Meeting the social and emotional support needs of older people using aged care services

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Aged care services touch the lives of substantial – and increasing – numbers of people. Yet the capacity of service systems to meet older people's needs, and to do so at standards acceptable to the Australian community, remains under question, subject to several major inquiries in recent years including the current Royal Commission into Aged Care Quality and Safety.

Recognising that the community expects aged care services to deliver supports which go beyond basic physical care, this report explores:

- the ways current aged care arrangements and processes of care work attend to older people's social and emotional needs; and
- the policy, regulatory and organisational arrangements which would more effectively ensure provision of quality, whole-of-person care.

In exploring these issues, we recognise the high value that older people place on their relationships with care workers and on the time that workers have available to provide care, as documented in the large body of scholarly literature on service quality. Older people's aspirations for quality caregiving relationships, and for decent social and emotional care, are shared in the wider community, and feature in Australia's quality standards, which emphasise person-centredness as an effective means of supporting wellbeing among older people.

However, the psychosocial dimensions of care are often overlooked in the aged care system, including by the funding models and the way aged care organisations and workplaces operate in practice. Thin industrial regulation, individualised funding and consumer-directed care, and an increasing share of profit-motivated provision are converging to promote fragmented, task-oriented models of care, rather than the holistic person-centred models consistent with quality. This report is concerned with what needs to change so that older people receive the care that they need and that the community expects.

Sources

The report draws data from several sources to explore how aged care services could better fulfil older people's social and emotional support needs.

First, analysis of publicly available data profiles trends in the use of aged care over the last decade. This analysis shows systemic pressure on service quality. The needs of older people using aged care in Australia have increased significantly over the last decade yet staffing ratios and skill levels have not.

Second, we analyse peer-reviewed research which explores quality from the perspectives of older people, their family members and care workers. This provides an outline of the factors known to build social and emotional wellbeing in aged care settings, including person-centred, relational models of practice and adequate time for care.

Third, we analyse survey data which explored experiences of caregiving among 1,231 aged care workers across Australia. Most of these were the personal care workers and community care

workers responsible for delivering the majority of 'hands-on' care to older people using home care and residential care services. The survey findings show that the way that care is usually organised and scheduled overwhelmingly constrains the capacity of workers to deliver person-centred care.

Finally, we draw on interviews with 10 care workers from residential and home care settings across Australia. Their views and experiences deepen the insights gained from the system-level data, research literature and survey, and feature throughout the report as vignettes illustrating key themes such as time for care, staffing levels, and the impacts of missed or rationed care.

Findings

- **It is structurally difficult for services in Australia to deliver person-centred care**

Trends in the use of aged care in Australia show that, compared with a decade ago, people using age care services on average require more, and more complex, assistance, often with multiple aspects of their physical, psychological, social and emotional lives. As a result, the Australian aged care system has to meet increasing levels of demand, and to respond to an increasing complexity of need among older people.

However, changing patterns of demand have not been matched with appropriate changes in funding models, staffing ratios or the mix of staff skills. This has made it structurally difficult for the service system to realise principles of dignity, respect, and person-centredness which are enshrined in aged care policy and standards and expected by the community. Meeting older people's needs has involved rising service intensity and has relied on rising intensity of work performed by aged care workers, particularly among the personal care workers who deliver the majority of direct care to older people.

Increased service intensity, and increased intensity of the work of care, are contrary to international research evidence linking better resourcing and multi-disciplinary teams to quality care. In *residential care*, insufficient staffing is the most commonly cited reason for 'missed care'. As well as contributing to poor clinical outcomes, this goes some way in explaining the very high rates of social isolation and mental distress among older people, along with over-prescription of medication to manage distress. In *home care*, rationing means significant unmet need. A majority of older people assessed as eligible for a home care package either do not receive one or receive services at a lower level than that for which they have been assessed as eligible. Care workers must support these people, using a lower level of resources than clients have been assessed as needing. In this context, psychosocial supports are likely to be further squeezed.

Moreover, the proposed new funding model for residential care, the Australian National Aged Care Classification (the AN-ACC), does not include assessment of older people's social and emotional needs. Without such assessment, older people's needs are likely to continue to be poorly met.

- **Older people and care workers value good caregiving relationships**

A substantial body of research documents what older people, and the care workers who support them, think is important in aged care, what constitutes quality and how systems and organisations can support its delivery. Older people's assessments of quality emphasise the social and emotional dimensions of care, including good relationships with care staff, staff having time and flexibility to care rather than being rushed and task focused, feeling at home, and feeling valued. Family members also value these dimensions.

Care workers similarly value the opportunity to provide attentive, relational care. They highlight the ways work organisation and working conditions shape prospects to deliver this, by enabling them (or not) to get to know older people, to show respect, and to facilitate older people's social connections. Time for workers to build relationships, and the flexibility to respond to their changing needs, are central themes in workers' accounts of quality.

- **High quality, person-centred care depends on high quality jobs in care work**

Research shows that the quality of care and the quality of jobs in aged care are inextricably linked. This research points to the need for policies and practices to drive a 'virtuous circle', in which good organisation of care work, good employment and working conditions, supportive management and an empowering work culture, collaborative teams, high quality, relevant education and training, and high job satisfaction among care workers underpin high quality, person-centred care.

- **Few care workers feel they can prioritise the relationships needed to provide person-centred care**

To explore the extent to which care work is organised around the type of person-centred care which older people and workers value, the survey asked about care practices in residential and home care settings; and workers' perceptions of time available to connect with older people, to build the relationships seen as important to quality care, and to respond flexibly to older people's needs.

Overwhelmingly, care workers consider the time they have available for person-centred care to be 'not enough': 87% of care workers said the time they had to listen and connect with older people was 'not enough'; and 84% said the time available to get to know older people's family and friends was 'not enough'. More than three quarters (78%) said they had insufficient time to support older people to do things for themselves (e.g. use a walker instead of a wheelchair). Less than a quarter of care workers (24%) agreed they have the time to get to know each older person as a unique individual. This was similar for workers in home care and residential settings, and in a range of direct care roles and organisational contexts.

Based on workers' perspectives, the constraints on delivering person-centred care appear embedded in organisations and management practices and underpinned by industrial arrangements which enable care to be rationed through short episodes of care provided by multiple caregivers. This is evident across the sector but particularly in home care. Less than a third of home care workers (29%) said their manager allow them to change routines based on older people's preferences (compared to 37% in residential care), and fewer than 2 in 5 felt their managers understood the importance of their relationships with older people (32% in home care and 38% in residential care). Many described how attending to the social and emotional needs of older people risked being seen by managers as 'slacking off' and could only be done in workers' unpaid time, if at all. Many saw their organisation emphasising financial priorities over quality care and felt there was a lack of commitment to improving quality for older people. Work in both residential and home care settings was seen to remain extremely task-based, rather than built around the strong caregiving relationships known to promote older people's independence and wellbeing.

What needs to change

Findings point to the need for changes at the level of the aged care system as a whole, and in aged care provider organisations.

Funding arrangements for quality care

Aged care funding needs to be:

- increased to levels *sufficient* to enable services to be provided to all older people who need support, with staffing levels and staff time adequate to meeting their increasingly complex needs.
- *flexible* enough to enable providers to respond to older people's changing needs on multiple time-scales – from daily fluctuations to end-of-life care. Incentives for task-based and fragmented care need to be addressed.
- *care centred* to ensure that funding, whether from public or older people's own resources, is directed to ensuring staffing levels that enable high quality care. To achieve this goal, any new funding model should:
    - mandate minimum hours of care per person, quarantine some portion of funding to staffing and staff development costs and restrict opportunities for squeezing service quality to maintain or increase profits.
    - include a well-designed assessment of older people's social and emotional needs for both residential and home-based care.

Quality monitoring and oversight

Quality regulation needs to:

- ensure that *monitoring, oversight and development of human resources* in aged care have robust means of ensuring that the goals of Standard 7 are realised, through promoting work organisation and work cultures that enable relational care.
- include *worker perspectives* in measuring the achievement of Standard 7.
- provide *incentives to relational care* and disincentives to fragmented, task-based care, so that the full range of older people's needs can be met, in line with community expectations.
- collaborate with the relevant authorities to *ensure that training is high quality,* relevant and timely.

Industrial settings and quality care

Industrial regulation in the aged care awards needs to ensure that:

- *working time* arrangements allow time for care and enable continuity of caregiving relationships and that prevent part-time contract status from being casualised in any way.
- *care workers and older people are protected* from risks that the platform-based 'gig economy' poses to workers' rights, the quality of care and older people's safety.
- *classification and pay structures* provide detailed descriptions of clearly articulated levels of care worker skills to enable workers to develop meaningful career paths in aged care and that remunerate the different levels of skills required appropriately.

Workforce training

Training should go beyond ensuring compliance, to ensure care workers have the relevant practice and relational skills to deliver high quality care.

- Additional skills should be recognised and compensated.
- To reinforce and extend learning gained during training, opportunities to reflect on care practice, such as regular supervision, should be available to all direct care workers.

Aged care organisations

Aged care employers need to develop the following, under the meaningful and supportive oversight of quality regulations:

- a strong focus on *enabling and delivering relational care* that meets the full range of older people's needs, including their social and emotional needs.
- *work organisation* that promotes relational care*,* such as consistent assignment, and enough time to deal with the regular irregularities that arise in the day-to-day provision of aged care.
- *leadership in person-centred care*, with strong and supportive relationships between managers and care workers, to enable workers to develop meaningful relationships with older people and their families and to empower care workers to respond to older people's needs in flexible ways.
- management practice that *supports care workers' professional development*, including regular supervision and paid time for training beyond compliance-related compulsory material.
- management that *engenders a collaborative team environment* in which care workers can use and share their skills and knowledge.

1. Introduction

The Royal Commission into Aged Care Quality and Safety is inquiring into how to ensure aged care services are high quality and person-centred. The Commission has been directed to consider dignity, choice and control and mental health alongside clinical and physical aspects of care quality. The Terms of Reference also highlight the critical role of the aged care workforce in delivering high-quality care.

As the share of older people in the population grows and life expectancy extends, the need for sustainable arrangements to support older people in their homes or in specialised residential settings also increases. Thus, care for older people has emerged as a central social policy issue in recent decades in Australia, as in other rich democracies (Muir 2017: 9).

How aged care systems can meet older people's needs in ways that ensure the well-being of older people is a core question for government policymakers, organisations that provide care, unions that organise paid care workers and advocate for fairer industrial arrangements, and society more broadly. In Australia, these concerns have been explored in several major inquiries in recent years, including the current Royal Commission into Aged Care Quality and Safety, which forms the context for this research report.

The Terms of Reference (ToR) for the Royal Commission into Aged Care Quality and Safety[1] establish the underlying goals and values for Australia's aged care system and shape our focus on how the organisation of aged care work affects the quality of social and emotional support that older people receive.

The preamble of the ToR states that the system should provide services that reflect and address older people's care needs, in line with 'the high standards of quality and safety' expected by the Australian community. The ToR themselves include directions to the Commission to inquire into: the quality of aged care services and the extent to which they are meeting older people's needs; the challenges and opportunities for delivering accessible, affordable and high quality services; 'how to ensure that aged care services are person-centred' and what the aged care industry (among others) can do to strengthen the system and ensure high quality. Significantly, the ToR also direct the Commission to have regard to 'the critical role of the aged care workforce in delivering high quality, safe, person-centred care and the need for close partnerships with families, carers and others providing care and support'. In considering quality and safety of care, the Commission is directed to have regard to aspects that go well beyond the physical and clinical. Social, psychological and emotional aspects are included, such as 'dignity', 'choice and control', 'mental health' and 'positive behaviour supports to reduce or eliminate the use of restrictive practices'.

Our focus on supports for older people's social and emotional wellbeing in aged care is also shaped by the new Aged Care Quality Standards and the Charter of Consumer Rights, both of which came into effect in July 2019. These key policies are framed in terms of values such as dignity, respect and choice in relation to the older person's personal and social life as well as their

[1] https://agedcare.royalcommission.gov.au/Pages/Terms-of-reference.aspx.

care.[2] Across these and other policy documents, the principle of 'person-centred care' and an encompassing conception of 'well-being', which includes psychological and social dimensions, are now established in aged care policy in Australia.[3] Further, the quality standards recognise that human resource arrangements are key elements of quality (Standard 7). The standards seek to ensure that workforce arrangements' support consumers' receipt of care and services when they need them, from people who are knowledgeable, capable and caring. They also recognise that organisations need to support the workforce by providing the time and tools for quality care, and ensuring workers have the qualifications and skills to interact with consumers in ways that are caring and respectful.

If realised in practice, the principles, standards, rights and values enshrined in Australia's aged care policy would offer a strong foundation for care of the high quality required to ensure older people's well-being. Realising these values depends greatly on the workers who deliver aged care services, as the ToR for the Royal Commission recognise. In turn, the capacity of aged care workers to deliver good services depends considerably on how their work is organised and valued.

1.1 Research aims

Against the background of rising emphasis on person-centred care in aged care, and the recognition of issues of quality reflected in the focus of the Royal Commission, the aim of this report is to examine:

1. how staffing arrangements and the organisation of care work in aged care services contribute to high quality care for older people; and

2. the policy, regulatory and organisational arrangements that enable the types of care that older people deserve, and the community expects.

Our specific focus is on how the organisation of care work shapes the *social and emotional well-being* of older people receiving services at home or in residential settings, since research shows that this is both particularly important to older people themselves, and particularly at risk of being overlooked in the operation of the aged care system. The social and emotional outcomes of care are especially important given the emphasis which aged care policy and standards place on person-centredness. Person-centred care emphasises that services be organised around, and responsive to the values of older people and their right to self-determination. In practical terms, person-centred care requires that workers know the people they care for, and that organisations permit, enable and support care workers to develop strong caregiving relationships in their practice. As most formal care for older people is provided by personal care workers who do not have professional training, we focus on staffing arrangements, work organisation and the psychosocial work environment affecting this group of aged care workers and shaping their prospects to deliver high quality care.

[2] Age Care Quality Standards: https://www.agedcarequality.gov.au/sites/default/files/media/Aged%20Care%20Quality%20Standards.pdf Charter of Consumer Rights: https://www.agedcarequality.gov.au/sites/default/files/media/ACQSC_Charter-of-Rights_A5-Booklet.pdf.

[3] See also, for example, Productivity Commission (2011: 71, 77); Australian Government (2012: 75), Australian Health Ministers Advisory Council (2015: 2-3).

1.2 Sources of evidence

This research report is based on four main sources of evidence. First, it provides analysis of publicly available data sources relating to the use of aged care services, complexity of need among service users, and system capacity to meet increasing levels of need (Section 2). Second, we analysed peer-reviewed research about quality in aged care (Section 3). The research review sought to identify what makes good quality aged care from the perspectives of older people, their family members and care workers, and to identify the conditions which support or stifle relational care and social and emotional well-being. The review of research informed the design of a survey of aged care workers (Section 4). The survey aimed to capture the experiences and ideas of care workers in aged care, primarily the community care and personal care assistants who deliver most of the 'hands-on' care in home care and residential settings. In particular, it was designed to explore the extent to which care workers can provide relational care and attend to the social and emotional wellbeing needs of older people, and the work and organisational factors that shape their capacity to deliver quality care. A smaller number of interviews with care workers were undertaken to deepen the insights gained from the survey and research review. Details of the research method and sample are in Appendices A and B.

2. Australia's aged care system and the problem of quality

This section outlines key dimensions of Australia's aged care system and service use. First, it highlights the importance of aged care, then draws on publicly available data to show how structural features and trends in the use and provision of aged care underpin growing work intensity. These trends make it challenging to deliver services capable of fully meeting older people's needs.

2.1 The social and economic importance of high quality aged care

High quality aged care services are essential to the well-being of older people who need them, but good aged care is also important for the well-being of other social groups and for society more broadly.

The aged care system is a critical part of Australia's social infrastructure. Everyone in society benefits from the knowledge that they can count on support, if needed, in their own old age (Armstrong et al. 2012). Family members, particularly middle-aged women, are more likely to be able to continue paid employment and other forms of social participation if the quality of formal care services is high (De Henau et al. 2016:12). Poor quality formal care not only impacts negatively on the well-being of older people; poor services can lead family carers to retain or take on responsibility for care they cannot realistically provide, and which might otherwise be appropriately provided in the aged care system. This means that both the costs of income support for family carers, and the costs of taxation revenue foregone when they reduce their working hours or leave the labour force to care, need to be considered in calculating the true cost of aged care (Brimblecombe et al. 2017; Muir 2017; Pickard 2019).

In addition to these broader social benefits, high quality aged care services also save costs within the health and aged care systems. Research has found that access to home care services delays entry into more expensive residential care (Jorgensen et al. 2018), while high quality residential care can reduce the likelihood that an older person will be transferred to a more expensive acute care hospital (Feng et al. 2018; Rantz et al. 2017).

Despite recognition of the way high quality aged care can both enhance quality of life, reduce health care costs and contribute to the economy, the work of care remains undervalued. The gendered nature of the work performed in aged care, demographic and employment characteristics, and dependence on government funding, contribute to fragmented processes of delivering care, low wages, and poor enforcement of regulation (Charlesworth and Howe 2018). Given that front-line aged care workers are 'mission critical' (Korn Ferry 2018) in aged care organisations, poor employment and working conditions make it particularly difficult to fully realise the social and economic benefits which can be expected from higher quality models of care.

2.2 Ageing and aged care service use

The aged care system touches the lives of a significant proportion of older people, particularly as they reach into their 80s and beyond. Older people using aged care services receive assistance with some of the most personal aspects of their lives.

Around 15% of Australia's population is aged over 65 years (SCRGSP 2019: Table 2A.1). Of these, more than a third need assistance with personal and other activities of daily living (ABS 2016: Table 28.3). As people get older, they are more likely to need help. Figure 2.1 shows that less than one fifth of people aged 70–74 need help with one or more of the personal activities of daily living that are at the core of aged care services: self-care, mobility, communication, cognitive or emotional tasks and health care. Among people aged 85 and over, three fifths need help in one or more of these activities.

Informal carers offer a great deal of assistance to older people who need it. Nearly three quarters (73%) of older people who need help receive help from family members or friends and neighbours (ABS 2016: Table 30.3). Nevertheless, a significant proportion of older people also receive assistance from the aged care system, in the form of residential care, home care packages and home support. [4]

Around one in twenty people aged 65 and over live in residential care. Just as people's need for assistance increases as they get older, so too does their use of aged care services. As Figure 2.1 shows, while around 2% of people aged 70–74 receive home care packages or residential care, more than a quarter of those aged 85 and over either receive a home care package (7%) or live in residential care (21%). Indeed, the majority of nursing home residents are aged 85 and over (59%), and just over two fifths of home care package recipients (41%) are in this age group.[5] Assistance to older people living in the community is also offered through the Commonwealth Home Support Program (CHSP).[6] In 2018, an average combined total of 5 hours per year of domestic assistance, personal care, individual social support, respite and nursing care was provided per person aged 65 and over.[7] Among recipients of *all* CHSP services, 51% were aged 80 and over and 29% were aged 85 and over.[8]

[4] The Royal Commission (2019) has published an overview of Australia's aged care system and detailed reports on the structure and operation of the system are produced annually; for the latest available see ACFA (2019) and Department of Health (2018).

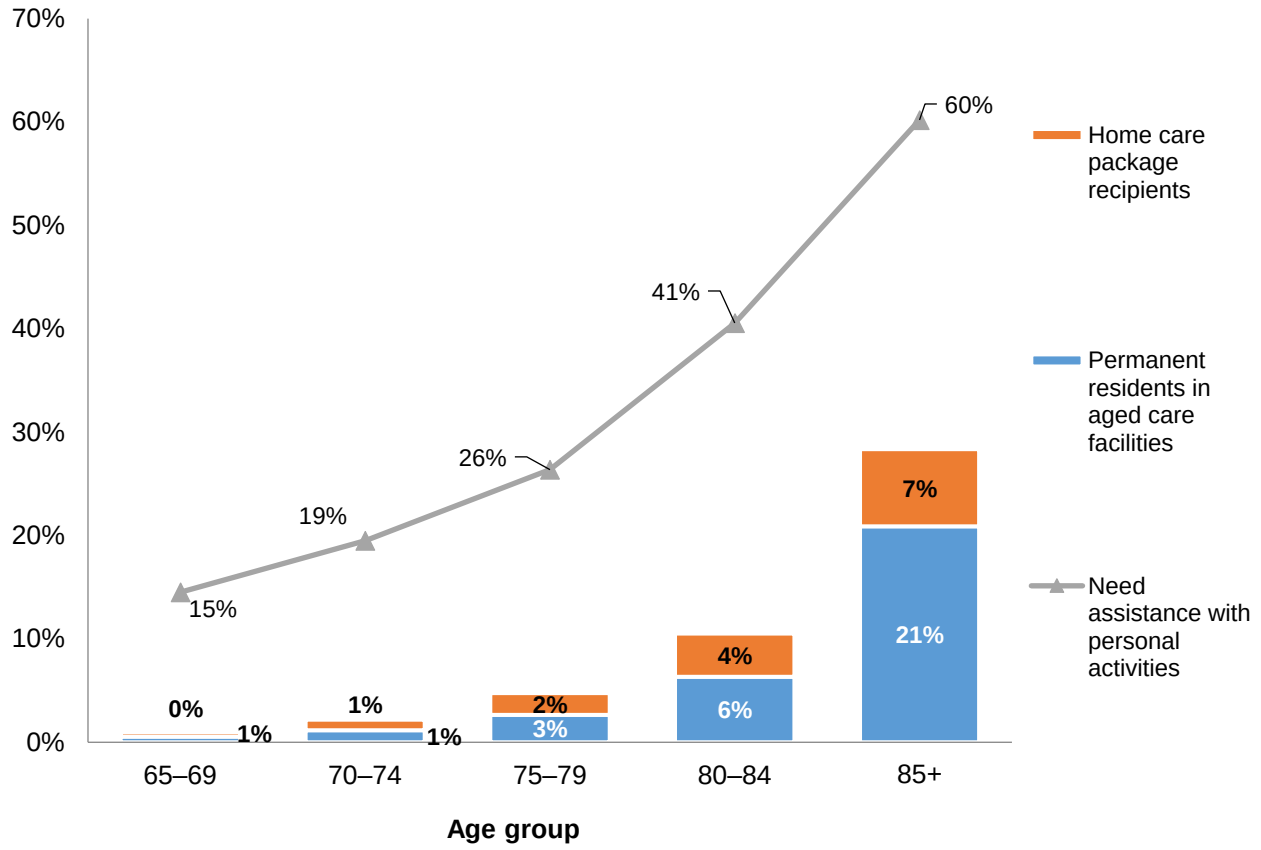
[5] Calculated from data available here: https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care.

[6] This program was formerly called Home and Community Care (HACC). A very wide range of services is offered through the CHSP, including meal delivery, home modification, transport, allied health, assistance with housing and other services (see https://www.myagedcare.gov.au/help-at-home/commonwealth-home-support-programme).

[7] To represent the main activities of home and residential care and maintain some equivalence with these services, domestic assistance, personal care, individual social support, respite and nursing care were selected from the broader range of services offered under the CHSP.

[8] Calculated from data available here: https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care. Data on the coverage of the CHSP is difficult to interpret for our purposes. In 2018, around three times as many older people received services under this program than receive residential care, but it is not possible from the publicly available data to determine which services they received, from the long list available under this program. For example, one-off provision of home modifications appears to be counted in the same way as regular support with personal care.

Figure 2.1 Receipt of aged care services and need for assistance, by age group



Sources: Aged care recipients, SCRGSP (2019, Table 14A.20; need assistance with personal *activities (self-care, mobility, communication, cognitive or emotional tasks and health care), ABS (2016, Table 28.1, authors' calculations)*

Table 2.1 Number of clients per 1,000 older people^, selected aged care services, 2011–12 to 2017–18

	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18
Permanent residential care	64.9	64.5	63.6	61.4	60.4	59.6	58.4
Home Care Levels 1–2*	18.1	18.3	18.2	17.2	16.7	17.0	20.3
Home Care Levels 3–4**	5.2	5.5	5.7	6.4	7.6	8.5	11.6
HACC/CHSP	225.3	222.8	220.0	222.6	n.a	197.1	206.4
Home Care Levels 1–2 and HACC/CHSP	*243.4*	*241.1*	*238.2*	*239.8*	*n.a.*	*214.1*	*226.7*
Permanent residential care and Home Care Levels 3–4	*70.1*	*70.0*	*69.3*	*67.8*	*68.0*	*68.1*	*70.0*

*Sources: Report on Government Services 2013, 2014, 2015, 2016, 2017, 2018, 2019; annual tables reporting 'aged care recipients per 1000 people' at 30 June of the preceding financial year. ^Older people defined as those aged 65 years or over and Aboriginal and Torres Strait Islander people aged 50–64 years. * Data for 2011–12 and 2012–13 is for Community Aged Care Packages (CACPs). ** Data for 2011–12 and 2012–13 is for Extended Aged Care at Home (EACH) and EACH Dementia (EACHD) packages.*

The mix of aged care services over time has changed, as the share of residential care has fallen and the share of home care packages has increased. However, as Table 2.1 shows, in relation to the population of older people, the overall level of provision of services has not increased during

the last seven years. In 2017–18, provision per 1,000 of people aged 65 years or over and Aboriginal and Torres Strait Islander people aged 50–64 years had not completely recovered the level of provision in 2011–12, following a dip in the intervening years. Thus, despite growth in the number of home care places and additional funding to the CHSP in the last couple of years, the proportion of older people receiving lower levels of home support has fallen since 2011–12, and the proportion receiving either permanent residential care or a high level (3 or 4) home care package has not increased.

2.3 Changing service and work intensity in residential aged care

Residents' levels of need have increased significantly over the last decade, but direct care staffing ratios have remained unchanged and the skills profile of the workforce has deteriorated. These trends make simply maintaining, let alone improving, service quality extremely difficult.

Over recent decades, the scope and scale of formal aged care services offered to older people in their own homes has increased, and access to residential care has become more strictly assessed, as governments have sought to respond to older people's perceived preferences to remain at home (AIHW 2009: 2) and to contain costs of residential care. One possible consequence of this policy approach is that, when older people enter residential aged care, they have higher care needs.

2.3.1 Rising levels of need

There is clear evidence that the needs of older people in residential care have increased. Figure 2.2 shows the proportion of older people living in residential facilities who had high care needs in each of the three domains measured by the Aged Care Funding Instrument (ACFI): activities of daily living, behaviour and complex health care. In each domain the share of residents with high needs increased considerably between 2008 and 2017.

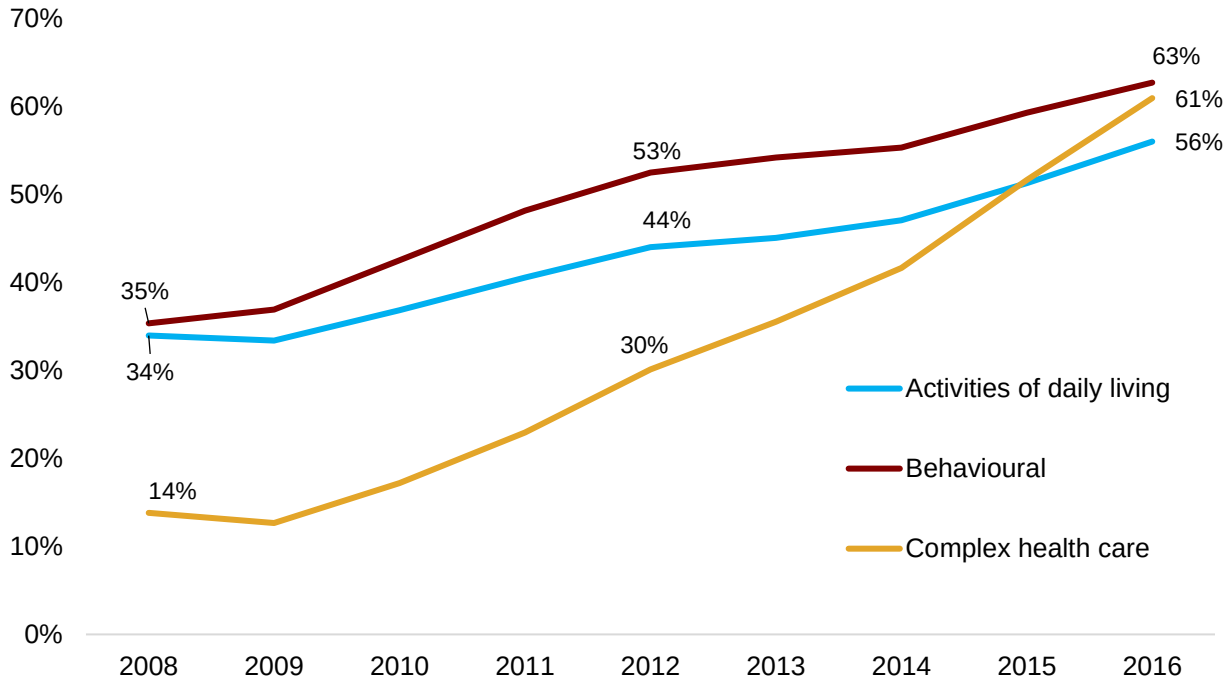
Further, many residents have high needs in more than one domain. Between 2008 (the first year for which data are available) and 2016, the share of older people who had a high level of need in *at least two* of the three domains ACFI measures nearly tripled, from 22.7% to 61.2% (see Table 2.2, row A.).[9]

This particular measure does not directly capture dementia. Information about whether or not an older person has dementia is also collected in the ACFI process, along with the three domains of need discussed above. These data show that just over 50% of residents across the period 2007-08 to 2016–17 had dementia, and these older people were over-represented among people with high behavioural needs.

[9] ACFI data are used by the Australian Institute of Health and Welfare to measure and report need in residential aged care; see for example, https://www.gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care/Explore-care-needs-in-aged-care. There some evidence that ACFI ratings of need have been rising for reasons not soley related to individual needs (AACS 2017: 13-14). However, the change in ACFI needs measurements shown in Table 1 cannot plausibly be attributed solely to measurement reliability issues.

The increasing needs profile among residents means that, on average, each resident requires more, and more complex, assistance, often with multiple aspects of their physical, psychological, social and emotional lives, than residents a decade ago. The change can be understood as a significant increase in *service intensity* in the residential aged care system overall. To meet this increase in need requires a higher ratio of direct care staff to residents and more skilled staff than a decade ago. Without more, and more skilled staff, it is not possible to meet increased need without reducing service quality and increasing *work intensity*.

Figure 2.2 Proportion of residents in aged care facilities who have high care needs, 2008-2016



Source: Authors' calculations based on ACFI data for reported years, see fn. 9.

Table 2.2 Average ratio of direct care workers to operational places in residential aged care, 2003–2016

	2003	2007	2012	2016	*% growth*
Share of residents with high care needs in at least 2 domains (%)#	n.a.	22.7	40.8	61.2	*170.2*
Equivalent full-time direct care workers^	76,006	78,849	94,823	97,920	*28.8*
Operational places*	148,547	169,594	187,941	195,825	*31.8*
Ratio of EFT direct care workers to operational places (B/C)	0.51	0.46	0.50	0.50	*-2.0*
Share of personal care assistants in direct care staff (EFT, %)^	56.5	64.1	68.2	71.5	*15.0*

*Sources: # AIHW 2019; authors' calculations based on the last valid ACFI assessment for people in permanent residential care on 30 June of 2008 [the first year available], 2012 and 2016 (ACFI was introduced in 2008 and earlier resident assessment instruments are not directly comparable); ^ Mavromaras et al. 2017, Table 3.3; * Reports on the Operation of the Aged Care Act 1997 for 2004, 2008, 2013 and 2017.*

2.3.2 Workforce size and skills

However, increased levels of need among older people living in residential care have not been reflected in a larger or a more qualified workforce. In relation to *workforce size*, evidence drawn from the major national survey of the aged care workforce shows that there was no increase in ratio of full-time equivalent (FTE) workers in direct care roles to the number of operational places[10] in residential aged care between 2003 and 2016 (Table 2.2, row D.) (Mavromaros et al. 2017).[11] The number of FTE direct care workers increased 29% across this period (Table 2.2, row B.), while the number of operational places increased by 32% (Table 2.2, row C.). This suggests falling staff ratios across the system, likely to preclude quality improvements.

In relation to the *skills profile* of the workforce, increased levels of need among older people in residential care have not resulted in a *more highly trained* workforce. One way to assess the skills profile is look at the *occupational* profile of the workforce. On this measure, the skills profile of the residential care workforce has deteriorated significantly. As noted above, personal care assistants (PCAs) do not have professional training of the kind that underpins nursing or allied health registration. The wages and opportunities for career development are also much lower for this group of workers. Yet the share of PCAs among the direct care staff has increased from 56.5% in 2003 to 71.5% in 2016, with a corresponding decline in the share of registered and enrolled nurses and allied health professionals and aides.

However, the level of training within occupations is not stable, and there is evidence from the Aged Care Workforce Survey that the training profile of PCAs has improved in recent years (Mavromaras et al. 2017: 22-23). The share of residential facilities with a low-qualified staff (defined here as fewer than half the PCA staff holding a Certificate III in aged care) fell from 26% in 2007 to 15% in 2016. Two thirds of facilities had a PCA staff among whom at least 75% had a Certificate III in 2016, up from 47% in 2007.

While the increasing share of PCAs with a Certificate III is a positive development, the Certificate III is a basic qualification, and a substantial number of PCAs still do not hold this. Further, relatively few PCAs have a higher qualification in the form of a Certificate IV in Aged Care. In 2007, only 4% of facilities had a PCA staff profile with half or more PCAs having achieved a Certificate IV. In 2016, the corresponding proportion of facilities was 8%. PCAs are also least likely among all occupational groups in residential aged care to undertake continuing professional education or training (Mavromaras et al. 2017: 30). Thus, it is unlikely that the skill levels of PCAs have increased enough to compensate for loss of specialised skills resulting from the deteriorating overall occupational skill profile in the residential aged care workforce.

As Table 2.2 shows, staffing ratios have not increased and the staffing skill mix has not adjusted to meet the increased needs of older people living in residential care in Australia. These trends go against the findings of international research on the relationship between staffing and care quality. While research has not definitively established the optimal level and staffing mix for residential care (Hodgkinson et al. 2011), higher staffing ratios and more care hours per resident have been linked

[10] The concept of 'operational places' is the most commonly used measure of the size of the residential aged care sector. This measure was used by Mavromaras and colleagues (2017) to calculate a slightly different ratio in their authoritative *National Aged Care Workforce Census and Survey* report (see Table 4.4 in the report which uses a headcount measure to calculate the ratio of direct care workers to operational places).

[11] The definition of staff used here is 'direct care workers', which includes include registered and enrolled nurses, personal care assistants and allied health professionals and aides.

to higher care quality (Boscart et al. 2018, Bostick et al. 2006). There is also evidence of links between higher care quality and a richer direct care staff mix; for example, that includes allied health workers in multidisciplinary teams (Livingstone et al. 2019).

2.3.3 Impacts on older people in residential care

Further, the staffing situation in residential aged care negatively affects the quality of care older Australians are receiving. A research survey on 'missed care' in Australian residential facilities has found that *all* of the 22 care activities included in the survey were missed at least some of the time (Henderson et al. 2017: 414). The missed tasks included those related to comfort and dignity (such as feeding residents while food is still warm, and assisting with toileting within 5 minutes), as well as tasks related to complex health care needs (such as IV/central line care and assessment). The survey focused almost entirely on support for activities of daily living, health-related care and care-related administration. Only one of the 22 measures relate to social and emotional support for older people: 'Emotional support for patient and/or family'. Like all the care activities, this too was frequently missed (Henderson et al. 2017).

The study found that the most commonly cited reason for missed care was too few staff. Problems in the skill mix were also reported, such that PCAs were required to work beyond their scope of practice. Other reasons for missed care related to problems in work organisation (such as unbalanced resident assignment and communication failures within the workplace team) or to what can be called the regular irregularities of working with very frail and often unwell people (such as 'urgent resident situation') (Henderson et al. 2017: 415). Overall, the study found 'that staffing levels and increasing resident acuity impacted negatively upon capacity to deliver care' (Henderson et al. 2017: 414).

Missed social and emotional support may be undermining older people's well-being. Studies focused on social and emotional well-being have found that loneliness and social isolation are prevalent among older people, in both community and residential settings, but more so in residential care (Franck et al. 2016: 1396). Almost a quarter (22.5%) of older people living in Australian residential care suffer from depression (Hillen et al. 2017), a condition linked to loneliness and lack of social support (Liu et al. 2016). Nearly a third of residents (31%) also display clinically significant anxiety symptoms (Creighton et al. 2018). Despite these high levels of psychological distress, access to professional psychological support is minimal in residential care facilities (Stargatt et al. 2017).

In addition to its direct impact on well-being, missed psychosocial care is likely to be related to documented over-prescription of anti-psychotic medicine in Australian residential aged care facilities to manage affected residents' distress (Lind et al. 2019).[12] A recent study found that staff feel 'overwhelmed with inadequate staffing and training when handling behavioural disturbances which caused a reliance on psychotropic medicines to cope with distress' (Sawan et al. 2017).

Dementia Australia (2019) has also highlighted the need for more effective psychosocial supports in aged care services: workers need to have better skills, and time in their work schedules to observe and understand the non-verbal cues and complex behaviours of people with dementia,

[12] There is also evidence that the effects of missed clinical care, missed psychosocial care, and inadequate staffing and training compound to increase residents' anxiety. A systematic review of correlates of anxiety found that 'receiving a more negative reaction to behavioural issues from staff, and the presence of more unmet needs were all found to be significantly and positively associated with anxiety' (Creighton et al. 2017).

assess their changing needs, and facilitate decision-making and inclusion, in line with the principles of person-centred care.

2.3.4 Proposed new funding model for residential aged care

A new funding model for residential aged care is currently under development. The Australian National Aged Care Classification (AN-ACC) is slated to replace the Aged Care Funding Instrument (ACFI), with trials planned for later in 2019.[13] There are clearly problems with the ACFI. However, these may not all be resolved by the AN-ACC in its current form.

First, the AN-ACC Assessment Tool does not include measures of older people's social and emotional needs, and without such assessment, these needs will likely continue to be poorly met. The only use of the term 'emotional' occurs in the 'Behaviour Resource Utilisation Assessment' component of the tool, in the form of a category of behavioural problems called 'Emotional dependence'. This is defined as 'limited to the following behaviours: (a) active and passive resistance other than physical aggression, (b) attention seeking, (c) manipulative behaviour, (d) withdrawal (including apathy) (e) depression, (f) anxiety, and (g) irritable' (Westera et al. 2019: Appendix 5). This approach pathologises the consequences of the aged care system's failure to meet psychosocial needs – in other words, older people who are emotionally distressed are defined as having behavioural problems, not as recipients of insufficiently caring support.

Second, the recommendations for implementing the AN-ACC establish price relativities (called 'relative value units') for 13 classes of resident need, anchored to a 'National Weighted Activity Unit' (NWAU), but do not recommend an actual price for the NWAU. Rather, the recommendations state that 'price is a policy decision for government', who can decide to implement the new system on a cost neutral or growth funding basis at the sector-wide level (Eagar et al. 2019: 18). To ensure the level and mix of staffing required to offer high quality person-centred care, residential care system funding needs to increase. The example of the NDIS is instructive: research has found that implementation has been hampered by central price setting at a rate too low to sustain high quality services (Carey et al. 2019; Cortis et al., 2018). However, to ensure that increased funding is spent on improving the quality of care, requirements for transparency and accountability by providers for expenditure of both government and service users' funds will also need to be strengthened. The growing share of for-profit ownership and the emergence of complex corporate and business structures pose particular risks to both revenue and quality, which regulatory authorities need to address urgently.

2.4 Changing models of home care

Assistance for older people to remain at home is delivered mainly through two programs: the entry level Commonwealth Home Support Program (CHSP) and the more intensive Home Care Packages (HCP) program, as noted above. The funding and delivery model for these programs has been significantly changed in recent years. Since 2015, the CHSP has been rolled out, and one of its key principles is 'consumer choice'. Older people have options to choose a provider, following a new, more centralised assessment process that should focus on their needs and goals. Since 2017, all home care *packages* have been required to be delivered on a 'consumer directed care' (CDC) basis. The aim of CDC is to give older people more choice about the kinds of services

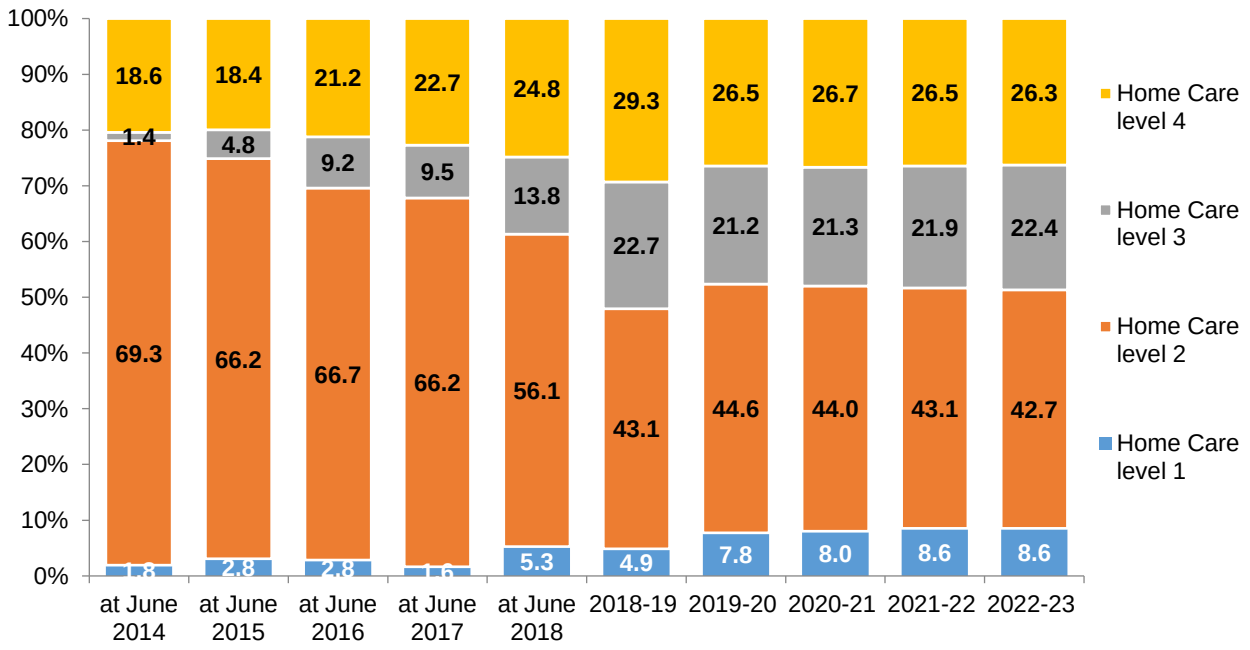
[13] https://agedcare.health.gov.au/reform/residential-aged-care-funding-reform.

they receive and how and when the services are delivered. Previously, funding for packages was allocated to providers, who controlled service provision and delivery (Gill et al. 2018). Choice of provider and increased control over the use of funds are central features of CDC, and funds are now 'individualised', that is, allocated to eligible individuals (Department of Health 2019a).

2.4.1 Rising levels of need

Data on the level of need in home care is not as well-developed as data on needs in residential care. However, within the limits of what is available, it is possible to infer that levels of need have risen in recent years and are expected to continue to be higher than they have been. Figure 2.3 shows the distribution of home care packages by level, over recent years and projecting forward, across the span of a decade. The figure shows that packages associated with higher levels of need (levels 3 and 4, the highest) became a much larger proportion between 2014 and 2018, nearly doubling from 20% to 39%. The projections for 2018–19 to 2022–23 continue this high share of level 3 and 4 packages, suggesting service intensity has been increasing in home care as well as residential care.

Figure 2.3 Home care packages by level, 2014–2018 actual, 2018–19 to 2022–23 allocated



Sources: Report on Government Services 2019, Table 14A.9 for 2014–2017; Department of Health Home Care Packages Program Data Report 3rd Quarter 2018-19, Table 1: Number of allocated home care packages across the forward estimates, for 2018–19 to 2022–23.

Patchy data make it more difficult to compare trends in needs and the workforce in home care than in residential care. However, available evidence suggests that meeting the needs of older people remaining at home has become increasingly difficult, partly because of rising service intensity and partly because of workforce issues.

Further, home care packages are rationed, via the Aged Care Approval Rounds process. While the number of packages is growing, as Table 2.3 shows, relative to the number of older people in the population, the increasing number of high level packages (levels 3 and 4) is only just compensating for the falling number of permanent residential care places (Table 2.1).

Table 2.3 Home care provision and workforce 2012–2016

	2012	2014	2015	2016	% change
Number of home care packages[#]	n.a.	66,954	73,550	79,819	*19.2*
Level 3 and 4 packages (% of total)[#]	n.a.	20.0	23.2	30.4	*52.4*
Annual hours of selected HACC services for people >65 years of age (million)*	25.9	26.9	29.7	30.4	17.3
Number of Community Care Workers (CCWs) (FTE)^	54,537			44,087	*-19.2*
Share of CCWs in direct care staff (FTE, %)^	75.9			78.7	*3.7*

*Sources: [#] Report on Government Services 2019, Table 14A.9. * Authors' calculations based on Report on Government Services 2017 Tables 14A.21 and Table 14A.1, includes personal care, domestic assistance, day centres, respite, social support only as provided to people over 65 and ATSI clients aged 50-64, figures for 2016 estimates only [the program now called CHSP was called Home and Community Care (HACC) during this period]; ^ Mavromaras et al. 2017, Table 5.3; Reports on the Operation of the Aged Care Act 1997 for 2004, 2008, 2013 and 2017.*

Further, the number of people assessed as eligible for home care far exceeds the number of places available, and there is a long queue, with extended waiting times, especially for higher level packages.

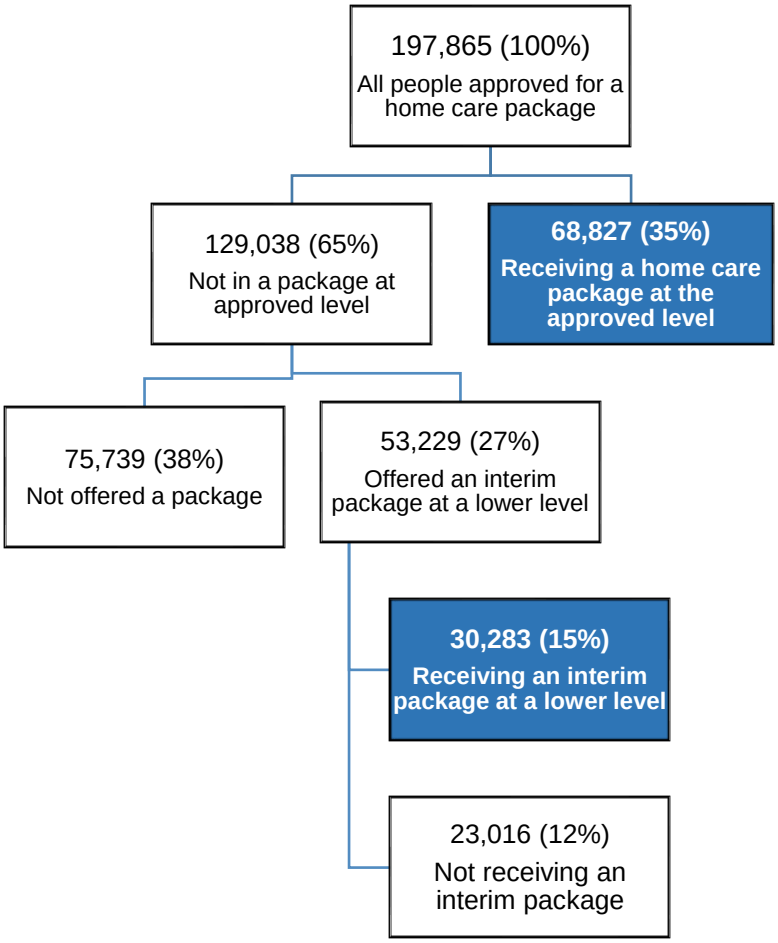
As Figure 2.4 shows, only 35% of all people approved for a home care package as at 31 March 2019 were in a package at the level for which they were approved. At best, most of the remaining 65% are likely to have received a lower level of support than that which they were assessed as needing. Fifteen percent of all older people approved for a package were in receipt of an interim package at a lower level. The remaining 50% of older people approved for a package were not receiving one. Of these the vast majority (43% of all those approved for a package) were also approved for lower level support under the Commonwealth Home Support Scheme, and many were also approved for residential care (Department of Health 2019b, 2019c). However, data on how many actually received either of these forms of support is not available.

Because older people are waiting for rationed care means there is always a level of unmet need among home care clients. At any point in time, a majority of older people eligible for home care at a certain level are either receiving less support (a lower level package or CHSP) or no support. Waiting times are considerable, from 3-6 months for entry into a Level 1 package following receipt of approval, to more than 12 months wait for an interim Level 2 package for someone assessed as requiring Level 4 support (Department of Health 2019b).

While older people are waiting for higher level packages, care workers must support these people, using a lower level of resources than clients have been assessed as needing. This places considerable demands on care workers, as well as leaving older people under-served.

International research shows that older people who do not have their needs for home care met, either through receiving no assistance or too little, were significantly more likely to suffer social and emotional problems, measured in terms of lower life satisfaction, more loneliness and higher perceived life stress (Kadowaki et al. 2015).

Figure 2.4 Older people eligible for a home care package, status at 31 March 2019*



Sources: Authors' calculations based on data in the *Home Care Packages Program Data Reports* for the 3rd and 4th Quarters 2018–19 (Department of Health 2019b, 2019c). * Percentages are all of the total number of people approved for a home care package.

2.4.2 Workforce size and skills

As Table 2.3 shows, the amount of home and community care provided increased in recent years, but the number of community care workers, who form the bulk of the workforce who deliver these services, fell considerably. The number of home care packages increased by 19% between 2014 and 2016, with the share of higher need packages increasing by more than 50%, and the number of hours of key CHSP program services increased by 17% between 2012 and 2016. However, the full-time equivalent number of community care workers fell 19% between 2012 and 2016.

Thus, in relation to meeting increased need, the falling *workforce size* suggests an absolute fall in capacity to meet needs at 2012 levels.[14] Further, levels of skill, as measured by qualifications, did not increase appreciably between 2012 and 2016, despite the increasing complexity of home care needs. The number of home and community care outlets in which 50% or more of community care workers held the relevant Certificate III was 65% in 2012 and 67% in 2016. Meanwhile the share of

[14] It is the three years since the most recent aged care workforce survey (Mavromaras et al. 2017), and there are no new data on the community care workforce. The 2016 survey found problems with recruitment and turnover in community care, so it is unlikely that the workforce has recovered even to 2012 levels. While the data in Table 2.3 cannot be used in a straightforward way to calculate a ratio of staff to packages/hours, it seems clear that the home care sector will have had considerable difficulty in meeting increased need for support in the community since 2016.

outlets in which 50% or more of CCWs had a relevant Certificate IV fell from 15% to 14% in 2016 (Mavromaras et al. 2017: 82).

2.4.3 Consumer directed care and its impacts

Impacts on older people

As noted above, the policy framework for delivery of home care has also changed in recent years. While the stated aims of policies such as consumer directed care are to empower older people and give them choices, these care models also place new responsibilities on older people and their families to select, negotiate, manage and monitor services. The impact of this on older people is difficult to assess. For more than two decades, the Australian government has received an annual Report on Government Services (RoGS), which provides information on the equity, effectiveness and efficiency of government services, including aged care. However, despite the introduction of consumer-directed care, there are still 'no data reported and/or no measures yet developed' about the extent to which aged care services are 'addressing client needs' or achieving the outcomes of 'enabling people with care needs to live in the community' or to achieve 'wellbeing and independence in residential aged care' (SCRGSP 2019: Figure 14.6).

While many studies find benefits for older people in individualised funding models such as CDC (Cash et al. 2017: 195), the design of these models assumes that older people are 'ideal consumers', possessing the knowledge and skills required to navigate the market that the government is seeking to create (Gill et al. 2017). Further, there are also systemic risks to the quality of care arising from the task orientation and fragmentation engendered by the individualised funding model, under which older people must decide how much of specific services they will purchase from their package funds.

Impacts on working conditions

Task fragmentation also contributes to deterioration in the quality of jobs in home care, and current industrial regulations, most notably the Social Community Home Care and Disability Services Industry (SCHADS) Award, exacerbate the risk of fragmentation associated with CDC. The SCHADS Award (2010) includes a low minimum engagement for casual employees (1 hour) and significant flexibility for employers in how they schedule part-time workers, with extension of scheduled hours paid at ordinary time rather than at casual rates, as is standard in the Awards covering male dominated industries (Charlesworth and Howe 2018). Further, the award does not currently cover travel time, which can be a significant proportion of the workday for community care workers (Charlesworth and Howe 2018). These provisions mean, at minimum, workers lack predictable incomes and are not paid for all the time they are at work. As noted above, care work is also undervalued, such that even when workers are paid for their working time, the rates of pay do not recognise the value (skills, demands and contributions) of their work (Charlesworth 2012, Meagher 2016).

Thus, in addition to reinforcing the task fragmentation of home care work, these regulations underpin poor employment conditions in the sector, by enabling insecure working hours, unpaid work, and low rates of pay. Such poor employment conditions are likely to make it more difficult to attract workers into aged care (Rubery et al. 2015), especially as the National Disability Insurance Scheme is rolled out and competes for similar occupational groups (Korn Ferry 2018:53).

Impacts on providers

New CDC care models also influence the behaviour of providers, who no longer have the assured revenue stream they had when funding was allocated to them, not to clients, and because funding is tied to a particular person, and so not available for cross-subsidisation or other potentially justifiable uses within provider organisations. This can affect client outcomes: under the prior block-funding arrangements, an organisation with a caseload of 20–30 clients operated with a total sum of money the care manager could allocate with discretion to meet the assessed needs of clients and any emergencies that might arise. Under the individualised funding model of CDC, it is not possible to move funds between clients, and it is difficult to manage unexpected events within an individual client's budget (Gill et al. 2017).

In the context of pressures for 'lean' business models, digital platforms have emerged to match workers and home care consumers. These platforms prize values of efficiency, consumer choice and worker fungibility, and enable short and fragmented shifts, and below award conditions (Flanagan 2019). Rather than being engaged in standard employment relationships, workers are generally treated as independent contractors, able to specify their price and undercut others, potentially creating a downward cycle. Further, platform-based care is organised in ways that stand at odds with professional paradigms of care work as skilled labour, as the importance of specificity, intimacy and trust in caregiving relationships are overlooked (Flanagan 2019).

Thus, CDC creates new dynamics within the home care sector which may lead to instability and turbulence in the provider landscape, which, in turn, could detrimentally affect working conditions and continuity of care for older people.

Figure 2.5 The impact of consumer-directed care: Olive's account of delivering home care

Olive trained as an enrolled nurse in the UK before moving to Australia nearly 40 years ago. She has worked in aged care for 15 years, initially as an enrolled nurse in a facility, but mostly as a home care worker. She says she was over-qualified for the role when she moved into home care but has always enjoyed being her own boss and working one-on-one with her clients.

Olive's employer is a large not-for-profit aged care organisation with sites across the country. She works permanent part time hours (20 hours per week). Despite approaching retirement age, she would prefer more hours. Her contract of 25 hours was reduced due to declining client numbers. She has stable hours, working 9am till 3 or 4pm across four weekdays, and but says she is working more split shifts. She sees four clients each day, most of whom are frail and live alone. Some also suffer dementia and/or other health issues. Olive says that since My Aged Care 'kicked in', her work has increasingly focused on domestic rather than personal care. 'We're their house assistants', she says.

Olive points to two areas where consumer-directed care is disadvantaging home care clients. The first is the wide discrepancy in the amount of social support time clients have in their packages, which isn't necessarily based on need, but more based on a client having someone to advocate on their behalf.

> *I personally have said "Mr So-and-So would really benefit if we could take them out." I see that that only happens if you have got active family members that are making decisions for you. "… I'd like my mum to go out once a week/twice a week. I'd like my mum to have a service here, there and everywhere." Otherwise people on their own, depending on their package, will get a couple of hours - something's done for them and then they're left on their own. I suspect they can manage, and in a lot of cases it's possibly better than being in a facility, a nursing home, but they're kind of like prisoners in their own home…'*

The second area concerning Olive is the reduced time for monitoring clients' overall health and wellbeing, stemming from time- pressured home care workers and less oversight by nursing staff and other professionals.

> *…well before My Aged Care our particular company had the support advisor visit [clients] either on a monthly basis, six weekly basis or a three monthly basis to make sure that they were keeping abreast of any deterioration in condition and any needs, and that they are supported - What their diet was, whether they've got enough money for supplies. We would go and cook… That's all fallen by the wayside now because packages don't allow for that. It's changed. They'll have a visit, and individually they can actually choose to have a six week or a three month visit or no visit at all…*

As well as clients being monitored less often, she says homecare workers are receiving less information about their clients and having fewer opportunities to raise concerns.

> *So what I'm finding at the moment is that we're being given very little information on My Aged Care and the details of what's happening with the clients. We're just robotic. We are going in there and we're performing these tasks and we'll give feedback. We've not had a team meeting since January. We've had training but not team meetings and when we were having team meetings then client discussion would come into it but now they're saying it's a privacy issue and you're not going to know anything about the client unless you're looking after them … So I might have a concern about one person and they don't want that discussed with everybody so it's not happening…*

At the same time, she says her organisation is focusing on training workers in how to recognise the sign of loneliness and depression. She is unsure, however, how and who will follow up with the clients whom workers flag.

3. Perspectives on quality: findings from research

The Terms of Reference for the Royal Commission into Aged Care Quality and Safety establish the underlying goals and values for Australia's aged care system, which include ensuring that services are person-centred, of high quality, and meet the social and emotional needs of older people, as well as delivering physical supports and clinically safe care.

Older people and their families have clear and fairly consistent ideas about what constitutes high quality aged care services, and their perspectives and experiences have been gathered in a substantial body of Australian and international research evidence. The care workers who work closely with older people and their families in aged care services also offer rich insights, being 'uniquely positioned to describe what makes up quality direct care and the barriers to providing that care well, based on their ongoing contact with residents' (Kusmaul and Bunting 2017: 146).

In this section we review this evidence, documenting how social, emotional and relational dimensions are central to the way care quality is understood by the people most intimately engaged in aged care services. Our main source is peer-reviewed research published in the last five years, although we include some important studies from Australia that were published earlier. The majority of studies examine the quality of residential care (typically referred to as 'nursing homes'), but findings from the few studies of home care make similar findings.

3.1 Views of older people and their families on high quality care

Research shows that older people's assessments of aged care quality emphasise the social and emotional dimensions of life and of care, including good relationships with care staff, friends and family, being assisted by staff who have time to care, feeling at home and feeling valued.

Research on the quality of aged care has increasingly sought to discover the perspectives of older people themselves in recent decades, partly because of the emergence of policy concepts such as 'consumer choice' and service concepts such as 'person-centred care'. Prior to this, quality improvement programs were primarily informed from the providers' point of view (Chou et al. 2002: 188). This was problematic because research has shown that 'factors assumed by service providers or policymakers to ensure quality of care may have little bearing on what residents perceive as important to their quality of life' (Chou et al. 2002: 188). Accordingly, the perspectives of older people and their families on the quality of aged care services have since been the subject of research, in studies that approach the issue from a variety of angles and use or derive a variety of concepts.

Some studies of **residential care** settings ask older people directly what they consider to be important features of 'good quality' and about their preferences in everyday life, in research based on open-ended interviews (see, for example, Bangerter et al. 2016; Milte et al. 2016; Rodriguez-Martin et al. 2013) or on surveys from which older people choose or rank quality dimensions

presented to them[15] (see, for example, Abbott et al. 2018; Burack et al. 2012; Milte et al. 2018, 2019; Roberts et al. 2018). Some studies frame 'resident satisfaction' as a measure of nursing home quality, on the assumption that identifying the most important dimensions of satisfaction, and the organisational factors that influence them, can inform strategies to improve quality (see, for example, Chou et al. 2002; Chou et al. 2003). Others examine whether person-centred care practices improve quality, measured by resident satisfaction and quality of life (Poey et al. 2017), or how the characteristics of facilities affect residents' quality of life (Shippee et al. 2015) or residents' 'thriving' (Björk et al. 2018).

Another set of studies engages the family members of older people living in residential care. This research responds to questions such as what makes a nursing home a home (Weeks et al. 2017), what shapes family satisfaction with nursing homes (Shippee et al. 2017, 2018) and whether family members' assessments of quality of care are affected by the degree of person-centredness in the nursing home environment (Lood et al. 2019).

So what do these studies find? Despite the different ways they are framed, and the various countries in which they have been conducted, their findings are remarkably consistent: older people's assessments of residential care quality emphasise the social and emotional dimensions of life and of care, including good relationships with care staff, staff having time to care, feeling at home and feeling valued. Family members also highly value these dimensions, although some studies find that they are more likely to be concerned about physical safety (see, for example, Milte et al. 2018; Lood et al. 2019).

A few examples give a sense of the consistency of older people's priorities in defining the quality of residential care, and the extent to which these priorities centre on social, emotional and relational issues.

In a series of studies, Milte and colleagues sought to identify and codify the dimensions of quality that mattered to older people living with dementia in Australian residential aged care and their families (Milte et al. 2016; 2018; 2019). Six dimensions emerged, of which two are about the nature of time to care – *enough* time (1) and *flexible* time (6), and three are about relationships and feelings (2, 3, 5).

1. the amount of time care staff are able to spend with residents
2. whether residents feel 'at home' in shared spaces
3. whether residents feel 'at home' in their rooms
4. whether the facility offered access to outside and gardens
5. whether the facility offered things to do that made the resident feel valued
6. how flexible staff are with the care routines.

[15] Note that where participants in such studies are presented with lists of quality dimensions to choose from or rank, those lists were generated from prior qualitative research, such as focus groups or interviews that gave older people and/or their family members the opportunity to express their views in response to open-ended questions. Researchers codify the finding from qualitative research and develop and test measures that can be used to gather data from much larger groups.

Abbott and colleagues (2018) offered 72 separate items of the 'Preferences for Everyday Living Inventory for NH residents' (PELI-NH) to older people living in 28 American nursing homes, and their top ten most important preferences were:

1. having staff show you respect
2. taking care of personal belongings
3. having staff show they care about you
4. having regular contact with family
5. doing what helps you feel better when upset
6. choosing who are to be involved in discussions about care
7. keeping room at certain temperature
8. choosing how to care for your mouth
9. choosing medical care professional
10. choosing how often to bathe.

Again, the primacy of relationships and feelings is clear; the quality of relationships with staff (1, 3), contact with family (4), finding comfort (5) and choice about who is involved in discussions and delivery of care (6, 9). Item 10 here (choosing when to bathe) could be seen as equivalent to item 6, 'how flexible staff are with care routines', in the studies of Milte and colleagues discussed above; while items 2 and 7 can be related to 'feeling at home' in one's room.

The studies discussed above establish how relational care is central to the way older people define quality of nursing home care (see also O'Keeffe 2014). Other studies seek to flesh out what this means in practice. For example, Bangerter and colleagues (2016) used qualitative methods to gain deeper understanding of eight key preferences of the 72 items on the PELI-NH inventory. Accordingly, the researchers used the open-ended responses to eight questions which, included 'how would you like staff to show they care about you?' and 'how would you like staff to show you respect?'. The researchers distilled the responses of 337 residents to these two questions into nine aspects of respectful and/or caring treatment as shown in (Bangerter et al. 2016: 705-6). Their findings reinforce the importance of caring relationships, communication, responsiveness and time to care in older people's preferences within residential care.

Findings based on research with older people themselves are confirmed in research with family members. A multi-country study conducted in Australia, Norway and Sweden (Lood et al. 2019) found that the more relatives perceived the care of their family members in residential care to be person-centred, the higher they assessed the quality of care to be.

Research on quality in **home care** also highlights how older people and their relatives see quality of care in terms of the extent to which older people's social needs, as well as their physical needs, are addressed (Cohen-Mansfield et al, 2018; Kajonuis and Kazemi, 2016; Kwan et al. 2019). Some studies compare perspectives on quality of home care users and users of residential care, finding some overlap. Abbott and colleagues (2018) found that, as for residents in residential facilities, older people using home care services prioritised opportunities for contact with family and friends, privacy, keeping active, going outside, and having choice over meals, entertainment activities and the timing of personal care, such as when to bathe.

A Swedish study (Kajonius and Kazemi, 2016) found that older people's accounts of quality in both home care and residential care tend to focus most strongly on the process of caregiving they experience, such as their treatment by, and interactions with, care workers. However, the study

notes how the structure of care, such as resourcing and staff training, set conditions for these interactions. Both sufficient resources and training were seen as needed to enable care processes to take place in the relational ways that allow older people autonomy and facilitate satisfaction.

Table 3.1 How nursing home residents would like staff to show care and respect

*Themes**	*Examples of how staff show care/respect*
Attitude	Staff should show interest, kindness and compassion and maintain a friendly and caring demeanor
Professionalism	Staff fulfilling their professional duties such as responding when a resident rings a call button, maintaining confidentiality, … following up with complaints/requests/issues and giving the resident what they need
Communication	Talking with the resident; staff should ask and answer questions [of] the resident, listen to the resident or including the resident in conversations or jokes
Greeting	Greeting and addressing the resident by a preferred name or in a particular manner
Care inquiry	Asking questions about resident care needs, listening to these needs and addressing complaints and needs of the resident
Person-directed care	Staff taking the time to get to know the resident beyond the requirements of their job, staff should provide special treatment and giving them what they want
Reciprocity	In order to get respect, the resident shows the staff respect
Physical contact	Physical treatment and handling of resident (hugs, pats on the back, gentle hold)
Etiquette	Show manners and be polite; respecting the privacy and independence of the resident

Source: Adapted from Bangerter and colleagues (2016: Table 2); examples are direct quotations.
** Themes were derived from coding open responses. Bangerter and colleagues report the percentage of respondents to the survey who framed their answer in terms captured by each theme; these percentages have been used to order these lists. Accordingly, 'attitude' was much more commonly reported than 'etiquette'.*

A systematic review of 17 studies of older people's views and experiences of home care confirmed the importance of social and emotional supports, time, trust and caring relationships in home care (Kwan et al. 2019). The authors report that 'Older people valued an approach that was person centred, flexible and proactive to respond to their changing needs and priorities, focusing on what they can or would like to do to maintain their independence. Allowing time to build trust between older people and their care workers helped to realise older peoples' aspirations and goals. Practical help to promote choice and reduce social isolation was perceived to be as important as personal care' (Kwan et al. 2019: 87)

The numbers of carers that deliver home care services to them are also important to older people and their family members. Structured interviews with over 200 Norwegian home care users and their relatives underline the importance of continuity of care (Gjevjon et al. 2016). However, findings indicate older people are able to establish trusting relationships with multiple carers, provided they have sufficient opportunity to get to know each other, and systems are in place to ensure carers are well informed of care needs. Relatives regarded the number of carers to be more important than did older people themselves.

It is important to note that while the older people and family members who participated in these studies clearly articulated the characteristics of good care, they also recognised constraints on its

delivery. Australian research on quality in residential care from older people's perspectives found that family members perceived that poor quality care often stemmed from systemic problems, particularly understaffing, but also poor training and poor preparation for the demands of the work. The result is care workers who pushed, tired, [and] exhausted, without adequate time to spend with residents to provide individualised care', and 'one size fits all', 'generic' care (Milte et al. 2016:14).

3.2 Views of staff on high quality care

Personal care workers can conceptualise high quality care and their conceptualisations align in important ways with those of older people, notably in their emphasis on social and emotional aspects of care relationships, and the importance of time to know, time to care, and continuity.

As the ToR of the Royal Commission recognise, the aged care workforce has 'a critical role … in delivering high quality, safe, person-centred care'. However, in a parallel with research on older people, several researchers have argued that the perspectives of front-line workers such as personal care assistants have been missing from discussions of care quality, despite their critical role in service delivery, because these discussions have tended to focus on the impact of nursing care when considering staffing issues (Ginsburg et al. 2016; Jansen et al. 2009; Kadri et al. 2018; Kusmaul and Bunting 2017; Oppert et al. 2018). In other words, personal care workers have been the 'unacknowledged persons in person-centred care' (Kadri et al. 2018). Nevertheless, in a growing body of Australian and international research the critical role of these workers has been recognised, in a wide variety of studies on both their understandings, perspectives, experiences and practices, and the organisational, working and employment conditions that enable them to offer high quality care. Importantly, a central theme across research about care workers and care quality is the interdependence of the well-being of older people receiving services and the quality of jobs, work environment and employment conditions of the workers who assist them.

As with many studies of older people themselves, some research with care workers asks them directly what they understand to be high quality care and how they seek to offer it, and what they value about working in aged care. The reviewed studies were undertaken in quite different institutional and cultural contexts, yet their findings converge on a set of goals, values and practices that align with the perspectives of older people and their families.

For example, a study with American PCAs[16] in nursing homes sought their perceptions of giving good care (Kusmaul and Bunting 2017). While study participants framed good care in terms of thoroughly undertaking the practical care and support of the older people they assisted, and keeping their environments clean and tidy, they particularly emphasised relationships that went beyond the physical tasks, some using the language of love. Good care was attentive, active and engaged, and good care workers took responsibility for the well-being of the older people and participated constructively in teamwork.

[16] Different, nationally specific terms are used in the international research literature to capture the group of workers called 'personal care attendants' in Australia. For consistency and ease of reading, the term personal care assistant (PCA) is used here as a 'translation' of these various terms.

Another study asked care workers in Ireland, the Netherlands and Sweden what they valued in their work in care for older people (Eldh et al. 2016). Social and emotional benefits were foremost in their responses; including forming relationships with the older people, recognising their needs and having the opportunity to respond to them, using their skills for the benefits of others, being part of team with a common goal and being appreciated for being there. Similar findings are reflected in a study among Canadian PCAs (Andersen and Spiers 2016), in which participants described their ideals for relationships with older people in their jobs. Their ideals, framed through concepts such as compassion, altruism, inclusion and a sense of vocation, informed their efforts to establish and maintain relationships with older people and their families, through learning, negotiation, adaptation, careful attention and communication.

A fourth study asked Swedish nursing home staff, primarily PCAs, how they enabled 'at-homeness' for the residents (Saarnio et al. 2017). As discussed above, 'feeling at home' is a value that research has found to be an extremely important dimension of care quality for older people themselves (see, for example, Milte et al. 2016, 2017, 2018). The participants described the enabling practices shown in Table 3.2. The practices described clearly reflect the importance of respectful, caring relationships and time to care (Saarnio et al. 2017).

A fifth, multi-country study sought directly to identify 'promising practices' in residential aged care, and identified the following eight 'practices that promote care as a relationship' and enable respectful treatment of both residents and staff: adequate staff and an appropriate staff mix; a stable workforce; time to care; standards (principles), effectively enforced and funded; appropriate training and education; appropriate working conditions; an integrated system (both at the facility and system levels) and tolerating some risks (Baines and Armstrong 2018).

The findings of these studies show that care workers can conceptualise high quality care and that their conceptualisations align in important ways with those of older people, notably in their emphasis on social and emotional aspects of care relationships.

Table 3.2 How care workers in a nursing home enable 'at-homeness' for residents

Practices crystallised from coding of reflective discussions	*Examples of these practices*
Striving to get to know the resident	• Collect information about new residents through conversations with them and their relatives • Learning about and from residents through ongoing interactions
Showing respect for the resident's integrity	• Being present in the caring situation, reading between the lines • Taking the position of being a guest in a resident's room to show respect • Accommodating residents' routines and when they needed help through, for example, giving them time to complete tasks they may be doing • Speak to and about residents respectfully and show them that they are important as people
Creating and working in family-like relationships	• Individual care workers having primary responsibility for specific residents • Caring for the same residents on a daily basis • Having fun and enabling residents to share sorrows and feel they have been listened to • Bodily contact with residents, such as hugs or hand-massage while having a chat • Helping residents connect with each other, e.g. at mealtimes
Helping to find a new ordinariness in the changed life situation of ageing and living in residential care	Care workers recognised that adapting to their changed life situation was something residents needed to deal with themselves. Practices to support residents included: • having conversations with them about the changes • reassuring residents that their new disabilities are not (e.g.) 'an inconvenience' to care workers • caring for residents and letting time pass
Preparing and making plans to secure continuity, to ensure residents feel secure	• Ensuring each resident has a care worker who has primary responsibility for their care • Explaining how and what is going to happen e.g. when changing continence pads or moving the resident between bed and wheelchair • Motivating and encouraging residents to do things they do not like doing, but need to do, relying on strong relationships

Source: Saarnio and colleagues (2017: 42-44); includes direct quotations and paraphrasing.

Figure 3.1 Building relationships in residential aged care: Titus' account

Titus came to Australia as a refugee more than a decade ago. He worked as a community health worker in his home country and decided to complete a Certificate III in Aged Care soon after settling in Australia. He needs to work long hours to support his children, one of whom has a disability, pay the mortgage and support his extended family overseas.

For the last decade Titus has been working more than 50 hours a week in total, in two permanent part-time roles. He is an aged care worker in residential facility and also works in a disability support role in a different organisation. In his aged care Titus works five days a week, a combination of morning, afternoon and night shifts on a fortnightly roster. He has two regular but non-consecutive days off each week.

His aged care employer is a not-for-profit aged care residence in a middle-class area. The facility has a broad mix of residents including people with dementia and 'challenging behaviours' who are all mixed in together, which can be 'tough times'. The reduction of staffing levels on the morning shift as well as heavy documentation requirements reduces the time he has to spend with each resident.

> *You have to regularly put into the computer what you did for the residents. Shower, grooming, shaving, brushing teeth, all what you have just done, change his bed. You have to list everything. …Sometimes it's like 20 minutes.*

He says he talks all the time to the residents telling them what he is doing or going to do with them. He enjoys night shift, where it's a little quieter and he can delve into their histories, which he says helps him to deepen his relationship with his clients.

> *I want to know more about the person who I am caring for. So, especially on nights when it's a bit quieter… you go into their history to really know how did they lived their life and what were things that they liked, what did they not … So, I know some of these things…One of the things that help me to strengthen the relationship is I try, even though it's too hard for me, I try to speak their language, that is the Greek language… I try, "Time to shower", or "Stand up" and "Face this way." You know? The basic ones I try to learn those things … so that strengthens the relationship.*

While Titus stresses the importance of chatting with each resident while he is going about helping them with the day to day tasks, what many residents really like to is to get out of the facility. However, with reduced staffing levels, particularly on the morning shift, staff struggle to find the time to take residents out and the sole occupational therapist is also stretched.

> *Some of them want to go out but there's no time for us to say, "I will walk you out there. We'll go around the block. We'll go to a community centre," whereas they will do that in disability. So, for these people it's too hard for them. Someone asked me, "Am I in jail?"… If someone asks me, "Am I in jail?" What does that imply to you?*

3.4 Creating a virtuous cycle of high quality care and high quality jobs

High quality, person-centred care is delivered by a system and care provider organisations that recognise that consumer satisfaction is inextricably connected to care worker job satisfaction, and that high quality aged care is linked to high quality aged care jobs.

The previous section established that most care workers can conceptualise high quality care. However, a bridge between conceptualisation and practice needs to be built within the organisations that provide aged care. These organisations constitute the environment within which care workers offer assistance and support, and although PCAs work most closely and consistently with older people, they cannot be expected to be individually responsible for the delivery of person-centred care (Hunter et al. 2016). In other words, it is essential not to romanticise care work or to assume that because care workers can *define* good care that they are always in a position to *deliver* it. While research with care workers reinforces the importance of caring relationships and time to care, it also suggests that system features and/or organisational practices, positive and negative, are critical enablers or constraints on their capacity to offer good quality care. In this section, we present our synthesis of more than 20 studies[17] that focus specifically on organisational and other factors that enable or constrain high quality, person-centred care. Our review reveals that, in general:

i) the higher the quality of care workers' jobs, the higher the quality of care;

ii) care workers' job satisfaction increases with the quality of their jobs; and

iii) older people's satisfaction with care increases as care workers' satisfaction with their jobs increases.

In other words, research shows that care quality, job quality, satisfaction with care and job satisfaction are linked in a virtuous cycle, as shown in Figure 3.2.

We begin by discussing two studies that ask quite general questions about what affects the quality of aged care. The first is a recent systematic review of 32 studies, which sought to identify the determinants of the *quality of relationships* in long-term care (Scheffelaer et al. 2018).[18] The study's broad findings are familiar from the previous section and include the need for a focus on each older person as a *person*, emotional investment in their work by care workers, reciprocity and trust. Significantly, however, several of the key findings relate to *organisational* factors, and in different ways to time to care. Here constraints that hinder good relationships feature strongly. Several included studies reported that a lack of time, high workloads and inadequate staffing meant that staff did not have time develop high quality relationships with clients (Scheffelaer et al. 2018: 17). Further, continuity – or the development of a care relationship over time – is an

[17] This includes a number of studies that themselves were reviews of multiple studies; for example, Andre et al. (2014), Scheffelaer et al. (2018) and Costello et al. (2019).

[18] Interestingly, the study included research about three different client groups -- physically or mentally frail elderly (our focus here), people with mental health problems and people with physical or intellectual disabilities. They found that a substantial number of the determinants of relationship quality apply to more than one client group (although there were relatively few studies on care for people with intellectual disabilities). The study does report some determinants reported only in care for older people.

important characteristic and outcome of good care relationships, which can be hindered by organisational policies of rotating staff or by high staff turnover. Hierarchical work organisation, which limits care workers' decision-making authority, was another practical obstacle to collaborative work with clients identified in several studies.

Figure 3.2 The virtuous cycle of high quality care and high quality care work jobs

The second is a recent Australian study, not included in Scheffelaer and colleagues' review (2018), of the facilitators and barriers to the practice of person-centred care (PCC), as perceived by PCAs working in residential aged care (Oppert et al. 2018). This study found that 'PCC is a phrase more talked about than implemented' in Australian residential care (2018: 686) and that the key barrier to providing it was insufficient time to spend with residents to attend to their psychosocial needs. This reinforces the findings of the 'missed care' research discussed above (Henderson et al. 2017). The other barrier mentioned by the PCAs interviewed was the difficult dementia behaviours of residents. However, the authors argue that these behaviours could be alleviated if the practice of PCC could be more fully realised, 'because the care is more individualised, thus reducing confusing and combative behaviours' (2018: 687). The 'facilitator' identified by PCAs was teamwork, which had the practical benefit of freeing up some time and the psychological benefit of enhancing psychosocial support for workers themselves.

There is much less research on home care. However, one noteworthy study of home care confirms the results of research on residential care, about the essential relationship between how time is organised and person-centred care. The study considered the perspectives of policy-

makers, managers, care workers, care recipients and family carers on home care in Ireland (McDonald et al. 2019). The study found that problems with time were at the centre of all problems with the quality of home care services and home care work. It took many older people too long to find and access services, while the time within home care services was too little, too rigidly controlled and fragmented. Work was organised into multiple short visits to perform specific tasks, and home care recipients experienced this as a lack of caring. This fragmented, task-oriented work organisation was generally perceived as undermining opportunities for older people and care workers to form caring relationships. These problems led many participants in the study agreed that home care packages should include 'companionship time', to enable care workers to meet the social and emotional needs of the older people they assisted. Overall, '[p]articipants agreed that time should be at the heart of person-centred care' (2019: 8).

Most of the other studies we reviewed explored more specific questions about the relationships between care quality and specific aspects of job quality and job satisfaction.[19] The general message in the research is that most factors that shape job quality and job satisfaction are not under the control of individual workers, but rather are determined by managers in organisations in the context of the structural features of the relevant aged care system.

The connection between care quality on one hand and care workers' job satisfaction and job quality on the other is confirmed in a large number of studies, regardless of the measure of care quality used: clinical indicators, older people's satisfaction with services, or staff reports of implementing person-centred care practices (Andre et al. 2014; Boldy et al. 2004; Edvardsson et al. 2011; McGilton et al. 2016; Plaku-Alakbaro et al. 2018; Roen et al. 2018).

A few examples again give the flavour of their findings. One major study from the US examined the relationship between care quality and employee job satisfaction in residential care facilities that together housed more than 50,000 older people. Care quality was measured by both clinical indicators (falls, pressure sores) and resident satisfaction. Job satisfaction was measured across four domains: supervisor support, respect and caregiving, working conditions and quality of training. The study found that residents were most satisfied when care workers 'were compensated fairly, supported by their managers, provided with stress assistance, and working in an environment that values communication' (Plaku-Alakbarova et al. 2018: 414).To address low job satisfaction and low care quality, the researchers recommend that managers implement policies that assist with stress by 'ensur[ing] adequate, consistent staffing and good communication between the professionals on duty', as well as 'cultivating a greater respect for the input of nursing aides, actively soliciting their opinion, and allowing them greater decision-making autonomy in certain aspects of day-to-day resident care' and creating participatory teams across professions to 'jointly decide on procedures for resident care' (2018:414). These findings have been replicated in

[19] 'Job quality' is measured in different ways in different studies, but generally includes factors such as workloads, teamwork, the supportiveness of leadership, extent of autonomy to make decisions about priorties in daily work, pay and other employment conditions, such as family-friendly working arrangements, recognition for doing a good job, opportunities for advancement, and good work organisation (e.g. consistent assignment to clients). 'Job satisfaction' is also measured in different ways. Some studies simply ask staff to rate their overall job satisfaction on a single scale of 1-5 (for example, Chamberlain et al. 2016). Others use multi-dimensional measures that generally includes similar factors as 'job quality', such as satisfaction with working conditions, staffing levels, collegial and supervisory support/leadership; capacity to use skills and give good care, and training.

a recent Australian study, which found significantly lower injury rates in residential facilities in which residents and staff were more satisfied with their care and jobs respectively (Jeon et al. 2019).

A large subset of studies seeks to identify specific organisational factors, working conditions and employment practices that enable high quality care through building high quality jobs (see Table 3.2). These studies, most of which have been conducted in Australia, the United States, Canada and the UK, recognise that job quality is a major problem in their respective aged care systems. They seek to identify the correlates of better care and better jobs, in the effort to meet the formidable challenge of providing both.

Another group of studies focuses on *problems* with care quality and job quality, such as rationing of care, stress and burnout, and staff intention to leave or turnover. These studies, which focus on hindrances to good care, make very similar findings to those focused on quality enablers, but in reverse. For example, a systematic review and meta-analysis of 17 studies found that care worker stress and burnout, which affect care quality by undermining care workers' capacities, are associated with lower job satisfaction, inadequate staffing, and poor work environment, including poor leadership and support (Costello et al. 2019). Burnout is a particularly challenging problem, because it tends to be associated with 'depersonalisation', which occurs when a care worker becomes less able to see older people as persons. Turnover is a problem for continuity and quality of care. Turnover is more likely among PCAs when they perceive their managers to fail to 'stand up for them and champion their best interests with higher wage earners and senior managers in the organization' (Matthews et al. 2018). However, turnover and absenteeism may be significantly reduced when the same PCA consistently cares for the same residents almost every time the PCA is on duty – a practice known as 'consistent assignment' (Castles 2013).

Research that focuses more specifically on working and employment conditions in aged care demonstrates the need to extend beyond organisational changes to deal with the industrial relations factors that undermine care quality. As discussed above, the SCHCDS Award specifies different conditions for home care workers compared with disability support and other community service workers. Those classified as home care workers and working on a casual basis have a minimum engagement period of just one hour, compared with two hours for disability workers, and home care workers have not had access to the pay increases arising from the 2012 equal pay case for social and community service workers (Macdonald and Charlesworth 2016). In the context of short episodes of care, provision of managerial and supervisory supports to workers, relational coordination, and other supports for best practice discussed above are likely to be difficult to embed. This underlines the importance of addressing the policy and regulatory factors that enable fragmented, task-based working arrangements to emerge and flourish.

Table 3.3 Connecting care quality to job quality

Empowering work culture	An **empowering work culture** improves quality of care: 'Improving employees' participation in decision-making, increasing empowerment and influence and making changes in the management style seem to be crucial factors to improve quality of care in nursing homes.' (Andre et al. 2014, p. 456) **Team inclusion** increases worker empowerment, and empowered workers deliver better quality of care and are less likely to leave their jobs (Barry et al. 2019)
Relational coordination of care	**Relational coordination of care** improves job satisfaction which improves care quality. Relational coordination involves both *communication* ties (frequent, timely, accurate, problem-solving) and *relationship* ties (shared goals, shared knowledge, mutual respect). The more relational coordination between care workers was, the higher their job satisfaction and the better resident quality of life. Aged care systems need to 'improve the training, pay and status of nursing aides so as to more fully engage them in achieving desired resident outcomes' (Gittell et al. 2008).
Work-family support	Higher average **work-family support** was strongly linked to higher care quality (measured as pressure sores, falls), despite managers' perceptions that providing more family support and ensuring care quality were conflicting goals (Okechukwu et al.2016). When **workers decide their work hours**, their performance and thereby care quality improves because workers have more resources to plan, execute and cope with work demands. Aged care employers should introduce flexibility initiatives, such as self-rostering, cross-training (extending worker skills to new areas) and supervisor support for work-family balance to better meet residents' needs and aid recruitment of care workers (Hurtado et al. 2016).
Supportive management and leadership	More **effective supervision** of PCAs by registered nurses was associated with higher PCA job satisfaction, lower PCA intention to leave, higher PCA job effectiveness, higher consumer satisfaction, better PCA decision-making and less PCA job stress (McGilton et al. (2016). By increasing care workers' personal resources (hope, optimism, self-efficacy and resilience), **good leadership** leads to improved clinical care outcomes. In a context where contracting out and private provision of aged care services create significant quality assurance, accountability and governance problems, the **contract specifications for aged care provider accreditation and oversight should include the support they provide to workers** (Xerri et al. 2019).
Use best practice care methods	PCAs were more likely to **use best practice methods of care** when the organisation had sufficient time and staff to enable it, when they worked in a well-connected team, and the level of informal interactions to transfer knowledge was higher (Estabrooks et al. 2015).

For more detail see Appendix Table C.2.

3.5 Worker skills and care quality

Care workers must have the relevant practice and relational skills to deliver high quality care. They need high quality, relevant training, paid time to learn, managers who support their professional development, and a collaborative team environment in which to use their skills and knowledge.

As discussed in section 2 above, the skills profile of the Australian aged care workforce has been changing as the share of PCAs grows and the share of professional care workers, including nurses and allied health workers, falls. This has raised concerns about the capacity of the workforce to meet the complex needs of older people in the aged care system, and to provide high quality, person-centred care (Milte et al. 2016; Wells et al. 2019).

Skills, knowledge and training related to care quality in several ways. Most obviously, care workers need to have the relevant practice and relational skills to be able to deliver high quality services.

Workers may have all the relevant skills but be unable to exercise them because they have too little time, or their opportunities are restricted in other ways. Yet being able to exercise one's skills and satisfaction with training are associated with overall job satisfaction in care work and as we have seen in the previous sub-section, when care workers are satisfied with their jobs, the quality of care is higher.

It is also possible that some care workers do not have the training and skills they need to deliver high quality care. For example, not all care workers understand the principles of person-centred care. An Australian study found that while three quarters of PCAs had a moderate to strong understanding of the principles of person-centred care, a quarter demonstrated 'superficial or limited knowledge' (Oppert et al. 2018:686). Such a lack of skills and knowledge may compromise care directly, leading to mistakes and poorer quality. Lack of skills and knowledge may also contribute to stress and burnout among care workers, particularly in relation to supporting older people with dementia, mental illness and at the end of life (Costello et al. 2019; McCabe et al. 2017), and further weaken their capacity to deliver high quality care.

Lack of training is recognised as a problem by many care workers themselves, by managers and employing organisations and at the system level (Korn Ferry 2018). However, attention must also be paid to how the training is delivered, otherwise '[w]ell-intentioned policy governing the training of direct care workers … who serve older persons, in practice, may become merely a compliance issue for organizations rather than a meaningful way to improve quality of care' (Kemeny and Mabry 2017: 295). In Australian aged care organisations, care workers are not routinely given work time to complete training beyond basic mandatory requirements and may be expected to undertake online training in their own time, which assumes all have the equipment and home circumstances that enable them to do so. Research shows that the strategies needed to improve the quality of training, and best enable the use of knowledge and skills gained in that training, share much with strategies to increase the quality of care. These include tailoring training to the needs of staff and their local workplaces, time to learn as well as time to care, supportive management that focuses on staff development as much as compliance, and a collaborative work environment, in which workers can use their knowledge and skills (Kemeny and Mabry 2017).

There is robust evidence that good training and support, including weekly, collaborative supervision, is highly effective in achieving person-centred care and reducing harmful behavioural management practices. A randomised controlled trial of a training and supervision intervention to enhance the quality of psychosocial care of nursing home residents with severe dementia in the UK found very significant decreases in use of anti-psychotic medications in the homes with the intervention (Fossey et al. 2006).

This review of research has shown that the search for determinants of quality takes place under the shadow of what we might call, following Andersen and Spiers (2016) 'the reality of PCA work'. Much of the research on organisational determinants of quality starts by discussing the challenges of workforce recruitment and retention, meeting the growing need for aged care services, the many pressures and difficulties care workers face, and the gulf between the aspiration to person-centred care and the reality. Nevertheless, there are some clear lessons from our research review of the organisational determinants of *care* quality. This review reveals that care quality is highly correlated with *job* quality, and that *older people's* satisfaction with care is highly correlated with *care workers'* job satisfaction. These findings point to the need for reform at the level of the aged care system (funding and regulation of both quality and industrial arrangements) and at the level of aged care organisations (working conditions, work organisation and management priorities and practices).

Figure 3.3 Helen's account of delivering home care

Helen became a home carer after being made redundant from her professional role in manufacturing. A friend encouraged her to move into care work, telling her 'You'd be great in this job'. Now in her mid-sixties, Helen has been a home care worker for 15 years. She is a grade 3 worker, supporting a range of clients from small children with to people in their nineties mainly requiring personal care.

She is employed full time and works a minimum of 96 hours a fortnight, although her contract is for 70 hours a fortnight. She currently works 12 days out of 14 because her organisation is so short staffed. She starts at 6am most days working with the younger clients and works evening shift with people with disabilities until 10pm, after a break in the afternoon, which she would prefer not to have.

With her aged care clients, a key concern is the inadequate time allocated for personal care tasks, particularly for people who are very frail or at the palliative stage of their lives. Helen previously worked for a government provider, but since the service was outsourced to a commercial not-for-profit provider, she has had less flexibility with changing the time allocated with clients. She is reluctant to ring up her managers when she needs more time.

> *…well, they say that's up to me. I should've done the service in the time.*

She also provides an example of the process involved to extend the time, using the case of an elderly client who is nearing the end of her life.

> *Well, usually on Monday, that lady that's palliative care now – she's 92…, I wash her hair and I strip her, and she gets wet from head to toe with soap and water, and then she gets a full massage of oils all over her body and under her arms. And that takes me an hour, but they only allocate me 45 minutes… I have brought that up, and our allocator – he allocates the jobs …, he says to me, he's been looking into it, and he has to get the OK by the manager to say that they can up the [time] – and then, ask the son will he pay the extra 15 minutes to do the service.*

In this case the son agreed, but it took time.

Helen sees the wellbeing for the clients is also dependent on having good staff, that is, those who are well trained and understand how to communicate with older people they visit, particularly when they are pressured for time.

> *A basic aged care shower is half an hour, and you can shower them nicely in half an hour, but it's the little conversations, and they love to have a talk with you… That bit is missing. And it becomes very cold and clinical I think when you walk in, "C'mon, let's have a shower. Hurry up…". I have a little conversation. I go to any person's house and by the time I leave,… I know how long they've lived in the house, "Is that your grand child?", "I love your garden. Did you plant those?", and they love that, and that's starting to go missing in our services.*

4. Delivering person-centred care: findings from a survey

This section reports findings a survey of aged care workers and includes further vignettes from interviews.

To explore care workers' experiences of delivering quality, person-centred care that builds the social and emotional wellbeing of older people, the survey explored:

- The extent to which workers are able to deliver services in ways valued by older people
- Perceptions of organisational supports and resourcing
- The consequences of staffing arrangements and work organisations for care provision and older people's wellbeing; and
- What would improve capacity to attend to older people's wellbeing in aged care.

Further detail about survey design, along with sample characteristics for the 1,231 respondents are shown in Appendix A. Given our focus on caregiving, analysis was restricted to those in direct care roles, on relevant measures (n=1,004).[20]

Further details of the interview method are in Appendix B. Pseudonyms are used and any potentially identifying details removed.

4.1 Delivering services in ways that are valued by older people

To explore whether care work was organised around notions of person-centred care, the survey explored workers' care practices; perceptions of time available (including time to connect with older people); and unplanned time to allocate flexibly to unexpected needs.

4.1.1 Person-centred practice

Only a minority of workers felt able to routinely engage in the practices which are characteristic of person-centred care, such as getting to know each older person as a unique individual and supporting individual decision-making. Few considered the time available for care tasks to accommodate provision of quality care, and to enable them to meet older people's needs. Figure 4.1 shows the extent to which care workers engage in five caregiving practices typical of person-centred care. Most (77%) reported working attentively, routinely assessing older people's needs each day they worked with them. However:

- less than a quarter of care workers (24%) agreed they have the time to get to know each older person as a unique individual
- only 2 in 5 reported that the older people they work with receive support to decide on their daily activities (39%)

[20] Those whose main roles were in kitchens and catering, laundry and cleaning, or other roles such as maintenance or administration were excluded from analysis of items relating to caregiving (n=227).

- only 2 in 5 said they used older people's life histories in planning their work (41%); and
- less than half of care workers agreed that older people receive care from people they recognise (44%).

As explained earlier, principles of person-centred care have more strongly guided policy and service delivery in Australia's home care system, than in residential care. However, on many measures, relatively low proportions of home care workers report being able to work in person-centred ways, suggesting that realities of practice are not meeting aspirations. Home care workers were less likely than those in residential settings to agree that older people receive care from people they recognise (35% compared with 47%), a factor which is likely to have become more problematic with the use of a casualised workforce under consumer-directed care. Home care workers were also less likely to agree that life histories were used to plan activities (24% compared with 44% in residential care), and smaller proportions felt older people were supported to decide on daily activities (33% in home care compared with 40% in residential settings).

Figure 4.1 Proportion of care workers who agreed with statements on relational practice^

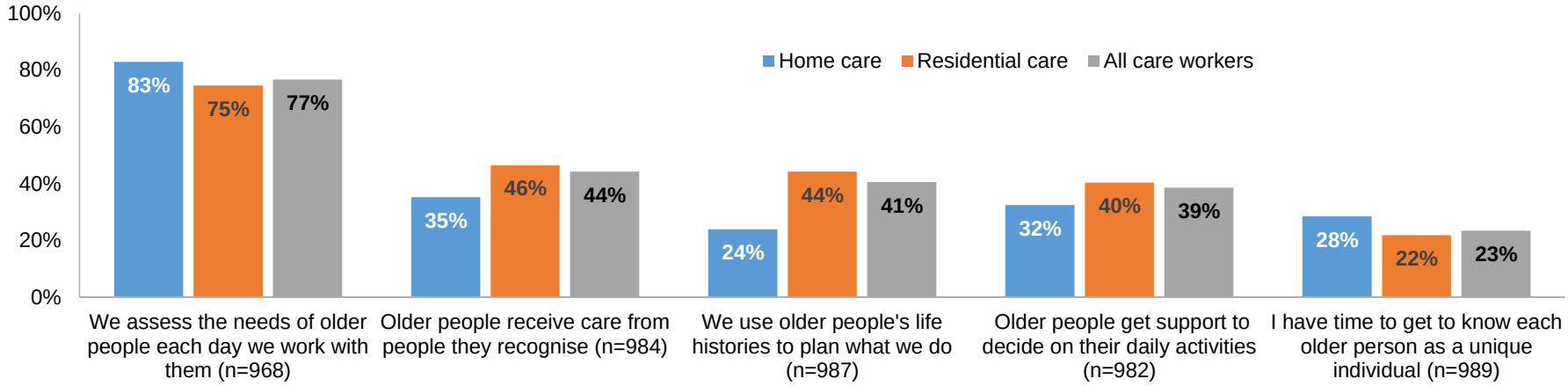
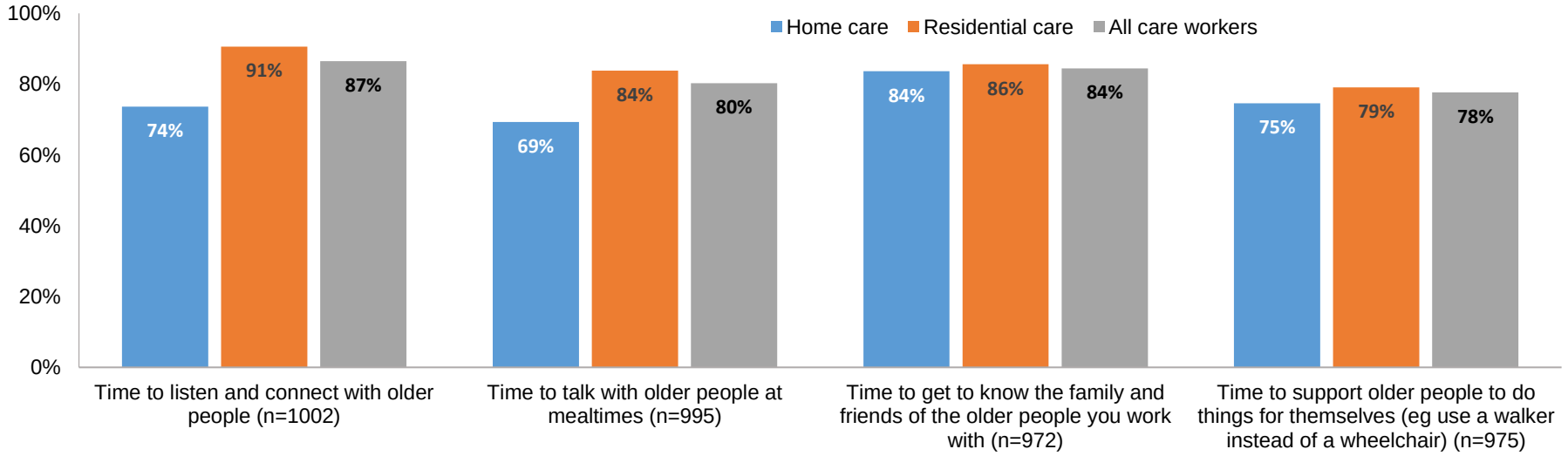


Figure 4.2 Proportions of workers who said time to perform task was 'not enough'^



^Note: 64 respondents reported working in settings other than home care or residential care. These are not reported as a separate category but are included in figures for 'All'.

Figure 4.3 Ellen's account: the importance of connection and the impact of understaffing

Ellen has been a home care worker for 25 years and works full-time, in a permanent role with regular daytime shifts. Her employer is a large faith-based not-for-profit with sites across Australia, who she describes as 'conscientious about the good quality of care that we provide to clients'. Ellen holds a Certificate III in aged care. She has a fortnightly client schedule, which can change daily. Ellen visits clients in their own homes and retirement villages. Most clients are in their eighties and nineties; her oldest client currently is 97. She sees the main aim of her job is to 'keep them out of nursing homes'. If her clients are still living in their own home in their nineties, she considers she has done a good job.

Ellen's role as a senior home care worker is a diverse one. She sometimes covers 'domestic shifts' if they are short staffed. In addition to the significant documentation, reporting and reviewing of care plans she does whatever is needed to keep people at home. This includes helping people with footwear, continence gear, laundry, showering, checking clients have taken their medication, clearing out fridges, changing beds, helping with mobilisation exercises, and organising gardening:

> *It just encompasses everything that you can think of that you do yourself every day', she says. People say to me, "What do you do with her?" And, I just say, "I do everything." Today I organised extra time at the end of the month for her to attend one of her friend's 90th birthday party.*

Her role is also much broader than completing the varied list of tasks and requests from her clients. She also works with clients to help ensure they are maximising their home care funding to maintain their independence and will advocate on their behalf. She says if she also has enough time with her clients, she makes sure she gets time to do the things the client needs

> *…there's a lot of funding that doesn't get used and if I work with clients like that I encourage them to use it to do things like modifications in their house that make things easier to use; sliding doors, ramps, equipment, all those sorts of things. If they need [them] and their funding in their package is enough we'll do things like that. We'll do dentures, we'll do hearing aids, if they have the funding for it.*

Ellen has supported some of her clients for more than 10 years and feels deeply attached them.

> *I love the people. I really do. You end up having lovely long-lasting relationships with the people you work with… You end up being a bit of a family member if you're with them long enough. You know, their family knows you and asks after you and they give you a little token Christmas present and stuff like that.*

Her relationship with her clients are critical for them, and may be their main social connection.

> *There's a lot of social isolation that is out there. If Meals on Wheels didn't visit someone five days a week they wouldn't see anyone else… Quite a lot of the service that I provide to clients is the listening service. If they haven't seen anyone and they want to have a chat I will have a chat with them.*

While Ellen considers she provides a very good service to her clients, clients equally value having a relationship with a home care worker they know and trust. The casualisation of the workforce makes it harder for all clients to have they type of relationship she has with many of her clients.

> *We're always understaffed. Because it's a casual job it's just really easy to ring up and say you're sick and then everyone has got to scramble around and try and fill all those shifts that you can't do… The way it impacts on the clients is that they have to be moved, so they don't get their normal time. Most of them will say, "Well, if she's not coming I don't want anyone."*

However, she says when the clients don't see regular carers and clients cancel the service this poses many risks.

> *They miss out on nutrition particularly. I'm always walking around saying, "Drink some water." "Eat some protein." "Stop losing weight."*

4.1.2 Time for person-centred care

A further set of measures captured workers' perceptions of the adequacy of time to perform activities characteristic of person-centred approaches: listening and connecting with older people, talking at mealtimes, getting to know family and friends, and time to promote independence.

Care workers' perceptions of the adequacy of time for four sets of relational tasks are shown in Figure 4.2 (above). Across each of the measures, respondents overwhelmingly reported having not enough time. This was especially apparent among residential care workers: over 90% said they had insufficient time to listen and connect with older people, as did around three quarters of home care workers (74%). More than three quarters of all care workers reported having insufficient time to support older people to do things for themselves (78%), and over 85% lacked time to get to know older people's family and friends.

Three items were included to capture availability of unplanned time, given that some needs cannot be planned for and flexibility in time allocations is needed to ensure responsiveness to changing or unpredicted needs (Figure 4.4). Overwhelmingly, staff in both home care and residential care settings reported there was not enough time to respond to unexpected needs (90%), to spend time with someone in low spirits (92%), or to do something special for someone (91%). There was little difference apparent among workers in home care and residential care settings.

Figure 4.4 Proportion who reported time for unplanned activities was 'not enough'(%)

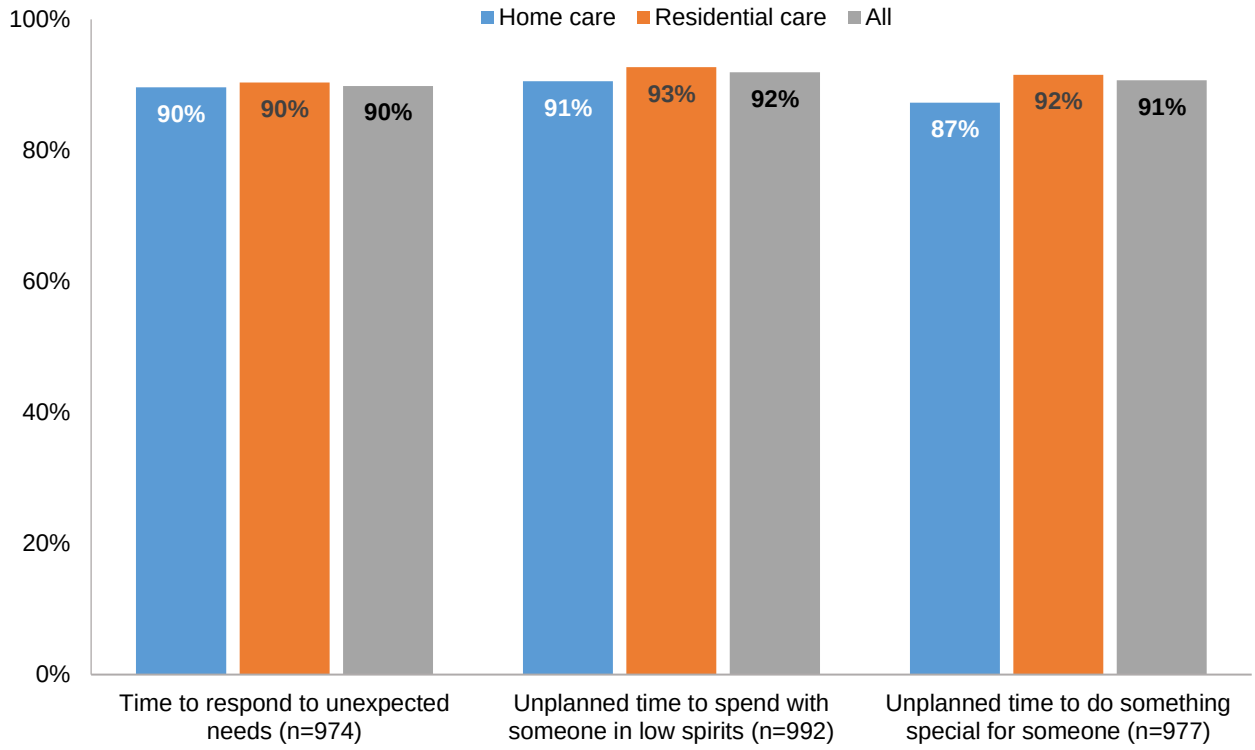


Figure 4.5 Relationships and 'rushed care': Berri's account

Berri has been working in aged care for just over three years. She moved into aged care when she was unable to find work in Australia using her communications degree obtained overseas, but really enjoys her new career as an assistant in nursing. While she would prefer to work full time in one organisation, she works across two, employed on a permanent part time in a not-for-profit residential facility, and casually in a private aged care home. This gives her access to the hours she needs to support her young family.

Holding Certificate III and IV qualifications she works shifts as a personal carer/AIN and shifts as a leisure and lifestyle/activities worker. In both facilities, most residents have some degree of dementia.

Berri talks a lot about needing to 'really understand' each resident in her care, and as a personal care worker considers that spending one-on-one time with clients is central to providing decent care. She describes how time is essential for relationships:

> *When we have time to understand what they want to do, what they don't want to do, what they want to eat, what they don't want to eat, where they want to go or where they don't want to go. When we have enough time to listen to them and follow them, there will be a good relationship then.*

For Berri, being able to understand each resident and forming good relationships with them comes down to having enough time; including time to read the detailed care plans, and enough staff, so she is not switching between residents and tasks. She describes a typical lunchtime, where she is juggling multiple tasks in the context of understaffing:

> *We have a lot of things to do, we have to feed, we have to take the trays into the rooms and we have to wash the clothes. And if I assist someone to the toilet, the food will get cold for everyone, and I have to rush, I have to say, 'can you please wait 'til after the lunch, and this is very painful. This is painful. How can someone wait and eat instead of going to the toilet? This upsets me. We still try hard to help them, but sometimes it is not possible. This is the reality.*

In contrast to her work as a personal care worker, in her activities and lifestyle role she finds she is generally less rushed and can spend time talking with residents, which is what she feels most people want.

> *…I have enough time to talk to them, 'how was your day?', 'how are you today?', or, 'how was last night', what are they waiting for, what is the plan of the day, 'what do you want to do'. I have enough time to communicate then, I have enough time to make them happy with the lifestyle, but sometimes not... The key thing they want is for someone to listen to them. When we listen, to what they want to tell us, they are happy.'*

Comments on time: workers in residential settings

For workers in residential settings, written comments highlighted how time to spend with older people was vastly inadequate to meet residents' needs, contributing to quality and safety risks. Numerous comments showed the small amount of time available each day to complete basic tasks, for example:

> *Expected to awake, shower, dress and assist resident to dining area in less than 15 minutes, no time always rushing, not good for myself or residents, shameful.*

> *15 min to shower dress them teeth hair and into dining room for meals*

My workplace have nailed it down to 7 minutes to get 1 person up/ showered. That is NOT enough time. I find all my interactions with the residents rushed.

I have 7 hours, 3 main meal services to 120 residents. That gives me 1.16 minutes to spend on each resident's meal selection.

I look after 72 people on a 7 hour shift that works out at 5 minutes per person without doing paperwork etc not good enough

I've tried to spend 15 mins in every 5 hour shift I've done just talking to/ being present with resident(s) in ways that are not about directing a task with them. In the whole 6 months I've worked in residential care I've managed to do it once.

Personal care workers in particular described how their workplaces were chronically understaffed, and that caregivers were required to work to very strict time limits for tasks. Many workers commented that they could only focus on the social and emotional needs of older people while they were performing activities of daily living (ADLs) such as hygiene, feeding and personal care tasks. One explained she could attend to social and emotional needs:

Only when I'm attending to their personal hygiene and toileting. I couldn't spend longer than 10-20 minutes and that includes all the tasks I have to perform with them. With the new standard put in place it makes it harder to everyone to catch up with the workload including the quality of time and the quality of care for the residents especially if there's not enough staff on the floor to accommodate the needs of all the residents.

Some explained how the difficulties they faced in meeting older people's needs related to the increased complexity of need they were observing among older people in their care, and the more complex mix of needs among older people entering residential aged care. This increased the need for more attentive, one-to-one care. For example:

Increasing frailty of many of our residents means that more residents require assistance with all their meals, i.e. no longer able to recognise a meal is in front of them to feed themselves, which then requires staff to feed them. Up to a 1/3 in our main dining room at lunch times require feeding. There are too few staff with too little time to assist all our residents to eat most of their meals.

Our high care bed bound residents are only getting care needs attended and not enough stimulation or emotional support as carers only get to attend to these people to assist with hygiene care skin care or mealtimes. All of these are task oriented with limited time and conversation. We are also experiencing a lot more younger mental health residents entering into the aged care sector this is also impacting our older residents who sometimes witness these mental health outbursts and struggle to cope/ understand or feel safe.

Workplace cultures in which frontline staff were rushed and had little choice but to leave residents with unmet social and emotional needs appeared standard, for example:

The time allocated for the carers to their job is just enough to give them a shower, but that's it, nothing else, no time to get to know the residents, or even their family, or to do anything more to support the residents' care needs.

There is never enough time to spend with the residents or their families. All care is rushed and no time for the little things or one on one time with the residents.

We are often asking residents to wait until we can attend to them and often unable to answer call buzzers immediately. Residents are often left waiting to be toileted or to be assisted from meals or from activities. Some things get forgotten because so much time has passed before we're able to attend to them we've forgotten. We often work back to complete documentation and other paperwork which we don't get paid for.

I get to spend more time than many staff because of my 1:1 treatment time and always hear about the things that happen that to the older people that they don't like. Always being rushed. Not being given choice about staying up or going to bed...one lady complained she was told she goes to the toilet too often.

Understaffing and unreasonable workloads also caused workers to focus on completing tasks rather than developing person-centred practices and models:

I try very hard not to be task orientated. Sometimes I'm successful & sometimes I feel like I can only do what "needs" to be done regarding their ADLs to then rush out of their room and attend to next resident or buzzer that has been going off for 10 minutes.

I've seen the hours in all departments of my facility drastically reduced. In one wing with 28 beds there used to be 4 PCAs and now there is 2. People coming into aged care facilities have more complex needs and at the moment with current staffing levels we only have the hours to provide basic care to residents. It's not holistic care anymore it more feels like a million tasks to get through instead of connecting with the residents and providing additional support. In residents with more complex needs who have behaviours if they decline care we don't have the time to build the rapport required to ensure they are adequately cared for. I find it incredibly sad.

As a result of these arrangements, social and emotional needs of older people were most likely to be unmet. Workers made comments like:

Compulsory care needs met. Emotional needs unmet

We no longer have time to offer that human touch to residents.

Only enough time to cover the care needs on a physical basis, but the emotional is what you do not have time to adequately meet. It is not that staff do not try, there just is not enough time for everyone.

While supervisors and management encourage us to spend more time with residents; they also still expect all jobs and care to be competed in a timely manner with minimal staff, resident physical care comes before mental or emotional care.

Several commented on how time arrangements led to safety risks, as it placed workers under pressure to make quick decisions without full information of individual residents and their histories and relationships. Some observed residents to be routinely neglected:

Each shift, there residents who are left to fend for themselves. They miss out on ADLs assistance, feeding assistance, toileting as the workload is too great for the amount of

staff. Only very basic care is able to be given. Carers are stressed because they know the work that is expected is never completed and cut corners and/or hope this is never found out. Carers don't complain about staff levels as there is never a positive response.

Management insist that we pump through resident's ADLs in an obscenely short period of time. Very limited time is available to spend quality one-on-one time with the residents. Clients with Behaviours of Concern take priority over others who miss out.

Any surplus time each shift is always spent with the residents with behavioural issues. The perfectly behaved and quiet residents are the ones who are left alone as there simply isn't enough time

Time pressure also meant therapists were unable to share strategies with other care workers, undermining quality and effectiveness where work was poorly coordinated care and implemented:

As a Diversional Therapist I am able to spend a lot more time with my residents one to one but due to time constraints with care staff it is very difficult to pass on strategies and get people to understand the unmet needs that responsive behaviours relate to on a regular basis.

Some workers mentioned they were able to find ways to increase their time with older people they cared for, to enable residents to do things for themselves (e.g. do their own hair, use a walker instead of a wheelchair). However, this was usually untenable as it limited the time available for other tasks and required them to find ways to cut corners or stay behind to complete tasks in unpaid time. Many found these 'individual solutions' difficult to sustain. Exacerbating this situation, being seen to spend time with residents could also be viewed negatively and treated punitively by managers:

The boss sees it as slacking off if we sit and communicate with them

If we try to do extra for our residents, management assume that we have too much time and then start giving us additional tasks (res care)

Clearly, being unable to deliver quality care undermines the wellbeing of residents. It also takes a toll on staff, who described feeling guilt and dissatisfaction. For example, many described skipping breaks or staying back on unpaid time to complete their workload and to minimise the impact of short-staffing on residents:

The time I spend with the older people I care for is my own, unpaid time. I stay back after my shift finishes to do this. There is no time during my shift to do these and other important activities. Several of my colleagues do this too.

Figure 4.6 Intensification in residential aged care: Nicola's account

Nicola came to Australia in her early twenties and commenced work in the kitchen of an aged care facility soon after arriving. Within a couple of years, she moved into a nursing assistant role, then gained Certificate III in aged care. As she needs to send money to family back in Chile, Nicola hasn't undertaken further study for financial reasons. In the last four years she has worked on a permanent full-time basis in a mid-sized residential facility, where she divides her time between nursing assistant shifts and activity/recreation officer shifts. She works six days a week, with one weekday off each week. Prior to this, she juggled two jobs in aged care for many years.

Nicola enjoys working in a cohesive team, but her workload is getting more and more demanding. The residence, which has around 70 beds, was designed more than a decade ago as a 'low care' facility. Today only one resident would be 'low care'. All others are dependent, and she estimates about one third suffer dementia. In her four years working in the facility, the health of residents has been declining and most new residents need a 'two-person assist'. Consequently, staff are needing and wanting to spend more time with each resident, but this is proving difficult looking after heavily dependent people with the same number of staff. Nicola says she has less one-on-one time to spend with each resident, which from her 30 years' experience as a frontline care worker is the thing most important to residents. Through her career in aged care she has observed many changes:

> *'Many years ago you had enough time to take them for a walk. Now you have no time to take them for a walk. The only walk that they get is to the toilet…. When I started doing nursing many years [ago]…. it was a really good nursing home…. We never had more than four – five residents to look after. Now between two you have more than 30 residents to look after….*
>
> *….We start at six o'clock (am). Before we used to have handover but the management reckon that it is a waste of time. We've been complaining that the job is getting too demanding and we don't have time to do paperwork and we are on the run all the time and we just are rushing to do everything. We don't even give quality care to the residents because we cannot talk to them. We just talk, "How are you?" and that's it. We shower them, we dress them. If they feel like talking we have to say, "I'm sorry I have to go to my next resident. I'm so sorry. If I have time I come back." Which I think is really wrong. We need some time to talk to them. Most of them don't have anybody to talk to.'*

Figure 4.7 Client complexity, staffing and quality care: Rhonda's account

Rhonda lives in a small country town and has worked in the local community run aged care facility for more than six years. She has a large family including a child with a disability and her 'passion for caring' motivated her to undertake a Certificate III in aged care. She works a 76-hour fortnight in a combination of morning, afternoon and night shifts on a rotating four-week roster and is employed on a permanent part time basis.

While Rhonda's facility is relatively small, the residents are highly diverse, in terms of their ages, level of independent, complexity of their health conditions and level of family support. Some residents are reasonably independent while others are 'two people assist' and require help with transferring, toileting, dressing, meals, and being turned in bed. It is home to older people with advanced dementia and young people with disabilities.

Rhonda says having residents with such diverse needs means every day is different and largely unpredictable.

> *There is no typical day because one day is different to another. In the mornings it might be okay. By the afternoon everything is just falling apart, especially with the ones that are high-dependent dementia ones that wander into people's rooms, screaming, crying, lashing out, can be very aggressive that we've got to deal with. So, we don't have a typical day at all.*

Rhonda's main concern is that residents want staff to take their time with the personal care and this is getting harder due to the reduction in staffing.

> *They just want somebody to sit down and talk to them and spend some time with them. They don't want to be rushed out the door or want to be a number… They just don't want to be seen as a number or a bum in a bed. We've got ones there that go, 'I don't want to be a nuisance'. 'Well, you're not a nuisance. You're here for a reason and we're here to support you', but they see that because we're that busy and that rushed for time, some of those people don't want to be a nuisance. They won't buzz their buzzer very often. They only buzz when they're really desperate or want something like the toilet.*

Rhonda describes how, as a result of time pressures, it is becoming harder to develop a deep relationship with each resident. She voices particular concern about the wellbeing of residents with advanced dementia, whom the facility is unable to support to participate in outings, and who tend to have limited family contact. She is also concerned about the quality of care provided at the end of life, when people have very high physical needs, and staff time is not sufficient to ensure dying residents receive appropriate emotional care and, importantly, don't feel alone.

Comments on time: workers delivering home care

Among workers in home care, a few said in their job they felt they had sufficient time to get to know clients, or that they were able to access extra time when they needed it. However, comments overwhelmingly reflected a lack of time to spend getting to know clients and developing relationships. Like in residential care, home care workers described how time was allocated based on the minimum required to complete basic tasks and was not responsive to the individual needs of older people. Care workers explained the arrangements that governed their working day:

> *Everything is by the clock, just given enough time to do the job then leave. The care has gone.*

Every task is timed, doesn't reflect individual needs of clients

Many of our clients do not see anyone else during the day and need the social interaction we do not really have time to provide properly. We are on a timer, have a list of tasks and the client has to follow us around if they want to talk or yell over the vacuum.

Some described being paid for only very short visits, which could be difficult and confusing for clients, and commented that time allocations and workloads did not enable them to deliver best practice care. Employers were described as being inflexible with time allocations, saying things like 'It's never enough time and the company won't give the clients any extra time or services'. Several workers attributed the lack of time to insufficient funding in home care packages. Under-resourcing was particularly apparent where care was for clients who were waiting for higher level packages, as upgrades to the level of care needed could take several months. Some home care workers linked the need to 'always watch the clock' to the commercial orientation of employers, for example:

We are always watching the clock, if we go over in our time, the client is charged the extra time, however it does not mean we will be paid the extra. The care workers are the only ones that care. The ones that work in the office, only care about making a profit and building onto the business.

Insufficient time for care was distressing for workers where they saw clients receiving inadequate care or 'ripped off' by their organisation.

Clients enjoy the interaction but time restraints make it impossible for us to do our job properly. Clients miss out on the one on one interaction and it shows when we have to leave they prefer we stay and talk for a while. Most only see us for weeks on end and look forward to us coming. It makes me feel bad when I have to leave knowing they are needing someone to talk to. I feel certain clients need more time just for more one on one. I've experienced this in community as well as residential. They are left on their own with nothing to do and no one to talk to. We need a better system to cater for this.

Many described that their rationing of time made them feel stress and guilt for having to rush to the next client, and that they had to bear the cost of going over allocated time:

I get paid by the minute and if I take over the scheduled amount of time at a service then I need to explain to my supervisor why, if I want to be paid.

Some commented that they needed to perform work that needed to be done during their unpaid time, such as providing additional support to clients or communicating with management.

Having a tight schedule of clients, I often go over into my own time so as to be able to assist my clients where necessary. Sometimes I am the only other person they see regularly.

Home care workers also commented about a lack of time for travel, especially in regional areas, along with the impact of parking difficulties, and having their time and locations tracked on company supplied phones.

Figure 4.8 Rita's account of delivering home care

Rita became a home care worker in her mid-thirties when she sought part time work to fit with raising school-aged children, rather than return to the management role she previously held. Twenty years later she continues to enjoy working as a home care worker with the same not-for profit organisation, who have provided Certificate IV in Aged Care training along the way. Rita is employed on a part-time basis for 56 hours per fortnight Monday to Friday, including some split shifts. However, she works anywhere between 60 hours a fortnight up 74 hours a fortnight.

Rita has seen many changes over the past 20 years including the increasing frailty and ill health of older people living at home. She supports many older clients on level 4 packages.

> *So, we have some people that maybe want to stay in their home but require hoister systems to get them out of bed, hoister systems to get them into a shower chair for showering, hoister systems to then get them to rest on a bed, and then hoister systems again back into a wheelchair for the day until the next services comes in.*

While her work is physically demanding, which is exacerbated by the time pressures, Rita has much praise for her long-term employer: they pay travel time and costs, including when travel takes longer because of heavy traffic or poor weather and they say, "If you go over time let us know, we're happy to pay for it," she says, although her work can 'bleed' into her non-paid lunchbreak.

However, she sees 'huge gaps' in the services provided under consumer-directed care that affect clients' social well-being and health, including insufficient respite for carers, too little nursing support, inadequately trained agency staff. At a policy level funding packages restrict her clients' opportunities to socialise.

> *They're not allowed to what they call double-dip. So, they're not allowed to go out with the community anymore if they get an aged care service package…*
>
> *In the early days of working, and I sound ancient, we actually used to do this where on a Friday, once a month, we'd all go to a local club, bring our clients and we'd all sit down and have lunch…there was a show on at the club, 'Come this Friday because they've got a show on'. There could be a comedian, there could be a dancer, there could be a singer. Then we'd all take clients home and no one was looking at time or cost or money. It was just a good way to integrate all of the care workers, all of the clients and everything. There might be a party of, say, 20 people. I understand now that that's changed a lot with rules and regulations and knowing where people are, making sure people can do that and they're capable and we're doing it correctly, but it really works socially and we were getting people to bring people together.*

However, Rita tries to build in some activities for her clients as she goes about her work, and also looks at ways for clients to have sporadic outings.

> *What you might do is get a jigsaw out at home and put it on the table and sit the client down with a cup of tea and say, 'Now, you start it and I'm gonna put the washing on. I'll pull the vacuum cleaner in and I'll get the bed stripped. Then I'll come back and do some as I'm coming through'… The other thing that's nice to do is say once every couple of months, 'Why don't we go out to the local club and have lunch and have a drink?' So, you look at your time for your client for that week and you try and organise it so that they could have a social outing. You might have to actually add time, so you might have to talk to your care provider about getting some extra time for that, and whether or not they have money in their package or whether the family are prepared to do a top-up.*

In her day-to-day work she sees continuity of care and the client/worker relationships as fundamental to maintaining and supporting her clients' health and wellbeing.

In the beginning, usually, it's their introduction to having care… Sometimes they don't want it. They think they're coping okay. They don't necessarily feel that they need anything other than cleaning. So, you might be introduced firstly to come in and clean, then you realise that they do need shower support and they do need dressing support. So, you've got to build up a trust. You've got to build up a personal rapport with the person. You've got to build up respect. This all takes time.

If there's no continuity of care, you're very unlikely to transition easily, whereas if they're getting the same person and you're talking to gently and you're saying, 'Look, you know, maybe next week how about I do a shampoo because it's difficult for you to do that?' We can introduce it gradually, so that in three months' or six months' time you know that you can be showering them or helping them more fully in the service that they need, and better able to look at what's happening and changing with them.

4.2 Organisational supports for person-centred care

To perform high quality, relational care that meets the needs of older people, care workers need appropriate supports organisations and managers, in well-resourced workplaces. Figure 4.9 shows the proportions of care workers who agreed with various statements relating to the presence of organisational supports for person-centred care. Responses indicate that aged care workplaces are characterised by very thin organisational support for person-centred care:

- Three in five careworkers (61%) said staff talk together about ways to provide person-centred care, and the figure was much lower for home care workers (37%), reflecting limited collegial contact among those working in isolation.
- In all settings, less than half said they have formal team meetings to discuss how they provide care (45%)
- Less than 2 in 5 (37%) think managers understand the importance of relationships with older people
- A little over a third (35%) agreed that managers allow workers to change routines based on older peoples' preferences, although this was lower among home care workers (29%) than among residential care workers (37%); and
- Less than a quarter (22%) get one-on-one support from a supervisor to discuss older people's care needs.

Workers' perceptions of a lack of organisational support is also reflected in the disjuncture between what they say is important to them, and what they think is important to managers. Figure 4.10 shows that while 74% of care workers prefer to focus on relating well with older people rather than quickly completing tasks, only 17% agree that managers prefer workers to focus on relationships over task completion. While many were unsure, more than half (55%) disagreed that managers prioritise person-centred over task-centred care.

Figure 4.9 Proportion who agreed with statements on organisational support for person-centred care

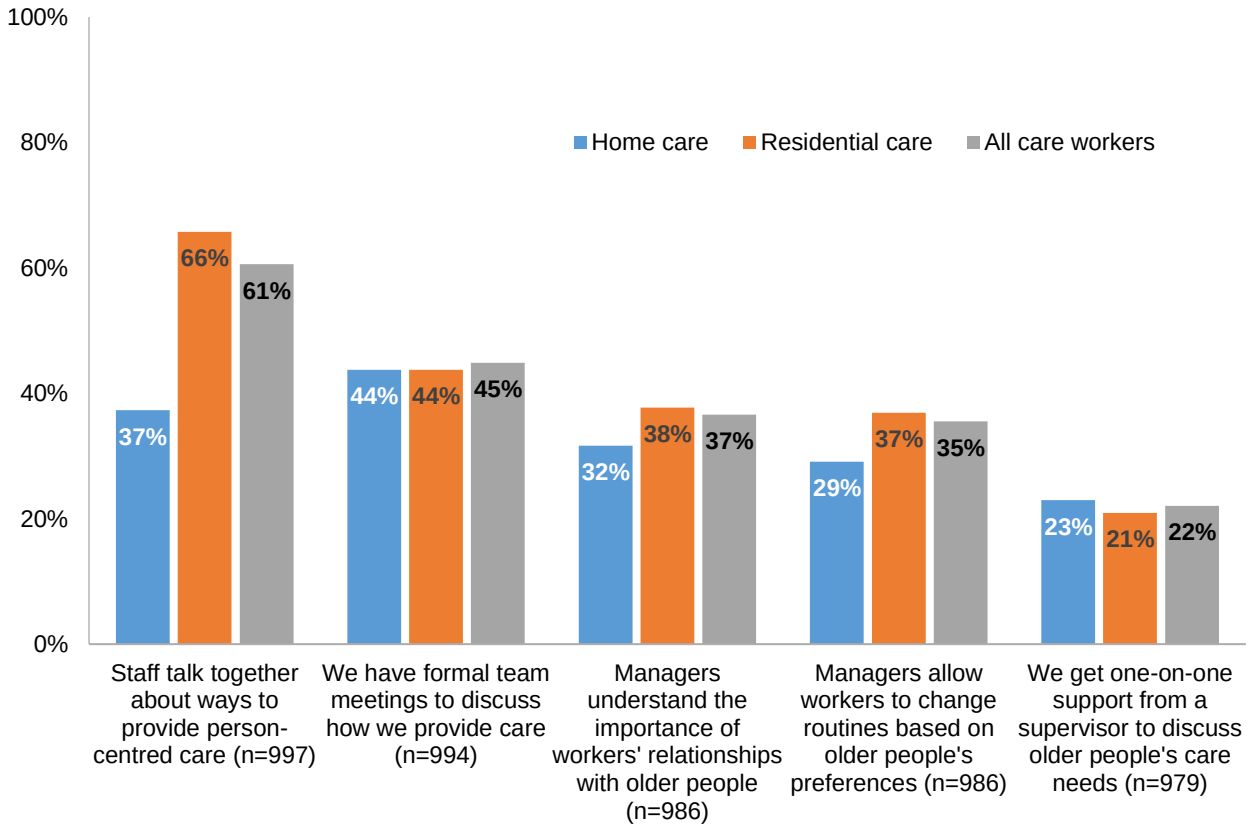
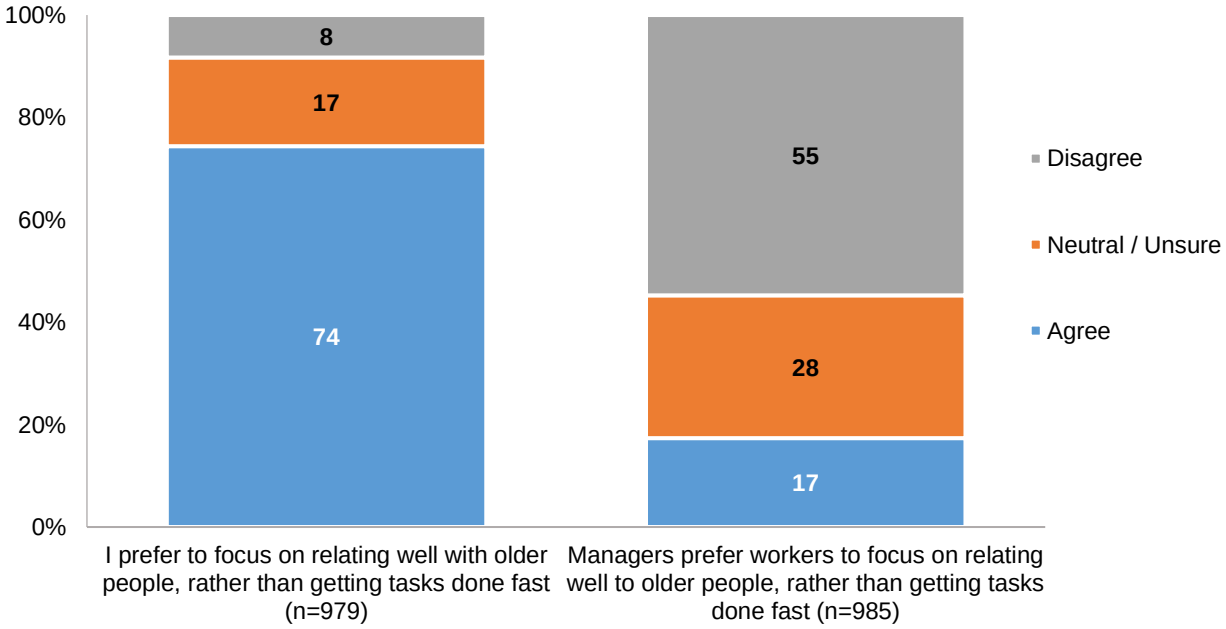


Figure 4.10 Care workers' priorities, and perceptions of managers' priorities (%)



Resourcing also offers an indication of capacity for person-centred care. This was measured using perceptions of having to prioritise based on urgency, working unpaid hours, and having well trained workers. Figure 4.11 shows that:

- Most care workers agree they have to prioritise based on urgency (83%), although this was higher among residential care workers (87%) than home care workers, 73% of whom agreed.
- Two thirds say they work unpaid hours to ensure older people get the support they need (65%)
- Only two in five perceive workers to be well trained to respond to client needs.

Under-resourcing for person-centred care is also apparent in perceptions of time in the working day. Figure 4.12 shows that:

- Three quarters (75%) said time to talk with colleagues about older people's needs was 'not enough', although this was higher among home care workers (82%) compared to residential care workers (74%)
- 70% said time speaking with a supervisor or team leader about older people was 'not enough'.

Figure 4.11 Proportion of care workers who agreed with statements on resourcing

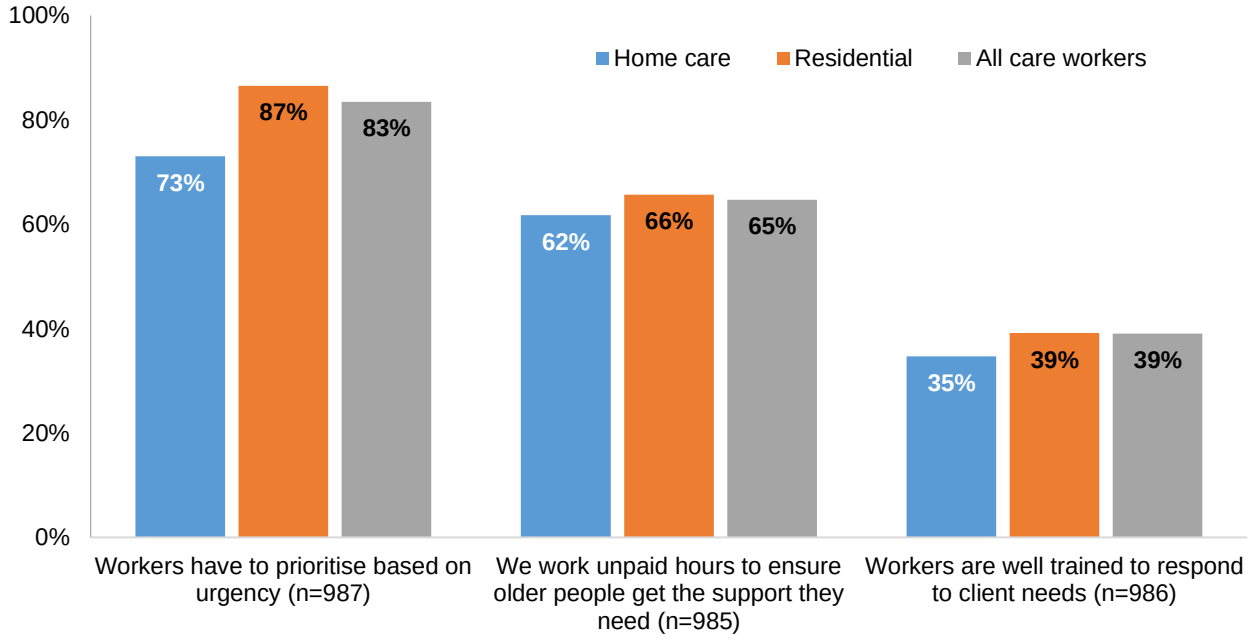
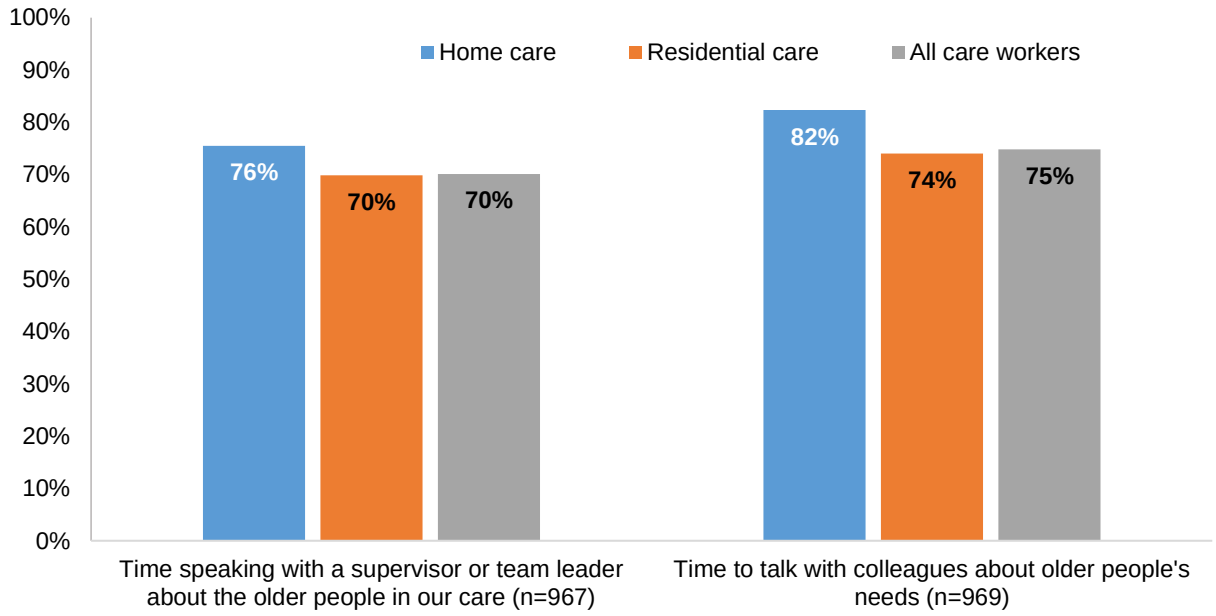


Figure 4.12 Proportion who rated time to talk with supervisors and colleagues as 'not enough'



4.3 Comments on organisational supports

Several comments workers made on their experience of caring for older people noted that engaging with older people was enjoyable, with some describing it as a passion and privilege. However, most comments indicated feelings of frustration with the barriers they faced in providing the high standard of care they saw older people to deserve.

- **Care quality is hampered by understaffing, workloads and rationed time**

Usually, these frustrations focused on intertwined issues of understaffing, high workloads and a lack of time. The following quotes were typical:

> *Management and Head office want personal centred care. Time and staffing levels fail in this being provided. (Residential care worker)*

> *Scheduling and filling the service is more important than providing quality care. We are pushed to our limits to complete task required because of minimal time allocated to client. The expectations of the employer is to get the job done no questions asked. (Home care worker)*

> *Managers talk about focusing on our residents but still expect tasks to be completed (Residential care worker)*

> *Managers say they want us to do person-centred care but will not provide time or increase staff levels to be able to do this. How can you stop and spend time you don't have, when the workload is already impossible and some residents already miss out on even basic care. (Residential care worker)*

They deserve to be able to be as independent as possible but poor staffing levels means that we take away some of their independence due to time restraints from low staff levels. (Residential care worker)

Where respondents worked in contexts in which they felt able to deliver person-centred care, staffing levels remained an issue:

Our facility is very person centered which is why more staffing is required to complete the necessary tasks as well as spend more quality time with consumers (Residential care worker)

- **Work is organised around tasks rather than strong caregiving relationships**

Workers pointed to particular barriers to working in person-centred ways, with work organised around tasks rather than relationships. For home care workers, the task focused environment was reflected in that care workers felt they were treated as 'substitutable', whereas they felt continuity in individual relationships was more beneficial for older people. As one explained:

We should focus on the person and know them in order to see changes in their health and daily needs. However if we're not the regular support person going into the home then we can't gauge the changes and our focus is mainly on the services listed on the care plan, again limited by time constraints. Continuity of care is very important to know the client and see change. (Home care worker)

Many others described task-focused managerial cultures cascading down through organisations to the detriment of older people, for example:

Managers have made us be task focused instead of person-centred (Home care worker)

Every shift we have set mechanical tasks to complete and a high number of residents to service which does not allow for any social interaction other than while we are with them for care. I feel very sorry for the residents as life for them in their old age is so regimented and can be rushed at times. They are not easily able to develop a lifestyle pattern of easy living with all the rushed goings on that occurs for morning showers and breakfast and then again at lunch and then again at dinner time and then preparations for bed. It is no life like home at all and I feel so much for them. They live in a sausage factory environment... (Residential care worker)

Scheduling and filling the service is more important than providing quality care. We are pushed to our limits to complete task required because of minimal time allocated to client. The expectations of the employer is to get the job done no questions asked. (Home care worker)

Our environment is centered around meal timetables and toileting. It lacks compassion and care for the elderly in their twilight years. Care in our Facility is a one size fits all with little regard to satisfying individual needs. (Residential care worker)

…we are always rushed and cannot chat with them for long or sit down and have a cuppa.. we are like uncaring robots because of our rosters and office staff (Home care worker)

- **Staff have limited ability to develop ways to improve their care practice**

Reflecting survey data outlined above, staff commented on their limited ability to meet with staff and talk about ways to improve practice.

> *We are not encouraged to talk about clients and about half of our team meeting are cancelled or we are rostered to work through them (Home care worker)*

> *Other than handover there are no formal meetings in relation to residents. I try to build rapport by asking about their lives when doing their care. More time to talk to them would be nice to give them assurance when they are scared or lonely. (Home care worker)*

> *My co-carers and I try our best to give the best care for our old people. But there are more improvements that carers can do specially when some resident behaviour arises which is almost beyond our knowledge of dealing with them. Our supervisors will give orders of what to do in those situations but never ask us if what they ordered us to do is working or not. We never have staff meetings concentrated just in our area of work, that's why there is a very big gap with communication. (Residential care worker)*

- **Financial priorities tend to take precedence over quality care**

A further set of written comments linked difficulties in providing decent care in their workplace to broader issues such as the dominance of a business ethos in aged care, an over-emphasis on costs, and systems in which older people are treated as commodities:

> *Such a wonderful opportunity to work with the elderly, unfortunately everything seems to be cost driven, not enough time is spent on doing what the client wants (Home care worker)*

> *Management fails residents in aged care as they tell us 'We are running a business' (Residential care worker)*

> *Care managers are not carers to the elderly they are really only real estate agents selling their rooms to make money...most residents don't know who they are they seem to only want people to buy a room. (Residential care worker)*

> *Aged care is purely a business 100% focused on profit and the residents are the machines that generate the profit. (Residential care worker)*

> *Hardest work I've ever done. They deserve better after all they fought wars, worked a full life, brought up families etc. It's a disgrace that their later lives have become a commodity (Residential care worker)*

4.4 Consequences for older people's wellbeing

Care workers' responses to survey questions also outline some of the ways staffing arrangements and work organisation in aged care impact on the quality of care received by older people, including instances of missed care. Respondents were asked which, of eight aspects of care, they had seen older people go without in the last fortnight (see Figure 4.15).

- By far, the most common type of care which was ‘missed’ (or not provided when needed) was emotional support to an older person who was lonely or distressed: 83% of workers had seen this occur in the last fortnight.
- Almost three in five had seen older people miss support to engage in diversional therapies and social activities (58%), and to receive support to walk and maintain mobility (57%) (although this was higher in residential care than home care, see Figure 4.15).

To deepen understanding of missed care in residential settings, residential care workers were asked an additional set of questions about how often they were unable to perform particular aspects of their work (see Figure 4.13). On each measure, the largest group reported being always or often unable to perform these aspects of their care work, with almost half saying they were ‘always’ or ‘often’ unable to help calm residents down when they are distressed, or to ensure residents are not left alone with supervision is required (48%).

Figure 4.13 How often residential care workers were unable to perform aspects of their work

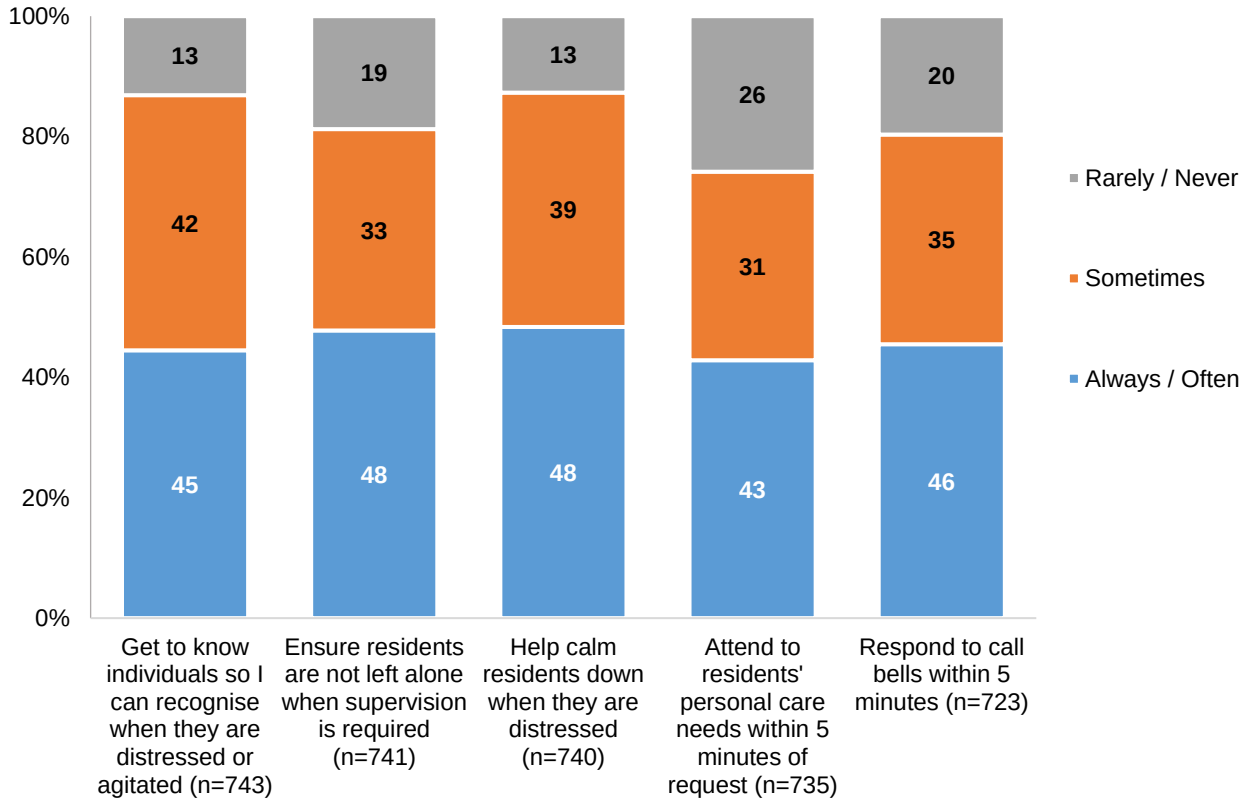


Figure 4.14 Outdoor time: Lisa's account of missed care

Lisa has worked as an extended care assistant (personal carer) for more than a decade and works in a large multi-site not-for-profit residential facility. Lisa talks very positively about her work, her colleagues and the residents. She says managers tries to accommodate staff preferences for shifts and work location (the facility is split into wings, including one which was originally a hostel, a nursing wing and respite beds). She works 72 hours a fortnight on a permanent part time basis. All shifts are weekday mornings, which is her preference. She particularly enjoys the personal care aspects of her role, helping residents maintain their independence and dignity.

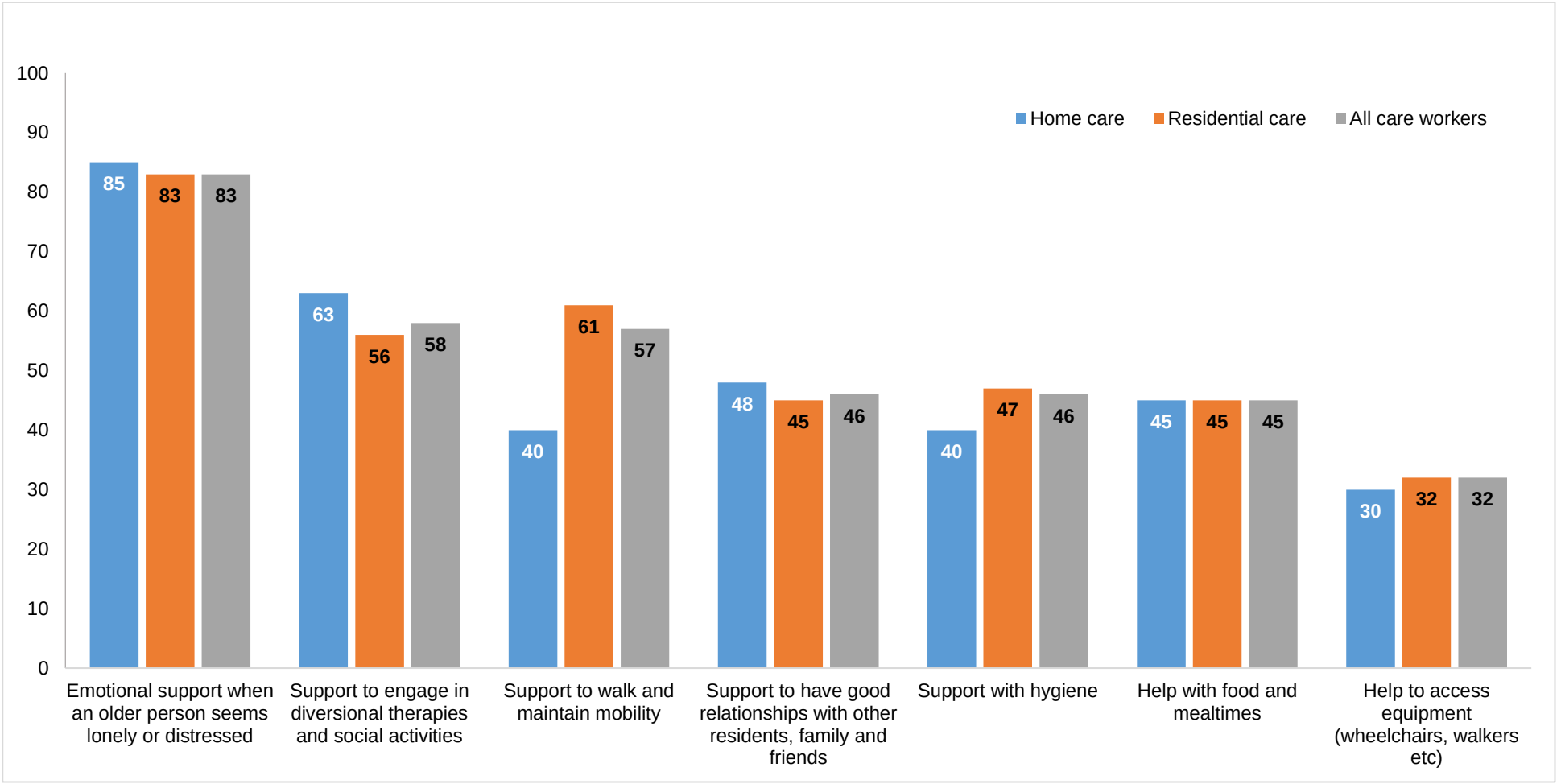
Lisa describes enjoying her work, and says her colleagues also enjoy it, many who have come to aged care after careers in other occupations (including hairdressing and truck driving). However, the workload could be 'excessive'. She describes:

> *Some days if we're short staffed and occasionally that can happen every other day in a month and it just drives us all nuts and we just shake our heads in handover and think we're not short again because the workload itself when we've got a full crew is crazy. When we're short staffed we just all freak out and think right we've got to try and do this and that's not healthy or safe but you have to try and manage the best we can which we do. We go above and beyond every day and go home absolutely exhausted but satisfied.*

Being short staff can make it particularly difficult to support older people's social activities. Lisa describes how residents particularly like leaving the facility, such as going out shopping or to a local park, as they return happier, even if they are exhausted. While she supports the organisations' 'residents first, paperwork second' approach, this is difficult to achieve in practice. When asked if there are any aspects of care where residents are missing out, her response comes quickly.

> *I'd say outdoor time and walks, vitamin D… We get told that we should be taking residents out for 10 minutes at a time but then we think, God where are we going to find that 10 minutes? I probably do nine residents one morning and think how am I going to spare another 90 minutes of outdoor time? Well it'd be more than that because you've got to get them, take them out, spend the time, come back in, toilet them, put them to the table for their meals and then take another one out.*

Figure 4.15 Proportion of care workers who had seen older people go without various types of care in the last fortnight (%)



n=894

Residential care worker comments underlined routine disrespect to older people, in some cases amounting to neglect:

> *I feel bad knowing that the residents are being "maintained" not "cared for" (Residential care worker)*

> *There's not enough staff provided even though we are a non-profit organization. You feel sad that all you can do is ADL's make sure they get food and water you have hardly any time for anything else (Residential care worker)*

> *Would be nice to have enough staff so we didn't have to rush them and to provide proper care e.g. shower at least every 2nd day. Not say short staff today sorry no showers. (Residential care worker)*

> *I feel that all the time and work they have given to their country, society, neighbourhood or whatever, they should be treated with respect, love and compassion in their twilight years. Not bullied or given mush for meals or forced to do what the carer wants them to do. They should have choices.....and a lot more. (Residential care worker)*

A lack of resources, and an inability to work in person-centred ways also a source of stress for workers:

> *My job while rewarding, has a huge amount of stress. The stress is not being able to meet the needs of the person at the time they need it most. Seeing shortcuts due to time and staff constraints that then impact physically and mentally on my residents. (Residential care worker)*

Figure 4.16 Boredom among older people in residential care: Naomi's account

Naomi became a personal carer when she returned to the workforce after raising her family. She had previously enjoyed volunteering with elderly people, so completed Certificate III in aged care, which was a major shift from her architectural and engineering background. For the past six years she has worked afternoon shifts at a not-for profit aged care residence where she is employed on a permanent part time basis for 52 hours a fortnight. The majority of residents need intensive assistance. With older people staying at home longer and coming into care later, most new residents now have some form of dementia when they arrive.

Naomi initially felt 'out of her depth' in her role but completed further qualifications in dementia care, and finds working with elderly people with dementia particularly satisfying. However, managing residents' behaviours is also challenging. Difficult behaviours, she says, largely stem from a lack of stimulation and insufficient attention from staff. She describes the need to provide the one-on-one attention and social interaction older people need, even when communication is not straightforward:

> *I enjoy when you get the time, which is getting harder and harder, of actually being able to give that little bit of one on one time. And to tell you the truth, that's where a lot of our behaviours are coming from. The residents that are bored. They're needing far more stimulation, and some are just needing that one on one. Someone to talk and to listen to them. I've had some girls saying to me, "Are you understanding what they're saying", and it's like, I'll be carrying on a conversation with the resident. I don't know what they're saying, but it's just picking up on the cues, the tone that they're using, and then I just use the right tone back, and you see that they're smiling, because to them it's like, "They're understanding me. We are having a conversation", which they often don't get a lot of. Nonsensical conversation, but always want to be heard. We want to give our opinion, and that doesn't stop when you have dementia.*

Of the 22 residents in the dementia unit, Naomi estimates only two are regularly taken out by their family members. She believed residents' boredom was exacerbated by the absence of scheduled activities on weekends. Poor facility design also exacerbated boredom. The facility had been designed for more independent residents, so didn't provide access to enclosed outdoor spaces. As a result, residents spent most days indoors.

4.5 Promoting older people's social and emotional wellbeing

Overwhelmingly, suggestions from workers to promote older people's social and emotional wellbeing focused on their need to access sufficient time to relate with older people and provide good care. Examples of this were numerous, and highlighted how care workers may be the only people older people have to talk to for long periods, and that the only time they were able to talk was while completing personal care or domestic assistance, which was not sufficient to meet older people's needs. Suggestions to improve care quality included just a small amount of time to be factored into staffing arrangements, such as time for a short chat:

> *Aged clients need time, social time, chat time - factor into service a 10 min chat period where support staff can catch up, chat and talk with the client. Emotional support is often needed as we can be the only person in for that day, week or month! Clients need social engagement. Add a social block each month to allow a positive focus, and give the client something to look forward too. (Home care worker)*

> *Our environment for working is timed to the minute. We have no allowance to sit for a cuppa or stroll in the garden to talk. It's frustrating that 5-10 minutes cannot be added adhoc. (Home care worker)*

> *It is very dispiriting to have to rush through a personal care service for an aged and frail person when you know this is the only personal contact until the next care worker arrives. (Home care worker)*

That time receiving personal assistance with hygiene and feeding may be the only emotional contact some people may have, was seen to undermine wellbeing, along with poor food quality.

> *Residents can be left for days on end with no emotional contact apart from bathing, toileting and feeding. Also the meals of which are provided are at times not fit for human consumption and the quality of the food can affect a person's physical and emotional wellbeing greatly. (Residential care worker)*

Many pointed out that staffing arrangements and the timing of tasks needed to be organised around the needs of older people:

> *I go back to time there is never enough time, maybe instead of us having numerous clients in a day, spending all day with the one client as some have 4 visits a day from 4 workers and most of the time it's 5 minute visits. I know from experience they don't like the short visits which as a worker upsets me. (Home care worker)*

> *Staff need more time so the residents get the care they deserve and that they pay for. If there were more staff on in the morning then they would not have to rush the residents to be ready for breakfast so much. They need to stagger the shift times for workers to fit in better with the needs of the residents. (Residential care worker)*

Comments also highlighted the need for continuity of care from regularity in client-worker contact:

> *I use[d] to have regular clients, I could keep an eye on how they where going, now they chop and change my clients and it is hard to keep an eye on their wellbeing. Ie Mrs Smith is starting to forget things, or Mrs Smith is losing weight, these are all things I would report back to the SC, now I just lost, I don't know half the clients I am sent to. (Home care worker)*

Others pointed to more staff as a potential solution, pointing to the need for one to one time including for older people who were isolated at home or in their room in a residential facility; staff available to engage in 'general chit chat' or play a game of cards:

> *Being short Staffed impacts on wellbeing of Residents, they are very aware when we don't have enough Staff even though Management tell Staff not to let them know. This worries Residents as they worry about how soon they will be attended and that Staff are rushing to get work done.*

Other suggestions included more workers to engage in structured recreational and 'lifestyle' activities; ensuring recreational activities were run with appropriate ratios as group sizes were often large; increasing engagement among older people and between older people and people and communities outside facilities; and improving engagement of families in residential facilities. A final comment called for a shift in the focus of the aged care system:

> *What could be done? Stop the focus on making money and profit, we should not be taking advantage of aged care, or disability for that matter. The government needs to take it back and fix it. Bring back the actual care, not the damn dollar. (Home care worker)*

5. Concluding discussion and recommendations

This report has assessed the ways current arrangements in aged care attend to older people's needs for social and emotional support. Our approach involved considering trends in aged care use in Australia and the changing nature of older people's needs; international peer reviewed research about what matters to older people and the workers who support them; and information from interviews and a survey, which captured the perspectives and experiences of over 1,200 aged care workers. While we found some differences in arrangements and experiences across residential facilities and home care, both settings face pressures of increasing demand for services and rising complexity of need. These challenges make aspirations for quality difficult to realise, in the context of static or declining levels of staffing.

Developing models of care provision which enable high quality delivery of social and emotional supports is particularly challenging at present. The convergence of thin industrial regulations, individualised funding models underpinning consumer directed care, and profit-motivated provision create conditions conducive to fragmented, task-oriented models of care, rather than the holistic person-centred models the research literature shows are consistent with quality.

Indeed, a vast body of international peer reviewed studies shows overlaps in the way older people and care workers think about quality, with both groups emphasising relationships, time to care and continuity as necessary underpinnings. Findings from our survey data and interviews reinforce the need to reorient aged care systems, and the work of care, around approaches which place similar emphasis on the psychosocial processes and outcomes of care.

While the policy emphasis on person-centred care and the aspirations embedded in Australia's new quality standards for aged care provide some way forward, our data indicates these ideas are far from reality. As the survey showed, only a minority of care workers feel able to get to know older people as unique individuals, to consider their life histories, and to support them in decisions about daily activities – key dimensions of person-centred care. Major constraints on quality care relate to the lack of time workers have available to spend with older people, high workloads and inadequate staffing. Despite aspirations for person-centred care, service delivery practices remain characterised by fragmentation and task-centredness. Many see the rotation of staff or staff turnover to preclude the relationship building needed for person-centred care. Many feel their managers don't understand the importance of relationships and are unable to provide an enabling environment in which staff can apply their skills to identify and respond to older people's needs and preferences.

Findings were corroborated across the survey and interview data and accord with national and international peer reviewed research. Further, the accounts of interviewees, presented as vignettes, underline further changes needed. Many had worked in aged care for long periods and had observed care to become more task oriented, rushed, and poorly supported, which appears counter to national policy aspirations, and rising community expectations of aged care.

To address these challenges, multiple changes are needed across systems and organisations, to develop the virtuous cycle in which high quality jobs lead to satisfied workers delivering high quality care, and to consumers who are supported to enjoy a decent quality of life.

At the level of the ***aged care system***, funding models and regulations need to enable, rather than constrain relational care. Government regulation, funding and accreditation processes also need to operate in ways that are sensitive to the time and skills workers need to provide psychosocial support. Previous research has suggested the need to widen the contract specifications for aged care providers, to ensure that support provided to organisations is predicated on support to workers (Xerri et al. 2019). This recognises the role of government at the apex of a supply chain, with capacity to shape outcomes and promote quality through the funding conditionality 'lever' this position gives it.

Accordingly, *aged care funding* needs to be:

- increased to levels *sufficient* to enable services to be provided to all older people who need support, with staffing levels and staff time adequate to meeting their increasingly complex needs.
- *flexible* enough to enable providers to respond to older people's changing needs on multiple time-scales – from daily fluctuations to end-of-life care. Incentives for task-based and fragmented care need to be addressed.
- *care centred* to ensure that funding, whether from public or older people's own resources, is directed to ensuring staffing that enables high quality care. To achieve this goal, any new funding model should:
    - mandate minimum hours of care per person, quarantine some portion of funding to staffing and staff development costs and restrict opportunities for squeezing service quality to maintain or increase profits.
    - include a well-designed *assessment of older people's social and emotional needs* for both residential and home-based care.

Australia's new Aged Care Quality Standards offer some promise, as the basis for a regulatory model which is sensitive to quality, and which promote it. These standards give clear signals as to the role of organisations in enabling high quality care, delivered in ways that maintain older people's dignity, inclusion and independence, to promote health, wellbeing and quality of life. They strengthen national quality assessment as a potential mechanism for driving systemic improvement. However, it is not yet clear whether this system of quality regulation will provide positive incentives, or the sanctions needed, to ensure that services receiving government funds meet standards.

Accordingly, *aged care accreditation and quality oversight* needs to be designed and resourced to ensure high care quality, in particular, to:

- *provide incentives for relational care* and disincentives to fragmented, task-based care, so that the full range of older people's needs can be met, in line with community expectations.
- ensure that monitoring, oversight and development of human resources in aged care have *robust means of ensuring that the goals of Standard 7 are realised*, through promoting work organisation and work cultures that enable relational care, including regular supervision to support care workers and enable them to reflect on their care practice.
- *include worker perspectives* in quality assessment, not least in measuring the achievement of Standard 7, Human Resources.
- *collaborate* with the relevant authorities to ensure that *training is high quality*, relevant and timely.

Industrial regulation establishes the employment conditions under which care workers undertake their work and provides the default framework for career structures in aged care.

Accordingly, *industrial regulation* needs to ensure employment and working conditions under its purview promote:

- *working time* arrangements allow time for care and enable continuity of caregiving relationships and that prevent part-time contract status from being casualised in any way. Work time arrangements in the SCHCDS award for home care workers, in particular the low minimum engagement and lack of payment for travel, along with the emergence of digital platforms as intermediaries, appear particularly poorly aligned with the priority of ensuring the time workers need to adopt relational approaches to care.
- *protections for care workers and older people* from risks that the platform-based 'gig economy' poses to workers' rights, the quality of care and older people's safety.
- *classification and pay structures* that provide detailed descriptions of clearly articulated levels of care worker skills to enable workers to develop meaningful career paths in aged care and that remunerate the different levels of skills required appropriately.

Aged care is an increasingly complex and demanding field of work, partly because of the increasing frailty of older people who receive it, and partly because of rising community expectations in relation to the quality of care. Thus, the aged care workforce needs to be more highly skilled than ever. Yet staffing trends have been going in the opposite direction. To support the development of a workforce with the appropriate level of skills, *training* should go beyond ensuring compliance, to ensure care workers have the relevant clinical and relational skills to deliver high quality care. To reinforce and extend learning gained during training, opportunities to reflect on care practice, such as regular supervision, should be available to all direct care workers.

A supportive regulatory environment, good employment conditions and high quality, relevant training are necessary but insufficient conditions for developing and assuring the quality of care for older people. Care workers also need to work in organisations that enable rather than constrain their capacity to deliver high-quality, person centred care.

Accordingly, at the level of *aged care provider organisations*, the following need to be developed and meaningfully and supportively overseen within quality regulation:

- a strong focus on *enabling and delivering relational care* that meets the full range of older people's needs, including their social and emotional needs.
- *work organisation* that promotes relational care*,* such as consistent assignment, and enough time to deal with the regular irregularities that arise in the day-to-day provision of aged care.
- *leadership in person-centred care*, with strong and supportive relationships between managers and care workers, to enable workers to develop meaningful relationships with older people and their families and to empower care workers to respond to older people's needs in flexible ways.
- management that *supports care workers' professional development*, including regular supervision and paid time for training beyond compliance-related compulsory material.
- management that *engenders a collaborative team environment* in which care workers can use and share their skills and knowledge.

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7. Appendix A Survey method and sample

The survey was designed to capture personal care workers' perspectives of delivering relational care and working in person-centred ways; the ways staffing arrangements and labour processes shape care quality; and the ways provision of relational care to older people could be improved. Items were informed by survey instruments used in previous studies of person-centred care, but modified to ensure alignment with the focus of our study, and to ensure applicability across residential and home care and simplicity for care workers. Of particular influence was the 'extent of personalising care' subscale of Person-Centred Care Assessment Tool (P-CAT) (Edvardsson et al, 2009) which has been validated and applied in Australia (Edvardsson et al, 2011). It captured staff discussion and team meetings about person-centred care, use of life histories, prioritisation of relationships over task completion, ability to shape routines around residents, and regular assessment of needs. Our items were also shaped by consideration of those used in Henderson et al (2018), which focused on missed care in residential aged care, along with measures used in Edberg et al (2015) and Chappell et al (2007).

Distribution involved targeting the link to the online survey to personal care workers involved in delivering residential aged care and home care, via United Voice and the Health Services Union. The survey was administered via Qualtrics and optimised for completion on smart phones and tablets. In total, 1,231 participants completed it within the 3-week survey period (late June - July 2019) and around 74% of respondents did so on mobile devices.

Accessing care workers and care facilities via trade unions is a common strategy for engaging research participants (e.g. Baines and Armstrong, 2019; Trydegard, 2012). The strength of this recruitment strategy is that it enables researchers to access staff distributed across a range of workplaces. However, the use of a union-based sample, rather than a Census or random sample means responses are likely to reflect conditions in larger, more established workplaces, and those with union-negotiated enterprise agreements in place, where better conditions and safety protocols could be expected to result from a stronger union presence.

As shown below (Appendix Table A. 1), this recruitment strategy resulted in sample characteristics which largely reflect characteristics of the wider aged care workforce. Survey respondents closely resemble the profile of the aged care workforce captured in the 2016 Aged Care Census (Mavromaros et al, 2017) in terms of gender, country of birth, and organisation type. However, the age profile of survey respondents is notably older, likely an outcome of the recruitment strategy.

Of the 1,231 respondents who completed the survey, most were in direct care roles in residential aged care (see Appendix Table A. 2, Appendix Table A. 3). Those whose main role was in kitchen and catering (n=100), cleaning or laundry (n=65) or other roles such as administration (n=62) were excluded from some analysis where questions related to direct provision of care to older people. However, their perspectives were included in analyses of open-ended comments. The classification of workers into direct care roles, based on respondents' main role, is shown in Appendix Table A. 1, and the distribution across home care and residential settings is in Appendix Table A. 3.

Appendix Table A. 1 Sample characteristics

	Aged care worker survey (n=1,231)	All direct care employees, 2016 Aged Care Census*
Gender		
% female	88	87
Country of birth		
% born outside Australia	33	32
Organisation type^		
% in non-profit organisation	52	58
% employed in private, for-profit business	36	34
% in government agency	6	7
Unknown	5	--
Age		
Under 25	2.5	6.4
25 to 34	7.2	18.8
35 to 44	11.4	19.5
45 to 54	29.7	28.0
55 to 64	43.6	24.3
65 and over	5.6	2.9
Employment arrangements		
Employed on a casual or contract basis	10.5	10.1
Hours of work		
15 hours or less	9	18
16 to 34 hours	57	56
35 hours or more	34	27
Multiple job holding		
Holds only one job	82	88
Works another job in aged care	10	4
Works another job not in aged care	8	8

* Mavromaros et al. (2017)

Appendix Table A. 2 Classification of direct care workers and other aged care workers, based on main role

	Not a direct care worker		Direct care worker		All	
	n	%	n	%	n	%
Personal Care Worker / Home Care Worker	0	0.0%	597	59.5%	597	48.5%
Assistant in Nursing	0	0.0%	149	14.8%	149	12.1%
Advanced Skilled Carer	0	0.0%	55	5.5%	55	4.5%
Nursing Assistant	0	0.0%	17	1.7%	17	1.4%
Enrolled Nurse	0	0.0%	24	2.4%	24	1.9%
Lifestyle assistant / Activities	0	0.0%	84	8.4%	84	6.8%
Therapy assistant - Physio / Occupational Therapy / Exercise / Massage	0	0.0%	55	5.5%	55	4.5%
Cleaning / Laundry Staff	65	28.6%	0	0.0%	65	5.3%
Kitchen/Catering Staff	100	44.1%	0	0.0%	100	8.1%
Other	62	27.3%	23	2.3%	85	6.9%
All	**227**	**100%**	**1,004**	**100%**	**1,231**	**100%**

Appendix Table A. 3 Whether respondents' main role was in home care, residential care or another setting

	Home care		Residential care		Another setting		All	
Not a direct care worker	19	8.6%	182	19.2%	26	40.6%	227	18.4%
Direct care worker	202	91.4%	764	80.8%	38	59.4%	1004	81.6%
All	221	100%	946	100%	64	100%	1231	100%

8. Appendix B Interview methods and sample

In addition to the survey, the study included interviews with ten workers involved in direct delivery of services to older people at home and in residential settings. These were conducted to capture workers' experiences of delivering care, including the challenges they face in providing the quality of care they see older people to need, and perspectives on the ways the organisation, staffing and delivery of aged care work could be improved.

Interviewees were recruited via United Voice and the Health Services Union. The interviews were conducted by telephone during June and July 2019. They were located in three jurisdictions and had worked in aged care for between 3 and 30 years. Their characteristics are shown in Appendix Table B. 1.

Interviewees were asked about their background and how they came to work in aged care; the setting they work in; the older people they work with; their working arrangements; what a typical work day looks like; aspects of the work they enjoy; time to provide care and assistance; relationships with older people and what helps strengthen them; what types of care older people go without; and what could improve care for older people.

Interview results were analysed to develop vignettes to illustrate themes emerging in the research review and survey.

Appendix Table B. 1 Profile of interviewees

Characteristic	Number
Gender	
Female	9
Male	1
Age	
25–34	1
35–44	1
45–54	3
55–64	4
65 +	1
Job Role	
Residential AIN/Personal Carer/Extended Care Assistant	6
Home care	4
Country of birth	
Australia	5
Overseas	5
Service Type	
Not for profit	9
For profit	2*
Multiple job holdings	
One job	8
Has another job in aged care	1
Has another job not in aged care	1

*1 worker had 2 jobs – 1 in NFP & 1 in For Profit

9. Appendix C Research review

Appendix Table C. 1 Service quality from older people and their families' perspectives

Source (alphabetical)	Home care or residential care?	Country/ Countries	Older people, families, or both?	Research method, including sample size
Abbott et al. (2018)	Both - nursing home (NH), home and community-based services (HCBS)	US	Older people - the psychosocial preferences of those receiving long-term services and supports (LTSS)	Interviews were conducted using two versions of the Preferences for Everyday Living Inventory (PELI) questionnaire: PELI-NH for nursing home residents (n=255) and PELI-HC for respondents from home and community-based services (n=528). The samples were analysed in SPSS separately to allow comparison between the different care settings.
Bangerter et al. (2016)	Residential - NH	US	Older people	Qualitative study with in-depth interviews followed by content analysis. The interviews were with 337 NH residents. Eight items from the PELI-NH were evaluated through open-ended questions to show how the resident wanted to have that preference met, for example, 'How would you like staff to show they care about you?' (p. 704).
Björk et al. (2018)	Residential - NH	Sweden	Older people by proxy (i.e. as reported by staff), staff, managers	Data for this study was drawn from the National Swedish nursing home survey (SWENIS). SWENIS collected data from (a) a resident survey completed by direct care staff, (b) a staff survey on the psychosocial climate of nursing home units, (c) a facility survey completed by managers. The sample sizes for this study were (a) 4,205 residents by proxy, (b) 3,604 staff, and (c) 191 managers.
Burack et al. (2012)	Residential - NH	US	Older people	Uses the Quality of Life Scales for Nursing Home Residents, which examines older people's perceived quality of life (QOL) in eleven domains. The survey was administered via face-to-face interviews with 62 NH residents from three large urban nursing homes.

Source (alphabetical)	Home care or residential care?	Country/ Countries	Older people, families, or both?	Research method, including sample size
Chou et al. (2002)	Residential – nursing home (high care) and hostel (low care)	Australia	Older people	Nursing home and hostel residents self-completed the Resident Satisfaction Questionnaire (RSQ). Statistical analysis was then carried out using the samples of 394 nursing home residents and 752 hostel residents.
Chou et al. (2003)	Residential – nursing home and hostel	Australia	Older people, staff	Data obtained from 996 residents and 895 staff from 62 facilities (36 hostels and 26 nursing homes) using the self-complete RSQ (Resident Satisfaction Questionnaire) for residents and the self-complete MJS (Measure of Job Satisfaction) questionnaire for staff. Resident satisfaction was assessed using six scales: room, home, social interaction, meals service, staff care, and resident involvement. Staff satisfaction was measured across five aspects of job satisfaction: personal satisfaction, satisfaction with workload, team spirit, training, and professional support.
Cohen-Mansfield et al. (2018)	Home care	Israel	Both - older people, families	Structured interviews with 72 older people and 117 of their relatives were conducted using the Quality of Care Questionnaire (QuCQ) developed for this study. This was followed by statistical analysis using SPSS.
Gjevjon et al. (2016)	Home care	Norway	Both - older people, families	Structured in-person interviews with 125 older people and 92 telephone interviews with mostly relatives (some close friends). The interview guide consisted of questions on background factors, perceptions of care received, and issues regarding continuity of care.
Kadowaki et al. (2015)	Home care	Canada	Older people	Data drawn from the 2008-2009 Canadian Community Health Survey. The sample comprised 3,244 people (aged 65 and above) who reported either having their needs met through professional home care or having unmet needs (whether they received home care or not).
Kajonius and Kazemi (2016)	Both	Sweden	Older people	Data drawn from the 2012 Swedish national survey which collected questionnaire data from over 95,000 older people.
Kwan et al. (2019)	Home care	England	Older people	Systematic review of 17 studies of older people's views and experiences of home care. The review identified 9 themes: Older people valued an approach that was person centred, flexible and proactive to respond to their changing needs and priorities, focusing on what they

Source (alphabetical)	Home care or residential care?	Country/ Countries	Older people, families, or both?	Research method, including sample size
				can or would like to do to maintain their independence. Allowing time to build trust between older people and their care workers helped to realise older peoples' aspirations and goals. Practical help to promote choice and reduce social isolation was perceived to be as important as personal care.
Lood et. al. (2019)	Residential	Australia, Norway, Sweden	Families	Data on quality of care and the person-centeredness of the care climate at two nursing homes in Australia, two in Norway, and two in Sweden, collected through a self-report questionnaire administered to relatives of residents (n=178).
Marquis (2002)	Residential	Australia	Older people, staff	Qualitative study with recurrent in-depth interviews with 24 residents and 11 care staff at seven facilities in Western Australia. Staff selected because residents identified them as providing a quality service.
Milte et al. (2016)	Both	Australia	Both	Data collected through (1) in-depth interviews with cognitively impaired people living in either residential care or the community (n=15) and (2) focus groups with relatives, or close friends, of people with dementia (n=26). Thematic analysis was undertaken in NVivo to identify key themes.
Milte et al. (2018)	Residential	Australia	Older people, family member proxies	Face-to-face interviews were conducted at 17 nursing homes across Australia (metropolitan and rural facilities) with residents (n=125) or, where cognitive impairment prevented resident participation, family member proxies (n=416).
Milte et al. (2019)	Residential	Australia	Older people, family member proxies	The questionnaire was completed by 68 residents of long-term care facilities as well as 185 family member proxies where cognitive impairment precluded resident participation.
Poey et al. (2017)	Residential	US	Older people	This study involved 320 nursing homes in Kansas. The nursing homes were either enrolled or not enrolled in a pay-for- performance program to promote PCC (person-centred care) called Promoting Excellent Alternatives in Kansas (PEAK 2.0). In 2014, 6,214 residents in 305 nursing homes were surveyed and, in 2015, 5,538 residents in 283 nursing homes were surveyed.

Source (alphabetical)	Home care or residential care?	Country/ Countries	Older people, families, or both?	Research method, including sample size
Roberts (2018)	Residential	US	Older people	Qualitative study with unstructured one-on-one interviews with 15 residents from two nursing homes. NVIVO software was used.
Roberts et al. (2018)	Residential	US	Older people	This study involved 244,718 residents from 14,492 facilities across all US states. Participants completed the 'Preferance Assessment Tool' to determine how they rated 16 daily care and activity preferences.Overall, involvement of family in care and individualizing daily care and activities were rated important by the largest proportion of residents. Most residents rated all preferences as important, but higher proportions rated some preferences as very important. These preferences were: having family involved was most preferred (rated as important significantly more frequently than 70% of other preferences). Other highly preferred aspects of daily care were caring for belongings, doing favorite activities, keeping up with news, choosing bedtime, getting fresh air, and choosing bath time.
Rodriguez-Martin et al. (2013)	Residential	Spain	Older people, relative proxies	Qualitative study employing grounded theory in its design and analysis. In-depth interviews were conducted with 20 residents, and 8 relatives acting as proxies for residents who were cognitively impaired, at a public nursing home.
Shippee et al. (2015)	Residential	US	Older people	Data from 369 Medicaid-certified NHs in Minnesota was obtained from multiple sources between 2007 and 2010. Facility-level characteristics – e.g. size, ownership type, payer mix, staff hours, turnover - came predominantly from facility reports to the DHS (Department of Human Services). Resident QOL was measured through six domains (environment, personal attention, food enjoyment, engagement, negative mood, and positive mood) using the Resident Quality of Life and Satisfaction with Care Survey, which is administered annually to a random sample of residents in Medicaid-certified Minnesota NHs. For 2010, 10,969 resident surveys were used.
Shippee et al. (2017)	Residential	US	Both	Data obtained from (1) family satisfaction interviews (n=16,790), (2) resident QOL surveys (n=13,433), and (3) facility characteristics for 375 facilities.
Shippee et al. (2018)	Residential	US	Families	Compares family satisfaction across two states, Minnesota (MN) and Ohio (OH), using family satisfaction surveys and facility characteristics from Certification and Survey Provider Enhanced Reports (CASPER) for both states (378 facilities for MN and 926 facilities for OH).

Source (alphabetical)	Home care or residential care?	Country/ Countries	Older people, families, or both?	Research method, including sample size
				Six key domains of satisfaction were measured: staff attitudes toward the resident, food choices, activities, facility cleanliness, autonomy, and how strongly the respondent would recommend the facility to others.
Soares et al. (2019)	Both	Europe – Austria, Finland, Lithuania, Portugal, Turkey, UK	Older people	A total of 95 semi-structured interviews with older people were conducted across six countries in Europe to identify common dimensions of professional competence in health and social care.
Weeks et al. (2017)	Residential	Canada	Family, friends	Mixed-methods study. A survey of family members or friends of residents living in twenty-three nursing homes (n=397) was followed by focus groups that were guided by the preliminary results of the survey.

Appendix Table C. 2 Research findings connecting care quality to job quality

Source (alphabetical)	Care quality-job quality connection	Main findings	Recommendations /System-level analysis (where given)
Andre et al. (2014)	An **empowering work culture** improves quality of care	Reviewed 10 studies; confirms that **supportive leadership; positive team relationships, good communication, participation and influence; feeling valued for contribution, adequate funding, higher total nursing hours, better working conditions and job autonomy, among other things, improve the quality of care.**	*Recommendations*: Organisational change. 'Improving employees' participating in decision-making, increasing empowerment and influence and making changes in the management style seem to be crucial factors to improve quality of care in nursing homes and can be done with little extra costs.' (p. 456) Notes that 'job dissatisfaction and burnout have been reported to be related to patient mortality' (p. 450).
Barry et al. (2019)	**Team inclusion** → empowered workers → positive staff and resident experiences	Study measured how much being treated as a member of the team by one's supervisor, co-workers, and other clinicians (doctors, allied health) affected how empowered RN and PCA staff felt. Empowerment was measured in terms of autonomy (e.g. 'I can be creative in finding solutions to problems on the job'), responsibility (e.g. 'I am responsible for the outcomes of my actions') and participation (e.g. 'I am often involved when changes are planned'). Resident experiences were not directly measured. **A sense of empowerment was significantly associated with feeling included in the team by one's supervisor and co-workers.** A minority felt included byother clinicians, and this form of inclusion was not associated with empowerment overall, but was strongly associated with high scores on the participation dimension of empowerment.	*System level framing of problem*: Meeting the needs of a growing ageing population will require a large, well-trained workforce. Currently, there are widespread shortages and high turnover, so recruitment and retention are high priorities. Empowerment is associated with job satisfaction and lower turnover,so increasing empowerment is one way to address workforce problems. *Recommendations*: To gain the empowering benefits of team work, the relationships in the team need to engender feelings of inclusion.
Estabrooks et al. (2015)	**Use of best practice care methods** increases quality of care	Aim was to understand organisational factors affecting use of best practice methods. **PCAs were more likely to use best practice methods when the organisation had sufficient time and staff to enable it, when they worked in a well-connnected team, and the level of informal interactions to transfer knowledge was higher.**	*System level framing of problem*: Growing extent and complexity of older people's needs in context of largely unregulated workforce. *Recommendations:* In designing strategies to increase use of best practices by PCAs, consider modifiable aspects of the organisational context. [Staffing, time pressure, team connection, opportunities for informal interaction.]

Source (alphabetical)	Care quality-job quality connection	Main findings	Recommendations /System-level analysis (where given)
Gittell et al. (2008)	**Relational coordination of care** improves job satisfaction which improves care quality	Relational coordination involves both *communication* ties (frequent, timely, accurate, problem-solving) and *relationship* ties (shared goals, shared knowledge, mutual respect). This kind of coordination is most important for achieving outcomes in settings with high task interdependence, uncertainty, and time constraints – like aged care. **The more relational coordination between care workers was, the higher their job satisfaction and the better resident quality of life.**	*System level framing of problem*: Longstanding calls to improve the quality of life in nursing homes, going beyond a focus on clinical outcomes. *Recommendations:* improve the training, pay and status of nursing aides so as to more fully engage them in achieving desired resident outcomes. Improve interdisciplinary collegial team relationships.
Hurtado et al. (2016)	When **workers decide their work hours**, their performance and thereby care quality improves because workers have more resources to plan, execute and cope with work demands	Inflexible schedules have been found to be detrimental to workers' well-being and associated with lower job satisfaction and higher turnover.**Higher schedule control** (more able to choose days off/vacations; when to start work day; take a few hours off; decide how many hours to work) **was associated with higher job satisfaction, lower turnover intention, longer tenure, more work hours.** Taking differences in all these and other confounding factors, such as staffing levels, into account, **higher schedule control was also associated with fewer pressure sores.**	*Recommendations*: Introduce flexibility initiatives, such as self-scheduling, cross-training [extending worker skills to new areas] and supervisor support for work-family balance to better meet residents' needs and aid recruitment of care workers.
Matthews et al. (2018)	**Good worker-manager relations** decrease turnover, a threat to quality	Manager-PCA relationships were measured with a survey to PCAs about their perceptions of their manager, which were compared to voluntary turnover data. Perceptions along four dimensions (affect – emotional attachment to manager; loyalty – think manager is loyal; respect – high professional regard for manager; and contribution – willing to make extra effort to achieve manager's goals). **Those who left rated their managers lower on all four dimensions. Controlling for other factors, including job satisfaction, leaving was associated with a perception of lower manager loyalty.** This finding is suggests vulnerable workers	*System level framing of problem:* High levels of turnover also increases the challenge of meeting the growing demand for LTC, increases costs for LTC facilities, and is a significant challenge for nurses, nurse managers and administrators. Low wage workers such as PCAs turn over for different reasons than other workers because they are relatively powerless. *Recommendation:* Managers should specifically focus on the loyalty dimension in their relationships with low wage earners in LTC, because these workers are more vulnerable and may look to their managers to stand up for them in relation to other high-waged colleagues.

Source (alphabetical)	Care quality-job quality connection	Main findings	Recommendations /System-level analysis (where given)
McGilton et al. (2016)	Improving nurse **supervisor performance** reduces PCA turnover and improves care quality	Reviewed 24 studies; found that **more effective supervision of PCAs by registered nurses was associated with higher PCA job satisfaction, lower PCA intention to leave, higher PCA job effectiveness, higher consumer satisfaction, better PCA decision-making and less PCA job stress.** Effective supervision defined differently in different studies; included factors such as supporting PCA problem solving, fostering teamwork,maintaining positive relationships and good communication, being reliable.	*System level framing of problem*: Inadequate levels of staff that provide supervisory support and clinical oversight contributes to poor practice and poor resident outcomes. *Recommendations (implied):* Increase the quality and quantity of nurse supervisors who provide direction; are respectful, fair, supportive, empowering and encouraging to PCAs; take an interest in PCAs' professional development; exercise discipline when required; provide feedback and inform PCAs about any changes in the nursing home that may affect them; and are competent, committed to their job and encourage teamwork.
Okechukwu et al. (2016)	**Better work-family support** at work improves work performance, which improves care quality	Despite managers' perceptions that providing more family support and ensuring care quality were conflicting goals, higher average work-family support was strongly linked to higher care quality. Two levels of work-family support were measured: supervisor level (e.g. 'supervisor makes [respondent] comfortable to talk about work-family conflict'), and organisational climate (e.g. 'have to put family/personal life second to job'). **Higher work-family support was associated with fewer pressure sores and fewer falls.**	*Recommendations:* Introduce family-supportive workplace policies.
Xerri et al. (2019)	**Supportive leadership** improves the quality of care, by increasing care workers' personal resources	Support from supervisors increases care workers' personal resources to perform well at work and reduces intention to leave. **By increasing care workers' personal resources (hope, optimism, self-efficacy and resilience) good leadership leads to improved clinical care outcomes.**	*System level framing of problem:* Contracting out and private provision of aged care services create significant quality assurance, accountability and governance problems. *Recommendations:* indicators used to assess quality of care need to be widened to capture specific measures of support for employees, including in the contract specifications for aged care provider accreditation, which should include the support they provide to workers.