

Working in Aged Care 2009: Phase Two of the ANF-University of Melbourne Study

Report prepared for the Australian Nursing Federation

Victorian Branch

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Executive Summary

This report presents findings from a survey of 541 members of the Victorian Branch of the Australian Nursing Federation conducted in 2009. This survey collected data from ANF members who were first surveyed in 2007. The 2009 survey provides a 'snapshot' of key aspects of work in the aged care sector. Some items of data were collected in 2007 and 2009, thereby providing an indication of how aged care workers are experiencing changes at work over time. There have been a number of important changes over the period between surveys. On the negative side, registered nurse to resident ratios appeared to have declined, and some types of co-worker and resident aggression have increased. Respondents reported being less satisfied with their jobs and more inclined to want to leave, as well as being more emotionally exhausted and depressed. They also reported that resident care was lower in 2009 than in 2007. On the positive side, respondents reported an increase in levels of social functioning, as well as reporting an increase in staff responsiveness to resident needs and in the emphasis placed on resident safety in facilities. In 2009 respondents were asked for the first time why they stayed in their jobs and the most frequent response was that they believed it was important that the elderly were properly cared for.

In 2007 and 2009 the majority of **participants** were registered nurses with there being an increase in Division 2 endorsed nurses and a decrease in Division 2 non-endorsed nurses over this period. In both 2007 and 2009 compared to public facilities overall private not for profit and private for profit facilities had significantly fewer registered nurses and significantly more PCWs.

Between 2007 and 2009, **registered nurse to resident ratios** increased. In the 2007 they ranged from 1:6 to 1:39 while in 2009 they ranged from 1:9 to 1:47. It is important to note that most of the changes in ratios occurred at private facilities while ratios at public facilities largely remained stable over time. This is probably as a result of the legally enforceable registered nurse to resident ratios at public facilities. Indeed in both 2007 and 2009 participants from public facilities, as compared to participants from private facilities, reported that each registered nurse had to care for significantly fewer residents. For example, in 2009 in high care public facilities the ratios ranged from 1:9 on the AM shift through to 1:14 on the night shift. This compared to an AM ratio of 1:15 and a night shift ratio of 1:37 in high care private facilities. In 2009 registered nurse to resident ratios were predictors of a range of outcomes. Overall, the more residents each registered nurse had to care for the more negative or poorer the outcomes were. In 2009, in relation to the types of **job changes** participants reported experiencing, the most common were increased managerial functions and multi-skilling. Registered nurses reported having to **work overtime** to get their jobs done significantly more frequently than PCWs.

In terms of **medication practices**, most participants indicated that they had not seen Division 2 non-endorsed nurses at their facility administering medications from DAAs. In both 2007 and 2009 most participants indicated that DAAs were either never incorrectly filled or incorrectly filled less than once per month. The two most frequently observed **medication errors** were residents missing their medications and medications being given at the wrong time. In general participants from public facilities tended to report that medication errors were made less frequently compared to participants from private not for profit or private for profit facilities. This, in part, may potentially be due to the legally enforceable registered nurse to resident ratios that are present in the public sector.

Between 2007 and 2009 the only increase in **co-worker aggression** towards residents was in relation to the frequency with which participants witnessed co-workers threatening to hit or throw something at a resident. In relation to **resident aggression** in 2009 participants reported experiencing residents trying to hit them with something, crying to make them feel guilty and shouting or swearing at them significantly more frequently than in 2007.

In 2009 participants reported being significantly less **satisfied with their jobs** than in 2007, with participants from private for profit facilities reporting the lowest levels of job satisfaction. In addition to some employee/facility variables, co-worker aggression and cost-cutting were key negative predictors of job satisfaction, while grievance procedures, performance practices and multi-skilling were key positive predictors. In 2009 participants reported that they were significantly more likely **to want to leave their current job** than in 2007. Participants from private for profit facilities reported the strongest desire to leave their current job. In addition to some employee/facility variables, cost-cutting and role extending were positive predictors of turnover intentions, while grievance procedures, performance practices, training and multi-skilling were negative predictors.

In 2009 participants reported that “believing it is important the elderly are properly care for” as the most important **reason for them continuing to work in aged care**. Participants reported that they were not continuing to work in aged care because it was the only job they could get. There was no difference between 2007 and 2009 in relation to **how committed participants felt to their organisation**. Staff cost-cutting was a negative predictor of organisational commitment, while grievance procedures, performance practices and multi-skilling were positive predictors.

In 2009 participants reported feeling **emotional exhaustion as a result of their work** more frequently than in 2007. In addition to some employee/facility variables, workplace aggression and staff cost-cutting were positive predictors of emotional exhaustion, while grievance procedures, performance practices and training were negative predictors. Participants reported significantly higher levels of **social functioning** in 2009 as compared to 2007. Resident quality of living cost-cutting was a statistically significant negative predictor of social functioning, while grievance procedures were a statistically significant positive predictor. In 2009 participants reported feeling significantly **more depressed** than in 2007. Workplace aggression, staff cost-cutting and nursing grade dilution were positive predictors of depression, while grievance procedures and training were negative predictors. Overall, participants working in public facilities where there tended to be better management practices and staff to resident ratios reported experiencing fewer negative psychological and physical health outcomes and more positive work related attitudes.

There were no differences between 2007 and 2009 in relation to **how satisfied individuals felt with their facility**. Co-worker aggression and resident quality of living cost-cutting were negative predictors of facility satisfaction, while grievance procedures, recruitment and selection, and performance practices were positive predictors of facility satisfaction.

In 2009 participants felt that staff were more **responsive to resident needs** as compared to 2007. Co-worker aggression and resident quality of living cost-cutting were negative predictors of staff responsiveness, while grievance procedures and performance practices were positive predictors. In 2009 participants felt **resident safety** was a significantly higher priority at their facilities than in 2007. Cost-cutting and nursing grade dilution were negative predictors of resident safety, while grievance procedures, performance practices and training were all positive predictors. Participants reported **resident care** as being significantly lower in 2009 than in 2007. Resident quality of living cost-cutting and nursing grade dilution were negative predictors of resident care, while grievance procedures and performance practices were positive predictors.

Overall, the study finds that two years on aged care workers, especially those in private facilities, continue to be under significant stress. This has seen participants increasingly report that their ability to provide high quality care for residents is being hampered. Worryingly having to work in these high pressure environments has seen a significant decrease in job satisfaction and an increase in the number of participants who are considering leaving their current job. This is concerning given that the aged care sector is already experiencing significant problems attracting and retaining qualified staff.

1. Introduction

This report presents data from the second survey conducted as part of an ongoing research project based on surveys of Victorian aged-care workers. The current survey data builds on data from the first survey that was administered at the start of the project in October 2007 (reported in November 2008). The third and final wave of data collection for the project will occur in 2010. The ongoing program of research is concerned with how, in an environment which is placing increasing pressure on aged-care provision, working arrangements are affecting quality of working life for aged-care workers and the quality of care which they are able to provide to residents. Accordingly, as well as providing descriptive data on the characteristics of aged-care workers and their working lives, we explore links between job design, work organisation and human resource management practices on one hand and employee and resident outcomes on the other. Our central motivation in conducting the research is to provide a solid empirical basis to inform practices within aged-care facilities, as well as government policy, in pursuit of favourable outcomes for aged-care residents, employees and providers.

The rapidly-ageing population in Australia is placing unprecedented pressure on aged-care provision and it seems likely that this pressure will continue to increase over coming decades. In Australia today there are some 2,800 residential aged care facilities providing care to more than 160,000 elderly people. The profile of people living in aged care facilities is increasingly frail, with 70% of all aged care residents requiring high levels of care compared to 58% a decade ago. This trend is predicted to continue with the number of aged care residents predicted to reach more than 250,000 by 2020, with the highest growth amongst residents aged 95 or older who will require the high levels of care. At the same time we have seen and continue to see a decline in the numbers of nurses working in aged care. For example, between 2003 and 2007, the proportion of registered nurses in aged care facilities fell from 21% to just 17%. So whilst the demand for aged care and the care needs of residents has been increasing the capacity for the aged care system to care for the elderly has been going down. This has resulted in significant pressures being placed on those individuals who continue to work in the aged care sector. Additional, contextual changes, such as the changes to the Commonwealth Aged Care Act (1997) and the increases in scope of practice for staff, have also further exacerbated these pressures and represent significant challenges for the aged-care industry. These challenges relate both to the quality of care which can be provided to residents of aged care facilities and the quality of working life for staff.

The data presented here are based on 541 responses from ANF (Victorian Branch) members working in aged-care in Victoria, who responded to the second survey conducted in March 2009. The responses of these participants were then matched to the original responses they had provided when surveyed in October 2007. The report provides both a summary of this longitudinal data and new cross-sectional data that was collected for the first time in the second survey in relation to the respondents, their workplace characteristics, work practices, management practices and worker and resident outcomes. In addition, it presents analysis of links between a range of these aforementioned factors, allowing inferences to be drawn about the impact of specific practices on the quality of working life and resident care.

The report is divided into four sections. In the section that follows, we set out the method employed in the study. In Section Three we present our findings. This section commences with overviews of the participants and of their workplaces, then turns to medication practices and workplace aggression. The section concludes by presenting data on quality of working life for respondents and quality of care provided to residents. Finally, the key findings of the study are summarised in Section Four of the report.

2. Methodology

2.1. Study Design

This second data collection phase forms part of a three year longitudinal study of the quality of working lives for nurses and personal care workers in aged care supported by an Australian Research Council linkage grant. The first round of data collection was carried out in October 2007 (hereafter referred to as Time 1). The second round of data collection was carried out in March 2009 (hereafter referred to as Time 2). The final round of data will be collected in 2010. This is the first large scale longitudinal study of work organisation in Australian aged care.

The study was based on a questionnaire which consisted of a series of scales relating to the quality of work organisation (e.g., scope of practice, work stressors) in aged care along with several outcome measures relating to facility functioning and resident quality of care (including medication errors) as well as work (e.g., job satisfaction, turnover intentions) and employee well-being outcomes (e.g., social functioning, physical symptoms, emotional exhaustion).

2.2. Study Population

A questionnaire was mailed to 1007 individual aged care workers who were members of the Australian Nursing Federation (Victorian Branch) and had responded to the first questionnaire in October 2007 (Time 1). The questionnaire was mailed out by the ANF to preserve the anonymity of participants. Completed surveys were returned directly to the researchers at University of Melbourne. One hundred and ten questionnaires were excluded because the respondent had ceased working in aged care or the address was incorrect. In total there were 541 useable questionnaires (a 60% response rate).

It is important to make clear that our unit of analysis is the employee. When we report data on workplace characteristics, these are based on the employees' reports of the characteristics of their workplaces, not on data collected from a sample of workplaces. Consequently, we cannot draw any inferences about the population of aged-care workplaces in Victoria, but only the reported characteristics of workplaces in which our respondents worked. Thus, for example, when we report that 25.4% of respondents who worked in public facilities worked the AM shift, it is important to be clear that this does not mean that 25.4% of all Victorian aged care workers employed in public facilities work the AM shift.

2.3. Study Measures

Next a brief description of the scales used to measure the variables examined in the study is provided. Where possible existing scales with well established high levels of reliability and validity were used. All scales used in the study demonstrated acceptable levels of internal validity. For a full listing of the items used in each scale please refer to Appendix A.

Job changes in the last 12 months

This set of four items asked participants to indicate the extent to which they felt they had experienced a series of different job changes in the last 12 months. The four different types of job changes were; *multi-skilling* (having undergone additional training to enable them to provide a broader range of care skills), *role extending* (had been required to take on new

tasks that may have previously been undertaken by others, e.g., medication administration), *increased managerial functions* (had been required to take on managerial tasks that were previously undertaken by others e.g., supervision of other employees), and *nurse grade dilution* (tasks they were previously responsible for were now the responsibility of by other employees with fewer qualifications). Participants were asked to respond either “Yes” or “No” to this question. Data in relation to this item was only collected at Time 2¹.

Medication Practices

Medication Administration by Non-Endorsed Div 2s

This single item asked whether participants had seen non-endorsed Div 2s administering medication from a Dose Administration Aid (DAA; e.g., blister pack) without supervision at their facility. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Data in relation to this item was only collected at Time 2.

Dose Administration Aids (DAAs) Incorrectly Filled

This single item asked how often in the last 6 months participants were aware that DAAs (e.g., blister packs) had been incorrectly filled. The response scale participants were asked to use ranged from 1 (Never) to 6 (Several times per day). Data in relation to this item was collected at both Time 1 and Time 2.

Computerised Medication Management Systems

This single item asked participants to indicate whether their facility had a computerised medication management system. Participants were asked to respond either “Yes” or “No” to this question. Data in relation to this item was only collected at Time 2.

Medication Errors

The six items in each of these scales asked participants to indicate the frequency a series of different medication errors were made by co-workers from different job categories at their facility. An example of an item used is “In the past 6 months how often have *Division 1 Registered nurses* at your facility given a wrong dose to a resident?” Participants were also asked to record their responses to this same item in relation to Division 2 Endorsed nurses, Division 2 Non-Endorsed nurses, and PCWs. The response scale participants were asked to use ranged from 1 (Never) to 6 (Several times per day). Data in relation to these scales was only collected at Time 2.

Workplace Aggression

Co-Worker Aggression towards Residents

The four items in this scale assessed how frequently in the past 6 months participants had witnessed co-workers behaving in an either verbally or physically aggressive way towards residents. An example of an item used is “In the past 6 months how often have you seen other staff push, grab, shove, or pinch a resident.” Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times). Data in relation to this scale was collected at both Time 1 and Time 2.

Resident Aggression

The five items in this scale assessed how frequently in the past 6 months participants had personally experienced either verbal or physical aggression from residents. An example of an item used is “How often in the past 6 months have you been yelled at, shouted at, or

¹ When we make reference to Time 2 we are referring to the data collected in March 2009 as part of the second phase of the research. When make reference to Time 1 we are referring to the data collected in October 2007 as part of the first phase of the research.

sworn at by a resident?” Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times). Data in relation to this scale was collected at both Time 1 and Time 2.

Job Stressors

Staff Cost-Cutting

The five items in this scale assessed the extent to which participants felt their facility had fewer and/or less qualified staff on shifts than previously in an attempt to cut costs. An example of an item used is “My facility focuses on cost saving by reducing staffing levels at the expense of resident care.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

Resident Quality of Living Cost-Cutting

The seven items in this scale assessed the extent to which participants felt their facility had lowered the quality of things like residents’ meals and dressings in an attempt to cut costs. An example of an item used is “My facility has reduced the nutritional quality of food for residents to save money.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

Management Practices

Grievance Procedures

The eight items in this scale assessed the extent to which participants felt their facility had clear and effective procedures for resolving disputes or complaints between residents, staff and/or management. An example of an item used is “My organisation has clear and effective policies and procedures in place for resolving complaints by staff”. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

Recruitment & Selection Practices

The two items in this scale asked participants about how rigorous they felt the employee selection processes were in their organisation. An example of an item used is “How rigorous is the employee selection processes for a job in this organisation (e.g., Does the process involve tests, interviews etc?)? Participants responded using a scale which ranged from 1 to 7. Data in relation to these items was collected at both Time 1 and Time 2.

Performance Practices

The five items in this scale asked participants to indicate how much effort went into measuring and assessing employee performance in their facility. Items in the scale also asked participants to indicate how closely job performance was tied to pay in their facility. An example of an item used is “How often is performance discussed with employees?” Participants responded using a scale which ranged from 1 to 7. Data in relation to these items was collected at both Time 1 and Time 2.

Training

Three questions were used to assess the amount of training the participant’s employer had paid for them to undertake in the last 12 months and the extent to which they felt that overall they had received sufficient training to do their job. An example of an item used is “To what extent do you agree or disagree that you get the training needed to do your job effectively?” Data in relation to these items was collected at both Time 1 and Time 2.

Work, Psychological & Physical Health Outcomes

Job Satisfaction

The three items in this scale assessed the extent to which participants were satisfied with their current job. An example of an item used is “All in all, I am satisfied with my job.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

Turnover Intentions

The three items in this scale assessed the likelihood that participants would leave their current job and/or how much they would like to get a new job. An example of an item used is “How like is it that you will look for a job outside of this organisation during the next year?” Participants were asked to record their responses using a scale which ranged from 1 (Very Unlikely) to 7 (Very Likely). Data in relation to this scale was collected at both Time 1 and Time 2.

Reasons for continuing to work in Aged Care

For this item participants were asked to indicate how important eight reasons were in them continuing to work in aged care. The eight reasons were; better pay than other jobs I could get, want to work part-time, want to work flexible hours, like close personal connections I have developed with residents, believe it is important the elderly are properly cared for, I like this job better than other jobs I could get, it is the kind of job I know how to do, this is the only job I can get. Participants were asked to record their responses using a scale which ranged from 1 (Very Unimportant) to 7 (Very Important). Data in relation to this item was only collected at Time 2.

Organisational Commitment

The six items in this scale assessed the extent to which participants felt committed or emotionally attached to their current organisation. An example of an item used is “I do not feel a strong sense of belonging to my organisation.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

Emotional Exhaustion

The nine items in this scale assessed how frequently participants felt emotionally drained and fatigued as a result of their work. An example of an item used is “How often do you feel emotionally drained from your work?” Participants were asked to record their responses using a scale which ranged from 1 (Never) to 7 (Every Day). Data in relation to this scale was collected at both Time 1 and Time 2.

Social Functioning

The four items in this scale assessed how frequently over the past few weeks participants had felt able to enjoy their life and capable of making decisions and dealing with problems. An example of an item used is “Have you recently been able to enjoy your normal day-to-day activities?” Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time). Data in relation to this scale was collected at both Time 1 and Time 2.

Depression

The four items in this scale assessed how frequently over the past few weeks participants had felt unhappy and unable to cope. An example of an item used is “Have you recently been feeling unhappy or depressed?” Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time). Data in relation to this scale was collected at both Time 1 and Time 2.

Physical Symptoms

This scale was designed to assess out of a total of 18 possible physical symptoms how many the participant had experienced in the past 30 days. Examples of physical symptoms listed include backache, headache, chest pain, and an upset stomach or nausea. Data in relation to this scale was collected at both Time 1 and Time 2.

Resident Outcomes

Facility Satisfaction

The twelve items in this scale assessed the extent to which participants felt that residents' rooms and nutrition were of a high standard. The privacy of residents and the extent to which family and friends were welcome to visit residents were also assessed. An example of an item used is "Family and friends are welcome to visit residents and be involved in their care." Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

Staff Responsiveness

The ten items in this scale assessed how responsive participants felt staff were able to be to the different needs of residents. An example of an item used is "How responsive are staff to a resident requesting assistance using their buzzer or call system." Participants were asked to record their responses using a scale which ranged from 1 (Very Unresponsive) to 7 (Very Responsive). Data in relation to this scale was collected at both Time 1 and Time 2.

Resident Safety

The nine items in this scale assessed the extent to which participants felt resident safety was a high priority at their facility, with the extent to which management provided the resources, procedures and training needed to ensure resident safety also being assessed. An example of an item used is "Management provides a working environment that promotes resident safety." Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

Resident Care

The six items in this scale assessed the extent to which participants felt residents were able to talk to staff as needed; staff showed a real interest in residents and residents in the facility were provided with appropriate care by staff. An example of an item used is "The nurses and personal carers have the skills to provide appropriate care." Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Data in relation to this scale was collected at both Time 1 and Time 2.

2.4. Data Analysis

Data were analysed using SPSS 16.0. The results section of the report contains information on both the descriptive statistical analyses and, inferential statistical analyses (specifically regression analysis) conducted on the different measures. More specific information on the analyses conducted for each measure is provided in the results section of the report.

2.5. Limitations of the Data

In a number of instances items are negatively skewed, for example resident aggression. For these reasons we have provided the dispersion of responses to the statement rather than relying solely on means and standard deviations. *Missing data* was treated as such and was not imputed.

3. Results

3.1. The Participants

Job Title

Time 1 & 2 Comparisons

The next table presents a comparison of the Time 1 and Time 2 job title data. The data indicates that overall there has been a slight decline in the numbers of registered nurses (RNs) and a slight increase in the number of personal care workers (PCWs) between Time 1 and Time 2. Within the RN category the most marked change has been in the numbers of Division 2 endorsed nurses and Division 2 non-endorsed nurses. The number of Division 2 endorsed nurses has increased by 4.6% whereas the number of Division 2 non-endorsed nurses has decreased by 3.7%.

Table 3.1.1

Job title (%)	Time 1	Time 2
RNs	81.5	80.6
<i>Div 1</i>	44.2	42.4
<i>Div 2 Endorsed</i>	13.0	17.6
<i>Div 2 Non-Endorsed</i>	24.3	20.6
Personal Care Workers (PCWs)	18.5	19.4

Group Comparisons – Organisation Type

The next table presents a comparison between Time 1 and Time 2 of the job title data across public and private facilities. Analyses revealed that at both Time 1 and Time 2 overall public facilities had significantly more registered nurses and significantly fewer PCWs as compared to private facilities. This is likely to be because public sector facilities have Enterprise Bargaining Agreement (EBA) ratio requirements. Importantly, whilst mandated ratios in the public sector have assisted in maintaining higher overall levels of Division 1 registered nurses, as compared to in the private sector, there has still been a decline in Division 1 registered nurses in public sector facilities between Time 1 and Time 2. These declines in Division 1 registered nurses have been accompanied by declines in the numbers of Division 2 non-endorsed nurses and rises in the numbers of Division 2 endorsed nurses at both public and private facilities. In public facilities there has also been a small increase in the numbers of PCWs between Time 1 and Time 2.

Table 3.1.2

Public Facilities – Job title (%)	Time 1	Time 2
RNs	86.6	86.1
<i>Div 1</i>	46.1	43.8
<i>Div 2 Endorsed</i>	14.1	19.1
<i>Div 2 Non-Endorsed</i>	26.4	23.2
Personal Care Workers (PCWs)	13.4	13.9
Private Facilities – Job title (%)	Time 1	Time 2
RNs	75.5	73.6
<i>Div 1</i>	40.5	37.9
<i>Div 2 Endorsed</i>	11.8	16.2
<i>Div 2 Non-Endorsed</i>	23.2	19.5
Personal Care Workers (PCWs)	24.5	26.4

Additional Participant Information

The next table presents additional information on the participants at Time 2. Please note that Time 1 data is not available to enable comparisons across time to be made for these items.

Table 3.1.3

Shift worked (%)	Time 2 Total Sample
AM	37.1
PM	19.3
Night	18.7
Rotating	24.9
Number of days worked per week (%)	
5 or fewer days	91.9
6-7 days	8.1
Hours worked per day (%)	
5 or fewer	3.0
6-7 hours	24.3
8 hours	37.8
8 or more hours	35.0

Table 3.1.3 (cont)

Average number of weekends worked per month (%)	
0 weekends	25.0
1 weekend	10.6
2 or more weekends	64.4
Average number of double shifts worked per month (%)	
0 double shifts	91.6
1 double shift	4.8
2 or more double shifts	3.5
Average number of breaks during a shift (%)	
No breaks	11.1
1 break	47.2
2 or more breaks	41.7
Average length of breaks during a shift (%)	
Shorter than 20 minutes	50.9
20 minutes or longer	49.1
Gross annual income (%)	Time 2 Total Sample
\$25,000 or less	14.2
\$25,001 - \$35,000	30.2
\$35,001 - \$45,000	20.4
\$45,001 - \$55,000	20.4
\$55,001 - \$65,000	6.4
\$65,001 - \$75,000	3.2
\$75,001 - \$85,000	2.8
\$85,001 - \$95,001	0.9
\$95,001 or more	1.5

Group Comparisons – Job Type

The following table presents a comparison of the data in relation to each of the Time 2 participant variables across the four job categories; registered nurses Division 1 (RNs Div 1), registered nurses Division 2 Endorsed (RN Div 2s Endorsed), registered nurses Division 2 non-endorsed (RN Div 2s Non-Endorsed), and personal care workers (PCWs). Analyses revealed that there were no statistically significant differences between any of the job type categories in terms of shift worked, double shifts worked per month and length of breaks during a shift.

There were however statistically significant differences across the different job types for days worked per week, hours worked per day, weekends worked per month, and number of

breaks taken during a shift. In relation to days worked per week PCWs were significantly more likely to work 6-7 days as compared to participants in the other three job categories. In terms of hours worked per day Division 1 registered nurses were significantly more likely to work 8 or more hours per day, while PCWs were significantly more likely to work 6-7 hours per day than participants from the other three job types. For weekends worked per month Division 1 registered nurses were significantly less likely to work two or more weekends per month compared to participants from the other three job types. Finally, in relation to number of breaks taken during a shift Division 1 registered nurses were significantly more likely to have no breaks and significantly less likely to have two or more breaks than participants from the other three job types.

Table 3.1.4

Shift worked (%)	RN Div 1s	RN Div 2s Endorsed	RN Div 2s Non-Endorsed	PCWs
AM	40.5	42.6	28.8	32.7
PM	18.1	13.8	21.6	25.0
Night	20.7	13.8	24.3	12.5
Rotating	20.7	29.8	25.2	29.8
Number of days worked per week (%)	RN Div 1s	RN Div 2s Endorsed	RN Div 2s Non-Endorsed	PCWs
5 or fewer days	95.6	90.5	93.7	83.7
6-7 days	4.4	9.5	6.3	16.3
Hours worked per day (%)	RN Div 1s	RN Div 2s Endorsed	RN Div 2s Non-Endorsed	PCWs
5 or fewer	1.8	2.1	1.8	7.6
6-7 hours	11.5	23.2	25.5	52.4
8 hours	40.1	48.4	42.7	18.1
8 or more hours	46.7	26.3	30.0	21.9
Average number of weekends worked per month (%)	RN Div 1s	RN Div 2s Endorsed	RN Div 2s Non-Endorsed	PCWs
0 weekends	36.4	17.9	17.3	13.5
1 weekend	11.8	13.7	6.4	9.6
2 or more weekends	51.8	68.4	76.4	76.9
Average number of double shifts worked per month (%)	RN Div 1s	RN Div 2s Endorsed	RN Div 2s Non-Endorsed	PCWs
0 double shifts	93.4	87.2	95.5	87.4
1 double shift	5.3	6.4	0.0	7.8
2 or more double shifts	1.3	6.4	4.5	4.9

Table 3.1.4 (cont)

Average number of breaks during a shift (%)	RN Div 1s	RN Div 2s Endorsed	RN Div 2s Non-Endorsed	PCWs
No breaks	18.4	8.4	6.4	2.9
1 break	51.8	41.1	38.2	51.0
2 or more breaks	29.8	50.5	55.5	46.2
Average length of breaks during a shift (%)	RN Div 1s	RN Div 2s Endorsed	RN Div 2s Non-Endorsed	PCWs
Shorter than 20 minutes	62.3	51.6	51.8	40.2
20 minutes or longer	37.7	48.4	48.2	59.8

Group Comparisons – Organisation Type

The following table presents a comparison of the data in relation to each of the Time 2 participant variables across the three organisation types; public, private not for profit and private for profit. Analyses revealed that there were no statistically significant differences between any of the organisation type categories in terms of number of days worked per week, number of double shifts worked per month, length of breaks during a shift, and gross annual income.

There was a statistically significant difference between private not for profit facilities and public and private for profit facilities in terms of shifts worked with participants from private not for profit facilities significantly more likely to work the AM shift as compared to participants from the other two organisation types. The analyses also revealed that participants from public facilities were significantly different to participants from private not for profit and private for profit facilities in terms of hours worked per day and number of breaks taken during a shift. Participants who worked at public facilities were significantly more likely to work 8 hours per day and have 2 or more breaks during a shift as compared to participants from either private not for profit facilities or private for profit facilities.

Table 3.1.5

Shift worked (%)	Public	Private Not for Profit	Private for Profit
AM	25.4	50.3	34.9
PM	21.4	20.8	17.8
Night	15.9	13.8	22.4
Rotating	37.3	15.1	24.9
Number of days worked per week (%)	Public	Private Not for Profit	Private for Profit
5 or fewer days	96.1	91.8	90.9
6-7 days	3.9	8.2	9.1

Table 3.1.5 (cont)

Hours worked per day (%)	Public	Private Not for Profit	Private for Profit
5 or fewer	0.0	5.0	2.9
6-7 hours	4.7	27.7	32.9
8 hours	63.3	32.7	27.9
8 or more hours	32.0	34.6	36.2
Average number of double shifts worked per month (%)	Public	Private Not for Profit	Private for Profit
0 double shifts	92.9	93.0	90.8
1 double shift	4.7	5.1	4.2
2 or more double shifts	2.4	1.9	5.0
Average number of breaks during a shift (%)	Public	Private Not for Profit	Private for Profit
No breaks	6.2	11.9	13.3
1 break	36.7	50.3	50.8
2 or more breaks	57.0	37.7	35.8
Average length of breaks during a shift (%)	Public	Private Not for Profit	Private for Profit
Shorter than 20 minutes	50.0	54.8	55.9
20 minutes or longer	50.0	45.2	44.1
Gross annual income (%)	Public	Private Not for Profit	Private for Profit
\$25,000 or less	7.8	14.8	16.9
\$25,001 - \$35,000	24.2	35.5	30.1
\$35,001 - \$45,000	29.7	14.8	19.1
\$45,001 - \$55,000	24.2	21.3	18.2
\$55,001 - \$65,000	6.2	3.2	8.9
\$65,001 - \$75,000	2.3	4.5	2.5
\$75,001 - \$85,000	2.3	1.9	3.4
\$85,001 - \$95,001	2.3	0.6	0.0
\$95,001 or more	0.8	3.2	0.8

Summary: The Participants

Overall at both Time 1 and Time 2 majority of participants were registered nurses with there being an increase in Division 2 endorsed nurses and a decrease in Division 2 non-endorsed nurses between Time 1 and Time 2. At Time 2 there were significantly fewer registered nurses employed in private not for profit and private for profit facilities as compared to public

facilities. The greatest percentage of participants worked the AM shift, with the overwhelming majority of participants working five or fewer days and 8 or more hours per day. Most participants worked two or more weekends per month but most did not work double shifts. Just over 11 per cent of participants did not have any breaks during their shifts, with the majority of participants who did have breaks having ones that were less than 20 minutes in length. Just over 85 per cent of participants had a gross annual income of \$55,000 or less.

In the job type comparisons PCWs were significantly more likely to work 6-7 days as compared to participants in the other job categories. In terms of hours worked per day Division 1 registered nurses were significantly more likely to work 8 or more hours per day, while PCWs were significantly more likely to work 6-7 hours per day. For weekends worked per month Division 1 registered nurses were significantly less likely to work two or more weekends per month. Finally, in relation to number of breaks taken during a shift Division 1 registered nurses were significantly more likely to have no breaks and significantly less likely to have two or more breaks than participants from the other job categories.

In the organisation type comparisons there was a statistically significant difference between private not for profit facilities and public and private for profit facilities in terms of shifts worked with participants from private not for profit facilities significantly more likely to work the AM shift as compared to participants from the other two organisation types. The analyses also revealed that participants who worked at public facilities were significantly more likely to work 8 hours per day and have 2 or more breaks during a shift as compared to participants from either private not for profit facilities or private for profit facilities.

3.2. The Workplace

Registered Nurse to Resident Ratio Comparisons

The next series of tables and graphs depict the mean² registered nurse to resident ratio for both Time 1 and Time 2 based on the type of care provided by the facility (mixed or high), the type of organisation the facility is (public, private not for profit or, private for profit) and the timing of the shift (AM, PM or, night)³. At Time 2 there were only six participants who worked in low care facilities. This sample is too small for meaningful comparisons to be made across time and consequently, comparisons can only be made between mixed care and high care facilities.

Table 3.2.1 Time 1 Mixed Care Facilities

Shift	Organisation Type		
	Public	Private Not for Profit	Private for Profit
AM	1:17	1:21	1:23
PM	1:18	1:31	1:33
ND	1:21	1:36	1:39

² A mean is an average and is calculated by summing the responses of all participants and then dividing this total by the total number of participants.

³ Due to missing data issues, inaccuracies in participants' recollections in relation to the number of beds at their facility and registered nurses on each shift (e.g., it is likely some participants have not included In-Charge nurses) these ratio figures should be interpreted with caution.

Table 3.2.2 Time 2 Mixed Care Facilities

Shift	Organisation Type		
	Public	Private Not for Profit	Private for Profit
AM	1:13	1:18	1:22
PM	1:17	1:29	1:33
ND	1:15	1:40	1:47

Figure 3.2.1

Time 1 Mean RN to Resident Ratios at Mixed Care Facilities

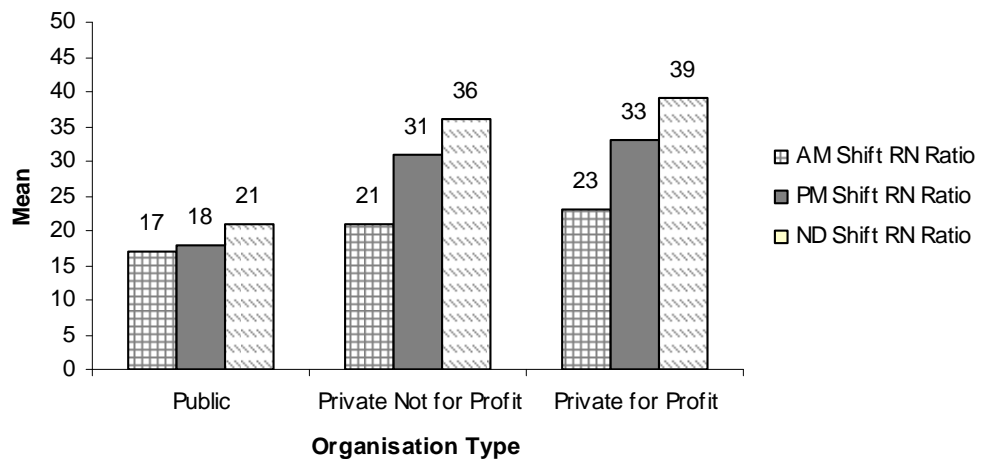


Figure 3.2.2

Time 2 Mean RN to Resident Ratios at Mixed Care Facilities

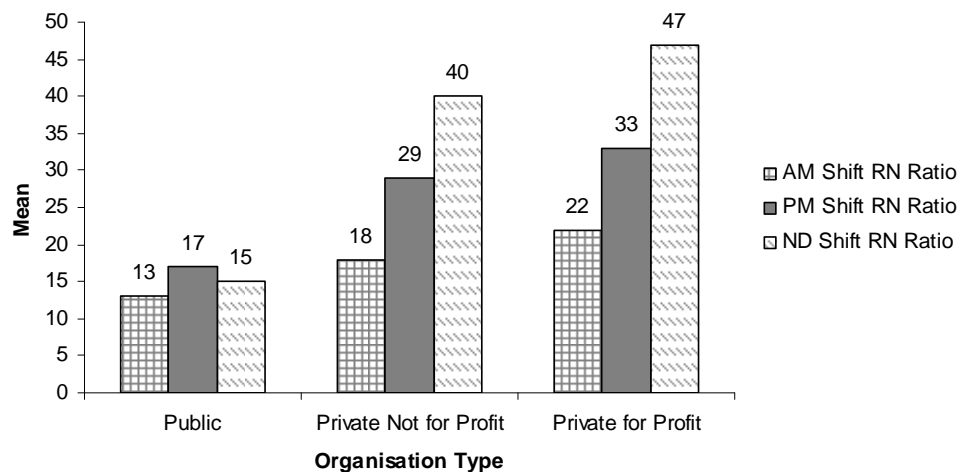


Table 3.2.3 Time 1 High Care Facilities

Shift	Organisation Type		
	Public	Private Not For Profit	Private for Profit
AM	1:6	1:17	1:16
PM	1:8	1:23	1:22
ND	1:14	1:29	1:29

Table 3.2.4 Time 2 High Care Facilities

Shift	Organisation Type		
	Public	Private Not For Profit	Private for Profit
AM	1:9	1:15	1:17
PM	1:10	1:23	1:24
ND	1:14	1:28	1:37

Figure 3.2.3

Time 1 Mean RN to Resident Ratios at High Care Facilities

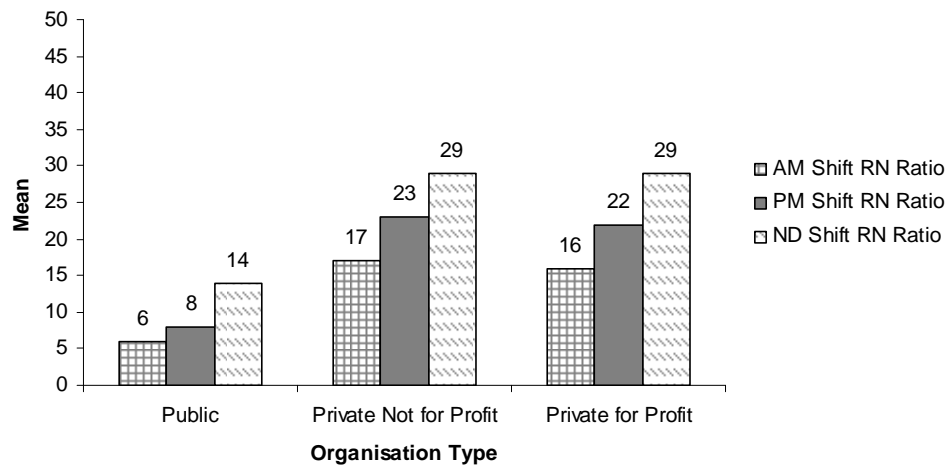
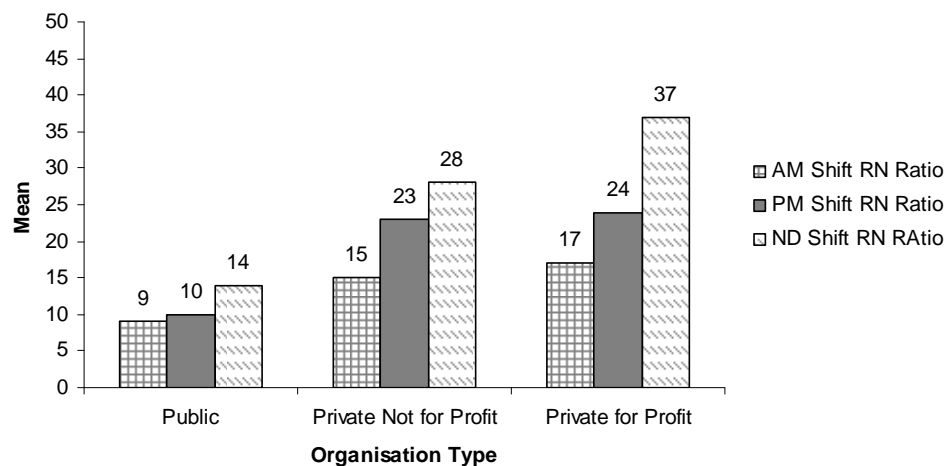


Figure 3.2.4

Time 2 Mean RN to Resident Ratios at High Care Facilities



Time 1 & 2 Comparisons

An additional set of analyses were performed to test whether the changes in ratios for each shift (i.e., AM, PM and, night) between Time 1 and Time 2 for each of the different facility types (i.e., mixed care, public; mixed care private not for profit; mixed care private for profit; high care, public; high care private not for profit; high care private for profit) were statistically significant⁴.

For mixed care public facilities the change from 17 to 13 residents per registered nurse on the AM shift approached statistical significance. The changes in relation to the PM and night shift for mixed care public facilities were not statistically significant. Similarly for mixed care private not for profit facilities the change from 21 to 18 residents per registered nurse on the AM shift was statistically significant but the changes in relation to the PM and night shift were not statistically significant. For mixed care private for profit facilities the change from 39 to 47 residents per registered nurse on the night shift was the only statistically significant change.

In high care public facilities the ratio changes in relation to both the AM and PM shift were statistically significant. The ratio levels for this type of facility for the night shift remained constant between Time 1 and Time 2. There were no statistically significant changes in ratio levels for any of the shifts for high care private not for profit facilities. Finally for high care private for profit facilities the only statistically significant change in ratio levels was for the night shift where the ratio went from 1:29 at Time 1 to 1:37 at Time 2.

Group Comparisons – Organisation Type

Analyses revealed that across the two different types of care provision (mixed or high) in private not for profit and private for profit facilities each registered nurse had more residents to care for as compared to the public facilities where each registered nurse had to care for fewer residents.

Registered Nurse to Resident Ratios as Predictors of Outcomes

A set of statistical analyses (regressions) was conducted to determine the extent to which the Time 2 average registered nurse to resident ratios for each of the shifts (averaging across the different organisation types and types of care provided) predicted worker, organisational and resident related outcomes. As part of the analyses the possible influence of a number of employee/facility variables was also controlled.

The analyses revealed that in relation to worker and organisational outcomes registered nurse to resident ratios on the AM shift significantly predicted job satisfaction, turnover intentions and levels of emotional exhaustion experienced by participants. The greater number of residents there were for each registered nurse to care for during the AM shift the more likely individuals were to be dissatisfied with their job, intend to leave their current job, and frequently feel emotionally exhausted as a result of their job.

In relation to resident outcomes the registered nurse to resident ratio for the AM shift was a significant predictor of both facility satisfaction and resident safety. The more residents there were for each registered nurse to care for on the AM shift the lower facility satisfaction was and the poorer resident safety was. On the night shift the registered nurse to resident ratio significantly predicted resident care. Analyses revealed that where there were more

⁴ Statistical significance refers to the results of statistical tests which seek to assess whether objective differences reflect “real” differences versus differences that have occurred randomly or merely by chance. If a finding is statistically significant it indicates that there is a 95% probability that the difference is “real” as opposed to being merely random.

residents for each registered nurse to care for on the night shift, individuals felt that the resident care at their facility was poorer.

Division 2 Registered Nurses in Coordinator Positions

This question asked participants to indicate if their facility employed Division 2 registered nurses in care/coordinator positions. Participants who answered “Yes” to this question were then asked to indicate if these Division 2 nurses also had line authority over aspects of Division 1 registered nurses’ practice. Please note that Time 1 data is not available to enable comparisons across time to be made for these items.

Across the total sample the majority of participants indicated that their facility did not employ Division 2 registered nurses in care/coordinator positions. The majority of participants also indicated that if Division 2 registered nurses were employed in care/coordinator positions at their facility that these individuals did not also have line authority over aspects of Division 1 registered nurses’ practice.

Additional analyses revealed that in relation to type of care provided by the facility that high care facilities were significantly less likely to employ Division 2 registered nurses in care/coordinator positions. However, if these facilities did employ Division 2 registered nurses in care/coordinator positions they were significantly more likely than mixed care facilities to designate that these individuals had line authority over aspects of Division 1 registered nurses’ practice.

In relation to organisation type additional analyses revealed that public facilities significantly differed from private not for profit and private for profit facilities in their use of Division 2 registered nurses in care/coordinator positions. Specifically, the majority of participants from public facilities reported that their facility did not employ Division 2 registered nurses in care/coordinator positions. Similarly, public facilities also differed significantly from private not for profit and private for profit facilities in the authority given to Division 2 registered nurses in care/coordinator positions. Specially, in public facilities these individuals were much less likely to have line authority over aspects of Division 1 registered nurses’ practice.

Table 3.2.5 Division 2 Registered Nurses in Coordinator Positions

Does your facility employ Div 2 RNs in care/coordinator positions? (%)	Mixed Care	High Care	Public	Private Not for Profit	Private for Profit	Total
Yes	57.7	36.6	18.8	60.3	50.2	45.9
No	42.3	63.4	81.2	39.7	49.8	64.1
If yes, do they have line authority over aspects of Div 1 RNs’ practice? (%)	Mixed Care	High Care	Public	Private Not for Profit	Private for Profit	Total
Yes	36.1	45.6	34.8	40.5	41.2	39.0
No	63.9	54.4	65.2	59.5	58.8	61.0

Management of Infectious Disease Outbreaks

This question asked participants to indicate how their facility managed the outbreak of infectious diseases. Please note that Time 1 data is not available to enable comparisons across time to be made for this item.

Most participants across the three organisation types reported that their facility managed outbreaks of infectious diseases by following the Federal Government's guidelines. Additional analyses revealed that there were no significant differences between the three different types of organisations types in relation to how they managed outbreaks of infectious diseases.

Table 3.2.6 Management of Infectious Disease Outbreaks

How does your facility manage outbreaks of infectious diseases? (%)	Public	Private Not for Profit	Private for Profit	Total
By following the Federal Government's guidelines on preventing, identifying, & managing outbreaks of gastroenteritis.	49.2	61.4	56.8	56.5
By following an internal policy.	10.5	3.9	9.8	8.6
Facility does both.	40.3	34.6	33.4	34.9

Changes to job in the last 12 months

This question assessed the extent to which participants had experienced four different types of changes to their job in the last 12 months. The four types of changes were; *multi-skilling* (having undergone additional training to enable them to provide a broader range of care skills), *role extending* (had been required to take on new tasks that may have previously been undertaken by others, e.g., medication administration), *increased managerial functions* (had been required to take on managerial tasks that were previously undertaken by others e.g., supervision of other employees), and *nurse grade dilution* (tasks they were previously responsible for were now the responsibility of other employees with fewer qualifications). Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Appendix A provides the individual items for each of the different scales. Please note that Time 1 data is not available to enable comparisons across time to be made for these items.

The following graphs indicate the means for each type of job change for both the total sample and the different groups based on job type (Division 1 registered nurses, Division 2 endorsed registered nurses, Division 2 non-endorsed registered nurses, PCWs) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate greater experience of the job change in the last 12 months.

Across the total sample participants reported experiencing increased managerial functions and multi-skilling the most. In relation to job type, overall Division 2 endorsed registered nurses reported experiencing significantly higher levels of multi-skilling, role extending and increases in managerial functions compared to participants in the other three job categories. In relation to nursing grade dilution personal care workers experienced significantly lower levels than participants from the other three job categories.

In relation to organisation type comparisons the only significant difference was in relation to the extent to which participants from the different types of organisations reported experiencing nursing grade dilution. Specifically, participants from public facilities reported significantly lower levels of nursing grade dilution as compared to participants from private not for profit and private for profit facilities.

Figure 3.2.5

[1=Strongly Disagree; 2=Disagree; 3=Disagree Somewhat; 4=Neither Agree or Disagree; 5=Agree Somewhat; 6=Agree; 7=Strongly Agree]

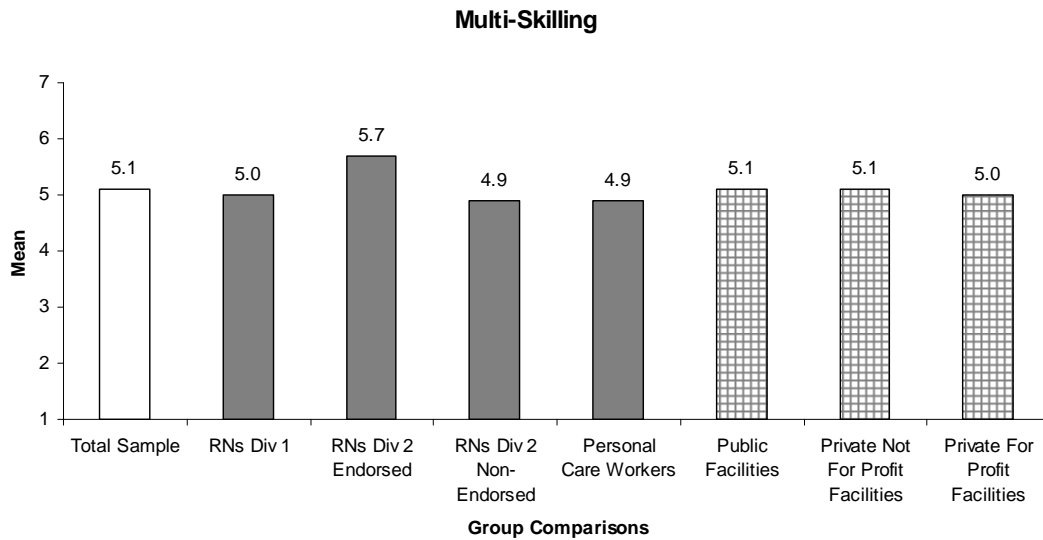


Figure 3.2.6

[1=Strongly Disagree; 2=Disagree; 3=Disagree Somewhat; 4=Neither Agree or Disagree; 5=Agree Somewhat; 6=Agree; 7=Strongly Agree]

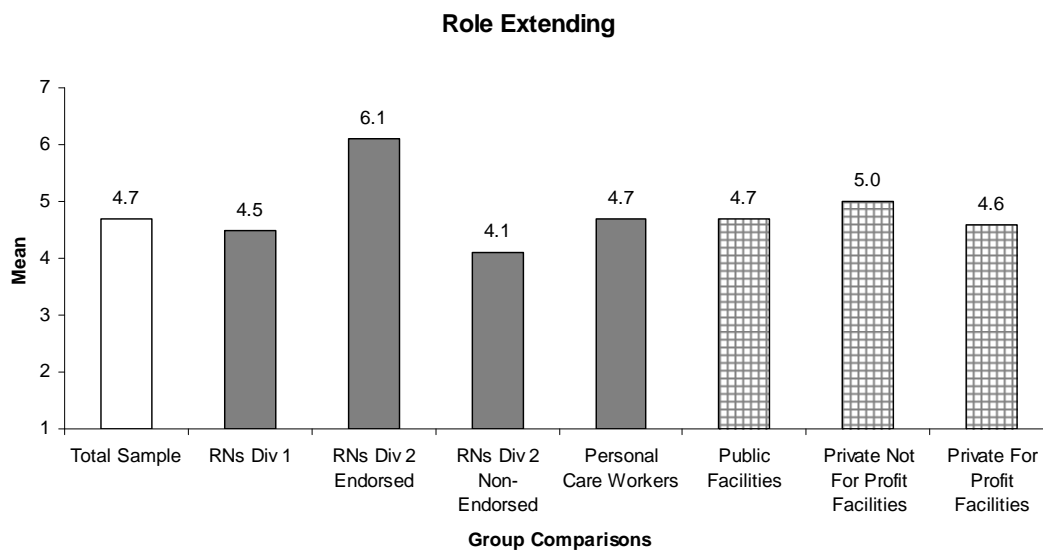


Figure 3.2.7

[1=Strongly Disagree; 2=Disagree; 3=Disagree Somewhat; 4=Neither Agree or Disagree; 5=Agree Somewhat; 6=Agree; 7=Strongly Agree]

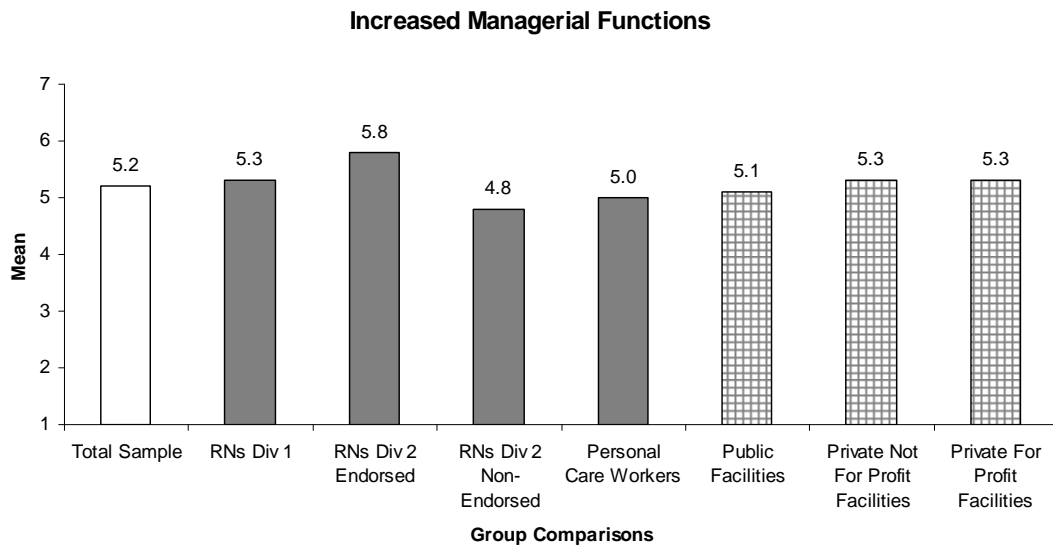
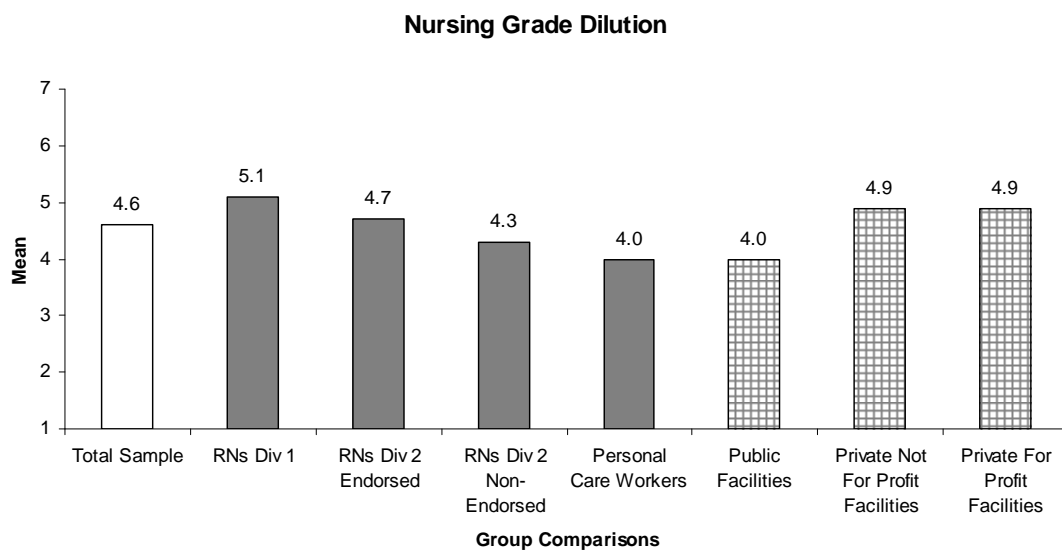


Figure 3.2.8

[1=Strongly Disagree; 2=Disagree; 3=Disagree Somewhat; 4=Neither Agree or Disagree; 5=Agree Somewhat; 6=Agree; 7=Strongly Agree]



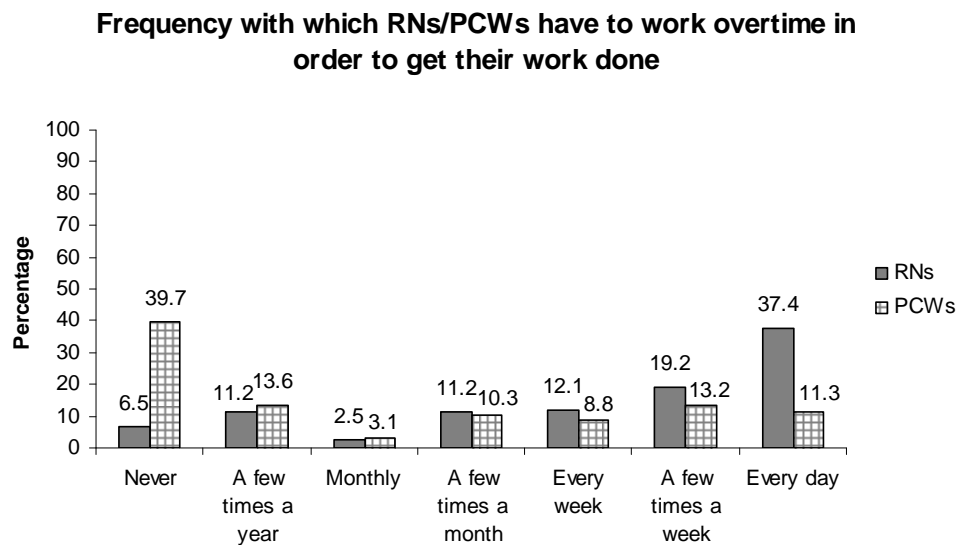
Frequency with which overtime has to be worked

These two questions asked participants to indicate the frequency with which registered nurses and PCWs at their facility had to work overtime in order to get their work done. Participants were asked to record their responses using a scale which ranged from 1 (Never) to 7 (Every Day). Please note that Time 1 data is not available to enable comparisons across time to be made for these items.

The following graph indicates the dispersion of responses based on the entire sample for each of the two overtime questions. Overall participants reported that registered nurses (both Division 1 & 2 combined) as compared to PCWs had to work overtime in order to get their work done more frequently.

Figure 3.2.9

RN Mean: 5.2 PCW Mean: 3.2
 RN SD: 2.0 PCW SD: 2.3

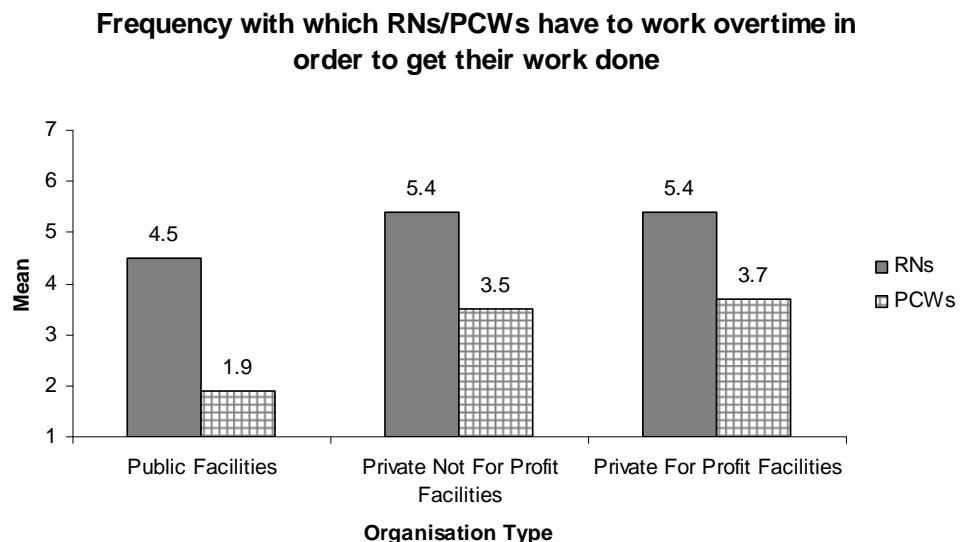


Group Comparisons – Organisation Type

The following graph indicates the means for both registered nurses (both Division 1 & 2 combined) and PCWs for the three different organisation types. Higher scores indicate overtime had to be worked more frequently. The frequency with which overtime had to be worked was significantly lower at public facilities for both registered nurses and PCWs.

Figure 3.2.10

[1= Never; 2=A few times a year; 3=Monthly; 4=A few times a month; 5=Every week; 6=A few times a week; 7=Every day]



Accreditation Standards

This question asked participants if they *felt* like their facility was currently meeting accreditation standards. Please note that Time 1 data is not available to enable comparisons across time to be made for this item.

Overall most participants across the three organisation types felt like their facility was currently meeting accreditation standards. Additional analyses revealed that participants who worked at public facilities were significantly more likely to feel that their facility was currently meeting accreditation standards as compared to participants from private for profit facilities. There were no other significant differences between the three organisation types.

Table 3.2.7 Accreditation Standards

Do you feel like your facility is currently meeting accreditation standards? (%)	Public	Private Not for Profit	Private for Profit	Total
Yes	90.4	87.5	81.0	84.9
No	9.6	12.5	19.0	15.1

Summary: The Workplace

At Time 1 registered nurse to resident ratios ranged from 1:6 to 1:39 while at Time 2 they ranged from 1:9 to 1:47. Significant differences were found between the Time 1 and Time 2 ratios in relation to the AM shift at mixed care, public facilities where the ratios went from 1:17 at Time 1 to 1:13 at Time 2. Significant differences between Time 1 and Time 2 were also found in mixed care, private not for profit facilities in relation to the am shift. In these facilities the ratio went from 1:21 at Time 1 to 1:18 at Time 2. Ratios at mixed care, private facilities on the night shift were also found to have significantly changed over time and went from 1:33 at Time 1 to 1:47 at Time 2. In high care, public facilities the ratio changes in relation to both the AM (Time 1=1:6, Time 2 =1:9) and PM (Time 1=1:8, Time 2 =1:10) shift were statistically significant. The ratio levels for this type of facility for the night shift remained constant between Time 1 and Time 2. There were no statistically significant changes in ratio levels for any of the shifts for high care private not for profit facilities. Finally for high care private for profit facilities the only statistically significant change in ratio levels was for the night shift where the ratio went from 1:29 at Time 1 to 1:37 at Time 2.

Registered nurse to resident ratios on AM shifts were significant predictors of job satisfaction, turnover intentions, emotional exhaustion, facility satisfaction, and resident safety. While on night shifts registered nurse to resident ratios significantly predicted resident care. In all cases the more residents each registered nurse had to care for the more negative or poorer the outcomes were. Many participants also commented on their questionnaire that they felt staffing levels were inadequate. In the words of one participant:

“I really hope one day the staff to resident ratios can be increased so there is more staff. We recently worked out that on average per shift we spend about 10 minutes or less in the 8 hours per resident! What a joke! HELP!”

Most participants indicated that Division 2 registered nurses were not employed in care/coordinator positions. Additional analyses revealed that high care facilities and public facilities were less likely to employ Division 2 registered nurses in this role. Most participants reported that their facility managed outbreaks of infectious diseases by following Federal Government guidelines with there being no significant differences found across the different types of organisations.

In relation to the types of job changes participants reported experiencing in the last 12 months overall participants reported experiencing increased managerial functions and multi-skilling the most. In relation to job type, overall Division 2 endorsed registered nurses

reported experiencing significantly higher levels of multi-skilling, role extending and increases in managerial functions compared to participants in the other three job categories. In relation to nursing grade dilution personal care workers experienced significantly lower levels than participants from the other three job categories. In relation to organisation type comparisons participants from public facilities reported significantly lower levels of nursing grade dilution as compared to participants from private not for profit and private for profit facilities. A number of participants also commented that recent changes to their job had negatively affected their ability to provide care for residents. In the words of one participant:

“I am doing the work of 5 people. My role has been extended because kitchen staff have left and not been replaced so now I have to give residents their food and drinks. The staff to resident ratio is extremely inadequate. It is impossible to do anything effectively under these conditions which are like something from the 3rd world. There is no one to replace sick/burnt out/exhausted staff so I am having to do double shifts. We are lucky to get any new staff because conditions are so bad. If staff complain they just get sacked. Nothing gets resolved and things just deteriorate.”

In regards to the frequency with which registered nurses or PCWs had to work overtime in order to get their work done, registered nurses reported having to work overtime significantly more frequently than PCWs with 37.4% of registered nurses having to work overtime every day. Overall registered nurses and PCWs from public facilities had to work overtime less frequently than participants from private not for profit or private for profit facilities.

Overall most participants reported feeling like their facility was meeting accreditation standards, with those participants from public facilities especially likely to report that accreditation standards were being met. A number of participants did however comment that the accreditation standards and system was not necessarily an accurate or adequate measure of the quality of care at their facility. For example in the words of one participant:

“My facility manages to meet accreditation standards because it “looks good on paper”, similarly another participant commented “Although the facility I work at meets accreditation standards I don’t actually believe these accreditation standards are an adequate measure of quality”.

3.3. Medication Practices

In order to assess the effect of recent changes to the administration of medications to residents this section of the survey asked participants to think about the practices related to medication administration in their facility. Below a summary in relation to each of the different scales used in this section of the survey is provided. Appendix A provides the individual items for each of the different scales.

Medication Administration by Non-Endorsed Div 2s

Participants were asked whether they had seen non-endorsed Division 2s administering medication from Dose Administration Aids (DAAs) (e.g., blister packs) without supervision at their facility. Please note that Time 1 data is not available to enable comparisons across time to be made for this item.

Overall most participants indicated that they had not seen Division 2 non-endorsed nurses at their facility administering medications from DAAs. Analyses revealed that participants were significantly more likely to have witnessed Division 2 non-endorsed nurses

administering medications from DAAs if they worked at a private not for profit facility or a private for profit facility than at a public facility.

Table 3.3.1

Have you seen Division 2 Non-Endorsed nurses at your facility administering medications from DAAs (e.g., blister packs)? (%)	Public	Private Not for Profit	Private for Profit	Total
Yes	9.8	39.7	27.5	26.5
No	90.2	60.3	72.5	73.5

DAAs Incorrectly Filled

Time 1 & 2 Comparisons

Participants were asked how often in the last 6 months Dose Administration Aids (DAAs; e.g., blister packs) had been incorrectly filled. At Time 1 participants were asked to record their responses using a scale which ranged from 1 (Less than once per month or never) to 5 (Several times per day). At Time 2 a slight variation was made to the scale with “Never” and “Less than once per month” being separated into two separate scale categories. The scale used at Time 2 therefore ranged from 1 (Never) to 6 (Several times per day). The following two graphs depict the dispersion of responses based on both the entire sample and also the different organisational categories (public, private not for profit, private for profit) for this item at Time 1 and Time 2. No more detailed statistical analyses could be performed to examine the differences between Time 1 and Time 2 because of the different scales used at each time point. However, between Time 1 and Time 2 there would appear to have been a slight increase in the number of participants reporting that DAAs were incorrectly filled at least once or twice a week. At Time 1 only 8.6% of participants reported DAAs being incorrectly filled this frequently while at Time 2 this figure had risen to 10.6%.

Figure 3.3.1

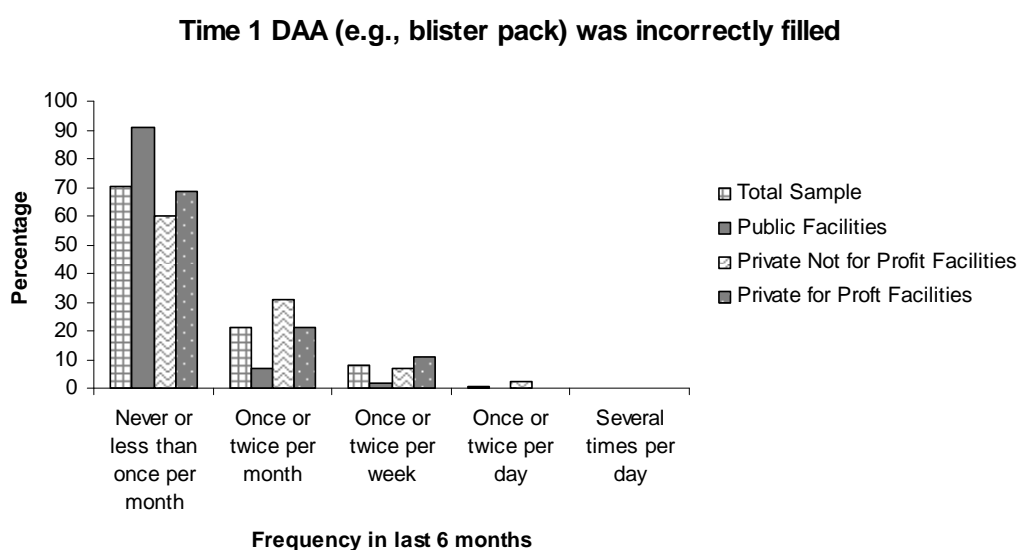
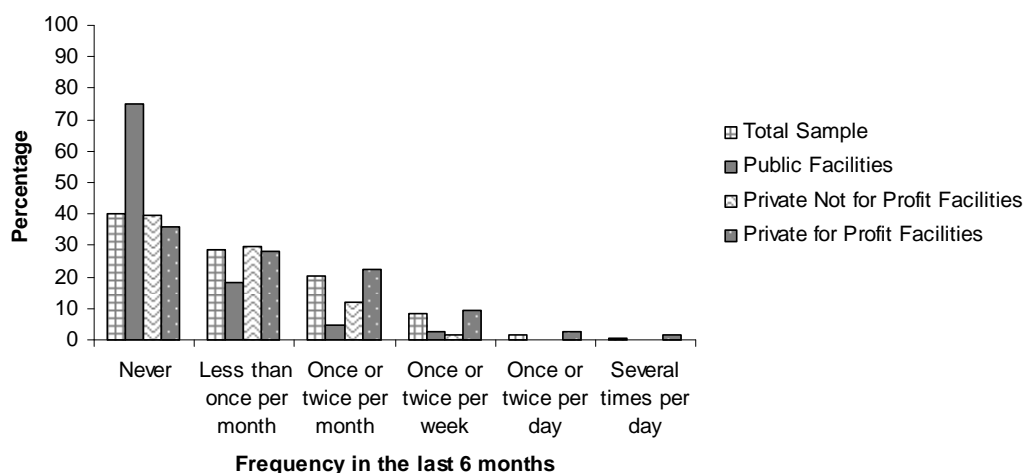


Figure 3.3.2

Time 2 DAA (e.g., blister pack) was incorrectly filled



Computerised Medication Management Systems

This question asked participants to indicate if their facility had a computerised medication management system. Please note that Time 1 data is not available to enable comparisons across time to be made for this item.

Overall most participants reported that their facilities did not currently have a computerised medication management system. Additional analyses revealed that there were not significant differences based on the type of organisation a participant worked in.

Table 3.3.2 Computerised Medication Management Systems

Do you have a computerised medication management system at your facility? (%)	Public	Private Not for Profit	Private for Profit	Total
Yes	15.9	13.0	15.1	14.6
No	84.1	87.0	84.9	85.4

Medication Errors

Total Sample

These items asked participants to indicate the frequency with which a series of different medication errors were made by individuals in four different job categories (RN Div 1s, RN Div 2s Endorsed, RN Div 2s Non-Endorsed, and PCWs) at their facility in the last 6 months. The response scale participants were asked to use ranged from 1 (Never) to 6 (Several times per day). The following graphs indicate the dispersion of responses in relation to each job category based on the entire sample for each scale item. Please note that Time 1 data is not available to enable comparisons across time to be made for these items.

Overall across the different job types the two most frequently cited medication errors were residents missing their medication and medication being given at the wrong time.

Figure 3.3.3

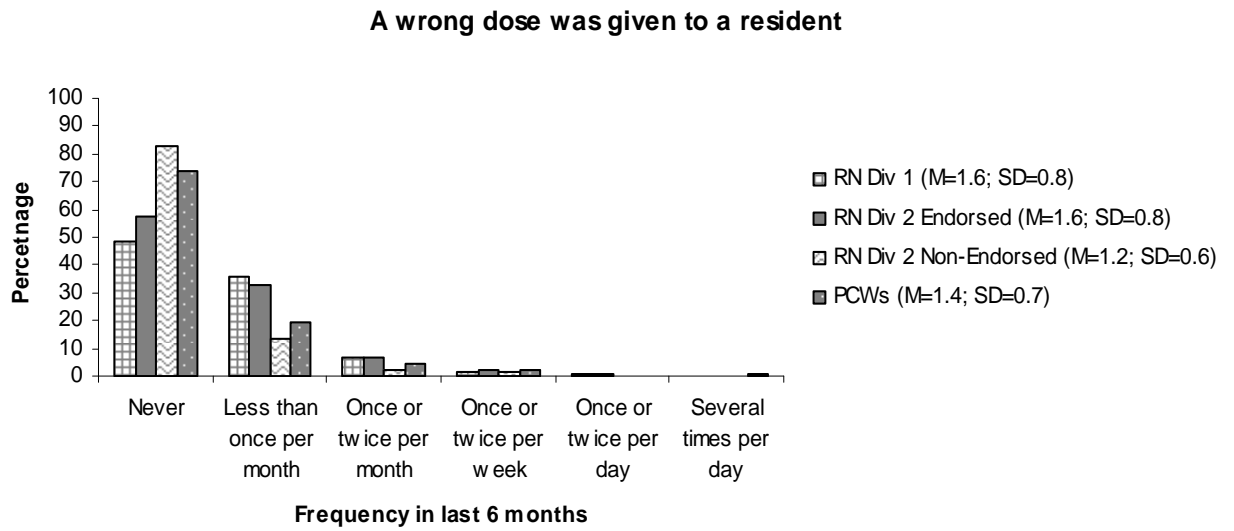


Figure 3.3.4

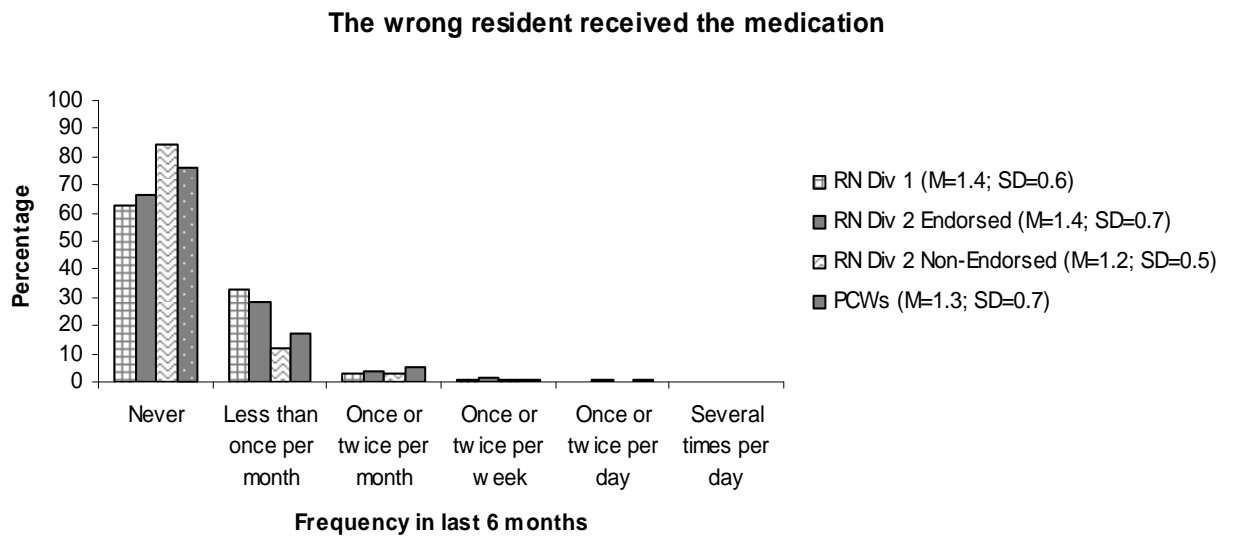


Figure 3.3.5

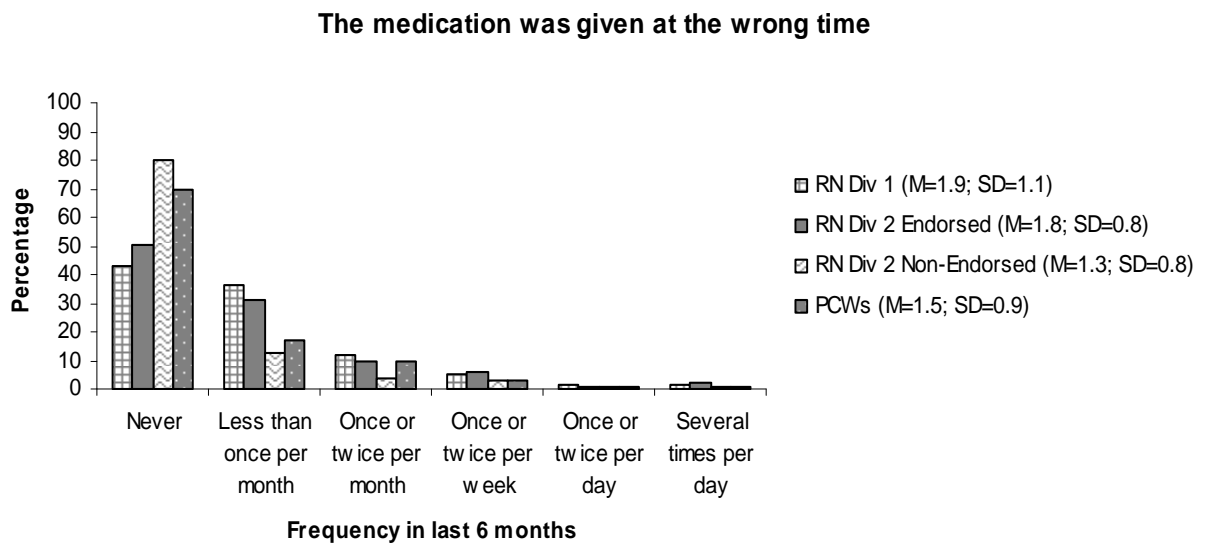


Figure 3.3.6

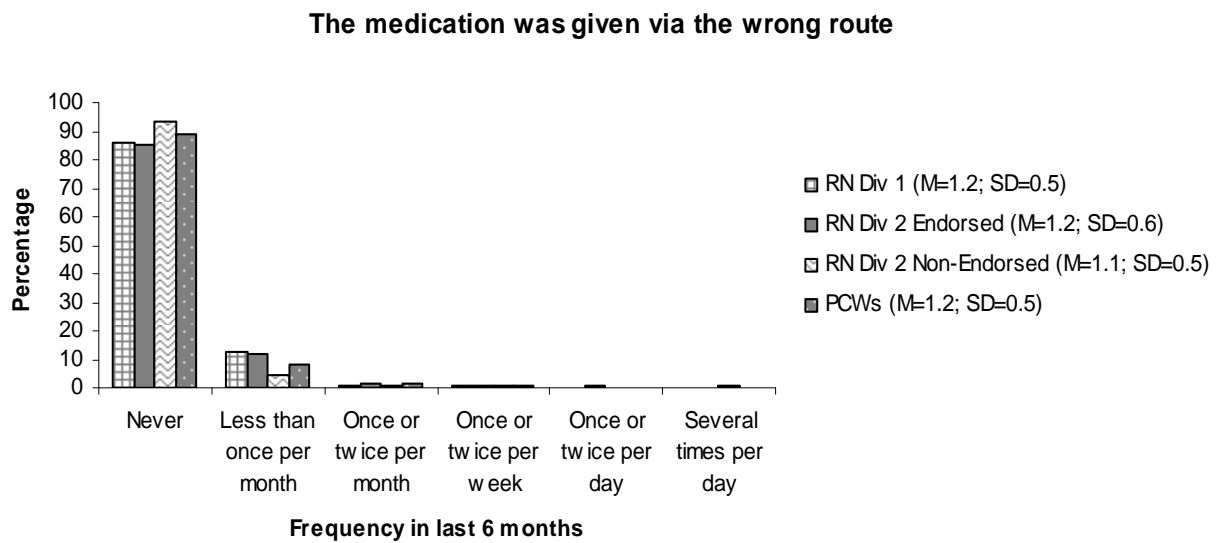


Figure 3.3.7

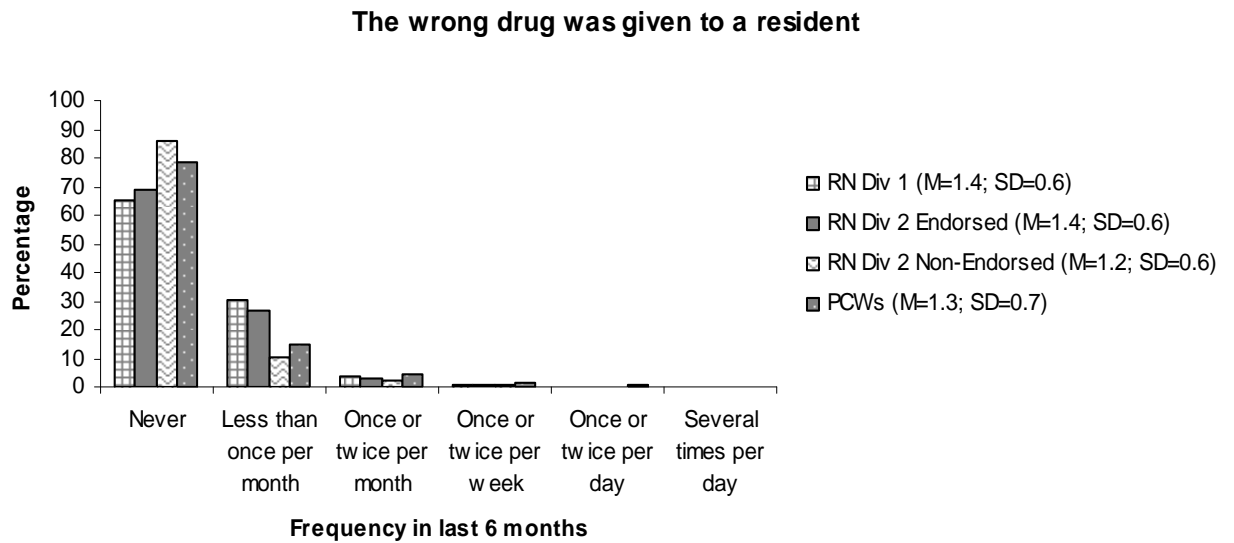
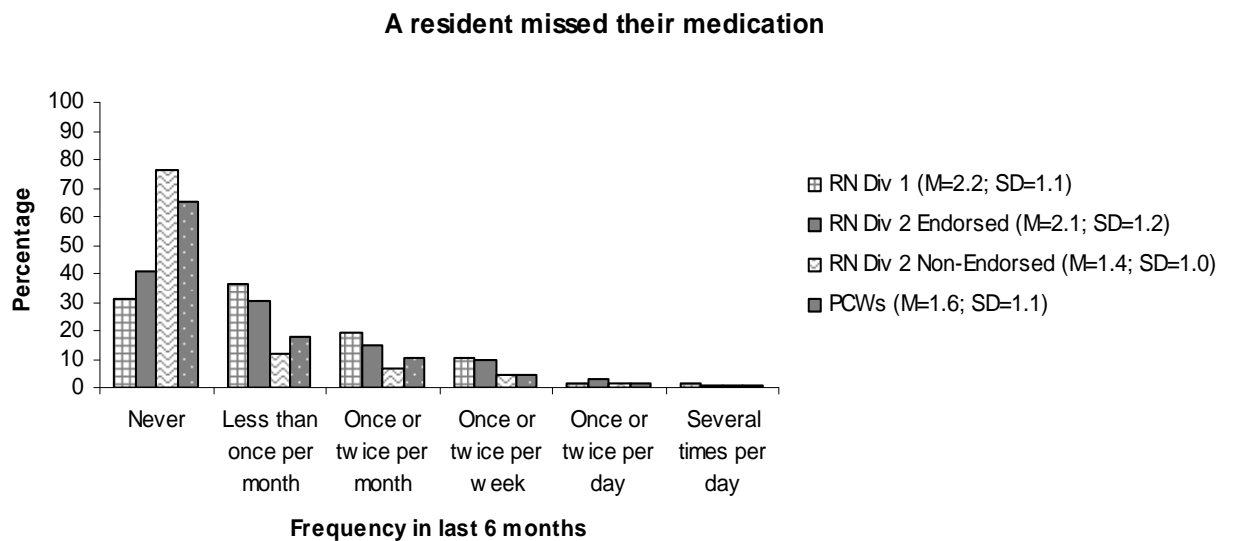


Figure 3.3.8



Group Comparisons – Organisation Type

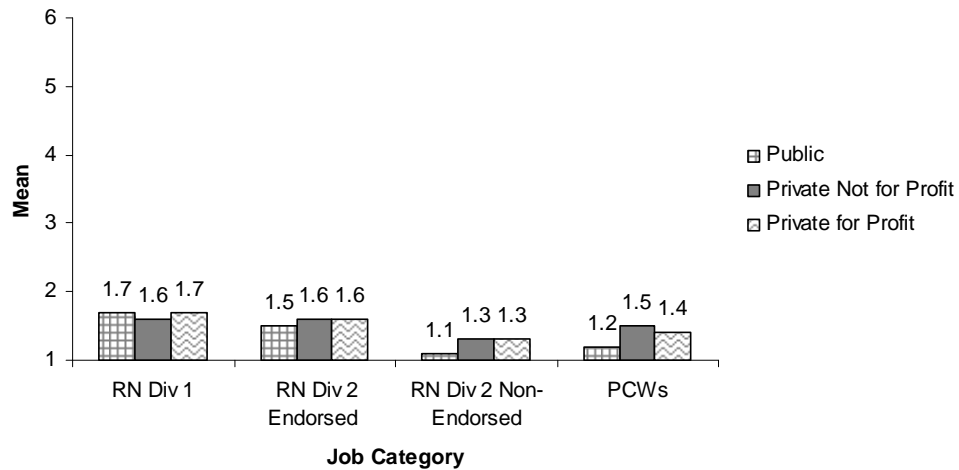
The following graphs present the Time 2 means for each of the different medication errors for the different groups based on organisation type. Higher scores indicate the medication error was made more frequently.

Overall analyses revealed that the frequency with which participants reported that either Division 1 registered nurses or Division 2 endorsed nurses at their facility made any of the different types of errors did not vary significantly based on the type of organisation they worked at.

Figure 3.3.9

[1=Never; 2=Less than once per month; 3=Once or twice per month; 4=Once or twice per week;; 5=Once or twice per day; 6=Several times per day]

A wrong dose was given to a resident

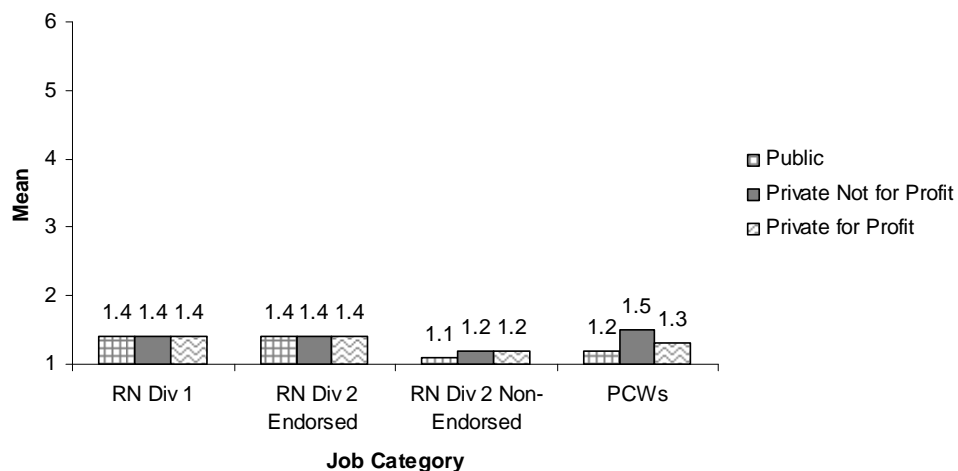


Analyses for this item revealed that there were no significant differences based on organisation type in relation to the frequency with which participants reported that Division 1 registered nurses, Division 2 endorsed nurses or non-endorsed nurses made this type of medication error. However, participants from public facilities did report that this type of error was made significantly less frequently by PCWs as compared to participants from private not for profit or private for profit facilities. This is potentially, in part, due to the fact there are extremely few PCWs employed at public facilities.

Figure 3.3.10

[1=Never; 2=Less than once per month; 3=Once or twice per month; 4=Once or twice per week;; 5=Once or twice per day; 6=Several times per day]

The wrong resident received the medication

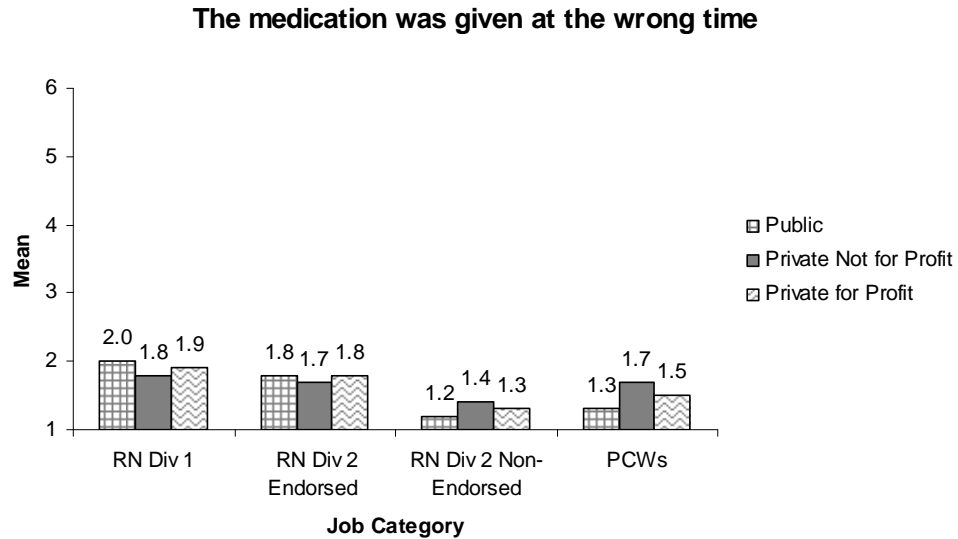


Analyses for this item revealed that there were no significant differences based on organisation type in relation to the frequency with which participants reported that Division 1 registered nurses, Division 2 endorsed nurses or non-endorsed nurses made this type of

medication error. However, participants from private not for profit facilities did report that this type of error was made significantly more frequently by PCWs as compared to participants from public or private for profit facilities. It is important to remember that there are extremely few PCWs employed at public facilities and this might, in part, explain this finding.

Figure 3.3.11

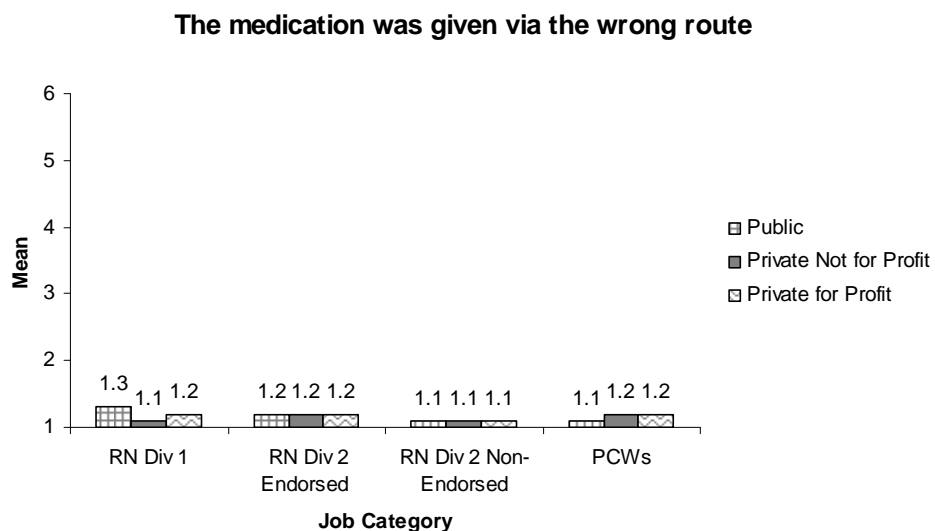
[1=Never; 2=Less than once per month; 3=Once or twice per month; 4=Once or twice per week;; 5=Once or twice per day; 6=Several times per day]



Analyses for this item revealed that there were no significant differences based on organisation type in relation to the frequency with which participants reported that Division 1 registered nurses, Division 2 endorsed nurses or non-endorsed nurses made this type of medication error. However, participants from private not for profit facilities did report that this type of error was made significantly more frequently by PCWs as compared to participants from public or private for profit facilities. It is important to remember that there are extremely few PCWs employed at public facilities and this might, in part, explain this finding.

Figure 3.3.12

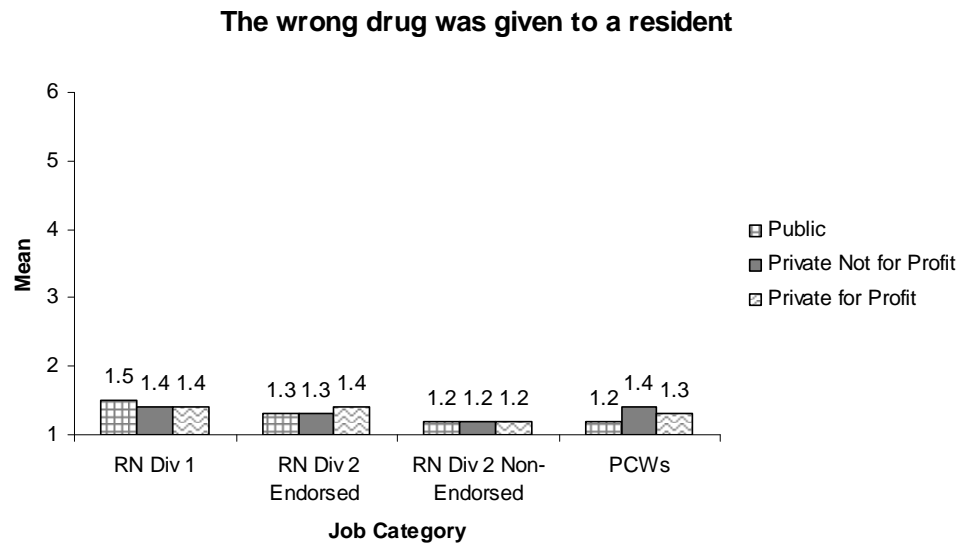
[1=Never; 2=Less than once per month; 3=Once or twice per month; 4=Once or twice per week;; 5=Once or twice per day; 6=Several times per day]



Analyses for this item revealed that there were no significant differences based on organisation type across any of the four job categories.

Figure 3.3.13

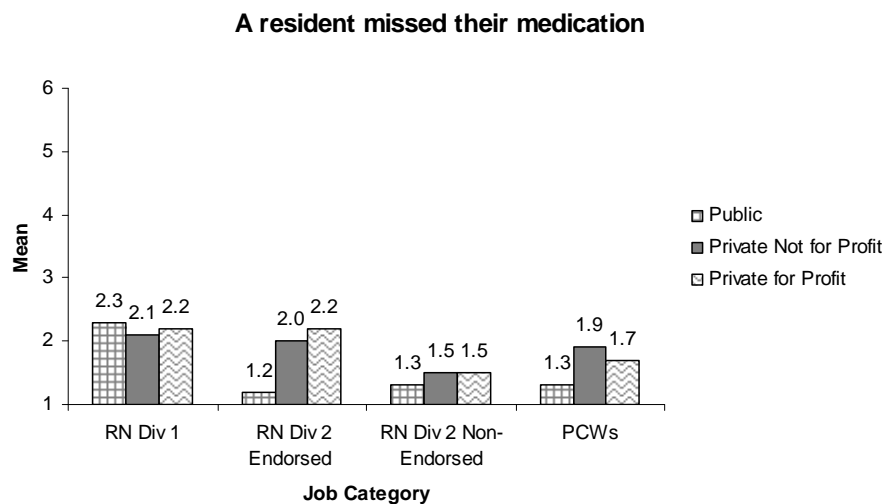
[1=Never; 2=Less than once per month; 3=Once or twice per month; 4=Once or twice per week;; 5=Once or twice per day; 6=Several times per day]



Analyses for this item revealed that there were no significant differences based on organisation type in relation to the frequency with which participants reported that Division 1 registered nurses, Division 2 endorsed nurses or non-endorsed nurses made this type of medication error. However, participants from public facilities did report that this type of error was made significantly less frequently by PCWs as compared to participants from private not for profit facilities. This is potentially, in part, due to the fact there are extremely few PCWs employed at public facilities.

Figure 3.3.14

[1=Never; 2=Less than once per month; 3=Once or twice per month; 4=Once or twice per week;; 5=Once or twice per day; 6=Several times per day]



Analyses for this item revealed that there were no significant differences based on organisation type in relation to the frequency with which participants reported that Division 1

registered nurses or Division 2 endorsed made this type of medication error. However, participants from public facilities did report that this type of error was made significantly less frequently by both Division 2 non-endorsed nurses and PCWs as compared to participants from private not for profit and private for profit facilities. This is potentially, in part, due to the fact there are extremely few PCWs employed at public facilities.

Summary: Medication Practices

Overall most participants indicated that they had not seen Division 2 non-endorsed nurses at their facility administering medications from DAAs. However, participants from private not for profit or private for profit facilities were more likely to have seen Division 2 non-endorsed nurses administer medications from DAAs than participants from public facilities.

At both Time 1 and Time 2 overall most participants indicated that DAAs were either never incorrectly filled or incorrectly filled less than once per month. Additionally, at both Time 1 and Time 2 participants from public facilities were significantly less likely to report that DAAs were incorrectly filled as compared to individuals from private not for profit and private for profit facilities. Across the entire sample most participants indicated that their facility did not have a computerised medication management system, with there being no significant differences based on organization type.

Across the entire sample the two most frequently observed medication errors were residents missing their medications and medications being given at the wrong time. In general participants from public facilities tended to report that medication errors were made less frequently compared to participants from private not for profit or private for profit facilities.

3.4. Workplace Aggression

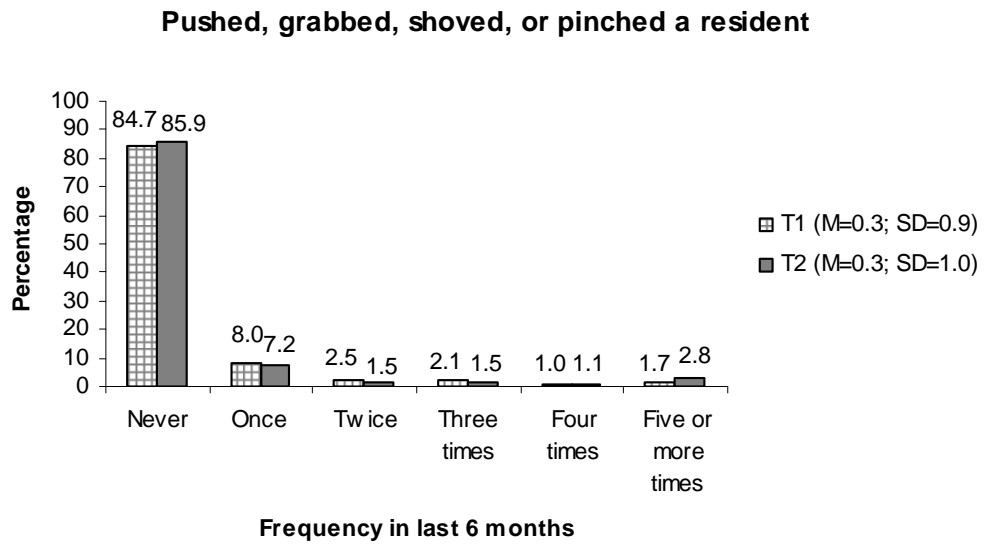
In this section of the survey participants were asked to assess the frequency with which they witnessed co-workers behaving aggressively towards residents and the frequency with which they experienced aggression from residents. Below a summary in relation to each of these different forms of aggression is provided. A bar chart for each scale indicating the dispersion of responses based on the entire sample for Time 1 and Time 2 is also provided. This is followed by comparisons for each of the scales across different job types (Registered Nurses, & Personal Care Workers) and organisation types (Public, Private Not for Profit, Private for Profit) at Time 2. Appendix A provides the individual items for each of the aggression scales.

Co-worker Aggression towards Residents

Time 1 & 2 Comparisons

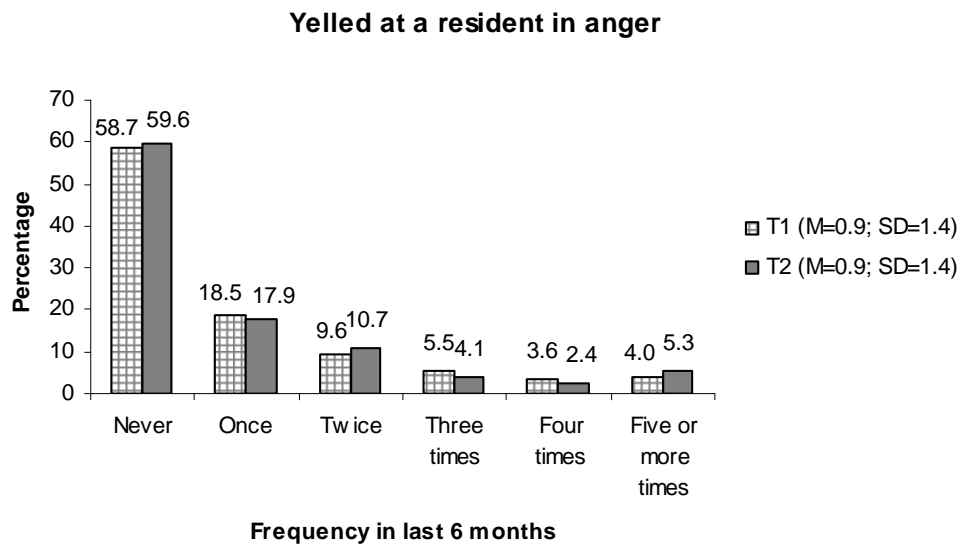
The items in this scale assessed how frequently in the past 6 months participants had witnessed co-workers behaving in either a verbally or physically aggressive way towards residents. Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times). The graphs that follow provide a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for each of the items in the scale.

Figure 3.4.1



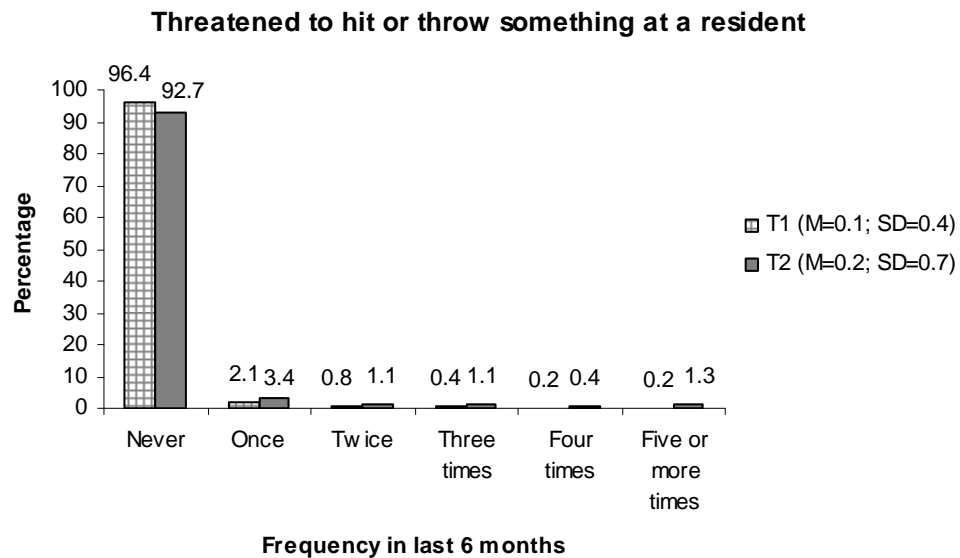
Overall there was no significant difference between Time 1 and Time 2 in how frequently participants reported witnessing co-workers push, grab, shove or pinch residents.

Figure 3.4.2



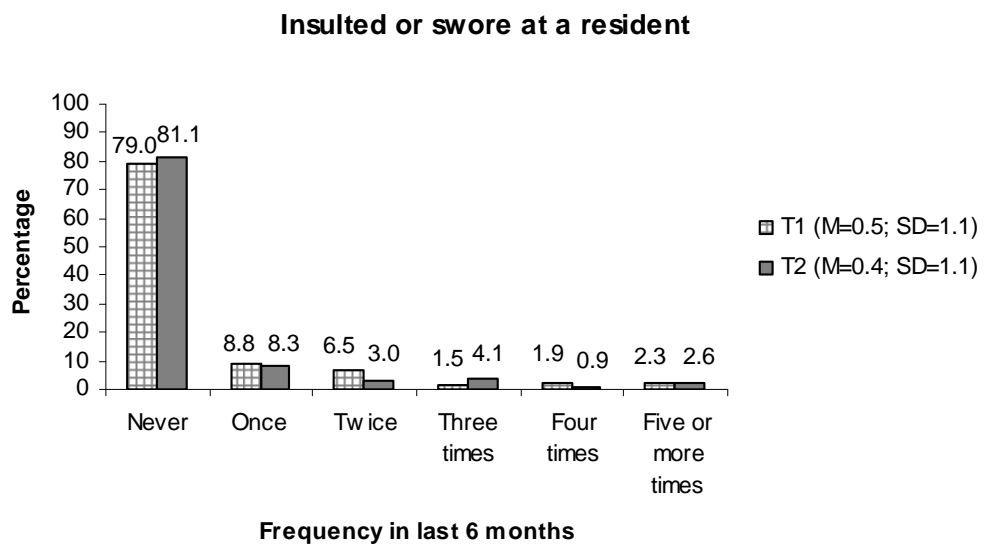
Overall there was no significant difference between Time 1 and Time 2 in how frequently participants reported witnessing co-workers yell at residents in anger.

Figure 3.4.3



Overall there was a significant difference between Time 1 and Time 2 in how frequently participants reported witnessing co-workers threaten to hit or throw something at a resident. At Time 2 participants reported witnessing co-workers threaten to hit or throw something at a resident significantly more frequently as compared to at Time 1.

Figure 3.4.4



Overall there was no significant difference between Time 1 and Time 2 in how frequently participants reported witnessing co-workers insult or swear at residents.

Group Comparisons – Job & Organisation Type

The following graphs present the Time 2 means for co-worker aggression for the different groups based on job type and organisation type. Higher scores indicate participants witnessed co-workers behaving aggressively towards residents more frequently in the past 6 months.

In the job type comparisons there were no significant differences in relation to the frequency with which registered nurses as compared to personal care workers reported witnessing co-workers behave in either a verbally or physically aggressive way towards residents. In relation to the organisation type comparisons there were also no significant differences for any of the items across the different categories.

Figure 3.4.5

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

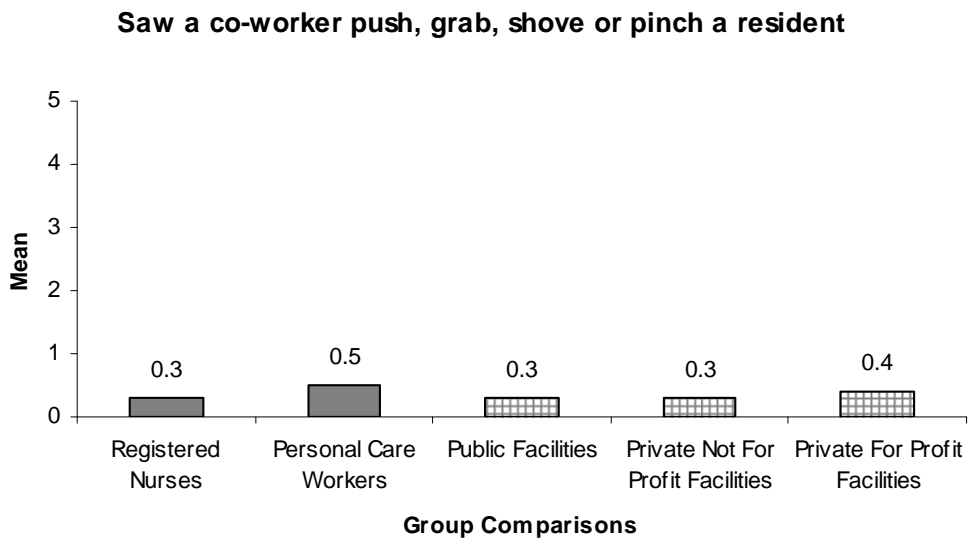


Figure 3.4.6

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

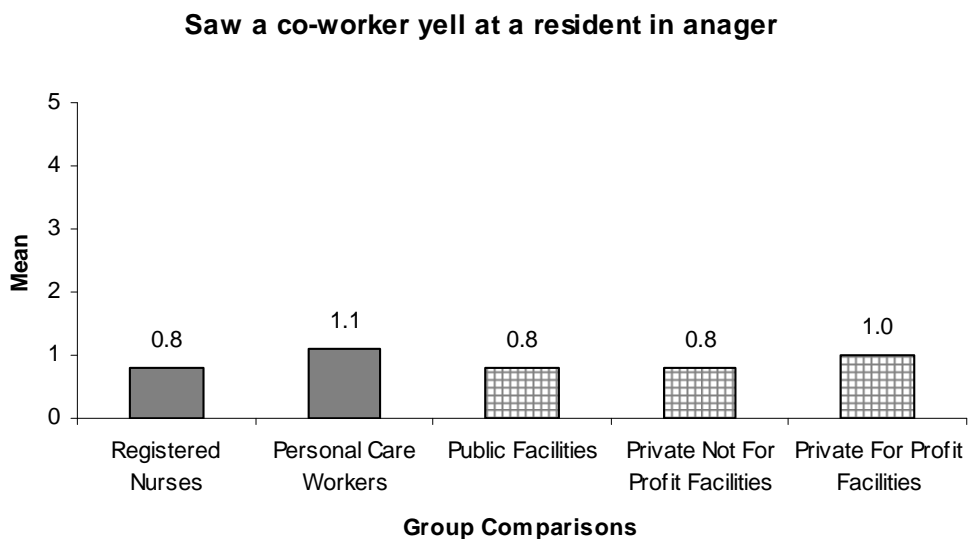


Figure 3.4.7

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

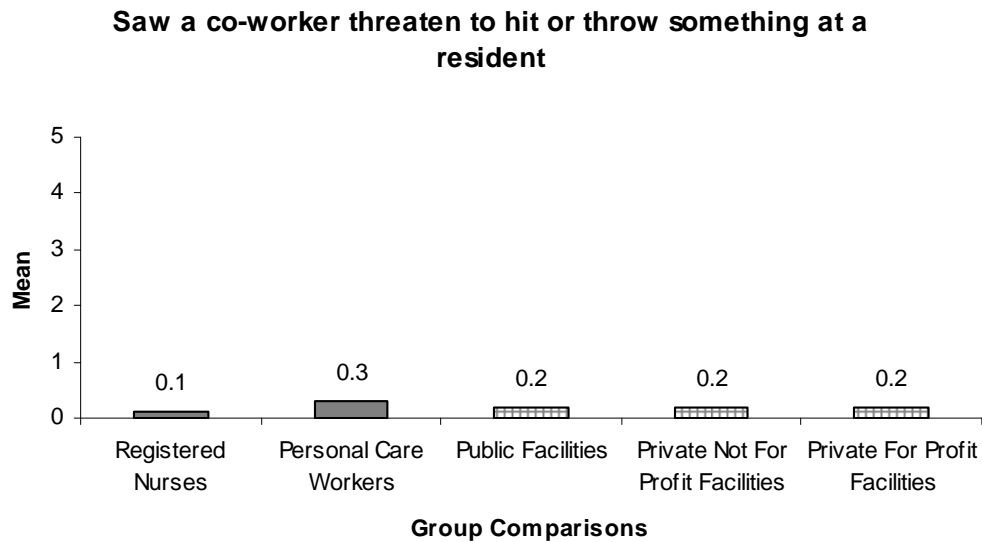
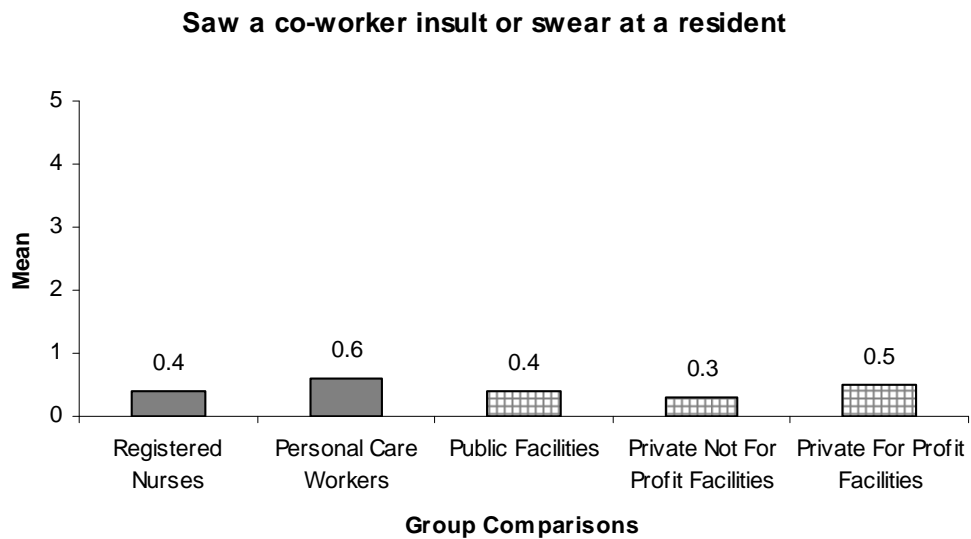


Figure 3.4.8

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

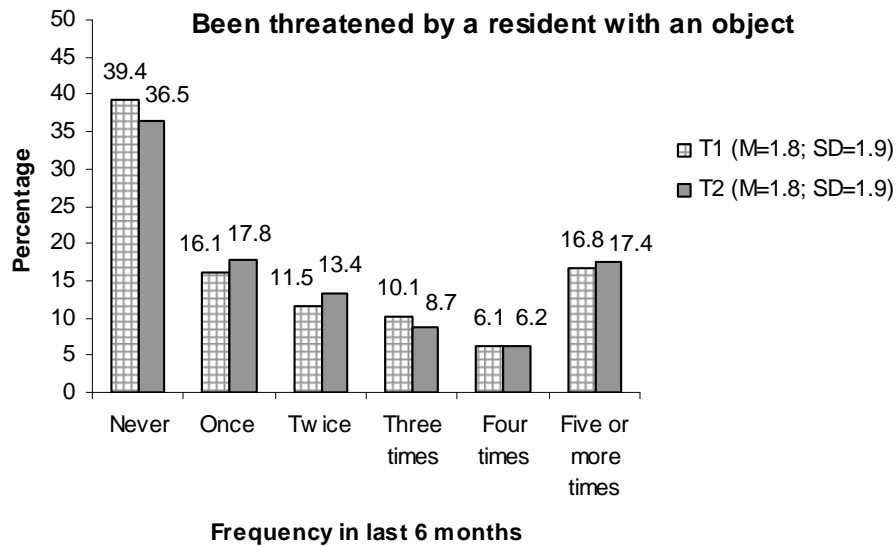


Resident Aggression

Time 1 & 2 Comparisons

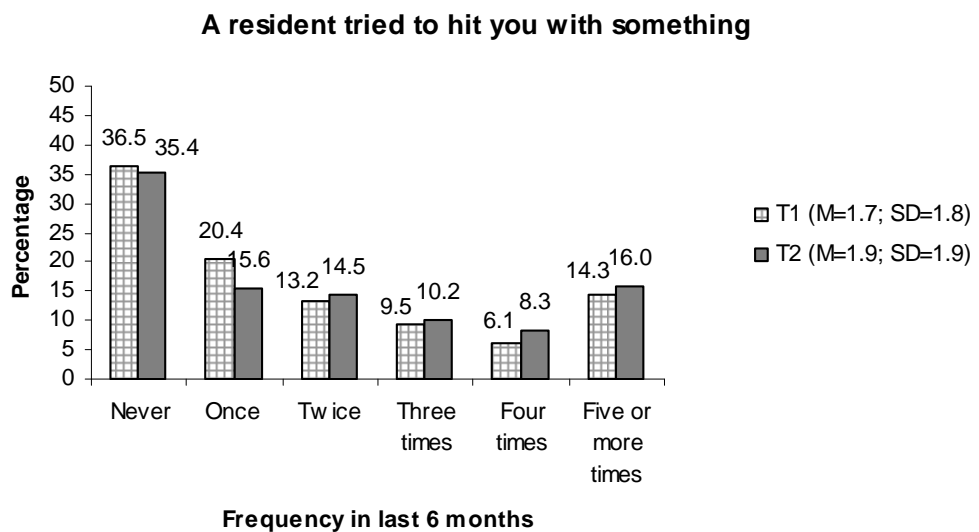
The items in this scale assessed how frequently in the past 6 months participants had personally experienced either verbal or physical aggression from residents. Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times). The following graphs provide a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for each of the items in the scale.

Figure 3.4.9



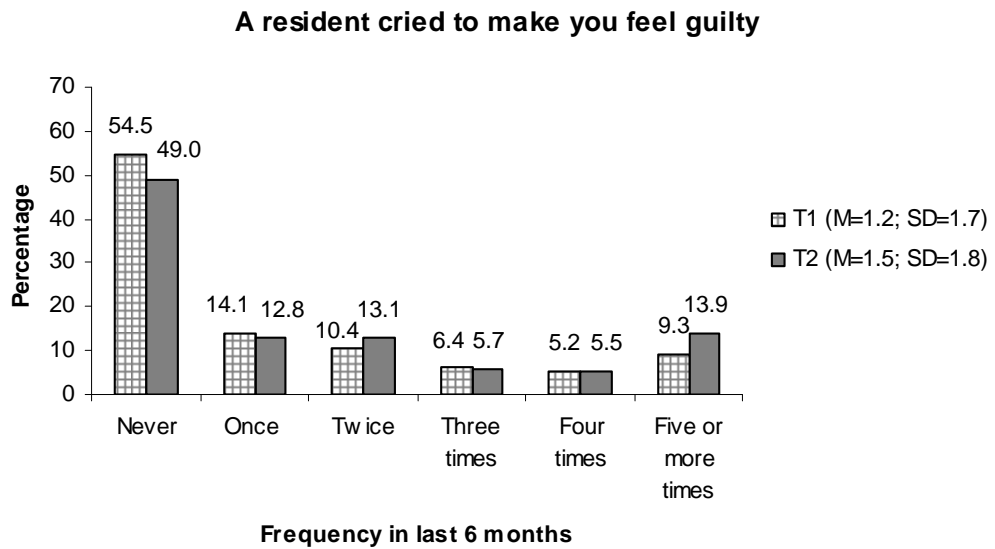
Overall there was no significant difference between Time 1 and Time 2 in how frequently participants reported being threatened by a resident with an object.

Figure 3.4.10



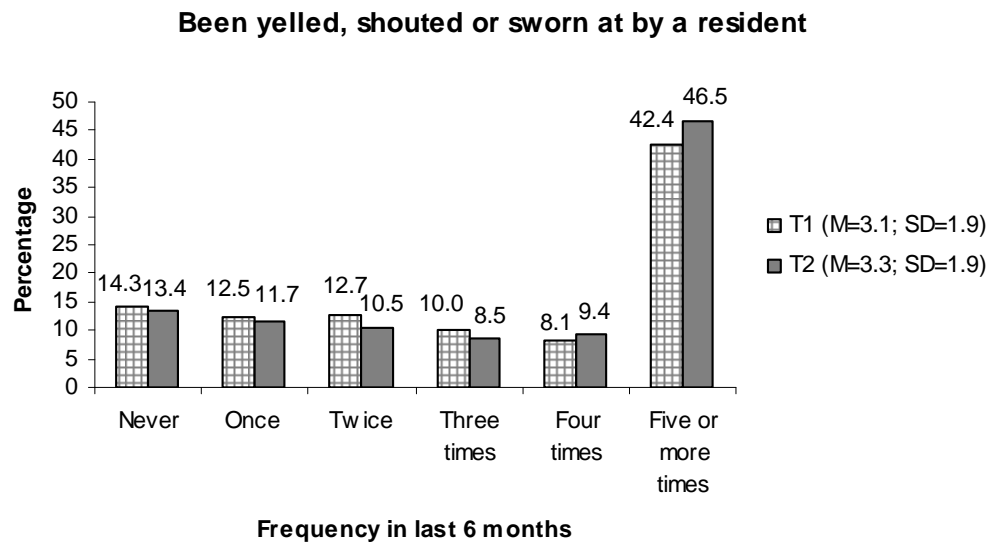
Overall the difference between Time 1 and Time 2 in relation to how frequently participants reported that a resident tried to hit them with something approached statistical significance. At Time 2 participants reported experiencing this form of aggressive behaviour from residents more frequently compared to at Time 1.

Figure 3.4.11



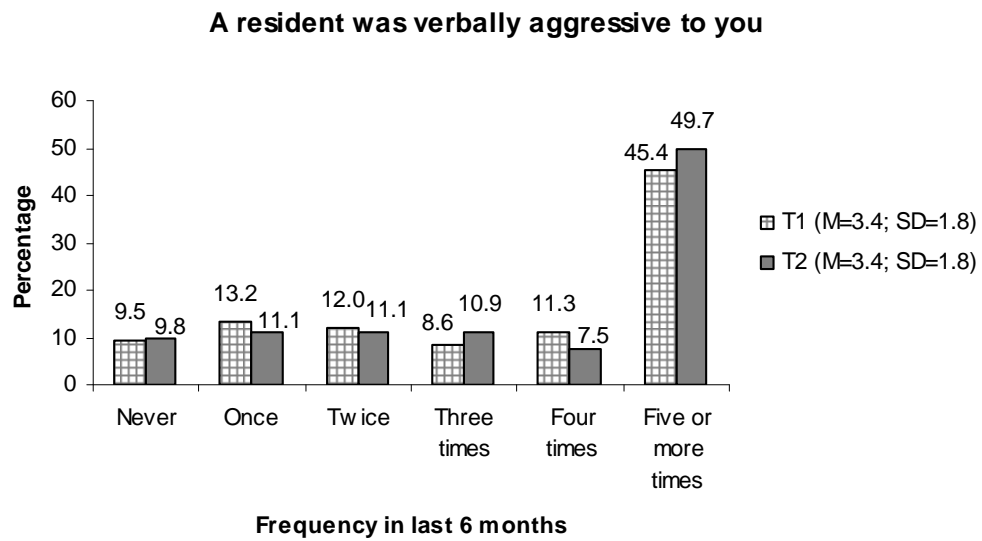
Overall the difference between Time 1 and Time 2 in relation to how frequently participants reported that a resident cried to make them feel guilty was significant. At Time 2 participants reported experiencing this form of aggressive behaviour from residents significantly more frequently compared to at Time 1.

Figure 3.4.12



Overall the difference between Time 1 and Time 2 in relation to how frequently participants reported that they had been yelled, shouted or sworn at by a resident approached statistical significance. At Time 2 participants reported experiencing this form of aggressive behaviour from residents more frequently compared to at Time 1.

Figure 3.4.13



Overall there was no statistically significant difference between Time 1 and Time 2 in how frequently participants reported that a resident had been verbally aggressive to them.

Group Comparisons – Job & Organisation Type

The following graphs present the Time 2 means for the resident aggression items for the different groups based on job type and organisation type. Higher scores indicate participants experienced aggression from residents more frequently in the past 6 months.

In relation to the job type comparisons personal care workers reported experiencing residents crying to make them feel guilty more frequently than did registered nurses. There were no other statistically significant differences based on job type. In relation to the organisation type comparisons participants who worked at private not for profit facilities reported significantly fewer incidents where they had been threatened with an object or hit with something by residents than did participants who worked in public or private for profit facilities. There were no other statistically significant differences based on organisation type.

Figure 3.4.14

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

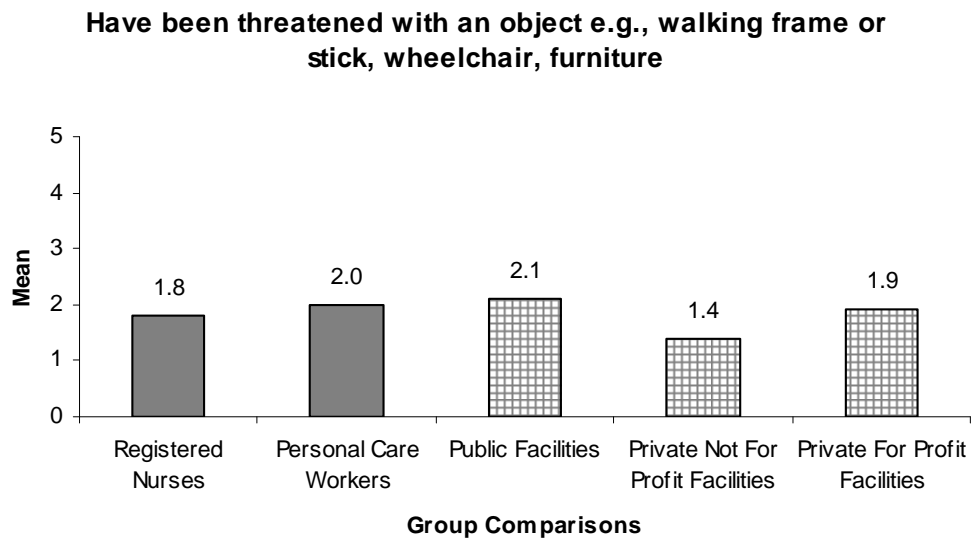


Figure 3.4.15

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

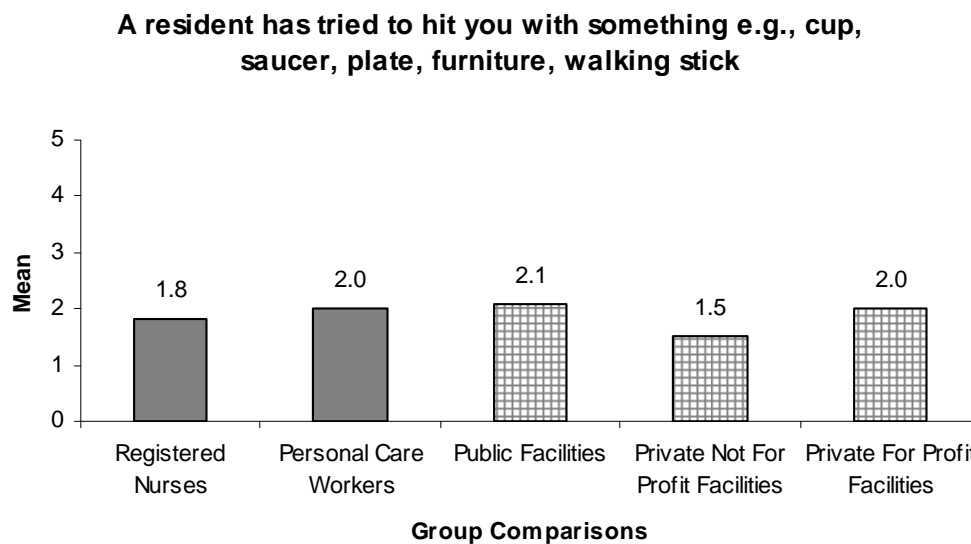


Figure 3.4.16

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

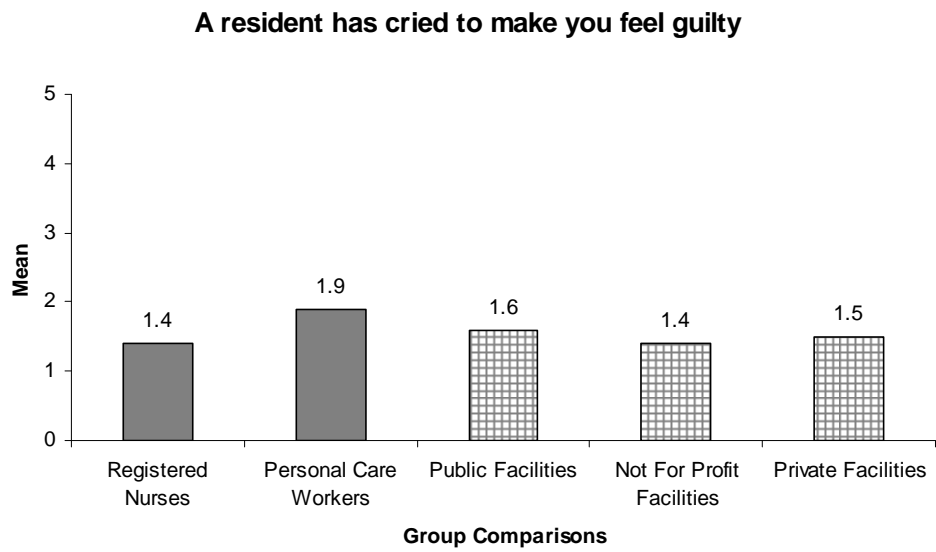


Figure 3.4.17

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]

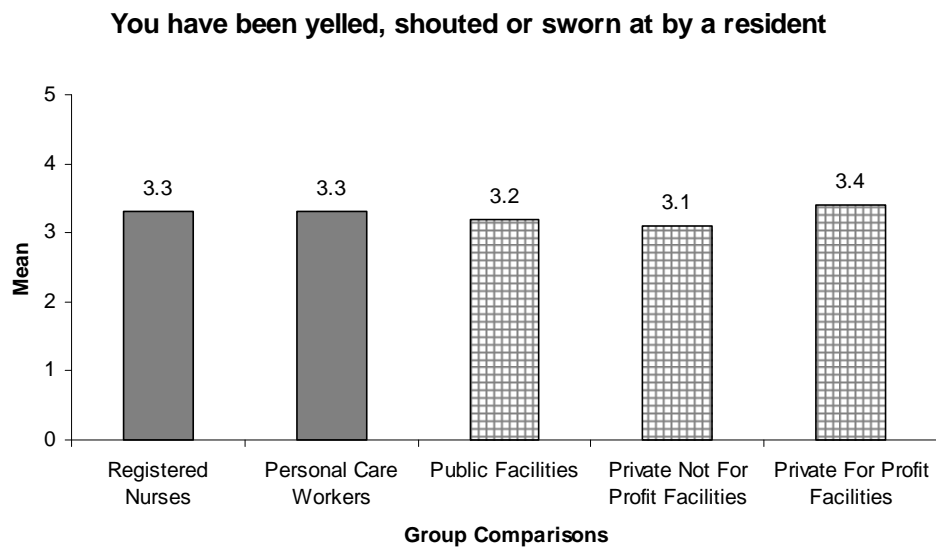
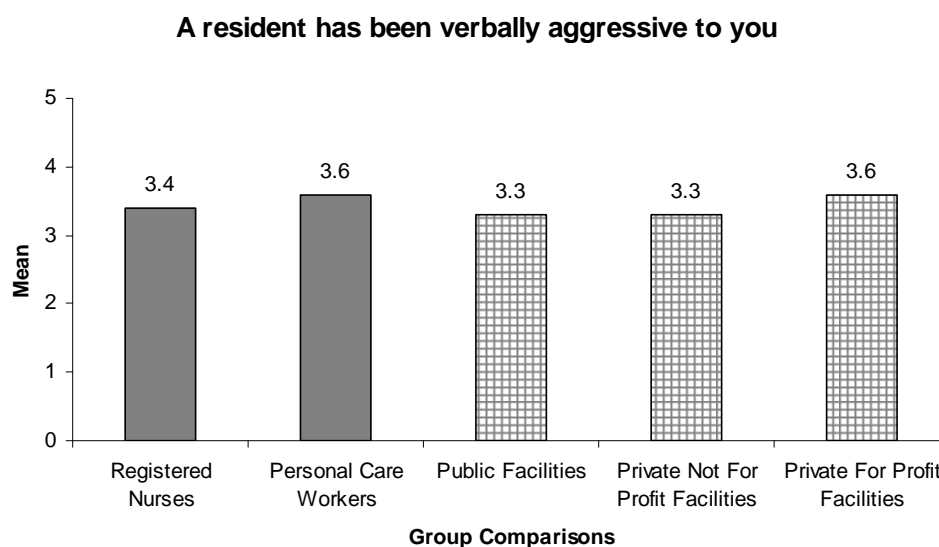


Figure 3.4.18

[0=Never; 1=Once; 2=Twice; 3=Three Times; 4=Four Times; 5=Five or More Times]



Summary: Workplace Aggression

Between Time 1 and Time 2 for co-worker aggression towards residents the only statistically significant difference was in relation to the frequency with which participants witnessed co-workers threatening to hit or throw something at a resident. At Time 2 participants reported witnessing this form of co-worker aggression more frequently than at Time 1. There were no statistically significant differences based on job or organisation type.

In relation to resident aggression at Time 2 participants reported experiencing residents trying to hit them with something, crying to make them feel guilty and shouting or swearing at them significantly more frequently than at Time 1. There were very few statistically significant differences based on job or organisation type.

3.5. Work, Psychological & Physical Health Outcomes

The scales in this section were designed to assess the extent to which participants were satisfied with their current job, intended to leave their current job, were committed to their current organisation, were emotionally exhausted as a result of their job, were functioning well psychologically and were exhibiting a range of different physical symptoms. A summary of each of these different outcomes is provided next. A bar chart for each scale indicating the dispersion of responses based on the entire sample for Time 1 and Time 2 is also provided. This is followed by comparisons for each of the scales across different job and organisation types at Time 2. Appendix A provides the individual items for each of the scales.

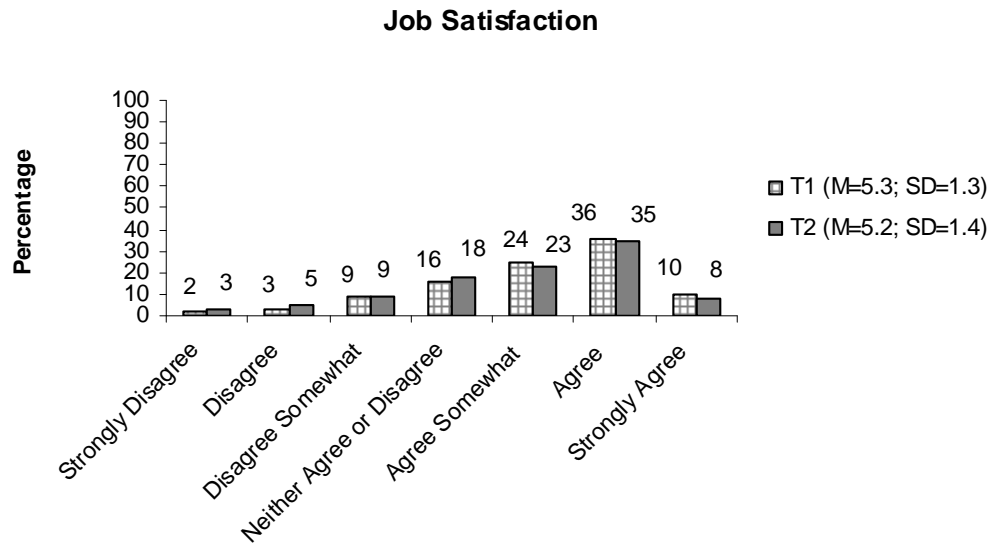
Job Satisfaction

Time 1 & Time 2 Comparisons

This scale assessed the extent to which participants were satisfied with their current job. An example of one of the items used in the scale is “All in all, I am satisfied with my job”. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). The following graph provides a comparison

between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.5.1



Overall the difference between Time 1 and Time 2 in relation to how satisfied participants reported being with their job was statistically significant. At time 2 participants reported feeling significantly less satisfied with their job as compared to at Time 1.

Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for job satisfaction for the different groups based on job type (Division 1 registered nurses, Division 2 Endorsed registered nurses, Division 2 Non-Endorsed registered nurses, PCWs) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate higher levels of job satisfaction.

In relation to the job type comparisons there were no statistically significant differences in the levels of job satisfaction reported by participants across the different categories. For the organisation type comparisons participants who worked in private for profit facilities reported significantly lower levels of job satisfaction than participants who worked in private not for profit facilities.

Figure 3.5.2

[1=Strongly Disagree; 2=Disagree; 3=Disagree Somewhat; 4=Neither Agree or Disagree; 5=Agree Somewhat; 6=Agree; 7=Strongly Agree]



Predictors of Job Satisfaction

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the degree to which individuals were satisfied with their job (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

- Significant Predictors of Job Satisfaction:
 - Employee/Facility Variables
 - Hours worked per day: The more hours per day an individual worked the less satisfied they were with their job.
 - Job Category: PCWs tended to be more satisfied with their jobs than registered nurses.
 - Work Stressors
 - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the less satisfied they were with their job.
 - Resident Aggression: The more frequently an individual experienced aggression from residents the less satisfied they were with their job.
 - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to also be less satisfied with their job.
 - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the

quality of living for residents were less likely to be satisfied with their job.

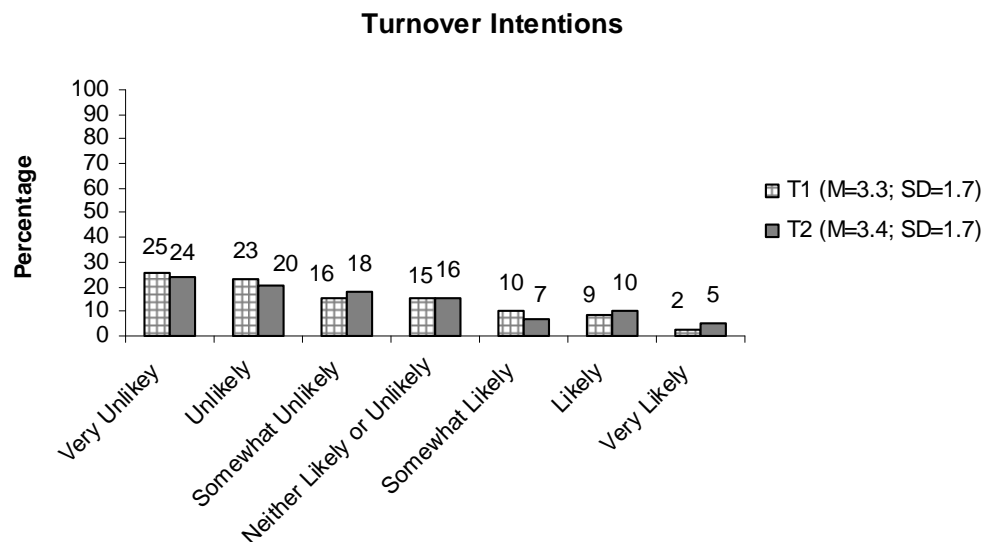
- Multi-Skilling: Individuals who had undergone additional training to enable them to provide a broader range of care skills were more satisfied with their jobs.
- Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to be satisfied with their job.
 - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more satisfied with their job.
- Overall the employee/facility variables accounted for 1.4% of the variance in job satisfaction. The work stressor variables and the management practices variables each accounted for an additional 36.7% and 9.5% of the variance respectively⁵.

Turnover Intentions

Time 1 & Time 2 Comparisons

This scale assessed the likelihood that participants would leave their current job and/or how much they would like to get a new job. An example of one of the items used in the scale is “How likely is it that you will look for a job outside of this organisation during the coming year?” Participants were asked to record their responses using a scale which ranged from 1 to 7. The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.5.3



Overall the difference between Time 1 and Time 2 in relation to how likely participants felt it was that they would leave their current job approached statistical significance. At Time 2

⁵ The simplest way to make sense of this is that it suggests that 47.6 per cent of the differences in levels of job satisfaction can be explained by differences in these variables. The remaining 52.4 per cent of difference in levels of job satisfaction must, therefore, be accounted for by other variables or factors. This logic applies whenever we report the percentage of variance accounted for by variables.

participants reported that they were significantly more likely to leave their current job compared to at Time 1.

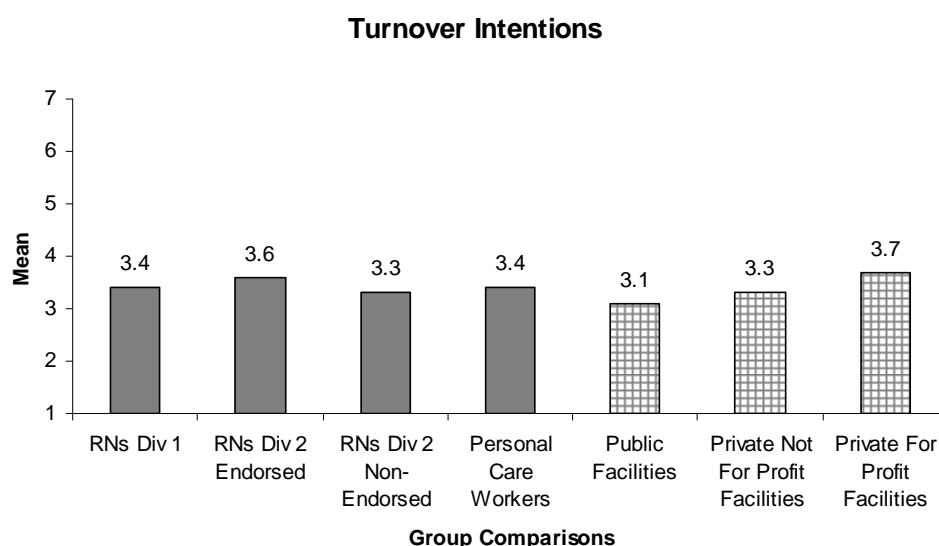
Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for turnover intentions for the different groups based on job type (Division 1 registered nurses, Division 2 Endorsed registered nurses, Division 2 Non-Endorsed registered nurses, PCWs) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate a greater likelihood participants will leave their current job.

In relation to the job type comparisons there were no statistically significant differences in turnover intentions across the different job categories. In the organisation type comparisons participants who worked in private for profit facilities reported significantly higher intentions to leave their current job than participants who worked in public or private not for profit facilities.

Figure 3.5.4

[1=Very Unlikely; 2=Unlikely; 3=Somewhat Unlikely; 4=Neither Likely or Unlikely; 5=Somewhat Likely; 6=Likely; 7=Very Likely]



Predictors of Turnover Intentions

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the likelihood an individual would leave their job in the next year (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

- Significant Predictors of Turnover Intentions:
 - Employee/Facility Variables
 - Hours worked per day: The more hours an individual worked per day the more likely they were to intend to leave their current job.

- Job Category: PCWs were less likely to leave their current job as compared to registered nurses.
- Work Stressors
 - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff were more likely to leave their current job.
 - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents were more likely to leave their current job.
 - Multi-Skilling: Individuals who had undergone additional training to enable them to provide a broader range of care skills were less likely to leave their current job.
 - Role Extending: Individuals who had been required to take on new tasks that might have previously been undertaken by others (e.g., medication administration) were more likely to leave their current job.
- Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were less likely to leave their current job.
 - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raise, promotions etc were less likely to leave their current job.
 - Training: Individuals who received adequate training to do their job effectively were less likely to leave their current job.
- Overall the employee/facility variables accounted for 0.8% of the variance in turnover intentions. The work stressor variables and the management practices variables each accounted for an additional 30.0% and 5.8% of the variance respectively.

Further Qualitative Evidence on the causes of turnover in Aged Care

Qualitative comments (see below) provided by a number of participants who had actually left the aged care sector in the last 12 months would seem to support the above findings and reinforce the particularly negative role excessive workloads and cost-cutting play in contributing to the likelihood that individuals will stop working in the sector. Of the surveyed participants who had actually left aged care most had however remained in the health care sector with only a smaller number opting to leave the health care sector all together.

Qualitative Comments

"I worked in a high level care facility for several years. I left mainly due to the pressures of an RN's job load where skilled staff cutbacks meant less and less support and more responsibility. The paperwork and justification of care is horrendous in aged care. Proprietors need to be more accountable for how they spend their money. I believe aged care facilities are in crisis with inadequately trained staff caring for these more deserving people. I know several RNs who have left aged care for the same reasons as myself, too much pressure with very little backup and too little pay. "

"I worked in one aged care facility for 16 years and was proud to work there. However, I became very tired, overworked and increasingly disillusioned over the last few years. This was due to: 1) less and less time to spend with residents, 2) more and more paperwork to meet accreditation standards and compliance, 3) more and more less trained staff i.e., PCWs with poor work experience, with residents at the same time becoming increasingly dependent with multiple medical conditions needing high levels of care, 4) continual overtime but never finishing or feeling satisfied. I now work as a practice nurse."

"I initially worked in private aged care as a Div 1 doing night shifts but I left because of the STRESS!"

"I have become a statistic and am no longer working in aged care. I found the work both physically and mentally draining but I admire those who dedicate their lives to it."

"I have recently left aged care because the ratios were not good enough even in public facilities and the work and expectations are just too hard."

"I have moved to another job and am now working as a Nursing Attendant in the private hospital sector. I found the care of residents and the actions and practices of the owners at this private facility very disturbing. I have worked in the Human Services field in a variety of different capacities for over 30 years and could not believe how unregulated this sector is. Before leaving this particular aged care home I reported numerous care concerns and unsafe work practices to the department responsible, but got absolutely nowhere. After talking to other workers within this profession who have attempted similar actions my experience seems to be the norm."

"I have ceased working in aged care because of the stress associated with working as a RN Div 1."

"I am no longer working in aged care. I have moved to the public sector where I get paid better and the ratios are better. Working in aged care is a thankless job."

"I am not working in aged care anymore. I found the expectation of the Div 1 RN had greatly increased and I was uncomfortable with this (at one point they were discussing 1 RN for 90 high level care residents with the assistance of 2-3 RN Div 2s). I have taken a job in Disease Management and feel much less stressed and much more appreciated by my employer."

"I stopped working in aged care 9 months ago due to poor wages, staffing and a lack of education opportunities. I have now secured a position in orthopaedics and I love it!"

"I retired 12 months ago. I was unable to perform appropriate quality care due to economical rationalisation - \$\$\$ signs instead of people. Hopefully something can be done to improve the plight of the residents and the nurses. My health has improved dramatically since I have left."

"I no longer work in aged care. I burnt out and had to leave. I now work in rehabilitation."

"I left aged care in January 2009 after working for 25 years in the field and recently 10 years at the one facility. There was too much responsibility, not enough pay and I was constantly chasing my tail."

"I am no longer in aged care and now work in an acute hospital environment. I left aged care due to dissatisfaction with working conditions."

"I left aged care in early 2008 due to high workloads and changes in the industry i.e., Div 2s being able to administer medications after doing a 3 day course."

"I had been in aged care for nearly 30 years and I have left for many reasons. I was sick of working short staffed and never having time to do what the elderly really needed - care, attention, taking time with them. Years ago it was much better. We used to have time to sit with them, cut their nails, do their hair, not rush them, not have to cut showers short. I did my job because I loved the elderly. I still miss them."

"I've been working in the residential aged care sector for the last 20 years. I love aged care. However, in June 2008 I left my beloved job in a private aged care facility due to continuous pressure from the provider to "get rid of those more expensive RN Div 1s" and replace them with the "new trend of employing medication endorsed or non-endorsed Division 2s". Furthermore I was told by doctors and other professionals that they witnessed a lot of providers using dirty tricks and nasty accusations to pressure RN Div 1s to resign. I was really fed up with those dirty tricks and I have moved to work in the community care sector."

"I moved out of the aged care sector 14 months ago. I was no longer able to work in such an environment with so much conflict and cost-cutting that compromised patient care."

Reasons for continuing to work in aged care

This question asked participants to indicate how important eight different reasons were in them continuing to work in aged care. The eight different reasons were; better pay than other jobs I could get, I want to work part-time, I want to work flexible hours, I like close personal connections I have developed with residents, I believe it is important the elderly are properly cared for, I like this job better than other jobs I could get, it is the kind of job I know how to do, this is the only job I can get. Participants were asked to record their responses using a scale which ranged from 1 (Very Unimportant) to 7 (Very Important). Please note that Time 1 data is not available to enable comparisons across time to be made for these items.

The following graphs indicate the means for each reason for continuing to work in aged care for both the total sample and the different groups based on job type (Division 1 registered nurses, Division 2 Endorsed registered nurses, Division 2 Non-Endorsed registered nurses, PCWs) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate individuals considered the reason to be more important in their decision to continue to work in aged care.

Across the total sample participants reported that "believing it is important the elderly are properly cared for" was the most important reason for them continuing to work in aged care and "this is the only job I can get" as the least important reason. In relation to job type, there were no statistically significant differences between participants from the different job categories in relation to the importance they attributed to each of the different reasons. Similarly, in relation to organisation type there were also no statistically significant differences.

Figure 3.5.5

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

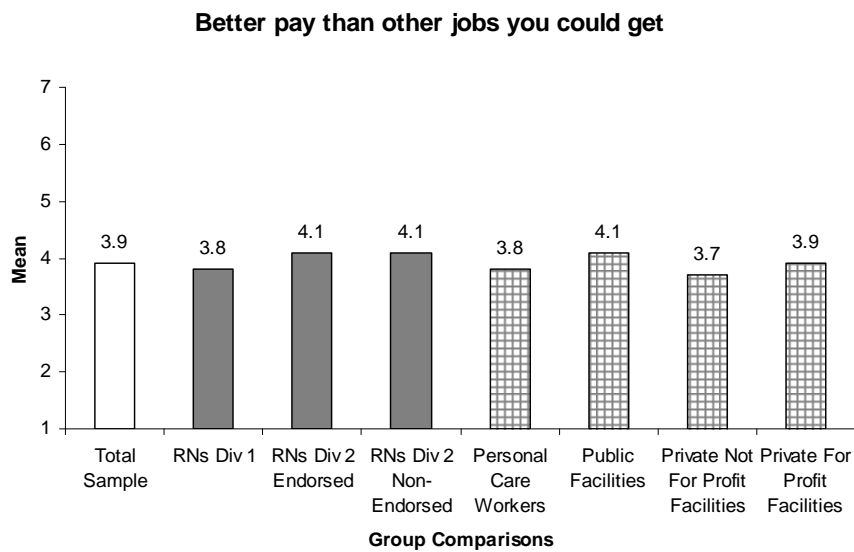


Figure 3.5.6

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

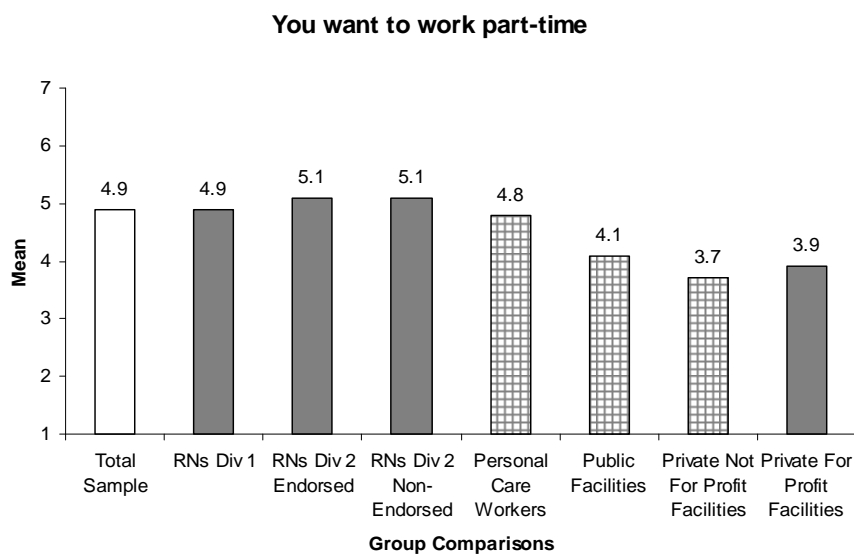


Figure 3.5.7

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

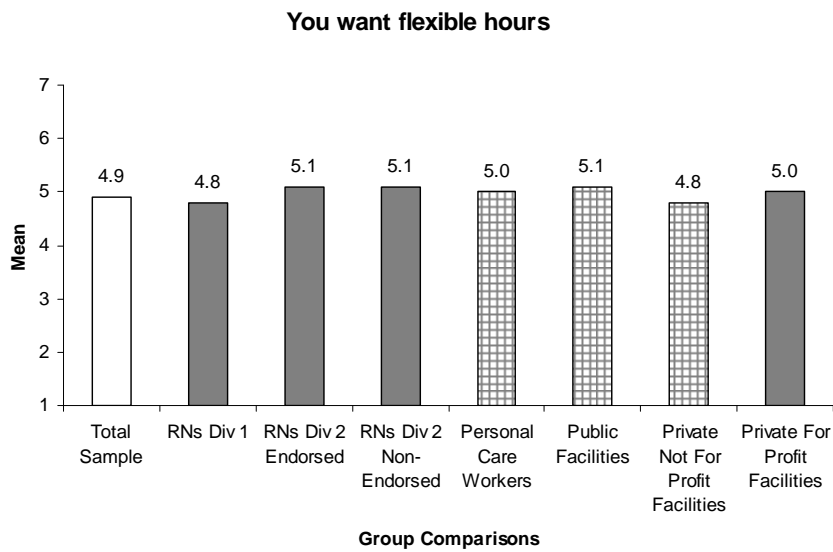


Figure 3.5.8

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

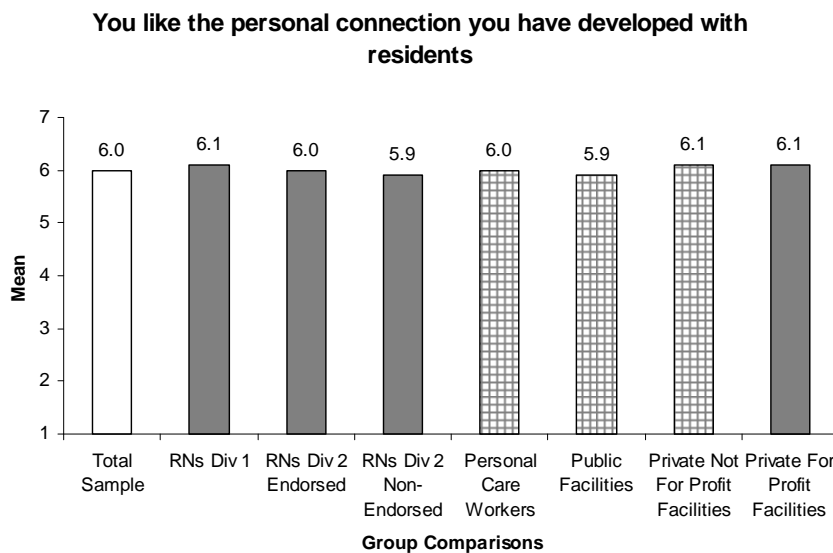


Figure 3.5.9

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

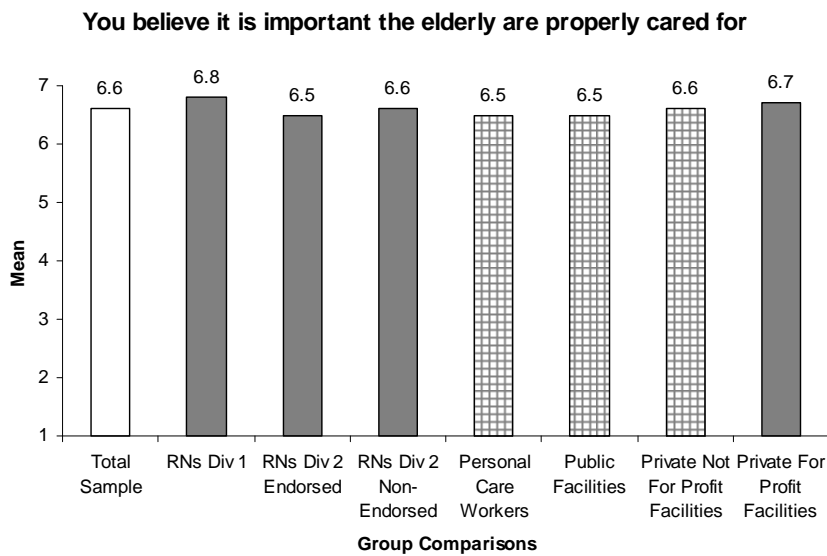


Figure 3.5.10

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

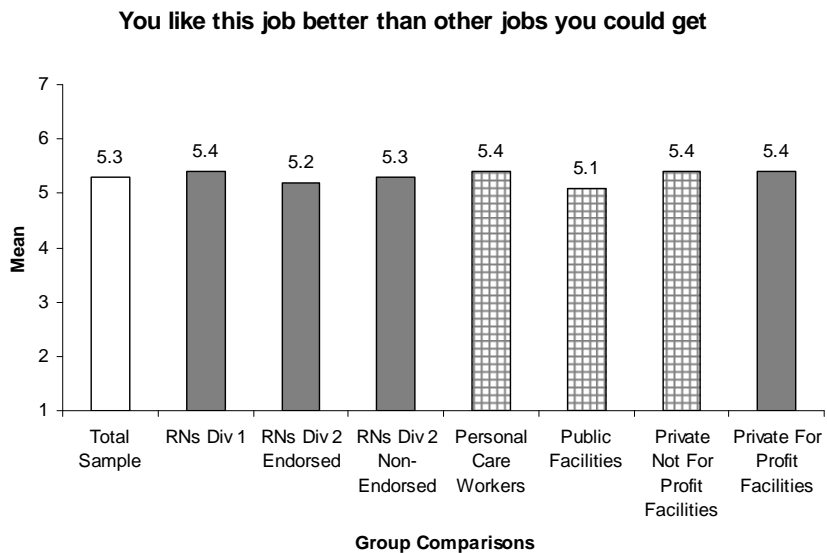


Figure 3.5.11

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

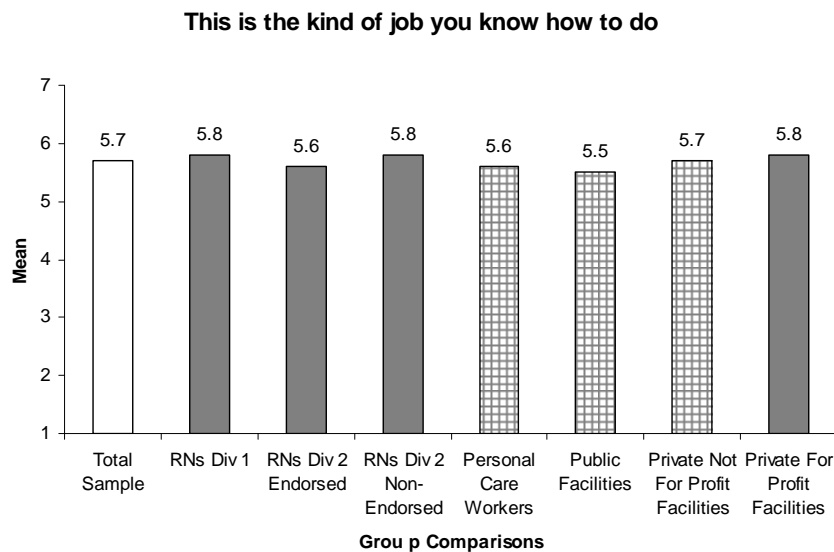
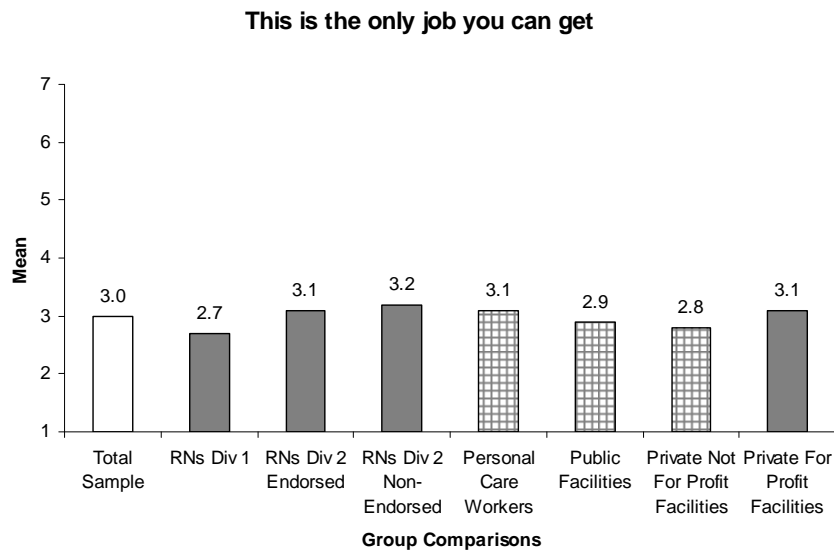


Figure 3.5.12

[1=Very Unimportant; 2=Unimportant; 3=Somewhat Unimportant; 4=Neither Important or Unimportant; 5=Somewhat Important; 6=Important; 7=Very Important]

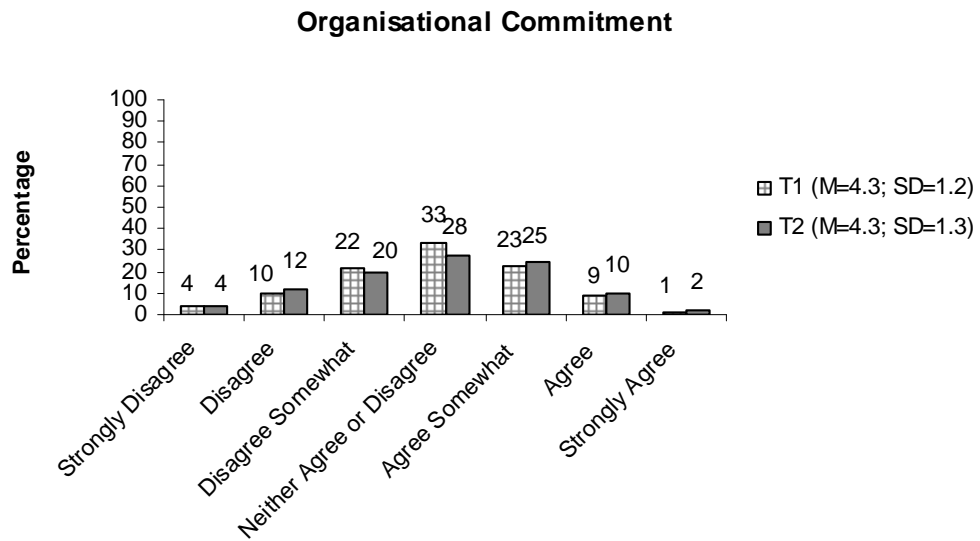


Organisational Commitment

Time 1 & Time 2 Comparisons

This scale assessed the extent to which participants felt committed or emotionally attached to their current organisation. An example of one of the items used in the scale is “I would be very happy to spend the rest of my career in this organisation”. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.5.13



Overall there was no statistically significant difference between Time 1 and Time 2 in relation to how committed participants felt to their organisation.

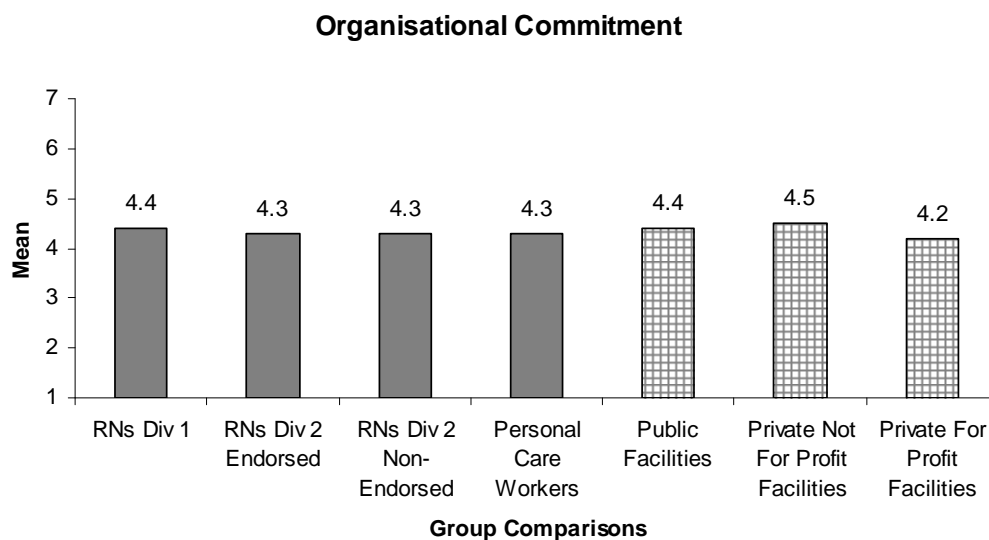
Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for organisational commitment for the different groups based on job type (Division 1 registered nurses, Division 2 Endorsed registered nurses, Division 2 Non-Endorsed registered nurses, PCWs) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate individuals are more committed to their current organisation.

In relation to the job type comparisons there were no statistically significant differences between any of the job categories. Similarly, in the organisation type comparisons there were also no significant differences across the different categories.

Figure 3.5.14

[1=Strongly Disagree; 2=Disagree; 3=Disagree Somewhat; 4=Neither Agree or Disagree; 5=Agree Somewhat; 6=Agree; 7=Strongly Agree]



Predictors of Organisational Commitment

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the degree to which individuals were committed to their organisation (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

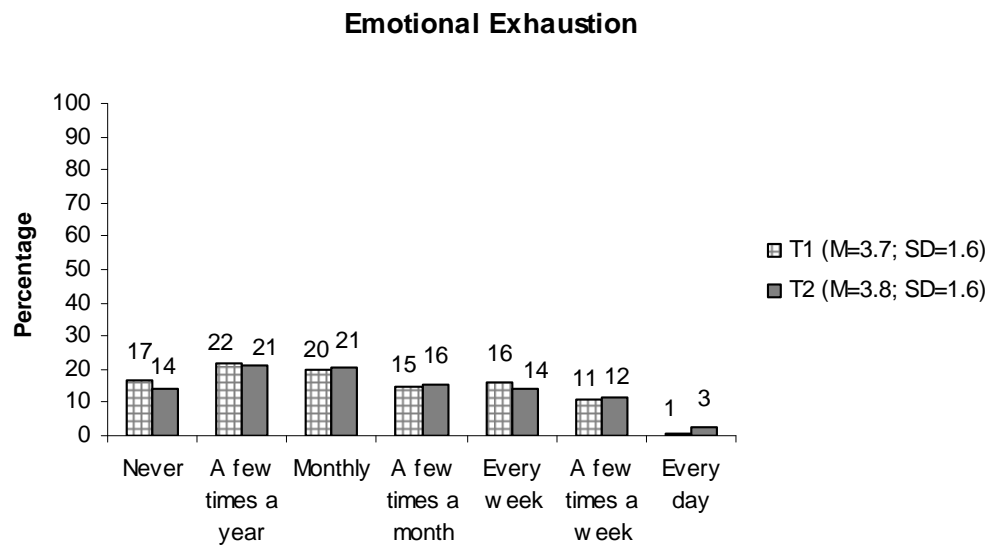
- Significant Predictors of Organisational Commitment:
 - Employee/Facility Variables
 - None of the employee/facility variables were statistically significant predictors of organisational commitment.
 - Work Stressors
 - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to report lower levels of organisational commitment.
 - Multi-Skilling: Individuals who had undergone additional training to enable them to provide a broader range of care skills tended to report higher levels of organisational commitment.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of organisational commitment.
 - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report higher levels of organisational commitment.
 - Overall the employee/facility variables accounted for 2.4% of the variance in organisational commitment. The work stressor variables and the management practices variables each accounted for an additional 24.1% and 7.2% of the variance respectively.

Emotional Exhaustion

Time 1 & Time 2 Comparisons

This scale assessed how frequently participants felt emotionally drained and fatigued as a result of their work. An example of one of the items used in the scale is “How often do you feel burned out from your work?”. Participants were asked to record their responses using a scale which ranged from 1 (Never) to 7 (Every Day). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.5.15



Overall the difference between Time 1 and Time 2 in relation to how frequently participants felt emotionally exhausted as a result of their work was statistically significant. At time 2 participants reported that they felt emotionally exhausted significantly more frequently as compared to at Time 1.

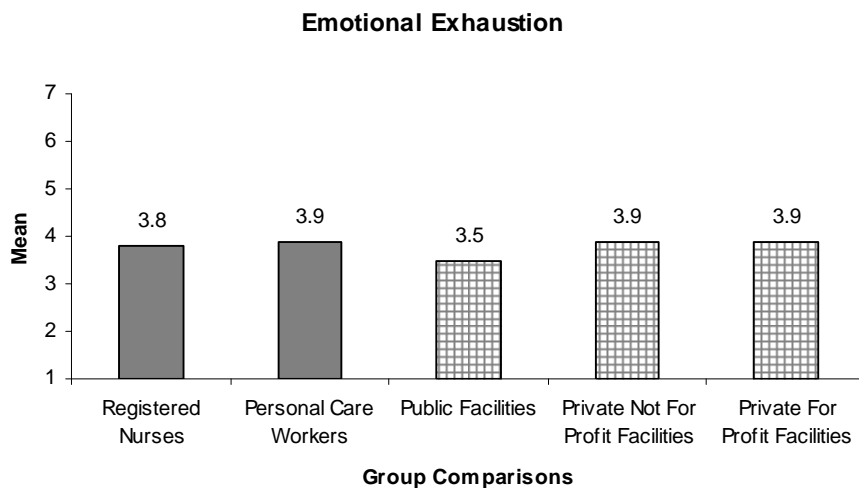
Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for emotional exhaustion for the different groups based on job type (Registered Nurses, & Personal Care Workers) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate that individuals reported that they felt emotionally exhausted more frequently.

In relation to the job type comparisons there were no statistically significant differences in emotional exhaustion across the different job categories. In relation to the organisation type comparisons analyses revealed that participants from public facilities reported experiencing feeling emotionally exhausted as a result of their work less frequently than participants from private not for profit or private for profit facilities.

Figure 3.5.16

[1=Never; 2=A Few Times a Year; 3=Monthly; 4=A Few Times a Month; 5=Every Week; 6=A Few Times a Week; 7=Every Day]



Predictors of Emotional Exhaustion

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the frequency with which individuals felt emotionally exhausted as a result of their job (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

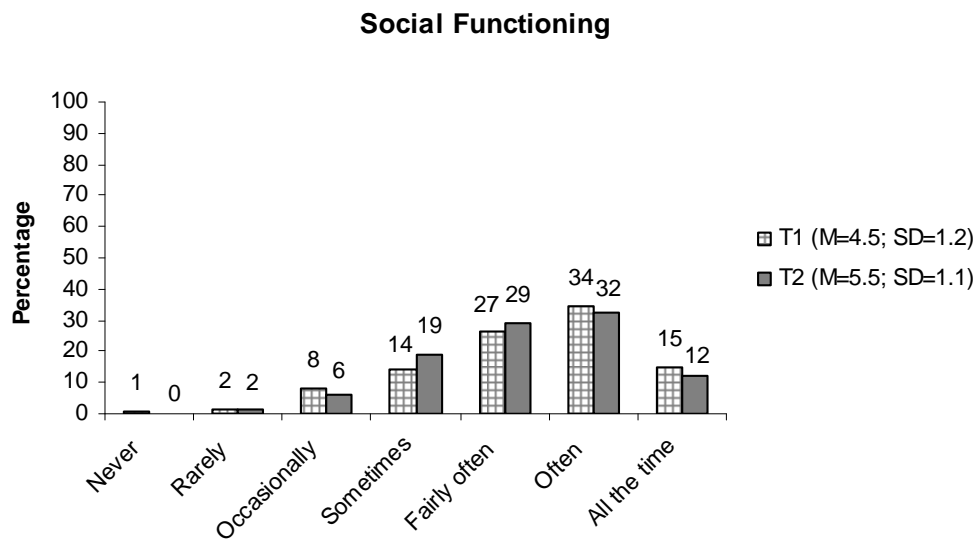
- Significant Predictors of Emotional Exhaustion:
 - Employee/Facility Variables
 - Shift Worked: Individuals who worked the AM shift tended to report higher levels of emotional exhaustion compared to individuals who worked PM, night or rotating shifts.
 - Hours worked per day: The more hours per day an individual worked the more likely they were to report feeling emotionally exhausted.
 - Work Stressors
 - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the higher their levels of emotional exhaustion tended to be.
 - Resident Aggression: The more frequently an individual experienced aggression from residents the higher their levels of emotional exhaustion tended to be.
 - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to report higher levels of emotional exhaustion.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures tended to report lower levels of emotional exhaustion.
 - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc tended to report lower levels of emotional exhaustion.
 - Training: Individuals who received adequate training to do their job effectively tended to report lower levels of emotional exhaustion.
 - Overall the employee/facility variables accounted for 1.4% of the variance in emotional exhaustion. The work stressor variables and the management practices variables each accounted for an additional 28.5% and 2.4% of the variance respectively.

Social Functioning

Time 1 & Time 2 Comparisons

This scale assessed how frequently over the past few weeks participants had felt able to enjoy their life and capable of making decisions and dealing with problems. An example of one of the items used in the scale is "Have you recently been able to enjoy your normal day-to-day activities?". Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.5.17



Overall the difference between Time 1 and Time 2 in relation to how frequently participants felt that they were functioning effectively socially was statistically significant. At time 2 participants reported that they felt like they were functioning effectively socially significantly more frequently as compared to at Time 1.

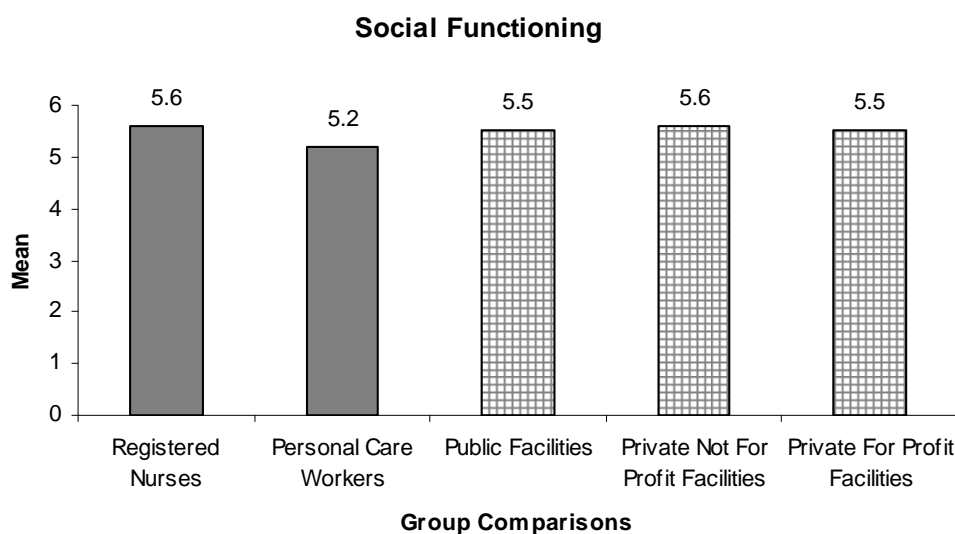
Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for social functioning for the different groups based on job type (Registered Nurses, & Personal Care Workers) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate a higher level of social functioning.

In relation to the job type comparisons personal care workers reported significantly lower levels of social functioning as compared to registered nurses. In the organisation type comparisons there were no statistically significant differences across the different categories.

Figure 3.5.18

[1=Never; 2=Rarely; 3=Occasionally; 4=Sometimes; 5=Fairly Often; 6=Often; 7=All the Time]



Predictors of Social Functioning

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the frequency with which individuals reported they were able to function effectively socially (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

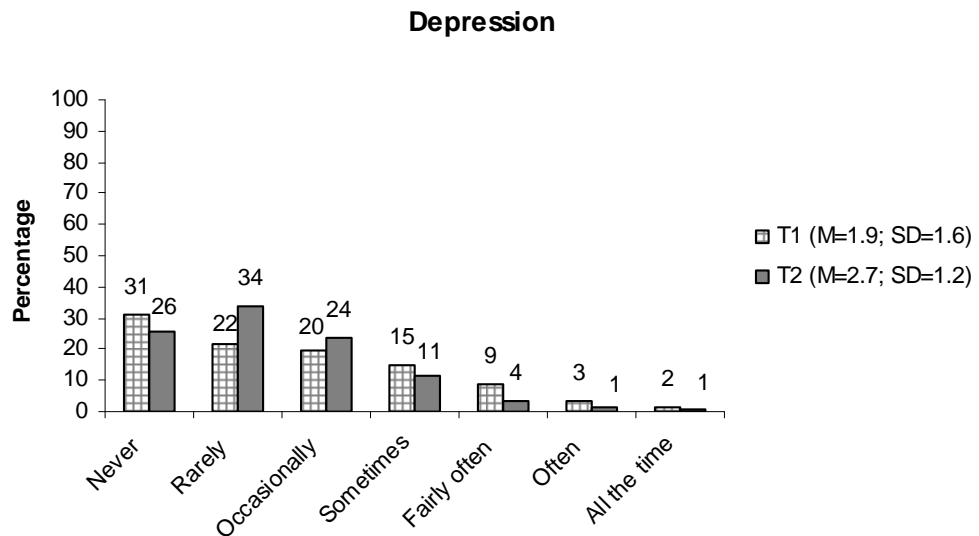
- Significant Predictors of Social Functioning:
 - Employee/Facility Variables
 - None of the employee/facility variables were statistically significant predictors of social functioning.
 - Work Stressors
 - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents were more likely to report lower levels of social functioning.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of social functioning.
 - Overall the employee/facility variables accounted for 3.1% of the variance in social functioning. The work stressor variables and the management practices variables each accounted for an additional 10.3% and 1.9% of the variance respectively.

Depression

Time 1 & Time 2 Comparisons

This scale assessed how frequently over the past few weeks participants had felt unhappy and unable to cope. An example of one of the items used in the scale is “Have you recently been feeling unhappy or depressed?”. Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.5.19



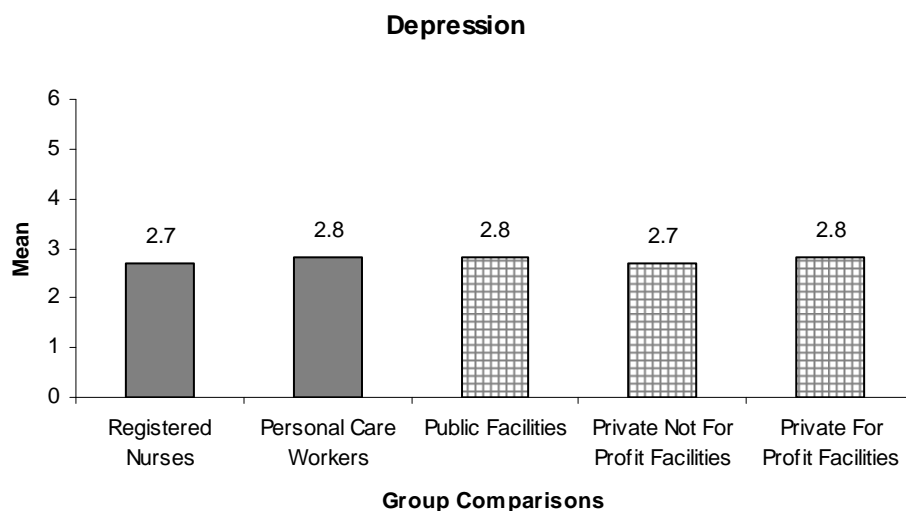
Overall the difference between Time 1 and Time 2 in relation to how frequently participants felt depressed was statistically significant. At Time 2 participants reported that they felt depressed significantly more frequently as compared to at Time 1.

Group Comparisons – Job & Organisation Type

The following figure presents the Time 2 means for depression for the different groups based on job type (Registered Nurses, & Personal Care Workers) and organisation type (Public, Private Not for Profit, Private for Profit). Higher scores indicate individuals felt depressed more frequently. In both the job type and organisation type comparisons there were no statistically significant differences in depression across the different groups.

Figure 3.5.20

[1=Never; 2=Rarely; 3=Occasionally; 4=Sometimes; 5=Fairly Often; 6=Often; 7=All the Time]



Predictors of Depression

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the frequency with which individuals reported feeling depressed (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

- Significant Predictors of Depression:
 - Employee/Facility Variables
 - Shift Worked: Individuals who worked rotating shifts tended to report lower levels of depression as compared to individuals who worked the AM, PM or night shifts.
 - Work Stressors
 - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the higher their levels of depression tended to be.
 - Resident Aggression: The more frequently an individual experienced aggression from residents the higher their levels of depression tended to be.
 - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to also report higher levels of depression.
 - Nursing Grade Dilution: Individuals who had tasks they were previously responsible for now performed by others with fewer qualifications tended to report higher levels of depression.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report lower levels of depression.
 - Training: Individuals who felt they received adequate training to do their job effectively tended to report lower levels of depression.
 - Overall the employee/facility variables accounted for 1.4% of the variance in depression. The work stressor variables and the management practices variables each accounted for an additional 15.2% and 3.7% of the variance respectively.

Physical Symptoms

Time 1 & Time 2 Comparisons

This scale was designed to assess out of a total of 18 possible physical symptoms (e.g., had an upset stomach or nausea) how many the participant had experienced in the past 30 days. At both Time 1 and Time 2 on average participants reported experiencing five different physical symptoms in the past 30 days. Participants also reported experiencing the same top five physical symptoms at Time 1 and Time 2 and these were:

1. Tiredness or Fatigue (At Time 1 80.7% of participants reported experiencing this physical symptom, while at Time 2 it was 82.8% of participants).
2. Headaches (At Time 1 66.7% of participants reported experiencing this physical symptom, while at Time 2 it was 66% of participants).
3. Backache (At Time 1 64.0% of participants reported experiencing this physical symptom, while at Time 2 it was 65.2% of participants).

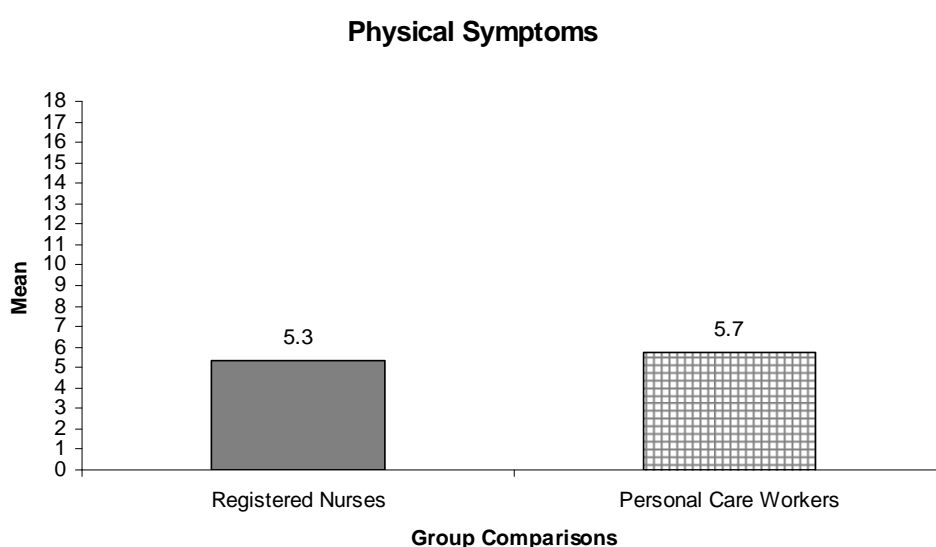
4. Trouble Sleeping (At Time 1 62.9% of participants reported experiencing this physical symptom, while at Time 2 it was 67.6% of participants).
5. Eye Strain (At Time 1 35.7% of participants reported experiencing this physical symptom, while at Time 2 it was 38.0% of participants).

Group Comparisons – Job Type

The following graph presents the Time 2 means for physical symptoms for the different groups based on job type (Registered Nurses, & Personal Care Workers). Higher scores indicate individuals experienced more physical symptoms.

Analyses revealed that across the different job types there were no statistically significant differences in the number of physical symptoms reported by participants in the different groups.

Figure 3.5.21



Predictors of Physical Symptoms

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the number of physical symptoms individuals reported experiencing in the past month (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

- Significant Predictors of Physical Symptoms:
 - Employee/Facility Variables
 - Hours worked per day: The more hours per day an individual worked the more physical symptoms they tended to report experiencing.
 - Work Stressors
 - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the more physical symptoms they reported experiencing.

- Resident Aggression: The more frequently an individual experienced aggression from residents the more physical symptoms they reported experiencing.
- Role Extending: Individuals who had been required to take on new tasks that might have previously been undertaken by others (e.g., medication administration) tended to report experiencing more physical symptoms.
- Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures tended to report experiencing fewer physical symptoms.
- Overall the employee/facility variables accounted for 1.5% of the variance in physical symptoms. The work stressor variables and the management practices variables each accounted for an additional 10.1% and 2.1% of the variance respectively.

Summary: Work, Psychological & Physical Health Outcomes

In relation to job satisfaction, at Time 2 participants reported being significantly less satisfied with their jobs than at Time 1. There were no statistically significant differences based on job type however, participants from private for profit facilities tended to report lower levels of job satisfaction compared to individuals from public and private not for profit facilities. In addition to some employee/facility variables, co-worker aggression and cost-cutting were key negative predictors of job satisfaction, while grievance procedures, performance practices and multi-skilling were key positive predictors.

At Time 2 participants reported that they were significantly more likely to leave their current job compared to at Time 1. There were no statistically significant differences based on job type however, participants from private for profit facilities reported significantly higher intentions to leave their current job as compared to participants from public or private not for profit facilities. In addition to some employee/facility variables, cost-cutting and role extending were statistically significant positive predictors of turnover intentions, while grievance procedures, performance practices, training and multi-skilling were statistically significant negative predictors.

Across the total sample participants reported that “believing it is important the elderly are properly care for” as the most important reason for them continuing to work in aged care. Participants reported that they were not continuing to work in aged care because it was the only job they could get. There were no statistically significant differences in relation to job or organisation type in relation to the reasons individuals cited for continuing to work in aged care.

In relation to organisational commitment there was no statistically significant difference between Time 1 and Time 2 in relation to how committed participants felt to their organisation. There were also no statistically significant differences based on job or organisation type. Analyses revealed that staff cost-cutting was a statistically significant negative predictor of organisational commitment, while grievance procedures performance practices and multi-skilling were statistically significant positive predictors.

At Time 2 participants reported feeling emotional exhaustion as a result of their work more frequently than at Time 1. While there were no statistically significant differences in emotional exhaustion based on job type, participants from private not for profit and private for profit facilities did report feeling emotionally exhausted significantly more frequently compared to participants from public facilities. In addition to some employee/facility variables, workplace aggression and staff cost-cutting were statistically significant positive

predictors of emotional exhaustion, while grievance procedures, performance practices and training were statistically significant negative predictors.

Participants reported significantly higher levels of social functioning at Time 2 as compared to at Time 1, with PCWs reporting significantly lower levels of social functioning as compared to registered nurses. There were no statistically significant differences based on organisation type. Resident quality of living cost-cutting was a statistically significant negative predictor of social functioning, while grievance procedures were a statistically significant positive predictor.

At Time 2 participants reported feeling significantly more depressed than at Time 1. There were no statistically significant differences based on job or organisation type. In addition to some employee/facility variables, workplace aggression, staff cost-cutting and nursing grade dilution were statistically significant positive predictors of depression, while grievance procedures and training were statistically significant negative predictors.

At both Time 1 and Time 2 on average participants reported experiencing five physical symptoms in the past 30 days. At both Time 1 and Time 2 the top five physical symptoms participants reported experiencing were tiredness and fatigue, headaches, backache, trouble sleeping and eye strain. There were no statistically significant differences between registered nurses and PCWs in the number of physical symptoms participants reported experiencing. In addition to some employee/facility variables, workplace aggression was a statistically significant positive predictor of physical symptoms, while grievance procedures were a statistically significant negative predictor.

3.6. Resident Outcomes

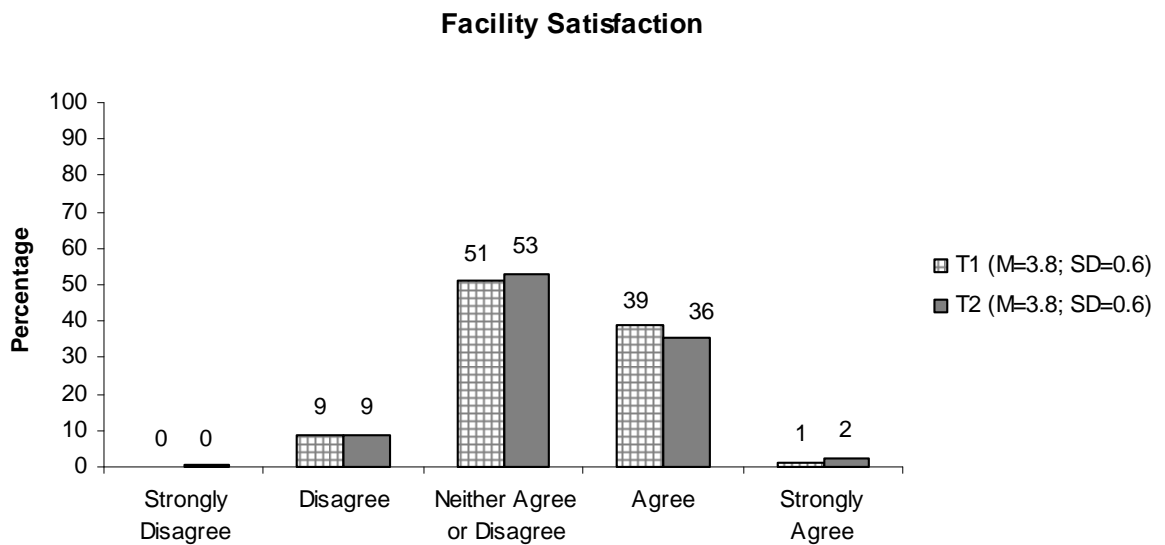
The scales in this section were designed to assess the extent to which participants felt the facility was of a high standard, staff were responsive to resident needs, resident safety was prioritised, and resident care was of a high standard. A summary of results for each of these resident outcomes is provided below. A bar chart for each scale indicating the dispersion of responses based on the entire sample for Time 1 and Time 2 is also provided. This is followed by comparisons for each of the scales across different job (Registered Nurses, & Personal Care Workers) and organisation types (Public, Private Not for Profit, Private for Profit) at Time 2. Appendix A provides the individual items for each of the resident outcome scales.

Facility Satisfaction

Time 1 & Time 2 Comparisons

This scale assessed the extent to which participants felt that residents' rooms and nutrition were of a high standard. The privacy of residents and the extent to which family and friends were welcome to visit residents were also assessed. An example of one of the items used in the scale is "When residents have a complaint something is done about it". Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.6.1



Overall the difference between Time 1 and Time 2 in relation to how satisfied frequently participants felt with their facility was not statistically significant.

Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for facility satisfaction for the different groups based on job type and organisation type. Higher scores indicate higher levels of facility satisfaction.

In relation to the job type comparisons there were no statistically significant differences between the two job categories. In the organisation type comparisons participants from private for profit facilities reported significantly lower levels of facility satisfaction as compared to participants from private not for profit facilities.

Figure 3.6.2

[1=Strongly Disagree; 2=Disagree; 3=Neither Agree or Disagree; 4=Agree; 5=Strongly Agree]



Predictors of Facility Satisfaction

A set of statistical analyses (regressions) were conducted to assess the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the levels of facility satisfaction reported by individuals (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

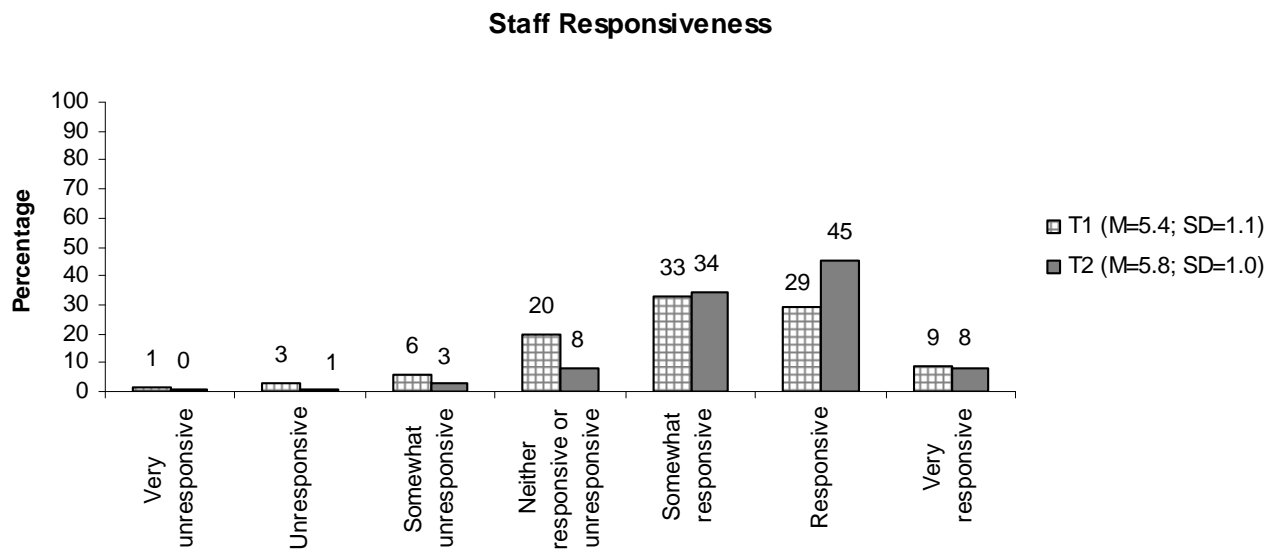
- Signification Predictors of Facility Satisfaction:
 - Employee/Facility Variables
 - Job Category: PCWs tended to report higher levels of facility satisfaction as compared to registered nurses.
 - Work Stressors
 - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the lower they tended to perceive facility satisfaction as being.
 - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive lower levels of facility satisfaction.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of facility satisfaction.
 - Recruitment & Selection Practices: Individuals who felt their organisation devoted adequate time and resources to recruiting and selecting the right people for positions were more likely to report higher levels of facility satisfaction.
 - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report higher levels of facility satisfaction.
 - Overall the employee/facility variables accounted for 3.0% of the variance in resident care. The work stressor variables and the management practices variables each accounted for an additional 44.0% and 9.9% of the variance respectively.

Staff Responsiveness

Time 1 & Time 2 Comparisons

This scale assessed how responsive participants felt staff were to the different needs of residents. An example of one of the items used in the scale is “How responsive are staff to a resident requesting assistance using their buzzer or call system”. Participants were asked to record their responses using a scale which ranged from 1 (Very Unresponsive) to 7 (Very Responsive). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.6.3



Overall the difference between Time 1 and Time 2 in relation to how responsive participants felt staff at their facility were to residents' needs was statistically significant. At time 2 participants reported that they felt that staff were significantly more responsive to residents' needs as compared to at Time 1.

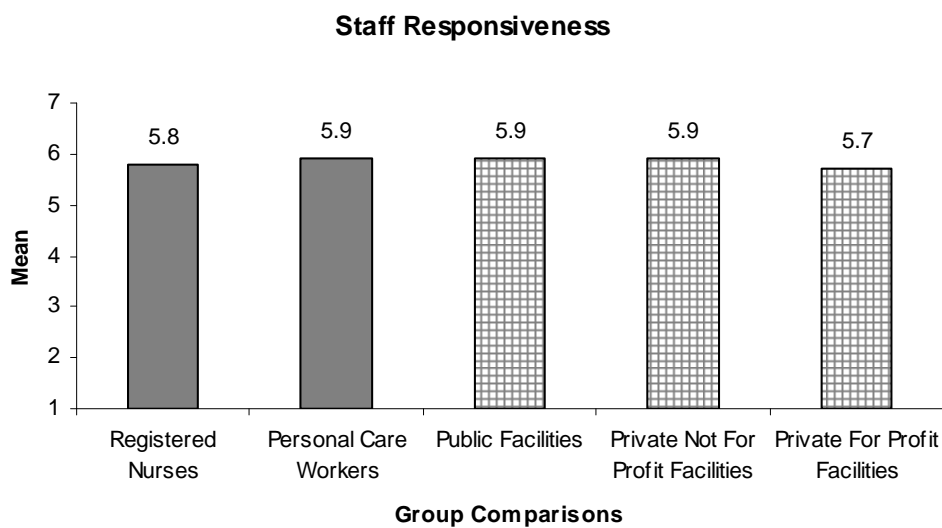
Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for staff responsiveness for the different groups based on job type and organisation type. Higher scores indicate higher levels of staff responsiveness.

In the job type comparisons there were no statistically significant differences in staff responsiveness across the different groups. In the organisation type comparisons participants from public facilities reported staff as being significantly more responsive to the needs of residents as compared to participants from private for profit facilities.

Figure 3.6.4

[1=Very Unresponsive; 2= Unresponsive; 3=Somewhat Responsive; 4=Neither Responsive or Unresponsive; 5=Somewhat Responsive; 6=Responsive; 7=Very Responsive]



Predictors of Staff Responsiveness

A set of statistical analyses (regression) were conducted to assess the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the degree to which individuals felt staff were able to be responsive to residents' needs (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

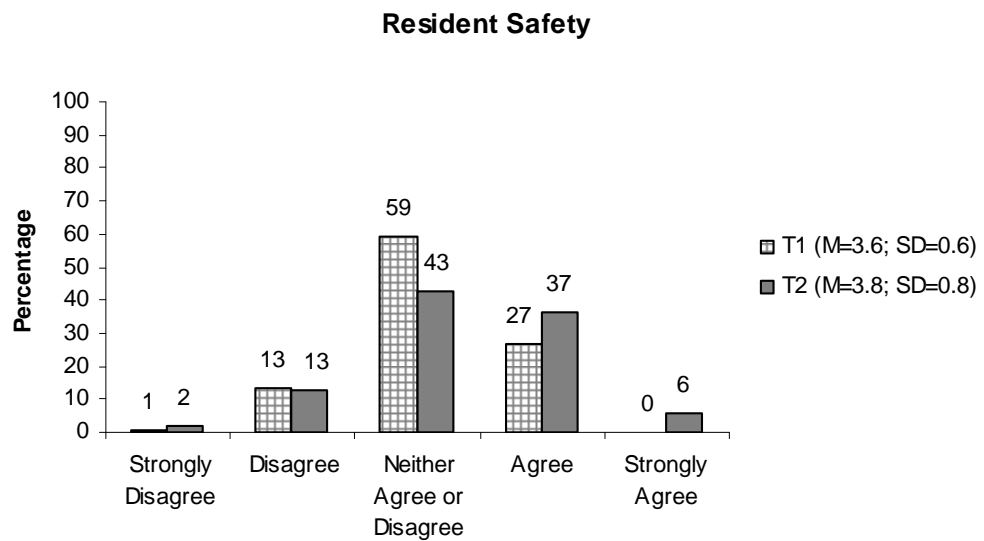
- Significant Predictors of Staff Responsiveness:
 - Employee/Facility Variables
 - Shift Worked: Individuals who worked the AM shift were more likely to report staff as being responsive to residents as compared to individuals who worked the PM, night or rotating shifts.
 - Job Category: PCWs were likely to report staff as being more responsive to residents as compared to registered nurses.
 - Work Stressors
 - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the less responsive they perceived staff to be.
 - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive staff as being less responsive.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report staff as being more responsive to residents.
 - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report staff as being more responsive to residents.
 - Overall the employee/facility variables accounted for 1.5% of the variance in staff responsiveness. The work stressor variables and the management practices variables each accounted for an additional 21.1% and 6.0% of the variance respectively.

Resident Safety

Time 1 & Time 2 Comparisons

This scale assessed the extent to which participants felt resident safety was a high priority at their facility, with the extent to which management provided the resources, procedures and training needed to ensure resident safety being assessed. An example of one of the items used in the scale is "The actions of management show that resident safety is a top priority". Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.6.5



Overall the difference between Time 1 and Time 2 in relation to the extent to which participants felt resident safety was a priority at their facility was statistically significant. At time 2 participants reported that they felt that resident safety was a significantly higher priority at their facility compared to at Time 1.

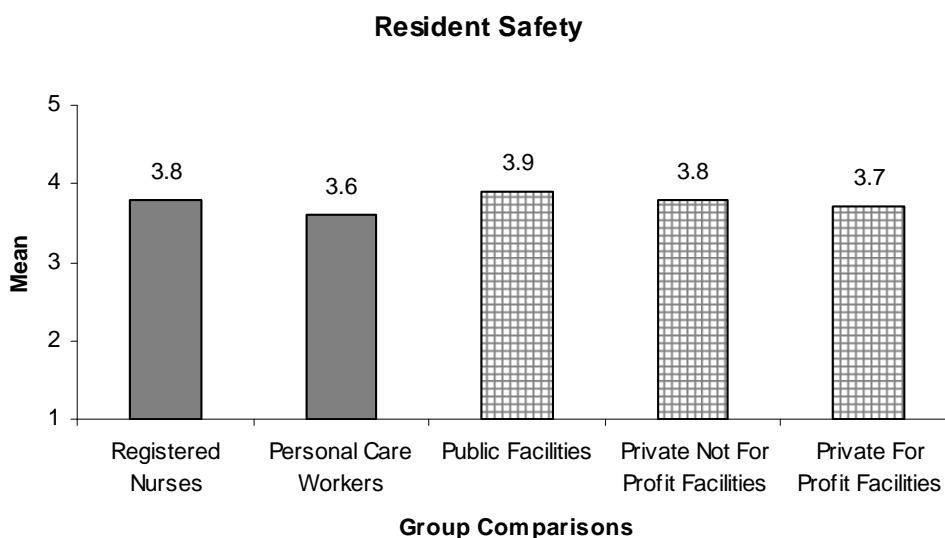
Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for resident safety for the different groups based on job type and organisation type. Higher scores indicate higher levels of reported resident safety.

In relation to the job type comparisons personal care workers reported significantly lower levels of resident safety as compared to registered nurses. In relation to the organisation type comparisons participants who worked in private for profit facilities reported significantly lower levels of resident safety as compared to participants who worked at public facilities.

Figure 3.6.6

[1=Strongly Disagree; 2=Disagree; 3=Neither Agree or Disagree; 4=Agree; 5=Strongly Agree]



Predictors of Resident Safety

A set of statistical analyses (regressions) were conducted to determine the extent to which job stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the level of resident safety individuals reported by individuals (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility, job stressors, & management practices) that were statistically significant predictors is presented.

- Significant Predictors of Resident Safety:
 - Employee/Facility Variables
 - None of the employee/facility variables were statistically significant predictors of resident safety.
 - Work Stressors
 - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to also perceive lower levels of resident safety.
 - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive lower levels of resident safety.
 - Increased Managerial Functions: Individuals who had been required to undertake managerial tasks that were previously undertaken both others (e.g., paperwork, supervision of other employees) tended to report higher levels of resident safety.
 - Nursing Grade Dilution: Individuals who had tasks they were previously responsible for now performed by others with fewer qualifications tended to report lower levels of resident safety.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of resident safety.
 - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report higher levels of resident safety.
 - Training: Individuals who felt they received adequate training to do their job effectively tended to report higher levels of resident safety.
 - Overall the employee/facility variables accounted for 2.7% of the variance in resident safety. The work stressor variables and the management practices variables each accounted for an additional 41.8% and 18.0% of the variance respectively.

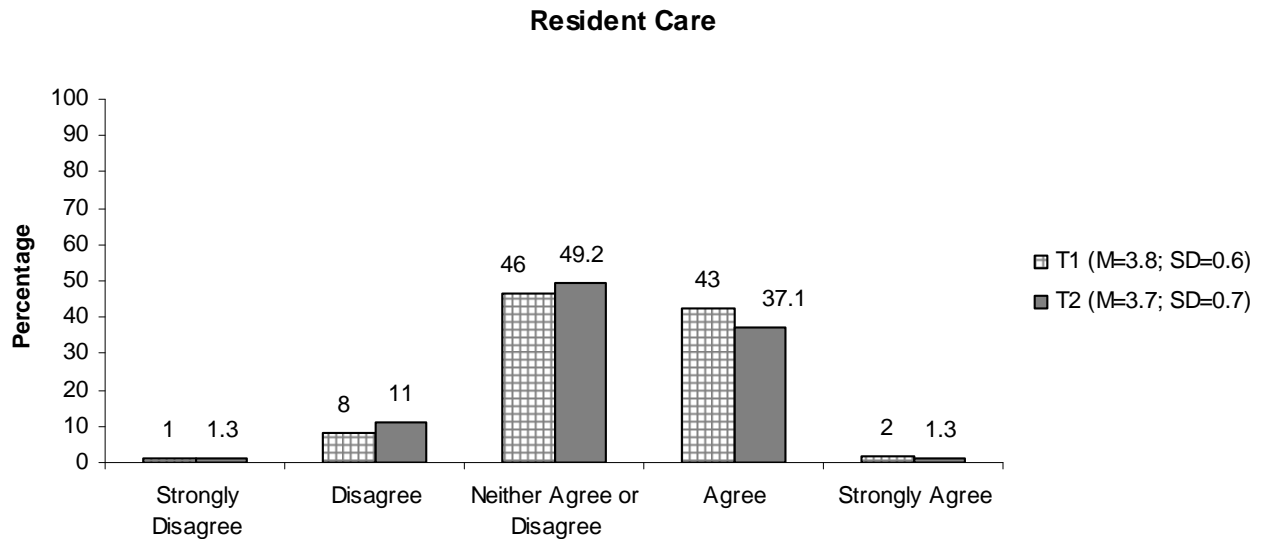
Resident Care

Time 1 & Time 2 Comparisons

This scale assessed the extent to which participants felt residents were able to talk to staff as needed, staff showed a real interest in residents and residents in the facility were provided with appropriate care by staff. An example of one of the items used in the scale is “The nurses and personal carers have the skills to provide appropriate care for the residents”. Participants were asked to record their responses using a scale which ranged

from 1 (Strongly Disagree) to 5 (Strongly Agree). The following graph provides a comparison between Time 1 and Time 2 of the dispersion of responses based on the entire sample for the scale.

Figure 3.6.7



Overall the difference between Time 1 and Time 2 in relation to the extent to which participants felt resident care was of a high standard at their facility was statistically significant. At time 2 participants reported that they felt that resident care was of a significantly lower standard at their facility compared to at Time 1.

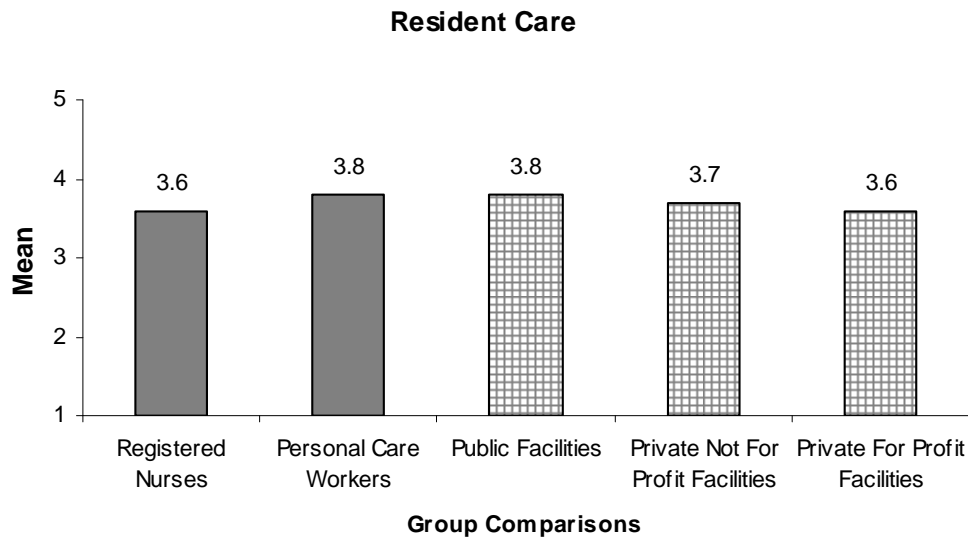
Group Comparisons – Job & Organisation Type

The following graph presents the Time 2 means for resident care for the different groups based on job type and organisation type. Higher scores indicate higher reported levels of resident care.

In relation to the job type comparisons personal care workers reported significantly higher levels of resident care compared to registered nurses. In relation to the organisation type comparisons participants from private for profit facilities reported significantly lower levels of resident care as compared to participants from public and private not for profit facilities.

Figure 3.6.8

[1=Strongly Disagree; 2=Disagree; 3=Neither Agree or Disagree; 4=Agree; 5=Strongly Agree]



Predictors of Resident Care

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., co-worker aggression, resident aggression, staff cost-cutting, resident quality of living cost-cutting, & job changes) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the quality of resident care report by individuals (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were statistically significant predictors is presented.

- Significant Predictors of Resident Care:
 - Employee/Facility Variables
 - Job Category: PCWs tended to report higher levels of resident care as compared to registered nurses.
 - Work Stressors
 - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive lower levels of resident care.
 - Increased Managerial Functions: Individuals who had been required to undertake managerial tasks that were previously undertaken both others (e.g., paperwork, supervision of other employees) tended to report higher levels of resident care.
 - Nursing Grade Dilution: Individuals who had tasks they were previously responsible for now performed by others with fewer qualifications tended to report lower levels of resident care.
 - Management Practices
 - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of resident care.

- Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report higher levels of resident care.
- Overall the employee/facility variables accounted for 1.9% of the variance in resident care. The work stressor variables and the management practices variables each accounted for an additional 28.4% and 7.7% of the variance respectively.

Summary: Resident Outcomes

There were no statistically significant differences between Time 1 and Time 2 in relation to how satisfied individuals felt with their facility. While there were no statistically significant differences based on job type participants from private for profit facilities did report lower levels of facility satisfaction as compared to individuals from private not for profit facilities. In addition to some employee/facility variables, co-worker aggression and resident quality of living cost-cutting were statistically significant negative predictors of facility satisfaction, while grievance procedures, recruitment and selection, and performance practices were statistically significant positive predictors of facility satisfaction.

At Time 2 participants felt that staff were more responsive to resident needs as compared to at Time 1. There were no statistically significant differences based on job type however, participants from public facilities did report staff as being more significantly more responsive to resident needs as compared to participants from private for profit facilities. In addition to some of the employee/facility variables, co-worker aggression and resident quality of living cost-cutting were statistically significant negative predictors of staff responsiveness, while grievance procedures and performance practices were statistically significant positive predictors.

In relation to resident safety at Time 2 participants felt this was a significantly higher priority at their facilities as compared to at Time 1. PCWs reported significantly lower levels of resident safety as compared to registered nurses, while participants from private for profit facilities reported significantly lower levels as compared to participants from public facilities. Cost-cutting and nursing grade dilution were statistically significant negative predictors of resident safety, while grievance procedures, performance practices and training were all statistically significant positive predictors.

Participants reported resident care as being significantly lower at Time 2 as compared to at Time 1. PCWs reported significantly higher levels of resident care as compared to registered nurses. Participants from private for profit facilities reported significantly lower levels of resident care as compared to participants from public and private not for profit facilities. In addition to some employee/facility variables, resident quality of living cost-cutting and nursing grade dilution were statistically significant negative predictors of resident care, while grievance procedures and performance practices were statistically significant positive predictors.

4. Conclusion

This report contains the findings from the second survey conducted as part of an ongoing research project. The data presented in the report are based on 541 responses from ANF (Victorian Branch) members working in aged-care in Victoria, who responded to the second survey conducted in March 2009 (Time 2). The responses of these participants were then matched to the original responses they had provided when surveyed in October 2007 (Time 1).

The data indicated that overall there had been a slight decline in the numbers of registered nurses (RNs) and a slight increase in the number of personal care workers (PCWs) between Time 1 and Time 2. Within the RN category the most marked change has been in the numbers of Division 2 endorsed nurses and Division 2 non-endorsed nurses. The number of Division 2 endorsed nurses has increased by 4.6% whereas the number of Division 2 non-endorsed nurses has decreased by 3.7%. At both Time 1 and Time 2 compared to public facilities overall private not for profit and private for profit facilities had significantly fewer RNs and significantly more PCWs.

Most participants worked the AM shift, five or fewer days per week and eight or more hours per day. The majority of participants worked two or more weekends per month. Less than ten per cent of participants worked any double shifts per month. The majority of participants had one or more breaks per shift with most participants reporting that their break/s were 20 minutes or shorter in duration. Sixty-five per cent of participants reported that their gross annual income was \$45,000 or less. Job type comparisons revealed that PCWs were significantly more likely to work more days per week but fewer hours per day compared to registered nurses. While Division 1 registered nurses were significantly less likely to work two or more weekends per month and have two or more breaks than participants from the other job categories. Organisation type comparisons revealed that participants who worked at public facilities were significantly more likely to work 8 hours per day and have 2 or more breaks during a shift as compared to participants from private facilities.

In relation to registered nurse to resident ratios overall comparisons across time revealed that the ratios in public facilities were largely stable, probably as a result of the legally enforceable registered nurse to resident ratios in these facilities. However, there were a number of statistically significant changes in the registered nurse to resident ratios at both private not for profit and private for profit facilities. In some instances this saw an improvement in the ratios, for example in private not for profit mixed care facilities on the AM shift the number of residents each registered nurse had to care for decreased from 21 at Time 1 to 18 at Time 2. However, there were also examples of worsening ratios across time. For example the registered nurse to resident ratio on the night shift at private for profit high care facilities increased from 1:29 at Time 1 to 1:37 at Time 2. Overall across time it was consistently the case that in both mixed and high care facilities on all shifts each registered nurse at these facilities had significantly more residents to care for compared to at public facilities. Again, this is likely to be because in public facilities there is legally enforceable registered nurse to resident ratios. Registered nurse to resident ratios was also found to be statistically significant predictors of a number of employee and resident outcomes. The more residents each registered nurse had to care for the more likely participants were to report lower levels of job satisfaction, an increased likelihood they would leave their current job and feeling emotionally exhausted. Participants also reported that the more residents each registered nurse had to care for the less satisfied they were with their facility, and the lower resident safety and care at their facility was.

Most participants reported that their facility did not employ Division 2 registered nurses in care/coordinator positions however, participants from private facilities were more likely to report that Division 2 registered nurses were employed in this capacity. Individuals from private facilities were also more likely to report that Division 2 registered nurses in care/coordinator positions had line authority over aspects of Division 1 registered nurses' practice. The majority of participants reported that their facility managed outbreaks of infectious diseases by following the Federal Government's guidelines.

In terms of the job changes participants reported experiencing in the last 12 months the two most common changes participants reported experiencing were increased managerial functions and multi-skilling. There was however some noteworthy differences based on job type. Specifically, Division 2 endorsed registered nurses reported experiencing significantly higher levels of multi-skilling, role extending and increases in managerial functions compared to participants in the other three job categories. While in relation to nursing grade dilution Division 1 registered nurses reported higher levels of this job change compared to participants in the other job type categories.

Working overtime in order to get work done was something the majority of participants reported having to do, with registered nurses (both Division 1 & 2 combined) reporting having to work overtime significantly more often as compared to PCWs. Participants from public facilities reported having to work overtime significantly less frequently compared to participants from private facilities. Overall most participants reported feeling like their facility was meeting accreditation standards, with those participants from public facilities especially likely to report that accreditation standards were being met. A number of participants did however comment that the accreditation standards and system was not necessarily an accurate or adequate measure of the quality of care at their facility.

Analyses revealed that participants were significantly more likely to have witnessed Division 2 non-endorsed nurses administering medications from DAAs if they worked at a private facility. Between Time 1 and Time 2 there would appear to have been a slight increase in the number of participants reporting that DAAs were incorrectly filled at least once or twice a week. At Time 1 only 8.6% of participants reported DAAs being incorrectly filled this frequently while at Time 2 this figure had risen to 10.6%. Overall most participants reported that their facilities did not currently have a computerised medication management system. Across the different job types the two most frequently cited medication errors were residents missing their medication and medication being given at the wrong time. In general participants from public facilities tended to report that medication errors were made less frequently compared to participants from private facilities.

At Time 2, as compared to Time 1, there were mostly no differences in the frequency with which participants witnessed co-workers behaving in an aggressive manner towards residents. An exception to this was the frequency with which participants witnessed co-workers threatening to hit or throw something at a resident. At Time 2, 7.3% of participants reported witnessing this form of co-worker aggression at least once or more in the past six months compared to only 3.6% at Time 1. At Time 2, as compared to Time 1, participants reported experiencing a number of different forms of aggressive behaviour from residents more frequently. Specifically, participants reported experiencing residents trying to hit them with something, crying to make them feel guilty and shouting or swearing at them significantly more frequently at Time 2.

At Time 2, as compared to at Time 1, participants reported being significantly less satisfied with their job and significantly more likely to leave their current job. Participants from private for profit facilities reported the lowest levels of job satisfaction and highest turnover intentions. In terms of their motivations for working in aged care the results clearly indicate that participants are not just working in the sector for the money, although they would

appreciate getting paid for the overtime they do and have pay levels that are comparable to nurses who work in acute care settings. Rather, the results strongly indicate that participants are working in aged care because of they have a passion for providing the elderly with quality care and because of the close relationships they have built with the residents they care for. Across time there was no statistically significant change in organisational commitment with participants consistently reporting relatively low levels of commitment to their organisation. At Time 2, as compared to at Time 1, participants reported significantly higher levels of emotional exhaustion and depression with 66% of participants saying they felt emotionally exhausted as a result of their job at least monthly and 6% reporting they felt depressed fairly often. In relation to predicting work and health outcomes such as turnover intentions and emotional exhaustion the main work stressor predictors were workplace aggression, staff cost cutting and multi-skilling. As expected participants working in facilities with better management practices and staff to resident ratios also reported fewer negative psychological and physical health outcomes and had more positive work related attitudes. Overall, participants from public facilities also tended to experience fewer negative outcomes and have more positive attitudes.

There were no statistically significant differences between Time 1 and Time 2 in relation to how satisfied individuals felt with their facility with participants reporting moderate levels of satisfaction at both points in time. Participants reported higher levels of staff responsiveness and resident safety at Time 2 as compared to at Time 1. However, participants also reported statistically significantly lower levels of resident care at Time 2. In relation to predicting resident based outcomes such as resident safety and care the main work stressor predictors were witnessing co-worker aggression towards residents, resident quality of living cost cutting, and nursing grade dilution. Well developed grievance procedures and performance appraisal practices were shown to result in more positive outcomes for residents. Registered nurse to resident ratios was also positively associated with resident safety and care.

To conclude, the study finds that two years on aged care workers continue to be under significant stress stemming from excessive workloads, cost cutting, a hostile work environment, and competing role demands. This has seen participants increasingly report that their ability to provide high quality care for residents is being hampered leaving them feeling overworked, tired and burnt out. Worryingly having to work in these high pressure environments has seen a significant decrease in job satisfaction and an increase, between Time 1 and Time 2, in the number of participants who are considering leaving their current job. This is concerning given that broadly the aged care sector is already experiencing significant problems attracting and retaining staff. Overall, and consistent with our Time 1 findings, participants from public facilities reported less negative psychological and health outcomes and more positive resident outcomes and work related attitudes. Finally, the findings indicate that these more positive outcomes can be achieved more broadly in the sector by increasing the numbers of high-skilled staff, providing staff with more training, using rigorous performance management practices and having well developed grievance procedures at facilities.

Appendix A: Individual Scale Items

Job Changes

Please indicate the degree to which each of the following statements describes changes in your job role over the last 12 months.

Multi-Skilling

1. You have undergone additional training to enable you to provide a broader range of care skills.

Role Extending

2. You have been required to take on new tasks that may have previously been undertaken by others (e.g., medication administration).

Increased Managerial Functions

3. You have been required to take on managerial tasks that were previously undertaken by others (e.g., paperwork, supervision of other employees).

Nursing Grade Dilution

4. Tasks you had previously been responsible for are now performed by other employees with fewer qualifications (e.g., as a RN some of your tasks are now the responsibility of PCWs).

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Medication Practices

Medication Administration by Non-Endorsed Div 2s

1. I have seen non-endorsed Div 2s administering medication from a DAA (e.g., blister packs) in my facility without supervision.

Note: Response scale 1="Yes", 2="No".

DAA's Incorrectly Filled

1. In the past 6 months how often have DAAs (e.g., blister packs) been incorrectly filled?

Note: Response scale ranged from 1 "Never" through to 6 "Several times per day".

Computerised Medication Management System

1. Do you have a computerised medication management system at your facility?

Note: Response scale 1="Yes", 2="No".

Medication Errors

Please indicate over the past 6 months how frequently medication errors that resulted in resident harm have been made by different categories of staff in your facility. Harm refers to the need for increased observation, technical monitoring, visit by a doctor, laboratory tests, medication intervention or treatment or resident transfer to hospital.

Please use the scale to indicate how often in the past 6 months **Division 1 Registered Nurses** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Medication Errors

Please use the scale to indicate how often in the past 6 months **Division 2 Endorsed Nurses** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Please use the scale to indicate how often in the past 6 months **Division 2 Non-Endorsed Nurses** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Please use the scale to indicate how often in the past 6 months **PCWs** have made each of the following medication errors.

1. A wrong dose was given to a resident.
 2. The wrong resident received the medication.
 3. The medication was given at the wrong time.
 4. The medication was given via the wrong route.
 5. The wrong drug was given to a resident.
 6. A resident missed their medication.
-

Note: Response scale ranged from 1 "Never" through to 6 "Several times per day".

Workplace Aggression

Co-worker Aggression towards Residents

Sometimes when conflicts occur with residents, the staff may find it difficult to respond in ways they are supposed to. Please use the scale to indicate how frequently in the past 6 months you have seen others act in each of the following ways towards residents:

1. Pushed, grabbed, shoved, or pinched a resident.
 2. Yelled at a resident in anger.
 3. Insulted or swore at a resident.
 4. Threatened to hit or throw something at a resident.
-

Note: Response scale ranged from 0 "Never" through to 5 "Five or more times".

Resident Aggression

Please indicate how often you have experienced each of the following in the past 6 months:

1. Been threatened with an object e.g. walking frame or stick, wheelchair, furniture.
 2. A resident tried to hit you with something e.g. cup, saucer, plate, furniture, walking stick.
 3. A resident cried to make you feel guilty.
 4. Been yelled, shouted or sworn at by a resident.
 5. A resident was verbally aggressive to you.
-

Note: Response scale ranged from 0 "Never" through to 5 "Five or more times".

Job Stressors

These questions deal with different aspects of work. Please indicate how often these aspects appear in your job.

Staff Cost-Cutting

1. My facility focuses on cost saving by reducing staffing levels at the expense of resident care.
2. My facility has fewer registered nurses on than they used to reduce labour costs.
3. My facility emphasises getting the job done as quickly as possible.
4. My facility cuts corners to get the job done.
5. My facility focuses on saving costs by having fewer activities and diversional therapies for residents than they used to.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Resident Quality of Living Cost-Cutting

1. My facility has reduced the nutritional quality of food for residents to save money.
2. My facility has reduced the portion size of meals to save money.
3. My facility has reduced the quality of dressings available for wound care.
4. My facility has reduced the quantity and quality of incontinence aids.
5. My facility is using DAAs (e.g., blister packs) to reduce costs.
6. My facility has the air conditioning turned off/down during the day to save money.
7. My facility has the heating turned off/down during the day to save money.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Management Practices

Grievance Procedures

1. My organisation has clear and effective policies and procedures in place for resolving complaints by residents or their families.
2. Complaints by residents or their families are resolved in a timely fashion in my organisation.
3. My organisation has clear and effective policies and procedures in place for resolving complaints by staff.
4. Complaints by staff are resolved in a timely fashion in my organisation.
5. Staff here are aware of the policies and procedures for resolving complaints by staff.
6. I have received adequate training from my employer in the policies and procedures for resolving complaints by residents or their families.
7. I have received adequate training from my employer in the policies and procedures for resolving complaints by staff.
8. Staff are allowed representation at meetings with management when a complaint is made against the staff member.

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Recruitment & Selection Practices

1. How rigorous is the employee selection processes for a job in this organisation? (e.g. Does the process involve tests, interviews etc?)

Response scale ranged from 1 "Not rigorous" through to 7 "Very rigorous".

2. How much money is generally spent selecting people for a job?

Note: Response scale ranged from 1 "Very little" through to 7 "A great deal".

Performance Practices

1. How much effort is given to measuring employee performance?

Response scale ranged from 1 "Very little" through to 7 "A great deal".

2. How often is performance discussed with employees?

Response scale ranged from 1 "Rarely" through to 7 "Daily".

Performance Practices

3. How closely are raises, promotions, etc., tied to performance appraisal?

Response scale ranged from 1 "Not closely" through to 7 "Very closely".

4. The wages in this organisation are not very competitive for this industry.

Response scale ranged from 1 "Completely true" through to 7 "Completely false"

5. How closely is pay tied to individual performance?

Note: Response scale ranged from 1 "Not closely" through to "Very closely"

Training

1. During the past 12 months, how much training have you had, paid for by your employer? Include only training away from your normal place of work, but it could be on or off the premises.
2. To what extent do you agree or disagree that you get the training needed to do your job effectively?
3. To what extent do you agree or disagree that you've had sufficient training and education to do the work you're doing?

Note: Response categories for question 1 were 1- none, 2- less than one day, 3 – one to less than two days, 4 – two to less than five days, 5- five to less than ten days, 6 – ten or more days. The response scale for questions 2 & 3 ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Work, Psychological & Physical Health Outcomes

Job Satisfaction

1. All in all, I am satisfied with my job.
2. In general, I don't like my job. [R]
3. In general, I like working here.

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Turnover Intentions

1. How likely is it that you will look for a job outside of this organisation during the next year?

Response scale ranged from 1 "Very Unlikely" through to 7 "Very Likely".

2. If it were possible, how much would you like to get a new job?

Response scale ranged from 1 "Not at all" through to 7 "A great deal".

3. How often do you think about quitting your job at this organisation?

Note: Response scale ranged from 1 "Never" through to 7 "All the time".

Reasons for continuing to work in Aged Care

1. Better pay than other jobs you could get.
2. You want to work part-time.
3. You want flexible hours.
4. You like the close personal connection you have developed with residents.
5. You believe it is important the elderly are properly cared for.
6. You like this job better than other jobs you could get.
7. This is the kind of job you know how to do.
8. This is the only job you can get.

Note: Response scale ranged from 1 "Very Unimportant" through to 7 "Very Important".

Organisational Commitment

1. I would be very happy to spend the rest of my career in this organisation.
 2. I really feel as if this organisation's problems are my own.
 3. I do not feel like "part of the family" at my organisation. [R]
 4. I do not feel "emotionally attached" to this organisation. [R]
 5. This organisation has a great deal of personal meaning for me.
-

Organisational Commitment

6. I do not feel a strong sense of belonging to my organisation. [R]

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Emotional Exhaustion

How often do you feel:

1. Emotionally drained from your work.
 2. Used up at the end of the workday.
 3. Fatigued when you wake up and have to face another day on the job.
 4. Working with people all day is really a strain for you.
 5. Burned out from your work.
 6. Frustrated by your job.
 7. You're working too hard on your job.
 8. Working with people directly, puts too much stress on you.
 9. Like you're at the end of your rope.
-

Note: Response scale ranged from 1 "Never" through to 7 "Every day".

Social Functioning

We would like to know how your health has been in general, over the past few weeks. Please answer the following questions by circling the answer which most nearly applies to you. Have you recently...

1. Felt capable of making decisions about things?
 2. Been able to enjoy your normal day-to-day activities?
 3. Been able to face up to your problems?
 4. Been feeling reasonably happy, all things considered?
-

Note: Response scale ranged from 0 "Never" through to 6 "All the time".

Depression

We would like to know how your health has been in general, over the past few weeks. Please answer the following questions by circling the answer which most nearly applies to you. Have you recently...

1. Felt that you couldn't overcome your difficulties?
 2. Been feeling unhappy or depressed?
 3. Been losing self-confidence in yourself?
 4. Been thinking of yourself as a worthless person?
-

Note: Response scale ranged from 0 "Never" through to 6 "All the time".

Physical Symptoms

During the past 30 days did you have any of the following symptoms? If you did have the symptom, did you see a doctor about it?

1. An upset stomach or nausea
 2. A backache
 3. Trouble sleeping
 4. A skin rash
 5. Shortness of breath
 6. Chest pain
 7. Headache
 8. Fever
 9. Acid indigestion or heartburn
 10. Eye strain
 11. Diarrhoea
 12. Stomach cramps (not menstrual)
 13. Constipation
 14. Heart pounding when not exercising
 15. An infection
 16. Loss of appetite
-

Physical Symptoms

17. Dizziness
18. Tiredness or fatigue

Note: Response scale 1 = "No", 2 = "Yes, but I didn't see a doctor", 3 = "Yes, and I saw a doctor"

Resident Outcomes

Facility Satisfaction

1. The food is good and nutritious here.
2. Residents are kept well hydrated.
3. Rooms and surroundings are clean.
4. Residents can keep many personal possessions in their room.
5. It is easy to arrange for a doctor to see a resident.
6. At night residents decide when they will go to bed.
7. Residents have privacy.
8. It is a cheerful place.
9. When residents have a complaint, something is done about it.
10. There are a range of activities for residents to be involved in.
11. Family and friends are welcome to visit residents and be involved in their care.
12. This facility utilises a community visiting scheme.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Staff Responsiveness

How responsive are staff to:

1. A resident requesting assistance using their buzzer or call system.
2. A resident calling out for assistance.
3. A resident requesting assistance to go to the toilet.
4. Resident incontinence.
5. Resident pain.
6. Resident nausea.
7. Residents' inability to sleep.
8. Resident discomfort.
9. Resident difficulty getting around.
10. Personal grooming of residents.

Note: Response scale ranged from 1 "Very Unresponsive" through to 7 "Very Responsive".

Resident Safety

1. Resident safety is never sacrificed to get more work done.
2. Our procedures and systems are good at preventing errors from happening.
3. Staff will speak up freely if they see something that may negatively affect resident care.
4. Staff feel free to question the decisions or actions of those with more authority.
5. Staff feel pressured to administer medications without appropriate supervision. [R]
6. Management provides a working environment that promotes resident safety.
7. The actions of management show that resident safety is a top priority.
8. This facility has a falls prevention program.
9. Staff at this facility receive education and training in resident safety on a regular and ongoing basis.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Resident Care

1. The nurses and personal carers have the skills to provide appropriate care.
2. Residents decide what they will wear each day.
3. Residents are able to talk to staff as needed.
4. Nurses show real interest in residents.
5. Personal carers show real interest in residents.
6. Life is better than residents expected when they first moved in.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".