such a climate, the opportunity for negative health outcomes affecting elderly people suffering with dementia, including

but not limited to, pressure injuries, unexplained weight loss, adverse behavioral and psychological episodes (and the need for restraints), may be more pronounced. In consideration of an expected boom in demand, requiring the care workforce to both renew and grow to three times its current size in the next three decades, staff disengagement and retention pose some of the most visible threats to the viability of high quality care in the Australian aged care sector (Baldwin, Kelly et al. 2015).

To date, current solutions for these issues has encouraged aged care providers to adopt a more efficiency-driven approach, outsourcing care to temporary agency staff when required, and setting up highly routinized work environments where care staff are required to undertake certain preventative duties at set times (Radford, Shacklock & Bradley, 2015). In many ways, an efficiency and output driven model of residential aged care has also been encouraged through the Australian Governments roll out of the residential aged care quality indicators.

In 2016, the Australian Federal Government launched new accreditation reporting standards, termed the Aged Care Quality Indicators (ACQIs), which are applicable to residential aged care organizations. The ACQIs comprise three measures: incidents of pressure injuries; sudden, unplanned weight loss; and, the use of physical restraints. The quality indicators are designed capture the end result of a coherent care strategy implemented at the organisational level, as residents who present with these clinical challenges upon entry are excluded from the reporting process. However, the human resource strategies, management practices, employee work behaviours and quality of care considerations, which may form the antecedents of the positive outcomes quality indicators, are not captured. Aged care employees have proportionally less training than other health care workers with clinical duties, and are responsible for a range of care tasks, not limited to low level clinical and hygiene care, in addition to resident cognitive stimulation, entertainment and hospitality. As such, aged carers are not necessarily equipped with the specialized and institutionalized clinical safety and care practices of nurses or doctors. While safety climate interventions at the management and employee levels offer an evidence-based mechanism to improve organizational performance against what might be considered to be quite clinically-oriented ACQIs (Zohar 2010, Law, Dollard et al. 2011), such interventions need to be more thoroughly customized, and also focus on the antecedents of quality care, in the context of aged care. The aim of the project here in is to examine whether, and to what extent, these broader management and employee antecedents impact on, or form a foundation for, the quality care of residents.

Method

A survey method was used to collect data from aged care workers within participating aged care organizations. The survey included a range of developed and pre-validated, psychometric scales to account for variables including:

Provision Care Outcomes	Management Support and Positive Work Behaviours	Human Resource Management Variables
Safety Participation	Perceived organisational support	Resource Adequacy
Proactive Care	Supervisor Support (leader-member exchange)	Turnover Intention
	Employee Well-being	Age
	Employee Stress	Migrant status
	Managerialism (micro-management)	
	Autonomy	
	Teamwork	
	Psychological Capital	

In addition to these, data was collected from employees concerning the number (percentage) of people they cared for (in the last three months) presented with:

- Pressure injuries
- Sudden, unexplained weight loss
- Behavior resulting in the use of physical restraints

These conditions correspond with the aged care quality benchmarks that form the basis of a new reporting paradigm for residential aged care providers, currently being rolled out across Australia. The measures used in this survey collected data at the employee level, and this is distinct from the national system (that collects information at the organizational level). In this case, the data was collected at the employee level to provide a way to examine the statistical relationship between employee's positive work behaviors and resident quality of care outcomes.

Sample

Utilizing the registered database of aged care organisations available on the MyAgedCare.com.au website, a list of accessible firms residing in and around the metropolitan areas of Sydney and Newcastle (NSW), and the Gold Coast and Brisbane (QLD), was assembled. Firms were emailed an information pack outlining the research project and participant requirements. In total, eight firms agreed to be involved. The participating organisations remain anonymous in this research, in line with research ethics protocols.

Of the eight participating firms, half possessed a for-profit governance structure, and the other half operated as not-for-profits, often with affiliations to a larger religious/charitable organization. Of the 410 sampled respondents, 215 were from the for-profit firms, and 195 were from the not-for-profit organisations.

Of the eight organizations, three managed multiple facilities. Thus in total, data was collected from a total of 26 residential aged care facilities. A total of six of the sampled facilities resided outside of metropolitan/ urban areas of Sydney and Brisbane/Gold Coast. Of the 410 valid surveys returned, those sampled aged care employees working in regional areas amounted to 114 respondents.

The data collection process involved researchers visiting each site in person, often within the designated breaktimes (in the day) of employees. Employees were invited to participate in the survey, with easy access to the attending researcher when further clarification about any of the survey items was necessary. Due to time restrictions and the large geographical distances present between the participating facilities, the data collection did not include those staff working on night shifts. 456 staff volunteered to participate in the survey. Of these, 46 possessed significant sections of incomplete/un-entered information, and were excluded from analysis.

Analysis

For the psychometric questions, respondents were asked to rate their level of agreement with each question on a likert scale from one (strongly disagree) to six (strongly agree). For the questions concerning the Aged Care Quality Indicators – pressure injuries, unexplained weight-loss and the use of physical restraints – respondents noted the percentage of residents in their care (in increments of 10%, starting with 0%), who presented with these conditions.

The raw survey data was transcribed into SPSS 24 statistical analysis software. A missing data analysis concluded that none of the sampled psychometric items had more than 10% missing data (often with between 0-1.5% of missing entries per item), as such, where missing data was present, the item mean was imputed. The exception to this was the items concerning the Aged Care Quality Indicators – pressure injuries, unexplained weight-loss and the use of physical restraints. Approximately 1/5th (22%) of the sampled aged care employees were not directly responsible for the clinical, day-to-day care of residents, but undertook roles including kitchenhands, leisure and lifestyle activities coordinators and cleaners. For the data regarding the aged care quality indicators, and their correlation with proactive care, only respondents who directly answered these questions were included in the analysis.

A Harmon's single factor variance test was conducted to ascertain the potential for common method variance in the data. Common method variance exists when respondents answer a survey in a way that is not truly reflective of their experiences concerning each question asked, but rather as a result of the bias created through the survey instrument. The Harmon's single factor technique ascertains how much variance was present within each respondent. Applied to the data used in this study, 23.5% of the variance explained one factor, suggesting a very low chance of common method variance.

The data were subject to exploratory and confirmatory factor analysis. This process examines the statistical relationship between each survey questions corresponding with the same, and different, variables. The purpose of this process was to develop a set of valid and robust variables that possess a high instrument reliability score (composite reliability), and a clear statistical distinction between other variables. This process applied to this data set yielded a strong instrument reliability for each tested item. The questions/items that make up each variable, their statistical association with the overall variable and the overall composite reliability of each variable are included in the analysis below.

Mean score and statistical correlation analysis was carried out on the variables. Prior to this, the variables were converted into percentage. The results presented in this report utilizes analysis of variance between the mean score of groups (ANOVA) (private and not-for-profit, and urban and regional) as well as two-tailed correlational analysis between variables.

Findings

The results from the employee and manager surveys are presented under three broad themes – provision of care, management support and positive work behaviours, and human resource management considerations. The topics explored under each of these themes are presented in the following table.

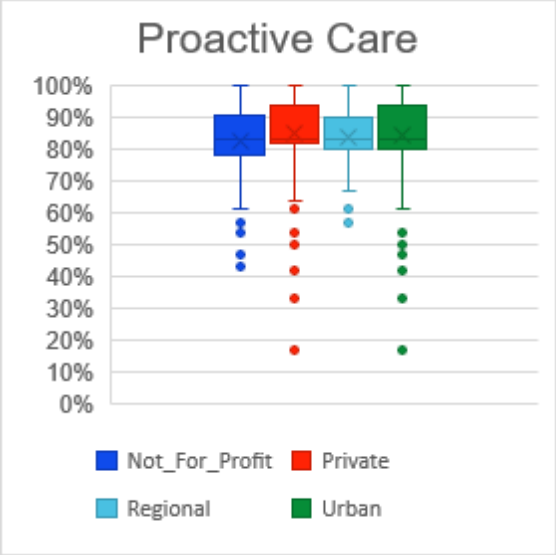
Theme	Topics and variables examined

Provision of Care	• Aged care staff approach to Proactive Care
	• Safety Participation
	• Employee level reporting of Aged Care Quality Indicators –
	  ○ pressure injuries,
	  ○ sudden weight loss, and
	  ○ the use of restraints

Management Support and Positive Work Behaviours	• Perceived organisational support • Supervisor Support (leader-member exchange) • Employee Well-being • Employee Stress • Managerialism (micro-management) • Autonomy • Teamwork • Psychological Capital
Human Resource Management Considerations	• Workforce age consideration • Use of migrant and non-English speaking labour • Staff turnover intention • Resource Adequacy

Provision of Care

Proactive Care



What is Proactive Care?

Proactive Care is a self-report measures that accounts for the ability of an aged care employee to prevent and/or recognise and respond to health issues facing. As the policies governing the provision and quality of aged care become more pronounced and clinically-oriented, proactive care is used here to examine the extent to which aged care employees are able to respond and address these. The questions that comprise this scale are provided in the table proceeding the adjacent graph.

Explanation of findings about Proactive Care

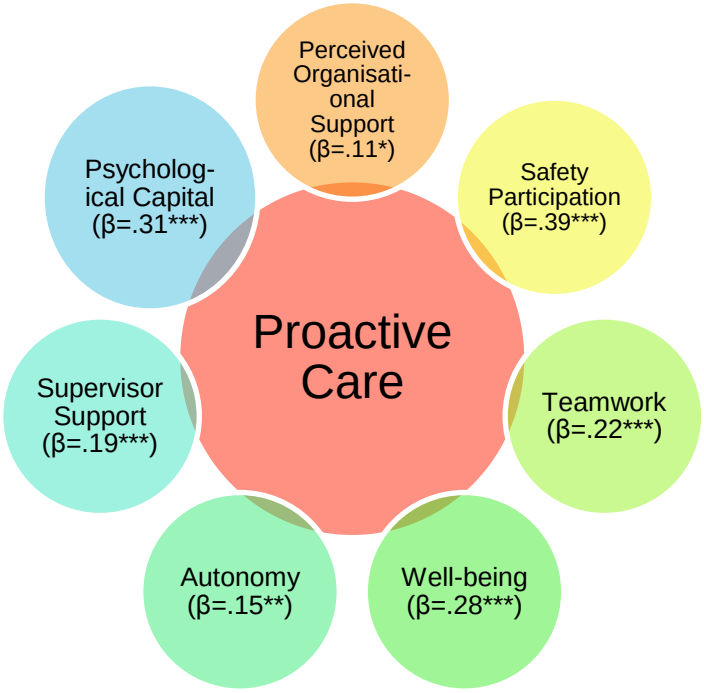
In general, the distribution of proactive care across the sampled aged care employees was high, with an average score of 84% in support. While no significant difference could be noted between the different types of aged care organisations, those aged care employees working in private organisations had a slightly higher average score for proactive care.

Proactive Care

	Factor load
I am able to recognise health problems in the residents that I care for	.776
I closely monitor any changes in the physical weight of residents	.808
I can generally identify who is likely to get a pressure injury, and monitor them accordingly	.859
I am good at preventing injuries or infections in residents	.778
I consider it my responsibility to keep residents healthy	.505
I am easily able to mobile, move, and lift residents when necessary	.564
Residents under my care get the best quality health experience	.658
Composite Reliability	**.90**
Overall Mean (out of 1)	**.84**

Correlations with Proactive Care

A two-tailed, correlation analysis of Proactive Care with other provision of care and positive work behaviour variables is provided below.



*p<.05, **p<.01, ***p<.001

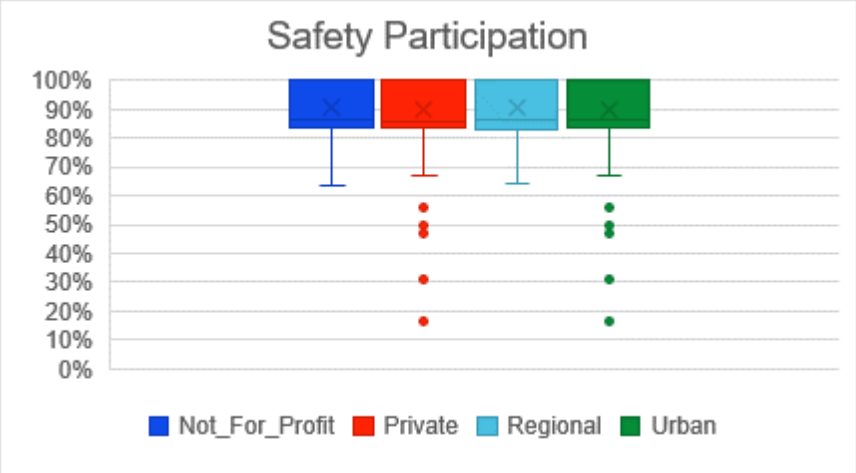
Explanation of correlation findings

Positive Proactive Care was associated with a range of other positive work behaviours and quality care indicators. Those with the strongest association include the employees' psychological capital (β=.31, p=.000), their levels of well-being (β=.28, p=.000), and their degree of safety participation (β=.39, p=.000). These results suggest that employees with higher well-being, and positive psychological capital, are safer and provide a better quality of care.

Safety Participation

What is Safety Participation?

Safety participation is a component of safety climate and is considered an antecedent to delivering safe clinical outcomes for those in care. It relates to adherence to organisational and professional safety policies.



Explanation of findings about Proactive Care

The overall mean of safety participation of the sample was 90.3%, and there was no significant difference observed between respondents in private or not-for-profit, nor those in regional or urban groupings. In general then, aged care staff rated their adherence to safety processes very positively.

Safety Participation

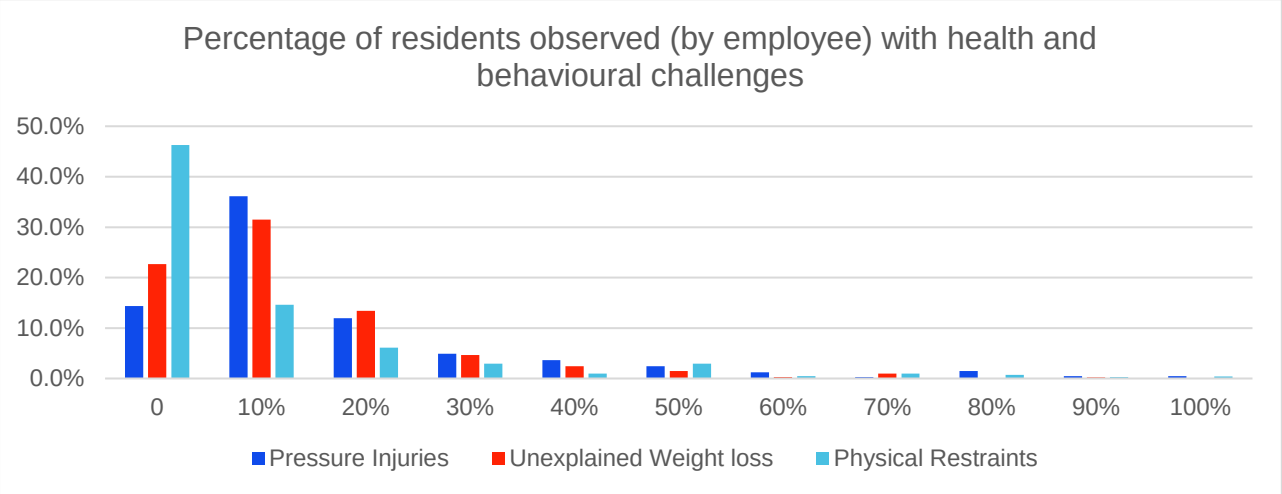
	Factor load
I use all of the necessary safety equipment to do my job	.877
I use the correct safety procedures for carrying out my job	.973
I ensure the highest levels of safety when I carry out my job	.902
I put in extra effort to improve the safety of the workplace	.751
I voluntarily to carry out tasks or activities that help to improve workplace safety	.544
Composite Reliability	**.97**
Overall Mean (out of 1)	**.90**

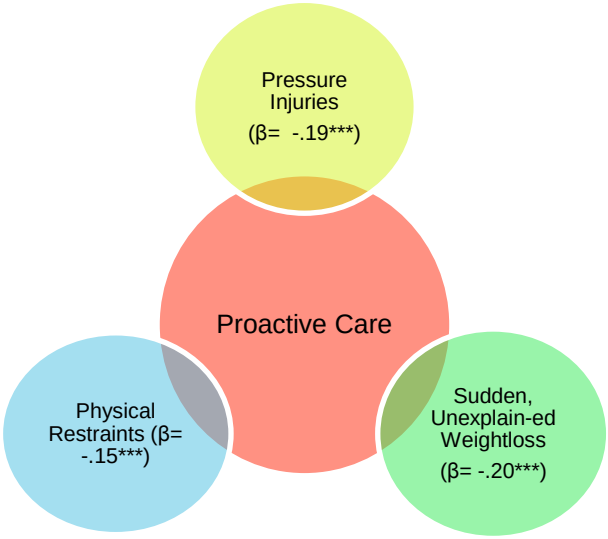
Aged Care Safety Benchmarks (Individual-level Reporting)

What are the Aged Care Safety Benchmarks?

In the survey data reported herein, aged care employees were asked to identify how many of the residents that they care for presented with pressure injuries, sudden unplanned weight loss, and/or utilize physical restraints.

It is important to note that the observations reported here are not wholly representative of the formal Aged Care Quality Indicator Benchmarking process, which pertains to a clinical assessment carried out by trained staff at the whole of organisation-level. What is reported herein amounts to the observations by individual aged care employees, and does not control for the number of residents cared for by each aged care employee, nor the degree of cross-over (i.e. multiple carers may care for the same number of residents with presenting challenges). The measures thus may be indicative of the types of health and behavioural challenges faced by aged care workers.





Explanation of findings

As can be noted in the above graph most employees reported than less than 30% of the residents they care for experience pressure injuries and unexplained weight loss, or require physical restraints. This suggests that the vast majority of residents are not experiencing adverse clinical or behavioural outcomes.

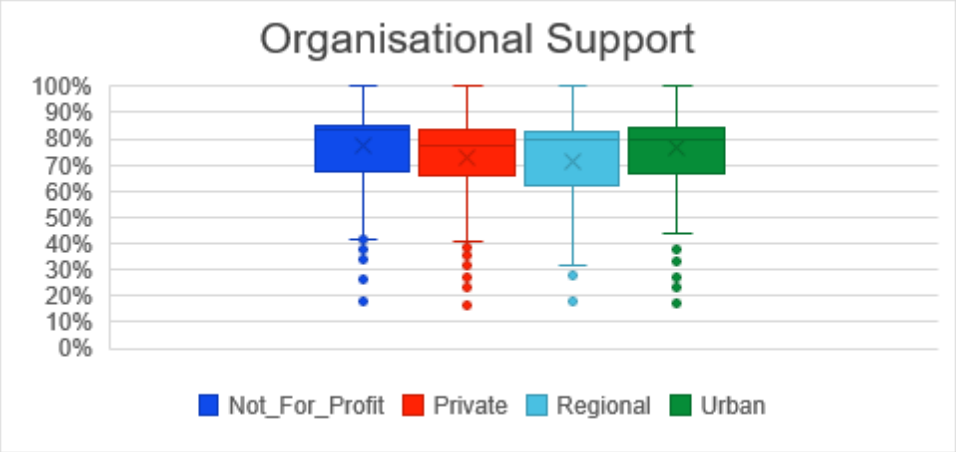
The adjacent correlation analysis indicates that positive proactive care was associated with lower instances of each of the quality indicators. This provides some justification for a small association linking employee positive work behaviour (proactive care) and resident clinical and behavioural outcomes. However, as the data indicates (with correlations less than .20) the statistical association is relatively low.

Management Support and Positive Work Behaviours

Perceived Organisational Support

What is Perceived Organisational Support?

Perceptions of supervisor and organisational support were examined using the shortened perceived organisational support scale (Rhoades and Eisenberger, 2002). Perceived organisational support captures the degree to which an employee feels that their organisation values their contribution and cares about their well-being. The questions comprising these scales, their factor loads, statistical (composite) reliability and overall mean are provided in the tables proceeding the graphs below.



Explanation of findings concerning Perceived Organisational Support

The average level of perceived organisational support observed across the aged care organisations was moderate 74.9%. A very slight difference was noted between for-profit (73%) and not-for-profits (77%), and urban (76.5%) and regional (71%), firms.

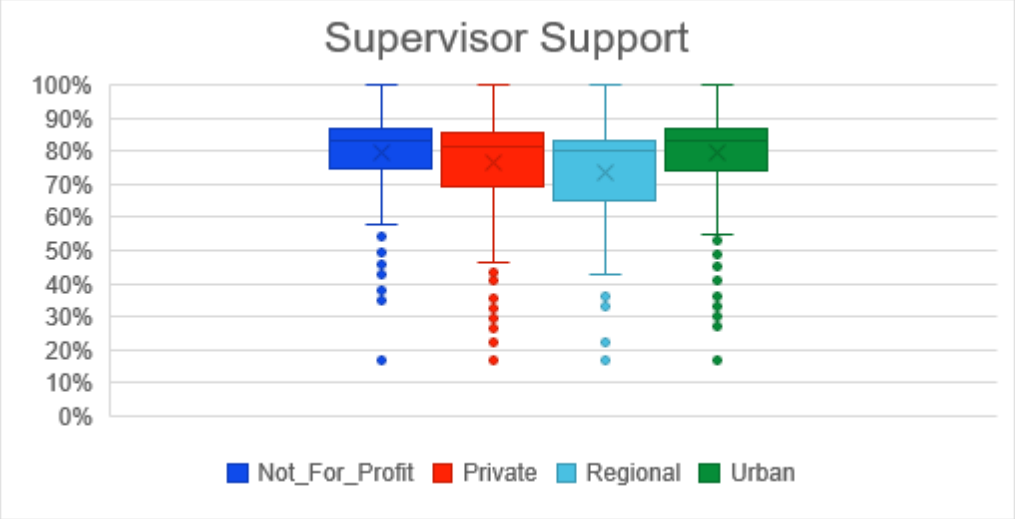
Perceived Organisational Support

The organisation that I work for…	Factor load
Cares about my opinion	.869
Cares about my well-being	.890
Considers my goals and values	.866
Provides help for me when I have a problem	.838
Would forgive an honest mistake on my part	.712
Would not take advantage of me	.681
Is willing to help me if I need a special favour	.712
Composite Reliability	**.94**
Overall Mean (out of 1)	**.75**

Supervisor Support (Leader-Member Exchange)

What is Supervisor Support?

Supervisor Support accounts for the relationship formed between a supervisor and employee, from the perspective of the employee. Theory suggests that employees with a supportive supervisor are more likely to reciprocate with positive work-oriented behaviours (Graen & Uhl-Bein, 1997). The leader-member exchange scale was used to capture this variable



Explanation of findings concerning Supervisor Support

The average level of supervisor support was 78%, but this was significantly lower in regional facilities (73.8%), and slightly higher in urban facilities (79.6%). This suggests that additional training might be required for managers in regional facilities, in order to enhance the supervisor-subordinate experience in these locations. As noted in the following section (Human Resource Considerations), higher supervisor support is associated with lower intention to leave, and hence improving supervisor support in general may have a positive impact in reducing turnover.

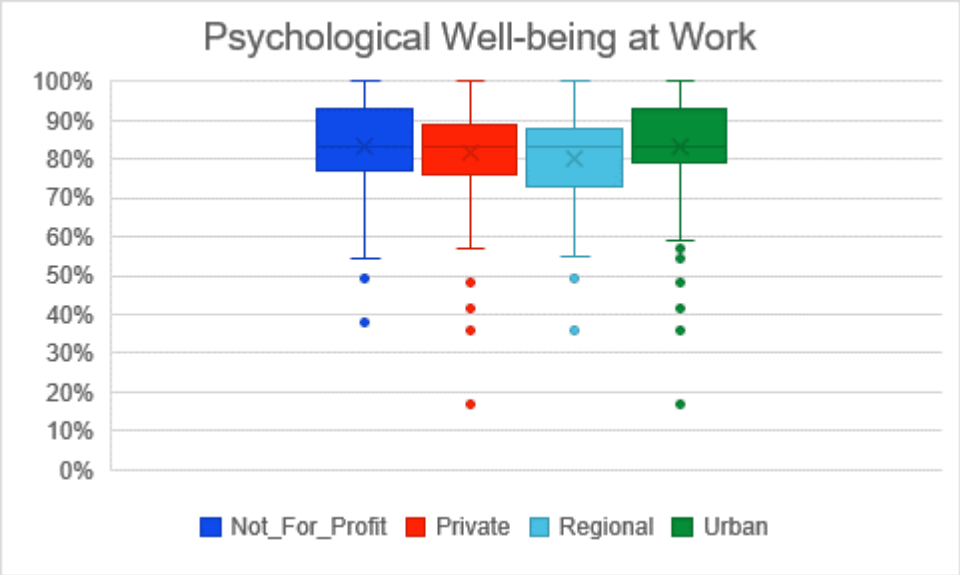
Supervisor Support (Leader-Member Exchange Scale)

My manager…	Factor load
Is satisfied with my work	.751
Understands my work problems and needs	.874
Recognises my potential	.845
Is willing to use their power to help me solve problems	.568
Would be willing to 'bail me out' at her/his own expense	.792
I have a good working relationship with my manager	.578
I would defend my manager if they were not present	.842
Composite Reliability	**.92**
overall Mean (out of 1)	**.79**

Employee Well-being at Work

What is Employee Psychological Well-Being?

An employee's psychological well-being account for their perceptions regarding the overall experience and functioning of the workplace, including their perspective of their job and the organisation.



Explanation of findings concerning Supervisor Support

The average well-being score was positive at 82.3%. Well-being was slightly higher for those working in urban facilities (83.5% versus 81%), but no significant difference was noted between for-profit and not-for-profit employees.

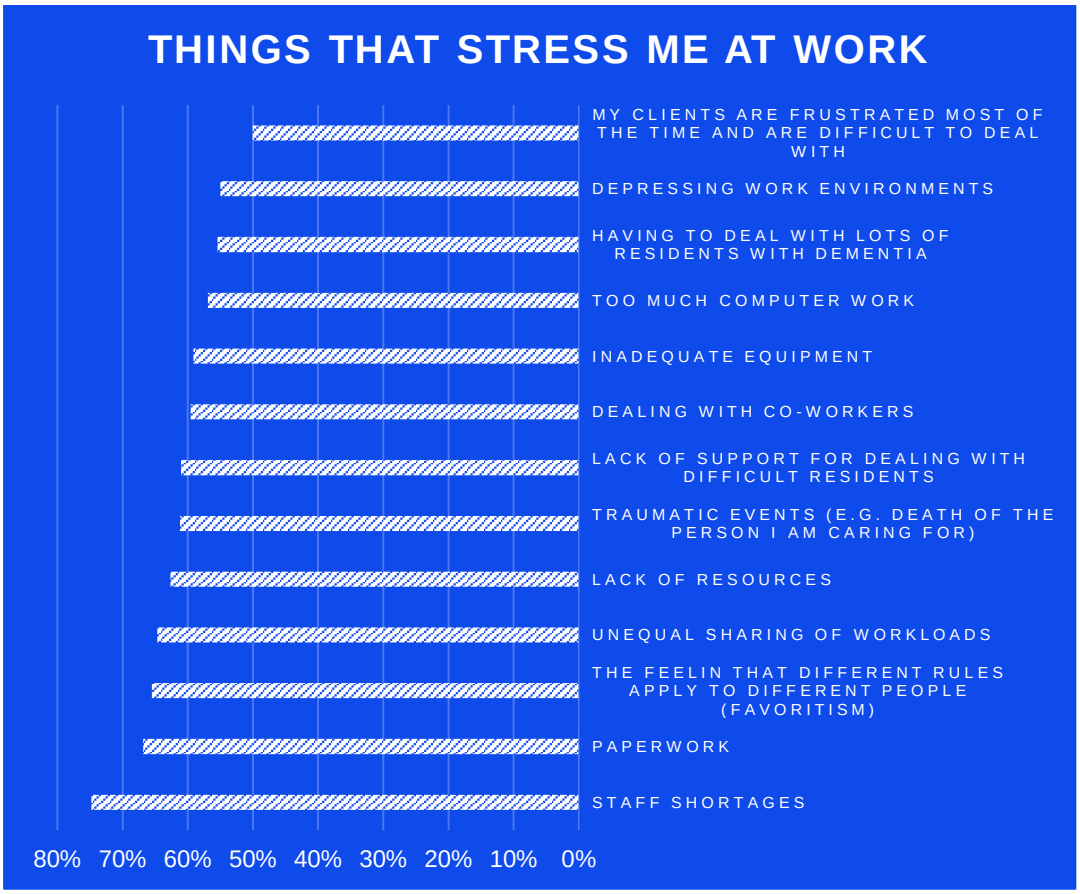
Psychological Well-Being Scale

	Factor load
Overall, I am reasonably happy with my work life	.653
Overall, I fulfil an important purpose in the work that I do	.812
Most days I feel a sense of accomplishment from my work	.763
I get enough time to reflect on what I do in the workplace	.790
Composite Reliability	**.85**
overall Mean (out of 1)	**.82**

Work Stress

What is Work Stress?

Work stress is a significant workplace issue that can affect the behaviour and performance of employees negatively. Many things cause work stress. The survey herein collected data from employees concerning the level of agreement concerning whether a certain factor (stressor) led to work stress.



Explanation of findings concerning Work Stress

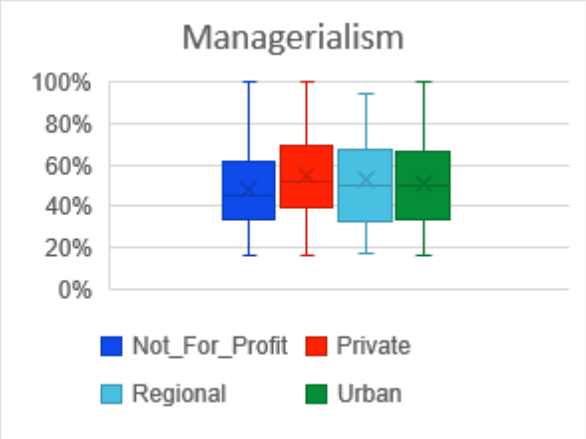
The highest scoring stressors were staff shortages, paperwork, favouritism and an unequal sharing of resources. For the most part, these (top-four) stressors relate to the way in which employees are managed within the firm. Of note, the scores for each of the stressors are quite high, supporting the notion that residential aged care work is quite stressful.

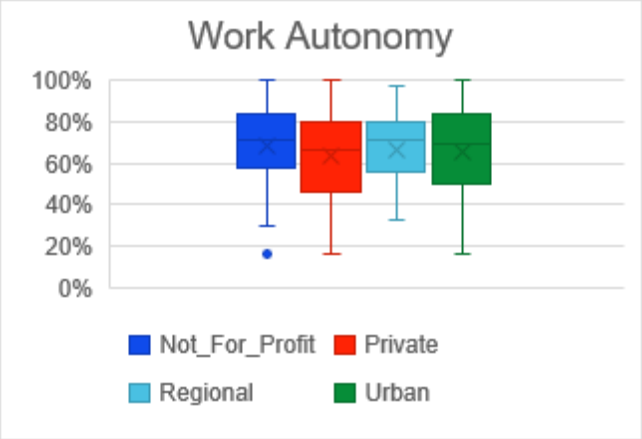
Managerialism and Autonomy

What are Managerialism and Autonomy?

Managerialism (also known as micro-management) is a negative work act that affects employees. The action can take the form of bullying of employees, and research has shown that supervisors have an enabling role in facilitating managerialism.

Autonomy at work is a positive work state, whereupon an employee has power of the way that they undertake their work. Research has linked autonomy with a range of positive work performance outcomes, and the act of giving freedom to enable an employee to decide how to undertake their work can increase their ownership of tasks as well as their ability to innovate.





Explanation of findings concerning managerialism and autonomy

The average level of managerialism was quite high at 51.7%, and this was significantly higher in for-profit facilities (55%), and lower in not-for-profit firms (48%). Noted in the following section (Human Resource Considerations), managerialism is associated with higher levels of intention to leave, and hence reducing acts of micromanagement within the firm may have a positive impact in reducing turnover.

The average level of autonomy was 65.4%. This was lower in for-profit firms (63%), and higher in not-for-profits (68%). Noted in the above (quality of care) section, autonomy has a small but significant association with proactive care.

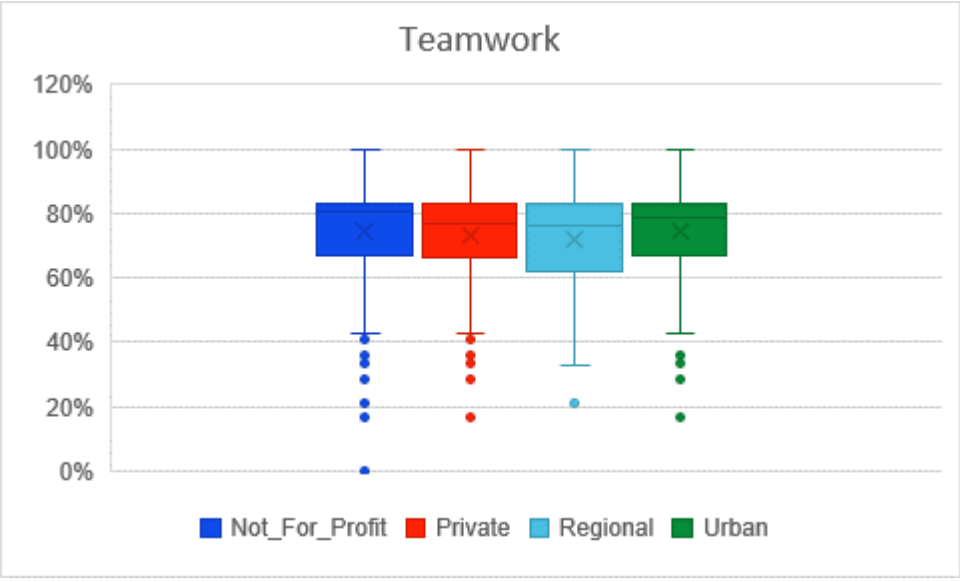
Managerialism and Autonomy Scales

Managerialism	**Factor load**
The organisation that I work for sets unrealistic targets	.782
I experience excessive work monitoring at work	.759
I am given meaningless tasks at work	.726
Composite Reliability	**.92**
overall Mean (out of 1)	**.52**
Autonomy	
I decide how I do my job	.745
I can decide on my own how to go about doing my work	.872
I have opportunities for independence and freedom in how I do my job	.680
Composite Reliability	**.85**
overall Mean (out of 1)	**.65**

Teamwork

What is Teamwork?

Teamwork accounts for group cohesion within working teams. The teamwork scale used here accounts for the ability of staff to resolve issues and make decisions in a cooperative and consultative matter within a work group.



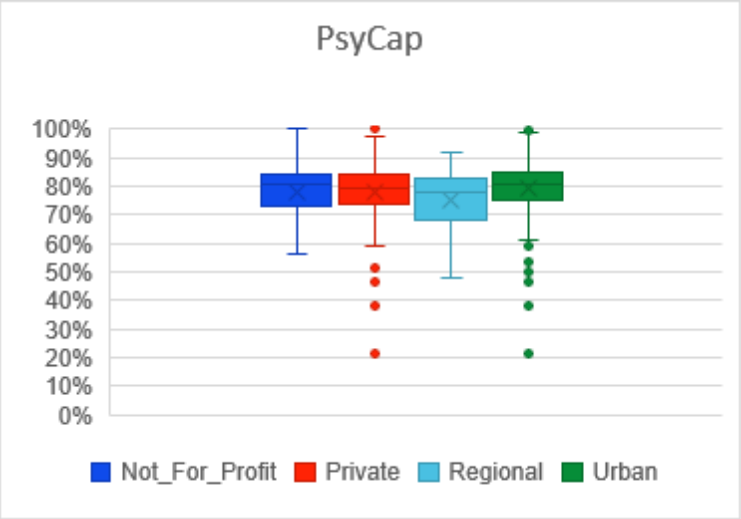
Explanation of findings concerning Teamwork

The average teamwork score was positive at 73.9%. No significant difference was noted between for-profit and not-for-profit, nor for regional or urban, employees.

Teamwork Scale

The people I directly work with…	**Factor load**
Resolve disagreements cooperatively	.894
Are cooperative and considerate	.860
Constructively confront problems	.901
Are concerned about each other	.873
Composite Reliability	**.94**
overall Mean (out of 1)	**.74**

Psychological Capital



What is Psychological Capital?

Psychological capital (PsyCap) is a relatively new addition to workplace behaviour research, but consistently, this variable has been shown to significantly impact on a range of work performance outcomes (Luthans et al., 2007). The variable captures the psychological states of hope, optimism, resilience and self-efficacy (the amount of effort ascribed to one's job). Psychological capital is an individual-level variable which amounts to the positive resources an employee bring to their role, that aids their focus and motivation at work, and ultimately their performance. Management factors such as the relationship a person forms with their manager, appear to have a link with a person's psychological capital, and studies have shown that training can enhance psycap levels. Furthermore, recent research has linked psychological capital to positive safety outcomes in health care settings (Brunetto et al., 2016).

Explanation of findings concerning Psychological Capital

The average level of psychological capital was high at 78.3%. Yet, psychological capital was significantly higher in urban facilities (79.5%) and lower for regional employees (74.5%). As psychological capital was shown to have a strong positive association with proactive care (β = .30, p=.000), and negative association with intention to leave (β= -.27, p=.000), advancing the levels of psycap in aged care employees emerges as a substantial pathway to improving organisational outcomes.

Psychological Capital Scale

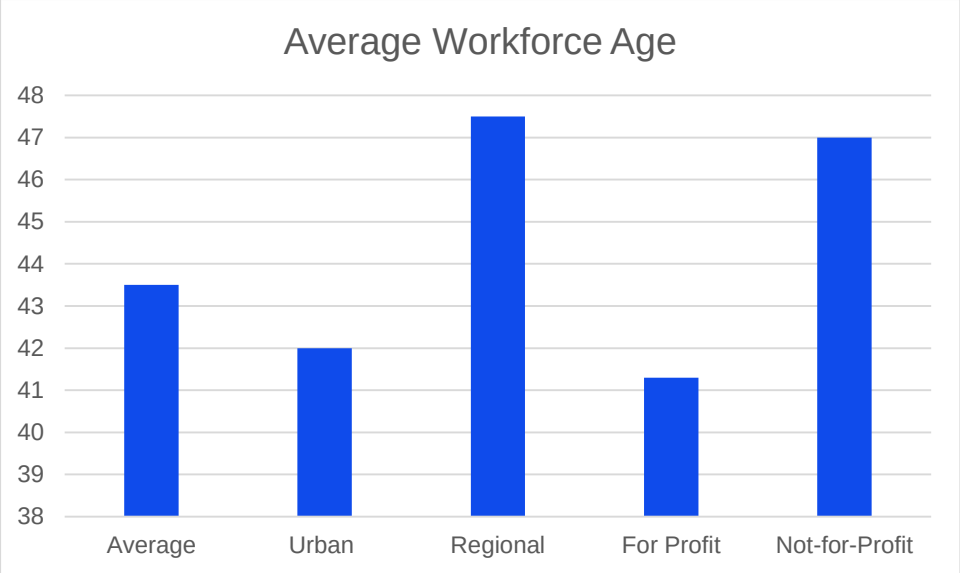
Hope (.84 Composite Reliability)	**Factor load**
At this time, I am meeting the goals that I have set for myself	.813
I can think of many ways to reach my current work goals	.782
Right now I see myself as being pretty successful at work	.794
Optimism (.79 Composite Reliability)	
I approach this job as if "every cloud has a silver lining"	.819
I always lookon the bright side of things regarding my job	.740
I'm optimistic about what will happen o me in the future at work	.559
Resilience (.74 Composite Reliability)	
I can get through difficult times at work because I've experienced difficulty before	.503
I usually take stressful things in my stride	.725
I usually manage difficulties, one way or another	.768
Self-Efficacy (.84 Composite Reliability)	
I feel confident in contributing to discussions about my workplace's strategy	.554
Representing my work area in meeting with management	.775
Presenting information to a group of colleagues	.777
overall composite reliability	**.86**
overall Mean (out of 1)	**.78**

Human Resource Management Considerations

Workforce Age

Why is the workforce age important?

The average age of a workforce is a useful metric in understanding workforce renewal planning. The Australian Productivity Commission Report on Aged Care (2011) noted that the average age of aged care workers was quite high, and that workforce renewal will remain a continuing challenge, even while the sector undergoes unprecedented growth.

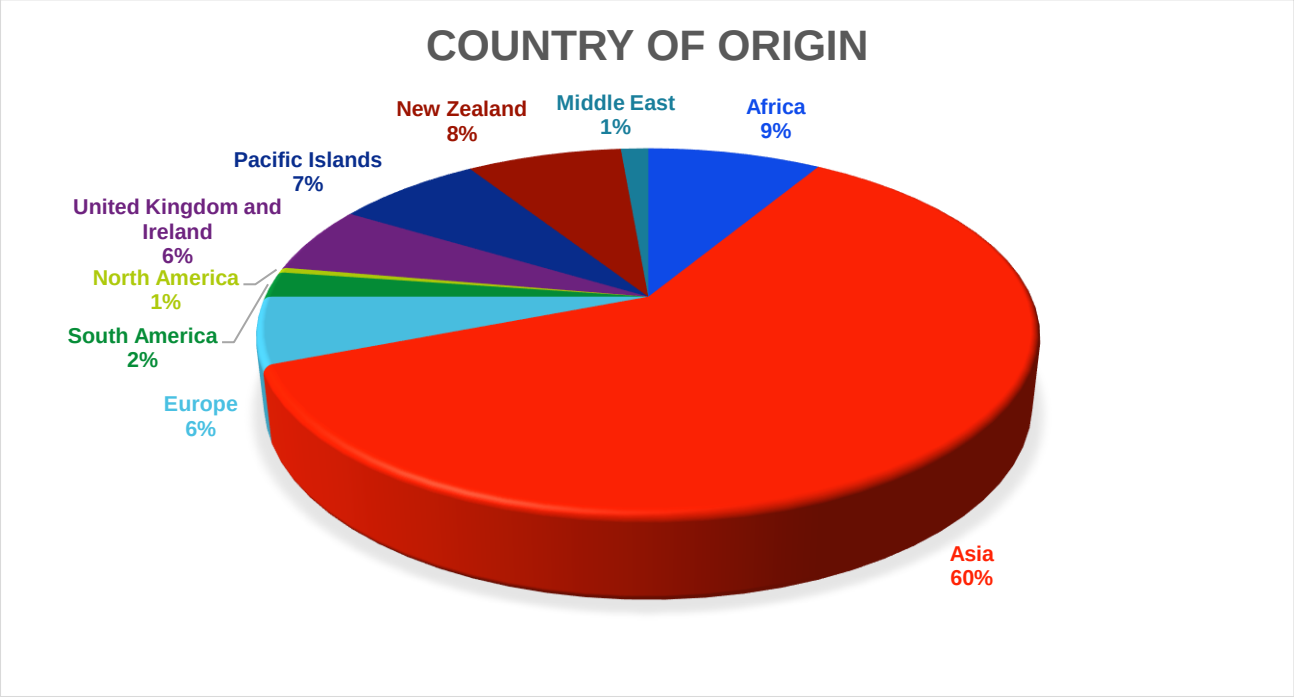


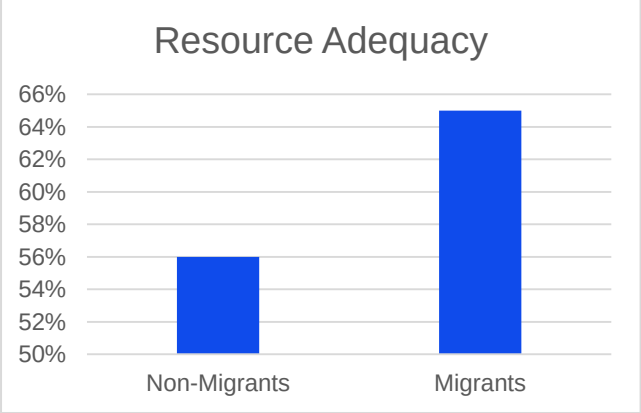
The above graph indicates that the average age of sampled respondents was 43.5. However, the average age of regional employees, and not-for-profit employees was significantly higher (47.5 and 47 respectively). This indicates that workforce renewal may be a more pronounced problem in regional areas, and for not-for-profits, who may struggle to offer employment benefit packages to attract new employees. Regional and not-for-profit aged care organisations, as well as their urban and for-profit equivalents, may benefit from instigating graduate pathway programs with local technical colleges and TAFE facilities.

Use of Migrant and English Second Language labour

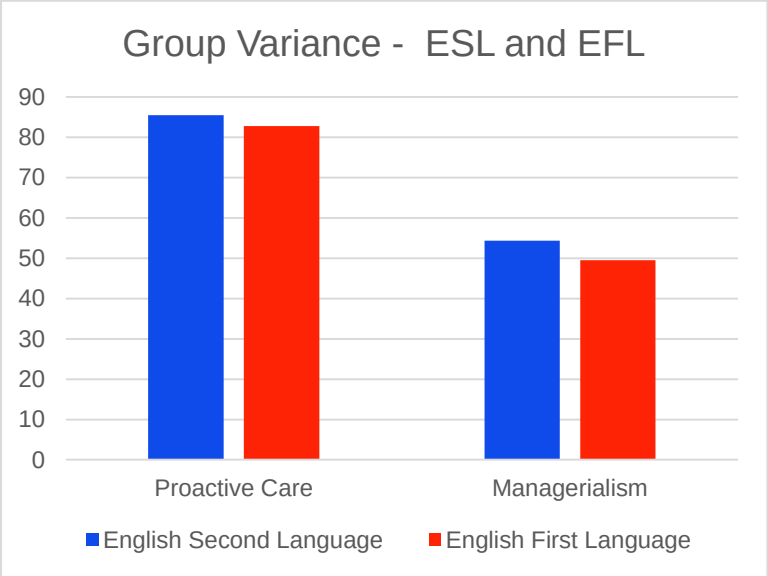
The Australian Productivity Commission Report on Aged Care (2011) highlighted a high proportion of migrant, and English Second Language (ESL) labour as a potential risk for advancing quality care in residential aged care, citing issues of cultural incongruities and comprehension of care difficulties.

Of the sample in this study, 52.9% of respondents identified as migrants. Displayed in the pie chart below, the majority of migrant labour migrated from Asia, including the countries of Nepal (9.8% of the entire sample), Philippines (7.8%), India (3.4%) and Sri Lanka (2.0%).



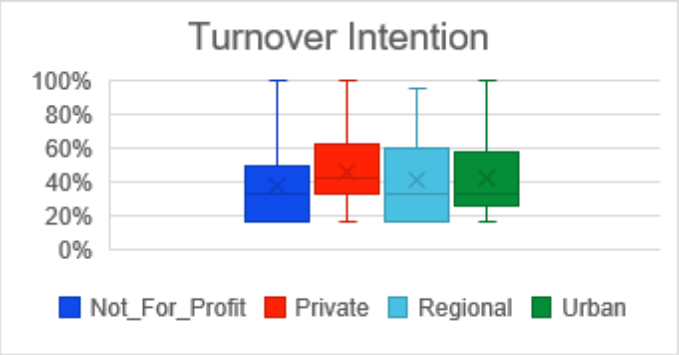


An analysis of group variance (ANOVA) was conducted to examine whether the sampled migrants responded differently to any of the given psychometric variables. The only variable that appeared to be significantly different was resource adequacy, which was reported to be higher (65%) for migrant workers, in comparison to 56% for non-migrants. This may suggest that migrants, perhaps coming from aged care and health care organisations from overseas, find Australian aged care facilities to be more adequately resourced.



45% of sampled respondents noted that English was their second language (ESL). An analysis of group variance indicated that proactive care was slightly higher for ESL participants (85.5% versus 82.8%). However, significantly higher instances of managerialism (micromanagement) were noted for the ESL group (54.4%) compared with the English first language group (49.5%). This suggests that there may be some inherent prejudice facing ESL employees, despite the fact that their approach to proactive care is equal, or in some cases better, than the English first language respondents.

Staff turnover intention



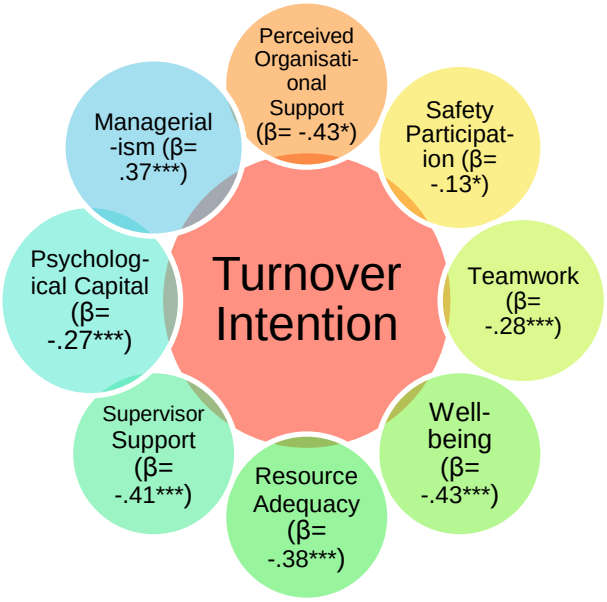
What is Intention to Turnover?

Turnover intention captures employee's desire to exit an organisation, thereby providing a useful metric for examining possible employee turnover in the short to medium term. As noted in the introduction, employee turnover has been noted as a significant challenge facing many aged care organisations.

Explanation of findings concerning Turnover Intention

The average turnover intention for all sampled respondents was quite high at 42.7%, however this was higher for for-profit employees (47%) and significantly lower for not-for-profit employees (38.5%). No difference was noted between regional and urban averages. Retention appears to be a more pronounced problem facing for-profit organisations.

Correlations with Turnover Intention



A two-tailed correlation analysis of turnover intention with other management and work behaviour variables is provided below.

The correlation analysis suggests that a higher turnover intention was associated with a range of negative work behaviours and depressed levels of management and organisational support. Mechanisms to improve retention may take the form of initiatives to enhance management support, employee wellbeing, and individual psychological capital. This may also benefit a range of other employee outcomes.

*p<.05, **p<.01, ***p<.001

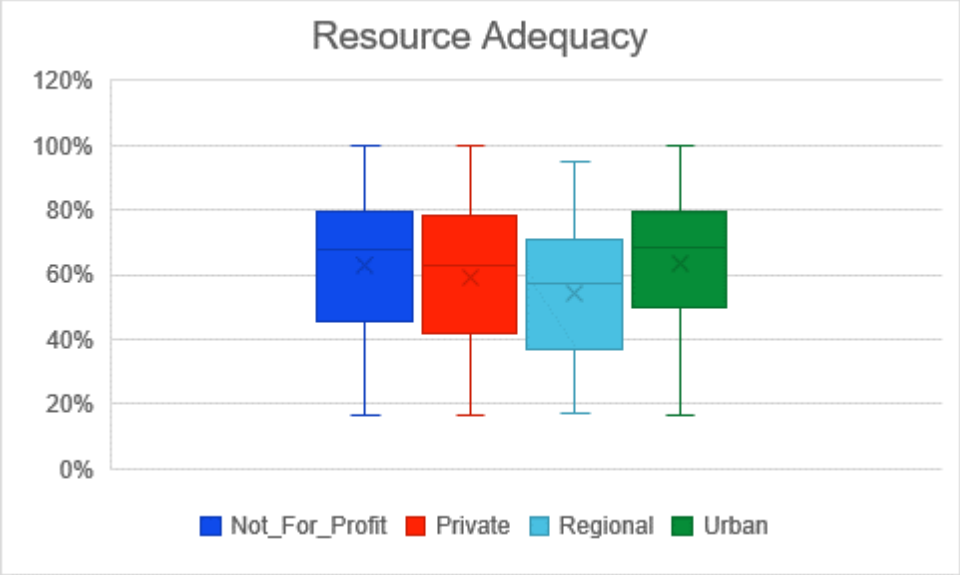
Turnover Intention Scale

	Factor load
I frequently thing about leaving this organisation	.849
It is likely that I would search for a job in another organisation	.838
It is likely that I would actually leave my current organisation within the next year	.883
Composite Reliability	**.90**
overall Mean (out of 1)	**.43**

Resource Adequacy

What is Resource Adequacy?

Resource adequacy is a variable that captures employees' perceptions concerning the degree to which their workplace is staffed and resourced in a way that is commensurate with responding to resident demands.



Explanation of findings concerning Turnover Intention

Resource adequacy was satisfactory overall, with a mean score of 60.9% agreement. Yet, this was significantly lower in the regional facilities (54% versus 63.9% in urban facilities). Resource adequacy was shown to be significantly linked to turnover intention, hence enhancing needs to advance resourcing (particularly around staffing) in regional areas, while challenging, poses one strategy to address turnover.

Resource Adequacy Scale

	Factor load
There are enough staff to get the work done	.864
There are enough trained staff to ensure quality of care for residents	.824
There is enough support to allow me to spend sufficient time with residents under my care	.896
I have enough time and opportunity to discuss resident care problems with other staff	.792
Composite Reliability	**.92**
overall Mean (out of 1)	**.65**

Implications of research

The results point to a number of key trends present across the sampled organisations. These include:

- Proactive care is significantly linked to lower instances of pressure injuries, unexplained weight loss and the use of physical restraints
- Proactive care may be encouraged through advancing management support, autonomy and psychological capital; and this action may also also positively influence safety participation and employee well-being
- The sampled aged care organisations face a number of management, employee work behaviour and human resource management challenges. However, in some instances, the degree to which these factors affect an organisation may be influenced by its governance type (for-profit and not-for-profit), and whether it is urban or regionally situated.
- Reducing turnover intention remains a key challenge facing sampled aged care organisations, and, as with improving proactive care, mechanisms to enhance retention may call upon a focus on management support, psychological capital and employee well-being.

Accounting for the breadth and depth of data presented in this report then, the following recommendations are submitted in an effort to aid aged care organisations and their managers in addressing workforce and quality of care challenges.

1. **All aged care organisations are unique – and localising strategies and management capability may be helpful in enhancing quality of care outcomes**

A scan of the academic literature and government reporting around aged care presents a range of common challenges associated with managing residential aged care. While evidence of these challenges has been found also in this study, what is clear is that what one aged care facility, in one location, may find as a pressing, immediate concern, another facility may not have an issue with. For example, in this study, workforce renewal posed a much more significant challenge for regional aged care facilities than their urban equivalents. Equally, levels of (high) managerialism and (low) autonomy were of particular concern for for-profit facilities, but this was not as pronounced for not-for-profit firms. Thus, this suggests that ‘one size fits all’ strategies to address macro level challenges associated with residential aged care management and quality of care concerns may not be as effective as localised, targeted initiatives that seek to improve particular challenges present on the ground.

To advance the development of localised strategies, a range of practical strategies may be adopted. In the first instance, the attitude of senior and local management needs to be open to innovations, suggestions and improvements that are organically created from employees (who are lower in the organisational hierarchy). To facilitate this, communication between employees and managers needs to be open, and managers should, where possible, be proactive in responding to, and facilitating experimentation and pilot actions around employees suggestions and ideas for improvement.

For issues related to turnover and workforce renewal, being challenges more pronounced in regional facilities, aged care organisations may choose to develop localised graduate programs with regional TAFEs, technical colleges (and where relevant) universities. The research presented herein also found evidence that migrant labour were no less effective in delivering proactive care than their non-

migrant counterparts, and therefore, advancing opportunities for skilled migrant pathways for regional facilities may be beneficial.

2. There is something special about Psychological Capital

The research presented herein, on several occasions, highlighted a connection linking employee psychological capital (hope, resilience, optimism and self-efficacy) with significant positive work outcomes (lower levels of turnover intention, higher proactive care). Previous research has also linked this to lower stress levels and absenteeism, and higher employee well-being (Luthans et al., 2007). In concert with improving management support levels (which were also shown to be impactful for positive work behaviours), instigating mechanisms to enhance employee psychological capital presents as a helpful mechanism in addressing the work-related stress and anguish that aged care employees are exposed to on a regular basis, without requiring very significant financial or resource investments.

There are a range of strategies that organisations can adopt to enhance employee psychological capital, including targeted (psycap) or generalised (mindfulness, resilience and stress relief) training and workshops for staff, as well as institutional mechanisms such as role-modelling and trained mentoring programs.

3. Myth busting and realism: migrants, not-for-profits and quality benchmarks

The study herein 'busts' several pervading myths concerning residential aged care. In the first instance, the research found that the self-rating of proactive care provided by migrants and non-migrants was indistinguishable (not significantly different). This is in contrast to existing anecdotal reports concerning the ability, on the whole, of migrant workers to deliver high quality care for residents. Of note however, those who identified as being English second language noted significantly higher levels of managerialism (micromanagement) which is a cause for concern, and a consideration worthy of correction.

In several instances, employees in the not-for-profit facilities were no worse, or better off than those in for-profit firms. In fact, not-for-profit employees reported more positive scores in the case of work autonomy, and lower scores in the case of managerialism (micromanagement), suggesting that these firms may be creating a more positive work environment conducive to bottom-up innovation.

While a significant association was noted linking proactive care with lower instances of pressure injuries, unexplained weight loss and the use of physical restraints, the statistical relationship was small. From a research perspective, this small association challenges the utility of the Aged Care Quality Indicators in providing facility managers data points that highlight the strengths and weaknesses of their practices, operations and staff. Rather, the Aged Care Quality Indicators only highlight when breakdowns in care have occurred, yet it is also possible that circumstances beyond the control of the immediate aged care employees and managers may manifest poor clinical health outcomes in residents. There are two key points to note here, the Aged Care Quality Indicators do not provide any information about the antecedents of why adverse clinical outcomes have occurred. Equally, they act frame the performance of aged care facilities in a negative light (and at best only highlight compliance, but not best practice). While it is important that aged care facilities do their utmost to ensure the quality care of residents, it may be appropriate for individual firms, at the local level, to develop goals and targets that celebrate achievements as well as highlight areas for improvement. Equally, data collection and management feedback loops may be extended beyond the aged care Quality Indicators to enable managers and staff insight into the antecedents (causes) of positive and negative outcomes for residents.

Conclusion

This report has presented results stemming from a significant survey study of 410 aged care workers across 26 residential aged care facilities. The findings highlight a number of workforce and quality of care strengths and challenges faced by residential aged care managers. To address these challenges, residential aged care managers are encouraged to develop localized strategies and solutions to resolve address challenges, instigate mechanisms to advance the psychological capital of employees, and develop performance metrics and data points that celebrate success and best practice, as well as highlight the antecedents of poor outcomes.

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