Explaining Reasons for Stress, Burnout and Self-Efficacy in Direct Care Staff in Supported Aged Care Accommodation Services

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CERTIFICATE OF AUTHORSHIP / ORIGINALITY

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged with the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used within the body of the thesis have been acknowledged.

Signature of Candidate
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ABSTRACT

The workplace environment can be a source of stress for many direct care staff who work in supported aged care accommodation services. Depression, fatigue, burnout, and heart disease are a few of the many health consequences of chronic work-related stress for these staff. This study aimed to better understand the stress phenomenon occurring in a sample of direct care staff working in the Australian supported aged care accommodation service sector. The relationship between direct care staff stress, burnout and self-efficacy for aged care work was investigated. The study was undertaken between 2007 and 2012 and conducted in 20 purposefully selected supported aged care accommodation services located in a Sydney Metropolitan regional area. Each supported service had comparable management structures, staff numbers, staff mix, older people demographics and held current Government accreditation status. A sample of 162 consenting direct care staff (registered nurses, assistant nurses, personal carers and recreational staff) completed a demographic questionnaire; the Expanded Nurse Stress Scale (ENSS); the Maslach Burnout Inventory (MBI); and General Self-efficacy Scale (GSE). Qualitative data (written narratives) were obtained from a single open-ended survey item inviting respondents to write about stressful experiences they may have encountered when interacting with the families of older people.

Descriptive statistics examined the frequency of data distributions, means, standard deviations and confidence intervals for normally distributed data and median and inter quartile ranges for skewed data. Parametric tests (t-tests) were used for normally distributed variables and non-parametric tests (Spearman Rho and Kruskal Wallis) were used for non-normally distributed variables. Correlational statistics (Pearson’s correlation and Spearman’s correlation) were used to determine possible relationships between the variables of the ENSS, MBI and GSE and variables of direct care staff demographics. Thematic analyses were conducted for the written narrative responses to the single open-ended survey item on stress associated with the families of older people living in supported aged care accommodation services.
The study findings confirmed high levels of stress of direct care staff was correlated with their work and with their interactions with families of older people. Strong associations were found between stress, burnout and self-efficacy for work, which were confirmed in the open-ended survey item responses. Having higher self-efficacy and valuing one’s work were identified as buffers for stress and burnout. Given the study findings, it behoves all stakeholders to enter into collaborative discussions that support and provide a healthy and satisfying work environment for all direct care staff.
CHAPTER 1 INTRODUCTION TO THE PROFESSIONAL DOCTORATE PORTFOLIO

For many Australians, the workplace environment can be a major source of stress. Depression, fatigue, burnout, and heart disease are a few of the health consequences of chronic work-related stress (Safe Work Australia, 2013). The terms ‘work stress’, ‘job stress’, ‘occupational stress’, ‘job strain’ are among a few of the terms commonly used to describe the nature of the phenomena of worker stress. Notwithstanding the huge body of literature that has evolved as a result of ongoing investigation to the understanding and contributing causes of this stress phenomenon, there continues to be debate around the various factors and minutiae of its construct and association. This is especially so when applied to the caring professions. Ongoing examination of the construct of stress, especially in nurses and other direct care staff (assistant nurses, personal care workers, recreational staff) employed in the supported aged care accommodation service sector (formally referred to in Government documents as residential aged care facilities) continues in an effort to develop further knowledge and understanding. The study embedded in this Professional Doctorate portfolio aimed to explore and explain the factors and constructs of the stress phenomenon in direct care staff workforce and in particular, in relation to the direct care staffs’ contact with the families of older people, and to provide recommendations for addressing this issue.

This Chapter introduces the contents of the professional doctorate portfolio and includes summary details of the research study that was conducted as part of the portfolio. The chapter commences with an introduction to the field of study and discusses the stress phenomena as it exists in the general work context. An overview of stress in the workforce and more specifically in the supported aged care accommodation service direct care workforce follows these introductory comments. A brief introduction of the Australian supported aged care sector and a profile of the various direct care staff who are employed in the supported aged
care accommodation services are provided, and issues are raised with regard to the relationships between direct care staff and the families of older people. My position in relation to the study topic, its aims and purpose are discussed, followed by an outline of the remaining components of this portfolio of work.

1.1. BACKGROUND TO THE STUDY

In my position as an owner and director of a small urban Sydney-based supported aged care accommodation service, I have had first-hand experience of work-place stress occurring with my employees, and this is an issue of concern to me. As with other business owners and employers, one of my major goals is to ensure that the workplace is a safe and happy place of work for all employees. I expend a great deal of my time and energy in achieving this end. However, there is frequently a discernible level of stress occurring among some of the direct care staff in this busy and demanding health care environment. One stress-inducing issue for many of my direct care staff is the interactions they have with the families of our older people, who are at times perceived by direct care staff as being very critical and difficult with regard to aspects of care and services being provided. Since direct care staff believe they are committed to and invest a great deal of effort into providing quality care for all older people, they are often perplexed and upset by criticisms from families of older people.

Some direct care staff say that criticisms and requests made by families are an ongoing source of stress for them. As a senior nurse with an ambition to ensure that older people who reside in my supported aged care accommodation service are provided with high level quality care, I am aware that a happy and stress-free workplace environment is one of the main factors in achieving this goal. Consequently, my interest in conducting this study was to explore the stress phenomenon for direct care staff working in the supported aged care accommodation service sector and to identify, and if possible, seek ways to address those identified factors that give rise to direct care staff stress.
The premise underlying workplace stress (sometimes referred to as occupational stress) is that the workplace has certain demands, and when these demands are unable to be met by direct care staff, they may become psychologically and/or physically distressed (Lippel, 1989; Maslach, 2003). Stress related to the work environment is recognized as a global phenomenon, increasingly affecting all categories of workers, workplaces and countries (Lippel, 2010). The supported aged care accommodation service sector has not been immune to this rising global phenomenon, since stress associated with the demands of work and/or the work environment has occurred across all employment sectors and organizations (Medibank Private, 2008; Safe Work Australia, 2013). Worker stress is associated with the rapidly changing global economy and the need for organizations to operate in cultures of increased speed, efficiency and competition, thus placing many organizations in a constant flux of change (Fugate, Prussia & Kinicki, 2010). Workforce downsizing, or the merging of small organizations with larger more competitive organizations, are examples of organizational changes that directly impact on the health of workers (Bamberger, et al., 2012).

Stressed employees may develop increasing levels of physical and mental illness including depression, anxiety, lower work performance, feelings of being overwhelmed, fatigue, and headaches (Guthrie, Ciccarelli & Babic, 2010; Safe Work Australia, 2013). Absenteeism, workers’ compensation claims and increased employee turnover are reported to be directly attributable to workplace stress (Guthrie, Ciccarelli & Babic, 2010). In European countries workplace stress-related problems are second only to musculoskeletal complaints as a cause of occupational illnesses (Eriksen & Ursin, 2002). Comparable data in Australia report mental stress in the workplace accounts for approximately five per cent of work related injuries (Safe Work Australia, 2013) and is the second most common cause of workplace compensation claims after manual handling (Safe Work Australia, 2013). Exposure to mental stress accounted for approximately eight per cent of female worker compensation claims compared to three per cent reported by male workers (Safe Work Australia, 2013). Nearly two thirds of those in the 45-
54 years and 55 years and over age groups experienced work-related stress or other mental health conditions, and those workers over 45 years of age accounted for 59 per cent of incidents involving exposure to mental stress (Safe Work Australia, 2013).

Stress-related workplace compensation claims are costly and the incidence of direct and indirect claims in Australian workers continues to rise substantially (Medibank Private, 2008). The escalating direct and indirect cost of work stress for the individual, the workplace and the community at large is becoming increasingly apparent with far reaching effects at a human, social, and economic and organization level (Dagenais, Caro, Haldeman, 2008). Consequently, the direct cost of lost earnings and medical and rehabilitation expenses borne by employees is of concern to them. From the organisations’ perspective, workplace stress can result in lost staff productivity, skills, experience and knowledge when a worker is too stressed to continue working. These costs are enlarged by the additional costs of recruiting, replacing and training replacement staff, and the increased workload and stress for co-workers that must be accounted for (Dagenais, Caro, Haldeman, 2008). In Australia, stress in the workforce is becoming a real issue for employers. In 2013, the median compensation payments paid to all workers for illness arising from workplace stress was $15,000, an increase of 35 per cent from the previous reporting period 2000 to 2001 (Safe Work Australia, 2013). Work-related psychological disorders for the reporting period 2009 – 2010 (n = 7045) remain higher than for many other conditions or injuries. Given the potential for employees to under-report workplace stress, it is likely that the phenomenon is much higher than official figures advise (Safe Work Australia, 2013).

People who work in the human service professions have long been considered to be most at risk for experiencing workplace stress (Maslach & Leiter, 1997; Marchand, 2007). As a human service profession, nursing has for many decades, been recognized and considered as a stressful occupation (Chang et al., 2006;
Chen, Chen, Tsai & Lo, 2007; Shirey, 2009) and this workforce cohort are at risk of being stressed by their work (Howe, 2002; Duckett, 2005). There has been a great deal of interest in the stress being faced by direct care staff as health care delivery systems undergo rapid structural changes associated with population demographics and modern health care requirements, such as improved fiscal performance (Howe, 2002; Duckett, 2005). De Bellis (2010) asserts that these workplace policies inevitably impact on health care workers, including direct care staff that are experiencing higher levels of responsibility and accountability, with reduced levels of autonomy, work overload and workplace stress.

Since the work of caring is demanding and direct care staff are required to assume a high level of responsibility and accountability towards older people, the emotional and physical stressors direct care staff face are contextualised within this high pressure, high responsibility work environment (Lambert, Lambert, Itano & Inouye, 2004; Chenoweth & Jeon, 2007). Exposure to the emotional aspect of human pain, suffering and death are commonplace for direct care staff, yet they are very often not supported in dealing with these workplace stresses (Senate Community Affairs Reference Committee, 2002). Care and support of direct care staff is an important element in providing support and care services for the health and well-being of older people (Hoffman & Mark, 2006; Duffield & Roche, 2007; Clark, Leddy, Drain & Kaldenberg, 2007) thus it is important that the workplace stress of direct care staff is addressed.

Apart from the importance of reducing workplace stress for direct care staff, reducing direct care staff stress is important for a ‘healthy’ health service. Direct care staff are retiring prematurely and leaving the direct care workforce because of workplace stress (Buerhaus, Donelan, Ulrich, Norman & Dittus, 2006; Clark, et al, 2007; Shirey, 2009). The demand for direct care staff has been exacerbated by the high rate of attrition from the direct care staff workforce (Duffield et al., 2009; Shirey, 2009). The prediction by Laschinger and Finegan (2005) that the direct
care staff workforce would face a serious shortage of workers and reach calamitous proportions by 2015 appears to have been realised (King et al., 2012).

In 2002, the Canadian Nursing Advisory Committee (2002) reported an increase in Canadian nurse to patient ratios of one to 133, compared with the 1990 ratio of 1 nurse to 119 patients in some regional areas, signalling extreme workforce shortages. In the United States of America, projected nurse workforce shortages are also very high, ranging from 340,000 to 1 million nurses by the year 2020 (Auerbach, Buerhaus & Stalger, 2007). Australia is faced with similar nurse workforce shortages (Senate Community Affairs Reference Committee, 2002; Australian Health Workforce, 2012). Whilst it is unclear what the requisite number of nurses is needed to operate effective health systems, including aged care services (Australian Health Workforce, 2012), research suggests that the current direct care workforce number is insufficient to meet future service demands (AHWAC, 2002; Richardson & Martin, 2004; Hegney, Eley, Plank, Buikstra & Parker, 2006; Martin & King, 2007; King et al., 2012).

One of the most common reasons given by nurses and direct care staff to retire early and/or to leave nursing in Australia (Duffield & Roche, 2007), the USA (Buchan & Aiken, 2006) and in European countries (Bourbonnais, Brisson, Malenfant & Vézina, 2005; Verhaeghe, Vlerick, Gemmel, Maele & Backer, 2006) is the stress associated with workplace policy and planning, workplace restructuring and down-sizing, and high care demands associated with reduced workforce numbers. Another reason cited for workplace stress in nurses and other direct care workers is the demand of providing care to an ageing, more dependent and sicker population (Chenoweth, et al., 2010; Sargent, Harley & Allen, 2009). This is especially the case in the supported aged care accommodation service sector, which represents the largest cohort of the Australian health care workforce (Richardson & Martin, 2004; King et al., 2012).

The rapidly growing numbers of older people with complex health issues, including conditions resulting in physical and cognitive impairment, are placing pressure on
supported aged care accommodation services and this is impacting on the direct care staff workforce (World Health Organisation, 2012; Chenoweth & Jeon, 2007). A small number of workplace stress studies have identified the high levels of stress occurring for all direct care staff working in the supported aged care accommodation service sector (Moyle, Skinner, Rowe & Gork, 2003; Eley, et al., 2005; Harley, Allen & Sargent, 2007; Venturato, Kellet & Windsor, 2007; Howe, 2009; Dwyer, 2011). Sources of stress for direct care staff relate to inadequate resource levels in the sector (Moyle et al., 2003; Eley, et al., 2005), the physical and emotional demands of aged care work (Harley et al., 2007) and the complexity and demands of caring for older people with multiple illnesses and needs (Venturato et al., 2007; Howe, 2009). As well, the continual changes and demands associated with the Aged Care Reform Strategies and Aged Care Structural Reforms, and the changing role of registered nurses working in the supported aged care accommodation sector, are a cause for stress in this group (Venturato et al., 2007; De Bellis, 2010; Dwyer, 2011).

One of the most palpable sources of stress for nurses and direct care staff is the negative image associated with caring of the older person in Australian society (Moyle, 2002; Abbey et al., 2006), and the lack of respect and value afforded to the work of direct care staff despite their dedication to the care of people who live in supported aged care accommodation services (Abbey et al., 2006; Chenoweth et al., 2012). Direct care staff report that this negative image is reflected in the ways that families of older people interact with them which is a source of stress and greatly upsets them (Jacovides, Fountoulakis, Moysidou & Lerodiakonou, 1999; Letvak, 2001; Chenoweth et al., 2012). Stress was found to escalate when direct care staff attempted to address and appease the requests of families for services and care for their relative (Letvak, 2001; Chenoweth et al., 2012).

The supported aged care accommodation service sector struggles to provide quality care with very limited numbers of direct care staff who are adequately educated and skilled for the role (Dwyer, 2011). However, these direct care staff
are the first people to feel the force of anxiety and concerns of family members about the level and quality of services provided to their relative (Venurato, et al., 2007). It is understandable that for many family members, the placement of their relative into a supported aged care accommodation service is a stressful experience (Kellett, 1999; Ryan & Scullion, 2000; Whitlach, Schur, Noelker, Ejaz & Looman, 2001; Argyle, Downs & Tasker, 2010). Concerns and fears associated with media images of poor quality care and abuse of people occurring in aged care environments also add to the families’ anxieties (Arling, Kane, Mueller, Bershadsky & Degenholtz, 2007; Tisher, Dean & Tisher, 2009). Menzies (1960) suggested that families who experience high levels of stress may transfer their anxieties and fears onto direct care staff, thus contributing further to the experiences of stress, a view confirmed by Australian direct care staff (Chenoweth et al., 2012).

Since a consequence of carer stress is job dissatisfaction (Maslach & Leiter, 2005), increased mood disturbance (Espeland, 2006), higher risks of suicide (Feskanich et al., 2002), and burnout (Maslach & Leiter, 2005), the stress associated with the work of direct care staff and their interactions with the families of older people is an issue of concern. Given my role as a director and manager, I considered these issues to be a worthy topic of research in my aim to provide a safe and stress-free workplace for my direct care staff employees.

1.2. MY PROFESSIONAL POSITION IN RELATION TO THE STUDY TOPIC

Complexity and intensity have characterized my work and leadership in the Australian supported aged care sector. My experiences as a provider of supported aged care services and senior executive have altered and shaped the meanings I bring to this study. I acknowledge my subjective involvement in this study as I bring to the research process my personal biases, attitudes and values about the provision of care in the Australian supported aged care accommodation service sector. These issues will have invariably influenced the research techniques I
employed to achieve the study aims and objectives, including my interpretation of the study findings and the recommendations that I have offered to the caring profession.

As an owner, director and manager of a supported aged care accommodation service for a period of over thirty years, I have identified and been involved with the implementation of the Aged Care Reform Strategies at the supported aged care accommodation service level. With the impetus of the Aged Care Reforms and the subsequent rapid changes that have occurred in the supported aged care accommodation service sector, I found that I was increasingly required to adapt to mandatory Government policy changes and to adopt a higher degree of flexibility and professional practice to meet the increasingly complex needs of older people I cared for. As a manager, I was also required to articulate these concepts and requirements to direct care staff working at different levels in the organization in ways that were meaningful for them. I felt very strongly about the need to improve services and outcomes for older people and to strengthen the carer/family relationships. From the frequent incidents of negative communications occurring between direct care staff and families of older people as were relayed to me, I realized that it was essential that I address this source of stress for direct care staff through leadership in the sector.

In my ambition to become a leader in the field of providing care to older people who live in a supported aged care accommodation service, my increasing awareness of the direct care staff concerns provided the motivation to seek further education to be suitably credentialed and skilled for my role, and to become more involved in future changes in the wider arena of policy development in this sector. I strongly believe in education as a means of self-empowerment. As a nurse director and manager, my objective is to join with current sector leaders to advance the discipline of clinical care in a supported aged care accommodation service, to empower all direct care staff and to contribute to the knowledge of the discipline of caring for older people. My reasons for pursuing research as a way of
informing policy and practice were advanced from my concerns with the limited impact that research has hitherto played in shaping professional care practices in the provision of supported aged care accommodation services in Australia. I recognized the need to incorporate evidence-based practice in all aspects of care delivery to generate improved quality outcomes to older people, while also paying attention to the health and well-being of the direct care staff who care for them.

1.3. STUDY FOCUS

This study aimed to measure and provide an understanding of stress and burnout associated with the work of nurses and other direct care staff, such as nurse assistants and personal care workers, in the supported aged care accommodation service sector, and to determine if there was evidence of an association between the demographic characteristics of these direct care staff and self-efficacy for their work and levels of stress and burnout. A secondary aim was to identify if direct care staff experienced stress associated with their interactions with the families of older people. This latter interest arose from my personal observations as a manager, and from my discussions with direct care staff and the managers of other supported aged care accommodation services, which suggested that these staff found it stressful when interacting with the families of older people. I have found in my work that families of older people are frequently disturbed and become distressed with the entry of their relative to supported aged care accommodation. Direct care staff often need to provide support to family members, particularly in helping to meet their emotional needs at this time. Whilst a number of supported aged care accommodation service sector workforce studies have identified the various stressors associated with care services (Arling, et al., 2007; Chenoweth et al., 2009; Tisher, Dean & Tisher, 2009), little is known about the stress effects on direct care staff that may arise from their interactions with families of older people living in supported aged care accommodation.
1.4. PORTFOLIO FRAMEWORK AND CHAPTER CONTENTS

This thesis provides the portfolio of work conducted as required by the Professional Doctorate program at the University of Technology Sydney. The Professional Doctorate program aims to foster excellence in professional practice by developing the capacity of a candidate to lead development of knowledge in a chosen professional context (Neumann, 2005). In line with Professional Doctorate guidelines (University of Technology Sydney, 2010), the candidate is required to be professionally active in their particular area of work practice and undertake a course of work that includes and addresses the topics of Health Care Policy, Leadership, and Professional Practice, and to conduct an approved research study relevant to their area of work. Whilst there is a stronger emphasis on the flexibility and the investigation of professional practice within a given field (Boud & Tennant, 2006), the Professional Doctorate portfolio is required to maintain a parallel level of rigor as evident in a traditional PhD program (O’Sullivan, Carter, Marion, Pohl & Werner, 2005; University of Technology Sydney, 2010). The portfolio of work is presented in eight chapters, this introductory chapter being the first.

**Chapter 1.** introduced the reader to the background to the field of study and raised for later discussion the stress phenomenon occurring in aged care work. My professional position in relation to the study topic was declared and discussed and the study aims and justification for the study provided.

**Chapter 2** sets the scene for the study by describing the context of the Australian supported aged care accommodation service sector and its influence on the experiences of nurses and direct care staff. The chapter includes information about: the demographic profile of the ageing population of Australia and the care arrangements for older Australians who require supported living arrangements; the history of the supported aged care accommodation sector and policy development including the Australian Aged Care Act; Australian aged care accommodation service sector policies (Accreditation Standards, Certification Standards and Procedures).
Standards and Complaints Policy); issues associated with policy translation; the roles and responsibilities of nurses and direct care staff; care models and practice issues in the supported aged care accommodation service sector; and the challenges associated with implementing supported aged care accommodation service policy reforms.

**Chapter 3** reviews the literature on nurses and direct care staff with a focus on issues of stress experienced by nurses and direct care staff in the supported aged care accommodation service context. The relationships between nurses and direct care staff and families are explored.

**Chapter 4** discusses the theoretical frameworks used in this study and provides a rationale for the use of each theoretical concept selected.

**Chapter 5** provides details of the study methodology, the study methods employed and ethical considerations in participant recruitment and conduct of the study.

**Chapter 6** reports the study findings in relation to the study respondents’ experiences of workplace stress and burnout and their self-efficacy for working in the supported aged care accommodation service sector. Qualitative data obtained from study respondents’ (respondents) written narratives to an open ended question are presented.

**Chapter 7** discusses the study findings in relation to the theoretical constructs of stress, burnout and self-efficacy, and the extant literature in these fields.

**Chapter 8** concludes the portfolio with recommendations arising from the study findings, and implications of the study findings for supported aged care accommodation service policy, practice and leadership in the sector.
1.5. CHAPTER SUMMARY

Chapter 1 provided the background to this portfolio of work. An outline of the portfolio was introduced and included a summary of the details of the research study with an introduction to the field of study and a discussion of the stress phenomena as it exists in the general work context. An overview of stress in the workforce and more specifically in the supported aged care accommodation service direct care staff workforce was implemented. A brief introduction of the Australian supported aged care sector and of the various direct care staff who are employed in the supported aged care accommodation service sector were discussed, and issues were raised with regard to the relationships between direct care staff and the families of older people. My position in relation to the study topic, its aims and purpose was discussed, including an outline of the remaining components of this portfolio of work as discussed in the following chapters.

Chapter 2 will provide an overview of the demographic profile of the Australian supported aged care accommodation system; the profile of its services; the policy context for sector reforms and the historical development of the sector. The impact of the reform process on the supported aged care accommodation sector and nursing services associated with meeting quality standards will be explored with regard to the increasing acuity and dependency of older people requiring supported care accommodation. Issues arising for nurses and other direct care staff services in meeting these challenges, concludes the chapter.
CHAPTER 2 THE POLICY CONTEXT OF SUPPORTED AGED CARE
ACCOMMODATION SERVICES IN AUSTRALIA

2.1. INTRODUCTION

As with all developed countries, Australia has instituted long-term policies to address the economic, social and cultural challenges to the existing health and supported aged care systems (Abbey, 2006; Elshaug, Hiller, Tunis & Moss, 2007). Continuing population growth of people over 65 years and especially the growing number of older people that require supported aged care accommodation services is a major contributor to such challenges (Department of Health and Ageing, 2012). Commencing with the Aged Care Structural Reforms of the 1980s (Palmer & Short, 2000), there has been continuous adjustment to supported aged care accommodation service policy and supported aged care accommodation services in attempts to meet the economic, social and cultural challenges of Australia while also addressing a growing demand for high care services (Gargett, 2010; Department of Health and Ageing, 2012a). While the Australian Government currently provides substantial subsidies in excess of $7.1 billion annually for older Australians living in supported aged care accommodation services (Department of Health and Ageing, 2012) to meet these challenges, the system remains under-resourced with regard to the number, distribution and skill sets of the direct care workforce (Chenoweth et al., 2009).

In Australia, adjustments to growing demands for supported aged care accommodation services have occurred over the past 40 years through a complex program of restructuring (Howe, 2000; Palmer and Short, 2000; Duckett, 2004; Abbey, 2006) and this has given rise to a continual source of political and public interest and debate. Commencing in the early 1980s, the development and continued adjustment of the type and mix of supported aged care accommodation services has been informed by interest groups with political, economic, medical and social welfare motives (Barrachough, 2002). Pressure from these groups has
cumulated in a series of reforms (Department of Health and Ageing, 2012) which have impacted on care practices in the supported aged care accommodation service.

Despite these reforms, the Australian Government Productivity Commission (2012) reported that Australia’s current supported aged care accommodation system and services will not meet the future challenges associated with an ageing population. The Commission (2012) found that the current supported aged care system difficult for older people, their families and health professionals to navigate. The issues of concern identified in the Productivity Commission’s (2011) review included limited supported aged care service availability, variable quality in services and service delivery and workforce shortages that were exacerbated by insufficient direct care staff skills (Australian Government Productivity Commission, 2011). Given that the major aims of the reform process have been about improving supported aged care accommodation service quality and improving the quality of life for older Australians, these aims will invariably impact on the supported aged care accommodation sector and supported aged care accommodation service delivery and policy development.

This chapter provides an overview of the demographic profile of the Australian supported aged care system; the profile of its services; the policy context for sector reforms and the historical development of the sector. The impact of the reform process on the supported aged care accommodation sector and nursing services associated with meeting quality standards are explored with regard to the increasing acuity and dependency of older people requiring supported care accommodation. Issues arising for nurses and other direct care staff services in meeting these challenges, concludes the chapter.

2.2. IMPACT OF A CHANGING DEMOGRAPHIC PROFILE

Using the life expectancy methodology as defined by the Australian Bureau of Statistics (2011), the average life expectancy for newborn Australian boys has risen
from 47.2 years in 1881–1890 to 79.3 years in 2007 – 2009 and for newborn Australian girls from 50.8 in 1881 – 1890 to 83.9 in 2007 – 2009 (Australian Bureau of Statistics, 2011). When compared with the United Nations’ estimates for 2005 – 2010, Australian life expectancy is ranked among the highest in the world exceeded only by Iceland, Hong Kong (SAR of China) and Switzerland for boys, and Japan, Hong Kong (SAR of China), France, Italy, Switzerland and Spain for girls (Australian Bureau of Statistics, 2011).

Improvements in the control of infections and parasitic diseases, medical and technological interventions, nutrition and living conditions have contributed to lowered mortality rates and higher rates of longevity in Australia (Australian Bureau of Statistics, 2011). In 1900, four per cent of the Australian population was aged over 65 years. In June 2010 this population cohort had increased between 13 and 14 per cent and it is projected to increase to between 21 per cent - 23 per cent by 2041 (Australian Bureau of Statistics, 2011). Based on population growth projections by 2050 the number of Australians over 65 years could be as high as 25 per cent of the total population, or about 8.8 million of a total population of 35.9 million people (Australian Bureau of Statistics, 2011). A concurrent rapid increase in the population aged 85 years and over is expected to rise to 5.1 per cent if the total population in 2050 (Australian Bureau of Statistics, 2011). Thus, the current and future impact of Australia’s rapidly ageing population on supported aged care accommodation services has attracted discussion and debate at government and community levels (Department of Health and Ageing, 2012). This debate centres on determining appropriate political and economic strategies to meet the needs of this ageing population cohort.

An associated issue is the retirement of the baby boom generation (those born between 1946 and 1964), some of whom would already be accessing supported aged care services accommodation services. This ageing cohort is expected to contribute to the escalating increase in the aforementioned projected figures of people requiring supported aged care services (Howe, 2000; Australian Institute of Health and Welfare, 2007; Australian Bureau of Statistics, 2011b). Increasing
immigration rates are also expected to further impact on the ageing population (AIHW, 2007). With the growth in the numbers of older people in Australia requiring care services, there is an increase in the diversity in the care needs, personal preferences, cultures and the wealth of this population group. It is expected that many ageing baby boomers will want to stay living in the community for the rest of their lives (Department of Health and Ageing, 2010).

The majority of Australians aged 65 years and over live independently in the community (Department of Health and Ageing, 2010). While older people will want to remain living in their own home, not all of them will remain healthy and independent throughout this later stage of life. As life span increases, it is anticipated that chronic illness and disability resulting in longer periods of life spent in ill health will also increase (AIHW, 2007). Within the 65 years and over cohort, it is expected that there will be a consequential increase in the number of people with chronic long-term illnesses such as cancer, cardiovascular disease and neurological health conditions (particularly the dementias) that will impact on supported aged care accommodation services (AIHW, 2012).

Dementia is generally a chronic, disabling health condition and a majority of people with dementia will require supported aged care accommodation services when in advanced illness (Alzheimer’s Association, Alzheimer’s Australia, 2010; AIHW, 2012 ). There are over 100 different types of dementia with Alzheimer’s disease being the most common, followed by vascular dementia and dementia with Lewy bodies (Alzheimer’s, 2012). The most prominent reasons for a person with dementia being placed in supported aged care accommodation is because of changes in their behaviour and inability to self-care as the disease progresses (Brodaty & Low, 2003). Behavioural changes associated with dementia include increased agitation, resistance to care, aggression and repetitive vocalizing and physical behavior such as pacing (Brodaty & Low, 2003; McKeith & Cummings, 2005; Chenoweth et al., 2009).
The number of people living with dementia and their impact on Australia’s health and healthcare expenditure is expected to increase rapidly in the near future (Alzheimer’s Australia, 2011). Dementia is associated with increased longevity, and is rated as one of Australia’s primary health issues and is expected to become an even more significant issue in the future because of its impact on social and economic resources, including supported aged care accommodation services (Alzheimer’s Australia, 2012). Although the rate of disease is not projected to increase, a 200% increase in numbers with dementia is projected over the next 30 years, due to population ageing and population growth (Goss, 2008). The estimated number of Australians diagnosed with dementia in 2011 was 269,000 (Alzheimer’s Australia, 2011) and at some stage over the course of the illness, the majority of these people are expected to require health and supported aged care accommodation services (Ministers Dementia Advisory Group, 2012).

In 2012, over one million older Australians, including people with dementia, are recipients of supported aged care services, of which 183,399 Australians were living permanently in supported aged care accommodation services (AIHW, 2012a). By the year 2050, it has been predicted that over three and half million Australians are expected to use supported aged care services each year (AIHW, 2013). Future challenges associated with the growing number of older people, especially those over 85 years of age, are the decline in the number of available informal carers needed to care for this older cohort in the community and the current level of direct care staff working in the supported aged care accommodation service sector (Alzheimer’s Australia, 2011).

2.3. PROFILE OF SUPPORTED AGED CARE ACCOMMODATION SERVICES

The supported aged care accommodation service sector is targeted for people with advanced physical and mental disabilities and who are unable to live independently, or with the support of home care packages, in their own home environments (Department of Health and Ageing, 2012). In recent decades the
supported aged care accommodation service sector has undergone considerable restructuring in the way services are both provided and delivered to older people. Various policy changes and commissions of inquiry have influenced what is commonly referred to as the *aged care reform agenda*. Supported aged care accommodation services are an essential component of the broader system of supported aged care services in Australia. The series of reforms that have shaped the supported aged care accommodation system are described in section 2.3 below. Table 1 provides a comparison of supported aged care accommodation programs that have been provided to this older population group over time and identifies the changes that have occurred in past decades compared with the present era (service models, funding models, building registration, bed numbers, average length of stay in supported aged care accommodation services, average entry age, and the number of providers and supported care accommodation services).

As the primary funder of supported aged care services, the Australian Government provides a wide range of supported aged care service programs that offer assistance to older Australians through two primary services: supported aged care accommodation services and community care packages. Supported aged care accommodation services is funded to provide extended care services to older Australians whose care needs are such that they are unable to continue to remain in their own homes (Australian Government Productivity Commission, 2012). The provision of supported aged care accommodation service places is targeted to people 70 years and over, while community care packages are provided generally to people over 65 years in their private place of residence through a selection of care and support packages according to the care needs of each individual (Australian Government Productivity Commission, 2012).

In 2012, the majority of the estimated three million Australians aged over 65 years of age that live independently in the community (Australian Government Productivity Commission, 2011; Department of Health and Aging, 2012) represented nine per cent of people aged 70 years and older (AIHW, 2012).
Table 1 – Supported Aged Care Accommodation Services

<table>
<thead>
<tr>
<th>Services</th>
<th>1960s - 1997</th>
<th>1997 to Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Aged Care Service Models</td>
<td>Nursing Homes</td>
<td>Low Care</td>
</tr>
<tr>
<td></td>
<td>Hostels</td>
<td>High Care</td>
</tr>
<tr>
<td>Supported Aged Care Funding Models</td>
<td>Deficit Funding</td>
<td>RCS to RCI to ACFI*</td>
</tr>
<tr>
<td></td>
<td>CAM/SAM Funding</td>
<td></td>
</tr>
<tr>
<td>Supported Aged Care Building Registration</td>
<td>3-3C**</td>
<td>9C** (high care) or 3C** (low care)</td>
</tr>
<tr>
<td>Supported Aged Care Bed Numbers</td>
<td>15-30 Beds</td>
<td>60-120 Beds</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>10-20 Years</td>
<td>12-14 Months</td>
</tr>
<tr>
<td>Average Entry Age</td>
<td>75 Years</td>
<td>83 Years</td>
</tr>
<tr>
<td>Supported Aged Care Providers &amp; Facilities</td>
<td>500-1,000 Providers</td>
<td>1,140 Providers (est.)</td>
</tr>
<tr>
<td></td>
<td>1,000-2000 Facilities</td>
<td>2,773 Facilities (est.)</td>
</tr>
</tbody>
</table>

* Refers to the funding assessment tools used over time
**3C and 9C refers to the building code for nursing homes and hostels (Department of Health & Ageing, 2003)

However, in 2011, over one million older Australians were recipients of supported aged care services, a figure which is expected to increase to 3.5 million by the year 2050 (Australian Government Productivity Commission, 2011). Almost 80 per cent of people aged over 80 years continue to live in private dwellings supported with community care programs and packages of care, while approximately 20 per cent live in supported aged care accommodation services (AIHW, 2012).

Community care services that are subsidized by the Australian Government consist of Home and Community Care (HACC), Community Aged Care Packages (CACP), Extended Aged Care at Home Packages (EACH), Day Therapy Centers (DTC) and Respite Care (AIHW, 2012). Additional assistance to Australian War Veterans is available through Veterans Home Care (VHC) (AIHW, 2012). Whilst the majority of supported aged care accommodation services are provided by the private, religious and charitable sector, the Australian Government is responsible for the major cost of services and assumes and maintains responsibility for all policy implementation (AIHW, 2012).
Supported aged care accommodation services comprise ‘care’ and ‘hotel’ services. Care services include all aspects of activities of daily living, along with the equipment needed for care provision, while hotel services include accommodation, meals, housekeeping and laundry. High level supported aged care accommodation services are mandated to provide 24 hour registered nurse cover to supervise all care services, and this requirement is extended to low level supported aged care accommodation services that have in excess of eight older people classified as needing high level care support (Australian Government, 2011a). There has been a continued growth in the number of high care older people choosing to remain living in low level supported aged care accommodation with extra services, through the Australian Governments’ ‘Ageing in Place’ policy.

Unlike the Pre Reform Era, not-for-profit supported aged care accommodation service providers are currently the major operators of supported aged care accommodation service beds in Australia, accounting for 59 per cent of the market share. The for-profit aged care providers operate 35 per cent of the market and various local, state and territory governments operate the remaining four per cent (Department of Health and Ageing, 2010; Thornton, 2012). The number of supported aged care accommodation places has continued to increase, from 134,810 in 1995 to 183,399 in 2012 (AIHW, 2012), provided by an estimated 2,725 supported aged care accommodation places throughout Australia as at June 2012. Occupancy levels are reported at 92.8 per cent for the year 2011-12 (AIHW, 2012), a decrease of three per cent compared to the previous reporting period 2010-11.

Care arrangements for the older person requiring supported aged care, both in the community and in supported aged care accommodation, are embodied in Schedule 1 of the Aged Care Act (1997). Access to aged care services (supported care accommodation, community care, and flexible care) is based on the Approval of Care Recipients Principles (Commonwealth Department of Health, 2012). Eligibility to any supported aged care service is based on formal assessment of the person by the Aged Care Assessment Teams (ACAT) in relation to their care needs. Not all persons formally assessed and approved for receiving community or
supported aged care accommodation services are able to access these services in the two years following their first assessment (AIHW, 2011). Access is limited by service availability in areas close to the person’s home in the community, or close to their family, and also by service type. If a person is assessed as needing secure living arrangements, as might be the case with some people with dementia, then service availability might be more difficult to obtain in the short term (Alzheimer’s Australia, 2011).

Admission to a supported aged care accommodation service is also based on the level of support required for the person who is unable to remain in the community with the assistance of formal community care services and informal family care support (Giles et al., 2009). Community support programs are not well-suited to people with higher levels of functional dependence, complex care needs and limited informal care networks (Thornton, 2012). Given the estimated growth in the more dependent 85 years and older cohort, it has been claimed that a significant increase in future Government spending on aged care services will be required, from 0.8 per cent of GDP in 2010 to 1.8 per cent of GDP by 2050 (Australian Government, 2010).

2.4. FUNDING SUPPORTED AGED CARE ACCOMMODATION SERVICES

Funding costs and arrangements for supported aged care accommodation services are controlled and regulated through a complex system and reflect in part, the complexities inherent in the broader Australian health and welfare system (Australian Government Productivity Commission, 2011). The Australian Commonwealth Government has funded supported aged care accommodation services since 1962 where a basic daily nursing home benefit of $2 was provided for all approved nursing home residents (Gargett, 2010). Currently, supported aged care accommodation services is funded through a mix of government subsidies, grant payments and user contributions (Australian Government Productivity Commission, 2011b). As the primary funder, the Australian
Government provides 70 per cent of funding for supported aged care accommodation services capped at $181.21 per day (Department of Health and Ageing 2012b) whilst additional user contributions comprise basic fees, and income and asset tested co-payments. In 2009-2010, government expenditure on supported care services was estimated to be around $11 billion, with two thirds of this expenditure directed to supported aged care accommodation services. An additional $728 million paid over the following four years was allocated to the supported aged care accommodation sector (AIHW, 2013) to meet the high costs associated with staffing of direct care services, such as nursing and personal care support (Productivity Commission Inquiry, 2011b). As the largest direct cost in all states and territories is directed to people with mild to late stage dementia (Hatoum et al., 2009), there were concerns that the supported aged care budget would be insufficient to meet the care and staffing needs required for this cohort of people forecasted to increase over the next 30 years (Access Economics, 2011).

Prior to the present era of fiscal reforms, the Resident Classification Scale (RCI) determined the amount of subsidies to be provided for all older people accommodated in supported aged care accommodation services. The RCS was one element of the Structural Reform Package of 1997 and the Aged Care Act (1997). Both nursing homes and hostels were amalgamated together under the RCS (1997), which was a single classification and funding tool developed to include the full spectrum of care needs of each older person who resided in a supported aged care accommodation service. The RCS was superseded in 2007 by the Aged Care Funding Instrument (ACFI) (Andrews-Hall, Howe & Robinson, 2007).

The ACFI is used to assess the level of services required to provide for the care needs of older people including personal hygiene, toileting, mobility, eating and drinking, and continence management. Additional financial support is provided for those older people assessed with behavioural issues of wandering, physical disruption, verbal disruption, cognitive deficits, depression and who may require regular technical care such as wound care or pain management (Department of Health and Ageing, 2008). Technical care must either be delivered or directed by a
health care professional i.e. a registered nurse or an allied health therapist in order to receive the appropriate funding (Department of Health and Ageing, 2009).

The challenge to obtain the right level of funding for each older person using the ACFI lies in the skill and knowledge of the direct care staff member who assesses the care needs of these people (Parker, 2011). Since the ACFI assessments are the only means by which funding for care needs of older people can be awarded to the respective supported aged care accommodation service, there is a great deal of pressure placed on highly qualified direct care staff to undertake a comprehensive assessment of the total care needs of the older person (Parker, 2011).

Following the implementation of the ACFI providers of supported aged care accommodation services claimed that changes in the way that ACFI is employed brought about further funding losses to the supported aged care accommodation service sector (Australian Government Productivity Commission, 2011). A reduction in funding was seen to have a direct negative impact on care provision and direct care staff workload. Victorian direct care staff stress-related illness was found to be attributed to the poor working conditions brought about by the fiscal constraints on the supported aged care accommodation service sector that were imposed by the Victorian Government in 2006 (Harley, Allen & Sargent, 2007).

In 2012, the Australian supported aged care sector underwent further funding reforms with the prospect of a new paradigm of individualized care and supported aged care services, should the recommendations of the Productivity Commission Inquiry (2011) be accepted and implemented sometime within the next three years. These recommendations may yet see another shift in the balance of supported aged care services, as has occurred previously (Courtney, Minichiello & Waite, 1997) with a direct negative effect for direct care staff.

The following section 2.5 provides the policy context for supported care reform in Australia, followed by an outline of the progress made over the past three decades.
and the challenges that beset the supported aged care reform process for supported aged care accommodation services in Australia in section 2.6.

2.5. POLICY CONTEXT FOR SUPPORTED AGED CARE ACCOMMODATION SERVICE REFORMS

Supported aged care accommodation policy development in Australia is implicit in the theoretical underpinnings of health policy development generally and is described as an organized set of values, principles, and objectives identifying areas for action (Palmer & Short, 2000). The impact of policy-development in Australia has resulted in intended and unintended effects on specific health agendas, as described in Section 2.8 below. In the supported aged care sector, macro-level decisions and relevant policy development over the previous decades have impacted on and had implications for all stakeholders (Bernier & Clavier, 2011).

FIGURE 1 - INTERRELATIONSHIPS OF CURRENT HEALTH REPORTS 1

These policies have been, for the most part, subjected to regular assessment and evaluation to determine achievements against intended objectives and to identify any unexpected or unintended consequences (Bernier & Clavier, 2011). A number
of different ‘players’ are involved in supported aged care policy development, including the Council of Australian Governments (COAG) (Figure 1). COAG is aligned to, but remains separate from, the Australian Parliament and is responsible for commissioning the Productivity Commission to undertake the various health related reports, for example ‘Caring for Older Australians 2011’, described in Section 2.6. Following public and industry comment and feedback and budgetary scrutiny the Parliament determines what is to be implemented from the various commissioned and Government reports of supported aged care sector policies (Ergas, 2009). Current Australian supported aged care policy is closely aligned with other health care policies (Figure 1) and involves a number of processes.

One of the prominent influences on Australian supported aged care policy is the philosophy and values imbued by the government in power. In the period leading up to the aged care reforms described in Section 2.4 the government was formed by the Australian Labor Party from 1983 till 1996, after which government was then won by the Liberal/National Party Coalition which remained in power for the following 11 years until 2007 followed by the Labor Party Government, which has quite distinct philosophical values with regard to supported aged care services provision. The Labor Party ideology is embedded in socialistic ideals and is broadly progressive, whilst the Liberal/National Party Coalition is governed according to economically liberal but socially conservative principles (Howard, 2005).

Despite their ideological and policy differences, both political parties’ approaches to supported aged care services have been somewhat similar. The political parties agreed to implement a series of reforms to address a supported aged care system that was identified by the Australian Government Social Welfare Commission (1975) as unsuccessful and inefficient. Under the umbrella of the Aged Care Reform Strategy (see section 2.6), a period of structural changes in supported aged care service delivery and funding models occurred (Gargett, 2010). Thereafter, supported aged care accommodation services has been the ongoing subject of extensive public debate, while legislation and policy reforms have led to
changes in funding and care models (Courtney, O’Reilly, Edwards & Hassall, 1997; Abbey, 2006).

Unlike government health policy, supported aged care policy is deliberately targeted to a particular population cohort through the establishment and enforcement of eligibility criteria (Gargett, 2010). However, the development of supported aged care policy is incorporated within the wider umbrella of health, social and economic policy (figure 2). For example, the 2011 Productivity Commission inquiry into supported aged care occurred as a result of the National Health and Hospitals Reform Commission (2009) review of impending challenges associated with the diverse health needs of an ageing population (Productivity Commission Inquiry Review, 2011a).

A number of other national inquiries have informed supported aged care policy, including the Senate Standing Committee on Finance and Public Administration’s Inquiry into Residential and Community Aged Care in Australia (2008); the Productivity Commission’s Annual Review of Regulatory Burdens on Business: Social and Economic Infrastructure Services (2008); and the Australia’s Future Tax System Review (2010).

The Government’s impetus to create a new paradigm of individualized care and care service environment in 2012 was informed by six recently generated national reviews (figure 2) including: the Productivity Commission and Commonwealth Reports: Building a 21\textsuperscript{st} Century Primary Health System; National Mental Health Report 2010; Disability Care & Support; A Healthier Future for all Australians; and Caring for older Australians. The six Productivity Commission Review Reports have effectively brought about nationally integrated strategies to create a new paradigm of individualized care for all older Australians and a new environment which supported aged care accommodation service providers will be required to provide (Commonwealth Department of Health, 2012).
Whist these Government initiatives have been widely applauded from the supported aged care accommodation service industry, consumer groups, unions and consumer groups (Mark Colvin, 7pm TV News NSW, 16/08/2012), it remains to be seen if the outcome is equally beneficial to direct care staff.

Development of supported aged care accommodation service policies is implemented by the Australian Government through a bipartisan approach and includes a number of stakeholder groups (Productivity Commission Review, 2011b). Contemporary policies relating to supported aged care accommodation services include funding, planning and service monitoring and are subject to annual reviews by the Australian Government’s Department of Health and Ageing (Gargett, 2010). Section 2.8 below provides details of the legislative foundations
for supported aged care accommodation service policy wherein government regulatory control is maintained through the Aged Care Act (1997) the Aged Care Grant Principles (2008), and the Accreditation Standards (1997). Australian supported aged care accommodation service governance requires the collective participation of the Government, the States and a number of other stakeholders such as the Complaints Commission (Hutter, 2005; Jourdain et al., 2005). Stakeholder involvement is considered necessary for forming policy to support the national health goals of service access, equity and accountability. The “risk-based regulation” governance framework has been a feature of this regulatory process (Hutter, 2005; Productivity Commission, 2011), as described in Section 2.6.

### 2.6. HISTORICAL DEVELOPMENT OF SUPPORTED AGED CARE ACCOMMODATION SERVICE POLICY REFORMS

#### 2.6.1. 1960-1986 PRE-REFORM ERA NURSING HOME GROWTH

During the pre-reform era, the Australian supported aged care accommodation service sector evolved from a cottage industry where during the 1960s, old homes were converted into individual, privately owned and run nursing homes (Kendig, 1990). Nursing homes had for some considerable time been perceived as a lucrative and profitable business, and many of the earlier established nursing homes were owned and operated by nurses (commonly referred to as ‘Matrons’), whilst others were owned and run by families. During this period, fewer nursing homes were operated and run by charitable or religious organizations (Palmer & Short, 2000; Gibson, 1998; Duckett, 2004) and it was not until the 1980s that active participation from charitable and religious organizations into supported aged care accommodation services became evident (Howe, 1998; Australian Bureau of Statistics, 2009). Business organizations and other non-profit groups were to shortly follow this ownership trend (Palmer & Short, 2000; Duckett, 2004).

The impetus of the cottage industry nursing home growth originated from a combination of regular guaranteed income support provided through subsidies
paid to approved nursing homes under the Nursing Home Subsidy Act (1956). The lack of suitable alternative accommodation for an ever-increasing ageing population in need of extended care, gave rise to some inappropriate admissions of persons to nursing homes who were considered to have little need for nursing care (Gargett, 2010). An additional factor associated with the nursing home sector growth was the increased numbers of older people being discharged from psychiatric hospitals following the de-institutionalization policy (Palmer & Short, 2002; Duckett, 2004; Australian Bureau of Statistics, 2009). Consequently, many of the people living in nursing homes were provided with a custodial model of care, where for the most part, the basic care needs of these people were provided by uneducated and unskilled direct care staff (Alyward et al., 2005).

The lack of formal nursing home admission policies or protocols further contributed to the rise in bed growth of people being admitted to nursing homes for social reasons, rather than for nursing care (Committee on the Care of the Aged and the Infirm, 1977; Gargett, 2010). Evidence of misappropriation of Government-paid subsidies to the sector, through the existence of various ‘loopholes’ in Government regulations, was an additional issue of concern for the Government and the public (Gibson, 2006). During this growth period, supported aged care accommodation services were, to some extent considered largely unregulated and uncontrolled, with limited incentives for providers to maintain economic efficiencies or quality care provision (Howe, 2001; Duckett, 2004). The lack of financial incentives for providers to admit persons with higher care needs, and the ineffectiveness of admission policies, directly contributed to the dilemma of nursing home growth (Gargett, 2010; Howe, 2001). Concurrent with this growth, there was growing public concerns about reports of inadequate or substandard care, and the abuse and neglect of some older people (Chandler et al., 2005; Gargett, 2010). Nevertheless, a generally-held public view was that the care of older people was a necessary social service, and many Australians began to view the business, or ‘profit’ motive of nursing home operators as exploiting the
elderly and their families (Clark & McCann, 2004; Brathwaite, Makkai & Braithwaite, 2007).

The accumulated public concerns about the poor quality of supported aged care accommodation services, the financial inefficiencies occurring in the sector, and concerns about the sustainability of maintaining high levels of government support for the rapid growth of supported aged care accommodation services led to an investigation of the sector by the Welfare Commission on Care of the Aged (1975). The study report formally acknowledged that the then supported aged care accommodation service system in Australia was unsuccessful and financially inefficient (Australian Government Social Welfare Commission, 1975), a claim that was consistently repeated in subsequent inquiries conducted over later years (Gray, 2001a). This was the catalyst for the Australian Government to commence a range of incremental structural changes focusing on improving care delivery standards and reforming funding mechanisms. In the ensuing years, further inquiries were conducted in response to the anomalies in the system and to address issues uncovered (Gray, 2001a).

Access and equity for older Australians were the two major reform planks of Government planning. During this early period of reform, the Government sought to differentiate care needs of older people with appropriate and commensurate financial support, which were paid through Government subsidies to providers. A two-tiered system of Government funding was introduced, based on the dependency levels of individuals. People with lower dependency requirements continued to attract payment (ordinary benefits) while those people with higher dependency care needs attracted a supplementary financial benefit (Gargett, 2010). Making subsidies available through this two-tiered funding model was an added incentive to providers of supported aged accommodation services to admit more dependent people with higher care needs (Gargett, 2010).

Additionally, this new funding strategy created two distinct supported aged care accommodation service levels (hostels and nursing homes) differentiated through
building criteria and resident dependency (Gray, 2001a). Building specifications for hostels (Class 3) were less rigorous than those required for nursing homes (Class 9) and hostel residents were less dependent on nursing services than those who resided in nursing homes (Gargett, 2010). Other differences lay in the requirements for registered nurse cover, as under the National Health Act (1953) nursing homes were legislated to provide 24 hour registered nurse cover, a requirement not mandated for hostels. Fire safety requirements were also less onerous for hostels than were mandated for nursing homes, as fire and emergency requirements were based on the higher dependency levels of nursing home residents (Gargett, 2010). During this reform era, the majority of direct care staff working in both the hostel and nursing home settings were considered to be inadequately educated, a factor that perceived to directly contribute to the existence of poor quality care services (Rhys-Hearn, 1986; Courtney, Minichiello & Waite, 1997).

From an historical perspective, the supported aged care accommodation service sector has transitioned over time from its early inception as a convalescent home to its current status as a mature and vital component of the overall health care system. The system provides health and care services to an increasingly frail and dependent cohort of older people. The history of the supported aged care accommodation service sector is outlined in Table 3 and later described in the context of the most notable reforms that have shaped this sector and had the most significant impact on the practice of care provision by direct care staff. These reforms commenced with the Pre Reform Era of 1960 to 1986, followed by the Aged Care Reform Strategy Era of 1987 to 1996, and the Aged Care Structural Reform Package Era of 1997 to 2012.

The Pre Reform Era, the Aged Care Reform Strategy Era and the Aged Care Structural Reform Package Era are distinguished by numerous commissioned reports that brought about policy development and incremental adjustments and changes to existing aged care policy.
Table 2 - Reform Eras and Major Reform Strategies

<table>
<thead>
<tr>
<th>Year</th>
<th>Reform Era</th>
<th>Major Reform Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960 – 1986</td>
<td>Pre Reform Era</td>
<td>Cottage Industry, Nursing Homes / Hostels, Patients / Dependency, Funding Strategies, Nurses</td>
</tr>
<tr>
<td>1987 – 1996</td>
<td>Aged Care Reform Strategy Era</td>
<td>Resident / Dependency, Aged Care Assessments, Teams, Residents’ Rights, Outcome standards, Funding Models – Cam/Sam</td>
</tr>
<tr>
<td>1997 – 2013</td>
<td>Aged Care Structural Reform Package Era</td>
<td>Aged Care Act 1997, Aged Care Principles 1998, High Care / Low Care, Resident Classification Scale, Aged Care Funding Instrument, Aged Care Classification Scale, Building Certification Accreditation Standards, Complaints Mechanism</td>
</tr>
</tbody>
</table>

Table 3 summarises the various reviews and reports occurring over the three eras of reform, noting that the terminology used historically to identify supported aged care accommodation services over this period are retained.

Table 3 – Government Reviews and Reports

<table>
<thead>
<tr>
<th>Year</th>
<th>Reports and Reviews</th>
<th>Findings / Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1977</td>
<td>Committee on the Care of the Aged &amp; the Infirm: Report</td>
<td>Identified rising expenditure, as well as gross dissatisfaction with aged care programs</td>
</tr>
<tr>
<td></td>
<td>(Holmes Report)</td>
<td></td>
</tr>
<tr>
<td>1982</td>
<td>Report of the House of Representatives Standing Committee</td>
<td>Identified inequitable NH funding across States; Uncontrolled growth of NHs and escalating costs of care; inappropriate NH admissions.</td>
</tr>
<tr>
<td></td>
<td>on Expenditure. “In a Home or Not a Home” (McLeay Report)</td>
<td></td>
</tr>
<tr>
<td>1984</td>
<td>Senate Select Committee on Private Hospitals &amp; Nursing</td>
<td>Identified presence of fraud- ‘ghost employees’ and overestimated costs. Ineffective planning of bed ratios – oversupply of beds. Recommendations of providing alternative forms of housing</td>
</tr>
<tr>
<td></td>
<td>Homes (Giles Report)</td>
<td></td>
</tr>
<tr>
<td>1985</td>
<td>Nursing Homes and Hostels Programs Reviews</td>
<td>Identified fiscal constraints and deinstitutionalization of care services</td>
</tr>
<tr>
<td>Year</td>
<td>Reports and Reviews</td>
<td>Findings / Recommendations</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>1986</td>
<td>“Quality, Staffing &amp; Dependency: Non-Government Nursing Homes (Rhys-Hearn Report)”</td>
<td>Identified variable care quality, staff numbers and mix. Recommended staff to resident ratios for different levels of care.</td>
</tr>
<tr>
<td>1986</td>
<td>Review of Nursing Homes &amp; Hostels (Rees Review)</td>
<td>Identified the different levels of service occurring, access and funding issues.</td>
</tr>
<tr>
<td>1987</td>
<td>“Living in a Nursing Home: Outcome Standards for Australian Nursing Homes” (Commonwealth / State Working Party on Nursing Home Standards)</td>
<td>Identified variable service quality and some sub-standard services. Recommended minimum measurable standards of service inputs, care and other service processes and resident outcomes.</td>
</tr>
<tr>
<td>1989</td>
<td>Residents’ Rights in Nursing Homes &amp; Hostels (Ronald’s’ Report)</td>
<td>Resident’s right and responsibilities defined, to ensure equitable standards for all residents despite ability to pay for services.</td>
</tr>
<tr>
<td>1991</td>
<td>Aged Care Reform Strategy – Mid Term Review 1990-91 (Department of Health Housing &amp; Community Services (Gregory Report))</td>
<td>Determined service access criteria at different levels of service need and monitoring of service standards against service need.</td>
</tr>
<tr>
<td>1991</td>
<td>Aged Care Reform Strategy – Mid Term Review 1990-91 Progress and Directions</td>
<td>Reviewed the impact of service standards on residents’ outcomes and funding models.</td>
</tr>
<tr>
<td>1993</td>
<td>Review of the Structure of Nursing Home Funding Arrangements - Stage 1</td>
<td>Reviewed the funding models for different levels of service, including user contributions.</td>
</tr>
<tr>
<td>1994</td>
<td>Review of the Structure of Nursing Home Funding Arrangements – Stage 2</td>
<td>Reviewed service need and costs and funding formulae.</td>
</tr>
<tr>
<td>2002</td>
<td>Review of the Resident Classification Scale (RCS) – Situational Analysis, Aged Care Evaluation and Advisors</td>
<td>Reviewed and made recommendations for streamlining the funding assessment tool procedures and recommendations.</td>
</tr>
<tr>
<td>2004</td>
<td>Review of Pricing Arrangements in Residential Aged Care (Hogan Review)</td>
<td>Recommended assessing care services costs separately to hotel service costs for people at different levels of dependency.</td>
</tr>
<tr>
<td>2005</td>
<td>House of Representatives Standing Committee on Health and Ageing Future Ageing</td>
<td>Focused on the long-term strategies to address the ageing of the Australian population over the next 40 years, noting the increasing prevalence of</td>
</tr>
<tr>
<td>Year</td>
<td>Reports and Reviews</td>
<td>Findings / Recommendations</td>
</tr>
<tr>
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</tbody>
</table>
| 2005 | Australian Senate Community Affairs Committee Report *Quality and Equity in Aged Care* | 1. Focused on the long-term strategies to address the ageing of the Australian population over the next 40 years. The draft report noted the increasing prevalence of dementia and discussed the availability and quality of care for people with dementia.  
2. Investigated the adequacy of aged care arrangements in Australia. |
| 2008 | Productivity Commission Trends in Aged Care Services: some implications | 1. Trends in the demand for, and supply of, aged care services and implications in terms of emerging challenges for services to become more flexible, responsive and efficient.  
2. Capacity of the aged care workforce to accommodate demands for services in the long term.  
3. Scope for productivity improvements in the aged care sector to contain future costs while improving service quality. |
<p>| 2009 | Senate Standing Committee on Finance and Public Administration: Residential and Community Aged Care in Australia | Called for another review of the Aged Care Act 1997. The development of an advisory body to report directly to the Minister of Health and Ageing. To consider current and future challenges to the aged care sector. To review the financial status of the sector. |
| 2011 | Productivity Commission Caring for Older Australians | Identified several key weaknesses with the current system of aged care. It is difficult to navigate; services are limited, as is consumer choice; quality is variable; coverage of needs, pricing, subsidies and user co-contributions are inconsistent or inequitable; workforce shortages are exacerbated by low wages and some workers have insufficient skills. |
| 2011 | Commonwealth of Australia National Health Reform: Progress and Delivery | Reviewed current systems and developed detailed options to redesign and reform Australia’s aged care system and to recommend a transition path to a new system. |
| 2011 | Senate Community Affairs | 1. Examined the planning options and |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Reports and Reviews</th>
<th>Findings / Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>References Committee Disability and Ageing: lifelong planning for a better future.</td>
<td>services available to assist people with a disability, and their carers, to plan for the future.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Considered the situation of the small minority of people who experience disability coupled with younger-onset dementia.</td>
</tr>
<tr>
<td>2013</td>
<td>Senate Community Affairs References Committee Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD).</td>
<td>Examined the scope, adequacy and resourcing of various models of care for people living with dementia and BPSD.</td>
</tr>
</tbody>
</table>

2.6.2. 1987-1996 AGED CARE REFORM STRATEGY ERA

Following the publication of the Giles Report (1984) of the Senate Select Committee on Private Hospitals and Nursing Homes, government and interest group inquiries into the supported aged care accommodation service sector verified the need for major reforms in several areas, including care standards, which provided the basis for the initial major reform known as the Aged Care Reform Strategy (1987) (Duckett, 2004). Prior to the establishment of the Aged Care Reform Strategy (1987), supported aged care accommodation services was considered fragmented (Gargett, 2010), with state governments maintaining a major responsibility for providing acute and community services and the Australian Government providing hostel and nursing home services. Nursing homes and hostels were regulated and funded as separate entities (AIHW, 2011) and the ability of older people to receive the service of choice was limited (Gargett, 2010). The primary purpose of the reforms was to move the balance of supported aged care accommodation services from nursing homes to community based care. This was laid out in the Aged Care Reform Strategy (1987) objectives:

1. Development of a coordinated system of planning for residential and community care services for the aged.
2. Closer integration of community and residential care programs to maximize the aged person’s real choice in regard to care.

3. Development of integrated assessment mechanisms for all forms of aged care.

4. Enactment of new legislation to underpin and consolidate the reform.

\((Gregory\ 1991c,\ pp.36-37)\)

Achievement of these four objectives brought about major changes to the then nursing home industry and concomitant care services, with an associated reduction in the number of nursing home beds and an increase in the number of care packages for older people living in the community. Additionally, the introduction of a system of nursing home standards monitoring (Outcome Standards, 1987) and sanctions against providers for noncompliance of the Outcome Standards, the establishment of aged care assessment teams (ACAT) to screen and monitor admissions to supported aged care accommodation services, and the introduction of new funding arrangement that was tied to a the dependency level of older people were also established. The Australian aged care reforms reflected the international trends to improve access, equity and economic rationalization of service delivery (Gibson, 2006), as well as quality of care, and were supported by systems of complex legislation, regulations and standards.

Through legislation, the integration of community services, hostels and nursing homes in a continuum of supported aged care accommodation services gave older people the choice of remaining in their homes with appropriate support, whilst promoting sustainable economic management. It was also considered a more efficient and cost effective model of supported aged care accommodation service provision (Howe, 2001; Department of Health and Ageing, 2003; Gargett, 2010). In addition, an important focus of the reform agenda was to improve the quality of care in supported aged care accommodation services and enhance access to levels of care consistent with the complex health needs of older people (Department of Health and Ageing, 2003; Gargett, 2010).
Whilst the aged care reforms impacted on supported aged care accommodation services with a concomitant effect on direct care staff work and their satisfaction levels in the aged care sector (Chenoweth et al., 2009; De Bellis, 2010), there was limited direct care staff involvement and influence on the Government’s supported aged care accommodation service policy development. Angus and Nay (2003) suggest that while the reforms provided the basis for bringing about economic and social rationalism to the supported aged care accommodation service sector, the reports that gave rise to the reforms marginalized the discourse of direct care staff and overnight the reform agenda transformed the work practices of direct care staff. Registered Nurses whose expertise in managing supported aged care accommodation services was largely ignored in the reform decisions, felt disenfranchised by the subsequent era of structural reforms and this was especially evident when introduced at the supported aged care accommodation service level (Chenoweth et al., 2002). Funded hours of care services were tied to the assessed care needs of each resident that were subsequently categorize into eight levels, category one achieving the lowest funding level and category eight the highest. The hours of care tied to each funded category were insufficient and inadequately aligned with the assessment of the care dependency and needs of older people. Subsequently, the ability of direct care staff to provide quality care services to highly dependent older people was unachievable and conflicted with the assessed dependency of the care needs of older people. Evidence of poor quality care provision continued to be a contentious issue for the public and the media and was a focus for Government commissioned reports (Australian Senate Community Affairs Committee, 2005).

2.6.3. 1997-2012 AGED CARE STRUCTURAL REFORM ERA

The policy frameworks introduced over the previous decade were considered to be economically unsustainable for future governments (Gray, 2001b). At the same time there was increasing recognition that a growing number of cases of abuse, neglect and poor quality care in the supported aged care accommodation service
population needed to be addressed (Department of Health and Family Services, 1998; Gray, 2001). In the (Coalition) Government’s 1996 Budget a significant program of reforms (Structural Reform Package) was announced. The elements of the Structural Reform Package were described as both ‘complex’ and ‘broad-ranging’ and instigated vigorous public debate prior to the approval and passing of the legislation (Gray, 2001). The legislative means for the introduction of this reform was brought about through the Aged Care Act 1997, which was passed by the Government in June 1997 and implemented from 1 October 1997 (Gray, 2001).

The Aged Care Act (1997) continues to underpin and drive the extensive program of restructuring supported aged care accommodation services that has occurred since its introduction (Harley et al., 2007; Productivity Commission, 2012). The implementation of the Aged Care Act (1997) brought about consolidation and ‘bedding down’ of the aged care reforms (Duckett, 2005). The primary motives for restructuring supported aged care accommodation services were fiscal restraint and improvement of service standards (Department of Health and Family Services, 1998) and these motives remain evident to this day (Department of Health and Ageing, 2012). The restructuring strategies included two primary mechanisms, one of which was to remove the funding of capital and domestic staff costs financed in the previous decade through the Standard Aggregate Module (SAM) and to remove funding for care services financed through the Standard Aggregate Module (CAM). Both these funding arrangements were paid on a cost reimbursement basis, and in the case of CAM, were indexed on a quarterly basis in line with national award wage movements. A central feature of the CAM module was the Resident Classification Instrument (RCI), a predecessor of the Resident Classification Scale (RCS) and was designed to classify the care needs of older people into five categories, one being the highest and five the lowest. Unlike funding for SAM, the funding obtained for an older person’s care needs (CAM) provided protected and heavily regulated funding to meet the wage costs for direct care staff (Department of Health and Family Services, 1998). The later
removal of SAM ensured that incentives to profiteer by some providers were removed (Department of Health and Family Services, 1998; Gray, 2001), and the replacement of CAM predestined that the incentives for maintaining an educated direct care staff workforce in sufficient numbers were removed. The second strategy was the introduction and implementation of mandatory quality improvement audits to protect the physical and financial wellbeing of older people who lived in supported aged care accommodation services (Department of Health and Family Services, 1998; Harley, 2007).

Quality service indicators, identified as the Accreditation Standards, were established under the Aged Care Act (1997) and the Accreditation Grant Principles (1999) (Department of Health and Ageing, 1997). The Standards are underpinned by assessment and quality assurance mechanisms and implemented through the Accreditation Agency (Department of Health and Ageing, 2012). The revised Accreditation Grant Principles (2011) describe the role of the Aged Care Standards and Accreditation Agency Ltd (the accreditation body) whose primary purpose is to remove or amend outdated provisions, improve implementation, enhance consumer engagement and provide greater clarity and consistency of administrative processes (Department of Health and Ageing, 2012).

The Accreditation framework includes four main elements: the Accreditation Standards, certification of the quality of the buildings, concessional and assisted resident ratios, and prudential arrangements (Department of Health and Ageing, 2012). The four Accreditation Standards cover supported aged care accommodation service management systems, staffing and organizational development, health and personal care, lifestyle and physical environment and safe systems. The four accreditation standards are further sub classified into 44 expected standards (nine outcomes in management, 17 outcomes in health, 10 outcomes in lifestyle and eight outcomes in environment. Common to all standards, are three sub classifications including: legislation, education and quality improvement.
A rating system is applied to each outcome with a set of guidelines being published to identify the criteria for awarding each level. The accreditation process includes a self-assessment program combined with official and unofficial assessment and inspections from assessors appointed by the Accreditation Agency. The Accreditation Agency is accredited by an external accreditation body and Assessors are suitably qualified (Department of Health and Ageing, 2012). However, as there is no reported evidence of the reliability of the assessment scores awarded by Agency assessors to individual aged care facilities, or the use of validated assessment tools, there is a question around the subjective nature of Agency assessment scores and consequently, Government decisions on the overall quality and standards rating of each supported aged care accommodation service (Grenade, 2003; Taylor, 2009).

The primary aim of the Accreditation Standards is to ensure that “older Australians receive world class care that is of a high quality and accessible” (Department of Health and Ageing, 2004, p. 13). The Accreditation Standards have attracted some criticism (Grenade, 2003; Taylor, 2009). Approved providers voiced their concerns with the associated high costs of implementing the standards, particularly when combined with claims of funding constraints and staff shortages (Grenade, 2003). The Standards were also identified by industry experts as being fragmented and disconnected, attributed to the inadequacy of information provided through legislative documentation and to the assessment process itself, as identified above (Taylor, 2009). A series of Government initiated reviews highlighted other issues associated with the Accreditation Standards, the Accreditation Agency, and with the accreditation process itself. These commenced with the Two Year Review of Aged Care Reforms undertaken by Professor Len Gray (Gray, 2001a); the Australian National Audit Office (ANAO) (Auditor-General, 2003); the Hogan Review (2004); the Senate Community Affairs Reference Committee, Quality and Equity in Aged Care (2005); the Campbell report (2007); and the most recent Productivity Commission 2011 report (2011), Caring for the Aged. Whilst there was a general consensus and acknowledgement from industry and consumer
groups that the accreditation process had facilitated improvement in quality of care and services in supported aged care accommodation service, further refining and management was required to be consistent with the Government’s objective of providing fair and equitable quality of care and services to older people (National Aged Care Alliance 2011; Productivity Commission, 2011).

One of the key platforms of the supported aged care accommodation service reforms has been in regard to the older people living in supported aged care accommodation services and the rights of their families to ensure that services are provided in ways that meet their unique needs and expectations of quality. Older people receiving care in a supported aged care accommodation service have a mandatory right to receive quality care within a safe environment. All levels of direct care staff have a legal obligation and a duty of care to provide care services in accordance with the Aged care Act 1997 and the Accreditation Standards 1998. These rights are enshrined to protect older people since they are for most part vulnerable and dependent on direct care staff and the supported aged care accommodation service for supplying them with quality care and accommodation. This vulnerability places them at risk of neglect and abuse (Fallon, 2006).

Fallon (2006) identifies abuse and neglect as falling into four categories. The first category relates to physical abuse that may involve inflicting physical harm, physical discomfort, pain or injury including perpetrated behaviours of slapping, hitting, rough handling and sexual assault. Psychological or emotional abuse is defined as those behaviours that diminish the identity, dignity and self-worth of the individual, while financial abuse involves the misuse of money and assets of belonging to the older person. Neglect is defined as care and other direct care staff failing to meet the needs of the person who is unable to meet their own needs (Fallon, 2006).

Complaints relating to the neglect of the care needs of older people have been at the forefront of negative media coverage for many years. Primarily prompted by aspirations of self-seeking sensationalism and concerns for tabloid distribution,
the media are frequently the purveyors of the existence of abuse and substandard care (Moyle, 2000). Cited references of abuse included older people being given freezing morning showers during the winter (Moyle, 2000) and the use of kerosene baths as a method of treatment for people with scabies (O’Brien, 2000). Publicity of this nature, while alerting the public of negative issues of supported aged care accommodation services also influences rapid responses from the government of the day.

In 2006, allegations of sexual abuse of an elderly woman in a Melbourne supported aged care accommodation service reported by the ABC Lateline television program (O’Neil, 2006), instigated an immediate response from the then federal Minister of Ageing, Senator Santo Santoro. The Minister proposed an immediate injection of $90.2 million over four years to implement wide ranging reforms to replace the existing Aged Care Complaints Resolution Scheme with a new Office for Aged Care Quality and Compliance (the Office). Other elements of reforms that resulted from reports of abuse included compulsory background checks for all direct care staff and volunteers, compulsory reporting by approved providers of incidents of sexual and serious physical assault, whistle blower protection and the appointment of a dedicated Aged Care Commissioner with increased powers to initiate investigations into the quality of care provided in supported age care accommodation services (Department of Health and Ageing, 2007).

The satisfaction of families of older people with supported aged care accommodation services is closely linked to positive experiences associated with supported aged care accommodation service provision (Maas et al., 2004). Thus the Australian public welcomed and encouraged attempts by successive Australian Governments to address any abuse of older people. The new complaints legislation was regarded as an invaluable tool to assist organizations to achieve the highest standards of quality services and to ensure that the safety and well-being of the older people are maintained (Stevenson, 2006).
The Aged Care Complaints Investigation Scheme (the CIS) was originally established in 1997 to act as a free and independent service managed by the Office of the Aged Care Quality and Compliance (The Office). The Office is underpinned by the Complaints Principles 2011 and regulated through the *Aged Care Act 1997* (Department of Health and Ageing, 2012). The CIS is an independent ongoing policy program that sits within the overarching aged care policy reforms of 1997. The benefits of being a smaller policy program within a larger policy program enable the CIS greater autonomy and control of service delivery, including accountability, responsibility and reporting mechanisms (Owen, 1993).

While not overtly based on any philosophical framework, the intent of the CIS is to provide an unbiased and secure avenue for individuals to seek redress for any concerns they may have about the quality of Government subsidised aged care services (Department of Health and Ageing, 2012). Individuals accessing the CIS may include people who are recipients of supported aged care accommodation services, family members, care providers, direct care staff members or other health professionals. The CIS, unlike its processor, where the primary role was one of investigation, has adopted a more timely and flexible approach that encompasses not only investigation of the complaint, but also conciliation, mediation and other non-investigative techniques.

The review and reform processes undertaken by successive Australian Governments have incrementally focused on consumer, rather than on industry needs, in aged care service legislation. The focus on the consumer is evident in the most recent review of the Accreditation Standards, culminating in the development of a renewed set of standards in collaboration with the Aged Care Standards and Accreditation Agency and aged care stakeholders (Productivity Commission, 2012). There has also been a focus on articulating more clearly the requirements of care under the Aged Care Act 1997, reducing duplication across the Accreditation Standards, and maintaining the present culture of continuous quality improvement (Productivity Commission, 2012).
Following initial consultations with the Ageing Consultative Committee, the Department of Health and Ageing (the Department) implemented a series of consultations with the aged care sector on a draft set of Accreditation Standards during March, April and May 2011. In line with policy development strategies, workshops were held nationally and attended by representatives from approved providers, peak bodies, unions, health professional organisations, and consumer and carer groups. Such strategies provided all participants the opportunity to comment on the draft Accreditation Standards (Productivity Commission, 2012). Further, the Government emphasised the need to place increased attention on the needs of the aged person through the provision of person-centred care, in line with other national and international health standards and practices. Evidence of the trend toward person-centred care is changing how care delivery is managed in Australia (Chenoweth et al., 2009).

2.7. IMPACT OF THE REFORM PROCESS ON THE SUPPORTED AGED CARE ACCOMMODATION SERVICE SECTOR

Reforms under the Aged Care Act (1997), including development and revision of the Standards, intend to benefit all relevant stakeholders, particularly aged care residents and their families (Department of Health and Aging, 2011). To a large degree these reforms have been achieved. Hostels and nursing homes have since merged into a single supported aged care accommodation service entity to support a more equitable funding model. The Resident Classification Scale (RCS) introduced in 1997 provided a single classification and funding tool that encompassed the full spectrum of the care needs of older people who received care in a supported aged care accommodation service (Grey, 2001) and was later superseded by the Aged Care Funding Instrument (ACFI) introduced in March 2008 (Department of Health and Ageing, 2012). In 1997, accreditation and building certification legislation provided a service standard framework to underpin quality assurance procedures. The increased flexibility in respite care availability and the introduction of daily care fees, income-tested fees and accommodation payments were also achieved (Abbey, 2006). The Structural Reform Package assisted in
ensuring affordable access to appropriate care options for people with high levels of care need. This meant that the older person and their family were able to choose to be cared for in their own homes with the assistance of community care packages (Grey, 2001b).

A number of reviews of the Reforms have been conducted to determine the progress being made, as documented in Table 3, section 2.3.4. Commissioned by the Government in 2002, the Review of Pricing Arrangements in Residential Aged Care (known as the Hogan Review, 2004) was completed at the end of 2003. Despite leaks to the media and speculation as to the contents of the review, it was not until the Government Budget of the 11th May 2004 that the findings of the review were released, along with the responses of governments to address the short and medium term recommendations of the review (Hogan, 2004). The Hogan Review primarily focused on the long-term financial viability of the supported aged care accommodation service sector, making only brief reference to quality of care and equity of access (Hogan, 2007).

The Hogan scant attention to care service quality and service access by the Hogan Review resulted in further public criticisms and debates that culminated in a Senate enquiry, referred to as the Australian Senate Community Affairs Committee Report into Quality and Equity in Aged Care (2005). During the implementation of the Structural Reforms, the Government attracted ongoing criticism and debate by the opposing political Labor Party. These ongoing criticism and debates informed the development of broad terms of reference for ensuing formal enquiry and reviews into the aged care sector (Brown, Ainsworth and Grant., 2012). The inattention paid to service quality issues culminated in further development of the Aged Care Accreditation Standards.

The Structural Reforms aimed to address the identified deficiencies related to the high costs of aged care, inadequate resource allocation, and poor management of outcomes for elderly recipients and to address the increasing community expectations and care needs of a rapidly ageing population (Ergas, 2009).
Productivity Commission’s report ‘Caring for Older Australians 2011’ (Department of Health and Ageing, 2012) specified that the aged care system was difficult to navigate, provided limited services and consumer choice. Additionally, service quality availability was considered variable as were pricing arrangements and co-contributions whilst existing workforce shortages were further aligned with low wages and insufficient skills of some direct care staff. The Productivity Commission identified that there was a significant need for more direct care staff with enhanced skills to meet the needs of Australia’s older population.

In response to these findings, the Australian Government launched a 10 year reform package (Living Longer Living Better) aimed at building a better, fairer, more sustainable and nationally consistent aged care system. The objectives of the ‘Living Longer, Living Better’ program are to create a flexible and seamless system that provided older Australians with increased choice, control and access to a full range of care services. Whilst the reforms gave priority to providing increased support and care in the home of older people through a range of home care packages, the reforms also enabled people to make service choices based on service content, costs, performance and their own perceptions of what would meet their own care needs (Department of Health and Ageing, 2012).

The recent reforms brought about a major reengineering of funding mechanisms to supported aged care accommodation services. The intended aim of the reforms was to divert funding from supported aged care accommodation services to fund approximately 40,000 home care packages to enable greater numbers of older people to live independently at home. Whilst this shift of services and funding from supported aged care accommodation services to community based care brought about some savings for the Government, the reforms has the potential to create a negative impact for residential aged care providers (Department of Health and Ageing, 2012; Thornton, 2012). It is predicted that the fiscal change brought about as a result of the reforms will have a concomitant effect on a lower funding base for all supported aged care accommodation services at a national level (International Economics, 2012; Thornton, 2012).
It is well understood that overall funding needs for aged care residents will increase over time as more Australians experience greater frailty and longevity and are unable to remain living and being cared for in their homes. Thus, many people admitted to supported aged care accommodation services will require higher levels of care that has not been evident in previous times (Hamilton & Menezes, 2011; Thornton, 2012). Despite Government awareness of this issue, from 1st July 2012 the ACFI scoring, and thus dollars allocated to the ACFI domains of Activities of Daily Living and Complex Health Care for all newly assessed residents had been reduced to approximately half of the previous funding level for this domain. The expected impact of this policy is a loss of care revenue to the level of $500million (International Economics, 2012). The impact of this Government fiscal strategy is yet to be revealed.

Thus, it is likely that having insufficient revenue to support high care needs for Activities of Daily Living and Complex Health Care will further reduce the quality of care for residents, despite the Government rhetoric that the ACFI is the means of matching appropriate funding to care needs (Access Economics, 2011). As well, loss of revenue engineered through a lowered funding base, combined with current increased running costs, is expected to place significant pressures on aged care providers’ ability to attract and retain a suitably qualified nurse workforce. The aged care sector may resort to a reduction of providing skilled direct care services in the name of fiscal efficiency (International Economics, 2012), since the new funding model requires remuneration for skilled direct care staff through increased subsidization from aged care residents with higher than average financial means. It remains to be seen how successful this policy will be in meeting the growing needs of older Australians.

2.8. THE REFORMS AND SUPPORTED AGED CARE ACCOMMODATION SERVICES

Of the various issues that impact on the good management of supported aged care accommodation services, most pertain to the direct care staff workforce...
which is claimed to be in ‘crisis’ (Scott, 2009). Many aspects of aged care work are extremely challenging for direct care staff. The majority of people requiring supported care are generally aged 80 years and over and their lives are often complicated by long term chronic health conditions, including dementia (Australian Bureau of Statistics, 2011). The cultural diversity of Australia’s ageing population and the direct care staff that work in the supported aged care accommodation service also bring challenges of their own for older people, their families, and the supported aged care accommodation service managers (AIHW, 2011). Providing quality care that is culturally sensitive is oftentimes a difficult task for direct care staff who themselves are vulnerable to racism and criticism from older people and families (Crisp & Taylor, 2009).

As previously identified in Sections 2.1 and 2.2, over the previous two decades of aged care reforms, an increasingly sicker and more dependent population is being cared for in supported aged care accommodation services. Subsequently, the role of all levels of direct care staff has undergone substantive change and development (Angus & Nay, 2003; Brown, et al., 2012). Caring for the older person in a supported aged care accommodation service has become a highly specialized area of practice (Brown, et al., 2012). All direct care staff are increasingly required to attain an acceptable level of knowledge and skills to manage a complex range of health care issues, including issues of mental illnesses and dementia (Dwyer, 2011).

A constant pressure for all direct care staff is the high level of illness and dependency of older people in Australia (Chenoweth et al., 2009). Direct care staff including nurse assistants and personal care workers are reported to spend over 80 per cent of their time caring for people with dementia, with 40 per cent of this time being spent caring for people with behavioral disturbances (Cassidy & Sheikh, 2002; Richardson & Martin, 2004). These direct care staff report experiencing abuse and violence from older people with dementia (Hegney et al., 2003; Morgan et al., 2005), which places an additional burden on the caring role. To some degree, these experiences occur for direct care staff because they have
not received the acceptable type and level of education for dementia care (Aylward et al., 2003). Neither do direct care staff have many opportunities for skilled supervision when providing care to older people with dementia, since the skilled direct care nursing workforce has been severely depleted by cost-efficiency measures in the sector, as previously identified (De Bellis, 2010; Chenoweth et al., 2012).

Within this challenging environment, supported aged care accommodation services are required to provide a range of additional services including physiotherapy and technical care interventions to people with more complex care needs (Department of Health and Ageing, 1999; Commonwealth of Australia, 2003; Productivity Commission, 2011). Of the direct care staff workforce, registered nurses assume the major responsibility for upholding care standards and are increasingly involved in roles of direct care staff supervision and education, assessing, planning, documenting and evaluating care, and providing financial and managerial oversight of the supported aged care accommodation service operations (Dwyer, 2011; King et al., 2012). Given that the cost of nursing services is high in Australia, most of the direct care is generally provided by assistant nurses, activities staff and personal care workers (King et al., 2012). These staff work under the supervision of registered nurses, but often at a distance, and this situation gives rise to stress and tension for each category of direct care staff (King et al., 2012).

The legislative requirements under the Aged Care Act (1997) that mandates 24 hour coverage by a registered nurse for high level supported aged care accommodation services does not apply to low level supported aged care accommodation services. With the ‘ageing-in-place’ policy being implemented in many low level supported aged care accommodation services, there is a growing number of older people with high level care needs being cared for in low level supported care accommodation services, for which there is often only ‘remote’ registered nurse supervision (De Bellis, 2010; King et al., 2012). This situation is an increasing source of stress for registered nurses (Chenoweth et al., 2012). Given
the increasing frailty, dependency and acuity of the older population of both high and low level supported aged care accommodation services, nursing services are being stretched to unprecedented levels. There is now intolerable pressure on a smaller number of registered nurses to supervise other less skilled direct care staff in high and low care facilities (Moyle, Skinner, Rowe & Gork, 2003; Chenoweth et al., 2012).

In 2007, Australian supported aged care health services was the ninth largest employer with a workforce of 260,000 employees, or almost three per cent of the total Australian workforce. Two thirds of this workforce is employed in the supported aged care accommodation service sector. However, only 14.9 per cent of the workforce consists of registered nurses and a smaller number of enrolled nurses (11.5%) (King et al., 2012). Not only is the level of funding for registered nurses who work in the sector not keeping up with the levels of pay received by acute and community counterparts, those working in the supported aged care accommodation service sector now have increasing levels of responsibility and accountability. Given the complexity and dependency of high level care requirements of older people, the level of skills in the direct care staff workforce is an issue (International Economics, 2012).

An example of the issues being faced by registered nurses in particular is in regard to the proposed changes to the ACFI effective from July 2013. The revised ACFI aimed to strengthen the evidence for claims being made for supporting care in the domains of Physical and Emotional care and Complex Health Care through the use of prescribed evidence based assessment tools. Without the ‘right’ tools, direct care staff feared that older people would receive less than the appropriate funding to purchase the required hours needed for skilled care as the measurement tool selected may not reflect the individual’s subjective experiences of their care requirements (Wylie & Nebauer, 2011).

Registered nurses are an integral and essential component of the direct care staff workforce, so the resignation of registered nurses creates a void that cannot be
filled by other levels of direct care staff. Insufficient numbers of registered nurses in the supported aged care accommodation service sector, as in other health settings, is an issue for Australia and has been identified in a number of direct care staff workforce reports (Richardson & Martin, 2003; Australian Health Workforce Advisory Committee, 2004; Productivity Commission, 2005; Martin & King, 2007; AIHW, 2008; NHHRC 2009; King et al., 2012). These workforce challenges are recognized by the Australian government as issues of concern (Department of Health and Ageing, 2012).

A shortfall in the direct care staff workforce numbers generally is acerbated by lower wages when compared to other care settings (NSW Nurses Association, 2011; King et al., 2012). Commencing with a budget of $390 million in 2010 and combined with an additional $103 million in new funding 2012, the Government implemented a post-hoc attempt to address the skilled direct care staff workforce shortage (Commonwealth of Australia, 2011). Whilst the Australian Government recognized that the success of current and ongoing health reforms within the supported aged care accommodation service sector is linked to the strength of the capacity of the direct care staff workforce, the Aged Care Act (1997, Schedule 1) omits to include registered nurses as health professions which are eligible to deliver supported aged care accommodation services. De Bellis (2010) suggests that this omission has effectively ‘silenced’ the voices of direct care staff (nurses) in supported aged care accommodation service policy development and evaluation.

Further, the omission of registered nurses within the Government literature as a critical component of the supported aged care accommodation service workforce reflects to some degree the social status of these direct care staff. Despite current expectations that direct care staff will attain a high level of knowledge and skills to manage this complex area of care (Productivity Commission 2011; Department of Health and Ageing, 2012), there remains a negative image of direct care staff and of the work they do (Venturato, Kellet & Windsor, 2006; Carryer, Hansen & Blakely, 2010). From a review of the direct care staff workforce in the USA,
declining enrollment, the changing work climate and the poor image of caring for the older person were four identifying factors contributing to direct care staff workforce shortages (Goodwin, 2003). Improving the image of the work of caring and supporting legislation that would help rectify direct care staff shortages were suggested as possible solutions to address USA workforce shortages in caring for the older person (Goodwin, 2003).

The Australian Nursing Federation (2011) clearly identified wage inequity as a major reason for the poor image of working in the supported aged care accommodation service sector. This is particularly so for the registered nurse direct care staff workforce with reported evidence of a decline of registered nurse numbers in the sector. The wages gap between registered nurses working in the supported age care accommodation service sector compared to registered nurses working in the public sector has continued to increase (Australian Nursing Federation, 2011). Registered nurses who work in the NSW supported aged care accommodation service sector may earn up to $205 a week less than their colleagues in the acute care sector. This disparity has been considered by direct care staff themselves, as a reflection of the reduced worth that government and society place on caring for older people (NSW Nurses’ Association, 2012).

Using commissioned research, the NSW Nurses’ Association implemented a campaign to lobby and inform the Government of the need to increase funding to supported aged care accommodation services whilst concomitantly campaigning for the introduction of a model agreement for improved work conditions and remuneration for all direct care staff (NSW Nurses’ Association, 2012). Both strategies were successful. The first model agreement negotiated and introduced in 2010 with the NSW Nurses Association and Age Care Australia (NSW), brought about greater recognition of qualifications held by direct care staff, safer workloads and an increase in wages of six per cent over two years for all direct care staff working in participating NSW supported aged care accommodation services (NSW Nurses’ Association, 2012).
While there are a growing number of collective agreements negotiated in the supported aged care accommodation service sector, the wages and conditions continue to be generally less favourable than evident in the public sector (Australian Nursing Federation, 2011). Not all direct care staff received the union-negotiated enterprise agreement. In 2012, from a total 280 for-profit NSW supported aged care accommodation services, thirty three services continue to work under the ‘safety net’ of the National Aged Care Nurses Award (NSW Nurses’ Association, 2012). Wage structures under the National Aged Care Nurses Award are based on the minimum wage negotiated through Fair Work Australia and are considerably less than paid under the union-negotiated enterprise agreement. Further, in some Australian States, wages for some direct care staff were scaled down following the 2010 National Aged Care Nurses Award restructured wage agreement (Leading Aged Care Services Advice, 2011).

Nursing assistants working in the supported aged care accommodation service sector are also undervalued, receiving a base rate of $18.44 per hour for the complex and demanding work they perform (National Aged Care Nurses Award, 2012). In New South Wales, this rate is slightly higher ($1.36 per hour) for nursing assistants who may be employed under a Union and Industry Enterprise Agreement (NSW Nurses’ Association, 2012). Wage inequities for these direct care staff are explained, in part, by the level of funding received for care needs of older people. The ability of providers of supported aged care accommodation services to purchase the required number of direct care staff hours and skill sets is aligned to the Government subsidies received for supported aged care accommodation services to each older person. This limitation tends to force providers to seek as many care dollars as possible through the ACFI funding model (De Bellis, 2010), and unlike the CAM funding period where funding for wages was not only cost reimbursed, funding for wages is tightly regulated and monitored by Government (Department of Health and Family, 1988).

Another issue being faced by the direct care staff workforce, particularly the registered nurse cohort, is that this workforce is ageing at the same time that it is
diminishing in size (Australian Bureau of Statistics (ABS), 2010). The ABS (2012) census data reveals the average age of Australian registered nurses working in the supported aged care accommodation service sector is 47 years of age compared to 45 years for acute care registered nurses. Historically, the caring profession is largely comprised of women and those women born between 1945 and 1964 (baby boomers) make up the largest proportion of the direct care staff workforce (Goodwin, 2003, Graham & Duffield, 2010). If the 'baby boom' generation of this direct care workforce were to retire at say 60 years of age, it could be expected that this generation of care workforce will have reached retirement anywhere between the years 2006 and 2024. The impact of the retirement of this generation of direct care staff, combined with a diminishing entrant intake, is expected to coincide with the expected rise in the ageing population and a subsequent increase in care services (Graham & Duffield, 2010).

A later study conducted by King et al. (2012) differs from the previous aging direct care staff workforce supposition. King et al., (2012) found that the largest loss of all direct care staff was in the 35 year age group having fallen from having 65 per cent in 2003 to 55 per cent in 2012. In fact, King et al. (2012) found those direct care workers 55 years and over increased from 17 per cent in 2003 to 23 per cent in 2007 and 27 per cent in 2012. The median age of registered nurses and enrolled nurses in 2012 was 51 years of age followed by recreational staff (50 years of age), enrolled nurses (49 years of age), and personal care staff (47 years of age). King et al. (2012) suggested that the increased incidence of older entrants to supported aged care accommodation service work may account for the age differentials.

In recognition of the demands of an increased ageing population and the associated rise in health care needs and costs, the Government, through its workforce package *Building Australia’s future Workforce* (Commonwealth of Australia, 2011) embarked on a series of well publicized programs to support the national direct care staff workforce. The programs included $130 million (NSW Nurses’ Association, 2012) for funding of 9,289 direct care staff to complete
certificate level training, 1471 direct care staff to undertake studies leading to an enrolled nurse qualification, 8,400 short courses and additional funding for 950 student nurse placements and 350 graduation nurse placements. These funding measures are expected to continue to December 2014 (Commonwealth of Australia, 2012). Additional funding was provided in 2010 for 395 undergraduate scholarships, 310 postgraduate scholarships and ten nurse practitioner scholarships (Commonwealth of Australia, 2011).

The aim of the then Labor Government was to expand and up-skill the direct care staff workforce to assist with improving quality health care services in line with the *Aged Care Reform Strategy and Review* recommendations (Australian Government, 2012). Evidence from industry journals suggests that both industry and other interested stakeholders applaud the Labor Government’s initiative of introducing funded training for the supported aged care accommodation service workforce despite some skepticism of continuation of this policy initiative following the change of Government in September 2013. At the time of writing this chapter, the uptake and success for this Government initiated education is not known.

Up-skilling was also a noted factor in King et al.’s 2012 review of the direct care staff workforce. King et al. (2012) found that a considerable proportion of the residential direct care staff workforce may have availed themselves of the opportunity to acquire skills and knowledge not previously gained. For example, in King et al.’s study at the time of data collection, 22 per cent of all study respondents across all occupation groups (registered nurses, enrolled nurses, assistant nurses, personal carers, and recreational staff) were engaged in further study (Aged Care (22.2%); Health (56%); Management (9.4%); Other (11.6%)). The item ‘Other’ consisted of twenty per cent of registered nurses and was identified by the authors as an issue of concern as not all of this cohort was expected seek continuation or future employment in this sector (King et al., 2012).
King et al. (2012) found that 68 per cent of registered nurses and care managers had specialized qualifications in supported aged care work (31% and 37%) respectively, to prepare them for leadership on a number of fronts. The specialities for the registered nurses and care managers leadership and management group included: Gerontology (24%); Palliative Care (23%), Psychogeriatric (3.4%); and Other (17.5%). Enrolled nurses represented a higher proportion of the registered nurse cohort (80.2%) and many respondents did not hold any specialized qualifications in aged care work. From a comparison of three direct care staff workforce surveys of the supported aged care accommodation service workforce conducted in 2003, 2007 and 2012, Martin & King (2008) reported that the proportion of Australian direct care staff workers with Certificate III in supported aged care work increased from 55 per cent in 2003 to 65 per cent in 2007 and in 2012 was reported by King et al. (2012) as being slightly in excess of 98 per cent of all of this cohort (King et al., 2012).

Whilst it is evident that increasing numbers of direct care staff are seeking minimum qualifications, the main barrier in obtaining formal and quality education and training in dementia care for direct care staff is the requirement to undertake this voluntarily (Alzheimer’s Australia, 2011). To date there is no legal or professional requirement for a minimum standard of training for the unlicensed direct care staff workforce such as Grade II, III or IV certificates in aged care work, nor are registered nurses required to undertake formal tertiary-level studies in aged care work (NSW Nurses’ Association, 2012). For many direct care staff, the knowledge and skills required to deal with the ever changing complexity of health care needs of older people are learned on the job (Martin & King, 2008).

In Richardson and Martin’s (2004) study, over 96 per cent of registered nurses considered that they had the knowledge and skills required to carry out their work, and 90 per cent considered that they were able to use their skills in their work practices (Richardson & Martin, 2004). Likewise, 92.2 per cent of nurse assistant responders considered that they had the knowledge and skills required to provide direct care for the residents, and 90.6 per cent of this cohort indicated
that they utilized their skills and knowledge within the workplace (Richardson & Martin, 2004). However, as Martin (2007) suggested, Richardson and Martin’s (2004) survey findings do not compare expected levels of knowledge and expertise required for aged care work with respondent’s answers.

Whilst maintaining and upgrading the skills and knowledge of the aged care workforce is intrinsic to the Aged Care Act (1997), there are limited incentives for unlicensed direct care staff to seek formal education. One barrier to formal training, is the meagre level of financial remuneration paid to direct care staff, even when higher levels of education and training are attained (Martin, 2007). The issues are similar for registered nurses, who are paid less than their acute and community care nurse counterparts, even with higher levels of formal education and relevant qualifications for care of older people (NSW Nurses’ Association, 2012). Another issue associated with inequitable remuneration for direct care staff workers is their decision to move out of aged care into other areas of nursing paying higher wages.

In a response to stem the tide of a skilled workforce loss in the supported aged care accommodation service sector, 87 recommendations were made by the Mason Review (2013) of the Australian health workforce released at the end of May 2013. The review found that workforce shortages were predicted to create of a shortfall of 109,490 direct care staff by 2025. A recommendation arising from the review was that the Government should consider refocusing its nursing scholarship funding towards postgraduate study for nurses in the care of the older person. The review commented that the current health system needed to redirect resources from the expensive acute care model to other models of care including multi-disciplinary and team-based care. The report suggested that the health services also needed to be reshaped, particularly for chronic conditions, to a patient centered model of care. A timeline for these recommended strategies is not yet available.
An issue that has the potential to impact on the supported aged care accommodation service sector is the multicultural mix of its direct care staff, many of whom use English as a second language (King et al., 2012). When examining the proportion of the direct care workforce born overseas, King et al. (2012) found that of the total study workforce, 33 per cent were born overseas. This is a one per cent marginal increase from 2007 to 2012 (33% to 35% respectively) compared to an increase of nine per cent from 2003 to 2007. Supported aged care accommodation services surveyed reported 29 per cent of their workforce was from culturally and linguistically diverse backgrounds. Of the total overseas born study workforce (34%), one third was from Asia, with similar percentages from New Zealand, United Kingdom, Ireland and South Africa (King et al., 2012). Personal carers made up 69 per cent of the total overseas born workforce and 72 per cent of this cohort spoke another language other than English. Registered nurses made up the second largest overseas born cohort (17.5%) with most speaking another language other than English (17.4%) (King et al., 2012). However, while there are increasing numbers of people immigrating from a multitude of different countries and cultures, Australia remains predominantly European in culture with the majority of people speaking English as the official language (Australian Bureau of Statistics, 2012).

The growing culturally and linguistically diverse direct care staff workforce presents challenges for the mostly Australian-born, English-speaking aged care resident population. Chenoweth et al. (2006) suggests that skilled direct care staff from different cultures is invaluable in providing culturally sensitive care to people of similar cultural backgrounds. An issue of concern is the extent to which these direct care staff are familiar with English used in the Australian supported aged care workplace and with the customs and norms of the Australian aged care culture (King et al., 2012). Being able to provide care to people who may have physical or mental limitations may be onerous for those direct care staff who have limited understanding of the English language and cultural norms in aged care services (Jeon & Chenoweth, 2006). This issue had been recognised as
problematic by culturally and linguistically diverse (CALD) direct care staff themselves (Chenoweth et al., 2012; King et al., 2012). A lack of knowledge of local idioms of speech, nuances, and colloquial expressions has the potential to result in conflict between non-English speaking background direct care staff and Australian-born residents, families and other health care workers (Alexis & Vydelingum, 2006; Chenoweth et al., 2006).

Another issue that has had a direct impact on the direct care staff workforce is the computerisation of systems associated with care services (Ely, et al., 2008; Yu, Li, & Gagnon, 2009). The use of computer technology has become an essential component of supported aged care accommodation services and in line with contemporary organizational operations and technology has also become an accepted aspect of service functions. Government communication via paper and postal services has gradually been replaced with internet communication. This then means that supported aged care accommodation services are required to purchase up to date computers, develop relevant policies and procedures, and implement training and education to all relevant direct care staff in the use of computer technology and communication strategies. Issues of data confidentiality and shared access to clinical and other information have impacted on service delivery and the workload of registered nurses especially in regard to the high level of documentation now required by the Government to justify funding levels (Ely, et al., 2008).

Commencing in July 2013, the implementation to the ACFI Answer Appraisal Pack came into effect (Department of Health and Ageing, 2013). The revised documents aimed to further strengthen the evidence requirements and reinforce the original intent of the ACFI and provide clarity for providers and direct care staff on issues that are frequently raised during validation assessments. The use of prescribed evidence based assessment tools for pain management in the Complex Health Care Domain and in other Physical and Emotional Care Domains are additional changes for ACFI. Without the ‘right’ tools, individual older people may well receive less than the appropriate funding to purchase the required hours.
necessary for direct care staff to deliver quality care services to meet the older person’s care needs. This is an issue that, anecdotally, is causing stress among service providers and direct care staff themselves.

In summary, there are many issues that beset the direct care staff nurse workforce. The inconsistency of regulatory reform, combined with limited financial investment, has contributed to the historically low status afforded to direct care staff working in the supported aged care accommodation service sector. In combination with these factors is the inconsistency of educational options, rewards and remuneration packages provided to registered nurses, compared to their counterparts in other health care settings despite their increasingly demanding and responsible roles in the supported aged care accommodation setting. These and the other stated issues raised give rise to tensions and stress in the workplace, which is the subject of this study.

2.9. THE FUTURE OF SUPPORTED AGED CARE ACCOMMODATION POLICY REFORMS

It has been predicted that by 2015, population ageing will place increased pressure on the current supported aged care accommodation service system and capacity of Australia to fund the health needs of older people especially those with a chronic illness and/or dementia (AIHW, 2013a). Australian supported aged care accommodation service policy has evolved over the past three decades and continues to develop in an attempt to address these issues (Productivity Commission, 2011). Despite the recent reform initiatives, it is clearly evident that supported aged care accommodation service policy remains in a constant state of flux as a result of Government’s responses to public expectations and pressures along with changing international trends in health and social support for a growing older population.

For the period 2011-2012 a total of 2,587 (94.7%) supported aged care accommodation services achieved accreditation compliance (Department of Health and Ageing, 2012). However, official complaints of poor or inadequate
supported aged care service provision continue to persist. From a total of 14 care service categories, five most commonly reported complaints were identified in the 2011-12 Report of the Operation of the Aged Care Act 1997 (Department of Health, 2012). Complaints relating to health and personal care (infections, infection control, infectious diseases, clinical care, continence management, behaviour management and personal hygiene) represented the highest number of complaints (2,596; 25.9%), an increase of nearly six per cent compared to the previous reporting period of 2010-11.

Issues related to communication and consultation (internal information of the complaints process; inadequate family consultation; and failing to advise enduring powers of attorney or guardians) was the second highest number of complaints recorded ($n = 1,318$, 13.1%), an increase of just over four per cent compared to the reporting period 2010-11. Research relating to issues of inadequate communication has been identified both in low and high level supported aged care accommodation services, an issue that is likely to result in dissatisfaction and concern for families, thus creating an environment for complaints (Bauer & Nay, 2011). Personnel (number of staff and training/skills/qualifications) was the third highest identified group of complaints with a total of ($n = 1180$, 11.8%) complaints, an increase of nearly three per cent compared to the reporting period 2010-2011.

Factors in the physical environment (call bells, cleaning, equipment, safety and temperature) represented 977 complaints (9.7%), an increase of fewer than three per cent compared to the reporting period 2010-11. Medication management (access and administration) represented 700 (7%) complaints; an increase of 5 per cent for the reporting period 2010-11). The increase in complaints associated with medication management may be explained partly by the increasing employment of non-qualified (professional) nurses to administer medicines to older people who are ‘ageing in place’ in low level supported aged care accommodation services (Tariq, Georgiou and Westbrook, 2012). To reduce medications errors, older people with altered pharmacokinetic and pharmacodynamics changes and taking multiple medicines require medicines to be administered by direct care staffs that
have sufficient in-depth knowledge of pharmacology (Lim, Chiu, Dormann, and Tan, 2010). From this previous discussion, it is clearly evident that the number and range of complaints about supported aged care accommodation service quality need to be addressed.

In September 2011, the Aged Care Complaints Scheme (the Scheme) replaced the former Aged Care Complaints Investigation Scheme. The impetus for change in the way complaints were investigated was precipitated by the findings of a 2009 review of the operation of the Complaints Investigation Scheme (CIS) conducted by Associate Professor Merrilyn Walton (Walton Review, 2010). In line with modern policy development strategies, the review incorporated 119 submissions and 20 face to face consultations from key stakeholders. The recommendations included the need for the CIS to place less reliance on procedures of investigation and adopt a broader range of alternative resolution processes to support the early resolution of complaints, and to use a risk assessment framework to assess and prioritise complaints (Walton Review, 2010; Department of Health and Ageing, 2012). As the CIS is embedded in legislation, supported aged care accommodation services have a legal obligation to provide a climate of open communication and a mechanism for managing and resolving internal complaints, a process that consumers are being advised of and using.

The future of aged care policy reform has wide-reaching consequences for supported aged care accommodation service providers and direct care staff. For example, while the Accreditation Agency is responsible for the assessment and reporting activities relating to a predetermined set of standards, the Accreditation Agency has a strong link with the CIS, undertaking actions on complaints where these have been referred to by the Department of Health and Ageing. The Accreditation Agency also has the powers, where necessary, to impose sanctions on supported aged care accommodation service providers in situations where standards are deemed not to be met and pose a serious risk to the health and well-being of older people who receive Government subsidies. Australian supported aged care accommodation services undergo an accreditation process
approximately every three years, combined with prearranged bi-annual interim support visits and regular unannounced visits (Department of Health and Ageing, 2012). While publicly reporting accreditation results aims to help consumers to make better choices about supported aged care accommodation services, it also provides a platform to provide stimulation of provider competition on quality improvement strategies (Stevenson, 2006).

2.10. CHAPTER SUMMARY

This chapter has provided information on the demographic profile of the Australian population and the historical development of the Australian aged care sector and supported aged care accommodation services. It has been argued that Australia’s older population is rapidly increasing and the aim of today’s supported aged care accommodation policy is to ensure a safe and pleasant living environment and quality care services for those older people who are unable to remain living in the community with informal and formal support services (Duckett, 2005; Productivity Commission, 2011; Department of Health and Ageing, 2012). It is evident that the growing complexity and the cost of aged care services for this older population have particular consequences for Government policy, and will also have an impact on the existing and future direct care workforce (Productivity Commission, 2011). Direct care staff who work in the supported aged care accommodation service sector work with uncertainty concerning future staffing levels and resident mix. Supported aged care accommodation services are often hampered by serious staff shortages in their efforts to provide quality care for older people, most of whom are increasingly more frail, ill and dependent than was evident in previous decades (Chenoweth et al., 2012). The constant pressure and stress of the physically and psychologically demanding work in the supported aged care accommodation service sector may impact negatively on direct care staff. Combined with the higher age of direct care staff who works in this setting, it is understandable that the wear and tear occurring in nurses and other direct
care staff will give rise to these staff leaving the sector (Leonard and Johansson, 2008).

The following Chapter will review the literature on nurse and other direct care staff stress, burnout and self-efficacy in the supported aged care accommodation service sector, the consequences of this stress for these staff and the factors that can protect them from feeling undue stress in their work. The review will also investigate whether direct care staff workplace stress is amenable to improvement and how this might be achieved.
3.1. INTRODUCTION

The aim of this literature review was to:

1. Investigate whether nurses and other direct care staff working in the supported aged care accommodation sector experience stress;

2. Identify what the negative effects of workplace stress are for these direct care staff including any experiences of burnout; and

3. Investigate work-related self-efficacy for nurses and other direct care staff and whether self-efficacy mediates stress for these staff.

4. An additional aim was to investigate if direct care staff stress is associated with the families of residents.

The literature review will critique what is already known about direct staff stress, burnout and self-efficacy in the supported aged care accommodation service context, both nationally and internationally, and identify gaps in the knowledge pertaining to the research topic. The literature review will be structured around a number of topic areas and will examine the symptoms and sources of stress and burnout and self-efficacy; preventative stress factors; and any experiences of stress that may have occurred arising from the interactions of direct care staff with the families of older people. The interrelationships between direct care staff and families of older people have been studied in formal care practice contexts, both as partners in care (Ward, 2000; Ward-Griffin & McKeever; Pillemer et al., 2003; Hertzberg, Ekman & Axelson, 2003; Robinson et al., 2007; Benzein, Johansson, Årestedt, & Saveman, 2008; Utley-Smith, et al., 2009; Bauer & Nay, 2011) and with regard to tensions arising from this co-care delineation (Goergen, 2001; Hertzberg, Ekman & Axelson, 2003; Bauer, 2006; Jeon et al.,
However, there are very few studies published in relation to the experiences of stress and burnout of nurses and other direct care staff associated with the families of older people in the Australian supported aged care accommodation service context. Therefore, the examination of these additional issues seeks to inform an area of nursing knowledge that has oft been neglected in consideration of the factors that give rise to stress in the aged care workforce. Where relevant, an examination of stress for these staff in other care contexts for older people will be undertaken. Whilst other care settings, such as in the acute care, will have their unique issues, any stresses arising for nurses and other direct care staff in these settings might shed light on common areas of stress for direct care staff that work in the supported aged care accommodation service sector.

3.2. CONTEXT OF THE REVIEW

As outlined in the introduction to the previous chapter, it is well reported that the care of older people is mentally, emotionally and physically challenging across all care practice environments. The experience of stress in the general nurse workforce in particular, has attracted considerable interest from researchers, governments and health services internationally, especially in recent years with the predictions of a nurse workforce ‘crisis’ (Duffield et al., 2007; Ricketts, 2011; King et al., 2012; Health Workforce Australia, 2012). Of less interest has been the experiences of stress for those direct care staff who work in the supported aged care accommodation sector including registered and enrolled nurses, assistants nurses, personal carers and recreational staff as all these staff have been subjected to stressors in their work environment (Ramirez, Teresi & Holmes, 2006; van den, Landeweerd, Tummers & van Meorde, 2006; Hasson & Arnetz, 2007; Karantzas et al., 2012). The reasons for stress for all direct care staff that work in the supported aged care accommodation service context are multi-layered and complex, and accordingly require consideration for this study.
Chapter two outlined how the rapid growth of Australia’s ageing population has seen ever-increasing numbers of people who require a wide array of health care interventions and services. To meet these growing population needs, the Australian Government embarked on a wide range of health care policy initiatives for older Australians, including the more recent 2012 *Living Longer, Living Better* policy. In previous decades, formal care options for most frail older people were limited to supported aged care accommodation services (also referred to as Nursing Homes and Hostels). In more recent years, older people are increasingly able to choose the aged care services they need, if available, and determine the place where they receive these services. Supported aged care services are now more readily available in the community through different levels of care ‘packages’. Therefore, the shift in care provision from residential (supported aged care accommodation services) to community and home based care, has implications for care services and practice in the sector.

Older people who unable to receive adequate care services in the community, both formal and informal, will tend to access supported aged care accommodation services. These people are older, frailer and more dependent than has been evident in previous decades and many have multiple morbidities including mental, cognitive and physical conditions (Aylward et al., 2003; Brodaty & Low, 2003). As a consequence of the increasing frailty and dependency of older people, nurses and other direct care staff consistently report high levels of strain and stress in caring for them (Healy, & McKay, 2000; Cheng et al., 2000; McVicar, 2003; Chang et al., 2006). The nursing research literature suggests that there are negative implications for nurses and other direct care staff when exposed to ongoing levels of work-related strain and stress (Schreuder, Roelen, Koopmans, Moen, Groothoff, 2010). As well, the tensions occurring with regard to the dissatisfaction of older people and their families with supported aged care accommodation services is a cause of stress and complaint (Graneheim, Johansson & Lindgren, 2013), which has impacted negatively on the reputation of the service provider (Productivity Commission, 2005).
Nurse and other direct care staff stress is reported to be associated with organizational deficiencies (Chenoweth et al., 2009) resulting in job/work dissatisfaction, emotional strain, illness, sick leave, interpersonal conflicts and physical strain (Hasson & Arnetz, 2007) and high direct care staff turnover (Richardson & Martin, 2004). Stressed direct care staff may tend to provide a poorer quality care, use unsafe work practices, and feel overloaded by work demands and report having insufficient time to complete required activities (Ramirez, Teresi & Holmes, 2006). Direct care staff that are stressed are also assessed as being less knowledgeable, competent and skilled than their non-stressed colleagues (Hasson & Arnetz, 2007). Some direct care staff report feeling stressed by racism and ethnic bias in the work place (Ramirez, Teresi & Holmes, 2006; King et al., 2012). These issues are discussed further in the chapter in relation to direct care staff stress, burnout and self-efficacy.

3.3. STRUCTURE OF THE REVIEW

Since supported aged care provision is complex, it requires knowledgeable, committed and skilled nurses and care staff. The focus in this review is on all staff who provide direct care services to older people in different health care settings: acute, community and supported aged care. These direct care staff include: qualified or licensed nurses, such as registered and enrolled nurses; unqualified or unlicensed staff who provide nursing care, variously described in the literature as care workers, long-term care workers, assistant nurses, nurse assistants, personal carers; and other staff who also provide some nursing care along with lifestyle services such as diversional therapists and recreational officers. The stresses experienced by these different direct care staff in the supported aged care accommodation service sector and factors related to the stress they experience, were of particular interest in this review.
3.3.1. SEARCH STRATEGY

An extensive search of the electronic, print and other grey literature was undertaken, as outlined below.

**Step 1 - A broad scan of the available literature on the experiences of nurse stress, Burnout, self-efficacy and resident’s families**


The search term combinations were applied in CINAHL then repeated in all other relevant Ovid databases: Cochrane Systematic Reviews, Eric, Medline and PsychInfo. The search was kept broad at this first level of analysis. It was found that repeated searches of selected authors from the bibliographies of retrieved articles revealed new studies that did not emerge in keyword search results. Consequently, the same search terms were also applied in further databases including: APAIS Health, PubMed, Community of Scholars and Australian Digital Thesis to identify relevant papers from the year 1997 onwards. A total of 25 papers were retrieved and scanned for relevance to nurse and other direct care stress, burnout, self-efficacy and any experiences of stress associated with the families of older people receiving nursing care.

**Step 2 - Refining the search to stress and supported aged care**

While a plethora of industry and profession-based newsletters, journal articles and commissioned studies report on nurse stress, both nationally and
internationally, there were few studies reporting the occurrence and causes of workplace stress in other direct care staff in the supported aged care accommodation setting. There was very little research on burnout and work-related self-efficacy for these staff and only a few studies which reported stress associated with the families of older people living in the supported aged care accommodation setting, which were the major foci of this study. Twenty five research articles were selected for their focus on direct care staff work-related stress, burnout and self-efficacy and associated factors in the supported aged care setting. One paper reported on self-efficacy in the direct care staff workforce and two studies focused on direct care staff stress and the families of older people. The remaining studies reported on issues associated with nurse stress generally and in relation to the families of older people in other nursing specialities.

**Step 3 - Selecting and reviewing the systematic literature reviews**

Since one of the criteria for the search was to identify evidence of stress, burnout and self-efficacy in various direct care staff in supported aged care accommodation services, the search focussed on identifying and critically appraising published systematic literature reviews and randomized controlled trials of studies in this field of inquiry. The Cochrane Library of Systematic Reviews, the Database of Abstracts of Reviews, and the Cochrane Central Register of Controlled trials were searched via OVID access. This database allows for the titles or completed reviews to be linked to the abstracts, however, the full text for some of these articles needed to be ordered from the abstract page at a cost. Two systematic literature reviews relevant to the issue were obtained via this route.

**Step 4: Selecting and reviewing research papers and other literature sources and assessing methodological quality**

Each study report was assessed and grouped into one of the following categories: experimental; descriptive; interpretive; critical; and discursive. A
comprehensive table was developed to assist in this process by reporting the following information in summary form: study author/s and qualifications; country, study title, aims, objectives, research question/s or hypotheses; study setting, sample and sample selection; study design, methodology, measurements, and ethical considerations; data collection procedures and analysis techniques; study findings, implications for nursing and recommendations. Each study was then allocated a rating of the level of evidence recommended by the NICE Guidelines (2006) (Table 4 below, as an example)

<table>
<thead>
<tr>
<th>Levels of evidence</th>
<th>Types of evidence</th>
</tr>
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<tbody>
<tr>
<td>1++</td>
<td>High-quality meta-analyses, systematic reviews, RCTs with very low risk of bias</td>
</tr>
<tr>
<td>1+</td>
<td>Well-documented meta-analyses, systematic reviews of RCTs, RCTs with low risk of bias</td>
</tr>
<tr>
<td>1-</td>
<td>Meta-analyses, systematic reviews of RCTs with high risk of bias</td>
</tr>
<tr>
<td>2++</td>
<td>High-quality systematic reviews, or conduct of, case-control or cohort studies with very low risk of confounding bias, or chance and a high probability that the relationship is causal</td>
</tr>
<tr>
<td>2+</td>
<td>Well-conducted case-control cohort studies with a low risk of confounding bias, or chance, and a moderate probability that the relationship is causal</td>
</tr>
<tr>
<td>2-</td>
<td>Case-control or cohort studies with a high risk of confounding bias, or chance and a significant risk that the relationship is not causal</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies, e.g. case studies, case series</td>
</tr>
<tr>
<td>4</td>
<td>Expert opinion, formal consensus</td>
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</tbody>
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Note: Refer to Appendix B for NICE (2006) Guidelines for systematic reviews and meta-analyses, C-randomised controlled trials, D-cohort studies, H-qualitative studies.

The literature was then grouped according to identified classifications, including: incidence of stress in the supported aged care accommodation service context; symptoms and outcomes of direct care staff stress; protection from distress (hardiness, morale, and self-efficacy for care work); sources of stress for direct care staff (i. emotional work; ii conflict with doctors; iii inadequate emotional
preparation; iv problems relating to peers; v problems relating to supervisors; vi workload; uncertainty concerning treatment; vii families of older people; viii discrimination in the workplace; ix other factors that contributed sources of direct care staff stress including: work-home life imbalance, inequitable and inadequate job remuneration; declining numbers of qualified direct care staff; lack of autonomy and control in the workplace; opportunity to provide quality care services; and levels of organisational support; job satisfaction; incidence and sources of burnout; and self-efficacy.

**Step 5 Review**

All studies were reviewed using the NICE (2006) criteria. Only three studies were rated at between Level 2 to 3 (NICE, 2006).

**3.4. LITERATURE FINDINGS**

As was previously discussed, international research studies that identified the incidence of stress in the supported aged care accommodation service context were found to be limited. Similar results were previously reported by Pitfield, Shahriyarmolki and Livingston (2011).

**3.4.1. INCIDENCE OF STRESS IN NURSING**

Commissioned workforce reports implementing both quantitative and qualitative research undertaken by Richardson and Martin (2004), Martin (2007), Duffield et al. (2007), Martin and King (2008) and King et al. (2012) identified both positive and negative workplace issues that gave rise to direct care staff stress. Common recurring themes within these aforementioned reports related to issues associated with the negative images of the work of caring, inadequate education and training, poor workplace conditions, unacceptable interpersonal relationships and personal issues. As well, issues of stress and workplace dissatisfaction were purported to have a direct relationship with the current retention and future recruitment of the Australian direct care workforce.
The supported aged care accommodation service workforce is generally recognized as a dynamic entity and while turnover is commonly reported, it is unknown to what extent direct care staff re-circulate throughout the sector (King et al., 2012). In Australia, the government’s recognition and acknowledgement that the diminishing carer workforce across all care cohorts was associated with stress and burnout led to the development and implementation of proactive strategies to address this ‘crisis’. Initiatives commenced with the implementation of the Senate Inquiry into Nursing (2002) The Patient Profession: Time for Action; the National Review of Nursing Education (2002) Our Duty of Care; and more recently, What Nurses Want: Analysis of the First National Survey on Nurses’ Attitudes to Work and Work Conditions in Australia (Holland, Allen & Cooper, 2012). In the 2011 Productivity Commission Report, Caring for Older Australians (Productivity Commission, 2011), the continuing decline in the nursing workforce was identified as a critical and foremost issue in the supported aged care accommodation services, particularly in regard to service quality (Noone, 2011).

The Nurse Workforce studies conducted by Richardson and Martin (2004), Martin and King (2008; 2012) were commissioned at the direction of the former Department of Health (2007) and the Department of Health and Ageing (2011) in response to concerns of carer workforce shortages within the supported aged care accommodation sector. The authors had concerns that the previous research findings on the direct care staff workforce in the supported aged care accommodation service sector were fragmented and not helpful in identifying more recent Australian direct care staff workforce issues and characteristics (Richardson & Martin, 2004; King et al., 2012) and emphasised the need to monitor the health of nurses and other direct care staff, including their stress levels, in order to implement rapid policy responses that would help to retain these skilled staff (Martin & King, 2008).
The literature review conducted by King et al., 2012) built on similar reviews previously conducted by Richardson & Martin (2004) and Martin & King (2008) with the addition of two categories; male direct care staff; and direct care staff whose first language was not English. From a total of 2,481 supported aged care accommodation services surveyed (King et al., 2012), 15,858 Australian direct care staff working in the supported aged care accommodation setting were invited to participate in the survey on issues they faced in their workplace. A total of 8,568 direct care staff provided valid responses, representing a 56 per cent response rate. Qualitative Interviews were obtained from 101 direct care staff, 50 of whom worked in supported aged care accommodation services.

Thirty five per cent of the direct care staff workforce surveyed consisted of migrant workers of which 80 per cent spoke a language other than English. The average age was 47; and 72 per cent were employed on a permanent part-time basis working between 16 to 34 hours per week. The reasons for working less than full time work (38 hours per week) were not made clear. Whilst approximately ten per cent worked multiple jobs, work satisfaction across all areas was high for most survey respondents except for their pay (King et al., 2012). Responses to the item ‘My job is more stressful than I had ever imagined’, scaled from 1 ‘strongly disagree to 7 ‘strongly agree’, revealed that 2012 (39.6%) survey respondents felt slightly less stressed by their work than was found in Martin and King’s 2007 survey (44.4%) (Martin & King, 2008). However, male and overseas-born survey respondents reported being stressed from their experiences of discrimination in the workplace and from their difficulties in communicating with older people. These findings are important, since only a few Australian and international stress studies have been conducted on the supported aged care accommodation service direct care staff workforce.

One of the few aged care service staff stress studies identified was conducted in Sweden by Hasson and Arnetz (2007). In a cross-sectional questionnaire survey of registered nurses, licensed practical nurses and nurse aides/assistants working in Swedish homes in the community (n = 298; 81.5%) and supported aged care
accommodation service (referred to as nursing homes) (n = 565; 82%) across two municipalities, Hasson and Arnetz (2007) compared direct care staff competence, work strain, stress and satisfaction in ‘elderly’ care. Hasson and Arnetz’s study was prompted by high rates of direct care staff sick leave and complaints of high workloads. The perceptions of direct care staff of their competence, work strain and psychosocial work environment were measured using the Quality-Work-Competence (QWC) questionnaire which had been extensively used in Sweden to measure the psychosocial work environment. The QWC is comprised of 11 scales including leadership, organizational efficiency, staff participation and social climate. Whilst there was no significant difference evident between municipalities, work stress was slightly higher (21.1%) for those direct care staff who worked in nursing homes compared to home-base care staff (19.1%). Work-related exhaustion was identified as the strongest predictor of work satisfaction for both groups (nursing homes, 24.5%; home care, 22.6%) (Hasson & Arnetz, 2007).

3.4.2. INCIDENCE OF STRESS IN SUPPORTED AGED CARE ACCOMMODATION SERVICE DIRECT CARE STAFF

From a systematic review of the prevalence of stress in staff providing direct care care for people with dementia living in a 24-hour care setting, Pitfield, Shahriyarmolki and Livingstone (2011) identified a total of five studies that reported on either the prevalence of, or the level of, psychological stress in direct care staff working with people who have dementia. Whilst the authors found that the studies were small and the psychometric properties of the instruments were unsatisfactory, the preliminary evidence suggested that these direct care staff did not have a high level of psychological stress or stress symptoms. Further, the risk of burnout for these study participants was found to be 37 per cent and five per cent respectfully for two studies and the remaining four studies reported low mean stress scores.
In King et al.'s (2012) Australian aged care workforce study, stress or other mental conditions accounted for 9.3 per cent of supported aged care accommodation services reports of work-related injuries and illnesses, compared with three per cent of stress reported by individual workers (King et al., 2012). Official Australian statistical information on mental stress specific to the supported aged care accommodation service direct care workforce is not easily identifiable from stress reported by the health workforce generally, in either Safe Work Australia’s databank (2013) or the Australian Bureau of Statistics dataset (2011). Whilst Safe Work Australia asserts that its databank is the most reliable and accurate compilation of mental health statistics based on reported workers’ compensation claims, these data are skewed towards those workers who claim compensation for stress-related illness.

Safe Work Australia (2013) revealed that direct care staff and especially personal care and nursing assistants, are among Australia’s most stressed workers particularly when compared to police officers and paramedics. Work pressure was the main cause of mental stress claims for all age groups within this cohort, with over half of women more likely to make a claim for mental stress than men (Safe Work Australia, 2013). The cost of claims for mental health is increasing annually, with approximately 7000 claims made each year at an average cost of $15,000 per person (Safe Work Australia, 2013). Further, claims for Exposure to a traumatic event were highest for the health and community sector.

3.4.3. SYMPTOMS AND OUTCOMES OF DIRECT CARE STAFF STRESS

Stress manifests itself in different forms, some being minor and others being major. Empirical and theoretical inquiry delineates minor stressors into two broad categories: daily hassles (Kanner et al., 1981) and continuous stressors (Pearlin, Menaghan, Lieberman & Mullan, 1981). Stress may arise from minor or common problems of daily life, as well as major challenges (Kanner et al., 1981) and discrete stressors (Pearlin, et al., 1981) of infrequent life events such as divorce, or loss of a job. Each of these stressors requires minor or significant
adjustments on the part of the individual. Daily hassles tend to be the myriad of
irritating, or frustrating, common daily stressors that have a greater effect on an
individual’s well-being. These daily stress events will give rise to greater levels of
stress compared with the less frequently experienced major life events, or
challenges (Pearlin et al., 1981; Kanner, 1981; Lazarus & Folkman, 1984). Emotional uplifts on the other hand, refer to positive life events and unlike daily
hassles that contribute to feelings of life dissatisfaction. Uplifts may provide a
buffer against the stress of daily life (Lazarus, 1980).

Daily hassles have been investigated across a small number of nurse practice
areas both in India (Velayudhan & Gayatridevi, 2012) and in Australia (Elder et
al., 2003). In a 2012 study analysis of the relationships of daily hassles on Indian
nurses (n = 100) and physiotherapists (n = 100) using the Daily Hassles Scale
developed by Kanner, Coyne, Scaefer and Lazarus (1981), Velayudhan and
Gayatridevi (2012) reported that Indian nurses experienced considerably more
daily hassles in their work than did physiotherapists. The authors observed that
as daily hassles increased, the self-esteem of both nurses and physiotherapists
decreased.

In a small exploratory Australian study of hassles and uplifts experienced by
Queensland nursing home and community nurses, and personal carers (n = 57),
Elder et al. (2003) found that caring for people with cognitive impairment
provided more uplifts and less hassles. Two study measurements, a 17 item 5-
point Likert-type Hassles Scale and a 20 item 5-point Likert-type Uplifts Scale
purposely developed for the study were used by the researchers. These scales
were developed from a series of focus groups with direct care staff and asked
about their work-related hassles and uplifts; the factors that eased hassles; and
the factors that reduced the more positive aspects of their job (Elder et al.,
2003). In this study, registered nurses were found to experience higher levels of
hassles on the Hassles Scale than other direct care staff; especially those hassles
associated with family behaviour towards them (Elder et al., 2003).
Stress theory posits that if daily hassles can be kept to a manageable level and dealt with effectively, stress can be reduced (Lazarus & Folkman, 1984). This assertion was found to be the case in a study conducted by Wardh, Hallberg, Berggren and Andersson (2003) in their examination of nursing assistants’ experiences when implementing new oral healthcare regimes for aged care residents. The study identified that in order to complete their tasks efficiently without undue stress, nursing assistants continuously adopted new strategies to combat the daily hassles of time pressures associated with high workloads, inadequate numbers of staff and financial restraints.

Over the past two decades, there has been a growing concern that continuing stress at work has undesirable effects on the health and safety of nurses (Duffield et al., 2007). Stress arising from factors in the work environment is identified as significant contributors to the safety of nurses within the acute care setting (Duffield et al., 2007). Increasing demands for greater efficiencies and productivity have negatively impacted on the coping strategies and self-reporting health outcomes of many nurses (Laschinger et al., 2005). From an exploratory cross-sectional survey of 308 American staff nurses using the SF12v2R self-rated health instrument (Ware et al., 2005), Andrews and Wan (2009) reported that whilst physical health contributes significantly to the overall experience of stress for nurses, mental health stressors are the most important influences on nurses’ decisions to leave the workforce. Leaving the workforce as a result of ongoing feelings of stress in care work has also been identified by Kelly, McHugh and Aiken (2011), Filipova (2011), and Wilson, Diedrich, Phelps and Choi (2011).

On the other hand, nurses and other direct care staff who are free from stress and are contented with their work environment are less likely to leave or retire prematurely (Richardson and Martin, 2004). An aged care workforce that is happy and satisfied with their work is associated with the well-being and well-being of the people they care for, for as Babikian, Artinian and Winter (2011, p. 237) found: ‘happy staff, happy residents’. A happy workplace can ultimately establish the foundations for quality care and a safe environment for care
recipients and providers (Duffield et al., 2007). Creating a healthy and happy care work environment has also been identified as important in recruiting and retaining nurses and other direct care staff (AbuAlRub, 2004).

While there are very few studies which have measured the effects of workplace stress on nurses and care staff in supported aged care accommodation services, a large number have been conducted with mainly qualified nurses in the acute care setting (Brunetto, Farr-Wharton & Shacklock, 2012; Cimiotti, Aiken, Sloane & Wu, 2012). The results of these studies are helpful in shedding light on work issues and related outcomes in nursing work. There appears to be a general consensus from this research that the experience of work-related stress has a negative impact on the quality of nurses’ working lives (Nordström, Wilde-Larsson & Johansson, 2012) and for some, ongoing stress at work may contribute to varying levels and forms of physical and mental illnesses (Long, Johnston & Bogossian, 2012; Letvak, Ruhm & McCoy, 2012).

The effect of stress is reported to be an important cause of negative health behaviour, such as tobacco consumption and drug taking (Lazarus & Folkman, 1984). These types of negative health behaviours have also been found in studies on nurses’ stress and identified in government reports establishing the potential risk of unresolved stress on nurses’ mortality (Kivimaki, 2007) and morbidity (Schaufeli, 1999). These reports make clear that some nurses may experience physiological and psychological changes resulting from their negative responses to their stress (McVicar, 2003). Physiological changes may include physical symptoms of increased blood pressure, tiredness, digestive disorders, weight loss or gain and headaches (Brunner, Chandola and Marmot, 2007).

Brunner et al., (2007) reported that chronic stress was a predicator of general and central obesity in their survey cohort. However, from a study of 194 licensed nurses, Zapka et al., (2009) refuted the notion that workplace stress contributes to weight gain through changed behaviour patterns as previously identified by Brunner et al. (2007). Zapka et al. (2009) found that not all individuals who
experience high levels of work-related stress resort to unhealthy eating habits to deal with their stress. Whilst 65 per cent of all nurse participants surveyed by Zapka et al. were indeed overweight including 28 per cent classified as obese and 81 per cent either ‘agreed’ or ‘strongly’ agreed that their work and their job was stressful, only 23 per cent reported overall dissatisfaction with their work.

An interesting area of research on work-related stress is the concept of stress as a process, with clear delineations made with regard to stressors, psychosocial mediators and the stress response (Lazarus & Folkman, 1984; Paterson & Neufeld, 1989). Psychological changes may include feelings of anxiety, depression, frustration, inadequacy or lowered self-worth; and behavioural responses of over and/or under eating, difficulty in sleeping, interpersonal difficulties, misuse of alcohol and/or other drugs, aggressive and/or passive behaviour and absenteeism (Lazarus & Folkman, 1984). These behaviours have also been identified in nursing stress research (Maslach, Jackson & Leiter, 1996). Nursing work and the structural features of the health care setting can be significant sources of stress for nurses and gives rise to negative behaviours (Duffield et al., 2007). Extended or intense periods of stress can negatively impact on a nurse’s health status and if work-related stress has not been effectively dealt with, there is a potential for a state called ‘burnout’ to occur (Maslach, 2003).

More recent research suggests there is a direct correlation between unresolved work stress and burnout (Lim, Bogossian & Ahem, 2010). Maslach (1982) observed that care staff who spent the majority of their working day in close contact with people with high care needs may experience higher levels of burnout than those who do not. Nurses and other direct care staff spend a considerable amount of their working day in close contact with older people providing ‘hands on’ care therefore, may be at greater risk of burnout than many other health care professionals or workers in other work areas, and may exhibit negative behaviours and consequent failure to give quality care (Lim, Bogossian & Ahem, 2010).
The word “burnout” was originally conceived in the 1940s to describe the point at which a jet or rocket engine stopped operating (Chermiss, 1980). It was not until the 1970s, that Herbert Freudenberger, a psychiatrist, first applied the term “burnout” to humans. Freudenberger used the analogy of a solid building that had been burnt out by fire when describing the status of health care providers who experienced a progressive loss of idealism, energy and purpose as a result of their work (Maslach, Jackson and Leiter, 1996). In their development of guidelines for the recognition, prevention and remediation of burnout in health care professionals caring for children with cancer, Spinetta et al. (2000) confirmed that the initial motivating factors of energy, enthusiasm and idealism at the commencement of employment became less evident over a period of time. Very often this diminished enthusiasm and commitment to the job progresses slowly and at first, and is almost imperceptible (Spinetta et al., 2000).

Maslach’s (2003) research in burnout in health care staff commenced in the 1980s with exploration of the loss of emotional feeling and concern for clients among human service professionals. Burnout was observed by Maslach (2003) to be a prolonged response to chronic emotional and interpersonal stressors resulting from an individual’s place of work. Such responses were more likely to result from what Maslach (2003) referred to, as a major mismatch between the nature of the job and the nature of the person who does the job. Maslach (2003) identified an individual’s experiences of burnout as a syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach, 2003).

Maslach (2003) found that burnout was more concerned with the social environment in which an individual worked, rather than with the individual’s personality. This finding was considered more likely to be related to how individuals interacted with one another in performing their work (Maslach, 2003). If other members of the work environment are not supportive of the individual’s efforts and concerns, the reality of the job and the individual's
expectations of the job begin to diverge and can lead to varying levels of frustration and unhappiness (Spinetta et al., 2000).

Thus, an unsupportive work environment, discord between expectations and reality, stress, frustration and job dissatisfaction are inherent contributing factors to burnout (Maslach & Jackson, 1981). To explain this process, Spinetta et al. (2000) discussed the development of burnout as being a five stage process. The first stage is one of mental exhaustion, followed by indifference, a sense of failure as a professional, a sense of failure as a person and in the last stage, being ‘dead inside’.

3.4.4. PROTECTION FROM DISTRESS

Not all individuals’ who experience high levels of stress experience burnout or become ill (Kobasa, 1979). This may be as a result of three stress protective factors that may be inherent in nurses including hardiness; morale; and self-efficacy or resilience (Garrosa, Moreno-Jimenez, Liang & Gonzalez, 2008).

3.4.4.1. Hardiness

The ability to cope with stressful situations may be influenced by an aspect of an individual’s personality (Kobasa, Maddi & Courington, 1981), referred to as ‘hardiness’ or ‘hardy personality’ (Kobasa, 1979). Hardiness is reported to lessen the effects of stress in an individual (Kobasa, Maddi & Courington, 1981). The concept of developing a hardy personality as proposed by Kobasa (1979), suggests that those individuals who demonstrate a high degree of commitment, control and challenge in response to situations perceived as stressful, may not experience the illnesses that others do who have lower levels of hardiness (Kobasa, 1979). Kobasa, Maddi and Courington (1981) refer to ‘commitment’ as the level of an individual’s involvement in life’s processes, ‘control’ as an individual’s recognition of their ability to influence life events, and ‘challenge’ as the recognition that change is a normal event resulting in development stimulation.
Kobasa, Maddi & Courington (1981) found that hardy individuals have a sense of curiosity, perceive their experiences positively and feel they are able to make a difference in most stressful situations. Further, hardy individuals are unperturbed with change, viewing such changes as both normative and stimulating, thus have greater capacity to cope with perceived stressful events (Kobasa, Maddi & Courington, 1981). On the other hand, individuals with low levels of hardiness view themselves and their environment less positively, seeing the environment as threatening and meaningless, imbuing the individual with feelings of inadequacy and powerlessness, with limited capacity to accept changes (Kobasa, Maddi & Courington, 1981). Fagan (2012) compared dementia and gerontological nurses’ stress and found that nurses who cared for people with dementia experienced higher levels of stress than those nurses who worked with a general ageing population. The identified variance in stress levels was as a result of the gerontological nurses’ perception of their ‘hardiness’ (Fagan, 2012).

3.4.4.2. Morale

Caring for others is central to the definition of nursing (Kashani, Eliason, Chrosniak & Vernalis, 2010). However, nurses who experience stress frequently neglect to care for themselves and fail to attend to their own health needs (Nahm, Zhu, An & Brown, 2012), for example, skipping meal breaks in order to cope with their workload. Kashani et al. (2010) surveyed the stress levels and related behaviours of nurse volunteers (n = 255) in a military medical centre during war time. The sample consisted of 175 women (n = 175); men (n = 79) of which (n = 10) were middle aged, married (women and men, n = 124), white (n = 130); black (n = 62), Asian (n = 23) and Hispanic (n = 20; other (n = 8). Despite the high levels of work stress reported by these nurses, their morale was reported as high and they had a strong degree of confidence in their ability to cope with work, despite the limitation of having inadequate sleep (Kashani, et al., 2010).
In another workplace stress study undertaken by Kashani & Chrosniak (2010), a self-report questionnaire was distributed to all nurses working on inpatient wards and outpatient clinics including adult medicine and surgery, gynaecology, paediatrics, psychiatry and psychology, intensive care, emergency services, specialty services and clinics where specialized nurses worked. The questionnaire asked nurses to identify on a scale from 1 (low) to 5 (high) their morale levels, and identify the sources of stress, sick leave days, days sick at work, availability of tools to cope with stress, and the amount of time spent each week on sleep, leisure activities and exercise. The key findings included very high stress in 55 per cent of respondents and moderate stress for 26 per cent of respondents. The reason for feelings of stress included: work (66%); fatigue (39%); finances (33%); home (25%); and health (18%). Morale was reported high for 47 per cent of study respondents and moderately high for 24 per cent (Kashani & Chrosniak, 2010).

In a study to identify intrinsic and extrinsic work values of 1477 members of the Queensland Nurses Union (n = 441 (47%); aged care (n = 57 (56%); public acute care; n = 498 (56%); private acute care), Hegney, Plank and Parker (2006) found that of the three cohort groups, aged care nurses experienced the lowest levels of morale and the highest levels of work stress. Morale and work stress was linked to study respondents’ perceptions of job satisfaction (Hegney, Plank & Parker, 2006).

Sharing a smile and a laugh can reduce anxiety and create an atmosphere of positivity and warmth between older people and direct care staff (Chenoweth et al., 2013) and also improve the moral of direct care staff (Spitzer, 2001). Healy and McKay (2000) found that those direct care staff who are overwhelmed with stress would frequently resort to the use of various coping skills including humour as a means to reduce their stress levels and to boost morale. Using humour to boost morale in a sample (n =129) of Australian direct care staff, Healy and McKay (2000) used Lazarus and Folkman's (1984) Cognitive Transactional theory as the framework for the study intervention. This strategy

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yielded a small but significant negative correlation \((r = -0.22, p < 0.05)\) between levels of reported stress and job satisfaction. When stress levels were elevated, job satisfaction decreased. The authors concluded that although increasing job satisfaction through use of humour may induce a good mood and morale, it is insufficient to overcome high stress levels of direct care staff (Healy & McKay, 2000).

### 3.4.4.3. Self-Efficacy for Nursing Work

Duffy, Oyebode and Allen (2009) found that the level of self-efficacy in one’s work is a high predictor for the incidence of job stress and burnout. Self-efficacy is the term used to describe a perceived sense of confidence in the ability to cope with the demands of life without incurring undue distress (Bandura, 1997). High self-efficacy is a universally admired and desirable perspective on the world. It’s the state of mind that says, ‘I can handle this’ and one which helps people through the most difficult times. Seeing a crisis or a problem as an opportunity for learning or to find a suitable solution is deemed as a good starting point for developing high self-efficacy (Bandura, 1997).

High self-efficacy for one’s work, or dealing with an issue at work, can be developed through vicarious learning; by direct education and skill development; and by practising these skills in a range of situations and through peer support. Gaining this state of mind builds resilience in the workplace, helping staff to gain a sense of achievement about what they can do, rather than a sense of loss about what they are unable to do. Self-efficacy is a predictor of being prepared to make professional and personal behavioural changes to accomplish goals (Bandura, 1997). Karantzas et al. (2012, p. 513) argues that “self-efficacy within the supported aged care sector may be a better measure than a global measure of self-esteem to pick up on personal attributes associated with work stress”. Phillips, Salamonson and Davidson (2011) developed a palliative care self-efficacy scale for assessing direct care staff self-efficacy in palliative care. The scale was administered to 405 direct care staff employed in nine supported care
environments. Scale results indicated low self-efficacy was associated with the direct care staffs’ inability to provide optimal palliative care, while the reverse was true for those direct care staff with high self-efficacy (Phillips, Salamonson & Davidson, 2011).

3.4.5. MEASURING STRESS

Inconsistency in the terms used to describe the sources and outcomes of stress in the nurse workforce within the literature is evident. The terms job stress and work stress have the same meaning and yet were used independent of one another sometimes within the same study. Additionally, preferences for terminology used to describe the concept and meaning of stress and stressors such as ‘strain’ and ‘stress’ were found to differ from study to study and the researchers’ explanations for the selection of terminology use was not always evident in the nurse stress studies reviewed.

There are wide variations in the different nurse stress studies’ methodologies, the philosophical bases supporting the study topics, the research questions, the study settings and populations, sample sizes, instruments used, and data analysis techniques. These study aspects were found to be too varied to enable a useful comparison between the studies. For example in some studies, stress is the dependent variable, in others, the independent variable whilst the use of the word ‘stress’ is completely avoided and yet the meaning of the construct used in place of the word ‘stress’ is stressful in nature. The variations in the nurse stress studies reviewed may in part be due to the constantly changing environment in which nurse stress is studied, and as suggested by Kim (2010), a plurality of philosophies may be necessary to reflect the many facets of nursing science, that is, no one view may be sufficient to understand, embrace or drive nursing knowledge in its totality.

As previously identified, the work and the workplace has long been identified as sources of stress for nurses (Gray-Toft & Anderson, 1981a; French et al., 2000).
To better understand these factors, Gray-Toft and Anderson (1981b) conducted a comprehensive review of the nurse stress literature and established that stress-related health issues in nurses can arise from the physical, psychological or social environment in which nurses work. The identified major sources of stress provided the basis for the development and testing of the 34 item instrument, the Nurse Stress Scale (NSS) (Gray-Toft & Anderson, 1981b). The 34-items subsequently comprised seven subscales including: Death and Dying; Conflict with Physicians; Inadequate Preparation; Lack of Support; Conflict with Other Nurses; Work Load; and Uncertainty Concerning Treatment (Gray-Toft & Anderson, 1981b). In their initial testing of the NSS with 22 hospital nurses from five patient care units, Gray-Toft and Anderson (1981b) hypothesized that the sources and frequency of stress experienced by nursing staff were as a response to the unit on which they worked. Thus high levels of stress would result in decreased job satisfaction and increased turnover in these work units. The findings from Gray-Toft & Anderson’s study supported the notion that nurse stress was found to have a significant negative effect on both job satisfaction and turnover (Gray-Toft & Anderson, 1981b).

In a later study and in response to major changes in health care delivery and the health care environment, French et al. (2000) expanded on the original NSS (1981), identifying an additional 25 stressful situations that nurses reported as being stressful. From these 25 identified sources of stress, French et al. (2000) determined that 14 questions indicated conceptual fit with five of the seven original NSS subscales; three questions were grouped into a new subscale reflecting discrimination in the workplace and eight questions were grouped into a second new subscale concerning patients and their families. The expanded Nursing Stress Scale (ENSS) (French et al., 2000) including its constructs, is discussed in more detail in Chapter 5.

The following table (see Table 5 below) was developed from the factors and sources of stress identified in the Expanded Nurse Stress Scale (ENSS) (French et
The ENSS provided a means to sort and identify sources of stress as identified and discussed in the nurse stress literature.

Table 5  Expanded Nurse Stress Scale 1

<table>
<thead>
<tr>
<th>Primary Domains</th>
<th>Sources of Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1. Death and Dying</td>
<td>Performing procedures that patients experience as 'painful'</td>
</tr>
<tr>
<td></td>
<td>Feeling helpless in the case of a patient who fails to improve</td>
</tr>
<tr>
<td></td>
<td>Listening or talking to a patient about his/her approaching death</td>
</tr>
<tr>
<td></td>
<td>The death of a patient</td>
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<tr>
<td></td>
<td>The death of a patient with whom you developed a close relationship</td>
</tr>
<tr>
<td></td>
<td>Physician not being present when a patient dies</td>
</tr>
<tr>
<td></td>
<td>Watching a patient suffer</td>
</tr>
<tr>
<td>Factor 2. Conflict with Physicians</td>
<td>Criticism by a Physician</td>
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<tr>
<td></td>
<td>Conflict with a Physician</td>
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<tr>
<td></td>
<td>Fear of making a mistake in treating a patient</td>
</tr>
<tr>
<td></td>
<td>Disagreement concerning the treatment of a patient</td>
</tr>
<tr>
<td></td>
<td>Making a decision concerning a patient when the physician is unavailable</td>
</tr>
<tr>
<td>Factor 3. Inadequate Emotional Preparation</td>
<td>Feeling inadequately prepared to help with the emotional needs of a patient</td>
</tr>
<tr>
<td></td>
<td>Feeling inadequately prepared to help with the emotional needs of a patient's family</td>
</tr>
<tr>
<td></td>
<td>Being asked a question for which I do not have a satisfactory answer</td>
</tr>
<tr>
<td>Factor 4. Problems Relating To Peers</td>
<td>Lack of an opportunity to talk openly with other unit personnel about the problems on the unit</td>
</tr>
<tr>
<td></td>
<td>Lack of opportunity to share experiences and feelings with other personnel on the unit</td>
</tr>
<tr>
<td></td>
<td>Difficulty in working with a particular nurse (or nurses) outside the unit</td>
</tr>
<tr>
<td></td>
<td>Difficulty in working with a particular nurse (or nurses) on the unit</td>
</tr>
<tr>
<td>Factor 5. Problems Relating to Supervisors</td>
<td>Conflict with a supervisor</td>
</tr>
<tr>
<td></td>
<td>Criticism by a supervisor</td>
</tr>
<tr>
<td>Factor 6. Workload</td>
<td>Unpredictable staffing and scheduling</td>
</tr>
<tr>
<td></td>
<td>Not enough time to provide emotional support to the resident</td>
</tr>
<tr>
<td></td>
<td>Not enough time to complete all of my tasks</td>
</tr>
<tr>
<td>Primary Domains</td>
<td>Sources of Stress</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>Too many non-nursing tasks required, such as clerical work</td>
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<td></td>
<td>Not enough staff to adequately cover the unit</td>
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<td></td>
<td>Not enough time to respond to the needs of residents’ families</td>
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<tr>
<td></td>
<td>Demands of resident classification system</td>
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<tr>
<td></td>
<td>Having to work through breaks</td>
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<tr>
<td></td>
<td>Having to make decisions under pressure</td>
</tr>
<tr>
<td>Factor 7. Uncertainty Concerning</td>
<td>Inadequate information from a physician regarding the medical condition of a</td>
</tr>
<tr>
<td>Treatment</td>
<td>patient Fear of making a mistake in treating a patient</td>
</tr>
<tr>
<td></td>
<td>Fear of making a mistake in treating a patient</td>
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<tr>
<td></td>
<td>Feeling inadequately trained for what I have to do</td>
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<tr>
<td></td>
<td>Not knowing what a patient or a patient’s family ought to be told about the</td>
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<tr>
<td></td>
<td>patient’s condition and it treatment</td>
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<td></td>
<td>Being exposed to health and safety hazards</td>
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<td></td>
<td>Being in charge with inadequate experience</td>
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<tr>
<td></td>
<td>Uncertainty regarding the operation and function of specialized equipment</td>
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<tr>
<td>Factor 8. Patients and Their Families</td>
<td>Residents making unreasonable demands</td>
</tr>
<tr>
<td></td>
<td>Residents’ families making unreasonable demands</td>
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<tr>
<td></td>
<td>Being blamed for anything that goes wrong</td>
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<td></td>
<td>Being the one that has to deal with residents’ families</td>
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<td></td>
<td>Having to deal with violent residents</td>
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<td></td>
<td>Having to deal with abusive residents</td>
</tr>
<tr>
<td></td>
<td>Having to deal with abuse from patients’ families</td>
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<tr>
<td></td>
<td>Not knowing whether residents’ families will report your for inadequate care</td>
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<tr>
<td>Factor 9. Discrimination</td>
<td>Being sexually harassed</td>
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<tr>
<td></td>
<td>Experiencing discrimination because of race or ethnicity</td>
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<tr>
<td></td>
<td>Experiencing discrimination on the basis of sex</td>
</tr>
<tr>
<td>10. Other Factors</td>
<td>Work-home life imbalance</td>
</tr>
<tr>
<td></td>
<td>Inequitable and inadequate</td>
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<tr>
<td></td>
<td>Declining number of qualified nurses</td>
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<tr>
<td></td>
<td>Lack of autonomy and control in the workplace</td>
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<td></td>
<td>Little opportunity to give quality nursing care</td>
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<tr>
<td></td>
<td>Low level of organizational support</td>
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<tr>
<td></td>
<td>Low job satisfaction</td>
</tr>
</tbody>
</table>


In a study of Queensland Nurse Union members, Hegney, Plank and Parker (2006) identified additional sources of nurse stress, classified by the researchers.
as extrinsic and intrinsic work values (see Table 6). The extrinsic and intrinsic work values identified by Hegney, Plank and Parker (2006) confirm the factors identified in French et al. (2000) Expanded Nurse Stress Scale (ENSS) (French et al., 2000).

Table 6 - Intrinsic and Extrinsic Nurse stress FACTORS 1

<table>
<thead>
<tr>
<th>Intrinsic Work Values</th>
<th>Emotional challenges of nursing work</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Physical demands of nursing work</td>
</tr>
<tr>
<td></td>
<td>Morale</td>
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<tr>
<td></td>
<td>Value of nursing work</td>
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<tr>
<td></td>
<td>- value by community</td>
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<tr>
<td></td>
<td>- value by health system</td>
</tr>
<tr>
<td></td>
<td>Rewards for skills and experience</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extrinsic Work Values</th>
<th>Remuneration- rate of pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rewards for skills and experience</td>
</tr>
<tr>
<td></td>
<td>Working Conditions</td>
</tr>
<tr>
<td></td>
<td>- Working hours</td>
</tr>
<tr>
<td></td>
<td>- Colleague support and teamwork</td>
</tr>
<tr>
<td></td>
<td>- Equipment</td>
</tr>
<tr>
<td></td>
<td>- Unsafe workplace</td>
</tr>
<tr>
<td></td>
<td>Perceptions of nursing as a career</td>
</tr>
<tr>
<td></td>
<td>- Nursing career prospects</td>
</tr>
<tr>
<td></td>
<td>- Career status</td>
</tr>
</tbody>
</table>


Hegney, Plank and Parker (2006) found that nurses perceived their workload as being heavy; their skills and experience were poorly rewarded; their work stress as high; their morale as poor and deteriorating; the skill mix at the workplace often inadequate; and the majority of nurses were unable to complete their work in the time available to them. Nursing morale was associated with autonomy; workplace equipment; workplace safety; teamwork; work stress; the physical demand of nursing work; workload; rewards for skills and experience;
career prospects; and status of nursing and remuneration. Similar sources of stress and morale occurring in nurses were also identified in a systematic review of the literature by Chenoweth et al. (2010).

The theoretical assumption of the extrinsic and intrinsic values that impact on a person’s morale is the congruence, or fit, between a person and their work and is an important predictor of work experiences (Taris & Feij, 2001). However, there is a 'saturation' point with regard to one’s value assumptions, in those adverse outcomes where feelings of stress may occur once a person's perception of their value, or worth, has been reached. Assuming Taris and Feij’s (2001) observations regarding 'saturation' as the catalyst for feelings of stress, the extrinsic and extrinsic values identified by Hegney, Plank and Parker (2006) may become sources of stress for some direct care staff should their point of saturation be exceeded.

The factors that are associated with nurse stress are included in the Expanded Nurse Stress Scale (ENSS) (French et al., 2000). These factors are identified in turn.

3.4.5.1. Emotional Work, e.g. Death and Dying

It is well documented that the work of caring can be a source of stress. Stress experienced by nurses and direct care staff can be due to caring for people with severe illnesses and disabilities and people who are terminally ill, as well as helping older people, their families and friends deal with illness and death. These stresses are amplified in the supported aged care accommodation sector as direct care staff provides care to residents through the transitional stages of later life to the end of life. Accordingly, nurses and other direct care staff often form long-term relationships with the older people, in some instances perceiving themselves as the older person’s family, and thus the terminal care of an older person has the potential to become a personal experience (Hanson, Henderson & Menon, 2002).
The emotion of caring is, therefore, stressful for some nurses and direct care staff (Gattuso & Bevan, 2000; Maslach, 2003; Mann 2005; Sabo, 2006). Despite the lack of consensus on the concept of caring (Watson, 2009), Kim (2010) posits that caring has two components: an activity and an attitude (Kim, 2010). When applied to caring in the supported aged care accommodation setting, the ‘activity’ of caring is mediated by the direct care staff-resident relationship through personal contact in the activity of providing personal care. The attitude aspect of caring is viewed as a complex phenomenon, involving cognitive, moral and emotional factors (Kim, 2010).

Chandler, Madison, and Han, (2005) argue that the concept of caring is in conflict with institutional and economic pressures of the health care business model. This argument supports the view of direct care staff themselves, who see that the caring role is degraded by using terms such as ‘multi-skilling’ to describe the contribution of direct care staff to the complex health care system (Aiken et al., 2008). Consequently, direct care staff perceive this issue as an erosion of their opportunity to implement both the activity and attitude aspects of caring when expected to focus on efficiency, rather than effectiveness. The additional demands being placed on nurses and other direct care staff to maintain efficiency, has seen the lowering of standards of care and a rise in the emotional cost of caring, with an associated international exodus of nurses, in particular (Duffield, et al., 2007; Aiken et al., 2008). This more recent shift from the caring nature of nursing work to a more technical and supervisory role, has given rise to stress and disenfranchisement in nurses (King et al., 2012).

In a review of nursing work within the predominantly female environment of supported aged care accommodation, Richardson and Martin (2004), Martin and King (2007), Gattuso and Bevan (2000) and King et al. (2012) argued that conflicts around issues of care, whether triggered by intra-psychic, interpersonal or structural factors, are particularly salient for women and that they add to the strains of emotional labour in supported aged care accommodation work. The authors found that the high levels of stress among nurses and other direct care
staff respondents was related to conflicts experienced in balancing caring and efficiency demands and the difficulties in managing emotions. In the organizational culture of supported aged care accommodation work as was experienced by these women, emotions such as frustration, anger and grief found little support and hence, staff involved in nursing work must labour to shield such emotions from managers, peers and older people (Gattuso & Bevan, 2000).

3.4.5.2. Conflict with Doctors

A significant source of stress in nursing work is conflict with physicians (Tabak & Koprak, 2007), where the individual’s ability to resolve conflict with a physician is dependent on the position held by the nurse and direct care staff and the type of strategies they use. Some strategies used may in fact cause further stress. The authors found that nurses who held senior positions and used dominance to resolve conflict were more likely to achieve successful outcomes. Using obliging and avoidance approaches were found to be linked to higher stress (Tabak & Koprak, 2007). Jackson, Clare and Mannix’s (2002) systematic literature review revealed disturbing evidence of workplace violence within Australian health care culture, mainly in the acute care setting, including verbal aggression by doctors towards nurses and a workplace rife with a wide range of violent incidences. These included patient, visitor and doctor to nurse aggression to the seemingly systemic ‘horizontal violence’ of peer bullying and aggression. Indeed, Jackson et al.’s (2002) survey respondents appeared to accept such violence as integral to the nursing workplace. This workplace violence was found to be as a significant detractor to recruitment and retention of nursing staff and impacted on patient outcomes (Jackson et al., 2002).

Hegney et al.’s (2006) comparisons of a 2001 and 2004 survey of Queensland supported aged care accommodation service nurses reported an increase in incidences of workplace violence reporting and some significant differences across the supported aged care accommodation service sector and in the sources
of violence. Hegney et al.’s findings were significantly higher than international figures of workplace violence (Hegney et al., 2006). Supported aged care accommodation service nurses and direct care staff reported both the highest general incidence and the highest increases of workplace violence, and nurses employed in private facilities reported the highest level and increase of violence from medical practitioners. Hegney et al. (2006) considered the possibility that Queensland Health’s zero tolerance of violence policy, combined with a heightened awareness of the range of violence definitions, may have resulted in increased reporting, but concluded this effect to be minimal.

### 3.4.5.3. Inadequate Emotional Preparation

Feeling inadequately prepared to help with the emotional needs of both an older persona and their family and being unable to provide a satisfactory answer to a question are contributing stressors for nurses and direct care staff (Gray-Toft & Anderson, 1981a; French et al., 2000). The need to balance the physical and emotional well-being of older people was found by Edberg et al. (2008) to have a negative effect on aged care nurses and other direct care staff. Edberg et al.’s (2008) exploration of nurses and care staff’s experiences of strain in dementia care, found that they that did not have the resources, opportunities or ability to provide emotional care to the older person and their family and were more likely to experience strain.

In a study investigating nurses’ and care staff’s stress associated with the families of older people living in assisted care, Bauer (2006) found that conflict between families, nurses and care staff may arise when there is a divergence of care expectations, particularly when families wish to maintain control of the care provided to the older person (Bauer & Nay, 2003). A lack of collaboration, including ineffective communication between nurses and care staff and family members, has the potential to result in negative family-staff relationships, which can give rise to stress in nurses and other direct care staff (Bauer, 2005).
Abrahamson, Suitor and Pillemer (2009) examined staff burnout and conflict occurring between the families of older people in assisted care and a representative sample of North American nursing home staff (n = 655) from 52 randomly selected Central New York nursing homes. Staff and family conflict was measured using the Frequency of Interpersonal Conflict scale developed by Pillemer and Moore (1988) which was reported to have an alpha of 0.86. Staff members were asked to report the frequency from 1 ‘enough time’ to 3 ‘very short time’ of any conflict that they may had with family members in relation to personal care, meals and food, administrative rules, laundry and clothing, resident appearance, toileting, and attentiveness to needs. The researchers found that conflict with family members increased staff burnout and decreased staff satisfaction (Abrahamson, Suitor & Pillemer, 2009). Interpersonal conflict was found to decrease when there was evidence of mutuality regarding expectations, and to increase when staff did not have enough time to provide care to the families’ relative (Abrahamson, Suitor & Pillemer, 2009).

Por’s (2005) comparative descriptive design pilot study of a convenience sample of 67 nursing students found that inadequate emotional preparation was perceived to be the most stressful issue for these students. These findings suggest that inexperienced nurses and direct care staff are perhaps more susceptible to emotional stress compared to more experienced nurses and direct care staff. Humpel and Caputi (2001) explored the emotional competency of Australian mental health nurses and work stress. The authors found that those nurses within excess of six years of experience had higher levels of emotional competency, particularly female nurses. In a slightly earlier study conducted by Katz, Sidell and Komaromy (2000), managers reported lacking the capacity to provide appropriate bereavement support for older people, their families and direct care staff. The authors suggested the need to implement effective training and communication programs to strengthen managers’ levels of emotional resilience (Katz, Sidell & Komaromy, 2002).
3.4.5.4. Problems relating to peers

Conflict among co-workers and/or among nurses, care staff and others, such as administrators, has been identified as a significant issue resulting in staff stress (Almost, 2006). Conflict is defined as a ‘process involving two or more people where one perceives the opposition of another’ (Almost, 2006, p.447). Almost (2006) discusses conflict from a theoretical model of antecedents and consequences. In this model, conflict antecedents stem from: individual characteristics of value differences and demographic dissimilarity; interpersonal factors including lack of trust, injustice or disrespect, inadequate or poor communication; and organizational factors of interdependence and changes due to restructuring.

In Almost’s (2006) study the consequences of workplace conflict for nurse participants included the individual effects of work stress, job dissatisfaction, absenteeism, intent to leave, increased grievances, psychosomatic complaints and negative emotions. Negative interpersonal relationships leading to conflict in the workplace related to the negative perception of others, hostility and avoidance, whereas positive interpersonal relationships resulted in stronger relationships and team cohesiveness (Almost, 2006). The organizational-level conflict situations led to impaired coordination and collaborative efforts among staff and also reduced productivity. The mediating factors between the antecedents and consequences of conflict related to the individual conflict management style and individual perceptions of the conflict situation. Almost (2006) suggests that long-term workplace conflict results in staff stress and consequently negative health outcomes.

3.4.5.5. Problems Relating to Supervisors

For staff feeling stressed in the workplace, mechanisms to cope with stress are more frequently derived from external sources, such as supervisor recognition and support, rather than sources internal to the nurses themselves (Coffey, 1999; McGilton & McGillis Hall, 2007; Karantzas et al., 2012). McGilton and
McGillis Hall (2007) investigated the effects of supervisory support on job stress and job satisfaction in a convenience sample of 222 Canadian nurse assistants from ten supported aged care homes. The researchers found higher levels of supervisor support were associated with lower job-related stress and lower job satisfaction (McGilton & McGillis Hall, 2007).

In a study to examine factors that impact on the intention to resign from the current workplace Karantzas et al. (2012) found that supervisor support was an intermediate variable for the indirect association between work stressors and job commitment ($b = 0.20, p < 0.01$) and was negatively related to work stress ($b = 0.18, p < 0.01$) and thus the intent to leave. Karantzas et al. (2012) suggests that mediating stress through increased supervisor support will influence the intention of direct care staff to resign.

From a survey of 79 forensic community mental health nurses across England and Wales, Coffey (1999) affirms that nurses' abilities to manage their stress is largely dependent upon the support of their peers and supervisors. However, direct care staff who are stressed by work may not always be aware of the importance of mediating their stress through their supervisor's or manager’s support (Coffey, 1999).

Support provided by older nurses to younger nurses increased levels of knowledge and skills of younger nurses (Watson, Manthorpe & Andrews, 2003; Gillies, 2006). The support provided by nurses who are older and more experienced may also have a positive effect on younger and less experienced nurses who may be experiencing stress (Gabrielle, Jackson & Mannix, 2008). In a qualitative study conducted by Gabrielle, Jackson and Mannix (2008) of older Australian hospital nurses ($n = 12$), study participants justified their professional value, perceiving themselves as good nurses who contributed to the learning and skill development and support of other nurses. Nurse participants were of the belief that a combination of maturity and experience enhanced both their perspective of nursing work and nursing competencies. Thus, the nurses who
believed they were good nurses had greater confidence in their ability to mentor and support younger nurses (Gabrielle, Jackson & Mannix, 2008).

This raises the question of what nurses mean by the term 'good nurse' and its applicability to a nurses' perception of their self-worth and ability to provide support. The term 'good nurse' is largely unexplored (Smith & Godfrey, 2002). From a qualitative study of American nurses (n = 53), Smith and Godfrey (2002) posited a tentative explanation suggesting that a good nurse is related to the ethics of nursing and this statement is intrinsically imbedded in the wholeness of each nurse, including factors of personal and professional characteristics, patient centeredness, advocacy, competence, critical thinking and patient care.

It appears that the respondents in Gabrielle, Jackson and Mannix’s (2008) study who described themselves as good nurses placed a high value on their personal attributes by virtue of the persons they deemed themselves to be. This concept was also identified in a nurse workforce study by Venturato, Kellett and Windsor (2007). Given that work-related support is a significant factor in predicting work stress in nurses (Coffey, 1999), it could well be that without the support, mentoring and training provided by older nurses who perceive this to be an important aspect of their professional role, younger inexperienced nurses might more likely experience increased levels of stress without such support and guidance.

3.4.5.6. Workload

Issues with the sufficiency and stability of nurses worldwide are occurring at a time when nursing authority is decreasing (Preston, 2009). Nurses have reported their dissatisfaction with the pace of change in working conditions, leading to poorer recruitment and higher attrition (Keenan, 2003; Duffield & Roche, 2007; Flinkman et al., 2010). Problems in nurse and direct care staff recruitment and retention in Australia (Hegney et al., 2006; Pearson et al., 2006; Chenoweth, Jeon, Merlyn & Brodaty, 2010) have been exacerbated in supported aged care accommodation services (RACFs) by increasingly complex care demands, very
high workloads, poor workplace conditions, lower professional and community status and poor pay parity (Australian Government, 2009; Sargent et al., 2009). Registered nurse and enrolled nurse attrition in this sector is associated with under-resourcing and unsupportive management systems (Horner & Boldy, 2008; Thornton, 2012; Tuckett et al., 2009).

National Institute of Labour Studies (2008) data comparing the supported aged care accommodation workforce in 2007 with 2003, showed a total workforce growth from 76,006 to 78,849 (full time equivalent) to meet the growing bed requirements in the sector, but a concomitant fall in registered nurse numbers from 21 per cent to 17 per cent and in enrolled nurses from 14 per cent to 12.5 per cent, impacting significantly on their workload and job satisfaction (Sargent et al., 2009). Challenged by poor staffing ratios and skill mix and inadequate resources, nurses and direct care staff struggle to deliver high quality care for people with increasingly complex co-morbidities in all health settings (Tuckett et al., 2009).

Work tasks within a nurses practice area have a direct relationship on nurse' perceived levels of stress (Duffield and O'Brien-Pallas, 2002). Excessive workloads for nurses have been found to be a significant predictor of stress potentially leading to emotional exhaustion (Laschinger & Leiter, 2006). Duffield and O'Brien-Pallas, (2002) argue that workloads for nurses in the acute care sector have increased as a result of substantial changes in the nurse work environment including changes to patient mix and acuity, restructuring of health services, bed shortages, staff shortages, and economic containment. One of the issues for nurses is that there is no standardised agreement on nurse to patient workload requirements for different health settings, or any objective measurement of nurse workload. Duffield, Roche and Merrick (2006) suggest that nurses may not be working 'harder' they may be working more efficiently.

In an Australian aged care sector study (Richardson & Martin, 2004), 53.6 per cent of the registered nurses felt work pressure, with 22 per cent strongly
agreeing with the statement that ‘I feel under pressure to work harder in my job’. Similarly, 44.8 per cent of assistants in nursing reported feeling pressure to work harder, 16.4 per cent of nursing assistants strongly agreed with the statement that ‘I feel under pressure to work harder in my job’. Conversely, 39.2 per cent of this cohort did not feel they were under pressure to work any harder, whilst 22 per cent were unsure of how they felt (Richardson & Martin, 2004). In a later nurse satisfaction study a fairly high proportion of Australian aged care nurses reported that they were working harder than ever (Chenoweth et al., 2012).

The rapidly changing roles of registered nurses working in supported aged care accommodation in line with the government reform strategies is one reason why these nurses say they are working harder than ever (Chenoweth et al., 2009; 2012). Registered nurses are increasingly required to provide a supervisory role, a role that they may not wish for, or may be inadequately trained for (Dwyer, 2011). Registered nurses also to carry greater organization responsibility, but are stymied by having limited decision-making power. This situation causes nurses undue stress that may decrease job satisfaction and increase the risk of burnout (Duffield et al., 2007; Chenoweth et al., 2012). Additionally, the non-replacement of registered nurses has increased the workload of the remaining registered nurse workforce (Duffield et al., 2007).

A survey of almost 4,000 Australian nurses and 56 survey respondents who participating in focus groups (Chenoweth et al., 2013) confirmed perceptions of increasing nurse workloads across the health and aged care sectors, in relation to the complex care needs of older people. Forty two of the nurse focus group participants who were over the age of 45 claimed they were functioning under higher stress, creating an additional emotional burden at a time when they were less resilient to exhaustion and frustration. These study respondents claimed they were just too tired to keep on working full time, and requested strategic support to stay in their positions part-time to help mentor younger and less experienced nurses (Chenoweth et al., 2013).
The direct care staff in Chenoweth et al.’s (2012) study were concerned about the complexity of recruiting suitable staff to vacant positions, the lack of appropriate available staff to quickly fill positions, qualified nurses not being replaced during the absence of experienced staff, and lack of succession planning for experienced nurses. Flexibility, particularly as it constrains succession planning, was associated with nurse stress and job satisfaction. Experienced nurses claimed they were not taking due leave, even though stressed, and were extending working life for fear that care quality would suffer in the hands of inexperienced and unqualified direct care staff. The main factor giving rise to this source of stress was the influx of highly dependent older people in all care settings without increasing qualified nurse numbers and the skills of other direct care staff (Chenoweth et al., 2012).

An inability to complete work within a given time is a source of stress for many nurses and care support staff (Laschinger, Finegan, Shamian & Thomson, 2001; Budge, Carryer & Wood, 2003). Nurses across most practice areas within the acute care sector, for example, report that for most shifts they are unable to complete work tasks to their satisfaction (Duffield et al, 2007). Inadequate nurse numbers, unanticipated changing acuity of patients, higher levels of casual and agency staff, directly influence nurse’s inability to complete their work within a given time (Chenoweth et al., 2012). The experience of stress as a result of the difficulty of completing ones’ work satisfactorily can negatively influence nurse retention (Duffield et al., 2007). Having insufficient time to complete the requirement of the job work is a real issue in the supported aged care accommodation service sector (Pekkarinen, Sinervo & Elovainio et al., 2008; King et al., 2012).

A large percentage of Australian direct care staff (35%) strongly agreed that they had insufficient time to complete their work within their specified shift (Richardson & Martin, 2004). Only 13 per cent of registered nurses reported that they had insufficient time to complete their work to their satisfaction within a specified time frame, and 40 per cent of this cohort estimated that they spent
less than one third of their time during their rostered shift providing direct care to residents (Richardson & Martin, 2004). Twenty one per cent of assistants in nursing and personal care assistants reported that they had sufficient time to complete their work, but reported that a considerable amount of their time (15.1%) was not related to the provision of direct care (Richardson & Martin, 2004). Research has identified that direct care staff needs to be afforded the right balance of time and work tasks to provide quality care (Richardson & Martin, 2004; Andrews & Wan, 2009).

3.4.5.7 Uncertainty Concerning Treatment

Several explanations are postulated for the stressful experiences for direct care staff arising from the uncertainty of providing treatment to the residents they care for. In the Australian supported aged care accommodation sector, the Aged Care Act 1997 and the Accreditation Standards guidelines legislate that each older person who resides in a supported aged care accommodation service must have a clearly documented and articulated current plan of care for each aspect of their care needs, and the care plan is developed with the input of all stakeholders including the older person, their families and direct care staff (Department of Health and Ageing, 2012). Without an individualized plan of care to provide support for the care needs of older people, direct care staff may lack a sense of direction and certainty in managing the older person’s care needs (Andrews & Wan, 2009).

Another explanation for uncertainty about the treatment (care) requirements of an older person may be due to perceptions of a lack of authority and empowerment in being able to make decisions without the authority and presence of the doctor of the older person. Such situations may arise as a result of a sudden health crisis necessitating immediate attention and intervention from a medical authority. When such interventions are not immediately forthcoming, nurses and direct care staff may feel distressed when unable to alleviate the pain and suffering of the resident (Healy & McKay, 1999). The
existence of a link between the sub-categories ‘conflict with doctors’ and ‘uncertainty with treatment’ may be consistent with the negative professional interactions between care staff and medical staff (Healy & McKay, 1999).

3.4.5.8. Situations with Older People and Their Families

There are two issues that give rise to stress in nurses and direct care staff in relation to their interactions with the families of older people. The first is a need to provide emotional support and advice to families as the older person experiences higher levels of deterioration over time and with a concomitant change in health and care status, sometimes quite dramatically (Stewart, Goddard, Schiff & Hall, 2011). The second issue relates to an increased awareness of the frustration that families feel when the level and quality of service and care they expect for their relative is not provided, given the increasing incidence of low nurse and direct care staff to resident ratios within ever-reducing aged care budgets (Jeon, Merlyn & Chenoweth, 2010).

Admission to a supported aged care accommodation service has long been recognized as an extremely stressful experience for both the older person and their families (Flynn et al., 2005; Gaugler, Mittelman, Hepburn & Newcomer, 2010), thus this decision is not undertaken lightly by family carers (Schur & Whitlatch, 2003; Argyle, Downs & Tasker, 2010). Most admissions to a supported aged care accommodation service are associated with a rapid decline in the health of the family member resulting in an increase in the emotional and physical challenges for the family carer (Gaugler et al., 2010). The major reasons for admission to a supported aged care accommodation service are dementia and behaviors associated with dementia (Miller & Weissert, 2000; Coehlo, Hooker & Bowman, 2007; Gaugler, Duval & Anderson, 2007; Gaugler, Yu, Krichbaum & Wymann, 2009). Distress, anxiety, fear helplessness and loss of control are some of the feelings commonly experienced by family carers with the admission of their family member to a supported aged care accommodation service (Kellet, 1999; Flynn et al., 2005).
Whilst some family members might feel a sense of relief with the admission decision, others may experience a sense of guilt and continue to feel stressed by the change in the family dynamics (Kellet, 1999; Flynn et al., 2005; Argyle, Downs & Tasker, 2010). Guilt felt by close family, such as a child or a spouse of the older person, arises from feelings of personal inadequacy, of not being capable of continuing to provide care, of the social stigma of institutional care and of being “blamed” by their families, friends and community for the decision (Flynn et al., 2005). At times the guilt felt by family members tends to be expressed as complaints about the systems operating in a supported aged care accommodation service and this includes the care provided to their relative (Kellet, 1999; Flynn et al., 2005; Haesler, Bauer & Nay, 2010).

When these aforementioned issues occur, the most important support that direct care staff can provide to the family is reassurance and advice that their relative is receiving the type of care they require at that point of time. Being advised and updated with detailed information about the care needs of older people from the families assists direct care staff to meet the individual care needs of each older person more effectively (Flynn et al., 2005; Bauer and Nay, 2011). A central tenet of providing holistic care in the supported aged care accommodation setting is to provide support to older people and their families and this principle is embodied in the Charter of Residents’ Rights (Haesler et al., 2007; Department of Health and Ageing, 2012).

The emotional involvement in providing reassurance to the families, as well as to the older person who will generally be quite upset at being placed into care, places considerable demands on nurses and direct care staff with heavy workloads and multiple care roles and responsibilities (Chenoweth et al., 2010; Schmidt, 2011). This type of emotional involvement with families and older people alike gives rise to ‘emotional labor’ as defined and discussed by Hochschild (1983). With the requirement to provide support, advice and often counseling for families, direct care staff can experience role conflict in deciding how to choose between meeting the needs of several residents and meeting the
needs of family members who are not coping well having their relative admitted to a supported aged care accommodation service. In some cases relatives continue to feel distressed, find fault and blame direct care staff for the perceived failings of the supported aged care accommodation service (Bauer & Nay, 2003; Haesler, Bauer & Nay, 2011)

A related issue is the wish of family to become more involved in providing care to their older relative. In recent years, the emphasis of providing a more holistic, or person-centred, approach to care has altered the dynamic between nurses and direct care staff, older people and families (Brooker, 2007; Jeon, Luscombe & Chenoweth, 2012). However, some nurses and direct care staff feel uncomfortable with certain aspects of family-assisted care. Families can be viewed as being an obstacle to care provision (Kellet, 1999) and are often prevented from providing care to their relative (Flynn et al., 2005). As a result, conflict between direct care staff and families may arise causing nurses and direct care staff to become stressed leading to burnout (Abrahamson, Suitor and Pillemer, 2009).

Families who are prevented from providing care to their relative, for example assisting them to walk or to toilet, often feel they lack any control in the situation (Graneheim, Johansson & Lindgren, 2013). This is more likely to occur when the family member, often a former carer, is not included in decisions relating to issues of care provision (Gaugler et al., 2004). These family members can become frustrated and angry when unable to participate in these decisions (Flynn et al., 2005). Combined with the mismatch between the expectation of family and the level and quality of care provided for their relative, being prevented from providing care themselves is a cause for family stress, and is often manifest as complaints and criticisms about care. This criticism is a frequent source of stress for nurses and direct care staff, who are also frustrated by their inability to improve both the level and quality of care provided, but feel a professional obligation to protect the older person from unsupervised family care (Edberg et al., 2008).
A more serious cause of stress for nurses and direct care staff is the perceived anger and violence directed at them by the family members of older people. Surveys of Queensland nurses in 2001 and 2004 reporting incidences of workplace violence found an overall increase in incidence reporting in supported aged care accommodation services (Hegney et al., 2006b). When compared to the acute and community care sector study respondents, these nurses and direct care staff reported both the highest general incidence and the highest increases of workplace violence, much of which were derived from older people, especially those older people diagnosed with dementia, and their relatives.

3.4.5.9. Discrimination in the Workplace

Understanding the unique characteristics of nurses and direct care staff is of vital importance in understanding the issues and pressures that individuals and particular nurse and direct care staff cohorts may encounter in the workplace (King et al., 2012). Nurses and direct care staff may experience stress as a result of conflict arising from racial and ethnic disparities (Leininger, 1991; Berdes & Eckert, 2001; Ramirez, Teresi & Holmes, 2006). People with various ethnicities and cultures are thought to hold disparate beliefs, which reflect their life views and world perspectives about these issues (Leininger 1991). Where personal traits of direct care staff, for example, ethnic origin, language and religion are not congruent with those of the older person, factors relating to poor communication, misunderstandings and conflictual relationships may arise for all direct care staff and the older person (Leininger, 1991; Chenoweth, Jeon, Goff & Burke, 2006).

Studies relating to cultural diversity and ethnicity in the direct care staff workforce have gained increasing attention in the United States and other developed countries including Ireland, Italy and North America (Ramirez, Teresi & Holmes 2006, Doyle & Timonen, 2009; Chenoweth et al., 2006). Racial diversity is increasingly evident within many American urban areas (Ramirez, Teresi & Holmes, 2006). In Australia, nurse assistants and personal carers have the most
contact and perform the most intimate personal care for older people (Martin & King, 2007), thus, this care cohort is reported as the most likely group of all direct care staff to experience work stress in relation to overt or perceived racism from older people (Ramirez, Teresi & Holmes, 2006).

In a probability sample of 22 New York State nursing homes and 104 nurse assistants across two separate twelve month periods, Ramirez, Teresi and Holmes (2006) identified racial tensions arising from verbal insults and other forms of derogatory language towards these direct care staff of different ethnic groups. These occurrences contributed to feelings of stress in the nurse assistants receiving verbal abuse. This study measured direct care staff to resident ratios, number of confused residents with behaviours that direct staff found difficult to handle, number of hours direct care staff worked in the unit and type of shift rotation worked. The data revealed a positive association between direct care staff stress related to racism and a sense of demoralization. There was a direct association between work-pressure stress, racist remarks by aged care residents and particular ethnic direct care staff groups including which was higher for Jamaican and Haitian direct care staff cohorts (Ramirez, Teresi & Holmes, 2006).

Ramirez, Teresi and Holmes (2006) used their study findings to assist ethnic direct care staff in learning how to protect themselves from racism by aged care residents. Direct care staff attended in-service support meetings to help work through these issues, however the direct care staff felt stressed and demoralized by attending the support group meetings for two reasons. The first related to the demand made on their time and energy to attend support meetings and the second was the requirement to voice and work through the issues involved with negative interactions with residents (Ramirez, Teresi & Holmes, 2006). Thus, attendances at support meetings to ameliorate the potential negative emotional and psychological outcomes of the situation were not perceived as a positive experience for most direct care staff that experienced racism from residents.
Perceived lack of value and respect for direct care of staff is evident in migrant direct care staff cohorts (Berdes & Eckert, 2001; Doyle & Timonen, 2009). From qualitative semi structured interviews of a convenience sample of 40 migrants employed in the Irish long-term care sector, Doyle and Timonen (2009) found that the experiences of European, South Asian and African migrant direct care staff were significantly different from other direct care staff. In Doyle and Timonen’s (2009) study, all but one South African direct care staff had experienced some form of racism or prejudice. Doyle and Timonen (2009) suggest that some migrant direct care staff cohorts are more likely to experience discrimination than other direct care staff cohorts. For example, African direct care staff was reported to have experienced the highest levels of prejudice and discrimination that were perceived by these staff as being largely racist.

Racial diversity is also quite evident within the Australian direct care staff workforce (Martin & King, 2008; King et al., 2012). In their 2012 workforce survey, King et al. (2012) reported on both men and care workers that spoke a language other than English were more likely to experience discrimination in their place of work. For 24 per cent of the total Australian migrant population English is not the primary language spoken at home (Australian Bureau of Statistics, 2012). As with the American direct care staff cohort identified in the study of Ramirez, Teresi and Holmes (2006), most Australian older people who live in supported aged care accommodation services are predominately of European extraction (Australian Bureau of Statistics, 2011) of which 85 per cent are women. It is therefore more likely that the experiences of discrimination for both men and direct care staff with English as a second language arise from mainly older Australian-born women (King et al., 2012).
3.4.6. OTHER STRESSORS RELATED TO THE JOB

3.4.6.1. Work-Home Life Imbalance

The ability to balance the demands of family and work are significant issues of stress for many direct care staff (Richardson & Martin, 2004). Over 70 per cent of the Australian direct care staff workforce surveyed in 2003 by Richardson and Martin (2004) had families, 45 per cent of whom provided care for household members of which 20 per cent provided in excess of forty hours per week of direct care. Of this cohort, 53 per cent worked flexible hours across a range of shifts to meet family demands and worked part-time hours to assist with balancing family and work. As previously stated, a large proportion of the Australian direct care staff workforce are women ($n = 94\%$) (Richardson & Martin, 2004) who are frequently designated as the primary person responsible for and undertaking the family carers' role. Thus, for many direct care staff, workplace flexibility and support is of vital importance to ensure that these staff are able to fulfil their various personal responsibilities and commitments (Cohen-Mansfield & Bester, 2006; Andrews & Wan, 2009; King et al., 2012).

Despite the overwhelming personal and work responsibilities, a total of 60 per cent of registered nurses in Richardson and Martin’s 2003 survey (Richardson & Martin, 2004) indicated their satisfaction with the flexibility available in their employment to balance both work and non-work commitments. Whilst these findings provided a positive picture of balance of work and family commitments through hours of work and job security, these direct care staff were only able to achieve their levels of satisfaction through part-time work. There is also evidence to suggest that those direct care staff who work part-time are more likely to experience higher levels of stress than direct care staff who work full-time because of the pressure of full-time family commitments as well as part-time work (King et al., 2012).

Stress also occurs in those direct care staff who work very long hours and work regular overtime (Velayudhan & Gayatridevi, 2012). To some extent the
requirement for direct care staff to work longer hours arises from workforce shortages in all health settings (Duffield et al., 2007). However, many direct care staff on low wages actively seek to work longer hours to cover the rising cost of living (King et al., 2012).

In the supported aged care accommodation service setting the potential for medication incidents is extremely high due to a number of factors, including time constraints associated with high direct care staff workloads (Tariq, Georgiou and Westbrook, 2012). Medication management issues represented the fifth highest sources of formal complaints for the supported aged care accommodation service sector (Department of Health and Ageing, 2012).

In an Australian study of direct care staff, Richardson and Martin (2004) found that eighteen per cent of registered nurses were not happy with their hours of work and a further 9.5 per cent were either mildly dissatisfied (5.4%) or mainly dissatisfied (4.1%). On the other hand in this same study, 60 per cent of assistants nurses indicated they were satisfied with being able to maintain a balance of flexibility to meet work and non-work commitments (Richardson and Martin, 2004). Andrews and Wan (2009) suggest that in order to address future direct care staff workforce issues, supported aged care accommodation service providers may need to address work policy issues to assist direct care staff achieve the balance of work they desire when faced with family and other demands on their time (Andrews and Wan, 2009). The findings identified in Richardson and Martin’s (2004) study continue to be evident and are similar to the more recent studies conducted by Martin and King (2008) and King et al. (2012).

3.4.6.2. Inequitable and Inadequate Job Remuneration

Lack of recognition of their work through inadequate monetary remuneration is stressful for a large number of direct care staff (King et al., 2012). The Australian direct care workforce has been reported as being poorly paid, in part due to the fact that this workforce primarily consists of women (Richardson & Martin, 2004;
Martin, 2007; King et al., 2012). For many years and on many levels, women have traditionally been deprived of equal earnings to the earnings paid to men (Barón & Cobb-Clark, 2010). Combined with this issue, is the fact that Government under the Aged Care Act, (1997) implemented and continues to maintain a level of cost containment through their funding to supported aged care accommodation services (Access Economics, 2011). Providers of supported aged care accommodation services are accordingly placed under strong pressure to either control or reduce costs (Martin, 2007). The inadequate funding level paid to supported aged care accommodation services has a direct impact on paid remuneration to direct care staff.

Motivation for monetary compensation for work is an inherent factor for all workers in all countries. In a 2012 study of the Australian direct care workforce, King et al. (2012) identified approximately 10 per cent of all direct care staff had more than one job. The need to seek additional employment and hours of work was associated with the low full-time employment rate of all direct care staff as only 28 per cent of this workforce had permanent full-time employment (registered nurses, 19.3%; enrolled nurses, 10.5%; personal care assistants, 6.9%; and allied health, 12.0%) with most direct care staff (71%) working permanent part-time (registered nurses, 61%; enrolled nurses, 74%; personal care assistants, 73%; Allied Health, 62.9), and the remainder (18.7%) working on a casual or contract basis (King et al., 2012).

In a study of Indian nurses, Velayudham & Gayatridevi, (2012) found that nurses who were poorly paid are more inclined to work excessive hours of overtime in order to support their homes and families whilst maintaining a reasonable standard of living. In Velayudham & Gayatridevi’s study, working overtime was found to have a concomitant negative effect on the health of direct care staff (Velayudham & Gayatridevi, 2012).

King et al. (2012) found that direct care staff continued to be dissatisfied with their pay they received for the work of caring. These findings had been identified
in the earlier studies reported by Richardson and Martin (2004) and Martin and King (2007). Richardson and Martin (2004) found that 18 per cent of Australian registered nurses were ‘totally dissatisfied’ with their remuneration for work (Richardson and Martin, 2004). As well, in Chenoweth et al.’s (2013) survey and focus group study of qualified Australian direct care staff there was great dissatisfaction expressed by direct care staff with regard to the marked wage disparity for them and the wages provided to acute care and community-based nurses with commensurate levels of expertise and responsibility. Martin (2007) also argues that whilst registered nurses’ remuneration reflects the Australian workforce generally, it remains lower than that of registered nurses in the acute care sector (King et al., 2012).

Similarly, Richardson and Martin (2004) found that Australian assistant nurses (51.0%) also expressed dissatisfaction with their pay and 21 per cent of this cohort claimed to be ‘totally dissatisfied’ (Richardson & Martin, 2004). The negative issues of working part-time and insufficient earning capacity for all direct care staff was found to be continuously offset by their satisfaction and commitment to the work of caring (Richardson & Martin, 2004; Martin & King, 2007; King et al., 2012).

Dissatisfaction with pay is similar to the findings of a larger cohort study of 1,579 mostly female (84%) American nurse aides conducted by Castle, Engber, Anderson and Men (2007). Castle et al. (2007) examined job satisfaction of nurse aides using the nursing home nurse aide Job Satisfaction Questionnaire (Castle 2007) specifically designed for their study. While the low respondent response rate (50%) might have biased the study findings, the nurse aide respondents’ low levels of satisfaction with remuneration for their work are an issue of concern. These findings concur with Richardson and Martin (2004) 2003 survey and King et al. (2012) 2012 Australian workforce survey of assistant nurses who, although possibly having higher levels of education than their North American counterparts also reveal dissatisfaction with remuneration for their work.
Another source of dissatisfaction with wage inequity in this female dominated health care sector is that women with similar education qualifications and experience to that of men continue to receive less remuneration than men for the same work (Martin, 2007). It is evident that remuneration is an essential aspect of the lives of all paid workers including those persons who work in the aged care industry (Richardson & Martin, 2004; Martin & King, 2007; King et al., 2012) and is a source of stress when perceived as inadequate for the level of work effort given.

3.4.6.3. Declining Number of Qualified Nurses

Another factor that gives rise to nurse and direct care staff stress, previously identified, is the declining number of registered nurses and enrolled nurses who comprise the supported aged care workforce. From a comparative analysis of three supported aged care workforce surveys, Richardson and Martin (2004), Martin and King (2007) and King et al. (2012) revealed a considerable amount of movement within the trajectory of the nurse and direct care staff workforce between the reported surveys of 2004 and 2007 and 2012 respectively. The total direct care workforce increased from 156,823 in 2003, to approximately 175,000 in 2007 and 202,344 in 2012, an overall growth of 29 per cent. However, whilst this workforce growth is representative of the direct care staff workforce generally, King et al. (2012) identified a decrease in the proportion of direct care staff that provided direct care to older people from 76 per cent in 2007 to 73 per cent in 2012. In King et al.’s (2012) 2012 survey report, the largest direct care staff workforce increase was evident within the personal care cohort (assistant nurses and personal carers) though this was slightly less than was reported in the 2003 to 2007 reporting period (an increase of 15,566 for 2007 to 2012; and 17,500 for 2003 to 2007 respectively). Conversely, whilst a reduction in registered nurses continues to be evident, with a decrease of 483 registered nurses between 2007 and 2012, this is considerably less than when compared to a decrease of 1,600 registered nurses during 2003 to 2007 reporting periods.
It is evident that one of the issues for registered nurses and enrolled nurses is the continued decline in their numbers as a result of government fiscal policy and aged care provider decisions, resulting in their replacement with unqualified assistant nurses and personal care workers. This is especially the case in low level supported care accommodation services (Department of Health and Ageing, 2012; Gargett, 2010). Consequently, the economic changes being driven by the government’s ‘Living Longer, Living Better’ (2012) aged care reform package suggests a lower funding base for all supported aged care accommodation services at a national level (previously discussed in chapter 2). This financial deficit for supported aged care accommodation services will for the most part be offset by a reduction in the total number and the hours of employment for registered and enrolled nurses (International Economics, 2012).

At the same time, for some aged care providers, the loss of revenue engineered through a lowered funding base, combined with current increased running costs, is expected to place significant pressures on the ability of provider to attract and retain a suitably qualified direct care staff workforce (International Economics, 2012). The findings of the Productivity Commission (2011) alerted the Australian government to the risk to service quality, and ultimately resident outcomes, arising from registered and enrolled direct care staff workforce shortages (Australian Government Productivity Commission, 2011). These changes are already being felt by direct care staff, and have been identified as factors in their growing stress levels. The major concern of registered and enrolled direct care staff is that their request to managers and senior executive for assistance with workplace shortages and skill-mix are not being heard (Chenoweth et al., 2012).

3.4.6.4. Lack of Autonomy and Control in the Workplace

A degree of autonomy within the workplace is an important source of job satisfaction to most workers (O’Brien-Pallas, Duffield and Hayes, 2006; King et al., 2012). A rigidly structured workplace bureaucracy and decision-making structures will also influence work satisfaction and can be a source of stress for
direct care staff (Richardson & Martin, 2004). King et al. (2012) reported different experiences of workplace autonomy in the direct care staff workforce. In 2012, from a scale of 1 ‘strong disagree’ to 7 ‘I strongly agree’, slightly more than 17 per cent of all registered and enrolled direct care staff indicated they ‘strongly agree’ that they were afforded high levels of work autonomy, an increase of slightly over four per cent from 2007 to 2012. In this same study, just over 11 per cent of personal care assistants indicated they ‘strongly agree’ with having high levels of work autonomy thus representing a smaller increase of slightly over one per cent for the period 2007 to 2012 (King et al., 2012). Interestingly, of all groups of direct care workers, allied health had the highest reported levels of work autonomy (25% in 2007 to 23.9% in 2012). King et al.’s (2012) workforce survey did not distinguish between those personal care assistants that worked in high and low care facilities therefore comparisons between these two cohorts could not be made. Since legislative requirements of skill mix govern mandatory staffing requirements for all high level supported aged care accommodation (Commonwealth Department of Health, 2000), this might have been reflected in personal care assistants perceptions of their lower levels of autonomy in the workplace.

In Australian high level supported aged care accommodation service sector, unregistered direct care staff must be supervised by registered nurses, therefore these direct care staff may not have the same levels of autonomy in their work as the allied health direct care staff. In low care supported aged care accommodation services there is no legal requirement for unregistered direct care staff to have direct supervision from a registered nurse (Commonwealth Department of Health, 2012). Consequently, the different levels of supervision required for personal care assistants who work in both high and low level supported aged care accommodation services may possibly have skewed the results. In other words, there may have been evidence of a higher level of work dissatisfaction in those personal care assistants that work under supervision in high level supported aged care accommodation services.
3.4.6.5. Little Opportunity to Provide Quality Nursing Care

The nexus between constraints on the ability of direct care staff to deliver high quality care caused by insufficient human and material resources, job stress, dissatisfaction with their work and turnover is well established (O’Brien-Pallas, Duffield & Hays, 2006; Castle et al., 2007). There are additional costs associated with stress-related absenteeism and stress and injury-related leave with the use of higher paid agency care staff. Direct care staff stress is directly linked to perceived and actual care standards that direct care staff is able to provide. The major factor associated with this stress is the changing balance of registered and unregistered direct care staff and personal care workers who comprise the direct care workforce (Duffield & O’Brien-Pallas, 2002; Bauer, 2006).

In the Australian supported aged care accommodation service sector, 90 per cent of direct nursing care is performed by unregistered direct care staff under the supervision of one registered nurse (Dwyer, 2011). Substitution of registered nurses with unregistered direct care staff, combined with the increasing frailty, complexity and acuity of older people, is an issue of concern for registered nurses in the acute care sector as well as in the supported aged care accommodation service sector (Duffield & O’Brien-Pallas, 2003). A systematic literature review (LaTrobe University, 2002) of direct care staff satisfaction across all direct care staff practice sectors cited the prevalence of burnout in relation to their inability to provide professional-level care as a serious issue.

As far back as the 1990s, registered nurses reported experiences of stress associated with the added role of supervising the work of other care nurses, and being ultimately responsible for the quality of care being provided by unqualified staff (Garland & Schirm, 1998). Perceptions of inadequate staffing and skills emerged as a strong contributor to direct staff stress and turnover in Schirm et al.’s (2000) series of focus groups with 36 qualified nurses and 65 nurse assistants. Whilst both study groups of staff viewed caring as the most important factor of their work, nurse assistants cited inadequate staffing as the
predominant characteristic affecting the quality of care they could deliver. The association of poor quality of care and inadequate staffing levels was confirmed in qualified nurses’ perceptions of their work. Therefore, satisfaction with care quality was a key factor in intention to stay, and it is evident that staff ratios impact on this issue (Schirm et al., 2000). Schirm et al. found that study participants’ highest recommendation for reducing nurse stress and improving nurse retention was to introduce appropriate education for all nurses that provided both formal skill instruction and on-the-job learning, thus encouraging mutual respect for the work all staff members contributed (Schirm et al., 2000).

Not being able to provide quality care in line with professional standards is accompanied by guilt and anxiety for direct care staff resulted in feelings of being overworked and stress that in turn reduces their self-estimation of worth (Chenoweth et al., 2009; 2012). Numerous studies identify similar issues and conclude that the universality and advanced disenfranchisement of all direct care staff indicates nothing less than substantial structural changes are required to rectify the poor conditions and low morale of these staff (LaTrobe University, 2002). The recommendations from the LaTrobe University (2002) and the Chenoweth et al. (2009) reviews include increasing the number of qualified nurses in the supported aged care accommodation service sector; improve opportunities for direct care staff to provide quality service and to increase the level and quality of targeted training for all levels of direct care staff.

3.4.6.6. Low Level of Organizational Support

The support for care service provision by providers and for direct care staff are powerful factors in job satisfaction including achieving a sense of well-being at work and with work. In their series of hermeneutic-interpretive interviews with 14 qualified direct care staff, Venturato, Kellet and Windsor (2007) found that direct care staff consistently used ‘battle analogies and the language of war’ to describe their working life. These direct care staff reaffirmed the views of 705 registered and enrolled nurses that responded to the earlier La Trobe University
survey study (2002) identifying constant tensions with change, workloads and the needs of stakeholders, conflict between expected tasks and responsibilities, limited authority and autonomy and constant constraints on resources and leadership.

Support in the workplace is a significant factor in predicting stress in direct care staff and is one of a number of adaptive strategies identified by some researchers (Ejaz, Noelker & Menne, 2008) with which a nurse may engage to assist in the management of their stress (Coffey, 1999; Lim, Bogossian & Ahem, 2010). A small number of studies posit that workplace support assists in protecting care staff from physical and mental deterioration (Chang et al., 2006; Lim, Bogossian & Ahem, 2010).

Informed by Kanter’s theory of workplace empowerment, DeCicco, Laschinger and Kerr’s (2006) non-experimental, mailed survey with a random selection of 79 qualified aged care nurses and 75 nurse assistants found strong support associations between perceptions of structural and psychological empowerment, feelings of management respect and reduced staff stress levels. Of the two, structural empowerment proved a stronger predictor than psychological empowerment in both feelings of respect and happiness at work. DeCicco et al. (2006) attributed levels of empowerment to management support.

One of the key factors in direct care staff workplace satisfaction is the perceived and actual management support provided to them (Upentieks, 2002; Wagner, 2006; Kramer, Maguire & Brewer, 2011). Feeling valued by the organization emerged as a significant theme in a web-based survey completed by 54 per cent of nursing staff from 14 USA hospitals, along with perceptions of organizational integrity with a trustworthy upper management that involved employees in decision making and providing effective leadership (Wagner, 2006). Recognising the value of direct care staff was a common theme in a support program that gave anecdotal nurse reports of successful outcomes as discussed by Hoban (2001) cited in Centre on Ageing (2003). The Public Affairs section of the Illinois
Long Term Care Council ran a multi-media promotional campaign called *Heroes Have Many Faces* which linked personal work stories of four direct care staff to national heroes. This campaign resulted in 600 employment inquiries (Hoban, 2001). The impact for the staff in Hoban’s 2001 study was the sense of being valued in the workplace, which was associated with workplace satisfaction and support.

Even amongst studies that do not focus directly on direct care staff overload, stress and burnout, few fail to mention the key factor of management support in relation to the problems of direct care staff retention. Buchanan and Considine’s (2002) project ‘Stop Telling us to Cope!’ conducted focus groups with 87 randomly selected exited nurses and 11 nurse union representatives. The results summed up the frustrations expressed by the 30,000 plus Australian nurses who had exited the profession over the past few decades. The authors concluded that the problems were not with the actual nursing role *per se*, but systemic management issues emerging from the paradigm shift that saw health care assuming a business ethos. This changing focus in Australian health services has led to more stressful working conditions for direct care staff, whilst reducing the intrinsic rewards that originally attract people to the care workforce (Buchanan & Considine, 2002; Chenoweth et al., 2010).

The substantial report by La Trobe University (2002) of 705 completed work exit questionnaires from qualified nurses who had worked in aged care services identified profoundly low job satisfaction as the most powerful themes. The surveys with non-returning qualified nurses found they were not attracted to return to the sector without major changes to working conditions, a need echoed in the study’s forums with representatives from peak bodies and professional and provider groups.

Evidence within the literature suggests that direct care staff who are feeling stressed and under-valued will leave the workforce (Aiken et al., 2002; Hegney et al., 2006; Duffield et al., 2009; Chenoweth et al., 2012). Direct care staff report
being less able to provide professional-level nursing services because of the high resident/patient to staff ratios (Aiken et al., 2002), the rapid throughput of patients/residents through the health and aged care systems (Chenoweth et al., 2012) and the lack of respect and value they are afforded by colleagues and the public (Richardson & Martin, 2004; Duffield et al., 2007; Martin, 2007; Martin & King, 2008; Blakeley & Ribiero, 2008). The consequences of these negative experiences impact on the general well-being and health status of nurses and can lead to continuing and unresolved stress (Cheng et al., 2000).

3.4.6.7. Low Job Satisfaction

The literature identifies mixed results from studies attempting to link perceived workplace stress with job satisfaction. None-the-less, stress levels at work are consistently linked to job satisfaction for all workers (Safe Work Australia, 2013; Wood, Veldhove, Croon, de Menezes, (2012); as well as for direct care staff (Aiken et al., 2002; Richardson & Martin, 2004; Martin & King, 2007; King et al., 2012). Grieshaber et al. (1995) defined job satisfaction as the ability of the worker to view their work either as being favourable or unfavourable. Moyle et al. (2003) considered the definition posited by Grieshaber et al. (1995) as 'too simplistic' since additional considerations, such as personality, can impact on how one perceives their work. Moyle et al. (2003) suggested that in most instances, work comprises numerous components and/or tasks, thus, some direct care staff may find satisfaction with one aspect of their work, whilst others may not.

The nature and response to workplace stress may differ for each individual depending on their personality, perceptions and previous experiences (Lazarus & Folkman, 1984). To illustrate the effects of stress on an individual, McVicar (2003) described individuals as passing along a continuum of feelings, from a positive state “eustress”, to a negative state “distress”. Therefore, an ability to cope with workplace stress by an individual is largely dependent on the extent to which the individual feels threatened by the stressor, the actions implemented
to reduce the impact of the stressor and the individual’s expectations of their coping abilities (Lazarus & Folkman, 1984). As a result, workplace stress may result or cause productivity losses through poor worker performance, increased absenteeism, work avoidance, poor morale and increased staff turnover (Lazarus & Folkman, 1984).

Letvak & Buck (2008) also found that direct care staffs who are dissatisfied with their work tend to experience lower levels of productivity and have higher levels of absenteeism, provide poorer quality of work to the residents in their care than others who enjoy their jobs, and tend to have higher turnover rates. The experience of high levels of stress experienced by direct care staff is consistently linked to their dissatisfaction with their work (Hegney, Plank & Parker, 2002). Direct care staff that feel stressed with their work role may avoid work responsibilities through absenteeism (Aiken et al., 2002), deliberately avoiding activities, taking shortcuts or making themselves unavailable when actions are required (Grieshaber et. al., 1995). On the other hand, direct care staff who demonstrate higher levels of satisfaction with their work are more likely to remain in the workforce (AbuAlrub, 2004).

An understanding of the fundamental nature of work satisfaction and dissatisfaction is explained by Hertzberg (1966). In the motivation-hygiene theory of work satisfaction/work dissatisfaction, Herzberg (1966) theorises that satisfaction of work arises from the presence of motivation factors and the absence of hygiene factors. Motivating factors, as defined by Hertzberg (1966) include achievement, recognition, the work itself and responsibility, whilst hygiene factors relate to the organization’s policy and administration, supervision, conditions of work, remuneration and status. Thus, recognising, understanding and implementing factors identified within Hertzberg’s (1966) theory may have a positive or desirable effect on direct care staff responses towards their work and their feelings of their work.
The intrinsic rewards of the caring role were found by Chenoweth et al. (2012) to act as motivators for direct care staff to work in the supported aged care accommodation service context. Increased staffing levels, pay parity with other nurse practice settings, supportive clinical supervision, effective education and training, a positive organisational ethos, and family friendly policies were seen as positive motivators of increasing personal values. Both the intrinsic and extrinsic rewards as discussed are essential elements for attracting new and retain existing direct care staff in the supported aged care accommodation service workforce (Chenoweth et al., 2010; Jeon et al., 2010).

The notion of developing positive experiences through empowerment within the work environment is supported by Laschinger et al. (2001). Implementing Kanter’s (1993) organizational empowerment theory to guide a study of 194 male nurses and 210 female nurses investigating work empowerment and work stress, Laschinger et al. (2001) determined that structural empowerment had a direct positive effect on psychological empowerment. High levels of psychological empowerment are reported to have a strong negative effect on work stress (Laschinger, et al., 2001). However, Lashinger et al. (2001) also reported that participants’ stress levels had not directly affected work satisfaction. These findings were confirmed by Healy and McKay (2000), who, in a study of 129 Australian registered nurses examined the possible stress-buffering of job satisfaction, reported that increased levels of job satisfaction were associated with decreased levels of stress and mood disturbance. Thus, for these nurses, high levels of job satisfaction are directly linked to a sense of empowerment in the job (Healy & Mckay, 2000).

3.4.7. SUMMARY OF WORKPLACE STRESS

In the supported aged care accommodation service setting a number of Australian researchers (Robinson & Cubit, 2007; Chenoweth et al., 2009; 2012; Haesler, Bauer & Nay, 2011) identified that direct care staff job satisfaction and stress in the workplace are inexorably linked to the opportunity to deliver quality
care services. Being empowered to influence outcomes for older people is key to
direct care staff satisfaction. These studies have all found that nurses and other
direct care staff struggle to deliver quality care for older people with increasingly
complex comorbidities when challenged by insufficient staffing ratios, skill mix
and inadequate resources.

A number of the intrinsic and extrinsic factors associated with stress for direct
care staff discussed in this section are also included in the Expanded Nurse Stress
Scale (ENSS) (French et al., 2000), which was employed in the present study.
Whilst many of the same practice and staffing concerns are shared by nurses, in
particular, across all care settings, supported aged care service staff have unique
problems. Outdated perceptions of their having lower skills than nurses working
in some areas of acute care provides them with reduced professional status,
which is a commonly-held view of the public and Government policy makers
(Chenoweth et al., 2012. This professional and public perception of skill
inferiority has contributed to the significant disparity between the salaries of
supported aged care service and acute care nurses (National Health and Hospital
Reform Commission, 2009). However, the stressors that direct care staff face are
more complex than status and salary: they are more to do with high work
pressures and increasing levels of mandatory documentation, under-resourced
facilities, unsupportive management systems and aggression directed to them
for the system’s failings by doctors, colleagues, older people in care and their
families (Horner & Boldy, 2008).

The LaTrobe University’s (2002) systematic literature review of retention issues
in Australian supported aged care settings identified that direct care staff stress
is a major issue. Addressing staff stress requires substantial structural changes,
such as rectifying poor working conditions and lifting staff morale. This study
notes that low morale and stress in unqualified direct care staff are associated
with low pay, low professional status, inadequate skills, staffing shortages, high
work demands and inadequate resources. In qualified nurses stress is associated
with the frustration with having to continually supervise poorly educated care
workers to maintain care standards and being distracted from direct care involvement because of having to undertake excessive paperwork. A large proportion of survey respondents indicated that improvements in staffing would be required to consider continuing to work in supported aged care accommodation services (LaTrobe University, 2002).

The perceptions of low job satisfaction in the Australian direct care staff workforce were challenged by Richardson and King (2003) and King et al. (2012). King et al. (2012) who found that overall, direct care staff are generally satisfied with their work of providing care to older people. When compared to a 2007 workforce survey (Martin & King, 2007), the proportion of qualified nurses who reported they were 'totally satisfied' with their job increased by five per cent from 2007 to 2012 (14% in 2007 to 19% in 2012) (King et al., 2012). The increase in job satisfaction for unqualified direct care staff was slightly smaller (19% in 2007 to 22% in 2012) (King et al., 2012).

A more recent Australian study conducted by Chenoweth et al. (2012) with nurses working in acute, community and supported aged care settings who provided care to older people and people with dementia identified many of these sources of stress. Registered nurses from two Australian states were surveyed from a set of items derived from four published nurse workforce questionnaires (Chronbach’s alpha range 0.75-0.96). There were 3,983 completed responses and ten focus groups with 58 volunteer survey respondents. Respondents working in all three care settings identified many issues of concern in their current jobs including a lack of autonomy and control over nursing practice, poor working relations with doctors and inadequate organizational support. Only 27 per cent of these survey respondents said they received supportive supervision, 12 per cent agreed that they received adequate managerial support, 11 per cent believed there were enough qualified nurses to supervise care and just eight per cent agreed that there were a sufficient number of qualified nurses to provide quality care.
The experiences of stress-inducing workplace factors that influenced the
decisions of these direct care staff to discontinue in their jobs confirmed the
issues and concerns identified in other nursing workforce studies (Duffield &
Roche, 2007; Tuckett et al., 2009). Nurses reported being dissatisfied with
deteriorating working conditions, their lack of authority over nursing decisions,
bureaucratic dominance of nursing policy and decision-making, wage inequity
between acute, community and supported aged care accommodation service
settings, and the insidious erosion of structures, policies and procedures that
enable nurses and other direct care staff to provide safe, quality care (O’Brien-
Pallas et al., 2006; Chenoweth et al., 2012).

The recommendations for improving workplace conditions that would assist in
reducing direct care staff stress and dissatisfaction were identified as; increasing
organizational and management support through system change; improving
leadership particularly at middle management level; and establishing a culture of
openness and respect among managers and direct care staff (Jeon et al., 2010).
Qualified direct care staff recommended instituting higher levels of practice
discretion, novel education and skill development opportunities to keep abreast
of changing population, health and treatment modalities (Chenoweth et al.,
2012). Nurses at all levels of responsibility recommended increasing the number
of qualified staffing ratios in light of the increasing age, frailty, comorbidities and
acuity of older people requiring nursing care (Jeon et al., 2010; Chenoweth et al.,
2012).

Additionally, team work and collaboration were identified by Pearson et al (2006)
as essential ingredients for improving workplace conditions for direct care staff.
From a systematic review of evidence on the structure, process, characteristics
and composition of a nursing team that fosters a healthy work environment,
Pearson et al. (2006) identified that strong teamwork and collaboration plays a
key role on staff satisfaction and thus, retention of the direct care workforce.
Retaining an experienced, skilled, knowledgeable and satisfied direct care
workforce is of importance for future care arrangements for Australia’s older population (Chenoweth et al., 2012).

In supported aged care accommodation services, direct care staff stress is an issue of concern to all stakeholders including families of the residents, since perceptions of inadequate staffing levels and skill mix are associated with poorer quality of care (Ventuato, Kellet & Windsor, 2007). Families perceive unqualified care staff including nurse assistants and personal carers as being un-skilled and at times, incompetent, in providing the level and scope of care required by their family member (Hertzberg, Ekman, Axelsson, 2003). These perceptions are reinforced by the media when reporting isolated incidents of negative care practices by direct care staff (Australian Broadcasting commission (ABC) 7.30 report; O’Brien, 2000; O’Neil, 2006). In their desire to provide the level and quality of care for their older relative, many families offer supplemental care, which at times is prevented by direct care staff, primarily because of policy decisions regarding resident safety (Edberg et al., 2008). These issues can be a source of family stress and anger, which tends to be directed to direct care staff (Hertzberg, Ekman, Axelsson, 2003).

Providing health care for older people is complex and demanding, especially when the person has dementia and/or behaviours that direct care staff and the family find difficult to prevent and manage (Opie, Doyle O’Connor, 2002). It is inevitable that this will give rise to tensions between direct care staff and families, and between service providers, managers and staff who are working under intense pressure. The combination of a range of stressors in the supported aged care accommodation setting is apparent, and is an issue requiring further research and policy deliberation if the sector is serious about protecting the health of their direct care staff.
3.5. CHAPTER SUMMARY

This chapter has included a review of the literature on stress, stressors and the effects of stress on direct care staff who work in the acute, community and supported aged care settings. The literature review was structured around a number of topic areas, including stress prevalence in nurses and other direct care staff, the sources of workplace stress, symptoms and signs of stress in these staff and preventative factors. Nurses working in all care settings report medium to high levels of workplace stress associated with their dissatisfaction with the pace of change in working conditions, complex care demands, high workloads, poor workplace conditions, and low professional and community status. Stress experienced by nurses and other direct care workers is also associated with under-resourcing and unsupportive management systems, and is exacerbated by pay disparities for acute, community and supported aged care nurses, and by dissatisfaction with the low salaries paid to other direct care staff. Miscommunication between managers, nurses and other direct care staff can also give rise to ongoing tension and job dissatisfaction, especially in cases of discrimination associated with language and cultural differences and work roles.

Protracted workplace stress can lead to burnout in nurses and other direct care staff and often becomes an issue of concern for managers at a point when the staff’s only option for resolution to their stress is to resign from the job. Since turnover of nurse and direct care staff is relatively high in supported aged care accommodation services, compared with other service industries, stress in these staff needs to be understood and addressed. While stress-inducing factors for acute care nurses are reported widely in the literature, very few studies have investigated stress for nurses and other direct care staff in supported aged care accommodation services and particularly in relation to their interactions with the families of older people. This particular issue is the major focus of the study. To gain a better appreciation of direct care staff’s workplace stress, burnout and
self-efficacy in supported aged care accommodation service settings, these constructs are examined theoretically in Chapter 4, which follows.
CHAPTER 4 THEORETICAL FRAMEWORK

4.1. INTRODUCTION

In novel areas of research it is helpful to use a guiding framework when constructing the research question/s, choosing the research methods and the data analyses procedures, and when interpreting the study results. In considering the usefulness of the selected theories to guide this study, reference was made to the examination of ‘goodness’ of theory-building by Waker (1998). Waker (1998) posits that a ‘good’ theory is defined by four specific criteria: variables relating to the area of investigation are clearly defined, recognized and understood; the domain or area of the investigation is established; the internally consistency through empirical testing has been achieved; and the theory provides specific predictions of the occurrence of the phenomena under investigation (Waker, 1998). Each of the theories selected to guide this study are reported to meet the ‘goodness’ criteria in a number of workforce studies (for example, Bandura, 1977; Cooper, Dewe & O’Driscoll, 2001; Shirey, 2006).

In considering a suitable theoretical framework to guide this study on direct care staff workplace stress in relation to the work of direct care and their interactions with the family of aged care residents, the literature was consulted widely to identify and examine what other researchers had used in exploring these phenomena. The literature identified an extensive examination of the concepts of stress, burnout and self-efficacy, either independently or in combination, across all categories of direct care staff working in a range of practice settings (for example, Healy & McKay, 2000; Englbrecht et al., 2012). However, only a small body of literature was identified that linked the concepts of stress with either the concepts of burnout or self-efficacy and none investigated these concepts in combination in direct care staff working in Australian supported aged care accommodation services. Since the concepts of workplace stress, burnout
and self-efficacy were the focus of this study, all three theories explaining workplace stress, burnout and self-efficacy were used for this study.

Lazarus and Folkman’s Transactional stress theory (1984) and Maslach’s Burnout theory (1981) provided a foundation for identifying the various stress and burnout factors experienced by residential direct care staff and in determining their impact. Bandura’s Self-Efficacy theory (1997) helped to determine if the perceptions of direct care staff of their self-efficacy to deal with workplace stress mediated their experiences of stress and burnout. Each theoretical model is discussed in turn, commencing with an overview of each theories historical background, constructs and conceptual development and the justification for their use.

4.2. THE STRESS CONCEPT

Stress is arguably an inescapable aspect of daily life and regardless of the stress ‘trigger’ is dependent on the ability of individuals to cope with the stressful situation (Lazarus & Folkman, 1984). The various methods employed by individuals to mediate their responses to stress demonstrates that stress-coping processes are also dynamic and symbolic of the individual expression of stress (Lazarus & Folkman, 1984). This then may explain why many stress related studies differ across all professional disciplines and organisational literature, employing a range of methodological approaches and variables to explain the stress phenomena (Lazarus & Folkman, 1984; Perrewe & Zellars, 1999). Although a number of models and theories have been developed to investigate the antecedents and outcomes of stress in the workplace, for example the Jobs Demands-Control model (Karasek, 1979), the Effort-Reward Imbalance model (Siegrist, 1996), and the more recent Job Demands-Reward model (Bakker & Demerouti, 2007), few have demonstrated a level of influence as has been evident with the transactional model of stress and coping as proposed by Lazarus and Folkman (1984).
From a medical perspective, the stress concept postulates that the body responds to various forms of stress through a unified defence system characterized by specific physical and hormonal changes (Selye, 1973). This notion of stress underlies much of the research that has since been conducted in chronic related diseases. One of the earliest theorists of the stress phenomena, Cannon (1939) conceived of the term ‘fight’ or ‘flight’ when describing the body’s physiological arousal in response to a threat to defend itself or to flee from danger. From laboratory experiments with animals, Cannon (1939) reported normal reactive physiological responses of increased heart rate and blood pressure resulting in increased oxygen to working muscles to aid fight or flight responses an individual may require to avoid the perceived impending danger.

The work of Cannon was to provide the basis for the later work of Hans Selye (Szabo, 1985). The various theoretical approaches and models of stress such as those developed by Hans Selye (1950) and Lazarus (1966) have provided the foundation for research into the study of stress and coping generally and of workers and their working environments. Lyon (2000) asserts that by 1956 the term stress began appearing in nursing literature, however, it was not until the 1970’s that nurse researchers, along with other health-related disciplines began to fully recognise stress as a concept (Lyon, 2000).

4.2.1. STRESS MODELS

Interest in the stress phenomena has evolved from a growing belief that “stress is an inevitable aspect of the life” of all individuals and has been commonly conceptualized as a stimulus, a response and an interaction (Lazarus & Folkman, 1984; Cooper, Dewe & O’Driscoll, 2001). The following illustration (Figure 3) adapted from the work of Sutherland and Cooper (1990), demonstrates the interrelationship between the stimulus and response concepts between the environment and the individual. The depiction of INTERACTION with the supporting arrows highlighting STIMULUS connected to RESPONSE is my addition
Stimulus models of stress postulate stress as a psychosocial demand resulting in a response of personal strain arising from environmental events for which the individual has little control over, such as war or major disaster (Lazarus & Folkman, 1984). The stimulus model assumes that “certain situations are normatively stressful” (Lazarus & Folkman, 1984, pp. 21) for all individuals without consideration to the respective approaches by individuals to the appraisal process (Lazarus & Folkman, 1984; Cooper, Dewe, O’Driscoll, 2001). The origins of a response model of stress as proposed by Selye (1956), is based in medicine (Cooper, Dewe & O’Driscoll, 2001), where stress is viewed as an independent variable and is the physiological responses to the demands made upon the body (Cannon, 1939; Selye, 1956). However, whilst the usefulness of the response model is justified in the medical context of diagnoses and treatments, the model does not assist in addressing identified stress causes or their specificity (Cooper, Dewe & O’Driscoll, 2001).
Limitations of the stimulus-response models are also noted by Lazarus and Folkman (pp. 21) who assert that “a stimulus gets defined as stressful only in terms of a stress response”. Therefore, little consideration is given to the properties of the events, or in the responses themselves (Cooper, Dewe & O’Driscoll, 2001). A further, limitation in the stimulus-response model is related to a lack of acknowledgement of the interrelationship of the individual to the environment and to the inherent differences in the individuals themselves and how these issues may affect the stress response (Lazarus & Launier, 1978; Lazarus & Folkman, 1984; Cooper, Dewe & O’Driscoll, 2001).

The interactional approach to stress, illustrates the existence of a “statistical interaction” between the stimulus and response concepts (see Figure 3). This model of stress has inherent limitations, as it does not explain the complexity of the relationship between the stimulus and the response concepts other than through a third moderator variable/s (Cooper, Dewe & O’Driscoll, 2001).

Without a theoretical rationale for the inclusion of a moderator variable/s, explication of the stress process is not assured, since the causal pathways between the concept’s relationships is limited (Cooper, Dewe & O’Driscoll, 2001). As noted by Lazarus and Folkman (1984 pp. 325) “the traditional antecedent-consequent model is limited because it tends to treat variables as if they are in a linear and unidirectional relationship and as static phenomena”. On the other hand, the transactional model of stress proposed by Lazarus and Folkman (1984) as previously discussed proffers the notion that stress is a “dynamic cognitive state” as a result of the relationship that occurs between the environment and the individual (Lazarus, Kanner & Folkman, 1980; Lazarus & Folkman, 1984; Cooper, Dewe & O’Driscoll, 2001).

4.2.1.1. The General Adaptation Syndrome (G.A.S)

The General Adaptation Syndrome (G.A.S) developed in 1936 by Doctor Hans Selye (Smith & Selye, 1979; Selye, 1980; Goldstein & Kopin, 2007) was one of the earliest conceptualizations of stress. Selye became known and was often
referred to as the ‘Father of stress research’ (Lazarus & Folkman, 1984). According to Selye, the General Adaptation Syndrome exhibits the effects of stress as the major cause of disease in the body of an individual as it fights to maintain a normal chemical balance and the psychological responses are universal to each individual (Selye, 1980). Selye observed that the body would respond to any external biological source of stress with a predictable biological pattern (see Figure 4) as an attempt to restore the body's internal homeostasis (Selye, 1950; Selye, 1980). This initial hormonal reaction was to become known as the ‘fight or flight’ stress response as previously popularized by Cannon (Goldstein & Kopin, 2007) and was evidenced a rapid reaction to a situation or activity perceived by the individual to be harmful.

In explaining the mechanism of the General Adaptation Syndrome theory, Selye determined that there are three significant stages to stress (Table 7). These stages comprise (1) the ‘stage of alarm’ during which the body's defensive forces are activated and mobilized; (2) the ‘stage of resistance’, the stage where the body defends and adapts to the stressor; and (3) the ‘stage of exhaustion’ that may occur should the experience and severity of the stress and the stress response be extended over a prolonged period of time (Selye, 1965, pp. 98).

For example, during the alarm stage, the activation of the primary stress hormones, cortisol, adrenaline and noradrenaline are released to provide instant energy, enabling a physical response to the impending threat. Repeated high levels of hormonal energy not eliminated by physical activity may result in adverse physical reactions to the body (Selye, 1965). Therefore, from a biological perspective, stress is both an active and reactive defence process, and as a stimulus, stress it is essential for daily functioning (Selye, 1965). From this theoretical premise, stress is viewed as an inevitable and necessary aspect of the human condition.
FIGURE 4 - PRINCIPAL NEUROENDOCRINE PATHWAYS THAT MEDIATE THE RESPONSE TO STRESS

1 (ADAPTED FROM SMITH & SELYE, 1979)
Table 7 - General Adaptation Syndrome 1

<table>
<thead>
<tr>
<th>GENERAL ADAPTATION SYNDROME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
</tr>
<tr>
<td>Enlargement of adrenal cortex</td>
</tr>
<tr>
<td>Enlargement of lymphatic system</td>
</tr>
<tr>
<td>Increase in hormone levels</td>
</tr>
<tr>
<td>Stage 2</td>
</tr>
<tr>
<td>Shrinkage of adrenal cortex</td>
</tr>
<tr>
<td>Lymph nodes closer to normal size</td>
</tr>
<tr>
<td>Hormone levels sustained</td>
</tr>
<tr>
<td>Stage 3</td>
</tr>
<tr>
<td>Enlargement/dysfunction of lymphatic structures</td>
</tr>
<tr>
<td>Increase in hormone levels</td>
</tr>
<tr>
<td>Depletion of adaptive hormones</td>
</tr>
</tbody>
</table>

(Adapted from Smith & Selye, 1979)

Thus, since the early work of Selye, debates regarding the theory of stress and its antecedents have continued to evolve, leading to an exponential increase in research and the subsequent development of theories and models of stress relating to the stress phenomenon (Perrewe & Zellars, 1999). Although many stress models exist, the transactional model of stress and coping, as proposed by Lazarus and Folkman (1984), has been perhaps the most influential of all, evidenced by the high volume of empirical literature using this model.

4.2.1.2. The Transactional Model of Stress

The transactional theory of stress, originally developed by Richard Lazarus and published in 1966, underwent further modification by Richard Lazarus and Susan Folkman and was published in 1984. Since the initial publication, empirical support for the use of the transactional model of stress is well evidenced in the
health related literature (Healy & McKay, 2000; Englbrecht et al., 2012) unlike other organisational stress models such as the job demands-control model (Karasek, 1979), the effort-reward imbalance model (Siegrist 1996), and the job demands-resources model (Demerouti et al., 2001; Bakker et al., 2003). Whilst evidence exists for the use of the job demands-control model (Landsbergis, 1988; Van der Doef & Maes, 1999) and the job demands-resource model (Demerouti et al., 2001; Bakker et al., 2007; Xanthopoulou et al., 2007) in the nursing literature, evidence of empirical support for the job demands-control, effort-reward imbalance and job demands-control models is generally limited (van der Doef & Maes, 1999; de Lange et al., 2003; van Vegchel et al., 2005). A review of 51 longitudinal studies using the job demands-control model by van der Doef and Maes (1999) found limited support for these models. A more recent study conducted by Bakker et al (2010) provided stronger support for the job demands-resources model (Demerouti et al., 2001; Bakker et al., 2003), though a later review of ‘high quality’ studies conducted by de Lange et al. (2003) found limited support for this model.

An examination of 45 studies investigating the effort-reward-imbalance model by van Vegchel et al. (2005) identified variable levels of evidence in support of this model. Van Vegchel et al. (2005) found considerable support for the extrinsic hypothesis, but little or inconsistent support for the over commitment and interaction hypotheses. Building on the job demands-control model and the effort-resources-imbalance model, the job demands-resources model was found by Cox, Pakenham and Cole (2010) to focus almost exclusively on characteristics of the external context, paying little attention to internal processes, therefore was unable to explain individual differences in stress outcomes. From this comparison of organisational stress models, the transactional model of stress was considered to be a superior model to explain direct care staff workplace stress and was therefore considered to be a suitable choice for this study.
4.2.1.3. Cognitive Appraisal

Cognitive appraisal is necessary to understand how individuals react to what they perceive are stressful encounters arising from their work environment (Lazarus & Folkman, 1984). From their seminal work on stress and coping, Lazarus and Folkman proposed cognitive appraisal consisting of two subjective appraisal events (primary and secondary) as a central and pivotal concept in the transactional stress model to explain the individual differences in the stress phenomena (Lazarus, 1981; Lazarus & Folkman, 1984; Folkman & Lazarus, 1985).

Unlike other models of stress, Lazarus and Folkman (1984) suggest that the individual’s cognitive appraisal or subjective evaluation of the characteristics of a stressor is significant in determining the individual’s perceived stress levels and their behavioural response to a stressor. For example, in their transactional model of stress, Lazarus and Folkman (1984) posit that an individual will first undertake a primary appraisal process or evaluation of a particular situation, or event, to determine and identify the various facets of the encounter with respect to its significance to the individual, and to the individual’s well-being (Lazarus and Folkman, 1984).

The initial appraisal process is distinguished by three evaluation categories: irrelevant, benign-positive, and stressful (Lazarus & Folkman, 1984). An irrelevant evaluation is posited by Lazarus and Folkman (1984) as an encounter appraised as being of no concern to the individual and therefore may simply be ignored (Lazarus & Folkman, 1984; Perrewe & Zellars, 1999). Benign-positive, on the other hand refers to an encounter that is evaluated by the individual as being of interest, or benefit, while a stressful encounter is evaluated as harmful, threatening or challenging (Lazarus & Folkman, 1984; Perrewe & Zellars, 1999). Harm and threat appraisals are associated with negative emotional reactions, whereas challenge appraisals are linked to more pleasurable emotions (feelings of happiness), or beneficial pursuits providing opportunities for personal growth.
or mastery of a particular situation, for example entering in an outdoor sporting event (Lazarus & Folkman, 1984).

The transactional model of stress proposes that should the initial appraisal be evaluated by the individual as undesirable, then a secondary appraisal is undertaken. Conducting a secondary appraisal enables the individual to determine how to manage or change the stressful encounter focusing on the coping methods and the resources that may be required (Lazarus & Folkman, 1984; Perrewe & Zellares, 1999). Appraisals of stressful encounters may differ, giving rise to different coping responses, some proving more effective than others. For example, an appraisal of an encounter is subject to various situational factors, including ‘ambiguity’ where the ‘information is unclear or insufficient’, and also to the individual’s characteristics. Therefore, the reaction, or coping response, chosen by one individual may differ from the response choice of another individual (Lazarus & Folkman 1984, pp. 104).

According to Lazarus & Folkman (1984), the appraisal process is affected by two factors: commitments and beliefs. If the individual is highly committed to the outcome of the stressful encounter, or the encounter has personal meaning for them, the individual may be more highly motivated to adopt strategies otherwise not considered to resolve the stressful encounter. From the belief perspective, an individual’s perceived control in the stressful encounter arises in the confidence of their ability to alter the event and therefore, to control the outcome. The appraisal process is, consequently, subjective and specific to the event integrating factors associated with the individual and the environment (Lazarus & Folkman, 1984). According to the primary and secondary cognitive appraisals of the stressor, the individual mobilizes the most appropriate coping responses, based on the individual’s level of commitment and perception of (Lazarus & Folkman, 1984).
4.2.1.4. Coping and Coping Resources

Coping is the final facet of Lazarus and Folkman’s transactional stress theory, conceptualised as a process (as opposed to a trait) of “constantly changing cognitive and behavioural efforts to manage specific external and /or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). The primary aim of Lazarus and Folkman’s transactional coping process unlike traditional approaches to stress, is to manage or alter the problem with the environment (referred to as problem-focused coping) that is causing the stress and to regulate the emotional response to the problem (emotion-focused coping). Coping in this context is neither static nor random, and depending on the status of the person-environment relationship at any given time, may require continuous cognitive reappraisals by the individual (Schmidt, et al., 2010).

The influence of emotion elicited at each stage of the appraisal process is an important aspect to the appraisal process (Lazarus & Folkman, 1984; Folkman & Lazarus, 1988; Lazarus, 1991; Siemer, Mauss & Gross, 2007). Lazarus (1991) posits that the individual’s primary appraisal of a stressful encounter is predominantly associated with the intensity and prevalence of emotion, whereas coping is affected by and linked to a number of differing emotional strategies (Gross, 2002; 2003). Lazarus and Folkman (1984) suggest that not all stressful encounters are managed through emotion-focused coping and demonstrated this argument with the following example:

“If a student takes a Valium to control distress that interferes with performance in an exam, that student is problem solving by attempting to manage feelings; If, on the other hand, a student carefully prepared by studying so that he or she could feel a sense of mastery over the danger, the distress of doing badly is being managed by problem-focussed coping”. (Lazarus & Folkman, 1984, p. 319).

As well, the way an individual copes in a stressful encounter may also depend on the resources available to them in dealing with the stress (Lazarus & Folkman,
1984). Such resources may be principally involve the individual’s characteristics (personal competencies, problem solving and social skills, or health), or environmental characteristics (physical resources, social support), which provide a buffering effect to their experiences of stress (Lazarus & Folkman, 1984). Of particular interest to this discussion is that of positive beliefs. The ability to view oneself positively is regarded as a valuable resource for coping and sustaining coping efforts (Lazarus & Folkman, 1984). Lazarus and Folkman (1984, p. 160) posit that “not all beliefs serve as coping resources...some beliefs can dampen or inhibit coping efforts” thus an individual’s beliefs may act as a personal constraint to coping. In this instance, stressful encounters may create demands that often exceed the resources of the individual, and the individual may experience even higher levels of stress or distress (Lazarus & Folkman, 1984). The relationship of stressors to the stress experience also needs to be considered, since not all stressors have the same characteristics or influence (Lazarus & Folkman, 1984).

4.2.1.5. Stressors

The type of stressor that influences the stress process can fluctuate and the impact of the stressor is dependent on the individual’s perception of its presence, the state of conditioning factors, and available coping mechanisms (Lazarus and Folkman, 1984; Vedhara et al., 2000). Empirical and theoretical inquiry has led to a delineation of the different types of stressors, which are subsumed into two broad categories (see Table 9).

A theoretical model of stress as proposed by Carson and Kuipers (1998) includes three domains of stress: stressors, moderators of the stress process; and stress outcomes. This model identifies three major sources of external stress, including specific occupational stressors, major life events and ‘hassels’ or ‘up lifts’ (Kanner et al., 1981; Pearlin et al., 1981; Pearlin, 1989). The first category is referred to as ‘major challenges’ (Kanner et al., 1981) or ‘discrete stressors’ (Pearlin1989). ‘Major challenges’ or ‘discrete stressors’ are defined as infrequent but significant
life events such as divorce, or a loss of a job, that may require significant adjustments on the part of the individual (Pearlin et al., 1981). The second category is referred to as ‘continuous stressors’ (Pearlin et al., 1981) or ‘quotidian’ stressors (Pearlin & Skaff, 1995) and is further divided into chronic stressors and daily hassles (Kanner et al., 1981). In particular, daily hassles are defined as the minor or common problems of daily life and it is these myriad of common daily stressors that may have a greater effect on an individual’s well-being than the less frequently experienced significant life events or challenges (Kanner et al., 1981; Pearlin et al., 1981; Lazarus & Folkman, 1984).

As proposed by Lazarus and Folkman (1984) the daily hassles of life may be more catastrophic for the individual in terms of adaptation and health, since daily life hassles are often chronic and not readily recognisable, or considered as important as a major life event such as a divorce, see Table 8.

Table 8 - Stressor Classification Categories 1

<table>
<thead>
<tr>
<th>Stressor Classification</th>
<th>Related to major life changes</th>
<th>Divorce Job loss</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discrete Major Events Challenges</strong></td>
<td>Related to major life changes</td>
<td>Divorce Job loss</td>
</tr>
<tr>
<td>Rare / infrequent</td>
<td>Observable</td>
<td></td>
</tr>
<tr>
<td><strong>Continuous/Quotidian</strong></td>
<td>Ongoing daily events</td>
<td>Chronic Stressors</td>
</tr>
<tr>
<td>Commonplace</td>
<td></td>
<td>Persistent/recurrent</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily hassles (up lifts)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minor/small daily events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Concerns of work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Caring for others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unexpected interruptions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Arguments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work deadlines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Malfunctioning oven</td>
</tr>
</tbody>
</table>

(Adapted from Carson & Kuipers, 1998)
From an appraisal perspective, daily hassles may be appraised differently by individuals depending on their characteristics and the coping resources they use (Lazarus & Folkman, 1984). Whilst the incidence of daily hassles is acknowledged in the nurse stress literature as being an important contributing factor to workplace stress (Halpern, 2005), there is little evidence to indicate that daily hassles have been examined other than in association with other stressors. For example, the effects of daily hassles were examined by Burch et al. (2009) in conjunction with other stress related factors identified in the Pressure Management Indicator in a cohort of health care workers across a variety of health related environments (diagnostic units and laboratories, an outpatient surgery centre and Level II trauma centre). In this study, daily hassles did not register as a strong factor in explaining staff stress levels. Unresolved stress in nurses arising from unremitting daily hassles is, however, linked with the concept of ‘burnout’ (Maslach, Jackson & Leiter, 1996; Maslach & Leiter, 1997).

4.3. THE BURNOUT CONCEPT

Maslach and Folkman’s (1998) theoretical model of burnout is the second theoretical framework used to inform the research questions and to identify and measure the burnout experiences of direct care staff, and to determine any existence of a relationship with the variables of stress and self-efficacy. The phenomenon of burnout in the workplace is increasingly a topic of interest in Western countries and across a number of workplaces (Maslach, Jackson & Leiter, 1996; Maslach & Leiter, 1997; Angerer, 2003). In workplaces that are constantly changing in structure and expectations, and oftentimes considered to be unhealthy and unsafe, staff feel they are no longer able to “fulfil their potential through intrinsically rewarding work for which they are given compensation” (Maslach & Leiter, 1997, pp. 1). Maslach and Leiter (1997, pp. 10) assert that “Burnout is more likely to occur when there is a mismatch between the nature of the job and the nature of the person who does the job”.

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There is evidence to suggest that burnout occurs in a wide range of occupations and has negative implications for workers and work organisations. This issue is strongly evident in the ‘helping professions’ (Freudenberger, 1973; Maslach, 1981) such as teaching, policing, and more particularly in care giving (Maslach & Leiter, 1997; Vahey, et al., 2004; Espeland, 2006). Demerouti et al. (2001) on the other hand, challenges the prevailing view that burnout is to be found exclusively in the ‘helping’ and ‘caring’ professions, claiming that workers in both the transport and manufacturing industries also experience burnout (Demerouti et al., 2001). Burnout is associated with the stressors of work where exposure to the prolonged emotional demands of the work negatively affects the coping abilities of the person (Tweed & Conway, 2006), resulting in feelings of a loss of energy and fatigue (Espeland, 2006).

The effects of burnout in the direct care staff workplace have been examined by researchers across a number of practice areas both nationally and globally (Browning, Ryan and Greenberg, 2006; Espeland, 2006; Brewer & Shephard, 2004; Aiken et al., 2002). In workplace studies direct care staff are reported to feel overwhelmed and dissatisfied with their work (Shirey, 2006). Direct care staff who work in hospitals have been found to be less satisfied than direct care staff who work in other practice environments (Aiken et al., 2002; Chenoweth et al., 2012). Increased workloads, inadequate patient to staff ratios, declining quality of patient care and verbal abuse are contributing factors to burnout in direct care staff (Aiken et al., 2003; Vahey et al., 2004; Shirey, 2006; Poghosyan et al., 2010).

The factors giving rise to burnout in nurses and other direct care staff are similar to the factors that cause them stress (Garrosa, Moreno-Jimenez, Lian & Gonzalez, 2008). Garrosa et al. (2008) posits that burnout in staff providing care services arises from the characteristics of the organization they work in, their inter-personal relationships at work and their emotional responses to their work. Direct care staff who are subjected to burnout have been found to experience a number of physical disorders including fatigue, headaches, insomnia, digestive
discomfort, and skin complaints (Espeland, 2006). Not surprisingly there is increasing empirical evidence demonstrating an association between the burnout variable, turnover and the intent to leave (Jourdain & Chênevert, 2010). Additionally, there are substantial costs associated with burnout and reduced work productivity, along with increases in staff absenteeism, turnover, health and well-being (Maslach, Jackson & Leiter, 1996). In light of the current predictions of direct care staff shortages in the aged care sector, and the inherent associated costs (Department of Health and Ageing, 2012), it is important to explore causal relationships among direct care staff in terms of their experiences of burnout.

Maslach (2003) found that burnout is experienced as a prolonged response to chronic emotional and interpersonal stressors arising in the individual’s place of work (Maslach, Wilmar & Leiter, 2001). Such responses are likely to result from what Maslach and Leiter (1997, pp. 10) refers to as a “major mismatch between the nature of the job and the nature of the person who does the job”. As such, the phenomenon of burnout is concerned with aspects of the social environment in which an individual worked; the characteristics of the individual and how these factors are directly related to the individual’s interactions with others in the workplace; and how the individuals perform their work (Maslach, 2003).

Three stages comprise the burnout experience (Figure 5): emotional exhaustion; depersonalization; and diminished personal accomplishment (Maslach, Jackson & Leiter, 1996). Emotional exhaustion occurs in the first stage of the stress response, whereby the individual exhibits feelings of being occurs in the second stage of burnout and is characterized by a negative or excessively detached response to other people, specifically the person who is being cared for. The third stage of the burnout experience is diminished personal accomplishment, in which an individual experiences a decrease in their feelings of competence and the successful achievement in their work. The consequences of burnout are considered to be exceedingly injurious for both direct care staff, the organization they work for, and very likely for the care recipients (Maslach & Jackson, 1982).
In the process of identifying and describing the burnout experience, Maslach, Jackson and Leiter developed a burnout measurement instrument called the *Maslach Burnout Inventory*.

![Figure 5 - Five Stages of Burnout](image)

**FIGURE 5 - FIVE STAGES OF BURNOUT** (SPINETTA ET AL., 2000)

Subsequent testing of the Inventory determined that it was a reliable and valid measure of the burnout phenomenon and was easy to administer to employees (Maslach, Jackson & Leiter, 1996). An unsupportive work environment, discord
between expectations and reality, and feelings of stress, frustration and job dissatisfaction are inherent contributing factors to burnout. To explain this process (see Figure 5), Spinetta et al., (2000) discussed the development of burnout as being a five stage process.

The first stage of burnout identified by Spinetta et al. (2002) is similar to that of Maslach, Jackson and Leiter (1996) and is described as one of mental exhaustion, followed by indifference, a sense of failure as a professional, a sense of failure as a person and the last stage ‘dead inside’. Altun (2002) identifies physical exhaustion, hopelessness, and feelings of illness, low morale and decreased self-esteem as symptoms of burnout. Nurses and other direct care staff are considered to be particularly susceptible to the burnout experience (Spinetta et al., 2000; Maslach, 2003), as nursing and care work often occurs in an often complex, under-resourced and stressful workplace (Spinetta et al., 2002; Chenoweth et al., 2010). Nurses who are dissatisfied in their work can suffer burnout, both of which have a direct impact on turnover (Aiken et al., 2002). A perceived lack of autonomy, where direct care staff at all levels feel unable to control their work environment, is an additional factor contributing to burnout. Autonomy, as it relates to the human agency, is an adaptive human behaviour that facilitates one’s ability to intentionally make things happen in one’s environment (Bandura, 2006). With the increasing care demands occurring with a rapidly ageing population who require supported aged care accommodation services, there is an increased likelihood that the staff who care for them will become stressed in this work when resources do not match demand (Pines & Maslach, 1978; Chenoweth et al., 2009). When considering the reasons for burnout in the direct care workforce there are similar antecedents giving rise to the development of stress in this workforce (Table 9).

Other significant predictors of burnout that have been identified included age, role conflict and role ambiguity (Leiter & Maslach, 1988) and the psychosocial characteristics of nurses and care staff (Garrosa et al., 2008). In a sample of 473
Table 9 - Stressors and Predictors of Burnout 1

<table>
<thead>
<tr>
<th>STRESSORS</th>
<th>PREDICTORS OF BURNOUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Related:</td>
<td>Emotional Exhaustion</td>
</tr>
<tr>
<td>Pain</td>
<td>Depersonalization</td>
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Spanish nurses and care staff working in different care settings, Spinetta (2000) identified high workload levels led to emotional exhaustion. Prolonged, unresolved and untreated stress at work potentially left the individual feeling ‘dead inside’, being unable to perform their work with commitment or enthusiasm, and contemplating suicide (Spinetta et al., 2000). Suicide was found to be among the top five causes of death among nurses and other direct care staff, with suicide rates in this cohort being higher than in the general population (Metules & Bolanger, 2000). Having a higher level of self-efficacy for managing stress in the workplace may assist to reduce levels of stress and risk of burnout in direct care staff (Pearlin et al, 1990). Bandura, 1994) suggests that self-efficacy beliefs have a direct influence on the choices that direct care staff may make in their work and the courses of action they pursue. People tend to select activities they expect to be successful. The amount of effort expended and perseverance in the face of obstacles or failures is determined by the level of self-efficacy present at any one time (Bandura, 1994).

4.4. THE SELF-EFFICACY CONCEPT

In this study, ‘self-efficacy’ was the third theoretical construct used to gauge and measure perceptions of personal accomplishment and self-efficacy with the work
of direct care staff and with their interactions with the families of older people. Self-efficacy theory was originally developed by the psychologist Albert Bandura (Bandura, 1977). Social Learning Theory, later referred to as Social Cognitive Theory, was used by Albert Bandura as a conceptual basis for the development and analysis of the self-efficacy construct. Social Cognitive theory implies that an individual’s behaviour, their personal characteristics and the environment in which their behaviour is performed are constantly interacting, thus a change in one component inevitably impacts on the other two components (Bandura, 1986).

In order to manage a changing environment, Bandura (1986) suggested that an individual requires a complex set of behaviours of cognitive, social and behavioural sub-skills and argued that effective use and execution of sub-skills is strongly related to an individual’s beliefs of personal efficacy in executing these skills. Self-efficacy is related to specific situations and tasks, unlike other similar concepts of self-esteem, self-confidence and locus of control, which are personal characteristics that provide some stability on an individual’s behaviours (Bandura, 1997). Bandura (1986, pp. 391) postulated that self-efficacy “is concerned not with the skills one has but with judgements of what one can do with whatever skills one possesses” and suggested that individuals have the ability to judge themselves to be very competent in a specific area and less competent in another area. In the context of Bandura’s argument, self-efficacy referred to an individual’s belief in their ability to accomplish specific goals at a level that is consistent with their belief about their confidence to accomplish a particular task, or achieve a particular goal (Bandura, 1986).

The basic premise underlying self-efficacy theory is that the expectations of personal mastery (efficacy expectations) and success (outcome expectations) determine whether an individual will engage in a particular behaviour (Bandura, 1977) (see Figure 6). An individual’s behaviour is explained as being a result of a combination of personal resources, contextual resources and motivation. The behaviour of the person and the outcomes of their behaviour, together with the
person’s characteristics, efficacy expectations and outcome expectations, underpin Bandura’s (1997) theoretical model of self-efficacy. In some respects the stress theory (Lazarus & Folkman, 1984) and burnout theory (Maslach & Folkman, 1998) described above share similar observations of human behaviour to Bandura’s (1997) self-efficacy theory.

**FIGURE 6 - SELF-EFFICACY MODEL (SHORTBRIDGE-BAGGETT & VANDER BIJL (1996) 1**

Judgments of operative self-efficacy are concerned not with the individual’s skill sets, but with beliefs about how they can employ these skills to adapt to continuously changing realities (Bandura, 1986). Bandura postulated that individuals with high self-efficacy (for example in adapting to change) have the ability to perceive negative situations as challenges, whilst those with a lower level of self-efficacy will perceive themselves unable to cope, or being able to rise to the challenge. Additionally, self-efficacy is viewed as a predictor of both personal and professional behaviours in direct care staff and its presence or absence has the potential to influence the effort and commitment applied in achieving target behaviours. Self-efficacy is amenable to change and can be positively influenced by education and training (Bandura, 2006).
According to Bandura, self-efficacy beliefs are influenced by four sources of information: performance accomplishments, vicarious experience, verbal persuasion, and physiological information (Bandura, 1997). When considering the role that self-efficacy theory plays with regard to dealing effectively with stressful situations it is the ‘fit between perceived coping capability and perceived task demands that carry negative consequences if unfulfilled….people who cope poorly with stress expect that marred performances in intimidating situations will be determined by their self-debilitating thought patterns, rather than by how much effort they mount. Indeed, the harder they try, the more they may impair their execution of the activity’ (Bandura, 1991, p. 33).

Bandura’s self-efficacy theory has relevance in investigating direct care staff stress and burnout, since beliefs in work role capabilities affect how much stress these staff experience in threatening or taxing situations, as well as their levels of motivation to act on the circumstances that give rise to workplace stress (Bandura, 1995; 1989; 1997). Therefore, the self-efficacy beliefs held by nurses and other direct care staff about managing their work situation may influence how they perceive themselves, their role, the environment in which they work and the people that they come in contact with.

4.5. CHAPTER SUMMARY

The theories of stress (Lazarus & Folkman, 1984), burnout (Maslach & Folkman, 1998) and self-efficacy (Bandura, 1997), are combined as a conceptual framework to guide the study and explain the reasons for nurse and other direct care staff stress, burnout and self-efficacy in supported aged care accommodation services. While Lazarus and Folkman’s Transactional stress theory (1984) and Maslach’s Burnout theory (1981) have been considered in relationship to qualified nurses, mainly in acute care settings, these concepts have not been extensively investigated for nurses and other direct care staff who work in supported aged care accommodation services. The study aimed to address this gap in the literature. Bandura’s Self-Efficacy theory (1997) was used...
to determine if direct care staff perceived that their personal self-efficacy for handling workplace stress mediated their experiences of stress and burnout. This, too, is a novel area being investigated in the study. The following chapter outlines the methods used to investigate these issues.
CHAPTER 5 STUDY METHODS

5.1. INTRODUCTION

Chapter 4 outlined the conceptual framework for the study, comprising Lazarus and Folkman’s Transactional stress theory (1984), Maslach and Jackson’s Burnout theory (1981), and Bandura’s Self-efficacy theory (1997). When combined into a conceptual framework Lazarus and Folkman’s Transactional stress theory (1984), Maslach’s Burnout theory (1981) were used to identify the various stress and burnout factors and their impact as experienced by residential direct care staff, and Bandura’s Self-Efficacy theory (1997) was used to determine if personal self-efficacy in their work mediated the experiences of stress and burnout of direct care staff. This chapter will outline and discuss the study methods employed to answer the research questions on direct care staff work stress, burnout and self-efficacy in a supported aged care accommodation service. Details will be provided on the study aims and research questions; research design; study setting; recruitment population and procedures; ethical considerations with regard to study participant recruitment and consent; measures used; piloting procedures; data collection procedures; and data preparation and analyses techniques used.

5.2. STUDY AIMS AND RESEARCH QUESTIONS

The study aimed to measure the types of stress and the levels of stress, burnout and self-efficacy experienced by direct care staff working in an aged care setting, and to identify the relationship between the demographic characterises of direct care staff with their levels of stress and burnout and self-efficacy for their work.
Research Questions:

1. What levels and causes of stress and are experienced by direct care staff in the supported aged care accommodation service setting?

2. What levels and causes of burnout are experienced by direct care staff in the supported aged care accommodation service setting?

3. What levels of personal accomplishment and self-efficacy are experienced by direct care staff in the supported aged care accommodation service setting?

4. Is there an association between the demographic characteristics of direct care staff and their levels of stress, burnout, and self-efficacy?

5. Is there an association between workplace characteristics of direct care staff and their levels of stress, burnout, personal and self-efficacy?

6. Is direct care staff stress associated with interactions with the families of older people living in the supported aged care accommodation service setting?

5.3. RESEARCH DESIGN

An exploratory-descriptive, cross-sectional research design was used for this 18 month study using three validated questionnaires and one open-ended survey question on direct care staff stress, burnout and self-efficacy in supported aged care accommodation service work. The exploratory descriptive cross-sectional design was selected to identify the nature and attributes of the phenomena of interest for different levels and categories of direct care staff at the same point in time (Speziale & Carpenter, 2002; Minichiello et al., 2004; Bazeley, 2004).

5.4. STUDY SETTING

A Sydney metropolitan geographic region was purposely chosen as the setting for this study. The region was identified from a Sydney regional map outlining the regions of Sydney and the suburbs in each region. Access to direct care staff across one or more states of Australia was not considered viable due to time constrains, and limited financial and other resources. Additionally, purposely
selecting a region in the Sydney metropolitan basin enabled access to all of the supported aged care accommodation services located within that region. Sampling from a single clustered group is considered an economical method of sampling and is also likely to have a higher similarity on some variables (Minchiniello et al., 2004).

5.4.1. SUPPORTED AGED CARE ACCOMMODATION SERVICES

5.4.1.1. Inclusion Criteria

Inclusion criteria included all supported aged care accommodation services located within the targeted geographical area that held current accreditation status from the Australian Government’s Department of Health and Ageing; was not a cluster-specific supported aged care accommodation services; and was able to gain consent from respective Boards of Directors to participate in the study. Cluster-specific supported aged care accommodation services were identified as those with a ‘clustered’ population of people, for example, mostly Greek-speaking, or mainly younger people with intellectual disabilities.

5.4.1.2. Exclusion Criteria

Supported aged care accommodation services that were cluster-specific; had not been accredited by the Australian Government’s Department of Health and Ageing; had a major compliance issue; received a major compliance issue once the study commenced; and were unable to gain participation consent from their Boards of Directors, were excluded. Supported aged care accommodation services that did not hold Accreditation status from the Department of Health and Ageing were excluded as they may have lacked the basic conformity and uniformity in services that were required by the then Department of Health and Ageing (Department of Health and Ageing, 2008). Cluster-specific supported care accommodation services were excluded from the study as they may have accommodation services applied different approaches to addressing direct care staff and population issues that may not have occurred in ‘usual’ supported aged
care accommodation services in the targeted region (Bigby, Webber, Bowers & McKenzie-Green, 2008).

5.4.1.3. Recruitment Procedures

The first step taken to recruit supported aged care accommodation services was to identify and verify all suburbs located in the targeted study region as outlined on the Sydney regional map. The second activity included the identification of all supported aged care accommodation services located in each suburb of the targeted study region. A directory of these facilities was obtained from the Aged Care Referral Centre based in the local regional public hospital. The hospital directory provided the names, addresses and status (charitable, religious, private corporations; and number of licensed beds) of each supported aged care accommodation service located in each suburb located in the targeted study region. The identified accommodation services were cross referenced and verified with the Commonwealth Department of Health and Ageing’s website listing of licensed and accredited supported aged care accommodation service for each of the targeted suburbs (Department of Health & Ageing, 2007).

Accreditation and licensing status of each supported aged care accommodation service was confirmed through the Department of Health and Ageing databank, obtained from information freely available in the public domain. Compliance with Accreditation Standards and other mandatory legislative requirements ensured commonalities in population, staff mix and staff ratios (1 care staff to 8-10 residents), accommodation, domestic and care services (Department of Health & Ageing, 2010). From a total of twenty four \( n = 24 \) supported aged care accommodation services located in the targeted metropolitan region, four were excluded, including two with clustered populations and two that were unable to obtain the necessary consent from their Boards of Directors. A total of twenty \( n = 20 \) supported aged care accommodation services were considered eligible for this study.
Following formal study approval by the University of Technology, Sydney (UTS) Protocol No. 2006-199 (see Appendix A), initial contact with each supported aged care accommodation service manager was implemented via a telephone call. It was at this time that introductions and explanations of the nature, purpose, objectives and expectations of the research study were provided. Managers were asked if they would be interested in the study and willing to participate. Following initial verbal assent from managers, a standardized written information sheet outlining the intent and content of the study (Appendix B), a copy of the University of Technology, Sydney ethics approval advice and a copy of the researcher’s identification were faxed to each service manager.

During the initial telephone calls to supported aged care accommodation service managers, formal consent formalities were discussed. Forwarding the study information to each manager assisted in allaying any suspicions that they may have had in regard to the authenticity of the study and of the researcher (Minichielolo et al., 2004). Ethical and Legal considerations in research are concerned with protecting human and animal subjects from harm (Minichiello et al., 2004), consequently, it was important to assure the managers that neither they nor their direct care staff would be harmed by participating in the study.

Within a period of four days (to allow managers the opportunity to review the faxed documents) a second telephone call was initiated and suitable times were arranged to introduce the researcher and to obtain formal (signed) consent. At each initial visit with managers, additional verbal explanations and information pertaining to the study were provided. Assurances were also provided to managers that direct care staff work schedules and practices would not be interrupted, or interfered with, during the course of the study. A total of twenty \( n = 20 \) care managers completed the Formal Study Consent form (Appendix C) authorizing the research to be conducted in their respective place of work.
5.4.2. STUDY POPULATION – DIRECT CARE STAFF

All direct care staff were invited to join the study included registered nurses, enrolled nurses, assistant nurses, personal carers, recreational staff and care managers who worked in the consenting supported aged care accommodation services located in the targeted study region.

5.4.2.1. Inclusion Criteria

All identified nurses and other direct care staff who were employed for a minimum of six months continuous service in the consenting supported aged care accommodation services, and who also had had direct contact with the families of older people were eligible to join the study. Direct care staff from non-English speaking backgrounds and with limited verbal and written English language skills, were encouraged to participate in the study provided they could give informed consent, as this was a requirement of ethical approval for the study (UTS Ethics Approval, Appendix A).

5.4.2.2. Exclusion Criteria

All nurses and other direct care staff employed for less than six months, who did not have direct contact with the families of older people and were unable to provide informed consent, were ineligible to participate in the study.

5.4.2.3. Recruitment Procedures

All of the targeted direct care staff met the inclusion criteria and were invited to participate. Consequently, an entire population sampling strategy was implemented for each participating supported aged care accommodation service. The aim of this approach was to ensure, as far as possible, that the sampling method optimized the highest possible number study respondents. Once management consent was obtained, notices and study flyers were posted on meeting boards to invite direct care staff to participate in the study and to attend a 15 – 20 minute briefing session to learn more about the study.
(Appendix D). In addition, all direct care staff were verbally informed of the study by the managers during shift handovers, and on a one to one basis for those direct care staff with little or no English language skills. The information briefing sessions were conducted by the researcher in a pre-arranged private location (for example, either a staff room or education room).

The briefing sessions were held in each at different times and also conducted in multiple ways to facilitate a higher and wider recruitment of respondent response rate. For example, briefing sessions for all direct care staff were held during their various meal breaks; at morning, afternoon and evening shift handover covering each day of the week; as a group session at pre-arranged times; and at other times on an individual basis. Since the study was not the subject of a research grant, and as it was being conducted as a major component of the Professional Doctorate program of study, there were no funds to employ a research assistant to recruit study participants and to obtain the study data. Therefore, all recruitment activities were undertaken by the researcher.

During all recruitment briefing meetings the researcher was clearly identified with a name badge when entering each supported aged care accommodation service and was introduced to the meeting attendees by the manager. These procedures helped to legitimise the study, and assured all direct care staff attending these meetings that managers endorsed its conduct. During each recruitment briefing meeting, attendees were offered morning and afternoon tea, and provided with chocolates to assist with the creation of a relaxed atmosphere. Attendees were also advised on what giving consent entailed and that their willing agreement to answer the questions in the anonymous Questionnaire Pack constituted giving informed consent for participation in the study. Those direct care staff who attended the meetings were also assured of their continued anonymity in the study and were advised that a non-identifiable coding system known only to the researcher would be used to label each Questionnaire Pack.
For direct care staff who identified themselves as having limited English language skills, arrangements were made to meet with those individuals in small groups or, if they preferred, on a one-on-one basis to provide additional information and to help in explaining the study and the expected requirements of becoming a study respondent. All the above explanations were provided to these direct care staff using simple English language terminology and phrases that could be readily understood by them.

5.5. ETHICAL CONSIDERATIONS

During the briefing meetings, attendees were informed that ethical approval had been granted by the Human Research Committee of the University of Technology Sydney, and they were provided a copy of the ethics approval statement. Attendees were also provided with written (Appendix E) and verbal information about the research study, including the study aims and objectives and the advice that the study may or may not, benefit direct care staff both in the short term and in future. Whilst it was anticipated that there would be no personal benefit resulting from the completion of the questionnaires and written narratives, the meeting attendees were advised that they might not benefit in any way and also that they might develop an insightful understanding of themselves and their work as a result of answering the questionnaire items. Additionally, during the briefing sessions all attendees, including managers and direct care staff, were informed that participation in the study was voluntary and that both the supported aged care accommodation service and any study respondents were free to withdraw from the study at any time. The meeting attendees were informed that should they have any concerns in relation to the study, they could at any time contact the study supervisor Professor Lynnette Chenoweth, or the University of Technology Sydney Human Research Ethics committee. At no time were prospective respondents pressured or coerced into participating in the study.
The meeting attendees were assured at the beginning and at different times throughout the briefing meetings that their confidentiality would be maintained during and following the research study. Attendees were advised that hard copies of the completed questionnaires and any transcripts of either interviews or observational data (if collected) would be stored in a key operated locked cabinet accessible only by the researcher, and that analysed data would be stored on a password operated locked computer also known only to the researcher. The attendees were informed of how the de-identified study findings would be shared with others through written articles, seminars, conferences and workshops.

The briefing meetings also provided the opportunity for the researcher to discuss and allay any concerns or fears that attendees may have had in relation to the study or to their role as a study respondent. An information sheet with the researchers contact details and time availability was provided to each attendee to enable them the opportunity to discuss and address any questions or concerns that they may have had. Attendees were reminded of the various strategies that would be maintained throughout the course of the study, including coding their questionnaire responses with unique numbered identifiers to ensure their confidentiality. Attendees were requested not to mark or label completed Questionnaire Packs with personal identifying information.

5.6. STUDY MEASURES

The study employed three validated study measures informed by three theoretical frameworks. The measures included the Expanded Nurse Stress Scale (ENSS) (French et al., 2000); the Maslach Burnout- Human Services Inventory Survey (MBI) (Maslach, Jackson & Leiter, 1996); and the General Self-Efficacy Scale (GES) (Schwarzer & Jerusalem, 1995). A demographic questionnaire was also added to this questionnaire pack, as well as a single opened-ended survey question relating to workplace stress associated with the families of older people. The study measures are described in turn as follows.
5.6.1. THE EXPANDED NURSE STRESS SCALE

Study respondent stress was measured with the Expanded Nurse Stress Scale (ENSS) (French, Lenton, Walters & Eyles., 2000). Permission to use the ENSS was obtained via an email request to one of the original authors, Susan F. French who at the time was located at McMaster University, Canada (Appendix E). The ENSS is an expanded and updated revision of the Nursing Stress Scale (NSS) developed by Gray-Toft and Anderson (1981b) to target nursing stress in health care environments (French et al., 2000). The original 34 items of the NSS measured the frequency and major sources of stress in a variety of patient care situations and were structured into 7 subscales including: Death and Dying; Conflict with Physicians; Inadequate Emotional Preparation; Problems Relating to Peers; Problems Relating to Supervisors; Work Load; and Uncertainty Concerning Treatment. Since the development of the NSS, major changes in health care delivery and the work environment of nurses encouraged French et al. to identify additional stressful situations not previously reflected in the original NSS (French et al., 2000). The development of an expanded version of the original tool was considered by French et al. (2000) as a more useful tool for exploring nurse stress in diverse nurse work settings.

French et al. (2000) employed a number of steps in the development of the ENSS. The first of these steps included conducting a series of focus groups of Canadian registered nurses and registered practical nurses working in a number of diverse health care environments. These nurses undertake work similar to nurses and other direct care staff in Australian supported aged care accommodation services. Themes derived from the focus group interviews revealed 20 \( (n = 20) \) additional stressful situations not previously included in the original NSS developed by Gray-Toft and Anderson (French et al., 2000). The second step of the development of the ENSS included a survey of registered nurses \( (n = 18) \) and registered practical nurses \( (n = 19) \) to test the original NSS and the 20 additional items originated through the focus group interviews.
Additionally, the authors included an open-ended question to identify further stressful situations not previously identified in the original focus groups.

Finally, the researchers reviewed the 25 additional stressful situations that emerged in this process to determine their conceptual fit with the original seven scales of the NSS. Of the 25 additional stressors identified, 14 questions indicated conceptual fit with five of the seven original NSS subscales; three questions were grouped into a new subscale reflecting discrimination in the workplace; and eight questions were grouped into a new subscale concerning patients and their families (French et al., 2000). French et al. (2000) then tested the final 59 item ENSS in a larger nurse sample \( (n=2,280) \) after having removed two items considered irrelevant. The completed ENSS contains 57 items in nine subscales comprising of the original 7 NSS subscales as previously noted including the additional 2 sub-scales (Patients and their Families; and Discrimination).

The ENSS sub-scales included:

1. Limited experience dealing with death and dying
2. Conflict with other healthcare professionals such as surgeons and physicians
3. Feeling inadequately prepared to help with the emotional needs of a patient or patient’s family
4. Problems relating to peers
5. Conflicts with supervisors
6. Workload
7. Uncertainty concerning treatment; inadequate information from physicians regarding the medical condition of a patient
8. The fear of failure to carry out nursing responsibilities and nursing tasks due to the unreasonable demands of patients and their families
9. Experiences of being discriminated and isolated by other nursing colleagues and other health care professionals.
Responses to the 57 items were via a 5 point Likert response scale, ranging from ‘1 = never stressful’; ‘2 = occasionally stressful’; ‘3 = frequently stressful’; ‘4 = extremely stressful’ and ‘0 = does not apply’ (French et al., 2000). The higher the total score, the more the respondent agreed with the notion that the situation as identified by the item is stressful. The ENSS authors recognized that not all situations would be applicable to all study respondents. For example some direct care staff may not come into contact with the physicians of older people as may have occurred in a supported aged care accommodation service where registered nurses have greatest contact. To address these anomalies, French et al. (2000) provided an additional statement of ‘never encountered’ using ‘0’.

The ENSS (French et al., 2000) is a validated instrument reported in the nurse stress literature. Internal consistency and reliability of the ENSS was assessed using Cronbach’s coefficient alpha. The 57-item ENSS demonstrated reliability of ($\alpha = .96$) (French et al., 2000) compared to the original NSS ($\alpha = 0.89$) (Gray-Toft & Anderson, 1981b). Individual subscale reliability ranged from ($\alpha = 0.88$) (problems with supervisors) to $\alpha = .65$ (discrimination). Factor analysis for ‘discrimination’ demonstrated that the items on sexual discrimination accounted for more variance than did the one item on ethnic discrimination. French et al. (2000) recommended that the discrimination items be used only as separate measures of stress until further instrument testing could be implemented (French et al., 2000). Discriminate validity of the ENSS was examined by computing Product Moment Correlations with overall Life Stress ($r = .17, p < .001$[one-tailed test]) and Health Problems Index ($r = .34, p < .01$ [two-tailed test]) French et al., 2000).

Since its original development, the ENSS (French et al., 2000) has been used in a number of nurse practice environments and countries. For example, an Australian nurse study conducted by Healy and McKay (2000) examined stress, coping strategies and job satisfaction in a volunteer sample of qualified nurses ($n = 129$) recruited from Victorian metropolitan and regional institutions. The authors reported a reliability coefficient of $r = 0.89$ for the total ENSS scale and
reliability coefficients ranging from $r = 0.64$ to $r = 0.77$ for the ENSS subscales (Healy & McKay, 2000). Similar findings were reported in a more recent descriptive study conducted in 2012 by Roopalekha, Latha and Swetha (2012) who examined stress and coping from a convenience sample of nurses ($n = 339$) employed across a range of nurse practice environments in a selected ‘super specialty’ hospital located in Kerala, India. In this study, the authors reported a reliability coefficient of $r = 0.96$ for the total ENSS scale and reliability coefficients ranging from $r = 0.52$ to $r = 0.86$ for the ENSS subscales (Roopalekha, Latha & Swetha, 2012). Finally, a 2013 single-group post-test-only correlational design study conducted by Campbell (2013) measured spirituality, stress and retention of a convenience sample of critical care nurses ($n = 80$) in a Cincinnati Magnet hospital located in North America. The authors reported high Cronbach values for all ENSS scales and subscales (total ENSS scale reliability coefficient $r = 9.54$; ENSS subscale reliability coefficients ranging from $r = 0.691$ to $r = 954$). However, the large number of scale items can be an issue. An extensive review of the literature indicates that the ENSS may not have been used in supported aged care accommodation service research previous to the current study.

5.6.2. MASLACH BURNOUT INVENTORY - HUMAN SERVICES SURVEY (MBI-HSS)

Burnout was measured by asking study respondents to complete the Maslach Burnout Inventory (MBI) (Appendix G) originally developed in 1981 by Maslach and Jackson to measure employees in the human service professions (Maslach, Jackson & Leiter, 1996). Permission to use the MBI was granted by the CPP Inc. Palo Alto, California in 2007 (see Appendix G). Maslach Burnout Inventory (MBI) has demonstrated validity and reliability (using Cronbach’s alpha with reliability coefficients of 0.84–0.90 for EE, 0.46–0.79 for DP, and 0.71–0.76 for PA). The MBI has been extensively used in nursing and other health practitioner research (Maslach et al., 1996; Poghosyan et al., 2009).

The 22 item questionnaire is designed to assess and measure three identified facets of burnout, for example, ‘I feel emotionally drained by my work’ and
‘working with people all day is really a strain on me’. The 22 MBI items are categorized and measured in separate subscales including, Emotional Exhaustion (EE) construed as ‘feelings of being overextended and exhausted by one’s work’; Depersonalization (DP) construed as ‘unfeeling and impersonal responses to one’s service, care treatment and instruction’ and Personal Accomplishment (PA) construed as ‘feelings of competence and successful achievement in one’s work with people’ (Maslach, Jackson & Leiter, 1996, p.4). The 22 MBI items require the respondent to allocate one score for each item from: 0 = never; 1 = a few times a year; 2 = once a month or less; 3 = a few times a month; 4 = once a week; 5 = a few times a week; 6 = every day. Reversed scoring is required for items 4, 7, 9, 12, 17, 18, 19, and 21.

The scores for each subscale (EE, DP and PA) are calculated separately and then aggregated for the total category group. An average degree of burnout is indicated if the EE, DP and PA scores are within an average range. Thus stress, indicated by high scores in the EE and DP scales are counter balanced by evidence of personal accomplishment or high scores in the PA scale. For example: EE (≤ 16 low; 17-26 average; ≤ 27 high); DP (≤ 6 low; 7-12 average; ≤ 13 high); PA (≤ 31 high; 38-32 average; ≥ 39 low) Maslach, Jackson & Leiter (1996).

Maslach, Jackson and Leiter (1996) report acceptable reliability for all subscales (EE = 0.90; DP = 0.79; PA = 0.71). Convergent validity is demonstrated and the reliability coefficients for the subscales were significant: EE (0.82); DP (0.60); and PA (0.80) (Maslach, Jackson & Leiter 1996, p.12).

5.6.3. THE GENERAL SELF-EFFICACY (GSE) SCALE

Perception of self-efficacy was measured by asking respondents to complete the General Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995) (see Appendix F). The GSE is a 10-item self-reporting psychometric 4 item Likert-type scale recording responses from 1 = Not at all true to 4 = exactly true with a sum range of 10 to 40. The ten items are a uni-dimensional outcome measure used to assess an individual’s perceived optimism of their ability to cope with a range of
difficult life situations. Author permission to use this instrument was not formally required as the instrument is freely available for non-commercial research and development purposes to all researchers in the field of self-efficacy subject to the appropriate recognition (Schwarzer & Jerusalem, 1995). A general letter of permission of use furnished by the University of Berlin is shown in Appendix I. The German version of the GSE was originally developed in 1981 by Jerusalem and Schwarzer as a 20-item version, and later as a reduced 10-item version (Jerusalem & Schwarzer, 1992). The GSE correlates positively with self-esteem and optimism, and negatively with anxiety, depression and physical symptoms (Schwarzer & Jerusalem, 1995).

The GSE (Schwarzer & Jerusalem, 1995) has been used in numerous and diverse research studies where it typically yielded internal consistencies between alpha $r= 0.75$ and $r = 0.91$. The original German instrument has been proven reliable and valid in various field studies (Schwarzer, 1993; Schwarzer & Jerusalem, 1996) and has convergent and discriminate validity. Previous studies are described by Schwarzer (1993) and Schwarzer and Jerusalem (1995) include not only the scale in English, German, Spanish, French, Hebrew, Hungarian, Turkish, Czech and Slovak, but also presents the results of five studies conducted to examine the psychometric properties of the German version (Schwarzer, 1993). A possible disadvantage of the GSE is the potential bias from self-reporting (Van de Mortel, 2008; King & Brunner, 2000; Spector, 1994) for example, if time-poor respondents are tempted to circle the highest score (4) and follow this system of completion from question 1 to question 10 without reading or comprehending the actual questions, the validity of the study outcomes may not be achieved (Van de Mortel, 2008).

5.6.4. DEMOGRAPHIC QUESTIONS

Personal information was obtained from each respondent through the completion of demographic questions (Appendix H). Respondent demographic items included fourteen ($n =14$) closed questions relating to gender; age.

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employment status (full-time; part-time; casual); employment position (registered nurse; enrolled nurse; assistant nurse; personal carer; recreational staff; number of years of employed in supported aged care accommodation services; highest level of education; number of hours worked in current area of employment; number of shifts worked (morning, afternoon or evening); if employed concurrently in a second supported aged care accommodation service (yes; no); number of hours worked in a second aged supported care accommodation service; primary language spoken at home; cultural background; competency in verbal English (high, medium or low); and competency in written English (high, medium, or low). A clear response format was developed for each of the demographic questions to more easily convert to the numerical format required for statistical analysis (Pallant, 2007).

5.6.5. SINGLE OPEN-ENDED SURVEY QUESTION

Limited qualitative data was obtained from respondents through written narratives on a single open-ended survey question item which they were invited to provide on a lined blank page attached to the Questionnaire Pack. The respondents were asked to record any experiences they considered to be stressful arising from their interactions with the families of older people in the supported aged care accommodation service.

5.7. PILOTING THE QUESTIONNAIRE PACK

The Questionnaire Pack was first piloted with a convenience sample of five direct care staff and their managers who were recruited from a supported aged care accommodation service with similar characteristics to the targeted study sample and not participating in the main study. The purpose of the pilot study was to determine the effectiveness of the instructions supplied with the Questionnaire Pack, the time required by pilot respondents to complete the surveys and to identify any other associated problems that the pilot respondents may have offered. Additionally, implementing a pilot test with the Questionnaire Pack
ensured that each of the questionnaire scoring instructions and items were clear, readily understood, were answered as required, and that question items were not potentially offensive to respondents (Pallant, 2007).

Explanation of the purpose of the pilot study was provided to the pilot respondents before administering the questionnaire pack. Consenting pilot respondents were assured of confidentiality of their identity and of their written responses.

The piloting procedures demonstrated that the pilot group of respondents were able to fully complete all items on the Expanded Nurse Stress Scale, Maslach Burnout Inventory, General Self-Efficacy scale, the demographic questions and the single open-ended survey question without any difficulties and in less than 25 minutes. Respondents with limited English reading and writing skills completed the questionnaires in approximately 30 minutes without any reported difficulties.

Pilot respondents stated that the wording in each instrument was easy to read and understand, and they were able to complete the questionnaires without feeling pressured or stressed. The piloting of each instrument contained in the Questionnaire Pack did not identify any discrepancies that required adjustment in the wording of the instruments. Further, no additional changes were required to implementation procedures to the main study. The pilot responses and comments made by the participating pilot respondents were kept secure and were not included in the analysis of the study data.

5.8. DATA COLLECTION PROCEDURES

5.8.1. QUESTIONNAIRE PACK

Direct care staff who consented to participate in the main study were supplied with a Questionnaire Pack (a large self-adhesive envelope; the ENSS, MBI, GSE measures; and demographic questions; one attached blank A4 line page; a self-
adhesive stamped envelope with the researchers name and postal address; a typed circular with clearly written instructions on how to complete each of the four surveys; and the researchers contact telephone numbers). Each Questionnaire Pack was coded with a unique identifying number for both the supported aged care accommodation service and the individual respondent. At the briefing meetings and later during distribution of the Questionnaire Packs, detailed completion explanations relating to the Questionnaire Pack were provided to managers and to respondents, and how to use the attached blank A4 page. Completion of the Questionnaire Pack constituted implied consent to join the study, therefore additional written consent was not requested.

Concerns were raised about the ability to obtain sufficient numbers of questionnaire responses including a poorer than anticipated return rate and incomplete item responses, which would have limited sample adequacy. These issues were identified in the literature (Minichiello et al., 2004) and acknowledged as possible impediments to use of surveys. Consequently a number of procedures to facilitate the highest possible return rate and completion of questionnaire item were implemented. Direct care staff that volunteered to be respondents was asked to complete the Questionnaire Pack at the end of each briefing session and immediately following obtaining their verbal consent to join the study. Respondents were advised that whilst they had the freedom not to answer individual items of their choice, fully completing the surveys would provide greater accuracy of information and analysis. Respondents were requested not to write any information on the Questionnaire Pack that would identify either themselves, the supported aged care accommodation service they worked in, or the names of any older person or family member who would be identified when reviewing their responses.

Collection of completed questionnaires was conducted on the day of the recruitment briefing sessions. Prior to submission of the completed Questionnaire Packs, respondents were asked to review each page of the completed Questionnaire Pack to check for incomplete items, and if they wished,
to complete these items before placing the Pack into the envelopes provided. Where a respondent was unable or unwilling to complete the Packs immediately after the recruitment meeting, they were asked to return the completed Questionnaire Packs within two weeks. Stamped, self-addressed and self-adhesive envelopes were provided to those respondents for this purpose. Additionally, a clearly identified locked box was placed at the clinical station of each supported aged care accommodation service in which the completed Questionnaire Pack could be placed by those respondents that were unable to complete the surveys by the end of the briefing and recruitment sessions or at other times when the researcher visited.

To minimize non-completion and non-return of the Questionnaire Pack, respondents with limited English reading and writing skills were advised that the researcher would be available to assist them at any time they had available during their working day, and that their manager had given permission to take time off from their duties to complete the Questionnaire Pack. Permission for giving these respondents extra time to complete the Questionnaire Pack had been granted during the initial interview with managers. With the permission of the manager, the potential respondents who had poor or had no written English language skills were invited to a small group, or one-on-one, meeting with in a private location to complete the Questionnaire Pack. Care was taken in assisting these respondents with understanding the items they had difficulties with, and how they needed to respond to each set of questions without pre-empting their responses. Systematic bias was minimised by ensuring that the words used when explaining item meanings and response choices were consistent with the words written on the Questionnaire Pack (Minichiello, Sullivan, Greenwood & Axford, 2004).

A weekly visit to each participating supported aged care accommodation service was instigated by the researcher to clear the locked boxes. During these visits prospective study respondents were reminded to complete and place their Questionnaire Pack in the locked box within the week if they wished to do so.
Care was taken to avoid placing any pressure on any direct care staff to complete and return the Questionnaire Pack during visits. Direct care staff was also reminded that the researcher was available to assist them with understanding the questions and the scoring rules if they still wished to complete the Questionnaire Pack.

Sampling bias in self-administered survey studies is common (Minichello et al., 2004), therefore the steps taken to minimize non-response rates occurred mainly through making multiple visits to the participating facilities during the two weeks following the distribution of the Questionnaire Pack. Despite repeated visits to each supported aged care accommodation service by the researcher and assurances of assistance to direct care staff on all weekday shifts and on weekends, not all of the targeted direct care staff who had attended the briefing and recruitment sessions in the 20 consenting supported aged care accommodation service decided to participate in the study.

Reasons for non-participation included direct care staff non-availability during the initial information session times; unwillingness to attend briefing sessions and to complete the Questionnaire Pack during breaks or other scheduled prearranged times approved by their managers. Factors that may have impacted on a lowered return rate included not initiating contact with those direct care staff that elected to avoid the briefing sessions and take their meal breaks outside of the supported aged care accommodation service in order to smoke cigarettes and to eat; non-completers that had initially demonstrated enthusiasm to participate in the study at the time of the briefings but later changed their minds and did not wish to formally withdraw; and the absence of permanent direct care staff on one or more various categories of leave; or had recently resigned from the supported aged care accommodation service.
5.9. DATA PREPARATION AND ANALYSES

5.9.1. DATA PREPARATION

Prior to entering the responses from the completed Questionnaire Packs into the statistical software SPSS Version 16 (SPSS Inc., Chicago IL), a codebook was prepared with a summary of the instructions and abbreviations used to convert and identify all the data. All changes to variables were recorded in the codebook as they were made. Each variable was defined and labelled with a unique and identifiable variable name that would also be useful when creating graphs. The identification number originally assigned to each Questionnaire Pack became the SPSS study respondent identification (ID) number. The ID number enabled data entry errors to be readily sought, including re-checking with each respective survey for accuracy during the data cleaning phase. A number of missing cases were identified in this way. Being able to verify the respondent ID with the raw data assisted with re-entering the correct data into the spread-sheet. During the data entry procedures a diary was used to record all data changes. The diary provided details on why relevant changes were implemented, including the conceptual processes leading to those changes (Pallant, 2007). Developing disciplined processes for the saving of data output at the end of each SPSS entry reduced data loss.

5.9.2. SINGLE OPEN-ENDED SURVEY ITEM ANALYSIS

Data obtained from the narratives provided by respondents on the single open-ended survey item were analysed with a mixture of analytical methods including a computer based analytical software program (Leximancer), and other standard content analyses procedures. Bazeley (2004) asserts that computer based tools provide a useful means to validate traditional or manual methods whilst reducing a degree of researcher error or bias in data interpretation. Each of these methods will be discussed sequentially.
5.9.3. INACCURATE AND MISSING DATA

Each completed questionnaire was examined carefully to assess for missing data and any misinterpretation, or inconsistency in responses, to minimise missing values from each subject or case. It is well documented, that it is rare to obtain complete data when doing research with human beings (Minichiello, Sullivan & Axford). Careful consideration was given to completed questionnaires with missing values to assess for inconsistencies, or misinterpretation in responses.

Descriptive statistics were run to determine what percentage of values were missing from each variable. The ‘Exclude cases pairwise’ option was selected for all analyses, as whilst this option excludes the case for a specific analysis due to missing data, the option does allow inclusion in other analysis where the necessary data is available. Whilst the SPSS software recognizes and interprets any blank cell as missing data, a decision was made to assign the numbers 99 as a specific value to indicate missing values. During analysis 99 was omitted from continuous variables as this number distorted the analysis.

Whilst most missing data were random, it was noted that many cases relating to respondent’s age were missing. It is well known that respondents who complete self-reporting questionnaires will often omit their age for reasons not always known (Pallant, 2007). Therefore, in order to maximise the number of scores for the ENSS and the MBI subscales, a technique was used to extrapolate scores where items were missing. More specifically, if less than 80% of items were unanswered, a sub-scale score was not calculated. If 80% of items or greater were answered, the following formula was used to calculate an extrapolation score. For example, for the MBI subscale there were 10 items in total, so if fewer items were answered no score was calculated. If eight or nine of the 10 items were answered an extrapolated sub-scale was calculated. Missing item scores, accordingly, has a direct effect on the total overall score. The extrapolated scores on the GSE were achieved by implementing the following method:
(i) summing the completed items,

(ii) then dividing by the number of valid or answered items,

(iii) then multiplying by 10 (the total number of items in the questionnaire).

Processes for screening and cleaning of data were also implemented to check for errors, including outliers that may have occurred during the data entry processes in both categorical and continuous variables. Each variable was initially investigated for out of range scores. The procedures carried out included inspecting the frequency distribution values, for example, gender was coded as 1=female and 2=male. If other codes appeared, a data entry error would have occurred. The second strategy included comparison of data with the original hard copies. This procedure was undertaken with all respondent surveys.

During this data preparation stage, a number of respondents had entered work hours far exceeding 40 hours per week, and in many cases double this number. Since these numbers of worked hours were very unlikely, the managers of the respective supported aged care accommodation services were contacted to verify the rostered hours of these respondents. After clarification with managers, it was evident that some respondents had included and documented the hours they had worked over a two week period instead of one week as requested in the demographic survey. This was understandable since most shift rosters were calculated fortnightly and not weekly.

Following clarification with the managers, the identified well-out of range hours was halved and this figure was then entered into SPSS as the actual hours worked. The halved hours were equivalent to a normal 38 hour week. Other out of range figures were evident in the hours worked in a second supported aged care accommodation service. These figures, whilst excessive, could not be verified as the hours were related to the respondent’s second job of work, therefore were entered as stated.
The variables used for this study included the dimensions of the ENSS (French et al., 2000), the MBI (Maslach, Jackson & Leiter, 1996) and GSE (Schwarzer & Jerusalem, 1995). The ENSS (French et al., 2000) contains 57 items grouped into 9 subscales reporting the levels of stress experienced by the respondents. The ENSS (French et al., 2000) items include, for example: *residents’ families making unreasonable demands; being the one that has to deal with the residents’ families; and not enough time to respond to the needs of resident’s families*. The nine ENSS (French et al., 2000) subscales included: *inadequate preparation to meet the emotional needs of residents; and performing job duties; conflict and concerns about nurses and supervisors; and death and dying*. The MBI (Maslach, Jackson & Leiter, 1996) contains 22 items grouped into three subscales that measure nursing staff experience of burnout in the aged care setting, including for example: *I feel emotionally drained from my work; I feel used up by the end of the workday; and I feel burned out from my work*. The 3 subscales included: *emotional exhaustion; depersonalization; and personal accomplishment*. Finally, the GSE (Schwarzer & Jerusalem, 1995) scale contained a total of ten self-reporting items measuring an individual’s perception of their self-efficacy.

The respondent demographic variables included: current age (in whole years as from last birthday); gender; employment status (full-time, part-time, casual, other); current position (i.e., registered nurse, assistant nurse, personal care worker, recreational staff); number of years worked in supported aged care accommodation services; qualifications (i.e., bachelor’s degree in nursing; registered nurse certificate, enrolled Nurse certificate Grade III or IV certificate in care work, or other relevant care qualification); hours per week worked in current supported aged care accommodation service; number of shifts worked (i.e., morning, afternoon, night); if currently working concurrently in other supported aged care accommodation services; number of hours per week worked in other supported care environments; primary language spoken at home; cultural background; English speaking skills (i.e., high, medium or low); and written English proficiency skills (i.e. high, medium or low). The Australian
Standard Classification of Cultural and Ethnic Groups (ASCCEG) was used for the classification and categorization of respondents’ cultural backgrounds into respective variables. Spoken languages were classified into variables identified and labelled according to the Australian Bureau of Statistics Australian Standard Classification of Languages (ASCL) (Australian Bureau of Statistics, 2005).

5.9.4. PRE-ANALYSES PROCEDURES

Data analyses preparation procedures were performed using SPSS Version 16 (SPSS Inc., Chicago IL), using different analytic techniques as required to interpret the different data (Pallant, 2007). An experienced statistician was consulted prior to and during the data analyses procedures to ensure the selected analyses techniques were suitable and the techniques were being used correctly. The statistician checked all analyses procedures being used and ran separate tests to determine correct interpretation of the study results by the researcher.

Descriptive statistical analyses were run on all quantitative variables to: (a) provide an understanding of the characteristics of the study sample; (b) check for any violation of the assumptions underlying the statistical techniques to be used for further analysis; and (c) address the specific research questions (Pallant, 2007). Descriptive statistics including frequencies (frequency, percent) and descriptions (mean, standard deviation, range of scores, skewness and kurtosis) were performed on both categorical and continuous variables. The Exclude Cases Pairwise option was employed to deal with missing cases. This option was favoured above other methods, as only the missing case would be excluded from the respective analysis. Using other methods (for example, the Exclude cases list-wise option) may have reduced the sample size.

Normality of the distribution of scores was assessed for all continuous variables by obtaining skewness and kurtosis values using the Kolmogorov-Smirnov statistical test. The Kolmogorov-Smirnov statistical test does not violate the assumption of normality. A non-significant result of Sig value more than .05
indicates normality (Pallant, 2007). Equal group sizes are important for some analysis such as in the Kruskal Wallis tests (Pallant, 2007). While the Kruskal-Wallis test is not as powerful as the Analysis of Variance (ANOVA) (Pallant, 2007), the Kruskal-Wallis test is a non-parametric test used to compare three or more groups of data and makes no assumptions about the distribution of the data. Data manipulation was implemented prior to the commencement of data analyses. This process consisted of reversing items on the MBI scale (Maslach, Jackson & Leiter, 1996) and adding up individual item scores and total item scores for each participant and each scale (ENSS, MBI and GSE). Scores were checked with the possible range of scores with each scale (for example, lowest score for GSE (Schwarzer & Jerusalem, 1995) scale = 10 x 1 =10; highest score = 10 x 4 = 40). The mean score values for each scale were compared to similar values obtained in previous studies. Categorical variables (age, experience) were collapsed into groups to facilitate some analyses. For example, age was used as a categorical variable and collapsed into approximately three equally sized groups (19 - 40 (32.5%); 41 – 51 (33.1%); 52 – 72 (34.4%) and experience was collapsed into three groups (0 to 7 years (32.9%); 8 to 15 years (34.2%); and 16 to 14 years (32.9%) for other analyses. Recoding of these new additional variables were implemented and recorded. Descriptive analysis were run for each new variable and output checked (out of range cases) for each variable.

Of particular importance to this study were seven ENSS (French et al., 2000) questions that were specifically inter-related with direct care staff and families of older people including: Question 3 Feeling inadequately prepared to help with the emotional needs of a residents’ family; Question 25 Being blamed for anything that goes wrong; Question 33 Not knowing what a resident or a residents’ family ought to be told about the resident’s condition and its treatment; Q34 Being the one that has to deal with the residents’ family; Question 45 Not enough time to respond to the needs of residents’ families; Question 52 Having to deal with abuse from residents’ families; Question 56 Not knowing whether residents’ families will report you for inadequate care.
Additionally, a further three ENSS (French et al., 2000) questions (Q 7 Residents making unreasonable demands; Question 35 Having to deal with violent residents; and Question 44 Having to deal with abusive residents) were identified as being of importance to the study as whilst these three questions dealt with the older people themselves, all questions were identified from the empirical literature (French et al., 2000) as issues that impact on care and subsequently may have contributed to the negative interactions with the families of older people.

5.10. DATA ANALYSIS TECHNIQUES

5.10.1. STATISTICAL ANALYSES

Descriptive statistics were used to summarise the characteristics of respondents (age, gender; employment status, position, years worked, qualifications, hours worked in primary supported aged care accommodation service of work, shifts worked, if working in another supported aged care accommodation service; hours worked at another supported aged care accommodation service, language, cultural background, English speaking skills, and written English skills. The descriptive statistics included examining the frequency distributions, means, standard deviations and confidence intervals for normally distributed data and median and inter quartile ranges for skewed data. Parametric tests (t-tests) were used for normally distributed variables and non-parametric tests (Spearman Rho & Kruskal Wallis) for non-normally distributed variables.

The relationship between ENSS domains ‘Conflict with Physicians’, ‘Discrimination’ and ENSS item Question15 ‘Residents’ Families Making Unreasonable Demands’ was examined using Spearman’s correlation and Mann-Whitney U. Though not as powerful and less sensitive in detecting a relationship among variables, nonparametric correlations, for example, Spearman’s Rank Oder Co-efficient (Spearman’s rho) and Mann-Whitney U test were used for analysis where variables were found to be not normally distributed. Spearman’s
rho is considered a satisfactory statistical tool for this study to measure the linear relationship of two variables including the magnitude (strength of the correlation) and direction (positive or negative association of variables). For example, if the correlation is either (or closer to) +1, or -1, the stronger (positive) the correlation between the variables; whereas 0 (or close to 0) indicates a negative association between the variables (Pallant 2007). Correlational statistics (Pearson’s correlation and Spearman’s correlation) were also used to determine if there is a relationship amongst the variables of the ENSS, MBI and GSE and variables of care staff demographics.

Analysis of Variance (ANOVA) technique was used for data normally distributed. ANOVA was considered suitable to detect any difference in the means of the groups being analysed. The four basic assumptions used in ANOVA are that the expected values of the errors are zero, the variances of all errors are equal to each other, and the errors are independent and are normally distributed (Pallant, 2007). Where there were missing cases within a data set, the list-wise deletion test was used, based on all variables in the procedure. Any continuous variables with significant skew and unable to be transformed to approximate a normal distribution, were analysed using the Mann-Whitney U test and Kruskal-Wallis test.

5.10.2. LEXIMANCER TECHNIQUES – ANALYSIS OF A SINGLE OPEN-ENDED SURVEY ITEM DATA

Leximancer is a computer based qualitative analytic tool developed by a small Australian company (Leximancer Pty Ltd) that was developed in 2006 by the University of Queensland’s Faculty of Social and Behavioural Sciences (Cretchley, Rooney and Gallois, 2006; Smith and Humphreys, 2006). Described as a ‘text-mining’ tool (Cretchley, Rooney and Gallois, 2010), Leximancer enables the user to navigate the complexity of unstructured text in a uniquely automated manner. The developers of Leximancer claimed that the tool is useful in areas associated with survey analysis, market research, social media monitoring and political
analysis as it embraces the complexity of language allowing the true meaning to emerge from the text itself, without the same level of bias as may occur from human analysis (Smith & Humphreys, 2006. The primary aims of data extraction with Leximancer are as follows:

1. To construct classifiers for multiple concepts that can predict whether a small segment of text contains one or more of the concepts.

2. To provide a meaningful name for each concept as a signifier: this is done to support interpretation and visualization.

3. To allow manual customization of the concept set prior to learning of the representations.

The foundations underpinning the Leximancer technique involves the semantic and grammatical clustering of words through multidimensional scaling of co-occurrence and interconnectedness (see Cretchley, Rooney & Callois, 2010). The latent semantic analysis work of Landauer and Dumais (1997) (cited in Smith & Humphreys 2006) provides the basis for the theoretic underpinning of Leximancer development (Smith & Humphreys 2006). Leximancer enables the user to analyse the contents of a textual document identifying and displaying the main themes, ideas and concepts by means of a conceptual map (Smith & Humphreys, 2006; Cretchley, Rooney & Callois, 2010). The concept map provided a visual display of the main concepts and their importance as identified in the document text, the strengths of links between concepts (the frequency of each concept occurrence), the relationships between concepts; the centrality of each concept and the similarities in the context in which the concepts occur (Cretchley, Rooney & Callois, 2010).

Visually, the Leximancer concept map is described as a Venn diagram displaying the most central extracted concepts discussed in the text (Smith & Humphreys, 2006). The centrality of a concept is defined in terms of the number of times a concept co-occurs with other defined concepts. When viewing the map, the
boldness of the text label identifies the frequency of the concept demonstrated by variations of shading from light grey (less frequent) to heavy black (highly frequent). The size of the concept point indicates its relationship and interrelationships to other concepts. A thematic group containing related concepts is differentiated by a colour surrounded by a circle, the brightness of the colour further differentiating the strength of the association between other concepts. For example, the closer to the red end of the colour spectrum, the more significant the concept overall reflecting frequency and connectedness of the concept to other concepts. Through the use of a map glider, the user is able to view those concepts that are less visual on the map, determining their significance and relationship to the central extracted concepts and to the identified thematic groups (Smith & Humphreys, 2006).

Some concepts that have a direct link in the text may be found adjacent on the map due to their direct association with another concept. To illustrate this point, the developers of Leximancer use the text of Romeo and Juliet, and draw attention to the concept of eyes and eye as being unrelated, yet both these words appear together on the map and in close association with the concepts of sun, night, light (Smith & Humphreys, 2006). A further illustration provided by Smith and Humphreys (2006) relates to the concepts of dog and bark. While the association of dog and bark are clearly obvious, the word bark may also be representative of the outer layer of a tree.

When a specific concept is selected, the user is able to explore the concepts occurrence with other concepts within the body of the text (Smith & Humphreys, 2006). Leximancer also identifies the most frequently occurring concepts and provides a count for each word, calculating the numbers as an overall percentage of total extracted words. The developers of this analytic software suggested that the responsiveness of the user will determine the effectiveness of the program as a data mining tool. A major benefit of this analytic software is the absence of the human factor, thus avoiding a level of subjectivity that may occur in traditional thematic analyses (Smith & Humphreys, 2006). There are identified
limitations to the Leximancer analytic software. Smith and Humphreys (2006) draw attention to the fact that the concepts extracted from text remain textual and, therefore, interpretation of meaning by Leximancer may be limited when compared to the more complex human interpretation processes. Despite this limitation Leximancer has been used effectively as a text mining tool in visually identifying the structure of concepts and themes across a 40 year history of the Journal of Cross- Cultural Psychology (Cretchley, Rooney & Gallois, 2010) and in an exploration of the inter-group dynamics in communication between people with schizophrenia and carers (Cretchley, et al., 2010).

5.10.3. NON-COMPUTER ASSISTED CONTENT ANALYSES

While Leximancer assisted in the process in organising the written data from a single open-ended survey question item and grouping these data into concepts and categories, the interpretation of the text relied on an ability to fully engage with the text and to identify the imbedded messages and meanings within it. The purpose of employing standard content analysis of qualitative data while adhering to rigorous procedures is to become fully immersed in the data before focussing on attention on the detail, the embedded messages and the meanings within the text (Tesch, 1990). A reported weakness of any aspect of content analysis is the need to restrict analyst bias (Bazeley, 2004).

The written data was manually examined using standard content analysis techniques (Burnard, 1991). First the respondents’ handwritten data were read and then word processed using Microsoft Word 2010. Editing of the text including spelling, grammar and abbreviations were avoided to assist in retention of authenticity of the written data. Respondents’ original allocated identification as used for the quantitative data was used as transcript identification. All transcripts were read and re read to enable reflection and immersion in the data and to develop an understanding of the data content. The re-reading of the written data brought about a sense of the concepts and themes, along with the negative and positive feelings that respondents conveyed about their personal
experiences with the families. Factors relating to other stress issues were not
generated in undertaking this qualitative analysis process, since the respondents
had identified these other sources and consequences of stress as being equally
important to them (Radnor, 2002).

When considering the method of analysis of written data, Burnard (1991 p. 461)
asserts that ‘there is no one method of analysis can be used’. Therefore, in
proceeding to analyse these data, an open coding method as discussed by
Burnard (1991 p. 461) and Corbin and Strauss (1990 pp. 12-14) was considered
appropriate and adopted. This method of analysis is based in the grounded
theory literature (Burnard, 1991; Corbin and Strauss, 1990). During the initial
analysis phase, categories were not imposed on the written data, rather, themes
were extracted. For example, using words and phrases as units of meaning,
frequently referenced concepts and themes were identified. The words and
phrases with similar meanings were grouped together into an initial set of
thematic categories. These categories were then refined to eliminate those
words or phrases with similarly related meanings, which avoided overlapping
these themes and ensured that a meaning was coded only once. The naming of
these themes was based on the theme content and meaning.

Following the identification of relevant themes, all thematic categories were
reviewed to verify their relevance to the study topic and to also identify any
additional themes (see results chapter 7). Each theme was then synthesised and
discussed with the findings obtained from the Leximancer-aided data analysis.
To synthesise the thematic categories, the identified themes were further
categorised into aggregated categories that were considered appropriate. A
conceptual model was then constructed to describe the relationship between
the identified categories that arose from the data. This model helped to reveal
the relationships between the stress triggers associated with the interactions of
direct care staffs with families, the organisational barriers they faced in their day
to day work and their personal coping strategies.
Using these forms of data analysis required a high level of personal reflection, or reflexivity (Radnor, 2002) that may have led to a personal bias in data interpretation. To reduce this bias, a process of reflection of the effect of personal experiences in the supported aged care accommodation serve sector might have influenced interpretation of these data. For example, personal interpretation of the intent of the meaning by staff in describing these stress factors and experiences might have differed to what was intended (Radnor, 2002). On the other hand, the shared experiences of the researcher and respondents within the Australian supported aged care accommodation service context, may have assisted in gaining a deeper understanding and interpretation of written data (Radnor, 2002). The notion of referential and relational meanings of language are more readily understood and interpreted when unified in a shared context for, “As we share a form of life, through our language we are capable of reconstructing experiences other than our own” (Radnor, 2002:16).

5.11. CHAPTER SUMMARY

supported aged care accommodation service Chapter 5 provided details of the study methods employed to answer the research questions on direct care staff work stress, burnout and self-efficacy in supported aged care accommodation services. Details on the study aims and research questions were provided; research design; study setting; recruitment population and procedures; ethical considerations with regard to study participant recruitment and consent; measures used; piloting procedures; data collection procedures; and data preparation and analyses techniques used.

Study participants included direct care staff currently employed in twenty located in one geographical region in the greater Sydney metropolitan area. Data were obtained via an anonymous questionnaire Pack which comprised demographic questions and three validated questionnaires on stress (Expanded Nurse Stress Scale (ENSS) (French et al., 2000); burnout (Maslach Burnout Human Services Inventory Survey (MBI) (Maslach, Jackson & Leiter, 1996): and self-
efficacy (General Self-Efficacy Scale (GES) (Schwarzer & Jerusalem (1995). A single open-ended survey item elicited written data from respondents about any stressful experiences they may have had when interacting with the families of older people living in the supported aged care accommodation service.

To analyse these data a range of statistical techniques were employed to identify the relationships between the constructs of work stress, burnout and self-efficacy in supported aged care accommodation service work, and respondent demographics. The statistical software SPSS Version 16 (SPSS Inc., Chicago IL) was employed to examine the frequency distributions, means, standard deviations and confidence intervals for normally distributed questionnaire responses. The narrative data were first sorted and categorised using computer-assisted software Leximancer (Leximancer Pty Ltd) and then were content analysed using the approaches outlined by Corbin and Strauss (1990) to obtain more comprehensive meaning from these data. The study results are presented in Chapter 6.
CHAPTER 6 – STUDY RESULTS

6.1. INTRODUCTION

Chapter 6 presents the study findings obtained from all data sources including: the Expanded Nurse Stress Scale (ENSS) (French et al., 2000); the Maslach Burnout Human Services Inventory Survey (MBI) (Maslach, Jackson & Leiter 1996); the General Self Efficacy Scale (GES) (Schwarzer & Jerusalem, 1995); a demographic questionnaire consisting of fourteen questions developed by the researcher; and narrative response to the single open-ended survey item on stress associated with interactions with the families of older people living in the supported aged care accommodation service. Data analyses were conducted to answer the following research questions.

6.2. RESEARCH QUESTIONS

1. What levels and causes of stress and are experienced by direct care staff in the supported aged care accommodation service?
2. What levels and causes of burnout are experienced by direct care staff in the supported aged care accommodation service?
3. What levels of personal accomplishment and self-efficacy are experienced by direct care staff in the supported aged care accommodation service?
4. Is there an association between the demographic characteristics of direct care staff and their levels of stress, burnout, and self-efficacy?
5. Is there an association between work place characteristics and direct care staff’s levels of stress, burnout, personal and self-efficacy?
6. Is direct care staff stress associated with their interactions with the families of older people living in the supported aged care accommodation service?

The study findings that relate to each of these research questions are presented in the following order: supported aged care accommodation service return rate; respondent demographic characteristics; levels of direct care staff stress, burnout and self-
efficacy; the relationships between direct care staff stress, burnout and self-efficacy; the relationships between stress, burnout, self-efficacy and staff demographic variables; and levels of direct care staff stress, burnout, self-efficacy arising from their interactions with residents’ families. Qualitative data obtained from study respondent narratives are presented as themes.

6.3. QUESTIONNAIRE RESPONSE RATE

Of the total 221 Questionnaire Packs distributed to each of the 20 participating supported aged care accommodation service, 162 (73.3%) direct care staff provided useable data for subsequent study analyses. The return rate of completed Questionnaire Packs for each targeted supported aged care accommodation service varied from 20% \((n = 2/10)\) to 100% \((n = 16/16)\). Descriptive statistics for the sample population return rate from each supported care environment are presented in Table 10.

Table 10 – Questionnaire Pack Distribution

<table>
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<tr>
<th>Facility</th>
<th>Distributed ((n))</th>
<th>Returned ((n))</th>
<th>Return Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility 1</td>
<td>10</td>
<td>9</td>
<td>90</td>
</tr>
<tr>
<td>Facility 2</td>
<td>10</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Facility 3</td>
<td>15</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Facility 4</td>
<td>10</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>Facility 5</td>
<td>10</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Facility 6</td>
<td>10</td>
<td>9</td>
<td>90</td>
</tr>
<tr>
<td>Facility 7</td>
<td>16</td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Facility 8</td>
<td>16</td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Facility 9</td>
<td>10</td>
<td>8</td>
<td>80</td>
</tr>
</tbody>
</table>
### Distributed\( (n) \) Returned\( (n) \) Return Rate\( \% \)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Distributed</th>
<th>Returned</th>
<th>Return Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility 10</td>
<td>10</td>
<td>8</td>
<td>80</td>
</tr>
<tr>
<td>Facility 11</td>
<td>10</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Facility 12</td>
<td>14</td>
<td>14</td>
<td>100</td>
</tr>
<tr>
<td>Facility 13</td>
<td>10</td>
<td>6</td>
<td>60</td>
</tr>
<tr>
<td>Facility 14</td>
<td>10</td>
<td>4</td>
<td>40</td>
</tr>
<tr>
<td>Facility 16</td>
<td>10</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Facility 18</td>
<td>10</td>
<td>8</td>
<td>80</td>
</tr>
<tr>
<td>Facility 20</td>
<td>10</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>Facility 22</td>
<td>10</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Facility 23</td>
<td>10</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>Facility 24</td>
<td>10</td>
<td>9</td>
<td>90</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>221</strong></td>
<td><strong>162</strong></td>
<td><strong>73.3</strong></td>
</tr>
</tbody>
</table>

### 6.4. RESPONDENT DEMOGRAPHIC PROFILE

The demographic profile of the study sample is presented in Tables 12 and 13. Not all questions in all surveys were completed by respondents. From the number of returned questionnaires (163) the number of complete questionnaires was 162. Respondents’ ages varied from 19 years of age to 72 years of age, with a mean age of 46.0 and standard deviation of 11.7. The histogram in Figure 7 displays the distribution of respondents’ ages.
Tables 11 and 12 lists other respondent demographic details. The majority of respondents were female ($n = 145/162; 90.1\%$) and worked part-time ($n = 89/162; 54.9\%$). One respondent was recruited from an employment agency and employed on a long term casual basis.

Respondents were grouped into three primary employment position groups. The first group included registered nurses, directors of nursing and nurse educators ($n = 64; 39.5\%$). The second group included assistant nurses and personal care workers ($n = 90; 55.6\%$). The third group included recreational staff ($n = 8; 4.9\%$). As none of the respondents identified as an enrolled nurse, this role category was not included in any subsequent analysis.

The total number of years worked by respondents ranged from a minimum of 0.33 years to a maximum of 42 years with a mean of 12.9 years (SD 9.1, see Table 13). The number of hours worked by respondents in their primary study site ranged from a
Of the total cohort \((n = 162)\), 34 \((21\%)\) respondents held a formal Australian nursing qualification (i.e. Registered Nurse Certificate); and a further 68 \((42\%)\) respondents held a non-tertiary qualification that was identified as either a Certificate Grade III or IV in Aged Care. Eight \((4.9\%)\) respondents held no stated qualification. Fifty two \((32.1\%)\) of all respondents held an additional qualification. For example, a small number of respondents \((n = 10/162; 6.2\%)\) held an overseas Registered Nurse or Nursing Certificate. Six \((3.7\%)\) respondents held a Bachelor of Nursing degree. Seven \((4.3\%)\) respondents were currently enrolled in a health related degree or certificate course, while five \((3.1\%)\) respondents held a management related tertiary qualification.

Three quarters of the respondent sample \((n = 121/162, 74.7\%)\) worked at least one morning shift in their primary study site. A further one-third of the respondent sample worked at least one afternoon shift \((n = 59/162, 36.4\%)\), and only 7.4% worked at least one night shift \((n = 12/162)\). One third of the sample worked in a second supported aged care accommodation service in conjunction with their primary place of employment \((n = 53/162, 32.7\%)\), working an additional mean of 22.6 hours (SD 11.8, range 5 to 58 hours) per week.

Approximately half \((48.1\%; n = 78/162)\) of respondents identified English as their primary language spoken at home. Language groups are reported according to the Australian Bureau of Statistics (2005) reporting format. Languages spoken at home included Northern European Languages \((n = 80/162; 49.4\%)\); Southeast Asian Languages \((n = 30; 18.5\%)\); Southern Asian Languages \((n = 16; 9.9\%)\); Southern European Languages \((n = 7; 4.3\%)\); Eastern European Languages \((n = 4; 2.5\%)\); Southwest and Central Asian Languages \((n = 4; 2.5\%)\); Eastern Asian Languages \((n = 5; 3.1\%)\); Australian Indigenous Languages \((n = 1; 0.6\%)\); and other including those languages consisting of languages from North and South American, and the African Continent \((n = 15; 9.3\%)\).
A high proportion of respondents \( (n = 85.4\%) \) were from identifiable cultural groups other than European. Twenty three respondents \( (n = 14.6\%) \) identified themselves as of European heritage. The cultural groups identified included Oceanic \( (n = 59; 37.6\%) \); North – Western European Cultures \( (n = 12; 7.6\%) \); Southern and Eastern European \( (n = 11; 7\%) \); North African and Middle Eastern \( (n = 4; 2.5\%) \); South – East Asian \( (n = 35; 22.3\%) \); North East Asian \( (n = 4; 2.5\%) \); Southern and Central Asian \( (n = 25; 15.9\%) \); People of the Americas \( (n = 2; 1.3\%) \); and Sub- Saharan African \( (n = 5; 3.2\%) \), with data missing for five participants. Approximately two-thirds of respondents rated their English speaking skills as high \( (n = 109, 67.3\%) \) and their written English skills as high \( (n = 100; 61.7\%) \).

<table>
<thead>
<tr>
<th>Table 11 – Respondent ( (n = 162) ) Demographic profile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td><strong>Current Nursing Position</strong></td>
</tr>
<tr>
<td>Director of Nursing/Deputy Director of Nursing/ Nurse Manager</td>
</tr>
<tr>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Nurse Educator</td>
</tr>
<tr>
<td>Assistant Nurse</td>
</tr>
<tr>
<td>Personal Carer</td>
</tr>
<tr>
<td>Recreational Staff</td>
</tr>
<tr>
<td><strong>Nursing Qualification Held</strong></td>
</tr>
<tr>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Nursing Certificate Grade III or IV</td>
</tr>
<tr>
<td>Overseas Nursing/Degree Qualification</td>
</tr>
<tr>
<td>Management Degree</td>
</tr>
<tr>
<td>Currently Enrolled in Health Related Degree</td>
</tr>
<tr>
<td>No Stated Qualifications</td>
</tr>
<tr>
<td><strong>Primary Language Spoken at Home</strong></td>
</tr>
<tr>
<td>English</td>
</tr>
<tr>
<td>English and Other</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Cultural Identity</strong></td>
</tr>
<tr>
<td>Oceania</td>
</tr>
<tr>
<td>European</td>
</tr>
<tr>
<td>South East Asian</td>
</tr>
<tr>
<td>North East, South &amp; Central Asian</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>Other (African, America)</td>
</tr>
<tr>
<td>Level of Verbal English Skills</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Medium</td>
</tr>
<tr>
<td>Low</td>
</tr>
<tr>
<td>Level of Written English Skills</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Medium</td>
</tr>
<tr>
<td>Low</td>
</tr>
</tbody>
</table>

Table 12 - Respondent age and employment details 1

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>151</td>
<td>46.0</td>
<td>11.7</td>
<td>19 - 72</td>
</tr>
<tr>
<td>Total years employed in Aged Care</td>
<td>161</td>
<td>12.9</td>
<td>9.2</td>
<td>0.33 - 42.0</td>
</tr>
<tr>
<td>Hours worked in current facility</td>
<td>162</td>
<td>32.2</td>
<td>8.1</td>
<td>4 - 40</td>
</tr>
<tr>
<td>Hours worked in another facility</td>
<td>53</td>
<td>22.6</td>
<td>11.8</td>
<td>5 - 58</td>
</tr>
<tr>
<td>Total hours worked including hours worked in another facility</td>
<td>162</td>
<td>38.9</td>
<td>11.5</td>
<td>15 - 80</td>
</tr>
</tbody>
</table>

6.5. LEVELS OF STRESS, BURNOUT AND SELF-EFFICACY

Descriptive analyses were conducted on respondents’ responses from the Expanded Nurse Stress Scale (ENSS), the Maslach Burnout Inventory (MBI) and the General Self-Efficacy Scale (GES) to identify the respondents’ perceived levels of stress, burnout and self-efficacy.

6.5.1. THE EXPANDED NURSE STRESS SCALE (ENSS)

For the 57 items of the ENSS, the number of missing respondent responses ranged from 0 to 15. Descriptive analysis were run for each of the nine ENSS subscales (see table 14). Table 13 shows that the highest mean sub-scale score (indicating the greatest stress) was Workload (mean 20.29, SD 7.65), followed by Residents’ Families (mean 19.94, SD 7.18) and Death and Dying (mean 14.28, SD 5.12). The distribution of
the ENSS was normal in seven of the nine subscales and was significantly skewed in two ENSS subscales *Conflict with Physician*, Figure 8 and *Discrimination*, Figure 9.

### Table 13 - Stress (ENSS) Total and Sub-Scale scores

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Number of items</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Skewness</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score</td>
<td>160</td>
<td>57</td>
<td>106.74</td>
<td>38.15</td>
<td>0-186</td>
<td>0.94</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-scale scores</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death and Dying</td>
<td>160</td>
<td>7</td>
<td>14.28</td>
<td>5.12</td>
<td>0-27</td>
<td>0.28</td>
<td></td>
</tr>
<tr>
<td>Conflict with Physician</td>
<td>160</td>
<td>5</td>
<td>6.50</td>
<td>5.09</td>
<td>0-20</td>
<td>0.013</td>
<td></td>
</tr>
<tr>
<td>Inadequate Preparation</td>
<td>160</td>
<td>3</td>
<td>5.76</td>
<td>2.81</td>
<td>0-12</td>
<td>0.07</td>
<td></td>
</tr>
<tr>
<td>Problems with Peers</td>
<td>159</td>
<td>6</td>
<td>9.62</td>
<td>4.53</td>
<td>0-21</td>
<td>0.38</td>
<td></td>
</tr>
<tr>
<td>Problems with Supervisors</td>
<td>159</td>
<td>7</td>
<td>12.73</td>
<td>6.60</td>
<td>0-28</td>
<td>0.62</td>
<td></td>
</tr>
<tr>
<td>Workload</td>
<td>160</td>
<td>9</td>
<td>20.29</td>
<td>7.65</td>
<td>0-36</td>
<td>0.46</td>
<td></td>
</tr>
<tr>
<td>Uncertainty With Treatment</td>
<td>158</td>
<td>9</td>
<td>14.47</td>
<td>7.02</td>
<td>0-31</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td>Residents Families</td>
<td>160</td>
<td>8</td>
<td>19.94</td>
<td>7.18</td>
<td>0-32</td>
<td>0.41</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>160</td>
<td>3</td>
<td>3.24</td>
<td>3.16</td>
<td>0-12</td>
<td>0.001</td>
<td></td>
</tr>
</tbody>
</table>

N.B. Higher scores indicate greater respondent stress

The responses to the 57 ENSS individual items were calculated (See Appendix K). The responses to the individual items within the *Residents’ Families* ENSS sub-scale, as well as additional items of interest are presented in Table 14. Question 15 of the ENSS, *Families Making Unreasonable Demands* was reported by two-thirds of the sample (n = 103/160) as being ‘frequently’ or ‘extremely’ stressful. An additional three items of the ENSS were reported by over a quarter of the sample as being ‘frequently’ or ‘extremely’ stressful. These ENSS items included Question 25: *Being Blamed For*
Anything That Goes Wrong \((n = 72/161)\); Question 52: *Having To Deal with Abuse From Residents' Families* \((n = 78/159)\); and Question 56: *Not Knowing Whether Residents' Families Will Report You For Inadequate Care* \((n = 61/160)\). Three ENSS items specific to the residents were reported by over half of the sample as being ‘frequently’ or ‘extremely’ stressful including Question 7: *Residents Making Unreasonable Demands* \((n = 84/1612)\); Question 35: *Having To Deal With Violent Residents* \((n = 93/160)\); Question 44: *Having To Deal with Abusive Residents* \((n = 88/158)\).
FIGURE 8 - SKEWNESS IN THE STRESS (ENSS) CONFLICT WITH PHYSICIAN SUB-SCALE 1

FIGURE 9 - SKEWNESS IN THE STRESS (ENSS) DISCRIMINATION SUB-SCALE 1
### Table 14 - Stress (ENSS) and Q 15 Residents’ Families Making Unreasonable Demands (N = 160)

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>Situation Not Encountered/Does Not Apply n (%)</th>
<th>Never Stressful n (%)</th>
<th>Occasionally Stressful n (%)</th>
<th>Frequently Stressful n (%)</th>
<th>Extremely Stressful n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 Feeling inadequate prepared to help with the emotional needs of a residents' family</td>
<td>159</td>
<td>19 (11.9)</td>
<td>23 (14.5)</td>
<td>68 (42.8)</td>
<td>28 (17.6)</td>
<td>21 (13.2)</td>
</tr>
<tr>
<td>Q7 Residents making unreasonable demands†</td>
<td>161</td>
<td>10 (6.2)</td>
<td>8 (5.0)</td>
<td>59 (36.6)</td>
<td>38 (23.6)</td>
<td>46 (28.6)</td>
</tr>
<tr>
<td>Q15 Residents' families making unreasonable demands†</td>
<td>160</td>
<td>11 (6.9)</td>
<td>3 (1.9)</td>
<td>43 (26.9)</td>
<td>33 (20.6)</td>
<td>70 (43.8)</td>
</tr>
<tr>
<td>Q25 Being blamed for anything that goes wrong†</td>
<td>160</td>
<td>31 (19.4)</td>
<td>12 (7.5)</td>
<td>45 (28.1)</td>
<td>20 (12.5)</td>
<td>52 (32.5)</td>
</tr>
<tr>
<td>Q33 Not knowing what a resident or a residents' family ought to be told about the resident's condition and its treatment</td>
<td>159</td>
<td>33 (20.8)</td>
<td>33 (20.8)</td>
<td>52 (32.7)</td>
<td>27 (17.0)</td>
<td>14 (8.8)</td>
</tr>
<tr>
<td>Q34 Being the one that has to deal with the residents' family†</td>
<td>159</td>
<td>22 (13.8)</td>
<td>24 (15.1)</td>
<td>54 (34.0)</td>
<td>35 (22.0)</td>
<td>24 (15.1)</td>
</tr>
<tr>
<td>Q35 Having to deal with violent residents †</td>
<td>160</td>
<td>10 (6.3)</td>
<td>8 (5.0)</td>
<td>49 (30.6)</td>
<td>31 (19.4)</td>
<td>62 (38.8)</td>
</tr>
<tr>
<td>Q44 Having to deal with abusive residents †</td>
<td>158</td>
<td>9 (5.7)</td>
<td>9 (5.7)</td>
<td>52 (32.9)</td>
<td>29 (18.4)</td>
<td>59 (37.3)</td>
</tr>
<tr>
<td>Q45 Not enough time to respond to the needs of resident's families</td>
<td>160</td>
<td>16 (10.0)</td>
<td>19 (11.9)</td>
<td>58 (36.3)</td>
<td>38 (23.8)</td>
<td>29 (18.1)</td>
</tr>
<tr>
<td>Q52 Having to deal with abuse from residents' families†</td>
<td>159</td>
<td>16 (10.1)</td>
<td>13 (8.2)</td>
<td>52 (32.7)</td>
<td>28 (17.6)</td>
<td>50 (31.4)</td>
</tr>
<tr>
<td>Q56 Not knowing whether residents' families will report you for inadequate care†</td>
<td>160</td>
<td>29 (18.1)</td>
<td>40 (25.0)</td>
<td>30 (18.8)</td>
<td>19 (11.9)</td>
<td>42 (26.3)</td>
</tr>
</tbody>
</table>

† Items belonging to the ENSS Residents Families sub-scale; grey shading indicates over a quarter of the sample reported as ‘extremely stressful’
6.5.2. MASLACH BURNOUT INVENTORY (MBI)

For the 22 items of the MBI the number of missing respondent responses ranged from 0 to 5. The number of valid responses for individual items ranged from 162 down to 157. Table 15 records the central tendency and spread of the three MBI sub-scale scores and Table 16 records the distribution of the sub-scale score categories (low, moderate or high burnout). The Depersonalisation (DP) sub-scale was significantly skewed (see Figure 10). The average DP score was in the low range, the average Emotional Exhaustion (EE) score was in the medium burnout range and the average Personal Accomplishment (PA) score was in the high accomplishment range.

Table 15 - Maslach Burnout Inventory (MBI) sub-scale scores

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
<th>Skewness</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional Exhaustion (EE)</td>
<td>161</td>
<td>20.5</td>
<td>13.4</td>
<td>0-54</td>
<td>0.14</td>
<td></td>
</tr>
<tr>
<td>2. Depersonalization (DP)</td>
<td>161</td>
<td>5.8</td>
<td>6.0</td>
<td>0-24</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>3. Personal Accomplishment (PA)</td>
<td>162</td>
<td>15.4</td>
<td>10.5</td>
<td>0-47</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

(N varies due to missing data)

Table 16 - Maslach Burnout Inventory (MBI) sub-score categorisation

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>1. Emotional Exhaustion (EE)</td>
<td>44.1 (71)</td>
<td>21.7 (35)</td>
<td>34.2 (55)</td>
</tr>
<tr>
<td>2. Depersonalization (DP)</td>
<td>64.6 (104)</td>
<td>19.9 (32)</td>
<td>15.5 (25)</td>
</tr>
<tr>
<td>3. Personal Accomplishment (PA)</td>
<td>3.1 (5)</td>
<td>6.8 (11)</td>
<td>90.1 (145)</td>
</tr>
</tbody>
</table>
6.5.3. GENERAL SELF-EFFICACY SCALE (GSE)

For the 10 items of the GSE, the number of missing respondent responses ranged from 1 to 5. Thus, the number of valid responses for individual items ranged from 161 down to 157. Descriptive statistics were run for the General Self-Efficacy Scale (GSE). The frequencies for responses to each of the GSE items appear in Table 17. The mean total GSE score was 31.6 (SD 5.2, range 18 to 40) and the distribution did not deviate significantly from normal (skewness statistic p=0.13).
Table 17 - General Self-Efficacy (GSE) Item Frequencies 1

<table>
<thead>
<tr>
<th>Item</th>
<th>N</th>
<th>Not at all true % (n)</th>
<th>Hardly true % (n)</th>
<th>Moderately true % (n)</th>
<th>Exactly true % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I can always manage to solve difficult problems if I try hard enough.</td>
<td>160</td>
<td>6.3 (10)</td>
<td>6.3 (10)</td>
<td>48.1 (77)</td>
<td>39.4 (63)</td>
</tr>
<tr>
<td>2. If someone opposes me, I can find the means and ways to get what I want.</td>
<td>157</td>
<td>17.8 (28)</td>
<td>24.2 (38)</td>
<td>44.6 (70)</td>
<td>13.4 (21)</td>
</tr>
<tr>
<td>3. It is easy for me to stick to my aims and accomplish my goals.</td>
<td>158</td>
<td>7.0 (11)</td>
<td>9.5 (15)</td>
<td>53.2 (84)</td>
<td>30.4 (48)</td>
</tr>
<tr>
<td>4. I am confident that I could deal efficiently with unexpected events.</td>
<td>159</td>
<td>3.8 (6)</td>
<td>7.5 (12)</td>
<td>45.9 (73)</td>
<td>42.8 (68)</td>
</tr>
<tr>
<td>5. Thanks to my resourcefulness, I know how to handle unforeseen situations.</td>
<td>159</td>
<td>2.5 (4)</td>
<td>16.4 (26)</td>
<td>45.3 (72)</td>
<td>35.8 (57)</td>
</tr>
<tr>
<td>6. I can solve most problems if I invest the necessary effort.</td>
<td>160</td>
<td>3.1 (5)</td>
<td>8.8 (14)</td>
<td>41.9 (67)</td>
<td>46.3 (74)</td>
</tr>
<tr>
<td>7. I can remain calm when facing difficulties because I can rely on my coping abilities.</td>
<td>161</td>
<td>3.1 (5)</td>
<td>6.8 (11)</td>
<td>45.3 (73)</td>
<td>44.7 (72)</td>
</tr>
<tr>
<td>8. When I am confronted with a problem, I can usually find several solutions.</td>
<td>161</td>
<td>1.9 (3)</td>
<td>10.6 (17)</td>
<td>50.9 (82)</td>
<td>36.6 (59)</td>
</tr>
<tr>
<td>9. If I am in trouble, I can usually think of a solution.</td>
<td>160</td>
<td>2.5 (4)</td>
<td>10.0 (16)</td>
<td>55.0 (88)</td>
<td>32.5 (52)</td>
</tr>
<tr>
<td>10. I can usually handle whatever comes my way.</td>
<td>161</td>
<td>1.9 (3)</td>
<td>9.3 (15)</td>
<td>50.3 (81)</td>
<td>38.5 (62)</td>
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</table>
6.6. RELATIONSHIPS AMONG THE VARIABLES OF STRESS, BURNOUT AND SELF-EFFICACY.

There were significant correlations between the respondents’ levels of stress (ENSS total score) and two of the burnout scales *Emotional Exhaustion* (MBI EE) and *Depersonalisation* (MBI DP) and the respondents’ levels of self-efficacy (GSE). There was no significant correlation between ENSS total score and *Personal accomplishment* (MBI PA; see Table 18). While MBI EE and DP were significantly correlated with ENSS total and sub-scale scores, MBI PA was only correlated with two ENSS sub-scale scores: *Death and Dying* (higher stress associated with higher sense of PA) and *Discrimination* (higher stress associated with lower sense of PA). Self-Efficacy (GSE) was significantly correlated with all scores except ENSS *Conflict with Physician*.

Table 18 - Correlations: Stress (ENSS), Burnout (MBI) and General self-efficacy (GSE)

<table>
<thead>
<tr>
<th></th>
<th>ENSS total score</th>
<th>MBI EE</th>
<th>MBI DP</th>
<th>MBI PA</th>
<th>GSE</th>
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</table>
### 6.7. RELATIONSHIPS BETWEEN DIRECT CARE STAFF STRESS, BURNOUT, SELF-EFFICACY AND THEIR DEMOGRAPHIC CHARACTERISTICS.

The relationships between the variables of stress (ENSS total score and 9 sub-scale scores), burnout (MBI – EE, PA, DP), self-efficacy (GSE) and the variables of staff demographic characteristics are reported in turn. In addition to the ENSS total score and sub-scale score, the relationships between the respondents’ demographic characteristics and five items from the ENSS Resident’s Families sub-scale are also identified.

#### 6.7.1. AGE

There were no significant differences detected in stress (ENSS) total scores in each of the three age groups (19 to 40 years; 41 to 51 years; and 52 to 72 years; F(2,146) = 0.06, p = 0.945). In one of the ENSS sub-scales, there was a noted significant difference in Conflict with Physician score in different age groups (H = 6.25, df = 2, p = 0.044), with the oldest age group (52 to 75 year olds) having the highest score on this sub-scale (see Table 19). There were no significant associations between respondents’

---

<table>
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<tr>
<th></th>
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<th>MBI EE</th>
<th>MBI DP</th>
<th>MBI PA</th>
<th>GSE</th>
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<td>r$_s$ = 0.29</td>
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<td>n = 160 p &lt; 0.001</td>
<td>n = 160 p &lt; 0.001</td>
<td>n = 160 p = 0.003</td>
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<td>n = 161 p &lt; 0.001</td>
<td>n = 161 p = 0.92</td>
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<tr>
<td>MBI DP</td>
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<td>r$_s$ = 0.15</td>
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<td>n = 161 p = 0.06</td>
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<td>MBI PA</td>
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<td>GSE</td>
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<td>n = 159 p &lt; 0.001</td>
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</tbody>
</table>

‘r’ indicates a Pearson’s correlation and ‘r$_s$’ a Spearman’s correlation. 
NB. High MBI PA scores indicate low sense of personal accomplishment; Grey shading indicates redundant correlations (e.g. MBI EE against MBI EE) and purple shading non-significant correlations.
age and responses to the ENSS items relating to families, Question 15: Families making unreasonable demands; Question 25: Being blamed for anything that goes wrong; Question 35: Being the one that has to deal with the residents’ families; Question 34: Having to deal with abuse from residents’ families; and Question 56: Not knowing whether residents’ families will report you for inadequate care.

The three burnout (MBI) scale scores did not differ significantly between the three age groups (EE: F(2,147) = 0.76, p = 0.471; DP: Kruskal-Wallis $\chi^2 = 4.99, \text{df} = 2, p = 0.083$; PA: F(2, 148) = 0.23, p = 0.795), nor was there a statistically significant difference between the three age groups on total General Self-Efficacy (GSE) scores (F(2,146) = 0.27, p = 0.767).

<table>
<thead>
<tr>
<th></th>
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<th>41 to 51 years</th>
<th>52 to 72 years</th>
<th>p value</th>
</tr>
</thead>
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<td><strong>ENSS total</strong></td>
<td>105.1 (38.4)</td>
<td>105.0 (36.7)</td>
<td>107.3 (39)</td>
<td>0.95</td>
</tr>
<tr>
<td><strong>ENSS Conflict with Physician</strong></td>
<td>6.0 (5.0)</td>
<td>5.5 (4.8)</td>
<td>7.9 (5.2)</td>
<td>0.044</td>
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<tr>
<td><strong>MBI EE</strong></td>
<td>19.8 (13.2)</td>
<td>21.8 (12.7)</td>
<td>18.6 (14.0)</td>
<td>0.47</td>
</tr>
<tr>
<td><strong>MBI DP</strong></td>
<td>5.8 (5.6)</td>
<td>6.9 (6.5)</td>
<td>4.4 (5.7)</td>
<td>0.08</td>
</tr>
<tr>
<td><strong>MBI PA</strong></td>
<td>15.7 (10.7)</td>
<td>15.4 (9.6)</td>
<td>14.4 (10.8)</td>
<td>0.80</td>
</tr>
<tr>
<td><strong>GSE</strong></td>
<td>31.8 (4.7)</td>
<td>31.4 (5.4)</td>
<td>32.1 (5.3)</td>
<td>0.77</td>
</tr>
</tbody>
</table>

**6.7.2. EMPLOYMENT STATUS**

The relationships between stress (ENSS total, sub-scales and relevant items), burnout (MBI: EE, DP, PA) and General Self-Efficacy (GSE) and employment status were computed. There were no significant differences between the three employment status groups on the ENSS total score, sub-scale scores, nor the items on families (ENSS total score: F(2.157) = 1.04, p = 0.356). There were no significant differences detected between the three employment status groups and any of the burnout scores.
6.7.3. EMPLOYMENT POSITION

The employment position groups’ stress (ENSS) levels differed in relation to the Conflict with Physician sub-scale score (Kruskal-Wallis $\chi^2 = 36.44$, df = 2, $p < 0.001$; see Table 21), but not the total score, nor any of the other sub-scale scores (see Table 20). The RN/DON/Nurse Educators group had significantly higher Conflict with Physician scores than the AIN/Personal Carers (Mann-Whitney U $z = -5.98$, $p < 0.001$), but not the Recreational Staff group (Mann-Whitney U $z = -1.10$, $p = 0.273$). Recreational Staff had higher Conflict with Physician ENSS sub-scale scores than the RN/DON/Nurse Educators group, but this difference was not significant (Mann-Whitney U $z = -1.80$, $p = 0.072$). There was also a statistically significant association between stress levels and staff role for ENSS Question 34: Dealing with residents’ families, this being reported as ‘frequently’ and as ‘extremely stressful’ by a greater proportion of the RN/DON/Nurse Educators group and the Recreational Staff group than the AIN/Personal Carer group (Kruskal-Wallis $\chi^2 = 15.91$, df = 8, $p = 0.044$; see Table 21).

Staff role was also significantly associated with burnout (MBI) depersonalisation sub-scale scores (Kruskal-Wallis $\chi^2 = 8.70$, df = 2, $p = 0.013$). The highest scores being amongst the AIN/Personal Carer group (significantly greater than the RN/DON/Nurse Educators group: Mann-Whitney U $z = -2.89$, $p = 0.004$; but not the Recreational Staff group: Mann-Whitney U $z = -0.64$, $p = 0.523$). The burnout (MBI) personal accomplishment sub-scale scores also differed significantly by respondent employment position (F(2,159) = 3.12, $p = 0.047$). Although the AIN/Personal Carer group had the highest scores (indicating low sense of personal accomplishment), none of the contrasts (comparing individual employment groups) were significant.

There was a statistically significant difference in General Self-Efficacy (GSE) scores between the three role groups (F(2,157) = 5.57, $p = 0.005$), with AIN/Personal Carers...
having the lowest scores and RN/DON/Nurse Educators the highest scores. The contrast between the RN/DON/Nurse educator group and the AIN/Personal carer group was statistically significant (p = 0.003).

Table 20 - Stress (ENSS), Burnout (MBI) and General Self-Efficacy (GSE) and Position

<table>
<thead>
<tr>
<th></th>
<th>RN/DON/Nurse Educators (n = 64)</th>
<th>AIN/Personal Carers (n = 90)</th>
<th>Recreational Staff (n = 8)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENSS total</td>
<td>111.0 (39.9)</td>
<td>103.8 (37.0)</td>
<td>104.9 (37.2)</td>
<td>0.51</td>
</tr>
<tr>
<td>ENSS Conflict with Physician</td>
<td>9.3 (4.9)</td>
<td>4.4 (4.2)</td>
<td>7.4 (5.0)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>MBI EE</td>
<td>19.4 (13.8)</td>
<td>20.6 (12.7)</td>
<td>26.5 (17.2)</td>
<td>0.37</td>
</tr>
<tr>
<td>MBI DP</td>
<td>4.5 (6.0)</td>
<td>6.8 (6.1)</td>
<td>4.6 (2.8)</td>
<td>0.013</td>
</tr>
<tr>
<td>MBI PA</td>
<td>13.4 (10.0)</td>
<td>17.1 (10.8)</td>
<td>11.1 (7.6)</td>
<td>0.047</td>
</tr>
<tr>
<td>GSE</td>
<td>33.1 (4.6)</td>
<td>30.4 (5.3)</td>
<td>31.6 (4.8)</td>
<td>0.005</td>
</tr>
</tbody>
</table>

NB: higher MBI PA scores indicate a lower sense of personal accomplishment

Table 21 - Relationship Between Staff Role and Stress (ENSS) Q34 (dealing with the residents’ families) 1

<table>
<thead>
<tr>
<th></th>
<th>RN/DON/Nurse Educators (n = 64)</th>
<th>AIN/Personal Carers (n = 87)</th>
<th>Recreational Staff (n = 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation not encountered/does not apply</td>
<td>4.7 (3)</td>
<td>21.8 (19)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Never stressful</td>
<td>12.5 (8)</td>
<td>17.2 (15)</td>
<td>12.5 (1)</td>
</tr>
<tr>
<td>Occasionally stressful</td>
<td>39.1 (25)</td>
<td>31.0 (27)</td>
<td>25.0 (2)</td>
</tr>
<tr>
<td>Frequently stressful</td>
<td>21.9 (14)</td>
<td>20.7 (18)</td>
<td>37.5 (3)</td>
</tr>
<tr>
<td>Extremely stressful</td>
<td>21.9 (14)</td>
<td>9.2 (8)</td>
<td>25.0 (2)</td>
</tr>
</tbody>
</table>
6.7.4. YEARS OF EXPERIENCE IN THE CARE OF OLDER PEOPLE

For the purposes of analysis, the number of years worked in caring for older people was evenly divided into three groups (0 to 7 years n = 53; 8 to 15 years, n = 55; and 16 to 42 years, n = 53). There were no significant associations between years of experience and any of the stress (ENSS) scores or items, nor the burnout (MBI) subscales nor the General Self-Efficacy (GSE) score.

6.7.5. NURSING OR OTHER HEALTH-RELATED QUALIFICATIONS

Information on qualifications was missing for eight participants. Of the remainder, 22.1% had a Registered Nurse Certificate, 44.2% had a Grade III or IV Aged Care Work qualification and the remaining 33.8% had other qualifications. The relationship between stress (ENSS), burnout (MBI) and General Self-Efficacy (GSE) and respondents’ educational qualifications were computed. There was a significant difference between the groups in the ENSS sub-scale Conflict with Physicians (Kruskal-Wallis $\chi^2 = 33.20, \text{df} = 2, p < 0.001$: see Table 22). Respondents with Certificate III or IV training had significantly lower scores for this item than Registered Nurses (Mann-Whitney U Z = -4.98, $p < 0.001$) and respondents with other qualifications (Mann-Whitney U Z = -4.68, $p < 0.001$). There was no difference in scores for Registered Nurses and those with other qualifications (Mann-Whitney U Z = -0.21, $p = 0.835$). There was a significant association between respondent qualifications and ENSS Question 34: Dealing with the residents’ families), (see Table 24), those with Certificate III or IV in Aged Care Work qualifications being less likely to nominate this as extremely stressful (Kruskal-Wallis $\chi^2 = 21.55, \text{df} = 8, p = 0.006$) (see Table 23).

General Self-Efficacy (GSE) scores differed significantly between the qualification groups, (F(2,149) = 4.47, $p = 0.013$); contrasts revealing a significant difference between those with Registered Nurse certificate and those with Certificates III or IV in Aged Care Work ($p = 0.017$), the latter group having lower self-efficacy, but not between any other groups.
Table 22 - Stress (ENSS), Burnout (MBI) and General Self-Efficacy (GSE) and Staff Qualification

<table>
<thead>
<tr>
<th></th>
<th>RN certificate (n = 34) Mean (SD)</th>
<th>Cert III or IV (n = 68) Mean (SD)</th>
<th>No certificate (n = 52) Mean (SD)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENSS total</td>
<td>111.3 (37.8)</td>
<td>101.4 (37.0)</td>
<td>112.0 (40.3)</td>
<td>0.26</td>
</tr>
<tr>
<td>ENSS Conflict with Physician</td>
<td>8.6 (4.4)</td>
<td>3.9 (3.7)</td>
<td>8.5 (5.5)</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>MBI EE</td>
<td>21.1 (12.4)</td>
<td>20.7 (12.7)</td>
<td>19.2 (14.6)</td>
<td>0.76</td>
</tr>
<tr>
<td>MBI DP</td>
<td>4.7 (5.3)</td>
<td>6.1 (5.8)</td>
<td>5.2 (6.0)</td>
<td>0.44</td>
</tr>
<tr>
<td>MBI PA</td>
<td>12.2 (8.3)</td>
<td>17.4 (11.1)</td>
<td>14.4 (10.4)</td>
<td>0.05</td>
</tr>
<tr>
<td>GSE</td>
<td>33.3 (3.7)</td>
<td>30.2 (5.4)</td>
<td>32.1 (5.3)</td>
<td>0.013</td>
</tr>
</tbody>
</table>

NB. Higher MBI PA scores indicate a lower sense of personal accomplishment

Table 23 - Relationship between Respondents' Qualifications and Stress (ENSS) Q 34 (dealing with residents’ families)

<table>
<thead>
<tr>
<th></th>
<th>RN certificate (n = 34) % (n)</th>
<th>Cert III or IV (n = 65) % (n)</th>
<th>No certificate (n = 52) % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Situation not encountered/ does not apply</td>
<td>2.9 (1)</td>
<td>26.2 (17)</td>
<td>7.7 (4)</td>
</tr>
<tr>
<td>Never stressful</td>
<td>5.9 (2)</td>
<td>18.5 (12)</td>
<td>13.5 (7)</td>
</tr>
<tr>
<td>Occasionally stressful</td>
<td>38.2 (13)</td>
<td>32.3 (21)</td>
<td>36.5 (19)</td>
</tr>
<tr>
<td>Frequently stressful</td>
<td>29.4 (10)</td>
<td>16.9 (11)</td>
<td>21.2 (11)</td>
</tr>
<tr>
<td>Extremely stressful</td>
<td>23.5 (8)</td>
<td>6.2 (4)</td>
<td>21.2 (11)</td>
</tr>
</tbody>
</table>

6.7.6. HOURS OF WORK IN STUDY SITE

The number of respondent hours worked more or less than 35 hours/week in the study site’s supported aged care accommodation service was significantly negatively skewed (p < 0.001), so analyses were conducted using Spearman’s correlation coefficients. There were no statistically significant correlations between numbers of hours worked and stress (ENSS) total or sub-scale scores, nor responses to the five ENSS items of interest. Of the burnout (MBI) sub-scales, there was a significant
negative correlation between number of respondent hours worked and MBI *Personal Accomplishment* scores (meaning the greater the hours worked the higher the sense of personal accomplishment; $r_s = -0.18$, $p = 0.025$). GSE was also significantly correlated with number of hours worked ($r_s = 0.17$, $p = 0.028$), with higher self-efficacy associated with greater hours worked.

### 6.7.7. SHIFTS WORKED

The relationship between respondent stress (ENSS), burnout (MBI), and General Self-Efficacy (GSE) and the shifts worked were computed. There was a strong negative correlation between the number of morning shifts and number of afternoon shifts worked ($r_s = -0.77$, $p < 0.001$, $n = 162$), and a significant but weaker relationship between number of morning and number of night shifts worked ($r_s = -0.28$, $p < 0.001$, $n = 162$; see Table 24). Consequently only the total number of shifts, and the number of morning shifts was analysed.

#### Table 24 - Distribution of Number of Rostered Shifts

<table>
<thead>
<tr>
<th></th>
<th>No shifts</th>
<th>One shift</th>
<th>Two shifts</th>
<th>Three shifts</th>
<th>Four shifts</th>
<th>Five shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Any shift</td>
<td>0.0 (0)</td>
<td>2.5 (4)</td>
<td>4.3 (7)</td>
<td>10.5 (17)</td>
<td>28.4 (46)</td>
<td>54.3 (88)</td>
</tr>
<tr>
<td>Mornings</td>
<td>25.3 (41)</td>
<td>4.3 (7)</td>
<td>12.3 (20)</td>
<td>7.4 (12)</td>
<td>15.4 (25)</td>
<td>35.2 (57)</td>
</tr>
<tr>
<td>Afternoons</td>
<td>63.6 (103)</td>
<td>3.7 (6)</td>
<td>8.0 (13)</td>
<td>6.8 (11)</td>
<td>8.0 (13)</td>
<td>9.9 (16)</td>
</tr>
<tr>
<td>Nights</td>
<td>92.6 (150)</td>
<td>0.6 (1)</td>
<td>2.5 (4)</td>
<td>2.5 (4)</td>
<td>1.9 (3)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

The overall number of shifts worked was not significantly correlated with respondent stress (ENSS), burnout (MBI) or self-efficacy (GSE). There was a significant positive correlation between one of the stress (ENSS) sub-scales *Conflict with Physician* and the total number of morning shifts worked ($r_s = 0.19$, $p = 0.014$, $n = 160$). There was a significant positive correlation between the number of morning shifts worked and the
MBI sub-scale Emotional Exhaustion ($r_s = 0.16, p = 0.038, n = 161$) and a significant negative correlation between the number of morning shifts worked and MBI sub-scale Personal Accomplishment ($r_s = -0.29, p < 0.001, n = 162$). There was no significant correlation between number of morning shifts worked and GSE scores ($p = 0.54$).

6.7.8. WORK IN OTHER SUPPORTED AGED CARE ACCOMMODATION SERVICES

The relationships between stress (ENSS), burnout (MBI) and General Self-Efficacy (GSE) and working in other supported aged care accommodation service as well as the study site were computed. There were no statistically significant differences on any of the three outcome measures between the ($n = 53/162, 32.7\%$) respondents who did and did not ($n = 109/162, 67.3\%$) work in other supported aged care accommodation services.

6.7.9. HOURS WORKED IN OTHER SUPPORTED AGED CARE ACCOMMODATION SERVICES

The relationships between stress (ENSS), burnout (MBI) and self-efficacy (GSE) and the number of hours respondents worked in other supported aged care accommodation service other than their study site were computed. There were no statistically significant correlations between ENSS scores and hours worked in other supported aged care accommodation service. In contrast, there was a statistically significant negative correlation between hours worked in other supported aged care accommodation service and responses to ENSS Question 15: Residents’ families making unreasonable demands ($r_s = -0.35, p = 0.017, n = 47$), meaning that the longer the hours worked elsewhere, the less stress reported by the respondent. There were no significant correlations between hours worked in other supported aged care accommodation services and either the MBI or the GSE scores.

6.7.10. PRIMARY LANGUAGE SPOKEN AT HOME

Analyses were conducted exploring the relationship between each of the stress (ENSS), burnout (MBI) and self-efficacy (GSE) outcomes and the primary language
categories (English, English and other languages, and Other Languages). In summary, the only stress (ENSS) domain that differed significantly between the three language groups was ENSS sub-scale *Discrimination* (Kruskal-Wallis $\chi^2 = 9.28$, df = 2, $p = 0.010$).

There were no significant associations between primary language and any of the five ENSS items associated with the families of older people (Table 25). Of the burnout (MBI) sub-scales, there was a significant difference between the language groups on MBI *Personal Accomplishment* ($F(2,159) = 3.44, p = 0.034$), with contrasts indicating that this difference was between those respondents who spoke English and those who spoke another primary language ($p = 0.029$). There was also a statistically significant difference between primary language groups for self-efficacy (GSE) scores ($F(2,157) = 5.51, p = 0.005$), see Table 25, with the contrasts indicating this difference was between those respondents speaking English and those speaking another primary language at home ($p = 0.004$).

**Table 25 - Stress (ENSS), Burnout (MBI) and General Self-Efficacy (GSE) and Primary Language Spoken at Home**

<table>
<thead>
<tr>
<th></th>
<th>English only (n = 78) Mean (SD)</th>
<th>English and other (n = 34) Mean (SD)</th>
<th>Other only (n = 50) Mean (SD)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENSS total</td>
<td>103.4 (38.9)</td>
<td>105.4 (38.8)</td>
<td>113.0 (36.4)</td>
<td>0.38</td>
</tr>
<tr>
<td>ENSS Discrimination</td>
<td>2.6 (2.8)</td>
<td>3.2 (3.3)</td>
<td>4.3 (3.4)</td>
<td>0.010</td>
</tr>
<tr>
<td>MBI EE</td>
<td>20.2 (13.1)</td>
<td>20.8 (16.3)</td>
<td>20.7 (11.7)</td>
<td>0.97</td>
</tr>
<tr>
<td>MBI DP</td>
<td>5.2 (5.5)</td>
<td>5.9 (6.7)</td>
<td>6.6 (6.3)</td>
<td>0.56</td>
</tr>
<tr>
<td>MBI PA</td>
<td>13.5 (9.2)</td>
<td>15.4 (12.0)</td>
<td>18.4 (10.8)</td>
<td>0.034</td>
</tr>
<tr>
<td>GSE</td>
<td>32.6 (4.3)</td>
<td>31.9 (5.6)</td>
<td>29.7 (5.5)</td>
<td>0.005</td>
</tr>
</tbody>
</table>

NB. Higher MBI PA scores indicate a lower sense of personal accomplishment

**6.7.11. CULTURAL BACKGROUND**

The respondents’ cultural backgrounds are listed in Table 26. The relationships between stress (ENSS), burnout (MBI) and self-efficacy (GSE) and respondents’ cultural
background (see Table 27) was computed using Kruskal-Wallis test. There was a statistically significant difference between different cultural background groups and scores on the ENSS sub-scale Conflict with Peers \( (F(4,149) = 3.11, p = 0.017) \), however none of the contrasts comparing individual groups was statistically significant (see Table 27). There was a statistically significant difference on the MBI sub-scale Expressed Emotion \( (F(4,151) = 3.42, p = 0.010) \), with differences between the North Eastern/Central/South Asian groups and both the Oceania \( (p = 0.045) \) and the South East Asian groups \( (p = 0.029) \). The MBI sub-scale Depersonalisation also differed significantly between the different cultural background groups \( (\text{Kruskal-Wallis } \chi^2 = 10.20, \text{df} = 4, p = 0.037) \). There were no significant differences in GSE scores between the cultural groups.

Table 26 - Primary Cultural Background 1

<table>
<thead>
<tr>
<th>Cultural Background</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian</td>
<td>37</td>
<td>22.8</td>
</tr>
<tr>
<td>Filipino</td>
<td>27</td>
<td>16.7</td>
</tr>
<tr>
<td>Polynesian</td>
<td>18</td>
<td>11.1</td>
</tr>
<tr>
<td>European</td>
<td>8</td>
<td>4.9</td>
</tr>
<tr>
<td>Asian</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>6</td>
<td>3.7</td>
</tr>
<tr>
<td>Indian</td>
<td>5</td>
<td>3.1</td>
</tr>
<tr>
<td>New Zealand</td>
<td>5</td>
<td>3.1</td>
</tr>
<tr>
<td>Multicultural</td>
<td>9</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>38</td>
<td>23.5</td>
</tr>
<tr>
<td>Not reported</td>
<td>2</td>
<td>1.2</td>
</tr>
</tbody>
</table>

N.B. These cultural groups were collapsed for the purposes of analyses.
### Table 27 - Stress (ENSS), Burnout (MBI) and General Self-Efficacy (GSE) and Cultural Background 1

<table>
<thead>
<tr>
<th></th>
<th>European (n = 23)</th>
<th>South-East Asian (n = 35)</th>
<th>North-Eastern, Southern and Central Asian (n = 29)</th>
<th>Other (n = 11)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENSS total</td>
<td>104.7 (39.6)</td>
<td>98.2 (31.7)</td>
<td>113.8 (31.9)</td>
<td>101.3 (41.7)</td>
<td>0.29</td>
</tr>
<tr>
<td>ENSS Conflict with Peers</td>
<td>9.2 (4.7)</td>
<td>8.1 (3.5)</td>
<td>11.2 (3.4)</td>
<td>8.6 (5.3)</td>
<td>0.017</td>
</tr>
<tr>
<td>MBI EE</td>
<td>22.7 (13.8)*</td>
<td>16.5 (11.6)</td>
<td>24.0 (12.7)*</td>
<td>14.2 (10.8)</td>
<td>0.010</td>
</tr>
<tr>
<td>MBI DP</td>
<td>6.8 (6.2)*</td>
<td>3.3 (4.0)</td>
<td>6.8 (6.3)*</td>
<td>4.0 (5.5)</td>
<td>0.037</td>
</tr>
<tr>
<td>MBI PA</td>
<td>13.9 (8.9)</td>
<td>14.6 (11.7)</td>
<td>17.5 (9.5)</td>
<td>16.3 (12.8)</td>
<td>0.56</td>
</tr>
<tr>
<td>GSE</td>
<td>31.9 (4.2)</td>
<td>31.9 (5.9)</td>
<td>30.5 (5.6)</td>
<td>31.4 (5.8)</td>
<td>0.75</td>
</tr>
</tbody>
</table>

* Significant associations  
NB. Higher MBI PA scores indicate a lower sense of personal accomplishment
6.7.12. PROFICIENCY IN VERBAL ENGLISH

The relationship between stress (ENSS), burnout (MBI) and self-efficacy (GSE) and respondents’ proficiency in verbal English were computed, see Table 28. There were statistically significant differences on the ENSS sub-scale Conflict with Physician between those with self-reported high versus low-medium verbal English skills (Mann-Whitney U Z = -3.11, p = 0.002). The two groups also differed on MBI Depersonalisation scores (Mann-Whitney U Z = -2.48, p = 0.013), MBI Personal Accomplishment scores (t = 4.21, df = 160, p < 0.001) and on GSE scores (t = -2.22, df = 158, p = 0.028).

Table 28 - Stress (ENSS), Burnout (MBI) and General Self-Efficacy (GSE) and Proficiency in Verbal ENGLISH 1

<table>
<thead>
<tr>
<th></th>
<th>High (n = 109) Mean (SD)</th>
<th>Low to Medium (n = 53) Mean (SD)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENSS total</td>
<td>108.4 (37.9)</td>
<td>103.4 (38.7)</td>
<td>0.44</td>
</tr>
<tr>
<td>ENSS Conflict with Physician</td>
<td>7.4 (5.4)</td>
<td>4.6 (3.7)</td>
<td>0.002</td>
</tr>
<tr>
<td>MBI EE</td>
<td>21.2 (13.7)</td>
<td>19.0 (12.6)</td>
<td>0.33</td>
</tr>
<tr>
<td>MBI DP</td>
<td>5.2 (6.1)</td>
<td>7.0 (5.6)</td>
<td>0.013</td>
</tr>
<tr>
<td>MBI PA</td>
<td>13.1 (8.8)</td>
<td>20.1 (12.0)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>GSE</td>
<td>32.2 (4.8)</td>
<td>30.3 (5.6)</td>
<td>0.028</td>
</tr>
</tbody>
</table>

NB: Higher MBI PA scores indicate a lower sense of personal accomplishment

6.7.13. PROFICIENCY IN WRITTEN ENGLISH

The relationship between stress (ENSS), burnout (MBI) and general self-efficacy (GSE) and respondents’ level of written English proficiency were computed. The
only ENSS score to differ between those with high and those with low to medium proficiency in written English was *Conflict with Physician* (Mann-Whitney U Z = -3.08, p = 0.002; see Table 30). The MBI *Depersonalisation* sub-scale scores differed between the two written English skills groups (Mann-Whitney U Z = -2.74, p = 0.006), as did the MBI *Personal Accomplishment* scores (t = 3.60, df = 160, p < 0.001). The groups differed significantly on GSE scores (t = -2.80, df = 158, p = 0.006).

Table 19 - Stress (ENSS), burnout (MBI) and General Self-Efficacy (GSE) and Written English Proficiency 1

<table>
<thead>
<tr>
<th></th>
<th>High (n = 100)</th>
<th>Low to Medium (n = 62)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENSS total</td>
<td>108.3 (38.0)</td>
<td>104.2 (38.6)</td>
<td>0.51</td>
</tr>
<tr>
<td>ENSS Conflict with Physician</td>
<td>7.5 (5.4)</td>
<td>4.8 (4.0)</td>
<td>0.002</td>
</tr>
<tr>
<td>MBI EE</td>
<td>20.7 (13.8)</td>
<td>20.1 (12.8)</td>
<td>0.77</td>
</tr>
<tr>
<td>MBI DP</td>
<td>5.0 (6.0)</td>
<td>7.1 (5.9)</td>
<td>0.006</td>
</tr>
<tr>
<td>MBI PA</td>
<td>13.1 (9.0)</td>
<td>19.0 (11.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>GSE</td>
<td>32.4 (4.7)</td>
<td>30.1 (5.5)</td>
<td>0.006</td>
</tr>
</tbody>
</table>

NB. Higher MBI PA scores indicate a lower sense of personal accomplishment

Variance in stress (ENSS) and burnout (MBI) scores explained by General Self-Efficacy (GSE) scores

General Self-Efficacy (GSE) scores significantly predict stress (ENSS) total scores (F(1,157) = 14.17, p < 0.001) and account for 8.3% of the variance. Burnout (MBI) *Emotional Exhaustion* scores also significantly predict GSE scores (F(1,157) = 14.88, p < 0.001), with 8.7% of variance in MBI *Emotional Exhaustion* accounted for by GSE. GSE score accounted for 5.9% of the variance in MBI *Depersonalisation* scores.
(F(1,157) = 9.92, p = 0.002) and 9.0% of the variance in MBI *Personal Accomplishment* scores (F(1,58) = 15.72, p < 0.001).

In the univariate analyses, the stress (ENSS) sub-scale *Conflict with Physician* was associated with respondent age, position, qualifications, number of morning shifts, and proficiency in verbal and written English. A linear regression model was conducted, including the variables of age, position, and qualifications, number of morning shifts. A statistically significant model was produced (F(5,136) = 6.38, p < 0.001) accounting for 19% of the variance in the ENSS sub-scale *Conflict with Physician* score, however the only significant variable was respondent position (RN/DON/Nurse Educator vs AIN/Personal Carer vs Recreational Staff, \( \beta = -0.33, t = -3.79, p < 0.001 \)).

Burnout (MBI) *Depersonalisation* scores were associated with respondent role, Oceania, South-East Asia and some other non-English speaking background cultural groups, and proficiency in written and verbal English. A linear regression model was conducted including role and cultural group. A significant model was produced for MBI *Depersonalisation* (F(3,152) = 3.47, p = 0.018), but only accounted for 6.4% of the variance. Both cultural group (\( \beta = -0.18, t = -2.15, p = 0.033 \)) and level of proficiency in verbal English (\( \beta = -0.20, t = -2.27, p = 0.025 \)) were significant predictors of MBI *Depersonalisation*.

Burnout (MBI) *Personal Accomplishment* was associated with role/position, qualifications, number of hours worked, primary language, number of morning shifts, and verbal and proficiency in written English. A linear regression model was conducted with these variables (with the exception of proficiency in written English). A significant model was produced for MBI *Personal Accomplishment* (F (6,147) = 4.99, p < 0.001), accounting for 16.9% of the variance. Two demographic variables were significant predictors of MBI *Personal Accomplishment*: total
number of morning shifts ($\beta = -0.29$, $t = -3.33$, $p = 0.001$); and proficiency in verbal English ($\beta = -0.27$, $t = -2.95$, $p = 0.004$).

6.8. SUMMARY OF ENSS, MBI AND GSE RESULTS

Analyses of the constructs of stress (Expanded Nurse Stress Scale, French et al., 2000); burnout (Maslach Burnout Inventory, Maslach, Jackson & Leiter, 1996) and self-efficacy (General Self-Efficacy Scale, Schwarzer & Jerusalem, 1995) included a full exploration of descriptive statistics, including assumptions of normality and correlational analysis. These analyses identified: (a) the levels of stress, burnout and general self-efficacy experienced by respondents, (b) the relationship between respondents’ characteristics and their levels of stress, burnout and general self-efficacy, (c) the workplace factors that are related to respondents’ perceived stress, (d) the relationship of workplace stress to the requests and criticism made by families of older people, and (e) the effects of workplace stress on respondents, including the stress arising from negative interactions with the families of older people. Analysis of variance (ANOVA) was used to determine if there were significant differences in the groups on the total scores of all items of the ENSS and GSE and sub-scales of the ENSS and MBI. Spearman’s Rank Correlation was used to determine if rank ordering of stressors by group was similar or different. A $p$ value of 0.05 or less was considered to be of significant in the comparison of results.

6.8.1. FACTORS ASSOCIATED WITH DIRECT CARE STAFF STRESS

Some key factors were significantly associated ($p < 0.001$ or $p = 0.05$) with direct care staff stress, burnout and general self-efficacy as shown in Table 31. Respondent stress (ENSS) was found to be significantly associated with the ENSS subscales Workload (mean 20.29) followed by Residents Families (19.94) and Death and Dying (mean 14.28). The ENSS item Question 15: Families Making
Unreasonable Demands was reported by two thirds \((n = 160)\) of respondents as either ‘frequently’ or ‘extremely’ stressful (see Appendix J). Four ENSS items including items specific to the interactions of older people and direct care staff were reported by over half of the sample as being ‘frequently’ or ‘extremely’ stressful, including Question 7: Residents Making Unreasonable Demands \((n = 84/161)\), Question 35: Having To Deal With Violent Residents \((n = 93/160)\), and Question 44: Having To Deal with Abusive Residents \((n = 88/158)\).

6.8.2. ASSOCIATIONS BETWEEN DIRECT CARE STAFF, BURNOUT AND SELF-EFFICACY

From a total of forty five \((n = 45)\) possible significant and non-significant correlations between respondents’ perceptions of their stress, burnout and general self-efficacy, a total of thirty \((n = 30)\) significant \((p < 0.001)\) associations were detected between stress (ENSS subscales Death and Dying; Conflict with Physician; Inadequate Preparation; Problem with Peers; Problem with Supervisor; Workload; Uncertainty With Treatment; Resident Families and Discrimination and ENSS total scores; burnout (MBI sub-scales Emotional Exhaustion and Depersonalization) and general self-efficacy (GSE) (Table 30).

A further seven \((n = 7)\) slightly less, though equally significant associations (see Table 30), were detected between perceptions of direct care staff stress, burnout and general self-efficacy (ENSS subscale Death and Dying and MBI Personal Accomplishment; GSE; ENSS subscale Conflict with Physician and MBI Depersonalisation; ENSS Problem With Peers and GSE; ENSS Problem With Supervisor; ENSS Workload and GSE; and ENSS subscale Discrimination).
Table 30 Summary of Associations: Stress (ENSS Sub-Scales) and Stress (ENSS) Total Scores, Burnout (MBI EE; DP; PA) and General Self-Efficacy (GSE) 1

<table>
<thead>
<tr>
<th>ENSS subscales</th>
<th>ENSS total score</th>
<th>MBI EE</th>
<th>MBI DP</th>
<th>MBI PA</th>
<th>GSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death &amp; Dying</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>p = 0.006</td>
<td>P = 0.017</td>
</tr>
<tr>
<td>Conflict with Physician</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>p = 0.012</td>
<td>N/S/R</td>
<td>N/S/R</td>
</tr>
<tr>
<td>Inadequate Preparation</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p &lt; 0.001</td>
<td></td>
</tr>
<tr>
<td>Problems with Peers</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p = 0.002</td>
<td></td>
</tr>
<tr>
<td>Problems with Supervisor</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p = 0.004</td>
<td></td>
</tr>
<tr>
<td>Workload</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p = 0.023</td>
<td></td>
</tr>
<tr>
<td>Uncertainty with Residents</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p &lt; 0.001</td>
<td></td>
</tr>
<tr>
<td>Residents’ Families</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p &lt; 0.001</td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>p &lt; 0.001</td>
<td>p &lt; 0.001</td>
<td>p = 0.003</td>
<td>p = 0.001</td>
<td></td>
</tr>
</tbody>
</table>

(p < 0.001) Significant; p = 0.05 Significant; N/S/R = Not Significant/Redundant

Significant associations were detected when correlating burnout (MBI subscales Emotional Exhaustion, Depersonalisation, Personal Accomplishment) and general self-efficacy (GSE), with stress (ENSS total scores), burnout (MBI Emotional Exhaustion, MBI Depersonalization, and Personal Accomplishment), and GSE (see Table 32). MBI Emotional Exhaustion was found to have a significant associated with perceptions of direct care staff stress (ENSS total scores) and MBI Depersonalization; and GSE (Table 31).
Table 31 - Summary of Associations: MBI (EE, DP, PA), GSE and Stress (ENSS Total Scores), Burnout (MBI EE, DP, PA) and General Self-Efficacy (GSE) 1

<table>
<thead>
<tr>
<th></th>
<th>ENSS total score</th>
<th>MBI EE</th>
<th>MBI DP</th>
<th>MBI PA</th>
<th>GSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI Emotional Exhaustion</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>MBI Depersonalization</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>N/S/R</td>
<td>N/S/R</td>
<td>Sp = 0.002</td>
</tr>
<tr>
<td>MBI Personal Accomplishment</td>
<td>N/S/R</td>
<td>N/S/R</td>
<td>N/S/R</td>
<td>N/S/R</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>GSE Self-Efficacy</td>
<td>p &lt; 0.001</td>
<td>N/S/R</td>
<td>N/S/R</td>
<td>N/S/R</td>
<td>N/S/R</td>
</tr>
</tbody>
</table>

(p < 0.001) Significant; p = 0.05 Less Significant; N/S/R = Not Significant / Redundant

MBI Depersonalization was also found to have a significant association with ENSS total scores of direct care staff and a slightly less significant association with GSE scores. Significant associations were detected between MBI Personal Accomplishment and GSE. GSE total scores of direct care staff were significantly associated with ENSS total scores.

6.8.3. STRESS, BURNOUT, SELF-EFFICACY AND DEMOGRAPHIC VARIABLES.

Stress (ENSS sub-scale Conflict with physician) was found to be significantly associated with: age (52 to 70 year old group, p = 0.044); the differences between the three employment positions groups (RN/DON/Nurse Educator, AIN/Personal Carer and Recreational Staff cohort p < 0.001); the RN/DON/Nurse Educator cohort (p < 0.001); the differences between the groups (RN certificate, Certificate III or IV, and Other, p < 0.001); respondents with Certificate III or IV (p < 0.001); respondents with other qualifications (p < 0.001); the number of morning shifts
worked (p = 0.014); respondents’ language groups (p = 0.034); the differences between the self-reported differences in respondents’ verbal English proficiency skills (high, low-medium, p = 0.002).

Stress (ENSS) sub-scale *Discrimination* was significantly associated with respondents’ primary language spoken at home (p = 0.010). ENSS sub-scale *Conflict with Peers* was significantly associated with respondents’ cultural background (p = 0.017). A significant association was found between ENSS Question 34: *Dealing with the Residents’ Families* and respondents’ with Certificate III or IV in Aged Care work (p = 0.006). Stress was associated with the position groups (RNs/DONs/Nurse Educator and Recreational Staff) who reported their interactions with the families of residents to be either ‘frequently’ or ‘extremely stressful’ (p = 0.044). Stress (ENSS Question 15: *Residents’ Families Making Unreasonable Demands*) was significantly associated with the number of hours worked elsewhere in addition to those hours worked in the study site facility of employment (p = 0.017). ENSS sub-scale *Conflict with Peers* was significantly associated with respondents’ cultural background (p = 0.010).

### 6.8.4. BURNOUT

Burnout (MBI) *Emotional Exhaustion* was significantly associated with the number of morning shifts respondents worked (p = 0.014), their cultural background (p = 0.010) and the number of weekly hours they worked at their study site (p = 0.036).

Burnout (MBI) *Emotional Exhaustion* was also significantly associated with respondents’ cultural background (North Eastern/Central/South Asian groups, the Oceania group, p = 0.010 and South East Asian groups, p = 0.029).

Burnout (MBI) *Depersonalisation* was also significantly associated with the number of morning shifts worked (p < 0.001) and three employment position groups (RNs/DONs/Nurse Educators, AINs/Personal Carers (p = 0.004) and Recreational...
Staff, \( p = 0.013 \), with the cultural background groups (North Eastern/Central/South Asian groups, Oceania and South East Asian groups, \( p = 0.037 \)), with lower proficiency in verbal English skills (\( p = 0.013 \)) and written English skills (\( p = 0.006 \)), and in those respondents who worked a higher number of weekly hours in the study sites (\( p = 0.025 \)).

6.8.5. SELF-EFFICACY IN SUPPORTED AGED CARE WORK

Significant differences were detected between self-efficacy (GSE) and position groups (RN/DON/Nurse Educator, \( p = 0.005 \)) and RN/DON/Nurse Educator and AIN/Personal carer groups (\( p = 0.003 \)) and qualification groups (RN Certificate, Certificate III or IV, and Other, \( p = 0.013 \)). GSE was significantly associated with the number of weekly hours respondents worked in their study site of employment (\( p = 0.028 \)) indicating that the higher the number of hours worked, the higher the respondents’ self-efficacy for their work. A significant difference was detected between GSE scores and the number of hours respondents worked in their second place of employment (\( p = 0.017 \)), primary language spoken at home (\( p = 0.005 \)) and for those speaking another primary language at home (\( p = 0.004 \)), cultural background (\( p = 0.006 \)), verbal English language proficiency skills (high, low-medium, \( p = 0.028 \)) and written English language proficiency skills (high, low-medium, \( p = 0.006 \)).

6.9. RESULTS OF THE OPEN-ENDED SURVEY QUESTION RESPONSES

Respondents’ written responses to the open-ended question survey item that was added to the end of the Questionnaire Pack “Please document any workplace stress associated with the families of residents” are reported thematically. The open-ended question item was added to give respondents the opportunity to add
information that they perceived as causing stress from the families of older people in whatever way they preferred.

Of the 162 respondents who completed the usable surveys, a total of 120 (74%) respondents provided written responses to the open-ended question. The written responses varied in length, with a high number of respondents providing a long list of concerns, in some instances filling up all of the A4 paper provided, whilst a smaller number of respondents wrote very little (two to three words) to air their concerns. Of the 120 responses provided, 12 (10%) respondents indicated that either they had not encountered any experiences of stress when interacting with families, or outlined their experiences of managing this aspect of stress in both positive and negative ways.

The written responses were first run through Leximancer, a computer software program developed by Leximancer Pty Ltd to assist with coding and classifying the written narratives and to determine concept frequency. This process assisted to group the concepts and classify the constructs, as illustrated in Figure 11.

Figure 11 identifies the primary concepts and themes’ including their relevance and connectivity to each other. A total of three primary theme categories and 18 theme sub-categories emerged from the Leximancer thematic analysis as relevant to perceptions held by direct care staff of their stressful experiences arising from their interactions with the families of older people. The word “families” was identified as a primary variable and central to the identified themes and concepts. Other emerging themes included “residents”, “resident”, “people”, “staff”, “job”, “situation”, and “times”. The concept “happy” was identified as a very small but significant theme and from the written statements was interpreted as being in reference to ‘keeping the family happy’.
FIGURE 11 - LEXIMANCER CONCEPT MAP 1
The results of the Leximancer analysis are presented in order of response magnitude (Figure 11). Once the data were allocated into the respective groups by Leximancer, the data were reviewed again to reduce duplications and ensure they were allocated to the correct code and sub-code, as listed in Table 32.

Table 22 – Stress Associated with Resident’s Families - Themes

<table>
<thead>
<tr>
<th>Theme Category</th>
<th>Theme Sub-category</th>
</tr>
</thead>
</table>
| Perceptions of Stress Arising From Interactions     | Meeting the requests of families  
| with Families                                       | Meeting the needs of families from different cultural backgrounds  
|                                                     | Interactions with families  
|                                                     | Responses to family emotional distress  
|                                                     | Acknowledging families concerns about care  
|                                                     | Meeting the care expectations of families  
|                                                     | Insufficient time to provide care services  
|                                                     | Perceptions of families mistrust towards direct care staff  
|                                                     | Family requests of specific care practices  
|                                                     | Perceptions of not being respected and valued                                      |
| Work-related stress                                 | Perceptions of discrimination  
|                                                     | Workforce issues  
|                                                     | Emotional issues relating to the workplace  
|                                                     | Strategies used to minimize experiences of stress                                 |
| Stress Arising From Interactions with Older People  | Perceptions of the behaviours of older people  
|                                                     | Perceptions of death and dying                                                     |

The respondents’ handwritten statements were re-read and similar statements were considered alongside each other to construct key themes, as described more fully in the Methods Chapter. These key themes and their sub-themes are reported below. Respondent quotes are numbered according to their unique identifier code. The respondents’ partial and/or complete statements are reported verbatim, and incorrect spelling and grammar remain unaltered from the original narratives. A total of three primary themes with subsequent sub-themes emerged from the data. These themes compared strongly with the themes sorted and categorised by Leximancer.
6.9.1. THEME 1: PERCEPTIONS OF STRESS ARISING FROM INTERACTIONS WITH FAMILIES

6.9.1.1. Meeting the Requests of Families

Study respondents confirmed that they were cognisant that families and friends were important to the well-being of older people and needed to be included in the holistic care of older people: “Families and friends are an integral part of the well-being of their loved ones family member within elderly care” (TS02). However, the requests of family for care services were considered stressful experiences for many respondents and were described as ‘demanding’, “unrealistic”, or “unreasonable”. The actual experience of meeting family care requests was expressed by one respondent as: “Too stressful to think of” (CA13) and another as: “The job is financially not worth it” (CA09).

Whilst meeting the requests of families was seen as an important objective for respondents, this same need was perceived to negatively affect the well-being of other older people: “In the past we had a family member who was never satisfied. We could have been attending another resident when we would have to stop and attend to his father. The reason was not an emergency but maybe to adjust the pillow or move his chair. I found this stressful. I spoke to the RN in charge and asked why it couldn’t wait till we were finished with our other resident. The answer was “to keep him happy”. Every resident has a right to be attended to without stopping half way” (XD02).

Respondents stated that: “the families are very unreasonable with their requests” (108); and made “unreasonable ‘demands’ and expectations” (EN14); and seemed unaware of the needs of other older people: “Some of the family ask as if the member of their family is the only resident” (HD17); and “Aggressive families who want one to one care are hard to deal with” (LB01). When a family member’s requests for improved care provision were supported by health professionals external to the supported aged care accommodation service, this caused one respondent to feel upset and stressed: “The residents daughter is
very demanding and verbally aggressive...and organized doctors to present us with a threatening letter blaming me for pressure area development and for immobility” (JD08).

The requests of families centred on the need for direct care staff to pay immediate attention to the care needs of their relative, “Expecting staff to attend to family member within minutes of the request” (AC01); and “This is in particular about a family member who comes in the facility whose husband has just had a stroke. If he is sitting in the water chair and is just leaning to one side a little bit, she would come straight to the nurses and expect them to leave whatever they’re doing to go and attend to her husband. She would prefer him seated in the wheel-chair after lunch which is two (staff) handling within an hour time frame (DM06). As expressed by respondent DM06, often the care requests of families would be made without consideration to the care needs of another person who the direct care staff may have been attending to.

Being blamed by families for the deterioration in the health status of an older person was cited as a stressful experience. This issue was highlighted by one respondent: “Mr X was admitted to our facility with a diagnosis of advanced dementia, over time his condition became worse accompanied by physical aggression towards staff and residents (sudden aggression).....family blamed staff about resident’s deterioration, they said that it was due to negligence” (VF09). Other examples of direct care staff being blamed for what the family regard as care deficiencies were cited “When a resident refuses a certain treatment and then families comes in and sees resident refusing and blames nursing staff” (RV10) and: “(the) resident is drowsy. Family insisted he’s heavily sedated. Wanted to transfer and accusing RN’s giving too much medication” (TS07).

Respondents also reported feeling that some family members projected their personal emotions onto direct care staff, and this caused these staff even more stress: “I feel that they are passing their emotions that are anger onto me”
The term ‘projecting emotions’ was used to describe how some families expressed anger at direct care staff for situations that the family were unable to control, or when they were dealing with personal crises: “Nurses usually become a soft target for families to rent their anger at things they cannot control ... in times of crisis, families (some) tend to project their emotions on the nurses” (CA01). Additionally, respondents reported that some families requested levels and types of care that direct care staff felt they were not trained to provide “When they insist to have things done this way, going beyond the scope of duty” (EN14). These issues were considered unreasonable and gave rise to stress in direct care staff.

6.9.1.2. Meeting the Needs of Families from Different Cultural Backgrounds

Meeting the different care requests of families from a range of cultural backgrounds was reported to be stressful for a number of respondents. Family members from some cultural groups were perceived by respondents to request unreasonable additional care for their relative: “We had a resident with Italian background. She had three daughters and two sons. They came and visited every single day, especially at dinner time. These people (are) very fussy, they want everything done for their mother straight away, doesn’t matter if we busy......I have to drop what I am doing....to do what they want....it was stress sometimes” (RV06). As stated by another respondent: “Dealing with culturally diverse relatives who demand loudly and aggressively for special treatment of their relative.....puts a lot of stress on nursing staff” (KD07). Given the growing multicultural mix of older people living in supported care accommodation, the source of stress arising from different cultural expectations of care service was an issue for a large number of respondents.

Also stressful was the need to negotiate appropriate types and styles of care for an older person with family members from different cultural groups who could not agree on these: “The resident was Muslim...three daughters constantly
arguing about the way she should be buried in the case of her death...speaking to each individually.... was daunting...I felt helpless and could not help...it was difficult to emotionally support the individual...” (GP01). Families from some cultural backgrounds were perceived by respondents to have little consideration of how their requests impacted on direct care staff: “Migrant families are extremely insensitive, demanding and unreasonable” (CA01).

6.9.1.3. Direct Care Staff Interactions with Families

One source of stress for some respondents occurred when families who were paying for the older person’s care insisted on care staff paying extra attention to them: “Families are very difficult demanding, aggressive and abusive and expect that we will do everything for their relative now as they are paying for their care” (LB12). One respondent reported being very stressed when family member’s requests and approach were considered unreasonable: “....I told him that his aunt is OK. He screamed at me and demanding me to ring and get the doctor. He’s so rude. Tried to explain him but he won’t listen to me. I’ve phoned the emergency doctor......he can’t find anything wrong with her” (LB17).

Another care staff respondent referred to their stressful experiences of feeling bullied because of their role: “ (they) Bully me because I am a nurse/staff” (GP04). Verbal abuse of direct care staff by families was a frequently cited source of stress: “I overheard a nurse been verbally abused by a family member (relative of a resident). I felt out of control as I didn’t know what to do. Relative accused the nurse of not showering her loved one. Not having witnessed the task as the nurse was on a different section I felt I could not go to her defence” (CA09).

6.9.1.4. Direct Care Staff Responses to Family Emotional Distress

Study respondents perceived that the families’ emotional distress was a reason for outbursts against direct care staff. This perception was referenced to in a number of different ways when describing the type of family behaviours described in the previous section, where some family members failed to consider the impact that these behaviours had had on the care staff. Eight respondents
used the word “guilt” in describing the reason for the families’ emotional outbursts towards the direct care staff, particularly with regard to admitting a relative to formal care and seeking care from direct care staff: “Some relatives tend to feel guilty they have had to resort to aged care for their loved one or require assistance from staff” (HD05), and “Feelings of guilt by the relatives associated with placing an aged relative in a facility” (DM10). The feelings of guilt around placement of a relative into supported aged care accommodation service were also considered to extend to other family members: “…Other members of the family feel guilty in putting their love ones in the Nursing Home” (NL03).

Respondents experienced stress from the impact of what they considered to be the families’ feelings of guilt: “I know we do a job…….challenging and hard work…….recognition not here…. guilt by the family relatives taken out on nursing staff” (CA09). Respondents perceived families’ feelings of guilt as being directly linked to some of the stressful responses and requests to direct care staff, and was also responsible for the sometimes negative attitudes of direct care staff towards older people and their families: “I think guilty on the part of the family plays a big part of why we get complaints and also the attitude of some of staff towards the residents and their families” (JD01).

A source of stress identified by respondents was the reluctance of families to be involved in helping to settle and comfort their relative at various times: “I had difficulty experienced dealing with this resident with unpredictable behaviours slowly dementing with selective memory loss. She really wants to go home. Suddenly before dinner (the resident) rang 000 on the blue phone….senior constable asked me if she was fine. She called the ambulance but they did not take to the hospital. Again two police officers came at 10pm …they felt sorry for her. When I spoke to her son he told me …there’s no way they’ll take her home. The problem was the family doesn’t want to take the responsibility to look after her and depend on the staff to deal with it” (LB18). Direct care staff experiences of stress were also acerbated by those families who were in constant contact:
“situations when family members try to unload their guilt by telephoning nursing staff re trivial matters” (AC01). These statements highlight the complex situations that give rise to direct care staff stress arising from their perceptions of the families’ feelings of guilt, stated by one respondent as “…guilt by the family relatives taken out on nursing staff” (CA09).

The existence of tensions between family members were cited as stressful experiences for some respondents: “What I personally experiences in my work and feel stressful is when the resident family fight and make our work difficult because they feel guilty about leaving their mum or dad at nursing home” (NL04); “Family conflict, within family circle” (EN14); and “Relatives who do not get on well with other members of their family….different members of the family had their own views of how their loved one is to be looked after” (NL03); and “I find myself getting a little stressed and feeling of not being able to help family members when they have different views and values about their loved ones” (GP01); and “There’s … occasion that family disagreement in care for resident did trigger conflicts and confrontation between staff and family members, doctor ad family members” (NL01).

In recognition of their perceptions of families’ feelings of guilt, and in an effort to reduce their own stress, some respondents stated that they attempted to offer counselling to family members: “Try to counsel families and make them understand why they complain is sometimes due to guilt” (AC07). Many of the respondents considered that feelings of guilt by families precipitated negative family behaviours and was a precursor to family members’ criticisms about attitudes of direct care staff towards them.

Respondents were cognisant of the support and time they provided to families to help allay their fears and anxieties. Being requested by families to ignore the care needs of one older person in order to attend to the care needs of their family member, was cited as a very stressful experience for respondents: “This is in particular about a family member who comes in the facility whose husband has
just had a stroke. If he is sitting in the water chair and is just leaning to one side a little bit, she would come straight to the nurses and expect them to leave whatever they’re doing to go and attend to her husband. She would prefer his seated in the wheel-chair after lunch which is two handling within an hour time frame” (DM06). As reported by one respondent, family member requests for what they considered to be unreasonable attention was a very unpleasant experience for them: “some family members are demanding of one’s time and can be emotionally charged regarding their concerns of their relative…” (HD05)

6.9.1.5. Acknowledging Families’ Concerns about Care Services

Issues relating to perceptions of inadequate or poor care services raised by the families were cited as sources of stress for respondents: “Complaints of very small things” (CA06), and that: “Food not suitable for resident”.... or...... “not enough food” (CA12), or: “Family complaining that care was not given to a resident” (CA12). Addressing these criticisms and concerns to the families satisfaction were perceived by direct care staff as being time consuming and stressful: “The relative......has complaints every time they visit over minor events but it is time consuming......it is very stressful” (HD02). While for the staff some of the family concerns and requests seemed trivial, or unavoidable, this was clearly not the case for family members: “So this family will be satisfied with our care but still they will complain and complain for nothing and this is the time that I felt I am really under pressure”(JD04); and “Some relatives will complain about not being showered properly: same clothes every day (the problem with the clothes is there are times different staff every day). Dentures not clean (the problem with this, the resident refused to give his/her dentures to the staff), the socks inside out.... and many things” (LB08).

One respondent clearly outlined the precipitating factors that led to the concerns made by one family and their subsequent feelings of distrust for direct care staff when caring for their relative: “Some resident, after the family placed in the nursing home he or she have no clothes and request the family bring them but
they have gone not coming for while.....when they bring the clothes having no name tag which could be gone missing in the laundry...black short dress. After a short time, it have gone after wash couple time then the complaint start. Every time they coming they checking looking for any single spot from them to complain” (LB05). The respondent went on to describe further sources of family concerns and requests that the care staff and nurses considered to be unrealistic: “The mother, father fall, due to their confusion or dementia. Complaining of losing weight, why mums or dad is not walking. Why no taking to the cinema...they confused, they don’t want to go” (LB05). These types of requests were considered to be very stressful for direct care staff who felt powerless and unable to prevent these situations from occurring.

The time spent on managing the families’ concerns was identified by respondents as an additional source of stress for them. Issues that were reported through the official complaints mechanism were greater sources of stress and involved considerable time expended by senior direct care staff: “When a resident dies and families cannot accept and then they go to the complaints (HCCC) etc.” (AC07). Official concerns made by six families that resulted in formal external investigations were cited as stressful experiences for direct care staff: “A visit by the Commonwealth Health Complaints unit........I could determine who made the complaint........I had spent nearly 2 hours with this relative who indicated they were happy with the outcome – continued to lodge a complaint – these unannounced visits by three officers for four hours was extremely stressful even though the outcome was in our favour” (HD02). Concerns raised by older people with a cognitive impairment became stressful when these same issues resulted in formal investigations: “Our recent big complaint that ended up at the complaints resolution committee was from a resident who said his jacket was stolen and we later found he had hidden it away and was just causing trouble, he was suffering from paranoia but all complaints have to be investigated and can be very time consuming.” (JD01).
Despite the considerable effort that respondents considered to be expended in resolving the concerns of families, they reported that some families would remain dissatisfied with the outcome of their complaint, causing even more stress for direct care staff: “One incident that turned out to be very stressful happened when I was talking to a daughter of a terminally ill patient.....I felt that we have resolved her issues about her father’s illness as she seemed a lot happier. After her father died she complained that he was allowed to suffer more than he should and that he didn’t receive the care he deserved. I felt this was unfair because I knew that I personally went the extra mile...” (PR01).

6.9.1.6. Meeting the Care Expectations of Families

Meeting the care expectations of families was considered to be stressful for respondents, particularly if families were perceived to have a limited understanding of the physical and mental health status of their relative. A respondent reported that a family member asked her: “.....Why does my parent look so tired....Why does she not talk to me? I have come a long way to visit” (AC01). These comments made the respondent feel helpless to change the situation. The lack of knowledge and understanding of the behaviours of a relative by families were a source of stress to respondents: “(family) is unrealistic regarding resident’s behavioural problems, verbal and physical aggression and noisiness” (JD04).

Respondents cited stress in regard to some families’ attitudes towards them, especially when they did not acknowledge a deterioration in the older person’s physical and mental health status: “Some relatives cannot accept that their loved one had dementia and are unable to believe their behaviours and disabilities are a part of condition and harass all staff” (HD05). Another care staff respondent identified how stressful it was when older people behaved in ways that the family could not understand or accept: “It is very stressful when the family come they asked you why my father not wear shoes. But he take it off... he is very hard” (AC17). Care staff cited feeling stressed when families who were fully
aware of their health status of their relative chose to ignore explanations from direct care staff as to why their relative was not behaving as they would like: “Some family is very hard to the staff even they know their mother, father, grandparents are confused, but they denied and listening to what they told them and gave the nurses a hard time” (LB05).

Some of the reactions of families to the unexpected death of a relative was cited as a stressful experience for one respondent: “When a resident unexpectedly passes away and then family want explanations as to why and how, because they thought resident’s health was well” (RV01). Thus, stressful experiences occurred for direct staff when families held unrealistic expectations that were unsatisfied, such as expecting that the health status of their family member will improve and that the person will experience happiness following admission to supported care: “Resident is sick – family is expecting to get better too much expectation from family” (TS07); and “…They expect miracles some times, ‘why my mum not get better’ or ‘why not happy?’” (JD04). Some respondents reported that they felt they were being held responsible for any deterioration in the health status of the older person, and this was very stressful for them: “There are some when resident is ageing and is becoming frail, their attitude is that this is because of the care they are given” (HD16).

This was reportedly the case when the physical and mental capacity of an older person who became increasingly impaired and direct care staff were unable to comply with the requests of families for treatment and particular care regimens: “Such as wanting to mobilize a person who is chair/bed fast, or a daughter requesting staff to make my mum play chess. It will improve memory.” (AC01). This type of stress for direct care staff was aptly described by one respondent: “One dementia resident whose son is a medical officer said to staff when dad forgets I talk to him and talk to him and talk to him. Try to bring back memories… you should do the same” AC01).
Inability of direct care staff to explain the circumstances surrounding the health status of older people to families was considered stressful: “the family had no idea about his condition, blamed staff about resident’s deterioration, they said it was due to negligence, when I confronted them to explain about the DSE process they told me to “leave the job if I can’t do it” (VF09). Respondents’ stated that the families’ perceptions of their limited knowledge and capability of direct care staff to care for an older person was cited as a stressful experience. As one respondent reported, it is “....disheartening to hear.....we are not giving proper and professional care” (JD05).

6.9.1.7. Insufficient Time to Provide Care

Study respondents reported that their experiences of stress occurred when the families were unaware of the time and frequency that care was provided for their relative, especially when families had expectations that could not be met: “Family member unrealistic expectations in the amount of time staff can spend with resident” (HD04); “Expecting staff to attend to family member within minutes of the request” (AC01); and “Family will often chase nurses and RNs down the corridor,.....and expects nurses to go immediately...after incidental things, for example a glass of water” (JD04). Respondents also found it stressful where families would not accept that care interventions had only recently been implemented prior to the families’ visitation: “…And they say to you ‘my father is very wet’. I said he just change a minute ago because he pull his pants and he wet on the hallway” (AC17).

Respondents’ experiences of stress was also associated with the extra time and effort direct care staff spent in providing care to older people which they felt was unappreciated by families, especially given the low wages they received: “They all expect the little extras to be done, makeup, nails, shaving...etc., on a one to one basis. No staff have time to do and insists on telling us it is our job because they pay for care for our wages” (LB12); and “There are some family members who like to take staff’s time during their regular visits. They need extra time and
reassurances” (HD16). Being unable to satisfy the families’ requests is a source of stress: “...we had a family member who was never satisfied. We could have been attending another resident when we would have to stop and attending his father. The reason was not an emergency but maybe to adjust the pillow or move his chair. I found this stressful” (XD02). Stress occurred when families expected direct care staff to give particular care and treatments to older people without consideration as to the treatments usefulness: “Demanding and aggressive family member.....she has been requesting daily therapy when no resident receives daily therapy at most three times per week.....she made each day a nightmare when communicating with her” (JD08). As another respondent stated, family members can be: “Constantly criticising even though there are more positives (to talk about)” (HD18); and “…very demanding and never been happy with the way you care with their relative” (JD06).

6.9.1.8. Perceptions of Families Mistrust Towards Direct Care Staff

An experience of stress for respondents was related to their perceptions of mistrust by families towards them: “Checking everything we do is right” (AC04). Families questioning the capabilities of direct care staff for basic care and either physically or verbally seeking verification that care had been provided was a cause of stress: “Do you know how, to shower/shave?” (DM07); and: “......he told me the staff just doesn’t know how to handle their mother’s behaviours” (LB18); and “Every time they are coming they checking looking for any single spot from them to complain...complaining of losing weight, why, mums or dad is not walking. Why not taking to the cinema. They confused, they don’t want to go” (LB05); or: “Family members ringing to check on family member late at night (routinely) at a busy time” (HD04). Mistrust of care provided by direct care staff included: “Families who don’t trust the nursing staff and who constantly give instructions” (LB01); “…resident’s daughter keep coming into bathroom and asking ‘are you sure, water is warm enough” (JD05); and “… ask for assist the resident for toileting, or change the pad on bed and they wait staying in the room even though we tell them to wait outside. Then they worry we can’t do it
properly” (LB01). Perceptions of mistrust of the capabilities of direct care staff included not accepting verbal reports made by direct care staff to families about their relative. Families would continue to seek information and/or verification from other more senior direct care staff. This mistrust was understood and acknowledged to arise from perceptions of families’ own experiences of stress: “families ... are very demanding because their love ones are in a nursing home” (FO08). Mistrust of direct care staff care practices was also stressful to direct care staff when they perceived the behaviours of family to impact negatively on other older people: “she goes into bathrooms, whilst nurse showering other resident (LBO1).

6.9.1.9. Family Requests of Specific Care Practices

Direct care staff stressful experiences arose when families requested care services to be provided according to the direction of families: “Through manipulation she force us to do daily therapy and if we missed a day due to illness she would abuse us” (JD08). One respondent cited a family member threatening direct care staff over the care goals of older people, which caused a great deal of stress for the staff involved: “threatening staff to (take the matter to) a higher authority if her needs not met immediately” (JD04).

In a number of instances respondents stated that direct care staff are blamed for the loss of the personal property of older people, particularly clothing, such as: “When families lost socks” (AC01), and when “Missing clothes from the laundry” (HD06). Interacting with families over missing items belonging to older people was particularly stressful for those respondents who had the closest contact with the resident: “There are circumstances that wives blame us it there is a garment / clothing missing from their family.....they probably blame us because we are the immediate carer” (EN07). For many respondents, the issue of missing clothing was felt to be beyond the control of direct care staff, particularly the laundry turnaround time following laundering: “...the clothes, they always complain about it and the nurse may you give it to another resident or throw away, but
really the laundry job... and some days they late because of weekend holiday. Mixed up. It always the nurses fault. They expect miracles sometimes” (NL04).

6.9.1.10. Direct Care Staff Perceptions of Not Being Respected and Valued

As previously identified, feelings of being unappreciated by the families was frequently identified as a source of stress in care staff. This stressful feeling arose from perceptions that the work of caring was not understood, not good enough and not valued by families, despite efforts expended by direct care staff to meet the various care needs of older people. This issue was upsetting for respondents because they genuinely felt fondness for the people they cared for: “The families don’t realise that the nurses become very close to residents and at times develop close relationships with them” (AC08). The bonds that developed between the older person and themselves was important to direct care staff, so when their efforts were not appreciated by families they felt stressed: “Families don’t realise that nurses do everything in their capacity to see that the clients are well cared for, there might be an occasional nurse who does a haphazard job, but majority of nurses do a great job” (FO03). Lack of family appreciation for their efforts were: “... stressful...the families are very unreasonable with their requests at times and not matter how hard we try to accommodate them, they seem to ignore our efforts” (AC08), since: “Sometimes I find families demanding so much from staff and not considering the side aspects of the staff giving services” (CA10); and: “No matter how hard we try often backfires. Very little appreciation shown” (HD18). As one respondent explained: “My personal view is that some families are not happy what we do, how hard you tried....not realising that we have got other residents to look after... think their resident is the only one here” (DM09).

The lack of family member acknowledgement of the vital role that direct care staff played in the care of older people was reported as a major source of stress. It was also stressful when families ignored explanations and offers of counselling, by less senior direct care staff who, nevertheless, had years of experience and
knowledge of supported aged care accommodation work: “They think the DON and Admin staff are the only ones to seek out, for solutions if there is a problem. Relatives who do not value your years of experience esp. trying to explain certain problematic issues.....not heeding any advice when give. Trying to help the residents in any emotional way – some relatives see it as a threat, their status” (RV04). “One day when new resident came, I be friendly with the family but it looks like they are unhappy with something. Next day they came again. I said hello to them but they never answer me. I thought maybe they didn’t hear. Again next morning they came to see their father. I smile with a big hello but they never answer me. I feel like they thought we nurse are useless. We are doing a great work for them but they thought any one can do this job and it is an easy task. It’s a really bad feeling for me and some of my other friends” (VF02).

Study respondents accepted that whilst they were not always successful in their attempts to provide quality care, being valued and appreciated for their efforts was important to them: “no person is perfect.....a little thoughtfulness and appreciation would go a long way” (FO03). It was evident that respondents placed a high value both on themselves and on their work: “I look at my role in management as our responsibility obligation that I take seriously and it is not a privilege. The daily hassles from staff, residents and families I usually am able to manage to come up with a Win-Win outcome... when I have control over things I deal with them but when I have no control over things, I let it go” (WC10); especially when compared to the external care services provided by public hospitals: “Public Hospitals would not know how to look after demented residents – when admitted to hospital do not fed them or do P.A.C., stick catheters in them, they come back to us with massive U.T.I.’s, starving, pressure ulcers on heels, sacrum, buttocks, elbows if they have the temerity to criticise us” (TS04). Therefore, the family’s poor opinion of care provided by direct care staff was even more stressful for them.

The work of caring as a valued service provided by direct care staff to older people, and the stress that this can engender in staff, is summed up as: “There
are some good days and bad days in every job. Things don’t always go perfectly but then again they don’t always go wrong. As nurses we frequently encounter situations at work that are physically and emotionally demanding. So we spend our working life caring and giving quality life to the people we care and putting the needs of our patients ahead of our own. The community as a whole regards us as tough, able to cope in all situations, always caring, loyal to our patients, dedicated etc, putting ourselves last. As a result this can lead us to feeling stressed, anxious angry and depressed” (EN06).

6.9.2. THEME 2: WORK-RELATED STRESS

6.9.2.1. Perceptions of Discrimination

Being subjected to discriminatory attitudes and actions from families and also from colleagues was cited by respondents as stressful experiences. The various ways in which family members exhibited their perceived discriminatory behaviours included references to the staff’s skin colour. This was the case for many of the care staff from non-English speaking backgrounds: “We are browned skin and family look at us and they think we are not good enough to care for their family member. This how I feel. They are looking at us because of our colour” (AC04).

Other care staff respondents stated that some families of non-caucasian backgrounds displayed what they perceived to be racist behaviour toward them: “There is a lot of racism from families who think they have a right to be critical of the nurse’s standard of care because of their ethnic background” (CA01), and “The resident and their family they racist sometimes” (AC17). Senior staff and managers were also cited as using these forms of discriminatory references towards care staff from non-caucasian backgrounds: “the RN is racist too .... report you to the Matron...” (AC17).

Feeling “used” and being treated as “slaves” were other terms employed by respondents to describe their experiences of stress arising from their
interactions with the families: “Often I feel used and put down by families” (CA01). Male nurses in particular reported they experienced a degree of suspicion from families of non-English speaking backgrounds: “Male nurse often face a lot of odd looks and distrust from some families especially NESB families” (CA01); “Often I feel used and put down by families” (CA01); “Treating staff like slaves” (EN14); and: “Treat the staff with no respect” (LB01). This treatment by families and older people was considered demeaning for some of the respondents: “I am an overseas student. I am study here and working here. But the funny thing is the resident of this nursing home they think we are the slave of them. They treat us very badly. Because they think they pay the money for this service and whatever they like we have to do” (BL05).

6.9.2.2. Workforce Issues

Respondents across all categories of work also identified the stress of aged care accommodation work itself, which was perceived to be: “Challenging and hard work” (CA09); “On the whole it is a very demanding job” (HD16); and: “Whether it be an AIN or an RN the job is very tough ...clients are difficult...aggressive and violent...takes a great deal of convincing ...trying to help them...as most of them suffer from dementia” (FO03).

Workplace experiences of stress for respondents were also related to working with direct care staff who were inexperienced and too few in number to undertake the work required of them: “Working with inexperienced staff – hard to meet deadlines” (HD12); and: “Occasionally the nursing can be short staffed which makes my job stressful” (RV02). Being short of staff was cited by respondents to be a precursor to a stressful work environment: “Stressful situations arise with short of staff” (AC15); and: “Most (of the) time when short of staff it’s very hard to do my job properly” (WC03).

The inability to maintain staff continuity on a daily basis was perceived by one respondent to impact on quality of care, leading to family grievances: “Some relatives will complain...same clothes every day. The problems with the clothes is
there (sometimes) different staff every day” (LB08). Other respondents identified a lack of time to complete their work impacted on their ability to provide quality care and was a stress factor and one of the reasons for the negative interactions occurring between care staff and families and older people: “Finding time to counsel individual family member while at the same time a tight schedule of work routine” (NL01) and: “I find it stressful as I have to divided my care and attention between many other residents” (RV06) and: “The conflicts and confrontation between staff and family members demands lots of time to counsel, resolve conflict in a way to secure the best care for residents” (NL01).

The inability to control their workload and their work environment were associated with respondents’ experiences of stress: “Stress arising from inability to fulfil a promise with family re resident care .....won’t happen...... everyone working part/time and poor chain of communication” (HD04); and: “(getting to) know your resident, what’s their likes and dislikes, then the routine changes” (RV09). “Working through your break time” (GP04) was a consequence of being unable to control the workload and gave rise to considerable stress. One respondent suggested that staff workload stress could be reduced if senior staff numbers increased and were employed on full time basis: “Stress levels in dealing with family would be reduced.....if charge RN worked 5 day/week. This particularly for smaller items such as repairing glasses.........interaction with pharmacy, orders such as B/P” (HD04).

The high ratios of older people and carers was of particular concern for respondents and was cited as being attributed to workplace stress: “...so stressful for me because not only do I have to deal with resident aggression, but with 6 to 1, or 7 to 1, ratio is already a pressure and time consuming ...it affects my work performance and likewise my emotional status” (EN07). The high workloads experienced by respondents were considered to have a direct relationship with the respondents’ interactions with the families and with their colleagues: “Sometimes they won’t talk to you, if you don’t look after their family member in the nursing home the way they want. They don’t know that you are
there for not only one, for more than 36 residents. That stresses me” (LB06). High ratios of direct care staff to older people was perceived to negatively impact on the available time direct care staff had to provide care to older people and as expressed by one respondent was highly stressful: “When particular residents are calling out nurse, nurse, nurse continuously etc. the sister says the doctor has prescribed something etc. Week later at report this resident is reported as being much quieter which is completely not true. Therefore, AINs are told to do something, talk with her. Do things with her! If we had all our residents attended to of course. But staff cut backs does not allow us the time we would like to have and to spend with resident” (IE08).

Working with a high ratio of older people was identified as extremely stressful: “My work situation is I am the sole occupational therapist in my facility with all levels of care with 176 residents…..to ensure meaningful activity is implemented to maintain the resident’s mobility and dexterity” (JD08). A high ratio of older people to direct care staff was also considered to lead to an: “Inability to provide the desired level of quality of care” (XD08), and to be unable to meet the expectations of families for extra services: “When a family member makes simple demands to buy batteries, shampoo or toiletries, make appointments, take to appointments. These above things are simple on a one-to-one basis, though become more difficult when a staff member has many other residents to care for” (XD08).

Perceptions of inadequate or poor communication occurring between direct care staff was identified as an additional source of stress in the workplace when workloads were high: “Some stresses come from others lack of communications, not caring, and prioritising” (XD10) and: “When other members of the team do not plan and do things on the spur of the moment, it sometimes stresses me” (XD10). Additionally, working with direct care staff that didn’t have the same level of commitment to their work was also a source of stress for some respondents: “The most pressures come from my job come from other staff dealing inadequately with family members causing problems larger than they
were to begin with. Management are then left to ‘pick up the pieces’ and resolve conflicts” (TS05).

Work-related stress was also a factor in the level of support that a respondent received from their managers, supervisors and other staff: “The unrealistic expectations of management expecting quality....out of the residents with physical needs with a high quota of residents” (AC15); “When attending to another resident they are calling out for nurse....Sister comes on the scene and approaches us that we are needed on the floor. Whereas the sister should support us and explain to the family that we are in the middle of something with another resident. Sometimes we AINs feel that the Sisters should get off their high chairs and help out. AINs get blamed for everything !!!!!. So it’s up to management to deal with the family and explain everything that is happening with their relative otherwise the is one reason why they continued to hustle and harass the AINs” (IE08).

Three respondents stated that the support provided by their managers provided positive workplace experiences and made them feel comfortable in their interactions with managers, supervisors and other staff: “The DON and DDON both of them are very good. We can speak openly if something we get wrong” (XD01). The support provided by managers was perceived to have improved staff morale: “with the support of management we had a case conference advising relative that she had her rights but so did our staff. Staff morale was very low but has improved knowing the excellent support given” (DM11). The supportive strategies implemented by a manager contributed to a high level of satisfaction and reduction of stress for one respondent: “Mr X was admitted to our facility...over time his condition became worse accompanied by physical aggression towards staff and residents (sudden aggression)...I referred to manager, spoke to the family and resident was moved to another facility due to the danger to staff and other residents” (VF09).
As well, support provided by staff supervisors was perceived by respondents to be associated with a decrease in stressful workplace experiences and a source of personal satisfaction with the work of caring: “My supervisor are very supportive and even though work is hard and always busy every day. At the end of the work I felt satisfied” (JD16). For one respondent feeling supported by senior staff was very satisfying: “Well, working in this nursing home is really nice for me because I can never find the staff like here in this nursing home, they are very friendly and helpful, when I was new they taught me in such a good way and being so friendly that I never felt like I’m new in this nursing home” (XD01). On the other hand, as a new employee a respondent found that the attitudes and actions of longer employed staff were stressful: “Some of the old staff look down on new staff’s they intentionally hate them and get angry with them with pity things it does not help promote effective work. They report you whiles they can correct you. It does not appreciate team work” (LB26). For one respondent the lack of support from colleagues was quite distressing in her first week of work: “When I first started here it was a really stressful job. It was my first time to do nursing. I don’t have any Nursing experience and plus the staff don’t help especially it was my first day. I work without pay for a least two weeks to get some experience, after that they give me a shift, and I tell you it was a stressful day for me, nobody want to work with me” (XD01).

6.9.2.3. Emotional Issues Related to the Workplace

As identified above, a small number of study respondents identified that they felt emotionally upset as a result of their stressful encounters with the families of older people: “It is very stressful keeping a neutral stance and not reacting emotionally towards the relatives” (HD02) and: “with my experience as AIN. Sometimes I get to much stressful....I feel very emotional sometimes” (HD14). Part of this sense of distress was the inability of a respondent to satisfy the requests and expectations of families: “....family member....are never satisfied with what you do for their loved one” (FO03) and: “I find stressful....is when they are never satisfied with what you do for their loved one” (FO05). In reflecting on
this source of stress, one respondent thought of it as burdensome: “Most of the time the wives of the residents pressure me too much. This so stressful for me.....small things they throw at us adds up and is really an enormous burden.....the families nagging and complaining will add up, or adds up. Everybody I think will just have a breakdown” (EN07).

As previously identified, the families’ dissatisfaction with care caused the respondents’ to feel undervalued by families. As well, many respondents stated that they cared a great deal for their older people, so when families undervalued them and their work and were made to feel responsible for events that were not under their control, they felt even more stressed in their work: “Sometimes when you know you looking after the residents in your best abilities, with love and kindness, and then, something happened that your can’t control it, for example a skin tear. Just the way they accused you and stares at you that stresses you” (LB06).

Respondents’ reported that their experiences of stress were often associated with the requests of those families who visited infrequently. Following the initial settling in period following admission to a supported aged care accommodation service, families were reported to became increasingly demanding of direct care staff: “Families often lose interest after the initial settling down period and can become demanding of staff” (XD06). Stress arose because: “Dealing with the families and/or family member is always stressful, cause the demands towards their family member in the facility involved our caring and services which the families didn’t experience in daily act” (CA11); and: “Dealing with unreasonable relatives is stressful and very hurtful when they visit little and make demands” (CA07).

Previously reported respondent perceptions of “threatening and abusive attitudes adopted by some families” (CA11; JD08) toward direct care staff was as a result of the impact of public influences and negative publicity as reported in the newspapers: “Relatives swallow all the negative press and are arrogant,
threatening, and demanding to staff” (JD04). These respondents felt that a focus on the negative side of aged care by the media was to blame for family abuse of staff: “Then having media information which is poor and substandard or misinformed and relatives expectations from this media outlook” (BL01) and: “… at times that they have different ideas about the nurses mostly due to the bad publicity that aged care homes received” (AC08).

6.9.2.4. Strategies Used to Minimize Experiences of Stress

Whilst a number of respondents identified a variety of methods that direct care staff used to minimize their experiences of workplace stress, one respondent was of the opinion that stress was an inherent factor of the work of caring: “Working as a nurse has its own inherent stresses and one can get used to those over time” (GP02). Apart from learning to adjust to the stress of aged care work, strategies adopted by respondents to alleviate their experiences of stress included providing additional information about the care needs of older people to the families: “Sometimes family members are taken by surprise we as carers try to explain and tell them something about the Recipients. For example Dementia” (DM07); and: “Trying to counsel families and make them understand why they complain...” (AC07). The information sharing was extended to including families in the care of older people, particularly for those older people that exhibited behaviours that distressed families. A strategy used to help alleviate stress arising from family concerns was to obtain their cooperation in the planning of the care for these older people: “Explaining to families that they have to take time and help staff with their relatives’ abusive aggressive behaviours” (TS01).

One respondent stated that by explaining to a family member that their relative was becoming increasingly vulnerable helped to relieve the stress for the family member and subsequently, to reduce the stress of the direct care staff concerned: “I counsel them that if they could not look after and “fix” their father, how did they think we could make them better. We all had to die” (TS04).
Respondents found that attending to family concerns promptly was also an effective strategy to reduce stress for families, as well as for direct care staff: “I find when dealing with complaints concerning resident and their families it is always best to deal with the problem promptly, this often saves a lot of stress to both the staff and the families” (JD01).

Making time to understanding the care needs of older people and the emotional needs of the families and responding in a proactive manner to requests, was cited by a respondents as a helpful strategy to minimise personal stress, whilst at the same time ensuring that both the older person and their families were happy: “It does help if one has some knowledge of family stresses” (JD01); and: “We had a resident with Italian background. She had three daughters and two sons. They came and visit every single day...these people very fussy....doesn’t matter if we busy...I have to drop what I am doing...so every time I’m on I make sure this resident is toileted before dinner, make sure she looks clean, because if one don’t do that they will tell us that their mum wants to go to the toilet...so my experience was started at first I was very stressful with this resident and her family, but at the end I was their best nurse, their favourite, only because I love my job very much” (RV05).

Both nurses and care staff stated that effective communication with families was an essential component of caring of the older person and as a strategy to minimize their own experiences of stress: “Communication is the key to all realms of healing to inform families” (TS02); and: “At times family members have unrealistic expectations of the residents health status. The most difficult aspect of this is often to do with information they receive from the medical officers and the lack of appropriate treatments given by the residents M.O. for comfort in end of life” (TS05). Understanding the difficulties arising from language limitations was cited by respondents as an important strategy to minimize direct care staff stress. One respondent reported that they sought assistance with communicating more effectively with families: “Language it’s the barrier to
communications, but I always ask for assistance and I am 100 per cent agree” (WC03).

By striving for positive communication and harmonious relationships with families and maintaining the “right” attitude towards them, care staff were able to minimize their own stress: “In my experiences I have no problems with this. As long as I do the right thing and love this people. You have to understanding more. Prepare yourself to dealing with this job…” (IE03).

Remaining calm, trying hard, using personal restraint during communication along with avoidance techniques and humour were among the strategies adopted by respondents to minimize their stressful experiences: “I try hard whatever comes any problems. I always remain calm when facing difficulties” (HD14); and: “I actually deal with families and residents openly / calmly, no problems” (AC12); and: “Inside me I call her names, I will better not repeat, but not to her” (IE10); and: “What I sometimes do is if I see them coming, I tend to get out of the way” (LB22): “When I feel angry with them and I started singing or had a joke with this resident and that will stop them from picking on something” (RV05). Taking time out for themselves was cited by respondent as a strategy to deal with stressful events: “I am taking two weeks holidays to time out and rest and am looking forward to walking and gardening while I am away. I am happy to know I am refreshed when I come back” (TS10).

Protecting oneself from negative outcomes when interacting with families was implemented by a respondent as means to minimise stress: “When a situation occurs...I am upfront about what I can offer and document every word and liaise regularly with my supervisor” (JD08). Gaining support from managers and supervisors was identified as a way to ameliorate perceived stressful situations with families: “Sometimes the families are not bad because we are only allowed say so much to families and then re-direct them to the RN on duty. So it’s up to management to deal with the family and explain everything that is happening
with their relative. Otherwise that is one reason why they continued to hustle and harass the AINs” (IE03).

On the other, hand when managers were not able to stem family complaints against care staff, nurse respondents felt highly stressed and disenfranchised: “Department treating our residents, through us,... as throw away objects. I get tired of the years in an out pushing against the negative tide. I will be glad to retire and write about all this. Daren’t do it now, the Accreditation people would hound us to death to shut me up. I cannot do this to my very good proprietor and staff” (TS04). The reflective statement of respondent TS04 provides an indication of the loyalty and value held by direct care staff for their comrades at work despite the inherent difficulties of the work of caring and the negative experiences associated with their interactions with the families of older people.

A small number of respondents reported, they had not encountered a situation that they considered to be stressful when interacting with the families of older people. This issue was prompted by the belief of direct care staff that they had the capacity and abilities to effectively manage situations that were potentially stressful and that the care they provided was of a high standard: “I didn’t have any bad experiences with any of the families” (HD17); and: “I rarely get stressed because I believe that I do my job well to the residents (KD07). As well, these respondents had faith in their ability to deal with any negative situation regarding families: “I Haven’t really encountered any stressful situations in my years of nursing and if I do happen to face one in the coming years will be able to manage and deal with it reasonably well” (GP03); and: “I’ve never found any stress of any kind involving a family member or their families. You just need to be calm, polite and listen, eye contact and good body language. If you sit and listen to their complaints or complements its amazing how consecrate they can be. Where there’s a will there’s a way” (HD14). For these respondents, it was evident that keeping families happy was a skill: One has to be very resourceful in order to maintain control and establish a happy medium between care and complaints. You are observant and in all fairness want to do your job properly then there is no
stress instead you enjoy your work and get job satisfaction” (816). This skill was aptly described as: “... needs a lot of understanding and patience to deal with the different personalities of the family of my recipients” (CA10).

6.9.3. THEME 3: STRESS ARISING FROM INTERACTIONS WITH OLDER PEOPLE

Respondents referred to older people as sources of stress, with most statements related to only two issues: ‘aggression’ and ‘resisting care’. The stress associated with having to face the decline of older people and issues of death was also a source of stress for respondents.

6.9.3.1. Respondents’ Perceptions of the Behaviors of Older People

Responding to the unpredictable behaviours of older people was cited as stressful when older people with limited ability refused to cooperate in their care regimens: “Mr X admitted.....diagnosis of dementia.......accompanied by physical aggression towards staff (sudden aggression)...very stressful” (VF09); and: “I just get stressed when some of the residents does not co-operate some times. But it doesn’t change in my dedication looking after them. I feel like a good person after I do them, services.

6.9.3.2. Respondents’ Perceptions of Death and Dying

The suffering and/or death of older people were particularly stressful and meaningful for some respondents, who likened their emotional attachment for older people to how they felt about a close relative: “I always worry about that I also be there for them” (WC02). Stress arose from: “Seeing my resident suffer” (GP04); and: “When they die I really miss them. Another stressful time” (1214). A sense of responsibility for an older person’s death was also stressful: “Looking after the old folk I get very closed in each and every one that I have cared for, after a while they get sick...they die. I feel as if I have not done my job, or I haven’t done my best, as if I have lost a family member....When they die, that will be the only time I wish that I never had this job. But! I still love my job” (LB14). Conveying the death of older people to families was also reported as stressful:
“Stress when talking to families, especially at night, when someone has died” (BL02) as was not being present at the time of death: “...this poor old lady ....was with us for four years.....suffering from progressive dementia and multiple stroke was kept in hospital to die and never allowed back to our care. We felt, as a team, disappointed and helpless, unhappy with what had happened to this particular lady” (NL01).

6.10. SUMMARY OF THE OPEN-ENDED SURVEY QUESTION
NARRATIVE THEMES

Three key themes and emerged from the written narratives of respondents’ perceptions of their experiences of stress associated with their interactions with the families of older people and included: (1) Perceptions of stress arising from interactions with families; (2) Stressors in the Workplace; and (3) Stressors arising from interactions with older people

Respondents felt that they were unable to meet the care requests, needs; concerns and expectations of families especially for some family members who had a cultural background different to their own. Respondents' interactions with families were often perceived as being threatening or abusive, and at times racist in intent towards respondents. Respondents perceived that some of the negative family behaviours towards them were caused by the emotional distress and sense of guilt that these families may have had about having to place the older person into supported care. The majority of the care staff respondents, as well as nurse and manager respondents, considered that the sense of distress and guilt that families experienced caused them to expect much higher care standards and more attention to the older person than were possible.

Workplace stress for respondents arose from the high pressure of their work and having to meet the growing expectations of direct care managers as well as families. Respondents found it stressful to care for many older people each day, while being expected to pay more attention to the needs of individual older
people whose families were perceived to be more demanding and critical of the care being provided. Consequently, having insufficient time to provide individual care, as often as was being requested by families, was a major source of respondent stress. This was compounded when the respondents felt that the care they provided was not valued by families and even more so, when the requests or perceived grievances of families were upheld by other health professionals, their managers and government agencies. Respondents felt powerless and demeaned, especially when combined with a sense of being undervalued and treated as an object of scorn.

Some respondents reported methods that they used to manage stressful situations when interacting with families, and these included effective communication techniques, learning to care for older people, and providing quality care. As well, when direct care managers and supervisors supported and assisted direct care staff in assisting with the requests of family they felt more able to enjoy their work and manage criticism.

The decline and death of older people was stressful and sad for respondents and this was accentuated when they felt unable to be with the older person at the time of death. Respondents experienced additional stress when the older person continued to demonstrate anxious behaviours and/or refused to accept their care. When respondents reported working closely with families in providing care, however, they felt relaxed with families and were more positive to care demands. In summary, while the majority of respondents reported enjoyed caring for older people and working in a supported care accommodation service, in order to feel less stressed in their work they needed to have their contributions recognised and valued by families and to feel respected by them.

6.11. CHAPTER SUMMARY

This Chapter highlighted the workplace experiences that direct care staff perceived to be stressful in the supported aged care accommodation service
sector, the effects of this source of stress and the potential for self-efficacy in aged care work to mediate levels of work-related stress. Many of the stressors arising for study respondents were related to the workplace and its demands; their interactions with the families of older people; including managing the requests and dissatisfaction of family; and the various characteristics and behaviours of older people they provided care to. Both the survey data on direct care staff stress, burnout and self-efficacy and the themes arising from the single open-ended survey question on stress arising from interactions with families, provided insight into these aspects of the work experiences of direct care staff. Chapter 7 which follows, discusses these findings in relation to the existing literature on direct care staff stress, burnout and self-efficacy in supported aged care accommodation service work and the theories that explain these concepts.
CHAPTER 7 – DISCUSSION OF STUDY FINDINGS

7.1. INTRODUCTION

In Chapter 6 the results of the analyses of the ENSS (stress), MBI (burnout) and GSE (self-efficacy) measures were reported. In addition, the personal demographics of direct care staff were analysed and reported in relation to the variables of the ENSS, MBI, and GSE to identify the existence of any significant associations between these constructs and staff characteristics. Data obtained from a single open-ended survey question were analysed and reported to identify respondent stress associated with interactions with the families of older people in care.

This chapter draws on the relevant literature and theory to situate the study, and to discuss and provide meaning to the study findings that were presented in Chapter 6. Possible explanations for the associations between item responses in the Expanded Nurse Stress Scale (ENSS) (French et al., 2000), the Maslach Burnout Inventory (MBI) (Emotional Exhaustion, Depersonalisation and Personal Accomplishment) (Maslach, Jackson & Leiter, 1996) and the General Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995) will be discussed. These associations will be considered in terms of the type and frequency of stresses reported on the ENSS, the MBI and the GSE, the stress experiences identified in study respondents’ open-ended survey responses and in relationship to the theoretical propositions of the study. The chapter concludes with a discussion of the suitability of the study methodology and its limitations, considers the implications of the study findings for direct care staff practice in the supported aged care accommodation service environment and makes recommendations for future research in the field.
7.2. SITUATING THE STUDY

The findings from this study provide clarity on the primary factors that were identified as causing stress for direct care staff and highlight the complex nature of the Australian supported aged care accommodation service setting and the stressful work environment for direct aged care staff. Meeting the legislative requirements and care standards amid the multiple expectations of different stakeholders were reported as being very stressful experiences for the majority of direct care staff respondents. Factors that were reported to help minimize stress experiences for direct care staff included support from managers, supervisors, peers and other health professionals, as well as strong leadership and resource availability. These findings confirm previously reported results of a much earlier Australian study by Healy and McKay (1999) that used the original version of the Nurse Stress Scale. A comparison of Healy and McKay’s study findings (1999) and other care-related stress literature will be discussed throughout this chapter.

From an initial examination of the data, the items and categories relating to identified stress levels revealed a number of situations that were significantly stressful for direct care staff study respondents. Many of these stressful situations did not occur in isolation and were correlated with direct care staff burnout, self-efficacy and personal characteristics. While there was considerable variability in the way that direct care staff stress was investigated and reported in previous studies there are, nevertheless, significant similarities in reported direct care staff stress levels, workplace characteristics and personal characteristics. Few previous studies have employed the Expanded Nurse Stress Scale (ENSS) and/or the Nurse Stress Scale in relation to supported aged care accommodation service environments. Another area of difference is that few studies have placed emphasis on stress associated with the families of older people living in the supported aged care setting.
7.3. KEY FINDINGS: STRESS, BURNOUT AND SELF-EFFICACY

Similar to a plethora of previous research on workplace stress for direct aged care staff (for example, Ramirez, Teresi & Holmes, 2006; Chenoweth et al., 2009; King et al., 2012) at the sub-categorical level, the ENSS Workload sub-category provided the greatest number of stressful situations for respondents. This predominant cause of staff stress was followed by Residents and Their Families and Death and Dying. When correlating each of the ENSS sub-categories with ENSS total scores, the ENSS sub-categories of Death and Dying, Conflict With Physician, Inadequate Preparation, Problems With Peers, Workload, Uncertainty With Treatment, Residents and Their Families and Discrimination were all equally and significantly important sources of stress for respondents.

When considering the frequency of stressful situations for the study respondents in relation to questions about the families of older people on the ENSS instrument (French et al., 2000), five items were identified as being the most stressful. ENSS item Question 15: Families making unreasonable demands was ranked as the highest source of stress for respondents, considered as either “frequently” or “extremely” stressful. The ENSS items, Question 25: Being blamed for anything that goes wrong; Question 52: Having to deal with abuse from residents’ families; and Question 56: Not knowing whether residents’ families will report you for inadequate care was identified as the next most stressful experiences for respondents. Confirming these data, the four most prominent narrative themes that caused respondent stress and feelings of burnout and which affected self-efficacy in their work included: (1) Families Care Requests; (2) Family and Direct Care Staff Interactions; (3) Time Pressures and Other Workforce Issues; and (4) The Requests and Care Requirements of Older People.

Similar to other studies on direct care staff stress and/or turnover (Buchanan and Considine, 2002; Hegney et al., 2006a; Duffield et al., 2009; Chenoweth et al., 2012) three other equally stressful situations for respondents were associated with the older people themselves and included ENSS items Question 7: Residents
making unreasonable demands; Question 35: Having to deal with violent residents; and Question 52: Having to deal with abusive residents.

To further explore these major areas of staff stress, an additional examination of stress correlations of p < 0.001 was undertaken. The MBI (Maslach, Jackson & Leiter, 1996) domains were measured separately with each ENSS item of stress and ENSS sub-category; the self-efficacy scale, and respondents’ demographics. While it is important to understand the stressful situations that occur most frequently and are the greatest sources of stress for direct care staff, it is also important to understand the relationships between stressful situations. For example, the stress constructs Death and Dying and Discrimination had equally significant associations with all three domains of burnout (MBI) (Maslach, Jackson & Leiter, 1996) and self-efficacy (GSE) (Schwarzer & Jerusalem, 1995) for work. The stress factors Conflict Physician; Inadequate Preparation; Problems with Peers; Workload; Uncertainty With Treatment; and Residents and Their Families were equally and strongly associated with feelings of MBI Emotional Exhaustion and Depersonalization that were also strongly associated with perceptions of low self-efficacy (GSE). On the other hand, whilst the ENSS sub-category Conflict with Physician was strongly associated with MBI Emotional Exhaustion and Depersonalization, Conflict with Physician was not negatively correlated with MBI Personal Accomplishment or with perceptions of self-efficacy for work.

With the exception of the ENSS Death and Dying and Discrimination, a number of significantly strong relationships were also found with ENSS Conflict with physician, Inadequate Preparation, Problems with Peers, Problems with Supervisor, Workload, Residents and Families, and with MBI Emotional Exhaustion and Depersonalization. The initial conclusion to be drawn from these relationships is that the subjective experience of stress, when correlated to the burnout dimensions of Emotional Exhaustion and Depersonalization, are precursors for the development of burnout for direct care staff (Maslach, Jackson & Leiter, 1996).
These findings confirm previous research in the area of work satisfaction which suggest that direct aged care staff are not stressed by the work itself. Rather, it is the working conditions and stressful events that impede undertaking their work which cause the most stress (Chenoweth et al 2012). The free responses written by respondents on the open-ended survey item confirmed the ENSS survey data and suggest that the conditions under which direct care staff respondents were working could have a long term effect on their health and well-being. Lazarus & Folkman’s (1984) theoretical proposition that events arising from the environment act as stress stimuli was, therefore, supported by the study findings.

Each of the significantly correlated stressful workplace situations will be discussed in turn. To further enrich and add credence to the key study findings, information derived from the written narratives of respondents on the open-ended survey question is integrated throughout the discussion. Stress theory indicates that the response of one individual to a stressful situation may differ from that of another individual (Lazarus & Folkman, 1984). Such differences may be due to the level of arousal for the individual level to a specific stress factor, and/or to the ability or manner of the individual in which a specified stressful encounter is appraised or dealt with (Lazarus & Folkman, 1984, p. 7). While the majority of respondent narratives reported stress associated with family interactions, the narratives varied in the reactions of respondents to this form of stress. The narratives also confirm the multiplicity of stressful experiences that can arise when direct care staff interact with the families of older people, and which also appear to have a significant impact on levels of work satisfaction. There is much to learn from this study about the complex nature of these stress factors and their potential to impact on workplace culture.

7.3.1. FAMILY CARE REQUESTS

The written responses of respondents to the open ended question identified the care requests made by families to be unreasonable and/or unrealistic and were the most constant source of stress for respondents. These findings corroborate
the findings from the qualitative ENSS data. Similar levels of stress were identified by Von Drabs et al. (2009) in their exploratory in-depth study of the experiences of workplace stress of six nursing home staff. In the current study, some respondents suggested that the care requests and care expectations of families may have been associated with negative media publicity regarding unacceptable supported aged care accommodation service provision as identified in Chapter 2. The media publicity may have initiated a level of fear in families that their own relative might be subject to neglect by direct care staff.

Consequently, receiving requests by families to give care that was considered to be unrealistic in consideration of the additional time this might involve for the staff member and/or, that the type and level of care was not suitable or required by older people, placed undue pressure on these staff. As well, since these respondents felt obliged to comply with the wishes of families’, they experienced dissonance between what they knew they could realistically provide to older people and what they would need to forego for other older people by so complying. This dilemma was reported to be a precursor to ‘giving up’ or feelings of burnout, as described by Maslach and Jackson (1981).

Some situations that were reported to have occurred with older people and their families were strongly associated with burnout (Emotional Exhaustion, and Depersonalization) and with the personal level of self-efficacy of the respondent. The numbers of hours that respondents worked were found to negatively impact on their perceptions of the demands made by families. Feelings of stress occurred when respondents perceived they were blamed for anything that went wrong, even when they did not have responsibility for the particular older person, and when they felt worried that a family member would report them for inadequate care.

Previous research identified similar stress situations had occurred for direct care staff giving rise to high levels of stress which often lead to these staff resigning or taking sick leave (Sofield & Salmond, 2003; Von Dras et al., 2009; Chenoweth et
One of the identified issues arising for respondents was that many families appeared to be often unaware of, or denied knowledge of the poor prognosis of their relative and/or general health status, which gave rise to criticism of direct care staff when the health and function of their relative continued to deteriorate.

The respondents perceived that families requested unreasonable care regimens and at times, restricted attempts by direct care staff to provide the necessary care that would benefit their relative. It is likely that these families were themselves very stressed with the deterioration they observed in their relative and were upset that the direct care staff did not do all they could to prevent this from occurring, and/or did not provide the type of care that they believed would help their relative. If families subsequently held direct care staff responsible for these changes in the health and well-being of an older person following admission, the direct staff felt stressed and at times quite worried about the concerns of families. As well, negative family reactions to the unexpected death of an older person was a source of stress for respondents, as was the denial of families of the physical and mental health status of the older person, despite the attempts by direct care staff to advise them of this.

The terms “demanding”, “unrealistic” and “unreasonable” were frequently used by respondents to describe family requests. This experience was consistent with similar findings of a study conducted by Von Dras et al., (2009) who used in-depth interviews with 12 direct care staff to identify stress in the workplace. As well, Bauer’s (2006) study of the experiences of direct care staff with families of older people found that staff perceived that many family members had no appreciation of the stress that their requests had caused them and as one Bauer respondent reported “......It should be explained that it isn’t on- on-one, and it is a busy job. It’s really heavy....” (Bauer, 2006, p. 48).

The study respondents confirmed that they were cognisant that visits by families and friends were important to the well-being of older people and stated that
meeting the requests of family was seen as an important function of providing care. The respondents also reported that very often families who placed requests they perceived as “unreasonable” on direct care staff did not visit their relative frequently and when they did visit, they were more critical of care and the health status of their relative than those families who visited more often and were more involved in helping to provide care to their relative. These findings signify the stress that families can experience in coming to terms with the decline in the health status of their relative. The respondents perceived that families projected their experiences of stress onto direct care staff. Hawkins, Howard & Oyebode (2007) argue that this issue is a common view held by direct care staff, and oversimplifies the situation that families faced when experiencing the continuing ill health, function and impending death of their older family member (Hawkins, Howard & Oyebode, 2007).

In Australia, the holistic care of older people is embodied in the current philosophy of care of the older person and is used to describe the way in which health care services are required to support the physical and psychological function and quality of life for these people (Access Economics, 2011; Australian Government Productivity Commission, 2011). From the context of the family of older people, the philosophy of person-centred care as posited by Kitwood (1997) suggests that family of older people are to be acknowledged by direct care staff as being central to the existence of family and therefore family are vital in helping to support the emotional well-being of the older person and also in making decisions about the care needs of older people. Studies have demonstrated that meeting the needs of the families of older people living in supported aged care accommodation services is paramount for the satisfaction of both older people and direct care staff (Chenoweth et al., 2009).

Encouraging and supporting families to be more fully involved in care services and contributing to the life of older people has been a significant step toward reducing the negative consequences for older people moving into supported aged care accommodation (Accreditation Standards, 2011). Nevertheless, while
many respondents may have been conversant with the current approach to a supported care philosophy and recognised the importance of families being involved in care decisions and in providing care, their written responses indicated that family contributions to decisions and requests in care were stressful for them.

It is possible that the leadership/managerial models the respondents were working under did not promote or enable a shared care model as emphasised in the person-centred framework of Kitwood (1997) and in the Accreditation Standards (Department of Health & Ageing, 2012). As well, these respondents might not have felt sufficiently supported by their managers to invest in a more inclusive form of care and decision-making with families (Jeon et al., 2011). Unless direct care staff have the time, energy and motivation to build rapport with the families of older people, then effective collaboration regarding the care of older people is less likely to occur (Bauer, 2006). The findings elicited from the written responses of respondents suggest that further research is needed to determine how direct care staff can best work with families in care and decision-making arrangements for older people.

7.3.2. FAMILY AND DIRECT CARE STAFF INTERACTIONS

Perceptions of negative family behaviours towards direct care staff and their work colleagues were cited as stressful experiences for respondents. Perceptions of issues of discriminatory language and actions were interpreted by study respondents as a lack of respect for the caring abilities and work roles of direct care staff; and of not valuing the efforts of direct care staff in caring for older people. Many of these issues raised were perceived by respondents to be outcomes of a lack of respect by families and their dissatisfaction with the level and quality of care that direct care staff provided to older people. Reported ‘disrespect’ shown to direct care staff was referred to as the use of racist remarks and abusive language; and providing constant instruction during the provision of care. In one narrative this included a family member requesting the
attending doctor to lay complaints against direct care staff for situations that were out of the control of the staff member.

Having to manage these forms of concerns by families for things that went wrong with the older person was reported by respondents to be a very stressful experience. These concerns were construed by many of the respondents as verbal abuse, which is reported to be a common form of aggression experienced by nurses (Sofield & Salmond, 2003). In Sofield and Salmond’s (2003) study, the families of older people were the third most common source of this type of verbal abuse towards nurses, following by physicians and patients. In this study a palpable issue for respondents was the distress that they experienced when families shouted at them. This issue was even more upsetting for respondents when they perceived that angry family outbursts were associated with blaming direct care staff for lack of care, or inadequate standards of care delivery.

Respondents felt that perceptions of blame from families escalated when they anticipated that families would report them for providing inadequate care. As identified above, in some instances the requests of families centred on the need for immediate attention to the care needs of their relative when they visited, particularly by families who did not visit often. For all families, meeting the care needs of their relative is important and in the opinion of families, their relative is the most important person in the supported care accommodation. This issue was stressful for direct care staff respondents who considered that the requests of families were made without consideration to the care needs of other older people that they may have been attending to, or who required scheduled care.

For respondents it was stressful when they perceived that families felt entitled to speak or act angrily towards them justified by the claim that families were ‘paying their wages’. In these cases family members might expect that direct care staff should provide quality care for their relative including implementing immediate attention to small things, for example pulling down the blinds in the older person’s bedroom when requested. These types of experiences were
reported to occur with some non-Caucasian families. Families from some cultural backgrounds were reported to be very attentive to the older person, and became aggressive and disrespectful in requesting that the care staff pay the same kind of attention to the older person. Some respondents felt that the requests of these families exceeded the professional limits that they were qualified to provide and in consequence, the requests were considered unreasonable.

Identifying and understanding the cultural needs and concerns of families was identified by Chenoweth et al. (2006) as an important issue for providers of supported aged care accommodation services and direct care staff. The authors suggested that the needs of the older person from different cultural backgrounds are often misunderstood and misrepresented, and this issue may potentially be exacerbated when the belief and value systems of direct care staff are divergent from those of the older person and their families. In this study, it appeared that the views of family members on the type and level of care that they expected to be provided for their relative differed to some degree to what respondents felt they were obliged to provide. This is an issue that requires the attention of supported aged care accommodation service providers and to some degree is a signal that direct care staff may require education and training in cultural competence.

Chenoweth et al. (2006) suggested that direct care staff must be cognisant and accepting of the various cultural values and social mores of all older people and this issue is to be extended to their family. This is especially important for direct care staff, since developing cultural competence is not only a professional requirement (Chenoweth et al., 2006), but is a requirement of the Aged Care Standards (Accreditation Standards, 2011). The issue of stress arising from cultural dissonance between direct care staff and families as identified in this study highlights the need supported aged care accommodation services to invest in targeted direct care staff education and training which focuses on developing culturally competent communication. Learning communication skills and
knowing how to provide culturally competent care would assist in empowering
direct care staff to positively manage their interactions with families from
cultures different to their own thus reducing their personal experiences of stress.
Additionally, improved cultural knowledge, skills and strategies would assist
direct care staff to deal more effectively when communicating with families is
more likely to improve the self-efficacy of the work of direct care staff.

It was evident that the respondents in this study placed a high value on their
contribution and on their work, which explains why their MBI *Personal
Accomplishment* scores were high, despite being quite stressed and having the
potential for burnout. Nevertheless, respondents accepted that whilst they were
not always successful in their attempts to provide quality care, appreciation for
the care they were able to provide was important to them. Consequently, if
these direct care staff were to acquire additional skills to deflect, or better
manage their interactions with families, they would be less likely to feel stressed
and demeaned. As identified by (Bandura, 1997), building up confidence and
skills to take action in areas that are amenable to change will assist direct care
staff develop higher levels of self-efficacy in their work and in turn greater job

The personal values and belief systems of direct care staff who work in
supported accommodation are important factors to take into account when
planning to implement the person-centred model of care (Kitwood, 1997). If
direct care staff feel that their efforts to meet the needs of older people and the
requests of families are not appreciated, they are more likely to give up trying to
meet the requests of family, or continue to try to meet these different requests
in a state of stress (Gray-Toft and Anderson, 1981a). This continuing source of
stress was frequently mentioned by respondents and was associated with a
strongly held perception that their care services were not understood, not good
enough, not valued and not appreciated by families. This lack of value for their
work was felt even more keenly by respondents when families failed to
acknowledge their many years of experience in supported aged care
accommodation service work. The respondents stated that families failed to appreciate the close bonds that they had developed with older people. These same issues of distress in direct care staff were previously identified in a study by Dodson and Zincavage (2007).

Some respondents stated that families did not trust them to provide satisfactory care to their relative, especially for those older people who had difficulty in communicating their own needs. The stress that families were themselves feeling was projected on to the staff by constantly making sure that everything was being done correctly, such as making sure the bath water was warm enough, or that the correct urinary continence pad was applied effectively. From the perspective of respondents, many of these requests and behaviours signified a lack of trust by families that direct care staff was not capable of providing good care for their relative.

Perceptions that families lacked respect for the knowledge and professional capabilities of direct care staff were an additional source of stress for respondents. This was particularly the case when families checked on the care practices of direct care staff to ensure that the appropriate care was in fact implemented and in a manner that the families were satisfied with. Sometimes, older people reinforced the distrust of families through providing families with misleading information, either intentional or not, such as telling family members that they had not been showered, or been given a meal.

In circumstances such as these, the respondents reported they offered family members counselling and information about the personal capabilities of the older person in order to increase the awareness of families of the failing cognitive capacity of these people. This technique was used, both as a way of correcting misinformation conveyed by the older person and to respondents to reduce their own stress. Perceptions that family members failed to believe direct care staff explanations were additional causes of stress for respondents. It is important for direct care staff to have the time to build up relationships with
families to gain the families trust and respect. In the current climate of fiscal restraint, having little or no time to establish trusting relationships and support with older people and their families may inhibit the ability of direct care staff to meet the emotional needs of both the older person and their family members. Similar issues were raised by Bauer (2006, p. 45) who argues that for those who espouse a rhetoric of family partnerships, for direct care staff providing support to families is secondary to “getting the job done”.

Some respondents perceived that the intrusive and non-trusting behaviour of families negatively impacted on the well-being and privacy of other older people, placing direct care staff in a very difficult position from the perspective of adhering to the Aged Care Standards (2011). As previously identified, perceptions of what respondents considered to be intrusive family behaviours included standing over direct care staff to ensure that correct showering techniques for their family member were implemented and correctly using continence aids. These types of family actions may have brought about a sense of powerless, leaving direct care staff at greater risk of burning out. The comments made by respondents describing these experiences as “threatening” and “manipulating” were associated with feelings of being very stressed and having lowered confidence in their work. Such feelings are often precursors to feelings of burnout (Maslach & Jackson, 1981) and particularly of low self-efficacy for their work (Bandura, 1997).

A common issue raised by respondents was being reported and blamed by families for losing clothing, despite having explained to families that they were not responsible for these issues and were largely unable to control this occurrence. While respondents reported their empathy with the families on this issue, family concerns caused respondents considerable stress, particularly for those direct care staff that had the closest contact with the older person. Damage to clothing, including loss or misplacement was an ongoing issue of stress for respondents as families were cited by as not accepting explanations that laundry staff were responsible for the older person’s laundry; or that the
older person had placed their clothing and shoes elsewhere; or that another older person had unknowingly taken the shoes, slippers or other possessions of their relative. A major reason for direct care staff stress was related to the disbelief of families for explanations provided by direct care staff and was perceived as yet another example of the claims by respondents that many families disrespected and mistrusted direct care staff.

Unlike issues of missing or damaged clothing, some of the concerns raised by the families were considered by respondents to be trivial. As with all concerns regardless of their content, a considerable amount of time was expended by direct care staff to ensure a positive outcome for the family member. Concerns that underwent official assessment were reported by respondents as greater sources of stress and this was particularly evident for those direct care staff that held management positions. Since registered nurses are ultimately responsible foractioning all complaints in accordance with current legislation (Aged Care Act, 1997), being unable to satisfactorily address the families concerns was cited by these respondents as being stressful, especially when these families continued to be dissatisfied with the outcome of the official complaint process.

In addition, concerns arising from the expectations of families of the care requirements or treatment that were regarded by respondents as being unrealistic, gave rise to even more stress for respondents. Differences in direct care staff and family expectations may have evolved through a lack of understanding and awareness on the part of direct care staff of how the family defined their expectations. As noted by Leventhal (2008, p. 58) “families have their own interests, concerns and expectations to be met” and these issues may conflict with the expectations of direct care staff.

The concerns mentioned hitherto reflect to some degree a mismatch between service expectations from the perspective of families and direct care staff has received little attention from the supported aged care accommodation service sector. For example, where families have paid an accommodation bond for the
room of older people in the supported accommodation and continue to pay a substantial amount of money for their care and accommodation expenses, they are more likely to feel justified in expecting a high standard of care, housekeeping, laundry and food services. Consequently, when services are not considered to be of a sufficient standard and/or similar to the services they have provided to their relative in the home situation, they may feel quite upset with the service provider. As it is usually direct care staff that are present at the time of family visits, it is understandable that the frustration of the family member will be directed at direct care staff working in the supported aged care accommodation service at the time of their visit. If these direct care staff do not understand the reasons for the complaint made by the family member and take their criticism personally, these staff will feel upset and possibly threatened. These perceptions can give rise to tensions between themselves and these family members.

As purchasers of supported aged care accommodation services, the expectations of the older person and families and the Government are unique and may sometimes be unrealistic (Leventhal, 2008). From the perspective of customer expectation theory, Levethal (2006, p. 53) argues that “expectations have been identified as the foundation of affective states such as being satisfied or dissatisfied with products or services” and when expectations are not met, will lead “consumers to .... complain about the product, supplier, service or service provider”. Therefore it behoves direct care staff to be assisted to form an understanding and an increased awareness of the expectations and requirements of each family member for the type and level of care services provided to their relative. As previously recommended, direct care staff must be enabled greater opportunities to learn effective communication approaches when dealing with family concerns. Achieving improved communication between direct care staff and families may thereby, help to avert unnecessary family distress and concerns. Supported aged care accommodation service providers and senior direct care staff would more likely benefit by investing in education
for direct care staff to teach them customer communication skills, as is evident in other service industries (Accreditation Standards, 2011).

It also behoves direct care staff to understand, that often times perceived grievances about care that are directed at them, may arise from the feelings and distress experienced by families associated with the decision to place their loved relative into care. Following the admission of a relative to a supported aged care accommodation service, families are often upset and confused. Anger, grief, feelings of guilt and a loss of control over the care of their relative are emotions often experienced by families (Bauer, 2006; Paulson & Lichtenberg, 2011; Graeheim, Johansson & Lindgren, 2013). Graneheim, Johansson and Lindgren (2013) reported that families felt a sense of guilt and shame as a result of their decision to relinquish care of a relative to the care of formal carers. Similarly, in this study the emotional outbursts of families that were directed at direct care staff were considered by most respondents as being attributed to feelings of grief and guilt experienced by families.

The respondents identified a number of consequences arising from family feelings of grief and guilt. A common assumption held by many families was the expectation that the admission of their relative to a supported aged care accommodation service would signal an improvement in the health status and general well-being of their family member. When the older person continued to deteriorate and/or was distressed following entry to a supported aged care accommodation service, this caused many family members to feel dismayed, guilty and upset. Similar issues of family guilt have been reported in other direct care staff workforce studies (Graneheim, Johansson & Lindgren, 2013).

The respondents perceived the feelings of guilt experienced by families as contributing to their reluctance to be involved in the care of their relative following admission to a supported aged care accommodation service. The consequences of families feeling guilty about the need to seek supported aged care accommodation for their relative was perceived by respondents to be a
catalyst for dissention and tensions in the interrelationships of families, and between families and direct care staff and was a precursor for the grievances and emotional outbursts exhibited by some family members. None the less, while respondents acknowledged the feelings of guilt experienced by families, their regular grievances and emotional outbursts caused stress to some respondents.

Acknowledging and having empathy for the feelings of guilt of families was considered to be insufficient to allay the feelings of stress experienced by respondents when they were blamed by families for service issues, some of which were perceived by respondents to be trivial. The respondents reported that the families lacked consideration for the impact that these types of concerns may have on direct care staff, especially since they felt they worked at a high pace in often very difficult circumstances. This issue was a catalyst for the stress respondents identified and highlights the need for the supported aged care accommodation service sector to reconceptualise appropriate staffing levels and ultimately, realistic funding models (Chenoweth et al., 2009).

7.3.3. TIME PRESSURES AND OTHER WORKFORCE ISSUES

7.3.3.1. Heavy Workload

The stress of respondent was also reported to be associated with high workloads, and this was one of the main factors that gave rise to distress associated with family complaints. A high workload was significantly associated with feelings of burnout, particularly for MBI Emotional Exhausition and Depersonalization and with very low perceptions of GSE Self-efficacy. The open-ended question responses indicated that respondent workloads exceeded their capabilities to meet the care needs of older people, and when these high workloads continued without ceasing, higher levels of stress may be induced. The respondents identified that existing workplace policies was the reason for inadequate direct care staff to older people ratios and thus, high workloads. VonDrass et al. (2009) identified staff shortages as a major stressor for direct care staff.
Supporting and maintaining a dedicated and skilled care workforce is an important factor in the delivery of quality supported aged care accommodation services (Brooker, 2007). Insufficient numbers of direct care staff and a lack of direct care staff continuity, are issues that give rise to direct care staff stress (Secrest, Iorio & Martz, 2005), particularly since staff feel unhappy in work situations where they are unable to complete the tasks that are required of them, and when the quality of their work is sub-standard as a result of being too pressured (Secrest, Iorio & Martz, 2005). Maslach and Jackson (1981) identified a lack of time and inadequate training as the primary contributing causes of burnout in direct care staff. Additionally, increased workloads that continue for some time may lead to increased sick leave and turnover (Duffield et al., 2007; Health Workforce Australia, 2012).

In the current study, having to work in a constantly pressured environment made the work of respondents more difficult and tougher, especially in attempting to meet the additional requests of families. Inadequate direct care staff numbers also negatively impacted on the abilities of respondents to engage in effective communication and provide emotional support to families. To address staff shortages, respondents suggested that senior staff numbers needed to be increased, especially to full-time work. This issue has also been a recommendation arising out the work of Duffield et al.’s. (2007) and Australia’s Health Workforce (2012) reports. Since there has been no definitive advice to providers of supported aged care accommodation services on the precise levels of direct care staff and direct care staff mix needed to achieve quality care services without compromising direct care staff health, this is an area of research that requires investigating (Martin & King, 2008: 2012).

High workloads were reported to impact on the interactions of direct care staff with families of older people and on the available time direct care staff were able to engage meaningfully with these families. This issue was particularly stressful for one respondent as this job was the first in her career. The concerns of respondents centred on being unable to meet the demands of families in relation
to the activity programs delivered to their relative, particularly when families resorted to what was considered to be verbal aggression.

7.3.3.2. Management Support

The respondents indicated that unpredictable staffing and scheduling programs introduced additional hardships for them in providing quality care services. These workforce issues signal the failure of good management practices. Despite staff shortages from time to time, the respondents reported that older people and their families often expected that direct care staff take on additional responsibilities of non-caring duties. This was reported to cause direct care staff to work through their rest and/or meal break entitlements. The perceived lack of concern for the welfare of direct care staff by family members was reported as being stressful. Experiences of stress were less pronounced, however, for those direct care staff who were provided with greater support by their managers. While not reported directly, managerial support might have included assistance with handling family concerns and formal complaints.

Lazarus and Folkman (1984, pp. 246) and Jeon et al. (2011) argue that management support and leadership provide buffers for both stress and the consequences of stress. Despite the criticism of care by families, respondents reported feeling less tense, when supported by their managers and supervisors; and were enabled to take meal breaks; and spend quality time with older people. These respondents claimed that the support and supervision they received improved morale and brought about a high level of personal and work satisfaction.

For other respondents, stress associated with their interactions with families was further exacerbated when respondents had a poor relationship with their managers and supervisors. The study findings show a significant correlation between the ENSS sub-category Problems with supervisors and the MBI and GSE scores. A significant cause of direct care staff stress was related to the perceived unrealistic expectations of managers and supervisors as to the level and quality
of care that must be provided to older people, despite the inadequate direct care staff to older people ratio operating. However, the assistance of managers and supervisors helped to ameliorate respondent stress when managing the concerns of families.

Direct care staff and nurse respondents who experienced greater stress when they felt unsupported by their managers and supervisors may also have been more likely to have experienced stress in other situations where peer review was important to them (Lazarus & Folkman, 1984). Another possible explanation for the high levels of stress associated with limited support from managers and supervisors may have been associated with personal unfulfilled expectations of what constitutes manager and supervisor support.

7.3.3.3. Peer and Health Professional Support

As with previous stress research (Healy & McKay, 1999), strong correlations were found in Problems with Peers, feelings of burnout and levels of self-efficacy. Those respondents who experienced high levels of stress associated with Problems with Peers also experienced high levels of feelings of MBI Emotional Exhaustion and Depersonalization. Reports of working with staff who would report them were very stressful issues for respondents. Additional causes of respondent stress included perceptions of poor communication with their peers and working with direct care staff that did not have the same work ethic as themselves. As with other sources of stress, whilst higher rates of burnout were combined with low levels of GSE Self-efficacy for work, levels of MBI Personal accomplishment for respondents remained high. Evidence of high self-efficacy in respondents may have contributed to belief in the value of their work in the supported aged care accommodation service and in developing close relationships with older people, despite having poor relations with some of their peers.

A strong association between respondent stress levels and conflict with the doctors was evident. Those respondents who experienced high levels of stress
associated with ENSS *Conflict with Physicians* also experienced high levels of burnout, MBI *Emotional Exhaustion* and *Depersonalization*. On the other hand, this source of stress did not lower the respondents’ levels of MBI *Personal Accomplishment* and GSE Self-efficacy. Stress associated with *Conflict with Physicians* was highest for the registered nurses, directors of nursing and nurse educator cohort, and for those direct care staff who worked on morning shifts.

Several explanations for the increased experiences of stress for these direct care staff are likely. Direct care staff aged 52 years of age and older were found to experience considerably more stress when interacting with physicians, this issue was found to be particularly evident for the registered nurses, directors of nursing and nurse educator cohort. Since these senior direct care staff would be likely to have more communication with physicians than junior direct care staff, particularly in regard to the treatment needs of older people, it is understandable that stress may arise when there were structural constraints to achieving adequate medical care. It is also likely that less experienced direct care staff are more open to and compliant with orders from doctors than older direct care staff with many more years of experience in supported care for older people.

Of the direct care staff workforce, registered nurses would also hold greater authority and responsibility for the welfare, well-being and care planning of the older people, so these registered nurses and directors of nursing may also interact more frequently with doctors during the morning shifts. Current direct care staff have acquired considerably more autonomy and decision making responsibility than was previously the case (Dwyer, 2011) and as a consequence they may have found the attitudes of some doctors to be hierarchical and not in keeping with the current culture of professional equality. For example, the stress that registered nurses and directors of nursing experienced with doctors can often arise over a disagreement with the appropriate care or treatment prescribed for an older person (Chang et al., 2006). These respondents might have found this issue to be particularly stressful if they were unable to express
their opinions, or if they felt that alternative treatments would have been more appropriate than those ordered by the doctor.

7.3.3.4. Cultural and Language Issues

Another group of respondents whose primary language was not English (51%) and/or were identified as having low to medium levels of proficiency in verbal and written English (33.5% and 38.3% respectively) reported experiencing higher levels of stress for ENSS Interaction with Physician, unlike respondents whose first language was English. Experiences of language and communication difficulties for foreign direct care staff has been identified as barriers to achieving workplace satisfaction (Omeri & Atkins, 2002; Magnusdottir, 2005; Chenoweth, Jeon, Goff, & Burke, 2006) so it is likely that any conflict arising from language difficulties between direct care staff and doctors might lead to ongoing stress and result in burnout. The potential for stress can also arise when direct care staff with low level English language skills feel inadequately supported by their managers and peers when negotiating care and treatment orders with doctors. Having lower levels of English in a predominantly English-speaking workplace can rise to feeling professionally unprepared for position responsibilities (Chenoweth, et al., 2006).

In considering the ENSS findings Inadequate Emotional preparation, stress arising from lower levels of English language skills suggests that these respondents may have been ill prepared to assist with the emotional needs of families as previously identified. The highly stressful “emotional” experiences as reported by these respondents were strongly associated with MBI burnout, evident by equally high levels of MBI Emotional Exhaustion and Depersonalisation. On the other hand, while these respondents experienced low levels of levels of GSE self-efficacy, they retained medium to high levels of MBI Personal Accomplishment that was associated with a strong belief in the value of their work.

From the open-ended question, it was clear that all respondents placed high value on their work. Viewing one-self positively is posited by Lazarus and
Folkman (1984) to be an important psychological resource for coping. When this sense of personal value was eroded in the interactions of direct care staff with peers, managers, supervisors, older people and families, their self-efficacy for their work was lowered. Consequently, levels of stress increased for the staff from non-English speaking backgrounds when the complaints and requests of family members were supported by doctors.

7.3.3.5. Knowledge and Skills for Supported Aged Care work

Lazarus (1991) asserts that individuals often have multiple emotional experiences at the same time, as a result of being involved in complex situations, and suggests that the meaning attached to a situation may be more important to the individual and indicative of its interpretation. As previously identified, not all respondents reported experiencing the same level of emotional stress from similar stressful interactions with peers and families. The inadequate emotional preparation identified by respondents may have been due to little or no in-service education and training in knowing how to deal with the demands of supported aged care accommodation service work, including: negotiating with doctors about treatment regimens; counteracting the potentially stressful interactions occurring with families and older people, managers, supervisors and work colleagues, and being available to families when an older person came to the end of their life. These aspects of aged care work have been identified as needing improvement across the supported aged care accommodation service sector (Australian Government Productivity Commission, 2011).

Over the past decade, evidence of the changing demographic profile of older people living in supported aged care accommodation services has undergone considerable change, and thus the work of caring for older people is also changing. To meet these challenges, new skills need to be developed (Australian Government Productivity Commission, 2011). For respondents the work of caring in a supported aged care accommodation service was reported as challenging, hard work and demanding, especially when direct care staff numbers were considered to be inadequate. Several studies confirm these
findings where the increased dependency and challenging behaviours of older people in supported aged care accommodation has increased the physical and emotional work for people who work in these care environments (Rodney, 2000; Denton et al., 2002; Brodaty & Draper, 2003; Duffield et al., 2007). In Germany, Goergen (2001) reported that supported aged care accommodation increasingly resembled geriatric hospitals and psychiatric wards as a result of the changing profile of older people. This issue was found to have a considerable impact on the psychological health of direct care staff (Goergen, 2001). It is even harder for direct care staff to maintain emotional health when they are faced with the stress of caring for older people who continue to deteriorate and treatment options are difficult to determine.

A high degree of stress was experienced by respondents due to a lack of clarity about the best treatment and care options for older people when their health deteriorated, identified by the ENSS Uncertainty Concerning Treatment score. The Uncertainty Concerning Treatment item was strongly associated with the MBI burnout total score (MBI Emotional Exhaustion and Depersonalization) and the ENSS total score. The Uncertainty Concerning Treatment item was also strongly correlated with lowered levels of GSE Self-efficacy. Several explanations are postulated for this stressful experience.

In Australian supported aged care accommodation services, the Aged Care Act, 1997 and the Accreditation Standards guidelines (2011) state that each person who lives in a supported aged care accommodation service must have a clearly documented and articulated current plan of care for each aspect of their care needs. Further, the care needs and care plan must be developed with the input of all stakeholders including the older person, families and direct care staff. Since respondents indicated that they experienced stress associated with not knowing treatment options and end-of-life care plans they may have lacked direction and certainty in enabling and managing the treatment and care needs of older people. Another explanation for the uncertainty regarding individual treatment requirements may have related to not having the authority to make
decisions about treatments, especially if the doctor is expected to make these decisions on behalf of the older person. Such situations may arise with a sudden health crisis for an older person, necessitating immediate attention and intervention from a doctor and/or a medical team.

When treatment interventions are not immediately forthcoming, such as when the doctor is unable, or unwilling, to make a visit to an older person within an appropriate period of time, direct care staff may feel distressed in being unable to alleviate the pain and suffering of the older person, or to arrest deteriorating health (Healy & McKay, 1999). The links between ENSS Conflict with Doctors and Uncertainty with Treatment may be a factor of a number of associated difficulties that direct care staff face in seeking adequate medical care for older people (Parliament of Australia, Senate Community Affairs References Committee, 2008; Australian Government Productivity Commission, 2008).

End-of-life care may be particularly stressful for some direct care staff. In this study, the stress responses of many respondents were strongly associated with caring for a person during the last stage of life. Similar experiences were found with direct care staff working in hospice settings (Hawkins, Howard & Oyebode, 2007). From a cross-sectional survey design to investigate the stress and coping strategies of 215 hospice nurses, Hawkins, Howard and Oyebode (2007) identified that the work associated with death and dying is a significant source of stress for these staff. In this study the experiences of stress arising from caring for older people during the dying process were strongly associated with each of the three MBE burnout factors: Emotional Exhaustion, Depersonalization and Personal Accomplishment, and also with low GSE Self-efficacy. These novel findings indicate that those participants that reported high levels of stress also reported high levels of burnout (low self-efficacy).

There are several explanations for death and dying being a source of stress for these respondents. Caring for older people in a supported aged care accommodation service has unique challenges not otherwise associated with
other health care settings (Australian Government, 2010). Providing care in a supported aged care accommodation service is an especially stressful occupation as a result of frequent contact between direct care staff with older people and their families. In many instances, older people admitted to supported aged care accommodation services are entering the final stage of their lives and caring for a person at this time of their lifespan, whilst accepted as an aspect of holistic care by direct care staff, suggest that they will also encounter emotional and stressful situations. The subsequent emotional difficulties direct care staff may experience are associated with the increasing frailty and ultimately death of older people and such emotions are justifiably heightened under these circumstances (Chang, et al., 2006). These feelings were clearly expressed by several respondents in the open-ended survey question item responses.

Forming attachments with the person who is being cared for in the latter stages of life is stressful for many direct care staff (Hawkins, Howard & Oyebode, 2007; Gannon & Dowling, 2011). To ensure that the care requirements of each older person are individually planned and implemented within a holistic focus, as mandated through the Residential Aged Care Standards (2011), direct care staff are required to: develop a close relationship with the person they care for; become knowledgeable and understanding of each person; pay attention to their physical and psychological health status, social, cultural and religious backgrounds; and all the while gaining an appreciation of the needs of family and other significant people. Thus, becoming attached to and involved with the people they care for may present a dilemma for some direct care staff, as was evident from the written responses of respondents where older people were referred to as being “like family”. The suffering or death of an older person was particularly stressful and meaningful for respondents who likened their emotional attachment for these people as similar to how they would feel about a close relative.

Further, some respondents identified feeling a sense of responsibility for the death of an older person, particularly when informing the families of the death at
night, or when the family were unable to be with their relative at the time of the
death. The development of an attachment and empathy towards the person they cared for, may at these times become quite stressful for direct care staff, especially for those direct care staff who perceive that some family members do not convey the same emotional attachment towards the older person as they themselves had developed. Other studies have highlighted the significance direct care staff place on their relationships with the people they cared for. For example, from an interpretative phenomenological study conducted in a public long-term supported aged care accommodation service, Gannon and Dowling (2011) identified similar results from a thematic analysis of interviews obtained from a sample of seven Irish nurses. Gannon and Dowling interpreted the nurses’ experiences as a sense of “loss” and these experiences of loss were heightened with the reciprocal nurse-older person relationship when developed through the auspices of person-centred care (Gannon & Dowling, 2011).

7.3.4. RESPONSES OF OLDER PEOPLE

As previously identified, respondents referred to older people as being a source of stress, with most references related to aggression from older people and to issues of death and dying or refusal to cooperate during the care process. Rodney (2000) studied the relationship between stress for nurses and the aggression of older people, and found that interacting with highly aggressive older people produced significantly more stress for direct care staff than did interacting with less aggressive older people. In fact, direct care staff who worked greater numbers of hours in a week was more likely to experience aggression from older people (Evers, Tomic & Brouwers, 2001). In a later study, Hasson and Arnetz (2008) conducted eleven focus groups to elicit an understanding of the current practices of direct care staff providing end of life care to older people and identified that providing care to older people with cognitive and physical deficits were strenuous aspects of working in the supported aged care accommodation services. Goergen (2003) found that the
work of direct care was made more difficult when older people refused to take their medication, fluids and food, and to accept personal hygiene. This raised the question of the inability of direct care staff to adopt successful coping mechanisms that may be due to their lowered perceptions of self-efficacy for their work. Evers et al. (2001) investigated the effects of aggressive behaviour and perceived self-efficacy on burnout among direct care staff finding that physical and psychological aggression from older people were significantly related to the emotional exhaustion of direct care staff (Evers et al., 2001).

Being subjected to what the respondents considered to be discriminatory attitudes and actions by older people was also stressful for them. This issue was more evident for respondents who belonged to a cultural group other than European and whose primary language spoken at home was a language other than English. The ENSS Discrimination sub-scale strongly correlated with MBI burnout, specifically for MBI Depersonalization and Personal accomplishment. Additionally, the ENSS sub-scale Discrimination was strongly associated with respondent’s lowered GSE self-efficacy. These findings were similar for stress, burnout and self-efficacy scores in relation to the interactions of respondents with the families of the older person.

A number of respondents stated that some older people who came from cultural backgrounds different to their own had racist attitudes towards them. The various ways in which older people exhibited discriminatory behaviours towards respondents included references to the dark colour of their skin. Feeling “used” and being treated as “slaves” were other terms employed by respondents to describe their stressful experiences of feeling discriminated against, which included interactions with families. As well, reports of discrimination occurred for some Caucasian direct care staff, with male nurses reporting that they were treated with suspicion by some older people and their families from non-English speaking backgrounds.
Similar findings were identified in a phenomenological study by Magnusdottir (2005) that explored the strangeness and communication barriers of becoming a foreign nurse. For overseas qualified nurses seeking to work as registered nurses in Australia, Chenoweth et al. (2006) identified the discriminatory barriers that English-speaking nurses from the United Kingdom, United States of America, Canadian and New Zealand were confronted with when seeking to work as a nurse in Australia. These barriers occurred with registration authorities initially and in a range of health and supported aged care accommodation service settings thereafter. These frequently occurring discriminatory issues for some overseas trained nurses were highlighted in Jeon’s & Chenoweth’s (2006) investigation of this issue for nurses with culturally and linguistically diverse backgrounds (CALD).

7.4. REDUCING STRESS AND BURNOUT THOUGH DEVELOPING SELF-EFFICACY

The study aimed to not only assess the stress, burnout and self-efficacy levels of respondents for supported aged care work and the associated factors, but also to identify factors that helped or hindered direct care staff to deal with workplace stress and whether having higher self-efficacy for their work was a protective factor. A stress-related issue that was repeatedly identified by respondents related to the emotional nature of supported aged care accommodation service work. The work of caring and dealing with a number of situations in the workplace, including interactions with families, older people and peers, significantly impacted on respondents feeling emotionally stressed, overextended and exhausted. High levels of emotional exhaustion combined with high levels of depersonalization are the earliest indication of employee burnout and signal low levels of confidence in the workplace (Maslach and Jackson, 1981: Angerer, 2003). Direct care staff that experienced emotional exhaustion may have felt overwhelmed with their work and experienced depleted levels of energy. Therefore, reducing or preventing stress through
building up self-efficacy is reported to alleviate aspects of burnout (Maslach & Leiter, 2005).

The personal characteristics of respondents, including the primary cultural group to which they belonged, were strongly correlated to feelings of emotional exhaustion. Those respondents identified from non-English speaking backgrounds and with limited English proficiency were more stressed and exhausted than their English-speaking colleagues. This stress burden was associated with feeling ill-prepared to communicate effectively with older people, their families and work colleagues and consequently they felt discriminated against, or demeaned, when their communication skills proved inadequate to solving difficult issues, such as meeting the requests of family that were considered to be outside their job role requirements. The primary language spoken at home, employment classification, and verbal and written English proficiency of respondents, all significantly impacted on their levels of self-efficacy beliefs. This form of stress has the potential to lead to low self-efficacy for work and feelings of burnout when people consider there are few solutions to the issue (Maslach & Leiter, 2005).

Additionally the number of morning shifts that respondents worked was associated with MBI *Emotionally Exhaustion* and *Depersonalisation* and being able to cope with the demands of work. MBI *Depersonalization* is a method developed by an individual to cope with their feelings of emotional (and often physical) exhaustion (Maslach, Jackson & Leiter, 1997). The open-ended survey question item responses indicated that the differences in stress levels for respondents working morning shifts as opposed to evening and night shifts resulted from their experiences of very heavy workloads. The levels of self-efficacy for work for respondents were also negatively impacted by the excessive number of hours they worked, especially for those respondents who sought additional hours of work in a second supported aged care accommodation service.
Maslach, Jackson and Leiter (1997) defined depersonalization as the negative feelings one has towards others. Therefore, direct care staff who were found to have low levels of MBI Depersonalization may be more likely to have developed negative and indifferent attitudes to the older person they care for and also to families, while those with higher levels of MBI Personal Accomplishment were more likely to have a higher quality of interactions with families. Responses to the open-ended question revealed most respondents had high levels of GSE Self-efficacy for their work, reflected by their high levels of MBI Personal Accomplishment.

MBI Personal Accomplishment was also found to be negatively associated with GSE Self-efficacy ($p < 0.001$). Self-efficacy in the direct care staff workforce is particularly important as it is a strong predictor of the ability of an individual to perform in situations that the individual may perceive as being stressful (Bandura, 1997). Perception of self-efficacy for work refers to the judgement of an individual to successfully cope with difficult situations (Bandura, 1997) and develops over the lifespan of the individual as they continually integrate information from five primary sources (performance experiences; vicarious experiences; imagined experiences, verbal persuasion and physiological and emotional states). These attributes and skills are also learnt in the workplace. For direct care staff, the development of self-efficacy beliefs could be influenced by the responsiveness of their work environment to their attempts at manipulation and control over that environment (Bandura, 1997).

These responses also revealed that on the whole, despite being stressed by their interactions with families and dealing with associated issues in care delivery, respondents enjoyed their work and acknowledged that they must prepare themselves to accept the many challenges and stresses that may arise when caring for older people. Work satisfaction has been found to be an important issue for direct care staff and is strongly linked to higher levels of retention (Ellenbecker, 2004; Karsh et al., 2005; Sikorska-Simmonds, 2005; Chenoweth et al., 2014).
Respondents attempted to alleviate their perceptions of stress associated with the challenges of their work in a variety of ways, even though one respondent was of the opinion that stress was an inherent aspect of the work of caring and therefore, must be accepted. The stress-relieving strategies adopted by the majority of respondents were adapted to the context of their work. Strategies included developing an awareness and understanding of the care needs of older people; adopting a proactive stance to anticipated challenges, for example by providing older people and families with the necessary information about care regimens in a timely manner; and working with older people and families in developing a plan of care to meet the care needs of the older person. Such strategies would assist to alleviate family distress with older people who displayed behaviours that families could not cope with, such as wearing shoes and clothing that didn’t belong to them, refusing care and calling out. Other respondents relieved their own stress by attending to needs and concerns of older people and family promptly, providing information and counselling to family when their relative became increasing vulnerable and by attempting to understand and respond proactively to the needs of families. These approaches signalled attempts by respondents to develop self-efficacy in their work, which would have assisted them to develop resilience in coping with the many different situations that might otherwise have caused a great deal of stress for them (Hasson & Arnetz, 2007; Lazarus and Folkman, 1984).

Respondents identified the need to care for themselves to minimize their experiences of stress which included developing resilience or self-efficacy for their work. These strategies included taking time out for themselves, whilst at the same time ensuring that both the needs of the older person and families were met. Some respondents used avoidance techniques to take care of their emotional well-being, such as being humorous and hiding when families visited. Using personal restraint and remaining “calm” and “trying hard” were additional strategies expressed by respondents as a means to minimize their experiences of stress. Understanding the difficulties arising from language limitations and
seeking assistance with communication is considered an important strategy to minimize personal stress (Lazarus & Folkman, 1984), especially in the health setting (Chang et al., 2006; Downs & Tasker, 2010). Maintaining the “right” attitude was reported by respondents as conducive to maintaining harmonious relationships with older people, thus minimizing their experiences of stress whilst maintaining high self-efficacy in their work (Hasson & Arnetz, 2007; VonDras et al., 2009). Since self-efficacy is amenable to improvement through education and training, peer influence/role modelling, supervised practice and workplace support (Bandura, 1997), assisting direct care staff to developing this capacity is worth striving for.

7.5. CONTRIBUTION TO SUPPORTED AGED CARE ACCOMMODATION KNOWLEDGE

This study has contributed to the knowledge on direct care staff stress and its sequelae and about the factors that can protect these staff from stress-related burnout, including developing self-efficacy for their work. A relationship was not found between working employment status (full-time, part-time and casual) of respondents and their experiences of stress, burnout and self-efficacy for their work. Nor was a relationship found between the years of experience working with older people and the variables of stress, burnout and self-efficacy. This finding is in contrast to recent Australian research that found that for many direct care staff with longer working experiences in supported aged care accommodation services their workplace stress was more likely to increase (Chenoweth, et al., 2013).

In this study, respondents older than 52 years of age were found to have experienced considerably more stress when interacting with physicians; and there were no other effects of age on respondent stress levels. These unanticipated findings support Chang et al.’s (2006) research that age bore little significance on total mental health scores when exploring the incidence of stress in a cross-cultural study of Australian and New Zealand nurses. By contrast,
Australian studies on work satisfaction have identified a decline in job enthusiasm for direct care staff with less than five years of experience in supported aged care accommodation services, while older age staff felt happier at work (Chenoweth, et al., 2013). It appears that other factors, such as having a supportive manager and having autonomy in one’s work, may explain differences in the findings relating to age and workplace stress (Chenoweth et al., 2012).

In support of Lapane’s and Hughe’s (2007) findings that insufficient staff numbers, poor pay, work interruptions and having too much work to do, this study identified that workplace factors were the predominant reason for direct care staff stress and burnout. The study also identified other issues in the workplace that gave rise to stress for these staff including expectations and interactions with older people, their families, managers, supervisors and work colleagues. What this study contributes is evidence and identification of a number of different sources of stress experienced by direct care staff and knowledge of the effect of these forms of stress on the working life of direct care staff and their sense of personal and professional value.

It is important for supported aged care accommodation service providers and managers to develop an understanding of the underlying processes and factors that influence the responses of direct care staffs to the workplace and their ability to cope in situations that are considered stressful for them. In keeping with Lazarus and Folkman’s (1984, pp. 296) premise that neither the environment, nor the person, remains static, any significant changes occurring in the supported aged care accommodation service sector have the potential to negatively affect direct care staff. Whist changes implemented through the Australian aged care reform process have occurred incrementally over the past 35 years, some of these changes seem to have brought about a degree of anxiety and distress to direct care staff. Many of the stressors identified in this study could be considered as inconsequential when viewed individually, however, it is the accumulation of these stressful events and challenges that give rise to stress and burnout (Lazarus & Folkman, 1984; Maslach, Jackson & Leiter, 1997).
If stress is not managed effectively, or if stress persists over a prolonged period of time, it can result in burnout (Maslach, Jackson & Leiter, 1997). Therefore, the self-efficacy beliefs held by direct care staff about their work are important in buffering them against constant feelings of stress, since self-efficacy in work plays a crucial role in psychological adjustment to these stressors and are central to the ability of an individual to overcome emotional issues. In a number of ways respondents described how their self-efficacy for their work gave them the confidence and skills to interact with and provide support to families more effectively. The higher self-efficacy for work, the greater the ability of direct care staff to coordinate and orchestrate their skills, knowledge and abilities in challenging situations (Lazarus & Folkman, 1984).

7.6. STUDY STRENGTHS AND LIMITATIONS

This study has a number of strengths and limitations that are outlined and discussed sequentially.

7.6.1. STUDY STRENGTHS

In exploratory areas of research, care must be taken to ensure that rigour is maintained (Speziale & Carpenter, 2002; Bazeley, 2004). Using written responses in a narrative form as an alternative research approach in qualitative research is based on the work of Paul Ricoeur where meaning is expressed by the respondent (Nygren & Blom, 2001). The dilemma of ensuring data authenticity in written narratives may arise through limitations of the respondents’ verbal and written capabilities of expression along with the inherent risk of ‘over-interpretation’ by the researcher (Nygren & Blom, 2001). Since the study aimed to give questionnaire respondents the opportunity to write freely about their experiences in relation to the family of the older people who they cared for, a single open-ended survey question item was added to the end of the Questionnaire Pack. The purpose of incorporating the single open-ended survey question was to elicit a deeper understanding of this potential source of stress as
the Expanded Nurse Stress Scale (ENSS) included items in relation to families, an issue that had received very little attention in previous research.

A limitation of this study was not obtaining more detailed explanations of direct care staff stress through in-depth interviews, which might have helped to obtain far richer information about workplace stressors, especially for many of the respondents who reported having limited English skills. Nevertheless, providing respondents with an opportunity to freely express their experiences and feelings via an anonymous narrative response to the question of stress from their interactions with the families of older people, afforded the respondents the opportunity to freely express their descriptions and feelings about their experiences. Many of the narrative responses to the open-ended survey item were lengthy and clear, and despite some English language idiosyncrasies were all focused providing rich data for comparison with and clarification of the questionnaire findings. Since a majority of respondents elected to provide narrative responses to the open-ended survey question, their statement not only confirmed many of the main study results arising from the ENSS, MBI and the GSE scales, they provided clear explanations for many of the questionnaire findings.

This study may be considered highly relevant to nursing and nursing workforce issues generally and to direct care staff workforce in particular. The research may provide current and future governments and managers of supported aged care accommodation service providers with the knowledge to understand the challenges that nurses and other direct care staff face in their daily work, including the expectations of and their interactions with older people, families and peers. Retaining an existing direct care staff workforce that is itself ageing and marginally older than the general workforce has many benefits, including maintaining the knowledge that has been built up over many years for the benefit of older people and their families, as well as for younger staff with limited exposure to the multiple challenges that occur in a supported aged care accommodation services. Consequently, the data arising from this study with
regard to the older age cohort will also be of interest to supported aged care accommodation service providers in future workforce planning.

These findings will also assist supported aged care accommodation service providers and managers in developing strategies to retain the direct care staff workforce whose first language is not English. Policy makers, including State and Federal governments may find the study findings helpful in developing policies to accommodate the needs of an ageing and a culturally diverse direct care staff workforce, whilst also developing incentives to attract new entrants to this staff cohort. Families may also benefit, as retention of a stable and contented direct care staff workforce facilitated through effective policies and management structures will assist in meeting the needs of family in ways that are mutually satisfying.

7.6.2. STUDY LIMITATIONS

While the study has strengths, there are a number of notable limitations that need to be identified. Respondent item omissions from demographic data, the Expanded Nurse Stress Scale (ENSS); the Maslach Burnout Inventory (MBI) and the General Self-Efficacy Scale (GSE) is one such limitation. These omissions reduced the amount of data suitable for analysis and may have potentially limited the power to detect significant associations between each of these main constructs. As these data analyses were for the most part correlational it was difficult to make causal inference from them.

In this study, participation of direct care staff may have been limited due to their reluctance to complete the questionnaires and to write down their experiences with families. While the free responses provided by respondents to the single open-ended question has helped to identify issues that can be addressed, such as through workplace policy and staff education and training for all direct care staff, not all questionnaire respondents wrote detailed responses. Many of the responses received could likely be biased in favour of those respondents who
had issues with families of older people, and/or who considered these issues to be of sufficient importance to record them. As well, responses could have been made by respondents who considered their English writing skills to be sufficient to write a response.

A limitation related to this study is the direct care staff respondent sample size (Hackshaw, 2008). When compared to cohort studies of in excess of 1000 respondents, this study could be considered small as it was restricted to a small sample of direct care staff obtained from a cluster of twenty Australian supported aged care accommodation services located in a single metropolitan regional centre. The sample design used may have introduced potential response bias as direct care staff that experienced stress in their workplace may have been less inclined to participate in the study (Bazeley, 2004). The sample size may also have produced different results to those obtained in a larger randomly selected cohort study. On the other hand, whilst the overall response rate may be considered high, the limitation is in the restricted area and clustering of the supported aged care accommodation services studied. Multivariate analyses were not conducted with these data as the sample size was insufficiently differentiated to gain any meaningful results.

Consequently, the study findings cannot be generalized to a wider population of direct care staff working in supported aged care accommodation services across Australia or in other countries, even though the results may resonate with managers and direct care staff who work in these care environments. Similarly, while the inferences drawn from these data could be generalized to the population of the study region because of the cultural diversity of the direct care staff population employed in the targeted supported aged care accommodation service organisations, these respondents might not be representative of the Australian direct aged care staff population generally.

Other limitations relate to the subjectivity of the researcher arising from personal knowledge and experience of the subject. This limitation may have
impacted on the interpretation of the written narrative data unlike verbal narratives where a facilitating researcher is able to elicit deeper meaningful responses through verification of the interview data with the interviewee (Nygren & Blom, 2001). In this study, the messages in the responses were clear and unmistakable, although it is evident from the grammar and expression of the written text, that the primary language of many of the respondents was not English.

Limitations are also reported to occur with the use of self-administered questionnaires that may negatively impact on the causal associations between variables due to systematic response distortions, method variance, and non-method bias (Spector, 2006). Whilst clearly defined instructions on how to complete the Questionnaire Pack were provided to each prospective respondent both in written and verbal form during the briefing sessions, control over issues of missing data were unable to be maintained. It was impossible to ensure that all questions were fully and correctly answered where Questionnaire Packs were completed by respondents at times other than at the specified briefing sessions.

A limitation in data collection was noted where two Questionnaire Packs had been completed by the same person, evident from identical handwriting and pen ink, though the answers to the two surveys differed. In this case it was possible that the Questionnaire Pack had been completed by one respondent for another respondent who might have had some difficulty to complete the questionnaire themselves. Given that a number of respondents were from non-English speaking backgrounds, this issue is likely to have occurred on more than one occasion. In addition, the anonymous questionnaire and narrative responses provided by the study respondents meant that it was impossible to further explore and clarify these data with respondents. This is an acknowledged study limitation which has denied obtaining further richness and texture to the qualitative study findings (Bazeley, 2004).
In this study, respondents were not asked to rank their various identified stressors according to those stressors they considered were of greater importance, a factor that could be perceived as a ‘missed opportunity’. Ranking of various stressors would be a significant and an important consideration in any future work.

The decision to omit collecting data on participating supported aged care accommodation service characteristics such as ownership, for-profit or not-for-profit status, size and the number of bed licenses was deliberately undertaken to assist in maintaining a degree of privacy for all respondents. However, these data may have introduced a level of analysis bias when correlated with respondents’ experiences of stress, burnout and self-efficacy for work. Whilst it is evident from respondents’ written responses that direct care staff enjoyed working in a supported aged care accommodation service providing care to older people, it is acknowledged that having more information about the supported aged care accommodation service characteristics would have helped to explore the relationships between respondents, supported aged care accommodation service characteristics and work-related stress and burnout.

This study may have benefited from using the WAYS of Coping Questionnaire (Folkman & Lazarus, 1988) to identify the coping methods used by direct care staff to modify their experiences of stress (Lazarus, 1993). According to Lazarus, distancing and denial are two emotion-focused methods of managing stress (Lazarus 1993). The literature suggests that problem-focused coping is a beneficial style of coping response where the individual may attempt to modify the environment and reduce or eliminate the stressor. Stress coping responses were identified in the written responses to the open-ended question, but no clear pattern was uncovered. The WAYS of Coping Questionnaire (Folkman & Lazarus, 1988) would have provided clear evidence of the coping styles and processes of direct care staff. These data might have identified negative coping styles, such as emotion-focused coping, which can have negative consequences for health, being an internal response to a stressor where the individual may
attempt to reinterpret the stressful situation instead of modifying its cause (Chang et al., 2006). Having this information would have assisted in identifying education and other strategies to help direct care staff with coping and/or reducing their experiences of stress.

Another limitation was the requirement to provide special assistance to those respondents with limited English reading and writing skills. Providing special assistance to these respondents could have introduced an (unintended) bias in the results for these respondents. As well, the decision to include the questionnaire data from the small number of Recreational Staff ($n = 8$) may have skewed some of the findings since their responses would likely differ somewhat to the responses of other direct care staff, given their different role in direct care work.

Finally, my own interest in this study may be construed as a study limitation. The targeted high level supported aged care accommodation services and some of the care personnel employed within those same services, whilst known to me on a professional basis, had had no direct or previous relationship with me. I was careful at all times to ensure that direct care staff did not feel that they were either pressured or coerced into participating in the study (Williamson and Prosser, 2002). As the primary researcher in this study, every effort was made to be as transparent as possible during all interactions with both direct care managers and care staff throughout the course of the data collection period.

While this study did not set out to understand direct care staff stress, burnout and self-efficacy from the perspective of any other person, such as older people or their families, the inclusion of the views and experiences of older people and family members may have provided a more balanced analysis of direct care open-ended survey question responses. It will be beneficial to elicit this information in further research.
7.7. RECOMMENDATIONS FOR FURTHER RESEARCH IN THE FIELD

A number of questions have arisen as a result of this study. The following questions that are worthy of further study include:

1. What questions, concerns and requirements do families of older people have that they do not express?
2. What are the common issues or concerns occurring between families and direct care staff?
3. What are the concerns of families that direct care staff needs to be aware of?
4. What are the implications of caring of older people in a culturally diverse direct care staff population?
5. What are the perceptions of families’ perceptions of the communication and their access to communication with direct care staff?
6. Do direct care staff want to be actively and formally involved in decision making regarding the reforms occurring in the supported aged care accommodation service sector and if so, how can this be achieved?

7.8. CHAPTER SUMMARY

Working in a supported aged care accommodation service to provide care to an increasingly frail, ill and dependent population, was found to be a stressful occupation for a number of respondents. While direct care staff enjoyed the caring role and their interactions with older people, they were frequently confronted with a number of stressful situations. For example, some behaviours of older people were difficult to reduce or manage particularly when direct care staff were caught up in situations where families were unhappy with their services. Caring for older people may be compromised when direct care staff become stressed (Goergen, 2001). In this study, direct care staff that experienced high levels of stress, were also at high risk of burnout, which has an even greater effect on the care and well-being of older people (Brooker, 2007).
Interactions with the families of older people who resided in supported aged care accommodation services were identified by direct care staff as one source of stress. In particular, the requests of families were identified as either “unreasonable” or “unrealistic”. Developing and maintaining harmonious relationships with the families of older people were identified as an additional challenge for direct care staff. These issues have a negative effect on direct care staff that work in supported aged care accommodation services thus placing them at further risk of burnout. The effects of stress and burnout among direct care staff is reported to be directly linked to a myriad of health issues, including absenteeism and turnover (Duffield et al, 2007). Further, direct care staff stress can lead to inadequate care and poor quality of care (VonDras et al., 2009) and in this study, stress was associated with strained relationships with families. As changing demographic shifts in current populations continues to bring about an increased demand for complex care in supported aged care accommodation services (Department of Health and Aging, 2012), managing direct care staff’s health and well-being is critical to ensure the continued availability of adequate numbers of direct care staff to care for this ageing cohort.

Supported aged care accommodation service providers have a duty of care and a legal liability under Safe Work Australia (2013) legislation to ensure that the well-being and health of their workforce is maintained. Whilst stress in Australia is recognised as a compensable work related illness, the degree to which stress is measured in this care setting is limited. Supported aged care accommodation service front-line staff is at a high risk of burnout, since feelings of being emotionally exhausted and depersonalised are exceptionally high in this work cohort. This study clearly identifies the sources, levels and effects of stress for this study population, which is likely to be representative of the broader direct care staff workforce in the Inner-West of Sydney and possible of other urban regions across Australia.

Having access to this information will improve our understanding the issues that arise for direct care staff in their practice environment; of the expectations of
families of supported aged care accommodation services; and of supported aged care accommodation practices. Government agencies and supported aged care accommodation service administrators can employ this information to promote a work environment that can eliminate or reduce the factors that contribute to stress and burnout of direct care staff and enhance their self-efficacy for supported aged care accommodation service work. It behoves providers of supported aged care accommodation services to retain a satisfied and productive workforce. The subjective stress experiences of direct care staff are linked to burnout and include many factors that are amenable to change through good governance, staff education and supervision and improved leadership (Aiken et al., 2002).

The findings from this study may also help to inform managers of supported aged care accommodation services, policy developers and other stakeholders on how best to involve families in the care decisions and monitoring of care outcomes for a relative during their stay in this care environment. Since this study was conducted as a way to investigate and identify the level and factors associated with direct care staff work stress and related burnout, and to identify if interactions with the families of older people were an issue for direct care staff, the findings help to make clear the issues that need to be addressed to address direct care staff work-related stress. These findings can help to support direct care staff, for the benefit of the staff, older people and their families. As well, the study was grounded on the belief that people are admitted to a supported aged care accommodation service to receive quality care and other services that their family were unable to provide, so efforts to enhance the consistency of quality care services will benefit both older people and their families.

Despite the existing challenges that face the direct care staff workforce, there should be considerable optimism about the future. Current Government policy initiatives involving education and leadership in the sector acknowledge the importance of securing an educated direct care staff workforce and the need to develop the leadership capabilities necessary to drive these expectations. It is
possible to achieve quality supported aged care accommodation services for older Australians, so long as the Government is not distracted by prevailing fiscal and economic conditions and is mindful that a highly skilled direct care staff workforce is needed to achieve this level of quality.

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8.1. CONTRIBUTION TO SUPPORTED CARE KNOWLEDGE

In Australia, the supported aged care accommodation service reforms have occurred for many years and during this period of reform the pressures on direct care staff who deliver supported aged care accommodation services has increased. Supported aged care accommodation service advocates have long argued that the inability of direct care staff to ensure acceptable standards of care is directly linked to poor policy development, resulting in structural constraints, inequitable resource distribution, inequitable wage allocation, poor incentives to direct care staff and bureaucratic inaction on the issues they raise (De Bellis, 2010). The greatest challenge for the supported aged care accommodation service sector is for direct care staff to work with the Government to address these policy issues, in order to attract and retain skilled and knowledgeable direct care staff (Chenoweth et al., 2012) and to ensure that they feel confident in and satisfied with their work.

This study is embedded in the Professional Doctorate portfolio with the aim of exploring an understanding of the stress phenomenon, its effects and protective factors in a sample of the direct care staff workforce that work in the supported aged care accommodation service sector. An issue of particular interest was to explore the stress that might arise for these direct care staff when interacting with the families of older people living in this environment, and to provide recommendations for addressing this issue if found. The study findings confirmed that direct care staff respondents experienced high levels of stress that correlated with workplace issues, including their interactions with the families of older people. A strong association and inter-relationship among the concepts of direct care staff stress, burnout and self-efficacy for supported
Aged care work was found in both the closed and single open-ended questionnaire survey item responses.

A number of workplace situations were identified as significantly (p < 0.001) and equally stressful for these direct care staff and many were found to be interrelated, for example caring for older people during the end stage of life; experiences of conflict with doctors, peers and supervisors; high workloads, feeling ill-prepared emotionally for the job and uncertainty with meeting the treatment needs of older people; and discrimination from staff colleagues and families. The stressful experiences of respondents were associated with what respondents believed were unreasonable requests by the families of older people, being blamed for anything that went wrong, making complaints and derogatory remarks to direct care staff and being reported by families for what was considered to be inadequate care. Other reported stress factors were associated with the challenges of caring for older people who were considered to be violent and abusive toward them; and trying to provide care services with inadequate levels of direct care staff. These stress factors identified by study respondents signified that the workplace is both complex and stressful, however these direct care staff reported innovation and resilience in the ways that they attempted to counteract these negative stressful events. These data contribute to our knowledge about direct care staff stress and its effects, and about the factors that can protect these staff from stress-related burnout, including developing self-efficacy for their work.

As an owner, director and manager of a supported aged care accommodation service, having access to these data will help me to share this knowledge with other providers in the hope of improving the supported aged care accommodation service workplace, as well as care services and outcomes for older people. These data will also help in knowing how to strengthen the direct care staff/family relationships for the benefits of the older people and the
direct care staff who care for them. The reasons for pursing this study, as previously discussed, was to become more involved in future changes of supported aged care accommodation service policy and practice development, especially in supporting the direct care staff workforce. Hitherto, my opportunity to do so was limited by not having the research skills to undertake a study in my area of professional interest. Enrolling in the Professional Doctorate in Nursing provided the opportunity I needed to pursue my interest in researching the stress I saw occurring in my direct care staff in their work, and also when interacting with families. The outcome of this study has therefore fulfilled my aim to contribute to evidence-based supported care practice.

8.1.1. REFORMS

As identified in Chapter 2, supported aged care accommodation services have undergone major reforms in Australia since the mid-1980s. As the Productivity Report 2011 identifies, these reforms will need to continue for many more years, and also warns that the current supported aged care accommodation service systems of Australia will not meet the future challenges associated with an ageing population. The Productivity Commission (2011) found the then supported aged care accommodation service system was difficult for older people, their families and health professionals to navigate, and to some extent this included opportunities for families to have their concerns and grievances fully satisfied in day to day care practices provided to their relative. This structural issue will give rise to experiences of frustration and stress for families, as well as for older people and those direct care staff that are caught up in what they feel is a litany of unnecessary criticisms and unsolvable dilemmas.
8.1.2. STRESSFUL ENVIRONMENT

The supported aged care accommodation service sector has been identified in many studies as stressful for direct care staff. The studies have also identified how direct care staff struggled to meet the challenges associated with the supported aged care accommodation service reforms that they feel have been thrust upon them. These issues were found to have negative implications for the physical and psychological well-being of direct care staff. Advocates for supported aged care accommodation services have long argued that the inability of direct care staff to provide acceptable standards of care within a workplace that is ill-equipped to undertake this complex role is linked to poor policy development. The respondents attested to this perception, pointing out the structural constraints, inequitable resource distribution, inequitable wage allocation, poor incentives for direct care staff and bureaucratic inaction on the issues they raise about the workplace.

In Australia, employee stress is a costly issue for all employers as work-related psychological disorders remain higher than for many other conditions, or injuries. Given the potential for direct care staff to under-report workplace stress, it is likely that the level of stress occurring in this workforce is much higher than official figures suggest. The effect of unresolved stress in this workforce is likely to further exacerbate the already diminishing direct care staff workforce, given levels of perceived stress of respondents. While the respondents’ levels of self-efficacy and inherent value for their work were perhaps the two major reasons that they did not experience complete burnout, the issue of unresolved stress arising from multiple factors must be taken seriously by supported aged care accommodation service providers, managers and the Government. It behoves the Government, supported aged care accommodation service providers, the public and direct care staff themselves to enter into collaborative discussions to determine how to create supported
aged care accommodation services that not only meet the quality care needs of older people, but also support and provide a healthy and satisfying work place for direct care staff.

8.1.3. LEADERSHIP

The importance of leadership in achieving positive outcomes for older people and in generating personal satisfaction was clearly identified by respondents. In the supported aged care accommodation service sector it is the role of registered nurses to provide leadership, and this involves effective supervision of all other care workers, combined with strategic delegation of a range of quality care services to older people. Since the registered nurse is ultimately responsible for the quality of care provided to older people, ensuring that effective supervision occurs is a major role for both clinical and managerial nurse leaders. Without effective leadership support, the respondents felt overwhelmed by negative workplace experiences.

With the increasing complexity of the supported aged care system and accommodation service sector, effective leadership is critical in achieving a quality care service setting. Senior direct care staff such as registered nurses must become supported aged care accommodation service leaders. As leaders, these staff must be innovative, add value to the service and ensure that the policies they have jurisdiction over focus on supporting older people, their families and direct care staff in a harmonious environment, where mutual respect and support is fostered. Research has clearly demonstrated that supporting and motivating direct care staff is intrinsic to maintaining a satisfied workforce, and to reducing staff stress including the psychological and physical effects of stress, and staff turnover.

By the very nature of their work and the predicted escalation of the demands and complexities faced on a daily basis, direct care staff will need to face the
challenge of ongoing Government reforms and shifts in care standards. Direct care staff leaders will need to employ a raft of innovative measures to manage these new requirements within the limitations of an inadequately resourced direct care staff workforce. To provide this new brand of leadership, direct care staff managers will require a level of education and training that is appropriate to the task ahead. Direct care staff leaders will need to harness clinical, research, education and managerial abilities, as well as learn how to negotiate the political agenda of the supported aged care accommodation sector. Payment for care of older people in Australia has long been a contentious issue and the focus of many reports and Commissions, all of which have not achieved a clear way to manage this issue. Australian supported aged care accommodation service policy makers should look to countries such as Scandinavia, Sweden, Denmark and the Netherlands to determine a more equitable and satisfactory means of obtaining and maintaining fiscal policy to ensure adequate remuneration to its direct care staff workforce.

8.1.4. COLLABORATION

Collaboration between Governments, university nursing faculties, supported aged care providers and experienced direct care staff must also occur in determining the appropriate leadership requirements for the sector. Experienced direct care staff will need to become involved in developing curricula on supported aged care accommodation service leadership, to strongly influence the ways that this education is provided to those who are suitable for the leadership role, make recommendations on payment arrangements for leadership education and actively lobby the Government to seek equality in financial remuneration for direct care staff with leadership skills and positions. Active lobbying is also long-overdue with regard to the wages for all levels of direct care staff and are issues that direct care staff leaders must engage with.
8.1.5. QUALITY

Direct care staff commitment to their work is an essential element to achieving quality care services to older people and is a primary consideration of the Government, implemented through the Accreditation Standards. Despite the rhetoric of ‘quality service’, ‘quality of care’ and ‘quality of life’, within the aged care sector, the notions of quality depend on the different parties’ expectations, as reported by respondents. What families expect and what direct care staff are able to provide are sometimes in conflict with each other. This is especially so for supported aged care accommodation service providers who are responsible for the implementation of ‘quality’ systems and ‘quality’ improvement practices within the framework of the Accreditation Standards, where the quality of services may differ from one supported aged care accommodation service to the next, depending on the subjectivity of both the provider and the receiver of supported aged care accommodation services. This is an issue that gives rise to stress for both parties, often escalating in accusations and recrimination.

Therefore, Governments, stakeholders and the direct care staff profession must bring together a system of collaboration to consensually develop means to not only maintain a committed workforce at every level of the organisation, but also to consensually develop and define a quality standard that uniquely defines the essential human needs of each older person receiving supported aged care accommodation services. For, without a committed direct care workforce and without a consensual acknowledgement and knowledge of what quality services and care resemble for individual older people, then family concerns and negative interactions with direct care staff will continue.

Research is needed to determine how all direct care staff can best work with families to collaborate in identifying the daily care goals of older people and
how families can share care with direct care staff in ways that they feel comfortable with. This level of communication needs to be guided and facilitated by the direct care leader of each supported aged care accommodation service, to provide clear guidelines for both families and direct care staff on how these shared arrangements might work; to clarify where formal care limitations exist and where informal care arrangements are possible.

This leadership is essential for ensuring that direct care staff from different cultural backgrounds do not feel intimidated and have a voice in discussions to identify what formal care entails, what direct care staff are able to provide and where support from families can assist. It is particularly important that senior care staff provide leadership with regard to ensuring that all direct care staff, older people and their families are fully cognisant of the policies regarding respect and civility in the workplace. This is an issue that requires the attention of supported aged care accommodation service providers and signals the need for managers and direct care staff to be educated in cultural competence and also in how they might communicate more effectively with older people and their families. If leadership is provided in arming direct care staff with the skills to deflect, or better manage anger and unreasonable requests made by older people and their families, they will be less likely to feel stressed and demeaned by these demands.

It appears that maintaining a committed and satisfied workforce at every level of the organisation is an essential element to the delivery of quality care. The evidence within this study suggests that leadership is seen to be critical for achieving positive outcomes for older people and producing direct care staff and family satisfaction. Of the direct care staff workforce, the registered nurse is ultimately responsible for the quality of care provided to older people, therefore the roles of these direct care staff must include effective supervision,
education, mentorship and support. Without strong leadership, the often difficult and stressful work of supported aged care accommodation service provision can turn positive direct care staff views about the values of their work to negative feelings and behaviors that impact on the whole care environment.

Since organisations with strong and effective leadership tend to attract high quality direct care staff (Chenoweth, 2012), this is the policy direction that the Australian supported aged care accommodation sector needs to adopt. National workforce surveys of senior nurses have revealed that many direct care managers and senior registered nurses contemplate early retirement, or to leave nursing altogether, rather than continue to work in a highly demanding, stressful workplace where there is little support for management mentoring and no hours allocated to direct care staff supervision (Duffield et al., 2009; Chenoweth et al., 2012). There is an urgent need for these senior direct care staff to provide leadership on this issue (Shirey, 2006; Jeon, Merlyn & Chenoweth, 2010; Jeon et al., 2010).

8.2. CHAPTER SUMMARY

It is important that Governments, supported aged care accommodation service providers and organisation leaders have an understanding of the underlying processes and factors that influence responses of all direct care staff to pressures in the workplace and in their ability to cope in situations that are considered stressful for them. Researching direct care staff work practices and different aspects of the work environment and service delivery is an invaluable way of learning how to be an effective leader.

In keeping with Lazarus and Folkman’s (1984, pp. 296) premise that neither the environment, nor the person remains static, the Government and supported aged care accommodation service providers need to be reminded that any significant changes occurring in the supported aged care accommodation
service sector may have a negative effect on the direct care staff workforce. It
behoves managers and senior staff to be aware of and make known to key
stakeholders the negative effects that can arise for direct care staff colleagues
with the imposed reforms, since a workforce that is happy, satisfied and
supported will tend to strive towards ensuring the happiness and well-being of
older people and their families. This is the major purpose of providing
leadership in the supported aged care accommodation service sector, and will
be one which I aim to strive for in my role as a leader and manager.
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Buchanan, J. & Considine, G. (2002). *Stop telling us to cope! a report for the NSW Nurses Association.* Australian Centre for Industrial Relations Research and Training (ACIR RT), University of Sydney.


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deVries (Eds.). *Extreme stress and communities: impact and intervention* (pp. 159-177). Dordrecht, the Netherlands: Kluwer.


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Senate Community Affairs References Committee (2011). *Disability and ageing: lifelong planning for a better future*. Canberra, Senate Printing Unit.


5 June 2006

Professor Lynn Chenoweth
KG05.00.04
Faculty of Nursing, Midwifery and Health
UNIVERSITY OF TECHNOLOGY, SYDNEY

Dear Lynn,

UTS HREC REF NO 2006-139 – CHENOWETH, Professor Lynn, JEON, Dr Yun-Hee
(for WALKER, Ms Irene, PhD student) - "Nurse stress associated with the family of
aged care residents"

Thank you for your response to my email dated 15 May 2006. Your response
satisfactorily addresses the concerns and questions raised by the Committee, and I am
pleased to inform you that ethics clearance is now granted.

Your clearance number is UTS HREC REF NO. 2006-139A

Please note that the ethical conduct of research is an on-going process. The National
Statement on Ethical Conduct in Research Involving Humans requires us to obtain a
report about the progress of the research, and in particular about any changes to the
research which may have ethical implications. This report form must be completed at
least annually, and at the end of the project (if it takes more than a year). The Ethics
Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that
data be kept for a minimum of 5 years after publication of research. However, in NSW,
longer retention requirements are required for research on human subjects with potential
long-term effects, research with long-term environmental effects, or research considered
of national or international significance, importance, or controversy. If the data from this
research project falls into one of these categories, contact University Records for advice
on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your
research in the future, please do not hesitate to contact the Ethics Secretariat at the
Research and Innovation Office, on 02 9514 8615.

Yours sincerely,

Mr Peter Treblico
Acting Chairperson
UTS Human Research Ethics Committee

Office City campus, No.1 Broadway, Sydney NSW
Campus City, Kuring-gai, St Leonards
UTS CRICOS Provider Code 00099F
INFORMATION SHEET - FACILITY MANAGERS

Research Project: Explaining Reasons for Stress, Burnout and Self-Efficacy In Direct Care Staff in Supported Aged Care Accommodation Services.

This research study is being conducted by Ms Irene Walker, a doctoral student of the Faculty of Nursing, University of Technology Sydney. The Study aims to:

1. Identify the factors that create stress in the Australian direct care staff workforce associated with their work and with their interactions with the families of older persons admitted to supported aged care accommodation service, and

2. Develop recommendations to reduce the stress levels of direct care staff associated with these families, and thereby improve their job satisfaction.

The researcher will investigate these issues with direct care staff through surveys and focus groups. Participation in this project requires your involvement in the following ways:

1. Consenting to the study being conducted in your facility.

2. Providing access to your direct care staff at times that is convenient to the aged care service and to these staff members.

3. Providing a suitable room to conduct the initial information session with direct care staff at the commencement of the study and also for the feedback session at the conclusion of the study.

4. Keeping in confidence the names of those persons who you may be aware of who are participating in the study.

5. Keeping in confidence any information arising from the study, until the researcher is ready to present the research findings to people outside of the facility you are employed in.

6. Enabling direct care staff participants to complete the surveys during their work day.
7. Providing a quiet area/room in which direct care staff may privately discuss any questions they may have and/or have the information forms, consent forms and surveys explained to them by the researcher.

8. Providing extra time if needed, for those direct care staff that have limited or no English literacy who may require the researcher to read out and explain the contents of the information and consent forms and surveys to assist with their understanding of the study and their participation in it.

If you are happy to agree to these conditions and to participate in this study, please sign and return the Consent Form in the enclosed stamped addressed envelope. If you need further information about this study you can contact Dr Lynn Chenoweth
Professor of Aged & Extended Care Nursing
University of Technology Sydney
02-99369 0288
Ethics Approval UTS HREC REF. No. 2006.139
INSTITUTIONAL CONSENT FORM FACILITY MANAGERS

Research Project: Explaining Reasons for Stress, Burnout and Self-Efficacy in Direct Care Staff in Supported Aged Care Accommodation Services.

Researcher: Irene Walker, Student, Faculty of Nursing & Midwifery, University of Technology, Sydney.

…………………………………………………………………………………………………………………………………………………………

(Name of facility manager)                               (Name of Facility)

1. Acknowledge that the study has been explained fully to me by the researcher and that am free to ask for further clarification throughout the project as required

2. Voluntarily give my consent for this study to be conducted in the above named Facility

3. Agree to communicate regularly with the researcher throughout this study as required

4. Provide the researcher with access to the necessary facilities within the aged care Service to conduct the study, including a quiet area/room in which nurses may privately discuss any questions they may have and/or have the information and consent forms, and questionnaires explained to them by the researcher

5. Acknowledge that I may withdraw my consent to participate in the project at any time and that this will not affect my status or my relationship with other management and the proprietors of the aged care service, the UTS or the researcher

6. Agree to maintain confidential any information pertaining to the participating care staff and family-close friends which arises from the study until such time as determined by the researcher

7. Understand that neither the facility nor I will be identified in any research findings and that all information I give to the researcher will be maintained in a secure and confidential manner during the project and will be retained for 7 years in a locked filing cabinet under the supervision
Appendix C

of the Chief Supervisor Professor Lynn Chenoweth at the premises of the University of Technology Sydney

8. Have been advised that the project has been approved by the University of Technology Sydney

9. Consent to provide time for nurse participants to complete the surveys during their working day

10. Consent to provide extra time if needed for staff who have limited or no English literacy and who may need to have further explanation and assistance with completion of the surveys

11. Understand that if I have any inquiries during the course of the study I may contact the Chief Supervisor:

   Dr Lynn Chenoweth,
   Professor of Aged & Extended Care Nursing
   University of Technology Sydney
   02-99369 0288

________________________________________  ____/____/____
Signature (participant)

________________________________________  ____/____/____
Signature (Witness)

NOTE:
This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any concerns or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: 02 - 9514 9615, Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.


**FACILITY MANAGER - REVOCATION OF CONSENT**

Research Project: Explaining Reasons for Stress, Burnout and Self-Efficacy In Direct Care Staff in Supported Aged Care Accommodation Services.

I hereby wish to WITHDRAW my consent to participate in the research project and understand that withdrawal from participating in this study WILL NOT make any difference to my current employment status or my relationship with the researcher.


________________________________________  ____/____/____
Signature (participant)


________________________________________  ____/____/____
Signature (Witness)

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any concerns or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: 02 -9514 9615, Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.

Ethics Approval: UTS HREC Ref No 2006-139
LETTER OF INVITATION - DIRECT CARE STAFF (Registered Nurses, Assistant Nurses, Personal Carers & Recreational Staff)

Research Project: Explaining reasons for stress, burnout and self-efficacy in direct care staff in supported aged care accommodation services.

Dear Direct Care Staff

You are invited to attend an Information session conducted by Ms Irene Walker, to learn about a research project that may be of interest to yourself and your colleagues. This research study is being conducted by Ms. Irene Walker, a doctoral student of the Faculty of Nursing, University of Technology Sydney. The Study aims to:

1. Identify those factors that create stress, burnout and self-efficacy in the Australian aged care workforce with and on the experiences of direct care staff with the families of older people.

2. Develop recommendations to reduce the stress levels of direct care staff and thereby improve their satisfaction with working in a supported aged care accommodation service.

The researcher will investigate these issues with direct care staff through surveys.

You are invited to meet with the researcher who will explain the study to you in detail. Your managers have given permission for you to participate in the study during your working day.

This discussion will be held in the ......................................................... (Location) ........................................ (Time) on ........................................ (Day) ................................. (Month).

I look forward to your attendance and meeting with you,

Irene Walker
INFORMATION SHEET – DIRECT CARE STAFF (Registered Nurses, Assistant Nurses, Personal Carers & Recreational Staff)

Research Project: Explaining reasons for stress, burnout and self-efficacy in direct care staff in supported aged care accommodation services.

This research study is being conducted by Ms Irene Walker, a doctoral student of the Faculty of Nursing, University of Technology Sydney. The Study aims to:

Identify factors that create stress in the Australian direct care staff workforce and including any factors associated with families of older people, and

Develop strategies to reduce direct care staffs’ stress levels and thereby improve their satisfaction.

The researcher will investigate these issues with direct care staff through surveys.

You are invited to meet with the researcher who will explain the study to you in detail. Your managers have given permission for you to participate in the study during your working day.

Participation in this study requires your involvement in the following ways

1. Completing a minimum of four confidential surveys which will take up to approximately 35 minutes of your time. You will be provided with the opportunity to complete the surveys during your workday if you choose.

2. Documenting

3. If required, the researcher, or a nominated member of your organization, will assist you to read and understand the questions on the Information Form and survey forms and also to complete the survey forms. Your facility manager has consented to provide you with the extra time that you may need for this.

4. Keeping in confidence the names of those persons who may participate in the study.

5. Keeping in confidence any information arising from the study.
If you are happy to agree to these conditions when participating in this study you are welcome to attend an information session where the researcher will explain the study in more detail.

If you require further information about this study you can contact:

Dr Lynn Chenoweth,
Professor of Aged & Extended Care Nursing,
University of Technology Sydney,
02-99369 0288
### MBI–Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely.

Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job–related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write a “0” (zero) in the space before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

#### Example

<table>
<thead>
<tr>
<th>How often:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>A few times a year or less</td>
<td>Once a month or less</td>
<td>A few times a month</td>
<td>Once a week</td>
<td>A few times a week</td>
<td>Every day</td>
</tr>
</tbody>
</table>

#### How Often 0–6 Statements:

1. ___ I feel depressed at work.

If you never feel depressed at work, you would write the number “0” (zero) under then heading “How often.” If you rarely feel depressed at work (a few times a year or less), you would write the number “1.”

If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a “5.”
# MBI–Human Services Survey

<table>
<thead>
<tr>
<th>How often:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Never</td>
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<td>A few times a year or less</td>
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<td>Once a month or less</td>
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<td>A few times a month</td>
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<td>Once a week</td>
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<td>A few times a week</td>
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<td>Every day</td>
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</tbody>
</table>

**How Often**  

<table>
<thead>
<tr>
<th>0–6</th>
<th>Statements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I feel emotionally drained from my work.</td>
</tr>
<tr>
<td>2.</td>
<td>I feel used up at the end of the workday.</td>
</tr>
<tr>
<td>3.</td>
<td>I feel fatigued when I get up in the morning and have to face another day on the job.</td>
</tr>
<tr>
<td>4.</td>
<td>I can easily understand how my recipients feel about things.</td>
</tr>
<tr>
<td>5.</td>
<td>I feel I treat some recipients as if they were impersonal objects.</td>
</tr>
<tr>
<td>6.</td>
<td>Working with people all day is really a strain for me.</td>
</tr>
<tr>
<td>7.</td>
<td>I deal very effectively with the problems of my recipients.</td>
</tr>
<tr>
<td>8.</td>
<td>I feel burned out from my work.</td>
</tr>
<tr>
<td>9.</td>
<td>I feel I'm positively influencing other people's lives through my work.</td>
</tr>
<tr>
<td>10.</td>
<td>I've become more callous toward people since I took this job.</td>
</tr>
<tr>
<td>11.</td>
<td>I worry that this job is hardening me emotionally.</td>
</tr>
<tr>
<td>12.</td>
<td>I feel very energetic.</td>
</tr>
<tr>
<td>13.</td>
<td>I feel frustrated by my job.</td>
</tr>
<tr>
<td>14.</td>
<td>I feel I'm working too hard on my job.</td>
</tr>
<tr>
<td>15.</td>
<td>I don't really care what happens to some recipients.</td>
</tr>
<tr>
<td>16.</td>
<td>Working with people directly puts too much stress on me.</td>
</tr>
<tr>
<td>17.</td>
<td>I can easily create a relaxed atmosphere with my recipients.</td>
</tr>
<tr>
<td>18.</td>
<td>I feel exhilarated after working closely with my recipients.</td>
</tr>
<tr>
<td>19.</td>
<td>I have accomplished many worthwhile things in this job.</td>
</tr>
<tr>
<td>20.</td>
<td>I feel like I'm at the end of my rope.</td>
</tr>
<tr>
<td>21.</td>
<td>In my work, I deal with emotional problems very calmly.</td>
</tr>
<tr>
<td>22.</td>
<td>I feel recipients blame me for some of their problems.</td>
</tr>
</tbody>
</table>

(Administrative use only)

<table>
<thead>
<tr>
<th>EE</th>
<th>cat.</th>
<th>DIP</th>
<th>cat.</th>
<th>PA</th>
<th>cat.</th>
</tr>
</thead>
</table>
Subject: RE: MBI- Human Services Survey

From: "CPP Customer Relations" <CPPCustomerRelations@cpp.com>

To: <ipw@netspace.net.au>

Tue, 29 May 2007 10:46:30 -0700

Hello Irene Walker,

Your CPP customer # is 353013. Your login/ ipw password/ 2134ipw

You will need to update your qualifications in order to purchase the MBI.

Thank you,

Todd Douglas
Customer Relations Advisor
CPP, Inc.
1055 Joaquin Rd 2nd Fl
Mountain View, Ca 94043
tdd@cpp.com
T: 800-624-1765 x174  F: 650-962-8916

The Leader in Workforce Development

www.cpp.com
The General Self-Efficacy Scale Questionnaire

Your feelings about how you manage

Please note the boxed responses after each question. Please circle one of these boxed responses to reflect your answer to each question.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all true</th>
<th>Hardly true</th>
<th>Moderately true</th>
<th>Exactly true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I can always manage to solve difficult problems if I try hard enough</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>If someone opposes me, I can find the means and ways to get what I want.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>It is easy for me to stick to my aims and accomplish my goals.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td>I am confident that I could deal efficiently with unexpected events.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5.</td>
<td>Thanks to my resourcefulness, I know how to handle unforeseen situations.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6.</td>
<td>I can solve most problems if I invest the necessary effort.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>7.</td>
<td>I can remain calm when facing difficulties because I can rely on my coping abilities.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8.</td>
<td>When I am confronted with a problem, I can usually find several solutions.</td>
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<td></td>
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<tr>
<td>9.</td>
<td>If I am in trouble, I can usually think of a solution.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I can usually handle whatever comes my way.</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

QUESTIONNAIRE PACK INFORMATION SHEET

Staff Code: ......................  Facility Code: .............Date: ..........  

Research project: “Explaining Reasons for Stress, Burnout and Self-Efficacy in Direct Care Staff in Supported Aged Care Accommodation Services.

Thank you for taking the time to participate in this research project. It is important to gain your participation to assist in identifying the factors that may create stress in the Australian direct care staff workforce arising from their work and from their interactions with the families of older persons admitted to a supported aged care accommodation service.

This Questionnaire Pack contains three validated questionnaires which relate to:

- Your feelings about your work
- How your work affects you
- How you feel about yourself

A fourth questionnaire consisting of a number of basic questions about you. It is important to know more about the people who have responded to the survey. These questions are non-identifying and codes are used so that your confidentiality is maintained at all times. At no time will you or your organization be identified.

The directions for completing each set of questions are located at the top of the front page of each questionnaire.

Should you require assistance to complete the questionnaire, please contact the researcher on Telephone No. 0416122996.

The questionnaires should not take longer that approximately 20 to 30 minutes to complete. You can complete these questionnaires in your own time i.e. during your meal break.

It is important that all questions are completed. Once you have completed the questionnaires, please check that every question on each page has been completed before placing in the envelope that is provided with the Questionnaire Pack. Ensure that the envelope is completely sealed and then place the sealed envelope in the locked box located at the nurses' station or hand directly to the researcher or her assistant.
For further information about this study please contact:
Irene Walker, Doctoral Student, UTS 0416122996
Demographic Survey – This is about who you are

1. Please enter your current age (in whole years as from last birthday).

2. Please circle your gender status.

   Male                                                                 Female

3. Please circle the statement that accurately reflects your current employment status.

   Employed full-time   Employed part-time   Casual Employment

   Other........................

4. Please circle or state your current employment position:

   Registered Nurse   Enrolled Nurse   Assistant In Nursing

   Recreational Staff   Personal Carer   Other ..............................

5. Please state the number of years you have worked in this aged care facility:

6. Please circle or list any nursing or health related qualification you may have or are currently undertaking:

   Registered Nurse Cert.   Enrolled Nurse Cert   Grade III Cert.   Grade IV Cert.

   Degree in Nursing.................................................................................................

   Other Academic Health Related Qualification ....................................................

   Highest overseas health related qualification/s ....................................................

   Other health related qualification/s ......................................................................

   Current enrolment in a health related degree/certificate .................................

7. How many hours per week do you work at this facility?

   ...........................................
Appendix J

8. Please circle the shifts you normally work each week and state the number of shifts worked for AM; PM; and Night shifts per week.

   AM Shift.  Number of am shifts worked.  ......  
   PM Shift  Number of pm shifts worked  ......  
   Night Shift  Number of night shifts worked  ......  

9. Do you work in another aged care facility?

   Yes  
   No  

10. How many hours per week do you work at your second place of work?


11. Please state the primary language you speak at home ..........................  

12. Please state your cultural background .................................  

Please circle the statement that you feel best reflects your English speaking skills.

   High  Medium  Low  

Please circle the statement that you feel best reflects your written English skills.

   High  Medium  Low  

xvii
EXPANDED NURSE STRESS SCALE

Below is a list of situations that commonly occur in a work setting. For each situation you have encountered in your PRESENT WORK SETTING, would you indicate HOW STRESSFUL it has been for you: (Enter the number in the right hand column that best applies to you. If you have not encountered the situation, write ‘0’).

<table>
<thead>
<tr>
<th>Never Stressful</th>
<th>Occasionally Stressful</th>
<th>Frequently Stressful</th>
<th>Extremely Stressful</th>
<th>Does Not Apply</th>
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</table>

1. Performing procedures that residents experience as painful ........... ____
2. Criticism by a resident’s doctor .............................................. ____
3. Feeling inadequately prepared to help with the emotional needs of a resident’s family ............................................................... ____
4. Lack of opportunity to talk openly with other personnel about problems in the work setting .......................................................... ____
5. Conflict with a supervisor ......................................................... ____
6. Inadequate information from a doctor regarding the medical condition of a resident ................................................................. ____
7. Resident’s making unreasonable demands ..................................... ____
8. Being sexually harassed .............................................................. ____
9. Feeling helpless in the case of a resident who fails to improve ....... ____
10. Conflict with a doctor ............................................................... ____
11. Being asked a question by a resident for which I do not have a satisfactory answer ................................................................. ____
12. Lack of opportunity to share experiences and feelings with other personnel in the work setting ...................................................... ____
13. Unpredictable staffing and scheduling ......................................... ____
14. A doctor ordering what appears to be inappropriate treatment for a resident .................................................................................. ____
15. Resident’s families making unreasonable demands ....................... ____
16. Experiencing discrimination because of race or ethnicity ............ ____
17. Listening or talking to a resident about his/her approaching death ................................................................. ____
18. Fear of making a mistake in treating a resident ............................. ____
19. Feeling of inadequately prepared to help with the emotional needs of a resident ............................................................................. ____
20. Lack of an opportunity to express to other personnel on the unit my negative feelings towards residents .............................. ____
Appendix K

<table>
<thead>
<tr>
<th>Never Stressful</th>
<th>Occasionally Stressful</th>
<th>Frequently Stressful</th>
<th>Extremely Stressful</th>
<th>Does Not Stressful</th>
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21. Difficulty in working with a particular nurse (or nurses)
   In my immediate work setting

22. Difficulty in working with a particular nurse (or nurses)
   outside my immediate work setting

23. Not enough time to provide emotional support to the resident

24. A doctor not being present in a medical emergency

25. Being blamed for anything that goes wrong

26. Experiencing discrimination on the basis of sex

27. The death of a resident

28. Disagreement concerning the treatment of a resident

29. Feeling inadequately trained for what I have to do

30. Lack of support of my immediate supervisor

31. Criticism by a supervisor

32. Not enough time to complete all of my nursing tasks

33. Not knowing what a resident or a resident’s family ought
to be told about the resident’s condition and its treatment

34. Being the one that has to deal with the residents’ families

35. Having to deal with violent residents

36. Being exposed to health and safety hazards

37. The death of a resident with whom you developed a close relationship

38. Making a decision concerning a resident when the doctor is unavailable

39. Being in charge with inadequate experience

40. Lack of support by nursing administration

41. Too many non-nursing tasks required, such a clerical work

42. Not enough staff to adequately cover the unit

43. Uncertainty regarding the operation and functioning
   of specialized equipment

44. Having to deal with abusive residents

45. Not enough time to respond to the needs of resident’s families

46. Being held accountable for things over which I have no control

47. Doctor(s) not being present when a resident dies

48. Having to organize doctors’ work

49. Lack of support from other health care administrators

50. Difficulty in working with nurses of the opposite sex

51. Demands of resident classification system

52. Having to deal with abuse from residents’ families

53. Watching a resident suffer

54. Criticism from nursing administration
<table>
<thead>
<tr>
<th>Never Stressful</th>
<th>Occasionally Stressful</th>
<th>Frequently Stressful</th>
<th>Extremely Stressful</th>
<th>Does Not Apply</th>
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<td>1</td>
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</table>

55. Having to work through breaks ........................................... ____

56. Not knowing whether residents’ families will report you for inadequate care ............................................. ____

57. Having to make decisions under pressure ................................____

Expanded Nurse Stress Scale – Individual Items

Proportion of respondents nominating the situation as ‘extremely stressful’ on the ENSS, presented by current nursing position

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<thead>
<tr>
<th>N</th>
<th>Performing procedures that residents experience as painful</th>
<th>Criticism by a resident’s doctor</th>
<th>Feeling inadequately prepared to help with the emotional needs of a resident’s family</th>
<th>Lack of opportunity to talk openly with other personnel about problems in the work setting</th>
<th>Conflict with a supervisor</th>
<th>Inadequate information from a doctor regarding the medical condition of a resident</th>
<th>Resident’s making unreasonable demands</th>
<th>Being sexually harassed</th>
<th>Feeling helpless in the case of a resident who fails to improve</th>
<th>Conflict with a doctor</th>
<th>Being asked a question by a resident for which I do not have a satisfactory answer</th>
<th>Lack of opportunity to share experiences and feelings with</th>
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<tr>
<td>RN/DON/Nurse educator %</td>
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<td>41. Too many non-nursing tasks required, such a clerical work</td>
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<td>Having to organize doctors' work</td>
<td>9.5</td>
<td>2.3</td>
<td>12.5</td>
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<td>49.</td>
<td>Lack of support from other health care administrators</td>
<td>12.5</td>
<td>5.9</td>
<td>25.0</td>
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<td>50.</td>
<td>Difficulty in working with nurses of the opposite sex</td>
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<td>2.3</td>
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<td>51.</td>
<td>Demands of resident classification system</td>
<td>30.2</td>
<td>11.8</td>
<td>25.0</td>
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<td>52.</td>
<td>Having to deal with abuse from residents' patients</td>
<td>34.9</td>
<td>28.4</td>
<td>37.5</td>
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<td>53.</td>
<td>Watching a resident suffer</td>
<td>29.7</td>
<td>46.6</td>
<td>25.0</td>
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<td>54.</td>
<td>Criticism from nursing administration</td>
<td>21.9</td>
<td>12.5</td>
<td>25.0</td>
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<td>55.</td>
<td>Having to work through breaks</td>
<td>10.9</td>
<td>18.2</td>
<td>12.5</td>
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<td>56.</td>
<td>Not knowing whether residents' families will report you for inadequate care</td>
<td>21.9</td>
<td>27.3</td>
<td>50.0</td>
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<td>57.</td>
<td>Having to make decisions under pressure</td>
<td>23.4</td>
<td>20.5</td>
<td>25.0</td>
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N.B. not all items were answered by all staff.
LIST OF ACRONYMS

Terminology used in policy and other formal documents published by the Australian Commonwealth Government is often paternalistic and medicalized and does not reflect a belief in trying to create a home-like environment for older people living in residential accommodation. This study provides an opportunity to influence current terminology through the use of a more contemporary approach using a person centred perspective.

Therefore, for the purposes of this study, those aged care staff who work in a formal care environment will collectively be referred to as direct care staff unless otherwise stated. The term ‘nurse’ is used in a number of ways in the literature and the status of the position is often denoted through the common use of acronyms. As nurses are referred variously in different research studies and countries of origin, the terms used in the studies are reported accordingly.

A qualified nurse is one who has successfully completed an approved program of tertiary level study that is recognized by the Nurse Register authority of the country or state/territory in which the award was obtained. Acronyms used to denote nurses throughout the literature may also include:

- APN  Advanced Practice Nurse
- DON  Director of Nursing
- EEN  Endorsed Enrolled Nurse
- EN   Enrolled Nurse
- NP   Nurse Practitioner
- NUM  Nurse Manager
- RN   Registered Nurse
Appendix M

An unqualified nurse may have achieved an approved program of study which is offered at a different level and for a much shorter period. While not acknowledged by Nurse Register authorities, this workforce qualification may be approved by the government and/or the aged care industry. Acronyms used to denote unqualified nurses throughout the literature may include:

- **AIN**  Assistant in Nursing
- **CAN**  Certified Nurse Assistant
- **LN**  Licensed Nurse (USA)
- **LPN**  Licensed Practical Nurse
- **NA**  Nurse Assistant/Nurse Aid
- **PCA**  Personal Carer/Personal Care Assistant

Additional to the fore-mentioned qualified and unqualified direct care staff are activity/recreational staff who provide social and recreational activities. These staff are often unqualified direct care staff who extend their caring role to include the provision of social and recreational activities to older people in the supported aged care accommodation service sector

- **AO**  Activity/Recreational staff

In Australia, residential aged care facilities provide a range of government and privately funded accommodation and hotel services to older people who are formally assessed as requiring levels of care and services that are unable to be delivered in the older person’s usual living environment. To reflect a person centred approach to this study, residential aged care facilities are denoted as supported aged care accommodation service/sector/environment/s. Thus, acronyms used to denote a supported aged care accommodation environment is variously described in the literature in the following ways:

- **NH**  Nursing Home
In this study, terms such as ‘older person’, ‘older people’ will be used for the purposes of presenting a person centred care approach to people who are recipients of supported aged care accommodation services. The older person receiving care and accommodation in a supported aged care accommodation service is generally referred to in the literature as follows:

Client: Person receiving care and treatment in the community sector (usually their own home)

Patient: Person receiving care and treatment in the acute care sector (hospital) or by a doctor or other allied health professional in their rooms or clinic

Resident: Person receiving care and treatment in a supported aged care accommodation service