**TITLE:** Scoping the skills and training needs of community aged care workers in rural localities: An Australian Study

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**ABSTRACT**

*Introduction:*

Like other developed nations, Australia’s population is ageing. This presents both challenges and opportunities for health and aged care services. The care needs of a growing population of community-living elders are now more complex given the high prevalence of multiple and chronic physical and cognitive conditions among this group. One of the significant global challenges in the next three decades is ensuring a significant workforce is trained and skilled to meet these care needs. In Australia, workforce estimates indicate a worsening of the current situation due to the ageing and imminent retirement of a large number of community aged care workers. The profile of the community care workforce is ageing and highly gendered with a median age of 52 years. Community based care provision is reportedly more complex given the prevalence of chronic health conditions among this population. Industry and policy demands for high quality and cost effective care into the future correspond with current and projected workforce and skill shortfalls as well as reported dissatisfaction with current training courses.

This is particularly problematic in rural areas. Issues of complexity and challenge in providing community aged care are well documented, particularly providing suitably skilled, knowledgeable staff. One of the challenges in smaller rural areas is the need for staff with broad skill sets to be able to provide the range of services that are needed. Yet there are a number of barriers to recruitment including relative poor remuneration and limited career opportunities. Accordingly this study explores skills and training needs in community-aged care across five diverse rural locations in a southern state of Australia.

*Methodology:*

Drawing on a multi method design, this research collected both quantitative and qualitative to review current skills and future training needs. The study brought together a consortium of five Aged Care providers Initial data was collected identifying industry knowledge and key issues impacting skills and training. Survey data was collected from Community Care staff employed across the five case study sites, measuring perceived competencies against national training standards. In-depth interviews were conducted with Managers of community aged care services, Community Care Workers in the community aged sector, and on-site educators.

*Results*

The combined data highlighted some challenges and gaps in current training models across key competency areas. This critical evidence ensures that training provided matches the needs of local rural contexts and allows aged care practitioners to work seamlessly between levels of community care settings. It enables rural aged care providers to determine where resources are placed in the provision of additional skills and training. In partnership with regional training organisations and tertiary educators, suggestions for new models of training will also be made that align with the current Australian Government’s agenda of keeping older people in their own homes for as long as possible.

**INTRODUCTION**

The implications of increased life expectancy in developed countries such as Australia are well noted. Projected, rapid increases in the number of Australians aged 65 and over indicate that this demographic group will constitute some 22% of the population by 2056. In other words, around 8.7 million older Australians will, to varying extents, require health and social forms of care and support to prolong their functional capacity for independent living (Australian Institute of Health and Welfare, 2017). The care needs of a growing population of community-living elders are now more complex given the high prevalence of multiple and chronic physical and cognitive conditions among this group.

Population ageing presents both challenges and opportunities for health and aged care services. A significant challenge in the next three decades concerns the recruitment and retention of an appropriately trained and skilled community care workforce. Estimates indicate a worsening shortfall of workers due to the ageing and imminent retirement of a large percentage of the current workforce. The 2011 Productivity Commission report commissioned by the Australian government, predicts that the paid care workforce in Australia will need to quadruple by 2050 to meet anticipated demand (Productivity Commission, 2011).

Australian regional and rural communities are particularly impacted by both service complexity and limitations, and by workforce and skill shortages. Equally, factors such as distance from service and training organisations, smaller workforce pools, the diverse service mix and the relatively poor health status of rural elders impact on care delivery capacity and budgets (Neville, Napier, Adams, Wham, & Jackson, 2016). The experiences of older people living independently in their homes are notably affected by these and other factors. Shortfalls in available workforce greatly limit the ability of older people to access the services they desire and require in order to remain living in their homes. This is of particular significance in rural and remote regions where poor access related to service complexity and limitations is exacerbated by workforce and skill shortage (Mavromaras et al., 2017).

**CHANGING LANDSCAPE OF COMMUNITY CARE**

The Australian Aged Care sector has undergone considerable reform in the past decade. The expansion of the community aged care sector followed government policy which espouses the value of supporting older adults to live independently in the community for as long as possible (Australian Government Aged Care Financing Authority, 2017). Continued expansion of the Aged care workforce is dependent upon a range of recruitment and retention factors. The aged care sector faces competition for staff with similar skills, and recruitment is hampered by its poor image. The community care workforce comprises health care professionals including registered and enrolled nurses, physiotherapists, and occupational therapists, and minimally trained community care workers (CCWs), also referred to as home care workers. CCWs assist elderly consumers with tasks such as personal care, cleaning, shopping, social support, assisting with mobilisation, attending medical appointments, administering medications and providing personal care (Palesy, Jakimowicz, Saunders, & Lewis, 2018). The work is characterised as poorly paid, menial and lacking career advancement.

Regional and rural aged care workforce issues across residential and community care settings have been examined in recent years (Hodgkin, Warburton, Savy, & Moore, 2017; Savy, Warburton, & Hodgkin, 2017). This work demonstrates the difficulties in attracting and retaining younger and newly qualified workers and the reliance of service providers on an ageing pool of female workers (Savy et al., 2017). In rural contexts, services must find ways to meet needs associated with consumer isolation and health complexity.

 A considerable body of research examines retention factors related to the aged care workforce (Husso & Hirvonen, 2012; Palmer & Eveline, 2012; Stacey, 2005). Typically, this work highlights aged care workers’ high levels of satisfaction with the kind of work they do, their relationships with consumers and the autonomy that they exercise as lone, community-based workers (intrinsic factors). However, extrinsic factors such as relatively poor pay rates, insecure hours of work, and the need for further training and career pathways, are causes of job dissatisfaction (Hodgkin et al., 2017). In a recent survey commissioned by the Trustee of Health Employees Superannuation Trust Australia (HESTA), an estimated 23% of aged care staff noted their intention to seek positions outside of aged care due to poor remuneration and insecure work (Trustee of Health Employees Superannuation Trust Australia HESTA, 2018).

In recognition of the nation-wide, workforce challenge, the Australian Government commissioned an Aged Care Workforce Strategy Taskforce (ACWST) to develop future-oriented solutions (Aged Care Workforce Strategy Taskforce, 2018). This report highlights that the current workforce is highly feminized and one of the oldest in Australia. It also documents the complex and challenging issues inherent in providing community and residential aged care. Challenges for rural and remote providers are acknowledged including the specific issues that differentiate remote locations from metropolitan areas. Consequently, the authors of this report proposed a Remote Accord to address the unique geographic, demographic and social issues that challenge aged care service provision within remote areas of Australia. Although potentially valuable, this proposal lacks detail and substance and is limited to remote and very remote communities. This paper seeks to address this limitation by examining how well equipped trained staff are to work with new developments in the delivery of community aged care including increased consumer complexity.

**METHODOLOGY**

This research brought together a consortium of five aged care providers in a rural region in Victoria, a Southern State of Australia, who together service the majority of community aged care consumers in that region. The study employed a mixed method exploratory sequential research design to capture a variety of complementary qualitative and quantitative data. In stage one, a survey instrument was drawn from the Australian Government’s nationally commissioned study on workforce (Mavromaras et al., 2017). Additional questions were included to assess the implications of rurality for workers in terms of proximity to their workplace and to their consumers. Questions relating to particular skill and training needs were included to gauge the potential and actual scope of practice and the responsibilities of community care workers. Significantly, this tailored instrument provided for comparison with the national data. Fifty-five staff participated in the survey.

Stage two consisted of interviews with Community Care Managers (n=8) and participants from stage one who had agreed to participate in either an interview or focus group. The interview schedules included topics concerning: workforce training and qualifications; efficacy of training and qualifications; consumer care needs and practices; workforce roles and responsibilities; workforce satisfaction and workers’ recommendations.

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## Analysis

 All survey data were entered into SPSS 24 for analysis, and checked for accuracy, missing values, and outliers. To ensure rigorous analysis of the interview data, a number of steps were undertaken. All interview and focus group data were audio recorded and electronically transcribed and, along with detailed field notes, ensured an accurate record of interviews. The transcripts were examined by two research team members to identify themes and patterns to categorise and systematically analyse the themes within the framework of the interview schedule (Miles & Huberman, 2002).

**FINDINGS**

***Stage One***

As noted earlier in this paper, the community care workforce is one of the oldest workforces in Australia. In the present study, the average age of all the participant was 49.5 years (SD = 11.1), with the CCWs having an average age of 52. 6 years (SD = 9.7). This is directly comparable to the national average age of 52 years for CCWs. The average age at which staff began working in aged care was 38.8 years (SD = 12.3) and the respondents had worked in aged care for an average of 9 years (SD = 9.3). For the CCWs, the average age at which staff commenced working in aged care was higher at 42.7 years (SD= 9.9) with an average 5.5 years of service (SD= 5.7). As per the national survey, the majority of participants were female (49 females, 5 males, and one undisclosed) with 90% of CCWs female. Again, this data closely reflects the national workforce data.

As highlighted earlier in the paper, difficulties in recruiting and attracting younger people into community aged care have been attributed to remuneration issues, the perceived status of the work and the limited opportunities for advancement. Understanding the pathways into community care is therefore crucially important. In the present study, this was addressed by asking respondents about their previous paid work before first commencing work in aged care. They were also to state their age when they first commenced in an aged-care role. Table 1 depicts these pathways. No-one in the sample had actually started their career as a CCW. This is a trend which has been observed at the national level with very few workers starting their career in aged care (Mavromaras et al., 2017). There is also no identified path into community care work; the respondents have come from a wide range of occupations. For nursing and allied health, a somewhat different trend emerges given the overlap between positions in acute and other healthcare settings.

Table 1 Previous occupation of community care workers

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Last occupation before first job in aged care** | **CCW in current project** | **Nursing and allied health worker** | **Non-direct care worker** | **CCW in national census\*** |
| **No previous paid employment** | 0.0 | 9.1 | 7.1 | 6.8 |
| **Nurse, acute care** | 3.3 | 27.3 | 0.0 | 1.7 |
| **Nurse, community care** | 0.0 | 0.0 | 0.0 | 1.2 |
| **Other healthcare** | 10.0 | 9.1 | 14.3 | 4.0 |
| **Carer in other setting** | 10.0 | 9.1 | 0.0 | 5.0 |
| **Disability care** | 3.3 | 0.0 | 7.1 | 4.5 |
| **Salesperson** | 0.0 | 9.1 | 14.3 | 9.7 |
| **Clerical worker** | 13.3 | 0.0 | 21.4 | 11.2 |
| **Hospitality worker** | 13.3 | 0.0 | 0.0 | 7.2 |
| **Cleaner** | 6.7 | 0.0 | 0.0 | 7.9 |
| **Professional (other than nurse)** | 0.0 | 9.1 | 0.0 | 4.5 |
| **Manager** | 6.7 | 0.0 | 7.1 | 4.3 |
| **Other paid employment** | 33.3 | 27.3 | 28.6 | 32.0 |

\**Source.* The Aged Care Workforce, 2016 survey

In order to gain an understanding of the respondents’ employment arrangements, they were asked a range of questions. Table 2 lists these arrangements by occupation. As shown in the national census, few CCWs (6.7%) and a higher rate of nursing and allied health workers (18.2%) are employed on a permanent full-time basis. The percentages employed on a permanent-part-time contact (CCWs 50% and Nursing & Allied Health 54.5%) are somewhat higher, however these are significantly less than at the national level where there was an increase in permanent part-time employment from 63% in 2012 to 79% in 2016. In comparison to the 2016 national average, a far greater proportion of CCWs (43.3%) are employed on a casual basis than the 2016 national average (15.3%). This suggests a highly casualised workforce.

**Table2: Form of employment and work schedule of staff**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **CCW in current project** | **Nursing and Allied Health Worker** | **Non-direct care worker** | **CCW in national census\*** |
| **Form of employment** |  |  |  |  |
| **Permanent full time** | 6.7 | 18.2 | 35.7 | 5.7 |
| **Permanent part-time** | 50.0 | 54.5 | 42.9 | 79.0 |
| **Casual or contract** | 43.3 | 9.1 | 7.1 | 15.3 |
| **Work Schedule** |  |  |  |  |
| **A regular day shift** | 69.0 | 100 | 92.9 | 76.2 |
| **A regular evening shift** | 3.4 | 0.0 | 0.0 | 1.0 |
| **A regular night shift** | 0.0 | 0.0 | 0.0 | 0.2 |
| **A rotating shift** | 3.4 | 0.0 | 0.0 | 3.0 |
| **Split shift** | 0.0 | 0.0 | 0.0 | 2.9 |
| **On call** | 6.9 | 0.0 | 0.0 | 0.8 |
| **Irregular hours** | 17.2 | 0.0 | 0.0 | 13.8 |
| **Other** | 0.0 | 0.0 | 7.1 | 2.1 |

\**Source.* The Aged Care Workforce, 2016 survey

The respondents were asked to provide information about their weekly, rostered hours. The responses show occupational differences in the number of hours worked with the average number of weekly hours for CCWs being 23.7 (SD = 7.1), for nursing and allied health staff the weekly hours worked were 31.7 (SD = 9.9), and for non-direct care staff, the weekly hours were reported to be 34.5 (SD = 8.7). The respondents were also asked to nominate the number of hours per week that they would ideally like to work. Their preferred working hours are listed in Table 3, which suggests that the majority of community care workers would prefer greater hours.

Table3: Preferred hours of work

|  |  |  |  |
| --- | --- | --- | --- |
| **Occupation** | **Less hours than currently working** | **The same hours as currently working** | **More hours than currently working** |
| **Community care worker** | 3.6 | 42.9 | 53.6 |
| **Nursing and allied health worker** | 36.4 | 36.4 | 27.3 |
| **Non-direct care worker** | 23.1 | 76.9 | 0.0 |

The main finding from these two tables is that more than 50% of CCWs would like to increase their hours of work. This finding suggests that there are significant areas of under-employment in the current workforce

In relation to qualifications to undertake the work, respondents were asked to indicate which post-school qualifications that they had completed, as seen in Table 4. The types of qualifications undertaken are reflective of the occupational roles undertaken. For CCW staff the most common qualifications were aged care or related qualifications such as Cert 111 in Aged Care (55.2 %), Cert 111 in Home and Community Care (51.7%) and Cert 111 in Individual Support (17.2%). Over 13% had undertaken a Cert 1V in aged care. Compared to the national data, CCWs in the present study were, on the whole, more qualified. In addition, more than 10% had a Cert 111 in Disability Work.**Table 4: Post-school qualifications completed by staff**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Qualification** | **CCW in current project** | **Nursing and Allied health care worker** | **Non-direct care worker** | **CCW in national census\*** |
| **Health** |  |  |  |  |
| Bachelor’s Degree in nursing | 3.4 | 9.1 | 0.0 | 1.4 |
| Bachelor’s Degree in Allied Health | 3.4 | 36.4 | 0.0 | 0.9 |
| Certificate IV/Diploma in Enrolled nursing | 0.0 | 9.1 | 16.7 | 3.5 |
| Other basic nursing qualifications | 3.4 | 9.1 | 0.0 | 2.6 |
| Post-basic nursing qualifications (not in aged care) | 3.4 | 0.0 | 0.0 | 0.6 |
| Post-graduate allied health qualifications | 0.0 | 0.0 | 0.0 | 0.4 |
| Other (Health related) | 10.3 | 0.0 | 8.3 | 5.6 |
| **Aged care** |  |  |  |  |
| Certificate III in aged care | 55.2 | 0.0 | 16.7 | 50.9 |
| Certificate III in home and community care | 51.7 | 0.0 | 0.0 | 26.6 |
| Certificate III in individual support | 17.2 | 0.0 | 0.0 | - |
| Certificate IV in aged care | 13.8 | 0.0 | 0.0 | 12.2 |
| Certificate IV in service coordination (ageing and disability) | 0.0 | 0.0 | 8.3 | 2.8 |
| Other certificate in care work | 6.9 | 9.1 | 0.0 | 8.2 |
| Post basic nursing qualification in aged care | 0.0 | 0.0 | 8.3 | 0.5 |
| Other (aged care related) | 6.9 | 0.0 | 8.3 | 5.7 |
| **Disability** |  |  |  |  |
| Certificate III disability/disability work | 10.3 | 0.0 | 0.0 | 8.6 |
| Certificate IV disability/disability work | 3.4 | 0.0 | 0.0 | 6.3 |
| Diploma disability/disability work | 0.0 | 0.0 | 0.0 | 0.6 |
| Diploma community services | 0.0 | 0.0 | 0.0 | 1.8 |
| Other (disability related) | 3.4 | 0.0 | 0.0 | 1.6 |
| Management |  |  |  |  |
| Certificate III or IV in management | 0.0 | 0.0 | 0.0 | 4.6 |
| Diploma in management | 3.4 | 0.0 | 16.7 | 3.5 |
| Bachelor or postgraduate in management  | 0.0 | 0.0 | 0.0 | 1.3 |
| **Other** |  |  |  |  |
| Other certificate III or IV | 24.1 | 18.2 | 41.7 | 14.9 |
| Other Diploma | 13.8 | 9.1 | 50.0 | 9.7 |
| Other bachelor or Postgraduate degree | 6.9 | 9.1 | 33.3 | 8.2 |

\**Source.* The Aged Care Workforce, 2016 survey *Note.* Multiple responses were allowed, totals will not sum up to 100. Certificate III in Individual Support was not an option during the Aged Care Workforce, 2016 survey

Table 5 shows that a higher proportion of CCWs (80%) in the current study had undertaken further training as part of their employment in the last 12 months when compared to the national average (73.5%) (Mavromaras et al., 2017). Similar to the national average, most of this training in the current cohort was mandatory.

Table 5 Training undertaken in past 12 months

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Undergone training in the last 12 months** | **CCW in current project** | **Nursing and Allied Health worker** | **Non-direct care worker** | **CCW in national census\*** |
| **No training** | 20.0 | 0.0 | 28.6 | 26.5 |
| **Mandatory training** | 70.0 | 81.8 | 42.9 | 67.4 |
| **Non-mandatory training** | 10.0 | 18.2 | 28.6 | 13.6 |

As illustrated in Table 6, a number of areas were identified by the CCWs and other staff as most needed. The most common types of training requested for CCWS were skills and knowledge to assist working with consumers who have mental health issues (44.4%), dementia care (48.1%) and managing challenging behaviours (40.7%). Training in palliative care (29.6%) was also highlighted for CCWS and for nursing and allied health care this was the ‘number one’ area of training listed (45.5%). This is reflective of a more general movement which has seen the care of people with life limiting illness increasingly moving away from the acute setting into the community.

Table 6: Areas of training identified as most needed, by occupation

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of training** | **Community care workers (n=27)\*** | **Nursing and Allied Health staff (n=9)** | **Non-direct care staff (n=6)\*** |
| **Mental health disorders** | 44.4 | 9.1 | 33.3 |
| **Dementia care** | 48.1 | 27.3 | 11.1 |
| **Person-centred care** | 22.2 | 18.2 | 33.3 |
| **Assessment of health status** | 7.4 | 18.2 | 22.2 |
| **Managing challenging behaviours** | 40.7 | 9.1 | 11.1 |
| **Communication** | 11.1 | 9.1 | 22.2 |
| **Palliative care** | 29.6 | 45.5 | 11.1 |
| **Management and leadership** | 0.0 | 18.2 | 33.3 |
| **Facilitating recreational activities** | 7.4 | 27.3 | 11.1 |
| **Wound management** | 18.5 | 27.3 | 0.0 |
| **Allied health** | 0.0 | 36.4 | 11.1 |
| **ICT** | 0.0 | 9.1 | 11.1 |
| **Consumer report documentation** | 22.2 | 9.1 | 22.2 |
| **Consumer relations** | 0.0 | 0.0 | 11.1 |
| **Conflict resolution** | 14.8 | 18.2 | 33.3 |

\*Note: 4 missing staff entries from non-direct staff. 3 missing staff entries from Community care workers

***Stage Two***

This stage sought to expand upon the above findings by capturing the experiences of hands-on workers, thus providing insights into their qualifications to do the job, their experience and preparedness to do the work they do, and their satisfaction with their conditions of employment. Eight Community Care Managers and seven direct care workers agreed to participate in an individual interview, and an additional eleven workers participated in 2 focus groups. Altogether five participants were male and twelve were female. All were of mature age or older, some over 50. One participant was aged 67 years.

*Suitably qualified*

The managers and their care coordinators are variously and appropriately qualified and experienced. Collectively, their qualifications include: Advanced Diploma Business Management; Diploma Community Services, Registered Nurse; B. Social Science (Social Welfare); Graduate Diploma Community Health; B. Applied Science (Physiology); and Diploma in Human Resources. All of the community care workers had acquired a Vocational Education Sector Certificate 111 qualification appropriate to the role of direct care worker. Most participants had been employed in CCW roles for a minimum of three years. One had had accumulated ten years’ service, another twenty-six. Most participants had come to this role after lengthy work experience in other fields including retail, child care, and disability care.

Rural workforce pools are likely to be smaller than those in Regional and Metropolitan areas. Rural towns are known for their relatively aged populations as well as for shrinking numbers of younger persons. This demographic reality holds implications for recruitment and retention strategies into the future. Across the Services, the managers described their workforces as relatively stable with minimal turnover. The managers acknowledged that many of their direct care workers were ageing. While many older workers are keen to stay in their roles, their capacity for consistently heavy work may diminish. The managers referred to the need for rostering concessions that mix light and heavy duties for these workers, many of whom are approaching retirement. The task of replacing them is both pressing and daunting.

 The community care workers referred to their basic qualifications for the role as instrumental and for the most part, interesting. For most, the Certificate 111 course provided general entry into the aged-care field but lacked particular orientation to community-based care. As one participant described:

It was very general, and it was definitely better than nothing and I would hope that everyone that works in home care or some aged care capacity has that as at least a minimum…they definitely could have expanded the dementia aspect in the course… it was a good course. It wasn't hugely onerous (6).

*Suitably Experienced*

For many new graduates, community care work presents immediate challenges. Although newly employed workers are usually ‘buddied’ with experienced workers for their first few shifts, thereafter they are rostered ‘solo’. Disappointment may ensue when new graduates anticipate a more clinical role. Although many consumers are quite frail and in need of personal care, observation and monitoring, the regular work is described as consisting of mostly domestic duties: *Most of the work is domestic assistance – shopping, meal prep, respite and some personal care thrown in (W2)*

New workers may be daunted, even deterred, by the domestic environments that constitute their workplaces. Here, they may encounter cluttering, hoarding, carer stress and family tensions along with the consumer’s decline, poor hygiene, loneliness and despair.

It can be a bit of a shock to…go into someone’s home and assist them to shower and deal with their bedding…the bathroom and toilet that hasn’t been cleaned for a week or two…it’s pretty yucky work really (W1)

This observation was supported by the community care workers. One participants suggested that the course did not prepare students for the amount of domestic work that they would be required to perform:

I didn't really realise when I came over to home and community care… how much domestic work there would be. I currently do, on average, about 13 domestic services a week and I only work four days (3).

This view was supported by another participant who defined the orientation of the course as more focussed on work in residential settings:

…it was more orientated around residential care rather than the community care, as in how to clean a house. Most people know how to clean a house, but what standard to go to…that wasn't really taught. That was something you picked up [with experience] (4).

For this worker, the relatively high percentage of domestic tasks was acceptable given her ‘liking’ for cleaning and for doing a thorough job. As an ‘older’ worker this participant regarded herself as more prepared for traditional, gender-based tasks:

That's where I find some of the younger people probably aren't as thorough as the older girls are. We're house cleaners. We've trained for 40 years. We've got it organised. (1)

In some situations, workers can be abused by consumers or they may witness abuse of consumers by their home-based carers: *verbal abuse or rough handling…workers ring us and say ‘he was screaming at her and swearing (W1).*

Individual workers respond differently to such confronting situations: *[It] comes down to their individual resilience as to how well they can adapt and think on their feet and how well they relate to people (W1)*

Others need support to deal with these situations: *Workers need support to keep going – they need to develop interpersonal skills to build a rapport with people who might not come from the same social background as they do (W2).*

The ‘workplace’ is not supported by usual OHS measures. Consumers’ homes may be awkward, even hazardous, for carrying out tasks such as using hoists. There may be a high risk of cross contamination and infection due to consumers’ unhygienic practices. These characteristics may overwhelm younger and newly graduated workers. As solo workers, they do not have the immediate support of co-workers and team members such as is provided in residential care settings in which residents’ needs are managed within controlled environments and routines.

The issues noted above engender strategies such as the following:

We don’t employ anyone in the community if they haven’t done a community placement…[we say] to them you need to do 2-3 days (unpaid) placement with a worker (W1).

We employ staff who are still in training. Under the guidelines we can employ staff to do domestic assistance only, without the personal care - they don’t need a Cert III qualification. We do it primarily to give them experience in…consumer engagement. Rather than them just coming out as a qualified grad and - here you go…we want to give them experience to say this is what it’s like (A).

The relative stability of the Services’ workforces suggests that once newly employed workers ‘survive’ the initial challenges, they are likely to stay on. It also suggests that support in terms of mentoring, assisted skill acquisition and consolidation is essential if workers new to the field are to be retained. Retention is also enhanced by the managers’ approach to rostering in which consumers’ care needs, temperaments and living conditions are matched with skills, experience and disposition of individual workers.

The need for workers to be skilled at observing their consumer’s level of functional ability and to be able to identify significant change in health status was emphasised. As one participant noted, workers need to be able to:

…think safely and independently. Definitely in relation to dementia clients…because there is no one set way to care for them…being able to make good judgments and quickly and it's also communication is a big thing (6).

This response reflects the difference in consumers in terms of their presentations of illness and their needs for individualised care. The older age of workers, along with practice in the field, was seen as advantageous for recognising and meeting these needs:

[the course] was enlightening…like in anything new you've got that trepidation, but I found you go and you meet people and I transitioned very easily. I mean, I was of an age anyway, so that I can relate to the people I deal with because I'm nearly their age or sometimes older than them, depending on the circumstances, whether it's people with disabilities and things like that (FG).

…because I'm that age and I could relate to them… when you get to a certain age there's always some common ground there in the background. So I found it pretty easy to do…(FG).

The common ground for older workers may be the result of caring or looking out for ageing parents. Two participants (FG; 1) referred to experiences as informal carers that have prepared them for their formal roles. From this perspective, the necessary skillsets align with lived experience and dispositional traits:

Well, you need skills that you actually can't be taught in the classroom. You need empathy and no one can teach empathy, you either have empathy for other people or you don't because... you get new consumers all the time, so you've got to be able to enter someone's home and they [must] feel comfortable with having you come into their house…it's a big ask, they open their door for a complete stranger coming in to provide a service (3).

You can't be judgmental. I just go in. Some people say, I'm sorry, it's such a mess. I'm not there to see their mess, I'm there to see them. The mess is beside the point (FG).

…home care workers needed to be caring. They also needed good common sense for how to deal with the various problems that this job can throw… common sense is not something that can be taught (FG).

Because of their age and life experiences, the participants appeared to be prepared for on-the-job challenges. Potentially confronting tasks such as cleaning in unhygienic households and taking care of aged bodies and incontinence are less likely to deter this group of workers. However, they understand that younger workers may be deterred by these aspects of the job and that they may need support to develop the ‘soft’ skills needed to flexibly and confidently navigate and complete some tasks with needy and difficult consumers. One participant observed that:

 …it's not a young person's job… you've got to be caring. I'm not saying no young people are caring, but a very small percentage are alert to the needs of elderly people I think (1).

Another participant referred to the difficulties that younger workers might face when they start out in this role:

…it is hard for younger female workers to do personal care for males (3).

Hence, being prepared for the role means that new workers must be prepared to adjust to it, to continue learning. As one participant suggested:

you have got to be interested in it…it’s a basic role but you still have to be right person for it (1).

From this perspective, the role, as it is structured, requires newly qualified encumbents to actively achieve role-fit. At the same time, role-fit may be advanced through organisational and support.

*Suitably remunerated*

Despite their overt commitment to and love of their role, the community care workers clearly voiced disappointment with their rate of remuneration and the insecurity of rostered hours. For one younger, casually employed worker, these conditions are discouraging:

…I think I would like to stay in the role, but the fluctuating work hours… [I know} it's a bit hard if someone - several people pass away or people go on holiday or people cancel their service for whatever but…the income can really fluctuate (6).

Another worker agreed and pointed to related difficulties in recruiting and retaining younger workers into the future:

I don’t think the wages are great...if you want more people to become involved in aged care, the wages have to go up I think; If you want to try and get a younger care team together, well you're going to have to increase wages and make it look like it's a career choice (1).

As one manager pointed out, the barriers to recruitment of younger, appropriately qualified and temperamentally-suited workers include the irregularity and insecurity of rostered hours, and unappealing pay rates:

…[we can only offer] insecure and random working hours…shifts are based on consumers. Our staff have regular consumers most of the time, but it only takes one, two or three of those consumers to be in hospital, to be sick, to be away…then they won't do as many consumers. It’s not too hard for me to give most of them 20 hours a fortnight but giving them 40…or 80 is impossible…there’s no way I can afford to pay them more than $22.70 an hour, even if I wanted to…(A).

Some of the community care workers were more accepting of the conditions, some pointing out that their managers would try to ensure that they were rostered for their desired hours:

I said I only really wanted somewhere between 20 and 25 hours a week. Some weeks it might be a little bit less because you get cancellations because clients are sick, or they're away or whatever. But the scheduler's really good, so if there's a cancellation they'll try and replace the shift for you (w3)

I do a lot of hours and get a very good income from it, but only because I work so many hours and I love to work (1).

I get anywhere between 35 to about 40 hours a week (4).

However, as one older participant noted, working extra hours to augment income may reduce the quality of work:

Look, you can get as many hours as you want. I think if you push yourself too hard, you can get to a stage of getting overtired and especially with some of the clients, they could be challenging. So you don’t want to sort of be short with them or you know (2).

This participant also observed that any push for higher wages may come at the expense of consumer care:

You’ve got to understand – you jump up and down wanting more money, then they’ve got to put up their costs, you know then the clients got to pay more (W2).

Other barriers include the difficulty inherent in attracting newly graduated and younger workers to a role more usually associated with mature and middle-aged women. However, the managers noted their need for a cross-section of age, experience and aptitudes to meet consumers’ needs:

... with the younger worker…they've got the enthusiasm. They're physically able. They've got the fresh eyes. But sometimes they don't have some of the life experiences that some of the… older workers -that can be anything from 40, 50, 60 - who can deal with some situations that are thrown at them. Some [younger workers] can adapt really quickly, and others just might be thrown a whammy by it (C1).

…the challenge is recruiting the range of experience of workers, experience in life skills, [we need] younger workers and older workers… it's the ability of the staff to go to different environments, open gates, walk up people's steps - safely driving (A).

The degree of a new worker’s preparedness for the role influences adaptation to the work and subsequently, retention:

I might only get 10 hours pay, but it might be spread over 15 hours because we have…gaps between services – this is the downside of doing community work. I'm lucky, I live central, I just nip home and have a cuppa. But…one of our carers…lives over in Albury and he says it's not worth driving back to Albury so he sits down in the park for three-quarters of an hour. I can't think of anything worse (1).

**DISCUSSION**

This paper has examined an Australian instance of a global problem: the demand and supply of skilled, quality aged-care staff to meet the increasing care needs of community dwelling rural older people. A central problem noted in this and a growing literature relates to the capacity of the industry to recruit and retain appropriately skilled workers. While the findings presented here imply that the local community aged-care workforce is stable, issues were raised about the current and future supply of staff. In Australia, the reasons for this relate to both local and national factors. As local communities age and younger people migrate to larger towns and cities, the need for services grows while the available workforce decreases. Added to this situation, the current workforce will reduce ‘naturally’ given the relatively older age of direct care workers.

The findings of this mixed methods study concur with national statistics that profile the aged-care workforce as ageing, gendered and inadequate. The average age of the participating CCWs was 52.6 and 90% were female. The survey responses suggest that the average age at which respondents entered the field was 42.7 years. This data demonstrates that community aged-care work is not the first career choice of younger people. The managers acknowledged that their reliance on their dependable but ageing workers cannot continue; strategies for replacing this cohort with younger, committed workers are urgently required. It follows that endeavours for recruiting and retaining a younger workforce must include measures for redressing the reductive and off-putting image of aged care work as the province of minimally skilled, older women who value intrinsic rewards over extrinsic compensations such as pay and secure hours of work. For this reason, calls to redefine and expand the role of community aged care workers are included as ‘solutions’ within the many explorations of industry shortcomings and failures (see for example the Aged Care Workforce Taskforce Strategy 2018). Importantly, such recommendations are accompanied by calls to raise remuneration rates and increase the security of hours of work. As many of the participants in the current study observed, these elements of the job are likely to deter younger workers, no matter if or how the role is expanded.

Proposals that radically redefine the CCW role may offer solutions to its current stagnation and neglect as well as to the problem of attracting younger workers to the field. For example, an overhaul of direct care roles based on an analysis of competency gaps, possibilities for job re-design and career pathways may provide a foundation for a close matching of roles with consumer needs and worker aspirations (Aged Care Workforce Strategy Taskforce, 2018). However, this level of redesign would require considerable support in terms of industry-wide agreement and funding to ensure a desired outcome.

The concern for ensuring an adequately skilled workforce extends to basic preparation for aged care roles. In the case of VET certification, gaps in basic training across both VET and higher education sectors have been highlighted with a particular emphasis on the lack of alignment between curriculum and the nature of the role (Aged Care Workforce Strategy Taskforce, 2018; Productivity Commission, 2011). A particular problem in this regard concerns the lack of industry placement for trainees. Currently students undertaking VET certificates III and IV are required to complete at least 120 hours of industry placement. However, the findings from this and previous studies indicate that few trainees request or are oriented towards placement in community care settings. The managers in this study employ strategies such as ‘buddying’ new employees with experienced workers for their first few shifts. In one case, such new workers are required to complete unpaid ‘buddied’ shifts as part of their orientation to the job.

The lack of placement time in basic training is a critical omission given that newly graduated workers must work solo soon after employment. Unlike residential aged care work, this role does not offer the educational advantages of working alongside other team members. Nor does it provide an immediate workplace culture in which novices are watched over, assessed and emotionally supported as they *become* care workers. The older, direct care workers who participated in this study spoke of their ready adjustment to the role given their age, their life experiences and their previous work roles. For younger, newly graduated workers, adjustment is likely to take longer and require supportive supervision; their lack of similar role preparedness can be costly in terms of the support needed to settle them into the role. Equally, it is costly when newly employed workers give up on the role soon after employment. There is a clear need for a well organised and purposeful student placement system as well as for orientation strategies that assist new workers to accommodate the requirements of the job, that is, to maximise their capacity to achieve role-fit and to enjoy their work.

The study also identified gaps in advanced skills in the areas of mental health, dementia, communication, and palliative care. The most common types of training requested for CCWS were skills and knowledge to assist working with clients who have mental health issues (44.4%), dementia care (48.1%) and managing challenging behaviours (40.7%). Training in palliative care (29.6%) was also highlighted for CCWS and for nursing and allied health care this was the ‘number one’ area of training listed (45.5%). This is reflective of a more general movement which has seen the care of people with life limiting illness increasingly moving away from the acute setting into the community (Duckett & Wilcox, 2015). The need for ongoing training and skill development in relation to changing and expanding client needs was emphasised by the participants. As community care is extended to increasingly frail clients, to clients with complex medical conditions and to NDIS clients, workers are expected to broaden and deepen their skillsets.

**CONCLUSION**

This study pursued questions concerning the changing aged care context and how well equipped recently trained staff are to work with new developments in the delivery of community aged care including: increased client complexity, and the rural complexity of service delivery. These data provide an overall picture of the complexity of service provision in this region and can be generalized to the broader Australian context as is evidenced by the recent Aged Care Workforce Taskforce Report (2018).

The findings of this study echo the issues identified at a National level in Australia, including, developing measures for redressing the off-putting image of aged care work through extrinsic benefits such as pay, opportunities for career progression and secure hours of work. Of significance in this study the need for advanced training in the areas of mental illness, specifically dementia and palliative care were given more attention by the participants. This highlights opportunities and scope to review existing curriculum and to develop training programs that target this need. This strudy illustrates the need for an investment from tertiary providers in developing health professionals’ understanding of the health and care needs of older people and for the Vocational sector to invest in improved training to meet the needs of both the community care workers and the clients of their services.

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