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Abstract

This paper is focused on working conditions in the Australian aged care sector. It investigates the relationships between work organisation and job quality within the different aged care settings of home-based and institutional care. The paper draws on a three-year collaborative action research project with three large aged care providers and the main national aged care union. This collaboration underpinned the development of small-scale work practice interventions aimed at both improving worker job quality and care quality. While many managers had difficulty in understanding what constitutes 'job quality' for frontline care workers, the collaborative and research-informed action research process provided a conduit for worker perspectives to be incorporated into the design, implementation and evaluation of specific work practice changes. Having the 'time to care' emerged as a crucial job quality issue for workers, who clearly want to respond to the individual needs of clients and residents. This finding underscores the importance of the care relationship in delivering both job quality and quality care and adds some nuance to the framing of the aged care job quality paradox as a 'love versus money' trade off.

1. Introduction

As in all developed countries Australia is faced with a rapidly ageing population and increased life expectancy. To meet the increased demand for aged care services it has been estimated that by 2050 Australia's aged care workforce will need to grow significantly to around 980,000 workers from 212, 000 workers in 2010 (Productivity Commission 2011). The major growth in aged care workers is projected to be in community-based aged care, a sector in which home care workers comprise over 80% of the workforce (King et al 2013, 71).

The latest available OECD data indicates that in Australia expenditure on long term care (LTC) of 0.8% of GDP is lower than the OECD average of 1.4% (OECD 2012: 174). Compared to other OECD countries, home-cased care is increasingly important as a form of LTC in Australia with aged care policy and funding directed towards growth in provision primarily through home based care. In Australia services in both sectors are mainly delivered by not for profit or voluntary agencies. While the for profit share of direct care employment in residential aged care has remained at around 34% of direct care employment, the private sector share of direct care employment in the home care sector increased to 12% in 2016, from 9% in 2012 (Mavromaras et al 2017, 49, 111).

A comprehensive 2011 review of the Australian aged care sector found that low wages and poor conditions were a challenge in meeting the predicted increase in labour demand created by population ageing (Productivity Commission 2011). In response to this review and as part of its aged care reform package, in 2012 the then Labor federal government announced a Workforce Compact to provide 'additional funding to aged care providers who take steps to improve the terms and conditions of their workers' (Charlesworth & Macdonald 2014). The government committed AU$1.2b to implement the Compact over four years from July 2013 to improve the capacity of the aged care sector to attract and retain staff. Measures included higher wages, improved career structures, enhanced training and education opportunities, improved career development and workforce planning, and better work practices. Interestingly, one of the least remarked features of the Compact was its focus on improved work practices in the sector. Indeed, this 'procurement' initiative held significant potential to improve working conditions on the ground going well beyond what is possible under the *Fair Work Act 2009*, the legislation governing minimum employment standards (Charlesworth & Macdonald 2014). The Aged Care Workforce Compact was to have provided wage supplements to aged care providers who signed up to enterprise agreements committing to above minimum wage increases. The Coalition opposed the scheme in Opposition on the grounds that the enterprise agreement requirement favoured unionised workforces, that it was costly and would increase the regulatory burden on employers. When the Coalition came to government in 2013, the Workforce Compact was abandoned (Charlesworth & Macdonald 2015).

As in other countries, the gendered Australian care system, reflected in funding models and policies, has arguably structured working conditions in aged care (Charlesworth 2012). A very recent reform in the aged care sector has been the rapid shift to what is known as 'cash for care' or individualised funding packages. In both Australian residential and community-based aged care, cash for care funding is known as 'consumer-directed care' (CDC). As has occurred in other OECD countries, while premised on providing additional choice to service users, the shift to cash for care has also been associated with containing burgeoning LTC expenditure. Yet here has been surprisingly little attention paid to the impact of CDC on the availability of frontline care workers or indeed on their working conditions. International experience suggests that there are some negative consequences for workers where funding models create opportunities for working arrangements that, while catering to user demand, are increasingly precarious (da Roit et al. 2015).

Indeed, despite predictions of a significantly increased demand for frontline aged care workers, since the demise of the Workforce Compact and currently within the context of CDC there has been little coherent aged care policy action or even the development of future strategies to address the consequences of poor job quality for worker attraction and retention. It is thus timely, both practically and strategically to better understand what might support better job quality of frontline aged care jobs at the organisational level and the links between job quality and the quality of aged care services.

To that end this paper draws on a three-year collaborative action research project with three large aged care providers and the main national aged care union to investigate the relationships between work organisation and job quality. The focus was on the job quality of frontline non-professional personal care attendants and home care workers who deliver services to clients in residential and community based age care. We argue that despite reluctance by organisations to adopt a ‘worker’ perspective in implementing change, improving job quality was demonstrated to have a positive impact on the care relationship. The paper proceeds by briefly outlining the key framings for our study around the gendered nature of care work and the concepts of quality jobs and quality care. This is followed by an overview of the collaborative action research methodology employed to pilot small scale interventions to improve work practices for direct care workers in three aged care provider organisations. The aim of these changes was to both improve job quality for frontline workers and care quality for service users. Following an overview of three such interventions, we discuss several key issues that arose in their design and implementation and the implications for getting job quality on the agenda in aged care. Finally, the implications of the research more broadly are discussed in the conclusion.

2. Key Framings

In setting the context for the study we briefly sketch out salient insights from the vast literature around the gendered nature of care work and its value as reflected in aged care funding models and policy. We then turn our attention to a somewhat separate literature on job quality and the link between job quality and care quality.

Gender and care work

Aged care in Australia, as in other countries is a feminised sector characterised by low wages, non-standard employment, low unionisation and often significant underemployment (Charlesworth 2012). The nature of direct care work in aged care means that it is profoundly undervalued because of its link with ‘women’s work’ (Palmer & Eveline 2012), reflected in poorer minimum employment standards than in other sectors (Charlesworth & Heron 2012). Further, as in other care sectors, inadequate government funding of the costs of service provision has limited the improvement of employment standards in aged care (Charlesworth 2012; Briggs et al 2007).

In our focus on the organisational level rather than the more macro policy level, our paper is broadly informed by feminist perspectives on the valuing of care work and the doing of gender in organizations (Acker 2006). A persuasive argument in understanding why workers persist in frontline care work, despite its low pay and poor conditions, is what Folbre describes as the ‘prisoner of love’ thesis (see Folbre, 2001), which can be turned against care workers ‘with arguments that they do a better job when they work for love, rather than for money’ (Folbre 2008: 376). This ‘prisoner of love’ approach focuses on the intrinsic motives that drive many care workers, which make it easier to devalue the work and to justify low wages in the sector (England 2005). Thus in Australia, as elsewhere, the view that care workers happily trade off low wages for intrinsic job satisfaction provides a sector-wide institutional logic (McDonald & Charlesworth 2011) that ‘shapes the expectations that employers, clients, communities and workers themselves have of the predominantly female workforce’s capacity to provide elastic and endless care regardless of wages and working conditions’ (Charlesworth et al. 2015: 598).

The extent to which this love versus money paradox is borne out in practice has been challenged by a number of empirical studies. Several studies have highlighted the crucial role that employers and managers can play ameliorating some of the worst impacts of funding models and through the organisation of work and working time, crucially by providing workers with enough time to care (Armstrong et al 2015), creating more potential for an improved satisfaction of workers with their working conditions and with their job (Rubery & Urwin 2011; Chesters & Baxter 2011). Most recently Hebson et al have highlighted the very real socioeconomic constraints negotiated by low-paid care workers as 'they make sense of their working lives' (2015: 328). As in the UK, many aged care workers in Australia are limited by the lack of the sort of post-school qualification that might help them gain better remunerated employment outside aged care. Thus the 'gendered and class-based processes that limit the "field of possibilities" faced by care workers is central to understanding the primacy they give to the intrinsic rewards of the job' (Hebson et al 2015: 327).

Job Quality

There is a huge international literature on the quality of work and a wide range of conceptual approaches to assessing job quality (for a useful summary see Findlay et al 2013). What has been described as a worker-centred concept of job quality, and the framing on which we mainly draw in this paper, focuses on the nature and content of jobs that 'foster the well-being of the worker' (Green 2006: 9). In this framing job quality is multi-dimensional and most typically associated with more objective characteristics such as good pay, job security, control over working time, access to training, skill utilization and promotion opportunities, and access to paid leave (eg Chalmers et al., 2005). Other approaches to job quality employ a more subjective lens and measure aspects such as job satisfaction or worker wellbeing, which can be best understood as outcomes of job quality (eg Lowe, 2007).

There has been relatively little attention to how job quality and care quality is produced at the organisational level (although see Burgess et al. 2013; Hebson et al. 2015). Recent scholarship however suggests that individual workers' job quality in care work is very much shaped by the ways in which work is organised within services and the ways in which supervisors support workers or not (eg Rubery & Urwin 2013; Howe et al 2012; Palmer & Eveline 2012).

In the 2012 National Aged Care Workforce Census and Survey (NACWCS) (King et al 2013) employees were asked to report their satisfaction with key aspects of job quality (see also Parvizian et al 2014a). While the concept of job satisfaction is often used as a proxy for job quality and has been much contested in the literature, particularly for failing to acknowledge the constraints that structure the sense workers make of their job and the satisfaction they experience in it (Hebson et al 2015), the NACWCS data provides some useful insights into dimensions of job quality that matter to frontline care workers.

Despite the evidence of relatively high job satisfaction for both personal care assistants and home care workers across a number of dimensions including overall satisfaction, work life balance, and with their use of their skills and abilities in the job, the survey results indicate several aspects of poor job quality identified by employees (see King et al 2013: 55ff, 139ff). Sixty percent of residential personal care attendants were dissatisfied with the pay they received and many reported they had fewer hours of work than they wanted. One of the key aspects of poor job quality identified in doing the work itself, was not having enough time to care. Being under pressure to work harder, and not having job autonomy were other dimensions of poor job quality reported. Home care workers were most dissatisfied with their level of pay (48%), with the use of their skills and abilities to do the job and with not having enough hours of work. Similar to the personal care assistants, they also reported dissatisfaction with not having enough time to care, although feeling under pressure and being stressed in their work caused most dissatisfaction for home care workers, along with poor job autonomy. Similar job quality concerns for both groups of workers were also raised in the results of the 2016 NACWCS (Mavromaras et al 2017).

Linking job quality and care quality

In an Australian study of aged care regulation, Braithwaite (2001) argued that the 'rationality' of the aged care market cannot improve the quality of care, precisely because it does not recognize the linkages between care quality and the quality of paid care work. However, the ways in which different dimensions of job quality underpin quality care (e.g. from the perspective of the clients/residents of aged care services) remains unclear. In many countries, including Australia, gross medical outcome indicators, such as pressure injuries and unplanned weight loss, are used to measure the quality of aged care. While there is recognition that care is relationship-based, this relationship is typically portrayed as dependent on workers' skills and attitudes (eg AACQA 2015), rather than being influenced by the *organisation* of work and care. Further, the *relational* nature of formal care is overlooked – mainly because effective care relationships take time and therefore money in what are often 'leaned-out' organisations (Armstrong et al. 2008). Qualitative research focused on the clients' perspective suggests that autonomy, individuality and independence are important aspects of care quality (Adams & Sharp 2013; Bradshaw et al. 2012). For aged care recipients, positive reciprocal relationships with workers (Adams & Sharp 2013), and care tailored to individual needs to maximise autonomy (Chin & Quine 2012) are seen as particularly crucial.

For aged care workers in Australia, as noted above, not having enough 'time to care' is a critical factor in employee job dissatisfaction (King et al. 2013) with cross-national research indicating that workers want to have the time to maintain and enhance the dignity of the people to whom they provide care, including through adequate staffing levels (Armstrong et al. 2012). In most developed economies, however, aged care services are increasingly organised around fragmented time schedules in home care (Hebson et al. 2015) or with inadequate staff to resident ratios in residential services (Baines & Daly 2015). Good quality care requires continuity between recipients and care workers, and among services. This requires a stable workforce, adequate staffing and an appropriate staff mix, as well as working conditions that allow workers time to develop and maintain care relationships with the elderly and importantly to use their skills (Baines & Armstrong 2015).

3. Methodology & Data

The Quality Jobs Quality Care (QJQC) Project was a three year (2013 – 2016) collaborative project between researchers from RMIT University, Flinders University and the University of South Australia, and partners from the aged care industry: three large aged care providers: Brightwater (WA), HammondCare (NSW) and Helping Hand (SA); along with United Voice, the main union representing aged care workers. The Project was funded in 2013, just before the change of government, under the Australian Government's Aged Care Service Improvement and Healthy Ageing Grants Fund.

The project aim was to develop innovative workplace tools, models and benchmarks to improve job quality and the quality of services in aged care. Two groups of direct care workers were the focus of the QJQC project: personal care attendants (working in residential services) and home care workers (working in community based services), who together make up the vast majority of the direct care occupations in the Australian aged care workforce.

The Project adapted the Collaborative Interactive Action Research (CIAR) framework to guide the process of collaboration within the project (Bailyn & Fletcher 2003). CIAR was developed as a methodology to underpin the ‘dual agenda’ approach used by North American researchers to focus on ‘small-wins’ organisational change to improve both organisational effectiveness and gender equity (Rapoport et al. 2002). It is a way of purposefully bringing researchers and organisations together in identifying barriers to the effective use of policies and to assist in implementing experimental changes to improve work practices. The researchers’ role in the process is to identify the organisational barriers, suggest intervention points for change and to track and assess the outcomes. CIAR has been used in a variety of settings in the US and the UK (Rapoport et al 2002; Lewis & Cooper 2005) as well as in Australia (Charlesworth & Baird 2007). Such projects have been a practical way of identifying, testing and implementing small-scale changes in workplaces that meet the ‘dual agenda’ of benefitting employees and organisations. The CIAR method presumes that the organisation, its workforce and the researchers all bring expertise that can be effectively combined to produce a dynamic collaboration.

Given the QJQC project’s ‘dual agenda’ of improved employee job quality and improved quality of care, the CIAR approach was used to identify sustainable small-scale work practice changes that might support both. There are four separate and overlapping stages of the CIAR research process (Bailyn & Fletcher 2003: 2), used in the QJQC project. These stages included: (1) identifying the work practices and policies that have implications for employee job quality and care quality; (2) providing a ‘work culture’ diagnosis for the organization to make the costs and consequences of the work practices visible for job quality and care quality; (3) identifying leverage points, or so-called ‘interventions’, for ‘small wins’ change that aim to improve job quality for the workers doing the frontline care work and the quality of the aged care service provided to clients; and (4) helping the organization implement the changes, that is, the ‘interventions’, and evaluating the outcomes, including scaling up, tweaking or abandoning interventions where warranted. The QJQC Project adapted the key principles and strategies of the CIAR approach to guide the collaboration processes within the project.

The QJQC project was implemented in four key phases. Phase 1 comprised an in-depth data analysis of the 2012 National Aged Care Workforce Census and Survey (NACWCS) (King, et al., 2013) to identify job quality benchmarks for aged care workers (personal care attendants and community care workers). As indicated above, the benchmarks identified key dimensions of job quality related to employment conditions (eg work hours, level of pay), and job design (eg work demands, skill development, organisational support) as well as benchmarks on work-related injuries and illnesses (see Parvazian et al 2014a and 2014b). A literature review of client-centred perspectives on what constitutes quality care was also completed (O’Keefe 2014).

In Phases 2 & 3 of the project, these industry benchmarks were then used to assist each the three aged care providers assess possible work practice issues in particular worksites and the consequences of these work practices for job quality and care quality. The project team worked in close collaboration with each of the industry partners to identify which of the job quality benchmarks were a priority within their organisation. An organisational scan and diagnosis was then conducted, including scoping interviews / focus groups with care workers, managers and supervisors, to identify priority job quality issues for the workplace interventions.

After providing a report on the organisational scan to each aged care provider, the project team then worked with them to design, implement and evaluate a workplace intervention to improve one particular aspect of job quality and to investigate associated improvements in care quality. Six interventions of six months each were planned in Phase 2 & 3 of the project; two in each of the aged care providers. Ultimately only five were completed though to final evaluation. They included home care worker ‘specialised’ mentoring and collaborative-person centred well-being mapping in residential care, both discussed below, as well as interventions to support the development of specialised dementia home care teams, rostering for regular hours in home care, and learning shifts in residential aged care. The sixth planned intervention on home care worker autonomy was scoped, but not implemented. This case study is one of those we explore below as it highlights the tensions around a narrow focus on client choice that can work against allowing care workers to practically assist clients realize their choices. In addition we undertook a series of focus groups with United Voice union members in NSW, SA and WA but that data is not explored here. In total, over 160 direct care workers and more than 40 managers were interviewed or participated in focus groups during the QJQC project.

In Phase 4, one of the final outputs of the project was a QJQC Toolkit, which translated the knowledge, experience and insight gained in the earlier project phases and from other Australian and international research into a set of practical and useful tools and resources for the aged care sector.

4. Analysis

In this section we focus on three of the interventions initiated in the QJQC project as they each raise particular, but different, issues about making a worker-centred framing of job quality visible, involving workers directly in the design of mooted work practice changes and, perhaps most importantly, the centrality of the care relationship, particularly in linking job quality and care quality.

Care worker mentoring

Agency A chose to develop a care worker mentoring program for one of their home care teams. The formal aim of this intervention was to increase support for home care workers (skills, confidence, capacity) and improve the quality of client care, particularly for those with complex needs. While focused ultimately on improved care quality, the idea of the intervention came primarily from long-term home care workers who were concerned that an increasing number of clients with complex care needs required greater care worker capability. The existing buddy mentoring scheme whereby more experienced care workers provided some initial support to new staff was seen to be inadequate.

Management agreed to upgrade three of the more experienced workers to become ‘specialised’ care mentors (SCMs) who provided training and support to both new workers and other care workers who could make a request for assistance, or be referred via the schedulers or a manager. SCMs provided support via phone and email and by attending home visits with care workers. Workers could book a time with mentors in advance, and they could also contact SCMs by phone for any urgent matters that came up during a home visit. The SCMs demonstrated the use of equipment or challenging care tasks, and helped with the introduction of care workers to new clients. They also identified training needs and set up small group or one on one training sessions on technical priority topics, such as catheter care.

The SCMs addressed immediate skill and knowledge gaps of care workers and used this information to set training priorities for education and training days. They also produced a number of resources for workers to create consistency in their care work practices, such as the use of a particular hoist for lifting clients. Care workers and managers both reported that the expanded mentoring program had improved the confidence and capability of care workers to deliver consistent, quality care to clients. Other benefits for care workers included improved efficiency and standards in tasks following instruction and modelling from specialised care mentors; reduced feelings of isolation; and improved safety for clients and workers.

In terms of a direct impact of in worker job quality, the main area of improvement from the care workers' perspective was enhanced skills and abilities to do the job as well as reduced pressure and stress. One of the new care workers interviewed spoke of the initial pressure of trying to be professional but not having sufficient capability to do more than 'fudge' their way through certain tasks with clients. She had since accessed the SCMs and said:

> *I found it reassuring... when you're not confident because you've been thrown in the deep end and you're not sure what you're doing, they come out and [go] through it all*

The pressure around doing the work appears to have reduced as a result of easy access to the SCMs with the care workers feeling more capable. However, there are still many structural barriers in delivering community care services that create significant pressure and stress. These barriers included having up to date information on clients and also having sufficient stock items for unexpected clinical issues (such as a skin tear requiring a dressing pack and dressing). In the more controlled budgetary environment of consumer directed care (CDC), access to stock items had become limited to enable the organisation to more easily identify which client would be charged for the items. However this meant that care workers were more likely to have to return to the office to restock.

In the final evaluations, managers also reported that they thought the SCMs had made a difference to the pressure and stress experienced by care workers. Agency A planned to maintain the intervention beyond the initial 6 months and roll it out to other home care teams across the organisation.

Wellbeing mapping

Agency B trialled a new program of 'wellbeing mapping' to enhance multi-disciplinary team coordination and cooperation, and improve the level of individualised care for their elderly residents experiencing some degree of cognitive decline. Various forms of client mapping has been used in dementia care to highlight a person's strengths, abilities, routines and preferences within the context of their diagnosis, current health status and physical and social environment (Aberdeen 2015). In this particular intervention, a number of residents were the focus of an individual wellbeing mapping session. While frontline care staff are often excluded from more formal case management meetings, in this intervention it was agreed that care workers, clinical staff and a wellbeing mapping facilitator would meet as a team with the client and/or family members in a one hour session, using a specialised framework that placed the client at the centre of the discussion. Care workers nominated residents for mapping sessions based on current care challenges they were experiencing or where little was known about the resident. Each nominated resident was then invited to attend (where appropriate) the mapping session and encouraged to invite their family members. Care workers who worked most often with the nominated client and clinical staff were invited to attend the sessions. The facilitator helped the team create a wellbeing map from a discussion about the person's history, strengths, abilities and preferences. This map then informed a wellbeing profile 'This is me' for staff; a 'Did you know' staff memo; and a support plan.

Interestingly this intervention in one of Agency B's residential sites started with an explicit focus on improving care quality rather than job quality and workers were not involved in the initial decisions on this particular intervention. A planning worksheet was used to outline the key aspects of the new approach to care and management views of the expected benefits for job and care quality and the evaluation plan. After being told about the planned intervention that would involve them directly, care workers were generally enthusiastic, identifying many potential benefits including increased knowledge of residents and the ability to further engage with them and tailor their care through a fuller understanding of the history and wellbeing needs of particular residents.

In both the mid intervention and final intervention evaluations, all participants agreed that care quality for those residents who had been the focus of a wellbeing mapping session had been enhanced. Interviews and small-scale surveys with care workers indicated that they generally felt more valued in their role and could give greater individualised support to residents, by having more understanding of, and different responses to, the residents' behaviours and needs. A number of family members were also reported to have benefited from the mapping process, because they had been reassured by the interest and care shown towards their relative.

While some care workers did not think that they had learnt a lot more about the residents who were 'mapped', the majority said that significant information gained about residents had led to a change in their care practices. This included having conversations about topics meaningful to the resident, and responding differently to their behaviour and needs. Several care workers reported that involvement in a mapping session later gave them 'permission' to ask for information from the resident and/or family that they otherwise might have felt was inappropriate in day-to-day interactions.

So what about job quality? While the intervention did not make any impact on care worker job conditions such as time to care and work pressure, it impacted on intrinsic job quality factors such as team relationships, communication, respect and acknowledgement, and empowerment. Care workers expressed generally positive views about the intervention and reported that they were rewarded from a better care relationship with these residents, which made them feel better about their work. In particular, the wellbeing mapping sessions built a relationship with residents' families and increased mutual understanding of the residents' care. While managers reported increased team cohesion, care workers did not generally report any change in team relationships. However, they did describe having improved access to clinical staff when needed, and being given more opportunity to share information about residents and sufficient time to read the information from mapping sessions.

One of the most important job quality improvements reported by care workers was increased respect and acknowledgment from clinical and allied health staff, who also reported they had increased respect for the role of care workers and their relationship with residents. Care workers commented that receiving acknowledgement for their contribution to mapping sessions was very important to them. Clinical staff believed that participation in the sessions had empowered care workers and that the more comfortable care workers became in the process, *'the more information they are willing to talk about'*. While there had been some initial resistance by clinical staff to the participation of the care workers in the mapping sessions, over the course of the intervention this resistance changed quite dramatically. In the final intervention evaluation, one clinical staff member described her reaction to a particular care worker with whom she had been involved in mapping sessions:

> *I was blown away by her …in-depth knowledge of the residents…the only reason she is going to know that information is if she's spent time and quality time with that resident. So now I have an understanding and deeper respect for that carer.*

This appreciation of different roles and perspectives was reciprocated by care workers, with another clinician commenting,

> *I've found that some care staff are including me or asking my opinion when they never used to before…now it's as though they are a bit more inclusive and understanding. So they don't mind coming to ask for my advice.*

In the final intervention evaluation, the views of care workers, clinical staff and the manager indicated a high level of support for the wellbeing mapping not only as an intervention but also as a continued practice. While care workers played little role in the design of the intervention, they did have some influence on both how the intervention was implemented over the 6 month period and in contributing to small changes. For example, feedback from workers in the mid-intervention evaluation had led to the introduction of daily staff handover sessions for care workers, improving the flow of information about residents and enabling care workers to be informed when doing their job.

Care worker autonomy

One of the six interventions designed but not implemented was around care worker autonomy. Management in Agency C initially expressed concerns regarding the difficulty of attracting and retaining home care workers particularly in its rural locations, and wondered what policies and practices could better support older workers in those locations. As part of the scoping process there was consultation with head office management and then a scoping process in a specific regional home care 'hub'. The scoping processes engaged local workers and managers around what they saw as the key job quality and care quality issues in their day-to-day work. The key job quality concern raised by workers was the shifting boundaries of their autonomy in the context of the move to CDC and the impact this had on the quality of care they could provide clients.

In initial scoping interviews and focus groups, care workers described tensions between maintaining a positive care relationship with their clients and what they perceived to be some unhelpful limits to their discretionary decision-making in the context of CDC. Many workers reported policies such as placing restrictions on workers contacting clients in hospital and being allowed to advise clients in advance about planned leave reduced both care workers' and clients' experience of being valued and empowered. Some workers believed that organisational policies and practices did not always allow them to respond in a timely and flexible way to clients' expressed needs or preferences which, in some cases, deviated from the prescribed tasks in the client's care plan. Care workers also stated that some policies and practices did not fully recognise the importance of their long-term care relationships with clients. One care worker described feeling particularly devalued when she was not provided with information about clients who, for example, were in hospital. When querying her coordinator in one case as to why she was not told about her client's fall and subsequent hospitalization, the coordinator cited privacy reasons and told the worker that 'it is nothing to do with you'. The worker considered that incidents like this disregarded the bond between a care worker and client, particularly as there had been a care relationship in place for a significant time.

Managers had a somewhat different perspective about the limits to care worker autonomy, observing that some care workers could overstep the professional boundaries of the care relationship and how important it was for care workers to abide by organisational policies and practices, such as not contacting clients independently. Managers however varied in their approach to the extent and nature of care worker autonomy under CDC. Some managers stated that they should be informed if clients requested any changes, no matter how small, to the care plan. They believed some workers could be vulnerable to clients taking advantage of them if they agreed to modify care plan activities without permission.

The QJQC researchers provided a report to senior managers on completion of the scoping process with workers and line managers. Several meetings involving head office staff, local coordinators and the QJQC research team followed this report. Managers generally acknowledged the challenge of supporting the autonomy of care workers in the CDC environment but identified the 'problem' as workers not fully understanding CDC and suggested that a more appropriate response was for the agency to run additional education of care workers. This was planned for after the time period possible for the proposed intervention.

5. Discussion

In the QJQC project, the collaborative and action research-informed process provided a conduit for worker perspectives to be incorporated into both design and the implementation of specific work practice changes. However, our role as researchers in bringing worker-centred understandings of job quality to the fore was sometimes problematic for our research partners. There is little doubt that we came to the research with the view to improve the quality of work for direct care workers, specifically the organisation of work, and that the methodology aimed to give workers a voice. This was explicit from the time the aged care providers came into the project. However, it was not until we met for a mid-project workshop that we, as researchers, came to fully understand the extent to which aged care providers had to shift their thinking in order to make job quality a priority. In some ways, this was never fully achieved.

It became clear even in the design stage that many managers in the three aged care providers had difficulty in coming to grips with a worker-centred understanding of what might constitute 'job quality' for frontline care workers. In almost all cases it was senior management, and in some cases it was local management, who decided on the nature and scope of particular intervention. Interestingly the one exception and the intervention that foundered at the design stage was in the planned intervention in Agency C outlined above, with the push by workers for an intervention to calibrate the extent of their day-to-day autonomy within the context of CDC.

None of the interventions were therefore driven by worker-centred understandings of what would improve their job quality. Of the five interventions that were implemented, two were focused specifically on job quality (learning shifts and regular scheduled hours) and three indirectly improved job quality through improvements in the care relationship (specialised dementia teams, care worker mentoring, wellbeing mapping). In these latter interventions, we consistently reiterated the need to focus on job quality, which was accommodated by two of the partner organisations. For the remaining partner organisation, the capacity to foreground worker-centred experiences was limited. Management did not seem to trust their workers to do the right thing by the organisation, and when researchers attempted to shape their final intervention around job quality we were accused of pushing our own agenda. This caused some reflection in the research team around the role of researcher-advocate. Even though we did not have a view of the kinds of interventions that organisations could implement, we did seek to have workers represented in the research and development of interventions – even though this was moderated in the actual interventions.

Nevertheless, in most cases through the process of designing and implementing the small scale change in work practices, managers, particularly line managers did come face to face with worker-centred understandings of job quality as the research process brought them written reports on worker perspectives pre, mid and post interventions. This greater awareness generally made it easier for managers to start to see the links between worker job quality and care quality, a feature which is emphasised in the write up of each case study in the QJQC Toolkit. There were, however, many dimensions of job quality that were consistently raised by workers that were not addressed or even impacted on by most of the interventions put in place. This situation suggests that there are impediments at the organisational level as well as in the broader policy and regulatory settings. For example, CDC has seen an intensification of a task-orientated approach to care particularly in home care, which in the case of Agency C was seen to lead to a diminution of care worker autonomy.

Having the 'time to care' consistently emerged as one of the most crucial job quality issue for workers, who clearly wanted to be able to respond to the individual needs of clients and residents in ways they thought appropriate. In the mentoring intervention outlined above, what were described as unrealistic plans for time to care were raised several times. In one focus group, a home care worker spoke of the pressure and stress to complete care (in this instance personal care) with insufficient time; a time allocation they had been told by a manager had not been able to be renegotiated with the family. This then led to a discussion in the focus group about the importance of taking the time to read the care plan before commencing care, to ensure awareness of any changes to the plan and/or the client's health status. Some care workers however continued to express concern that they often did not have time to read the care plan at all or in full, with the family often pressuring the care worker not to read the plan.

In the well-being mapping intervention while clinical staff reported that care workers seemed to spend [more] time with the residents than prior to the mapping, care workers did not report any changes in their time to care. Indeed, some care workers said that it was hard to give the time to residents that they would like to due to the pressure of other tasks that required completion with one saying, *'…having a chat with them…you don't have time for that'*. Several care workers observed that as the resident group became older and frailer, they needed more physical assistance, and that at times they were needing to work under pressure to assist residents and 'rush' them. Interestingly the site manager argued that that time to care is always going to be an issue in aged care. While she understood that care workers view quality care as having time to sit down and chat to the resident, she tried to encourage workers to consider the interactions they have with residents as they provide care as equally important. This does not account however for workers feeling too rushed during such interactions to actually have time for the resident.

The issue of time goes beyond the direct time required in actual engagement with clients and residents to provide quality care. Time spent in the 'work to do the work', was also a concern of many care workers involved in the interventions. While not specific to the interventions, workers consistently raised the issue of a lack of time, for example, insufficient travel time allocated for home care visits, pressure in relation to time to care in completing tasks in a particular time and for some home care workers, long work days with no scheduled meal breaks. One home care worker reported her experience thus:

'I had a 12 hour day and I rang up and said listen I can't do this in 12 hours … I said when will I have a break? When do I eat my lunch? I got told to eat it as I'm driving'.

The need for consistent attention to be given to improving job quality for care workers by designing work that is doable in the time allocated and allows enough time to develop and maintain care relationships is important for organisations, government regulation and policy and employee wellbeing.

6. Conclusion

Other than a brief window of opportunity provided by the Aged Care Workforce Compact, during which 'decent working conditions' were put on the policy agenda for aged care workers, it has been difficult to get traction around the concept of job quality. Although organisations and governments might recognize they have problems in recruiting and retaining enough direct care workers to meet demand, this challenge is rarely considered beyond a perfunctory 'workforce planning' approach (Charlesworth 2016). In placing workers at the centre of small-scale interventions, the QJQC project attempted to challenge this thinking and raise awareness of what constitutes a quality job and linking the impact of job quality to the provision of quality care.

The QJQC project suggests that is a lot of congruence between worker and client perspectives about how work might be organised to provide quality care inasmuch as they both focus on the development of a functional and positive care relationship. A relationship in which clients value receiving care that recognises their individuality and supports their autonomy and independence; and workers gain job satisfaction from knowing the client, being able to respond to their care preferences and provide the level of care required. Such relationships require stability and consistency in staffing (Jeon 2016), the acquisition and development of appropriate skills and competencies, adequate levels of staffing and the allocation of sufficient time in which care can be provided and care relationships developed (Baines & Armstrong 2015; Rubery et al 2015). Our research contributes to these understandings of aged care work that draw on both worker and client perspectives in highlighting the importance of the organization of work to the quality of care, and linking this to policy arguments about fully recognizing the centrality of quality jobs to the delivery of quality care services.

While making changes at organizational level can have an influence on specific care relationships and the organization of work for discrete groups of workers within aged care services there is a clearly a need for a more institutional approach. With this in mind we are using the research to attempt to influence broader outcomes. Firstly, the findings from the research were used to develop a toolkit around the process that aged care providers can embark upon in order to improve job quality for their direct care workers (Skinner et al 2016). This toolkit is freely available for training organisations, aged care providers, peak bodies and managers to use when seeking to address job quality issues. Providing a step by step guide to the process of designing, implementing and evaluating small scale changes in the workplace the toolkit provides a mechanism for moving beyond workforce planning toward an approach that is more focused on work conditions and worker wellbeing as necessary to the development and maintenance of health care relationships (Skinner et al 2016).

Secondly, as the need for better policy to promote quality work becomes more evident, it is important to link organisational action around job quality and work design to the specific regulatory frameworks within which care work is undertaken and care relationships developed. This is because in practice the scope for real managerial 'choice' or strategy around workplace level work practices may well be limited within the particular funding and regulatory context of aged care (Rubery et al 2015: 754). While our focus has been on the Australian aged care sector, the literature suggests that the interaction between care and employment regimes differ across countries (Williams 2012) and that much could be learned from an comparative investigation into how care relationships are constructed and practiced in different national contexts. In an effort to influence national policies that would again put work conditions and practices in the aged care sector back onto the agenda we are embarking on a cross-national study of the policy, regulatory and organizational factors that shape the quality jobs, quality care nexus.

7. References

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