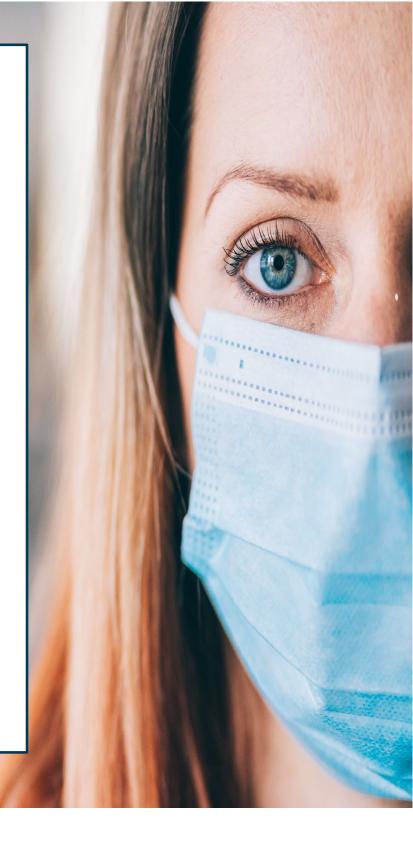# SUPPORTING THE RESIDENTIAL AGED CARE WORKFORCE FOR COVID-19 RECOVERY

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REPORT BY
PETA S. COOK,
BENJAMIN C. PINKARD, &
RANDOS JACKALAS
KOROBACZ

UNIVERSITY OF TASMANIA

UNIVERSITY *of* TASMANIA

Clarence... a brighter place

In the spirit of reconciliation, the authors of this report acknowledge the muwinia and palawa people, the traditional custodians of the land upon which this research was undertaken. We pay respect to their elders past, present and future, and we acknowledge their continuing connections to country.

For further information contact:

Dr Peta S. Cook
University of Tasmania
Private Bag 22
Hobart Tasmania 7001
Email: Peta.Cook@utas.edu.au
Telephone: +61-3-62264726

Executive Summary

The first Australian case of COVID-19 was confirmed in late January 2020 (Australian Government, Department of Health 2020c), with a national pandemic declared on 27 February 2020 (Australian Government, Department of Health 2020b). The first death from COVID-19 of a person living in an Australian residential aged care facility (RACF) occurred on 4 March 2020 (Han 2020). This RACF, Dorothy Henderson Lodge (New South Wales), subsequently became the first Australian COVID-19 cluster site. While federal and state/territory governments in Australia successfully implemented a range of strategies to reduce COVID-19 viral spread, Australia nonetheless had one of the highest total percentage rates of death from COVID-19 within RACFs during 2020 globally (Australian Institute of Health and Welfare 2021b; Cousins 2020). The Australian Royal Commission into Aged Care Quality and Safety determined that the Australian federal government's response in preparing the aged care sector for COVID-19 was "insufficient" (Cousins 2020: 1323). Within this climate, staff working in RACF continued to provide care and support to those living in residential aged care, and did so at their own risk and with significant under resourcing (financial, material, and human).

This project has examined the impact of COVID-19 on staff working in Tasmanian RACFs as told in their own words. This involved in-depth interviews with twenty Tasmanian RACF staff working across roles including cleaning, cooking, care work, allied health, laundry, pastoral support, leisure and lifestyle, medication support, nursing, maintenance, supervision, and management. At the time of the interviews, these participants were working across 21 different not-for-profit Tasmanian RACFs that ranged from very large to small facilities, and across nine different aged care providers. The interviews occurred prior to and following the opening of Tasmanian borders to interstate and international visitors (15 December 2021), and therefore the research was able to capture changing political and pandemic circumstances (for example, before and following the spread of the COVID-19 Omicron variant in Tasmania) as it impacted the Tasmanian residential aged care sector.

Interview transcripts were subjected to thematic analysis, through which we identified patterns (or themes) of shared meaning-making across the data. From these findings, recommendations were generated that, if implemented, could better support the residential aged care workforce now and into the future. These recommendations are presented in the report with some suggested strategies on how they may be addressed. The nine recommendations are:

- Recommendation 1: Support age-friendly communities, programs, and initiatives
- Recommendation 2: Promote aged care to the community and future workforce

- Recommendation 3: Recognise the contributions of, and invest in, residential aged care staff
- Recommendation 4: Reduce the administrative load for residential aged care staff
- Recommendation 5: Create context-specific emergency strategies
- Recommendation 6: Support and pay for time-out breaks from PPE and masking
- Recommendation 7: Improve communication pathways
- Recommendation 8: Provide paid professional development and training opportunities for residential aged care staff
- Recommendation 9: Support the mental health and wellbeing of residential aged care staff and residents

Acknowledgements

During 2020, I heard anecdotal reports from some aged care staff on the difficulties of working in aged care during COVID-19, particularly considering the existing societal negativity towards aged care. This prompted me to raise these issues with the Clarence Positive Ageing Network (CPAN), as well as investigate existing research on the impact of COVID-19 on staff working in residential aged care facilities (also known internationally as nursing homes and long-term care facilities). Through this, it became abundantly clear that the personal and professional experiences of COVID-19 on residential aged care staff was being overlooked. This project was the emerging result.

I wish to thank members of CPAN for their honest feedback during the initial discussions and ideas for this project. Furthermore, I thank Julie Andersson (Clarence City Council) for providing support for contacting residential aged care facilities in the City of Clarence, which helped with gauging initial interest and, later, with recruiting participants.

Funding for this project was received from the City of Clarence; support which made the project possible. I also wish to acknowledge the in-kind support of one residential aged care provider, who provided support for distributing participant recruitment materials amongst their staff, allowing me to visit selected facilities to meet with their staff and talk about the project, and provided ten gift vouchers to distribute to their staff (who confidentially participated in this project). Information about this project was also distributed by other aged care providers as well as relevant unions. Thank you also to the participants who distributed the project materials to their colleagues and friends.

In the early stages of this project, Dr Melissa-Jane Belle provided feedback on the ethics application and conducted two interviews. I thank her for her assistance. I also thank Dr Benjamin Pinkard and Mr Randos Korobacz for their excellent work as research assistants, who helped with transcribing the interviews, conducting data analysis, and writing sections of this report.

Finally, I thank the participants for sharing their experiences honestly and openly, particularly during a time that has been quite challenging to you personally and professionally. I greatly appreciate your contributions, which have helped the research team to generate the recommendations herein.

Peta S. Cook

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Overview and Background

COVID-19 and Australian political responses

In December 2019, the World Health Organization (WHO) received reports from China of a novel pneumonia cluster. This was to become identified as SARS-CoV-2; the virus that causes COVID-19 infection. COVID-19 subsequently spread worldwide, with the first Australian case confirmed in late January 2020 (Australian Government, Department of Health 2020c). The Australian federal government declared a national pandemic on 27 February 2020 through activation of the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* (Australian Government, Department of Health 2020b), with the WHO (2020b) following on 11 March 2020 in declaring a global pandemic.

In mid-March 2020, the Australian federal government started to implement lockdown restrictions that involved reducing opportunities for mass gatherings as well as international border controls. This was followed in late March by some states and territories closing their borders, with Tasmania the first state to do so on 20 March 2020 (Duckett and Stobart 2020). Through such responses, Australia was able to significantly contain and reduce the spread of SARS-CoV-2. With less infections than most other high-income countries, Australia has been internationally heralded as a leading example of an effective response to COVID-19 (Cousins 2020; Thwaites 2020). These outcomes were enabled by political and public health measures that, at times, differed at federal and state/territory levels (Cook et al. 2021; Duckett and Stobart 2020). Specifically for residential aged care facilities (RACFs), a common response was restricting human movements and physical contact, including visitations to people living in RACFs as well as limiting resident-to-resident interaction (Cook et al. 2023, in press).

The Australian federal government, with regulatory responsibility for aged care, released a suite of RACF restrictions on 22 April 2020, but had no outbreak plans for RACFs (Australian Government, Department of Health 2020a; Cook et al. 2023, in press). State and territory governments responded with their own restrictions on RACFs (which sometimes went further than federal regulations), but again with no specific outbreaks plans for RACFs. For example, in Tasmania, a COVID-19 outbreak in April 2020 at a rural hospital led to a state-wide limit on visitors to RACFs, with entry only permitted for medical staff and visitors for compassionate and end-of-life reasons (Gutwein 2020). Significantly, RACFs were also permitted to impose restrictions in addition to that required by federal and state/territory governments (Cook et al. 2023, in press).

Growing frustration over visitor restrictions and the impact these were having on people living

in RACFs and their families and friends, led thirteen aged care peak bodies and consumer advocacy organisations to develop an *Industry Code for Visiting Residential Aged Care Homes during COVID-19* (Council on the Ageing 2020), which was initially released on 11 May 2020. This was done in recognition that lockdown measures and visitor restrictions across Australia were negatively impacting older people living in RACFs including their mental and physical health, wellbeing, and quality of life (Cook et al. 2023, in press; Ibrahim 2020).

Facing increasing public and media scrutiny, the Australian federal government started to release a weekly snapshoot of COVID-19 infections and deaths in RACFs from 12 September 2020 (Australian Government, Department of Health and Aged Care 2022a). From mid-November 2020, the Australian federal government released a new three-tier escalation plan whereby residential aged care providers could only restrict visitors under the highest Tier 3; when there is an outbreak of COVID-19 in the community (Australian Government, Department of Health 2020d).

Despite measures such as RACF lockdowns and visitor restrictions, Australia had one of the highest total percentage rates of death from COVID-19 within RACFs during 2020 at 75% (Australian Institute of Health and Welfare 2021b; Cousins 2020). Furthermore, the Australian Royal Commission into Aged Care Quality and Safety determined that the Australian federal government's response in preparing the aged care sector for COVID-19 was "insufficient" (Cousins 2020: 1323). Post-2020, the death *rate* of people living in RACFs from COVID-19 has declined due to high

vaccination rates and less severe COVID-19 variants, but the *number* of resident deaths has continued to increase. For example, from 1 January to 29 July 2022, 2,477 RACF residents died from COVID-19; more than 2020 and 2021 combined (n=917) (Australian Government, Department of Health and Aged Care 2022b). With RACFs battling these outbreaks across all Australian states and territories and staff shortages from aged care staff needing to isolate or leaving the industry during 2021 and 2022, the Australian Defence Force was used to fill non-clinical gaps until 30 September 2022 (Australian Government, Department of Defence 2022). From 14 October 2022, rules related to mandatory isolation following a COVID-19 positive test and management of close contacts ceased, with Tasmanian RACFs required to develop their own workplace policies following guidelines produced by Tasmania Government's (2022) Aged Care Emergency Operations Centre.

The coronavirus pandemic also coincides with intense scrutiny of the aged care sector from the Royal Commission into Aged Care Quality and Safety. In its interim report, the Royal Commission into Aged Care Quality and Safety (2019) noted that the needs of older people in receipt of aged care services were not being met due to inadequate levels of social and medical care associated with service shortages and systematic under-resourcing including low staffing levels and employment precarity. They further noted the aged care system had become "a signifier for loss, abandonment and fear" (2019: 61), and that societal attitudes towards aged care and older people including ageism – "discrimination based on age" (Gendron et al. 2016: 997) – may be

contributing factors. These structural and social issues compromise optimal care and quality of life for people who live in RACFs. Indeed, the little attention given to RACFs in Australia during the coronavirus pandemic echoes the experiences in Italy, where the failure to contain outbreaks in RACFs were associated with three factors: "inadequate communication and management guides for RACF[s]; … delay in the provision of personal protective equipment (PPE) to the sector; and … failure to control the spread of the virus within facilities" (Crotty et al. 2020: 1034). As further noted by Crotty et al. (2020: 1035), "[Residential aged care] Facilities have not been designed with infection prevention strategies in mind and staffing ratios are highly variable. …. [U]rgent action is required to protect RACF residents, workers and the community at large". These numerous factors influence the care people living in RACFs receive, as well as the health and wellbeing of those working in the aged care sector.

Within such pressures and difficulties, and with increasing community and media negativity towards the aged care sector, the Australian residential aged care workforce has continued to provide support and care for people living in RACFs.

Background literature

During and following 2020, a vast array of scholarly research emerged on the social consequences of the coronavirus pandemic on different population groups, particularly those who were adversely impacted. This has included examining how COVID-19 and the associated social and political strategies to manage or contain it, have marginalised or increased insecurity and inequality for those in the precarious workforce (such as casuals, contract workers, and the 'gig' economy), frontline workers, people living with disabilities, the LGBTIQ+ community, and older adults (Bismark et al. 2022; Cook et al. 2021; Cook et al. 2023, in press; Curryer and Cook 2021; Thorneycroft and Nicholas 2021).

As the coronavirus pandemic unfolded, social and psychosocial research continued to emerge, with a strong focus internationally on the frontline health workers and the health sector more broadly (for example, Coto et al. 2020; Feingold et al. 2021; Giusti et al. 2020; Lai et al. 2020; Young et al. 2021). This is understandable given the significant role health workers have played in monitoring COVID-19 spread and supporting those people whose health has been impacted by infection. The findings from these studies reveal that the pandemic has adversely impacted on the mental health and wellbeing of health workers including, in some cases, suicidal ideation. In Australia, survey-based research by Bismark et al. (2022; see also Smallwood et al. 2021) noted healthcare workers were experiencing burnout,

depression and anxiety, overwork, and fear of spreading the virus from the hospital to the community, their homes, and their families. In addition, McGuinness et al. (2022) noted that, during 2021, Victorian health and aged care workers were reporting post-traumatic symptoms, a contributing factor to which can be their witnessing of COVID-19 related deaths (Mosheva et al. 2021). Research from the United States suggested that such poor mental health outcomes could be reduced by sufficient access to personal protection equipment (PPE) and access to mental health support (Coto et al. 2020; Khajuria et al. 2021).

The coronavirus pandemic has not only impacted health workers personally; it has also shed light onto structural and planning challenges within the Australian healthcare system. Returning to the research by Bismark et al. (2022), their participants noted the Australian healthcare system was ill-prepared and ill-equipped to manage a pandemic. Health workers further noted the need for a stronger and fairer health system including safer working conditions and addressing health inequalities within wider society (Bismark et al. 2022). While this strong focus on frontline health workers is understandable given the demands on international health systems, other sectors and workers have also continued to provide care and support to marginalised community members during the coronavirus pandemic but have been largely overlooked in existing research. This includes the aged care sector.

There is very little research examining the impact of COVID-19 on those who work in RACFs (also internationally known as long-term care or nursing homes). Research from other nations has begun to identify the significance of aged care workers as frontline workers and have called on governments to address staffing issues and retention rates, economic reform, and improve RACF infrastructure (Chu et al. 2021). In Italy, nursing homes were severely impacted by the first wave of COVID-19. Trabucchi and De Leo (2020: 387) reported that "in the province of Bergamo [in northern Italy], more than 600 nursing home residents, from a total capacity of 6400 beds, died between March 7 and 27, 2000". In addition, nursing homes in Italy were requested to take people infected with COVID-19 from the wider community to ease the strain on hospitals – a strategy that helped viral spread within nursing homes (Arlotti and Ranci 2021; Carter Anand et al. 2021). In Spain, Martín et al. (2021), reported that aged care workers had heightened anxiety, depression, stress and insomnia, which impacted on their mental health and health-related quality of life (HRQoL), as well as experiencing "secondary traumatic stress" due to increased workloads, interactions with distressed residents, social pressures from employment, and fear of infection (Blanco-Donoso et al. 2021: 244). In Australia, research focusing on RACFs in Sydney explained that the "COVID-19 pandemic and associated restrictions created major challenges for older people's engagement with their communities, including in-person services [...], suggest[ing] that the COVID-19 pandemic created barriers to access to centre-based aged care services, with severe consequences for the health and wellbeing of older people and carers" (Hamilton et al. 2022: 1-8). Subsequently, there have been concerns that aged care workers will leave the sector due to burnout, staff shortages, increased staff

turnover, and workforce issues that have been exasperated during the coronavirus pandemic (Lowrey 2022; White et al. 2021).

Respecting and supporting the aged care workforce is crucial not only for recognising their contributions as care workers and essential workers, but also for ensuring that the needs of older people living in aged care are met following the coronavirus pandemic. This is crucial for respecting and supporting Australia's ageing population. As of 30 June 2020, 16% of Australia's population were aged 65 years or over (4.2 million people), and this is expected to grow up to 23% of the total population by 2066 (Australian Institute of Health and Welfare 2021a). In Australia, only 6% of people over the age of 65 are living in Australian RACFs (which grows to 20% for those aged 80 years and over), but this is high proportion when compared to other OECD nations such as New Zealand, Canada, and United States (Dyer et al. 2020). Regardless, the ageing Australian population means the number of older people needing to live in a RACF will grow. In addition, in the City of Clarence, 20.1% of its citizens were aged 65 years or over in 2016 (Australian Bureau of Statistics 2017a, 2017b). This makes RACFs a crucial infrastructure within the City of Clarence.

This project responds to the crucial role of aged care workers and reveals first-hand accounts of the personal and professional impacts of the coronavirus pandemic. As such, this project forefronts the experiences of people working in Tasmanian RACFs by capturing their voices.

Significantly, the project also fills a research and knowledge gap in Australia and internationally on this topic.

Research Approach

The research questions guiding this project are:
- What are the experiences of people working in Tasmanian RACFs during COVID-19?
- How can the experiences of people working in Tasmanian RACFs during COVID-19 inform better ways to support and recognise the aged care workforce now and into the future?

Through these questions, the project aims are to understand the opportunities, challenges, and difficulties that people working in Tasmanian RACFs have faced during COVID-19, and to use these insights to develop recommendations for problem-solving and improved practices.

To recruit participants, contact was initially established with all RACFs in the City of Clarence (Tasmania) before expanding to aged care facilities in other Tasmanian local council areas. Contact was primarily established via email, which included providing the participant information package (consisting of the information sheet and consent form) as well as project flyers. This approach allowed residential aged care providers to distribute information to their workers without needing further support from the project team. In addition, one residential aged care provider provided additional support by distributing information about the project to all their facilities in southern Tasmania and supporting the project's chief investigator to visit selected RACFs discuss the project with interested staff

during handovers, morning tea or afternoon tea. Some unions expressed interest in the project and included a project brief in their newsletter. Finally, some social media posts were made about the project, calling for expressions of interest.

Participants were required to have worked (paid or unpaid) in any role at a Tasmania RACF during 2020 or 2021. There was no requirement that, at the time of participating in this project, the individual would still be working in a Tasmanian RACF. This approach allowed people who had left the sector during 2020 or 2021 to still participate in the project and share their experiences (including why they left). Once potential participants expressed their interest in the project, they received the participant information package. In some cases, participants received the participant information sheet and consent form through their workplace (for example, through a bulk email or in the tearoom). Notably, it was emphasised in the participant information package that participation was confidential (including if they received information about the project through a residential aged care provider), voluntary, and conducted independently of the Clarence City Council and residential aged care providers. The project received ethics approval from the Tasmanian Human Research Social Sciences Ethics Committee (Project ID: 24668).

Participant recruitment occurred over eight months, with interviews occurring in late 2021

and early 2022. In total, 24 individuals submitted a complete participant informed consent sheet, of which 20 individuals were interviewed. While 20 participants may appear to be a small number, this is highly appropriate for qualitative research that focuses on in-depth understandings of participant's lived experiences (Tranter 2013). In addition, one method of determining an appropriate sample size in qualitative research is saturation, which refers to when no new ideas or concepts are revealed or emerge from data collection. This can occur quickly in homogeneous populations. In this project, due to the homogeneity of the sample (that is, all participants were current or former staff in a Tasmanian residential aged care facility), saturation was achieved at nine interviews. Subsequent interviews help to reinforce the issues raised by previous participants, and thus provided further credibility and depth for the research findings.

Interviews were in-depth and semi-structured. This means that while there was an interview schedule followed by the interviewer, this remained flexible and open to issues raised by the interviewee and what they wished to discuss. This approach meant the interviewer was flexible to the participant's needs and interests, which was vital to capturing the participant's personal and professional experiences during the coronavirus pandemic as well as developing trust and rapport between the interviewer and interviewee. Importantly, interviews allowed the participants to explore what was important and meaningful to them; information that would be impossible to capture through pre-defined questions and measures as required by survey methods. In addition, interviews allowed these experiences to be articulated and explained, something which again survey methods cannot capture. Following the interview, all participants received a $20 gift voucher to thank them for their time and contributions. Ten of these gift vouchers were provided by one residential aged care provider specifically for their employees. These were distributed confidentially to the participants by the research team, so the participant identities remained unknown to the residential aged care provider.

Significantly, interviews occurred prior to as well as following Tasmania opening its state borders to other Australian jurisdictions (as well as internationally), which occurred on 15 December 2021 (Gutwein 2021). Therefore, the data reflect the changing political and pandemic circumstances including before and during the use of protective personal equipment (PPE) and, following the Tasmanian border opening, the spread of the COVID-19 Omicron variant in Tasmania and Tasmanian RACFs. Due to this, some participants who were interviewed in 2021 prior to PPE use later shared their masking, PPE, and post-border opening experiences in 2022 via email or in an additional interview.

Due to the ongoing coronavirus pandemic and in the interests of protecting participants and the residents living in RACFs in which the participants worked, all interviews were conducted via telephone or video conferencing (Zoom). The interviews were scheduled at a date and time suitable for the participant and interviewer, which included weekends and night-times. During the interviews, the participants shared their professional

experiences of working in residential aged care during COVID-19 and the related personal impacts of this, reflections on the COVID-19 outbreak management plans in the RACFs in which they worked, and provided suggestions on how best to support people working in RACFs. These topics were purposively kept broad to give participants the flexibility to answer and explore the questions in a way that made sense to them and their experiences. Participants were also invited to raise any related issues during the interview. The experiences that participants shared spanned structural, social, cultural, health, personal, relational, and economic domains. In total, 21 hours and 20 minutes of interview data were collected, with the average interview length being 52 minutes. Interviews were audio-recorded and transcribed verbatim. This generated 615 pages of interview data. Once transcription was finalised, the transcripts were de-identified to protect participant identities and the transcripts were then subjected to thematic analysis. Thematic analysis initially involved associating codes to each sentence in the transcript as based on ideas raised by the participant, and then grouping those codes into categories. This process allowed us to identifying patterns (or themes) of shared meaning-making across the data.

Table 1 provides an overview of the participants. This includes their pseudonym, gender identity, the position/s they hold in the Tasmanian residential aged care workforce, the size in the facility or facilities in which they work and, at the time of the interview, their cumulative years or months of experience working in Australian residential aged care (noting that some participants may have had additional years of international experience or worked in home and community care, which are not included in the table). All participants worked in one or more Tasmanian not-for-profit RACFs which vastly differ in size. This includes very large (≥150 residents), large (100-149 residents), medium (50-99 residents), and small (≤49 residents) RACFs, with these size classifications based on information provided by the Aged Care Guide (https://www.agedcareguide.com.au/).

Regarding gender, all participants identified as either a man (n=6) or woman (n=14), and no participants identified as non-binary, transgender, or gender diverse. Seven participants were not born in Australia and were from non-English speaking backgrounds. The participant's years of experiencing of working in Australian residential aged care varied from five months to 11+ years. Finally, the positions in residential aged care performed by participants varied significantly and were differentially labelled depending on the aged care provider. Some participants also worked in more than one role. Sometimes these roles were in the same practice area, but sometimes not. For some participants, they worked across different roles in the same RACF, while others worked different roles across different RACFs. To protect participant identities and ensure clarity on role descriptors, their work roles were grouped under the following practice areas:

- Caring, nursing, and allied health (includes registered nurses, care workers/ assistants, and allied health professionals such as physiotherapy)
- Social and spiritual support (includes lifestyle/ leisure coordinators/ workers, chaplains/ religious ministers,

counsellors, social workers, and various other pastoral care roles)

- Hospitality and facility services (includes food services, laundry workers, cleaners, gardeners, and property and maintenance workers)
- Management and supervising (includes managers and supervisors that may have qualifications and experiences in the previous three categories, and thus they may work in multiple roles)

The only practice area that was not captured was administration. Table 1 provides an overview of the project participants. Table 2 details the local council areas (LCAs) where the RACFs in which participants work are located (n=8) and what LCAs participants live in (n=7). This reveals that 55% of the project participants live in the City of Clarence, though may not work in that LCA. In total, the participants worked across 21 different RACFs and across nine different residential aged care providers.

Name	Gender identity	Position/s	Length of work experience in RACFs (years, months)	Facility size/s
Lixin	Man	• Caring, nursing, and allied health	4 years	• Very large
Heather	Woman	• Social and spiritual support	6-7 years	• Large x 2 • Medium x 3 • Small x 1
Tumai	Man	• Caring, nursing, and allied health	7 years	• Medium
Sonya	Woman	• Caring, nursing, and allied health • Management and supervisor	5 years	• Medium
Adya	Woman	• Hospitality services	5 months	• Medium
Sarah	Woman	• Social and spiritual support	10 years	• Medium
Gemma	Woman	• Hospitality services	4 years	• Medium x 2
Felicity	Woman	• Social and spiritual support	2.5 - 3 years	• Large x 3
Afan	Man	• Caring, nursing, and allied health	4 years	• Very large x 1 • Medium x 1
Charlotte	Woman	• Social and spiritual support	4.5 years	• Medium x 4 • Small x 1
Olivia	Woman	• Hospitality services	11 years	• Medium
Sophia	Woman	• Caring, nursing, and allied health Management and supervisor	3 years	• Medium
Annie	Woman	• Hospitality services	2 years, 2 months	• Medium x 2
Sharon	Woman	• Social and spiritual support	2 years	• Medium x 2
Henry	Man	• Management and supervisor	8 years	• Medium x 4 • Small x 1
Athena	Woman	• Caring, nursing, and allied health	4 years, 2 months	• Small
Ben	Man	• Social and spiritual support • Caring, nursing, and allied health	10 years	• Medium x 2
Leah	Woman	• Hospitality services • Management and supervisor	8 years	• Medium
Lucas	Man	• Hospitality services • Management and supervisor	5 years, 8 months	• Large
Emily	Woman	• Social and spiritual support	5 years	• Medium

Table 1: Participant profile and demographic data

Local council area (LCA)	Number of participants who live in the LCA	Number of aged care facilities where participants work in the LCA
Clarence City Council	11	3
Hobart City Council	2	6
Brighton City Council	2	0
Sorrell City Council	0	1
Launceston City Council	2	4
Glenorchy City Council	1	4
Kingborough City Council	1	1
Waratah/Wynard City Council	1	1
Circular Head Council	0	1

Table 2: LCAs in which participants work and live

Findings and Recommendations

With over 21 hours of interview data and 615 pages of interview transcripts, there is a significant amount of data informing our findings and recommendations. Throughout the interviews, it was clear that participant's experiences of working in residential aged care had provided them valuable and important insights into how residential aged care functions and how that impacts on the residential aged care workforce. In addition, each participant was passionate about their work and some, despite professional and personal difficulties, wished to continue working in the sector. During the project, however, some participants left the sector. It was evident the participants were under significant stress, and the extra demands placed on the residential aged care workforce during the coronavirus pandemic had deepened pre-existing stressors and introduced new concerns and problems. The participants lamented the impact of the coronavirus pandemic on residents and wished more consideration could have been made of the resident's needs and wants (for example, working with residents to decide how to manage physical distancing restrictions). There were also numerous findings that echoed those of the Royal Commission into Aged Care Quality and Safety (2021) including the need to reform the aged care system to ensure that:

- The older person is placed first in decision-making including in the provision of high quality care;

- The older people's care preferences are prioritised, which would involve aged care staff having time to spend with each resident to get to know them personally;
- Wages for residential aged care staff are commensurate to the value of the work and tasks that they perform, and is equal to the wages in other industries with similar work roles (for example, registered nurses in hospital and care workers in disability services);
- Staff time with residents is increased (this also relates to participant's discussions on administration, which are examined in Recommendation 4); and
- Professional development and training are offered including trauma-informed care (this is discussed more in Recommendation 8).

These are known and established issues in residential aged care, many of which reflect the complicated Australian aged care structure and regulations. For these reasons (in addition to them being raised through the Royal Commission into Aged Care Quality and Safety), we have not discussed these in detail in the report. The exception to this is professional development and training, as we believe that many residential aged care facilities already offer this to their staff in varying degrees or forms but may not offer or structure it in a way that staff desire or need (see Recommendation

8). In this report, we have placed emphasis on exploring themes that are either not discussed in detail or captured with the Royal Commission into Aged Care Quality and Safety (2021) report. Therefore, this report supplements these existing findings. Furthermore, the findings presented in this report are unique as they are specific to the coronavirus pandemic in the Tasmanian context, though the findings are also relevant to national and international contexts. In this way, this report helps to deepen understandings of what emerges or impacts residential aged care staff during crisis or emergency situations. In total, we make nine recommendations. Within the discussion for each recommendation, we have included some suggestions on how the recommendation might be implemented or achieved. We suggest that if recommendations are implemented, further quantitative and qualitative research should be undertaken to understand if these have an impact on aged care staff and, where relevant, the wider community.

Recommendation 1: Support age-friendly communities, programs, and initiatives

[…] when I said that's what I wanted to do [work in residential aged care], people thought that was really strange. And like a waste of time, 'don't you want to work with young people and help them turn their lives around? There is no point, with older people because they are nearly dead anyway'.
(Charlotte [social and spiritual support])

[…] a GP patting somebody on the head, or kind of shaking their finger in front of someone and calling them 'dear' and say, Or saying, 'you don't need to know about that dear. Don't worry about that!' […] And they just sometimes stand in the doorway and shout out 'how you're doing. You're doing all right, you're okay'. And then they can check that off on the list. And you're paid for it like it's a proper 15-minute consultation.
(Charlotte [social and spiritual support])

During the interviews, some participants noted that working in the aged care sector is accompanied by stigma. Stigma is a social judgement on an attribute, which serves to discredit an individual and marginalise them from full social acceptance (Goffman 1963). While some of this stigma is based on negative social views of the aged care industry (which relates to Recommendation 2), it is notable that stigma towards residential aged care staff also emerges from social beliefs about older age and working with older people. This relates to ageism, which refers to "a process of systematic stereotyping of and discrimination against people because they are old, just as racism and

sexism accomplish this for skin colour and gender" (Butler 1975: 35). This often involves negative assumptions and judgements regarding older adults' personalities, cognitive functionality, levels of social connection, and physicality (appearance and performance) (Thorton 2002).

Ageism is a significant social issue. In 2021, the WHO (2021) released a 'Global report on ageism' which reported that, across the world, one in two people hold ageist attitudes towards older people. In addition, ageism has been shown to impact on the health of individuals and increase healthcare costs (Chang et al. 2020; Levy et al. 2020). Importantly, while ageism impacts older people profoundly, it also influences "how all age groups view their own ag[e]ing and older adults" (Monahan et al. 2020: 893). Stigma and ageism thus have consequences for people to choosing – and attracting people - to work in residential aged care as well impacting on staff retention and the social inclusion of staff and residents of residential aged care in the wider community.

The twin issues of stigma and discrimination were raised by various participants, and extensively discussed by Charlotte (above). Charlotte noted that their university lecturers and peers tried to steer them away from working with older people, has witnessed ageist practices of visiting medical and health professionals within residential aged care, and is aware of residential aged care staff who are

reluctant to reveal to others where they work (a topic that is further addressed in Recommendation 2).

Stigma and ageism are complicated issues. There are actions that can be taken, however, to help reduce stigma and ageism towards older adults and those who work with them. It has been extensively shown that age-friendly communities, programs, and initiatives can challenge and breakdown negative stereotypes, and help to foster intergenerational understanding and inclusion (Cook et al. 2018; Cook 2019). In addition, age-friendly communities recognise the valuable interrelationship between the individual and where they live such how inclusivity, accessibility, health, and participation influence and impact on personal dignity and quality of life (WHO 2007; 2015; 2018). Age-friendly communities remain an important action item and international agenda for the WHO (2017; 2020a) and the United Nations which – along with addressing ageism and the provision of good-quality long-term care – play a crucial role in their ten priorities for the 'Decade of Healthy Ageing' (2021-2030). Notably, there are a range of opportunities and benefits in being an age-friendly community including:

- individuals can age-in-place through the creation of accessible and inclusive places, spaces, and facilities;
- citizens having access to clear information and communication;
- sustaining or growing population size;
- citizens being encouraged to become involved in or continuing with community engagement and participation;

- facilitating new business opportunities for economic sustainability or growth; and
- potential of healthcare cost reduction (Cook 2019; Menec et al. 2011).

The City of Clarence can build on its existing age-friendly commitment to expand existing and create new initiatives, as well as integrate age-friendliness with other strategies and policies (such as the Community Health and Wellbeing Plan, Access and Inclusion Plan, Youth Plan, Tree Plan, Hobart City Deal, and City Heart Project). For more information on recommendations for age-friendliness that are specific for the City of Clarence (and which are also relevant for other jurisdictions), see Cook (2019).

Strategies that we suggest in addressing this recommendation are:
- Examine and implement recommendations from Cook's (2019) work on "Examining community needs and wants for an age-friendly, intergenerational city: A report for the City of Clarence", which is based on comprehensive qualitative data produced by younger and older citizens in the City of Clarence and focuses on their needs and wants for an age-friendly community.
- Explore initiatives to reduce ageism within the aged care workforce such as the free Advocates Training offered by EveryAGE Counts (https://www.everyagecounts.org.au/advocates_training) (see Recommendation 8).

Recommendation 2: Promote aged care to the community and future workforce

I think the way aged care staff is represented in the media has been quite shocking. And I think that the fact that we're being quite demonised at times that [...] sort of, you know, incompetent or uncaring or, you know, 'the cause', even when you look at the way the media reports a COVID case in a hospital versus a COVID case in an aged care facility. You know, it's either, unlucky, heroic, acute care workers dealing with it, or its, you know, incompetent, lazy aged care workers causing it [COVID-19 viral spread]. And I think that is really, one of the reasons we're probably trying to, we're having trouble recruiting people into the industry.
(Sonya [Caring, nursing, and allied health; Management and supervisor])

Well, the, the media is very quick, to comment on something that's wrong. For instance, there was a story that was based on [a Tasmanian RACF] a couple of months ago about a dirty something on the floor. That got blown up in the [media], but that wasn't the whole story. [...] The media doesn't pick up the good things that happen. [...]
(Emily [Social and spiritual support])

Related to Recommendation 1, participants raised the poor profile of aged care as a workplace and job. Sonya and Emily (above) note that public opinion of the aged care sector is fuelled by media reporting, who often focus on negative events and incidences (for example, the damaging findings of the Royal Commission into Aged Care Quality and Safety). Similar issues can be found in the United States, where Miller et al. (2018) report that in media coverage of nursing homes from 1999 to 2008, only 12.6% of a total of 16,280 media articles featured positive news stories. In addition, from October 2018 to June 2021 (which coincides with the Royal Commission into Aged Care Quality and Safety), the Australian media's selection of images to depict aged care often illustrated residents in stereotypical ways such as alone, isolated, disembodied (for example, reliance of stock images and pictures of wrinkled hands or hands on walkers), or focused on elite figures (for example, prominent social figures) (Thomson et al. 2022). As Thomson et al. (2022, original emphasis) assert, the Australian news media therefore "privileges the *eliteness* of news value and engages in symbolic annihilation of older people; lower-status people, such as aged care workers, who are chronically underpaid; Indigenous Australians; and queer individuals" when representing Australian aged care. In addition, during the coronavirus pandemic, global media have focused on a 'hero' narrative for frontline workers, which has positively impacted the perceived value of healthcare works in general (Manchha et al. 2022) but there has not been the same valorisation of aged care workers who are often overlooked as frontline workers and as part of the broader health and care workforce (McAllister 2020).

These findings regarding how aged care is reported and visualised in the media are significant given that media reporting on policy, quality of care and standards in aged care can influence public trust in the aged care industry; a trust that has been declining in Australia (Gilbert 2021). The impact of such reporting can be harmful on aged care staff and destructive for the aged care sector.

Notably, as there is also "widespread public ignorance of the professional roles within aged care in general, and the work of nursing in particular" (McAllister 2020: 201), it is underappreciated the complexity of providing and maintaining the standards of daily living needs of residents, as well as the diversity of work roles within the aged care industry. An example of the reductionist lens applied to aged care employment opportunities is the perception of it being 'dirty work'. This was noted by Sarah:

It's not all wiping bums and taking people to the toilet for goodness sakes. There is a lot more to it [...].
(Sarah [Social and spiritual support])

This perception of aged care work as 'dirty work' can be stigmatising due to the handling of bodily fluids and wastes, something which is more likely to be experienced by care workers and who may also internalise this stigma (Ostaszkiewicz et al. 2016). In addition, health professionals who perceive aged care to be 'dirty work' are less likely to seek employment in the sector (Manchha et al. 2022).

Significantly, the perception of aged care as 'dirty work' impacts the aged care sector as a whole and not just those roles that can involve contact with bodily fluids and wastes (Clarke and Ravenswood 2019). Such stigma can be internalised by aged care workers and lead to a reluctance to reveal to others where they work, as noted by Charlotte:

And, you know, people [working in aged care] will say things about, they decide if they go somewhere to a barbecue or something, whether they say they work in [residential] aged care or not. Sometimes they do. And they sort of defend the sector. And other times they're like, 'I just don't have the energy today'.
(Charlotte [social and spiritual support])

The residential aged care sector needs to promote the industry as a field of choice to future and current healthcare workers. For example, work placements should be offered to nursing and allied health students, which need to be an immersive experience that includes, but extends beyond, care work. It is vital to provide work placements for students that involve a comprehensive orientation of the residential aged care work environment. This will establish a supportive and welcoming environment for students as future employees by creating a positive and enjoyable learning experience (Robinson et al. 2008) and provide improved familiarity with aged care work (Cooke et al. 2021). Universities and professional bodies could consider more active use of aged care student placements to highlight the opportunities that the sector offers to new graduates in health professions (Clarke and Ravenswood 2019), which could

include requiring students to complete one of their placements in an aged care setting (Cooke et al. 2021).

Due to the combination of stigma, negative public perceptions and media reporting, and known problems with renumeration and staffing ratios with the aged care industry, it is perhaps not surprising that aged care is not a career choice for many. Regardless, these negative perceptions of working in aged care need to be changed. Improving working conditions, addressing staff retention and community engagement could improve the image of the sector and reduce some of the stigma attached to working in aged care (Manchha et al. 2021), though many of these changes will take time.

Therefore, in the short to medium term, we recommend a concerted focus and campaign to help improve the image of the aged care sector (and residential aged care in particular), which will help to address the stigma regarding older people and working in the aged care sector. Some mechanisms through which this may be achieved include:

- Create partnerships with the local council and community groups to explore ways of connecting RACFs and residents to the community. This could include:
    o Holding small community events in the RACF.
    o Designing events in community spaces of interest to aged care residents, which ideally will involve co-production.
- Providing transportation for residential aged care residents to attend special community events (for example, via a bus provided by the RACF or a community bus service).
- Developing positive news stories and promotional videos on residential aged care, which include an emphasis on relationships (between staff and residents, but also between the residents, facility, and community).
- Partner with local community newspapers to distribute positive news stories on local RACFs.
- Approach universities with placement offers across the health professions, which will provide immersive experience for students that includes, but extends beyond, care work.
- Engage with universities to develop a support network for students and graduates who choose to work in aged care facilities.
- Investigate the viability of the City of Clarence establishing their own RACF. Potential benefits to Council would include:
    o Developing a community hub for Council run or sponsored events and activities (this allows for the integration of the residential aged care community with the rest of the community);
    o Creating partnerships with the University of Tasmania for health, medical, social work, and allied health student placements, as well as for research purposes;
    o Creating new employment opportunities;

- Supporting age-friendly programs and initiatives, including the ability of people to 'age-in-place' (see Recommendation 1);
- Being leaders and innovators in supporting ageing populations, destigmatising ageing and older age (including health conditions that are more common in older age, such as dementia), and responding to employment needs within the community and the residential aged care sector.

In regard to the City of Clarence establishing their own RACF, it should be noted that traditionally aged care services were primarily provided by local governments and the not-for-profit sector. While the not-for-profit sector continues to dominate the provision of aged care services in Tasmania, local governments across Australia have largely withdrawn while for-profit providers have increased. This movement away from a welfare model and towards a model that is market driven has facilitated precarity within the aged care sector and "increase[d] the vulnerability of the market, aged care providers, and consumers" as well as the aged care workforce and service delivery (Savy and Hodgkin 2021). Therefore, local councils could investigate the potential and viability of addressing such problems through investing in residential aged care.

Recommendation 3: Recognise the contributions of, and invest in, residential aged care staff

[…] a lot of us start, like, earlier than we need to, and I think they need to recognise the fact that, the only reason like we're not getting too stressed out is because we're starting earlier, then we should be. And I know that we probably shouldn't be, and they would argue that we shouldn't be getting there early either. I think they need to realise that. It's because we are managing to get everything done, that doesn't mean we need, like to have more and more work sort of put up to us.
(Olivia [Hospitality services])

We were given more duties to do less time, so the same amount of time to do everything on top of normal cleaning plus all the COVID cleaning. We did not get any extra time during our normal days.
(Gemma [Hospitality services])

In Recommendation 2, it was noted that the public profile of aged care needs improving. In Recommendation 3, the focus is on recognising the contributions of those who work in aged care, which includes investing in the retention of current staff.

Staff retention is a well-known issue in Australian aged care. According to the Australian Government, Department of Health (2021), 277,671 people were employed in an Australian RACF in November 2020, with over

75% of staff in direct care roles (n=208,903). However, retaining these staff was an issue, with 29% of care workers and 37% of nurse practitioners and registered nurses leaving their employer in the previous 12-month period (Australian Government, Department of Health 2021). In addition, with many long-term employees retiring from the aged care workforce, valuable knowledge and skill sets are being lost (Hodgkin et al. 2017). Based on their research, Radford and Meissner (2017: E5) suggest that to improve retention of staff in RACFs, lessons can be taken from the home and community aged care sector (who experience less staff turnover and higher rates of job satisfaction), such as "redesigning roles in residential care to increase autonomy, focus on interprofessional team development, improve the team culture and add more virtual supervision to improve satisfaction". Additionally, staff turnover negatively impacts residents' health and wellbeing, therefore it is vital that governments and service providers address the issues of stressors in the aged care workforce, which will have a flow on effect and improve quality of care (Cimarolli et al. 2022).

It was evident through the interviews that all participants had experienced extra workplace demands and stressors during the coronavirus pandemic. It was frequently mentioned the storage of staff, increased workloads, and poor recognition for their contributions including financial and non-financial compensation. As

noted by Olivia and Gemma (see above), more was required from hospitality services to meet COVID-19 cleaning protocols and ensure the safety of staff and residents, but no extra time or allowances were given for these services – they were expected within existing workloading and routines, but it was not possible to do so without working overtime. That is, while more time was required for private and communal room cleaning, resident's care (for example, to listen to their concerns and providing them companionship particularly during lockdowns), and for laundry and kitchen staff to provide quality services, it was clear from our participants that no extra paid worktime was allocated for these tasks nor compensation for the overtime required to complete additional COVID-19-related tasks (for example, extra renumeration, time in lieu, or other forms of compensation and recognition). Interviewees further reported experiencing fear and uncertainty in the initial stages of COVID-19 and, while having to manage their anxiety, needing to conduct risk assessments. These negative experiences were further compounded by bonus payments supplied by the federal government not covering all work roles in aged care. The participants in our research who missed out on these payments felt their contributions were not being recognised or acknowledged at all (at the facility, provider, or government level), despite the sacrifices they had made. For example, the federal government's 2020 Workforce Retention Bonus Grant for residential aged care staff (two payments of up to $800), included staff in direct health and care roles only: "personal care workers, registered nurses, enrolled nurses and allied health" (Australian

Government, Department of Health 2020e), as noted by Gemma:

Well, the government doesn't class cleaning, laundry, kitchen, reception as frontline workers. Only nurses and carers are called frontline workers. Even though we [hospitality services] have to be there every single day. We don't get the benefits like the frontline workers did. [...] We are in the [resident's] rooms a lot longer. And we are exposed more than the carers are.
(Gemma [Hospitality services])

In recognising this shortfall, some Australian aged care providers developed payment schemes for non-eligible staff (Cheu 2020). While the subsequent 2022 Aged care workforce bonus payment (two payments of up to $400) did cover more residential aged care staff (such as hospitality services), some positions – such as administration, gardening, and maintenance staff – remained excluded (Australian Government, Department of Health 2022).

While these payment schemes may benefit some aged care staff in the short-term, they are problematic for what they do not achieve. Not only do they fail to address chronic staff shortages within aged care and pay disparities compared to other health sectors, but the payments also fail to address work-related stresses, recognise the aged care workforce as a collective whole, and provide ongoing support to the residential aged care sector. Furthermore, while financial compensation or rewards are one way to recognise staff, non-

monetary incentives have also been shown to make staff feel valued and included as well as reduce staff stress and turnover, and positively influence employee morale, performance, motivation, and engagement (Peluso et al. 2017; Wickham 2022). The significance of small gestures was noted by Emily:

There was a great boost in self-esteem four to six weeks ago when the governor delivered, or her staff delivered, I think it was three vases of flowers from their garden for the staff and residents. That was a real boost. So, if there were you know, if Mr. KFC dropped in, 'here are some vouchers, your staff been doing a great job'. But there's nothing that comes back positively from the community.
(Emily [Social and spiritual support])

Some examples that may help to recognise the contributions of residential aged care staff and invest in the current residential aged care workforce include:

- Local councils or community groups holding a special event for all aged care staff to celebrate and thank them for their contributions during the coronavirus pandemic and to the community more broadly (which could become an annual event). Such public-facing events could be promoted to the media. Such attention could improve the public image and reduce some of the stigma attached to the aged care sector, working in aged care, and societal attitudes towards older people (Curryer and Cook 2021; Manchha et al. 2021, 2022) (see Recommendation 1).

- Showcase staff through recognition schemes and social programs. This could involve monthly ("Spotlight of the month") or quarterly initiatives. Some schemes may be directed at the entire staff (such as an occasional onsite massage service) or individuals (for example, employee recognition such as card and small gift on their birthday or employee awards such as movie tickets) (for example, see Cheu 2019, Dixon 2009).

- Share updates on events and activities in the facility through social media and media releases. This could partner with initiatives developed in response to Recommendation 2.

- Include praise and recognition as part of staff handover meetings.

- Examine how sectors, such as home and community care, foster job satisfaction and staff retention.

- Offer flexible working conditions (such as work schedules and rosters) that are responsive to staff needs, and career development opportunities (see Recommendation 8).

- Community engagement and initiatives such as low-impact dance classes or walk-a-thons to help raise awareness and improve relationships, health and wellbeing, and provide social experiences to staff and residents.

- Reduce paperwork requirements and increase time allocated to spending time with residents (see Recommendation 4).

Recommendation 4: Reduce the administrative load for residential aged care staff

[...] I'm trying to be diplomatic but there's so much tape, or bureaucratic stuff that has to be done that more managers are needed to be able to do all the quality and etcetera, etcetera, etcetera. [...] Anyway, and no money was spent, no extra money was spent on the carers, you know, on the people on the ground that deliver the service to individuals that we're supposed to care for. And the carers are just lovely, but they do so much. You know, they, they, often they, you talk to them, and then they just say we don't have enough time [shrugs with open arms and smiles]. You know?
(Heather [Social and spiritual support])

Documentation in RACFs is a reporting and accountability mechanism to support and demonstrate quality care. This results in large amounts of record keeping that track daily routines in the operation and provision of aged care. Importantly, how RACFs operate is informed by federal legislation that translates into standards, policies, and procedures. This includes proof-of-evidence of meeting the Aged Care Quality Standards, which consist of eight standards, and the quarterly National Aged Care Mandatory Quality Indicator Program, which focuses on the resident's needs for quality of care and quality of life (Australian Government, Aged Care Quality and Safety Commission 2021; Australian Government, Department of Health and Aged Care 2022c). Other forms of accountability and paperwork

(which may be used as proof of meeting the required standards) are care plans, medication charts, progress notes, and activity check lists, which are intended to enhance care and facilitate communication between staff particularly those in care roles.

As the coronavirus pandemic unfolded, RACFs were required to continually update and implement infection control measures. This increased workload complicated the usual functions of RACFs. With the continuation of the coronavirus pandemic into 2021 and 2022, rules, regulations and reporting requirements have continued to shift and change, which has further increased the load on aged care staff and RACFs to meet and record compliance (for example, weekly data reporting and monitoring of COVID-19 vaccinations). Furthermore, aged care providers and individual facilities have sometimes implemented their own monitoring and recording procedures on top of what was required. As result, participants experienced a noticeable increase in administrative demands that was felt across all areas of aged care (also see Recommendation 3). Participants commented on the record keeping that was required to log visitors entering RACFs, which at times required an additional staff member (or took a staff member away from their duties), but no extra resourcing was provided. Heather also discussed her experiences of supporting families and incoming (or potential) residents to complete complex paperwork, and which was made more challenging by physical

distancing requirements (and thus, were completed at-a-distance). She commented:

And we're talking about families that might not have the technology, or the internet, or you know, all those sorts of things. And like, we had an hour and a half worth of paperwork to get through. And I'm talking chunks of paperwork, agreements and things. And so I had to, with one in particular, had to drive to their home, which wasn't that far, [...] leave the big packet of stuff on their doorstep [gesticulating placement of paperwork], run away, go back to the office, and ring them up to do a Zoom meeting, and right, on this next page, we're looking at this, and it should look like this [demonstrating holding up paperwork to the camera]. And you know, was, it, we made it work. But it was just a stressful time having to do those things as well.
(Heather [Social and spiritual support])

As can be seen in Heather's example, residential aged care staff went to great lengths to meet their work duties during the coronavirus pandemic including providing additional communication and support to residents and their families. For Heather, usual administrative practices became a drawn-out process, as she needed to support families in technological methods of communication and delivering paperwork to them in addition to her usual role of supporting them to complete the necessary paperwork. Some of these administrative requirements also had emotional consequences and impacts (for example, managing family and friends upset by

lockdowns or mandatory vaccination requirements) that participants needed to manage and negotiate.

This situation of overwork has been exacerbated by increasing compliance requirements. As reported by CompliSpace (2022: 18), the previous Accreditation Standards of four standards and 44 expected outcomes were replaced by the Aged Care Quality Standards on 1 July 2019, which are "a 197-page Guide setting out eight Standards, 42 requirements, and more than 600 examples of actions and evidence that providers must follow to ensure compliance". As a result, workload increases have become normalised in the industry. This was exasperated by reporting requirements during the coronavirus pandemic. For example, during 2022, 85% of aged care workers reported increased workload due to Aged Care Quality Standards, and 94% of aged care workers reported increased workload due to the coronavirus pandemic (CompliSpace 2022). The consequence of increased reporting requirements has been a reduction in the quality of social interactions and the building meaningful of relationships with residents, as Ben noted:

[...] the last four years, the paperwork became so unbearable that all you're doing really is besides medications and wounds and, you know, the basic care was paperwork, because paperwork became a real nightmare. [...] They bought in you know, [...] a lot of documentation to support the evidence of how you looked after them [the residents], and why and, and, you know, just for compliance, and so forth. So yeah, a lot of it was paperwork, and but yeah, just in

reference to, if they [the residents] were sick, look after them of course, and treat them. But there wasn't a lot of space for social chatting because you just didn't have time [...]. And that's why I wanted to, that's why I went into aged care. I was in hospital and aged care at the same time, and I thought I want to go into aged care because I love the fact that I can follow through the lives and spend time with them a lot [the residents]. But then, after three, four or five years, I started getting less and less time and just it was really just task-orientated work rather than spending time socially with, with the residents.
(Ben [Social and spiritual support; Caring, nursing, and allied health])

What is notable about Ben's comment (as well as Heather's at the start of this Recommendation) is that the compliance and regulatory requirements of aged care detract from the function of aged care – to provide quality of care and quality of life to residents. For Ben (above), developing and nurturing relationships with residents is what attracted him to the industry, but the increasing task-orientation of his care-related work as well as the increasing administration requirements, was taking away from his enjoyment of work. Similar points were raised by Sonya (below), who noted that the detailed care plans are an inefficient means to accurately reflect a resident's care requirements and fail to recognise the importance of forming relationships with residents in understanding the resident's needs and wants:

[...] I spend a lot of time doing care plans and assessments that nobody ever, ever looks at because they're very complex and not intuitive documents and, you know, there's a recognition that in residential aged care, we know our residents very well. We know our staff very well. We are a community, it's a cliche but we are. So, there's no need to, like the acute system, we don't need to continually refer to a care plan because you know, it's not a new person that we don't know. So, while there absolutely needs to be care plans in place, so if new staff or you know, that stuff can be look it up, but it doesn't need to be a very, very complex document. It needs to be a simple document, the basic essential information. And somewhere along the line, it's become so complex that actually the, the compliance side of ticking boxes for nurses is taking as much time as the actual looking after people and so on. It's not sustainable.
(Sonya [Caring, nursing, and allied health; Management and supervisor])

Relationships are central to aged care work – they are the top reason aged care staff stay in the industry (43%) (CompliSpace 2022) and what attracts them to the sector (Aged Care Workforce Industry Council 2022). As Felicity noted:

I just happen to want to work in aged care, because I like the rapport build with residents in the relationships and not having new people every day and I get to know them. And that's exactly why and just making their lives better.
(Felicity [Social and spiritual support])

In addition to the importance of relationships, person-centred care models are associated with job satisfaction in aged care (Edvardsson et al. 2011). Significantly, the eight-standards in the Aged Care Quality Standards focus on a person-centred model but excessive paperwork, standardisation, staff shortages, and a lack of leadership, support, lifestyle programs, training and understanding of person-centred principles, can interfere from providing such a model (Seah et al. 2022; Warmington et al. 2014). Employing a relationship framework within a person-centred model helps to support and recognise the importance of relationships, and how they can foster community within RACFs that includes staff, residents, and resident families (Brown Wilson 2009).

From these findings, we recommend:

- Employ person-centred care model in a relationship framework, to best support residents and to help attract and retain residential aged care staff.
- Train staff (specifically, management and staff in care roles) in person-centred care models (see Recommendation 8).
- Discuss with staff how to tailor care plans to better suit their needs and those of residents.
- Review paperwork and administrative requirements and reduce where possible.
- Examine ways to acknowledge staff for their contributions towards person-centred care models (see Recommendation 3).

Recommendation 5: Create context-specific emergency strategies

Australia's response to the coronavirus pandemic operated within a broader framework of international plans, national committees, legislation, and government networks including state/territory governments (McLean and Huf 2020). Due to the urgency of the pandemic, information was communicated in a top-down fashion. Communicating in this way has several benefits including offering a clear chain of command, easy identifiable goals, and quick implementation of decisions (Samson et al. 2018).

However, many participants felt that decisions related to aged care were made outside of the context of their workplace environment, which hindered their ability to execute policy demands. Each RACF is unique in its context and local community, residential occupancy, residential profiles, types and degrees of care provided, staffing levels, services, and architectural design. Lixin felt there was a lack of shared understanding of the demands in the workplace environment between upper-level management and operational staff:

> [...] a lot of our decisions are made up north in Launceston, so they might not necessarily know what's happening on the ground here in Hobart [...]. [...] But what happens, happens up north is probably, you know, there's properly a difference with what happens up north and down here in the south.
> (Lixin [Caring, nursing and allied health])

Other participants noted that decisions were being made about the function and administration of Tasmanian RACFs (where, at the time, had not experienced any coronavirus outbreaks) were being made from other Australian states/territories (which had experienced coronavirus outbreaks), and often reflected the pandemic situation elsewhere in the country. For these participants, they felt these plans lacked contextual relevance and needed to be more reflective and responsive to what was happening in Tasmania.

While centralisation of decision-making processes is a common response in times of crisis, the practise does tend to favour expertise at the top of end of the organisation, while overlooking the knowledge and expertise of front-line employees implementing policy at the bottom end (Bernhardsdóttir 2015). This can have a negative effect on the ability of an organisation (in this case, individual RACFs) to implement policy, as it denies employees the access needed to contribute to decision-making processes. This can have a negative follow through effect on the workplace environment, as it does not encourage employees to develop decision-making, collaborative, or leadership skills. This disconnected relationship between top-end management ground level staff can manifest into diminished motivation, lower performance outcomes, and reduced organisational commitment (Nankervis et al. 2014).

Crisis and emergency management requires a rapid response and a high degree of agility from

age care professionals and support workers to safeguard against possible dire consequences. This can be achieved through the creation of a site-specific, Interdisciplinary Emergency Management team, with delegated frontline authority to convene and translate external directives into actionable emergency strategies, specific to the needs of the RACF (Ohrling et al. 2022). A team drawn from all areas of a RACF, will be able to quickly mobilise available resources, knowledge, skills, and abilities, and provide an internal face to the decisions being made. This will contribute to the building of organisational resilience and institutional capacity to respond effectively to crisis (Ohrling et al. 2022).

Recommendation 6: Support and pay for time-out breaks from PPE and masking

Due to the infectivity of SARS-CoV-2, the use of face masks and other personal protective equipment (PPE) became an important public health measure to prevent the spread of the virus, particularly in health and care environments. PPE is a specific piece of clothing or protective equipment that provides a physical barrier between people and droplets from coughs, sneezes or other body fluids from infected people and contaminated surfaces (Yildiz et al. 2022). The most common types of PPE used in the aged care sector (when and where required) are gloves, disposable plastic aprons/gowns, masks, glasses, and face shields.

In 2020, very few Tasmanian RACFs used PPE except where it was typically used (for example, use of gowns and gloves in food preparation). This significantly changed after 15 December 2021 when the Tasmanian borders opened to interstate and international visitors. For our participants, this meant that all workers inside of RACFs were required to wear varying levels of PPE for the entirety of their shift. Staff found wearing PPE neither straightforward nor comfortable. Our participants noted personal safety and practicality of use as concerning, describing issues such as wearing the same PPE when resting, eating, and working in humid environments. As Leah comments:

Yeah, I've noticed especially, even just with the masks, but especially during full PPE, staff were a lot more agitated. Because you're constantly overheating and sweaty and even, even with the

masks, you are suffocating while you work. Because these masks are very fitted to your face. You're basically just breathing in the same air all day even though it's being filtered.
(Leah [Hospitality services; Management and supervisor)

PPE requirements had an immediate impact on participants' overall job satisfaction, comfort levels, and ability to perform their work. Common complaints associated with prolonged PPE use include redness and soreness at the contact points on the skin including around the eyes, nose, and ears (Yildiz et al. 2022). While all employees were required to wear PPE, where a staff member worked determined the amount of PPE to be worn as well as the duration of wear. For example, those working in administration were only required to wear masks and were able to be mask-free when alone in the office, but other staff (such as hospitality services, particularly cleaners) were required to wear protective equipment such as gloves, plastic apron or gown, and a mask (and potentially, a face shield) for prolonged periods of time and, potentially, without a break. As Adya, Annie, and Gemma comment:

And it's just you're doing a physical job and you're doing your work and you are sweating so much in the mask, where people in the office just sit there, nothing against office people. […] Now 20,000 steps a day minimum, plus I can do. So, you know, it's a physical job and you're wearing a mask and sweating, and you can't breathe and then you get in

trouble because you pull it down [the mask] for five seconds.
(Gemma [Hospitality services])

[…] it gets very very hot because you're constantly moving when you're cleaning.
(Annie [Hospitality services])

[…] you know, the wearing mask is like difficult to do, do like breathing as well. And yeah, I feel like a little bit uncomfortable with that […] because the wearing masks for a long time is quite, quite difficult.
(Adya [Hospitality services])

Staff whose work was physically demanding, such as cleaning or cooking, found their work particularly uncomfortable as no or little breaks from the PPE were scheduled and the available PPE was made of non-breathable material. This impacts the bodies' natural ability to regulate heat, which can result in excessive perspiration, faster dehydration, an increase in cardiovascular strain and decreased productivity (Bongers et al. 2021). For those working in food services areas, this discomfort is further exasperated by the increased humidity. Prolonged use, and particularly in environments like these, can lead to a breach to the PPE barrier, as people instinctively will wipe their faces (Cherrie et al. 2006). Furthermore, some participants reported that PPE was ill fitted or not fit-for-purpose. For example, disposable plastic aprons were reportedly of poor quality and either too large or too small, and had a limited lifespan. PPE that is not fit for purpose nor fit the users comfortably does little to support aged care workers and can promote poor safety practices.

To help overcome these concerns, we advise refining PPE standards to include the following recommendations:

- Encourage and renumerate hospitality and care staff to have to have short but frequent PPE cooling breaks during their shift. This will allow staff to reduce their core body temperature, hydrate, and adjust or replace PPE as needed. This will reduce the onset of fatigue and dehydration, while improving staff physical and cognitive performance (Bongers et al 2021).

- Where possible, provide a cooler working environment to reduce the amount of heat stress (Davey et al 2021).

- Provide education and training for proper use of PPE with a specific focus on why it is used. In-service training that provides the reasons why PPE is used and the benefits of its use will increase the likelihood of staff using it properly and consistently (Yildiz et al. 2022).

- Supply quality and readily available fit-for-purpose PPE that can accommodate different body types. Practical and well-fitted PPE reduces the amount of interference and irritation experienced by the wearer, while also contributing to a workplace culture of acceptance (Yildiz et al. 2022).

- Seek and act on feedback from users with a specific focus on quality, fitness, and comfort of PPE. Listening and acting on staff concerns will encourage staff to be actively engaged in safe and secure infection control practices (Vidua et al. 2020).

Recommendation 7: Improve communication pathways

Participants frequently raised their concerns about the communication pathways and the distribution and provision of information, which they often believed was inadequate or poor. As was highlighted in Recommendation 6, communication methods reflected a top-down approach to distributing information and initiating change. Email was frequently noted as the primary way to deliver information, which allows distribution to a wide audience and for information recall. However, many participants felt the amount of information was overwhelming, detached, and difficult to manage. As Sharon notes:

> *Personally, the directives that came from [my employer] were probably not helpful. You know, [...] as I said, when you get wordy emails or directives that you have to get vaccinated, doesn't help the situation. When you've got real people with real lives, trying to work out what is best for them and their family. Some staff did leave as a result, and refused to be vaccinated and left the organisation.*
> *(Sharon [Social and spiritual services])*

While regular emails were intended to provide information on policy and evolving changes, many participants reported that the emails felt impersonal or overloaded with information. As policy responses to the coronavirus pandemic placed a strong emphasis on the body and bodily autonomy, questions surrounding vaccinations and mandates were issues that were inherently personal to individuals. This is not to say that mandated vaccination policies

for staff in RACFs are right or wrong, but rather the impersonal nature of email means it can lack empathy or personal connection, which are qualities needed to effect change (Chou and Budenz 2020).

This was further compounded by information overload; a situation where there is so much relevant and potentially useful information that it becomes a hindrance rather than helping (Mohammed et al. 2022). This was not simply information coming from aged care providers; for participants, they felt overwhelmed by the amount of coronavirus-related information in general. For example, there has been enormous interest and threat perception surrounding the coronavirus, and this has led to the production of a lot of information from various sources that may be conflicting or false (Mohammed et al. 2022). Information overload about COVID-19 and a lack of comprehension of the behaviour of pandemics, made it difficult for the public to "separate fact from fiction and rumour from deliberate efforts to mislead" (Mohammed et al. 2022: 185).

For information from aged care providers, some participants felt that the information provided was good but, for others, they felt the communication was poor. In cases of poor communication, this was based how the information was delivered (dictatorial and instructive tone), the inaccessibility of information, or lack of information. Sharon notes:

Well, I think probably everyone could be a bit better. Not not just the organisation, the government just, it probably doesn't help because you're working amongst nurses and the nurses have that medical background or that they're getting information that you as a normal person, you know, a lay person non-medical person, wouldn't necessarily receive. So, you're receiving other information that might increase that level of fear.
(Sharon [Social and spiritual support])

Like all disciplines and fields of expertise, health and medical professions have their own specific language so they can work quickly and efficiently without the need for too much explanation. However, this language can be confusing or alienating for people who are unfamiliar with it. Unfamiliar jargon or language disconnects people from the messages and goals of the organisation, which undermines their ability to understand and leaves them feeling isolated. However, several participants offered examples of when they thought communication was done well, as Leah comments:

[...] if we've got questions, we feel we can go to our manager or take it higher up if they don't have the answer. Pretty good actually, it's definitely felt like a team environment from both the floor staff and from HR [human resources] and all the higher ups. It's been good because we've actually had our CEO and some of the higher ups, visiting the facilities and checking on staff and answering any questions that they've got and that's quite good to see.
(Leah [Hospitality services; Management and supervisor])

In this example, instead of trying to lead and initiate change through an email, direct face-to-face leadership was able to translate organisational needs into meaningful goals, provide individualised support, and promote inclusion. Face-to-face communication offers a more personalised approach to people's information needs, as it cab address gaps in understandings between managers and employees (Jensen 2018). This encourages employee engagement, job satisfaction and stronger working relationships; all of which are necessary to provide residents with appropriate and timely care in emergency situations (Ohrling et al. 2022).

From these findings, we suggest the following:
- Ensure that language used in communications is inclusive, supportive, and respectful.
- Explore ways of decentralised communication, such as on-site peer-to-peer communications (for example, communicate with people leaders who have the responsibility to provide that information to staff face-to-face).
- Ensure there are people on-site who are workloaded to support staff and answer their questions.
- To provide a personalised and supportive approach, explore integrating visitations to individual RACFs as part of the role of the leaders of aged care providers (see the previous example from Leah).

Recommendation 8: Provide paid professional development and training opportunities for residential aged care staff

In line with Recommendations 79 and 81 from the findings of the Royal Commission into Aged Care Quality and Safety (2021) and relating to Recommendation 6 in this report, investing in professional development and training opportunities is a vital component of developing a more dynamic and responsive workforce (Stone 2014: 675). Most participants mentioned a need, or desire for more, workplace training and development either for themselves or others. While training and development may have been offered by the aged care provider (though in some cases, participants suggested it was lacking), staff were often unable to attend due to the timing (and not offering repeat opportunities), lack of renumeration, or staff shortages. As Sophia and Leah comment:

[…] There were there weren't enough staff to actually attend because they were on the floor [providing care to residents]. Oh, they don't want to come [in] for training because they're at home. On the day off, they are thinking why don't they come to work, you know, to be trained on something.
(Sophia [Caring, nursing and allied health; Management and supervisor])

[…] it's sort of setting up new staff to, not quite fail, but it's not setting them up in a way that's really going to benefit them. Because you've also got new staff training new staff. So, if I just had, like, basic training course, to run them through properly.
(Leah [Hospitality services; Management and supervisor])

Notably, Leah is in a position where she trains staff but has not been given the opportunity to develop her skills in this area. Therefore, while she successfully onboards new staff into hospitality services, Leah would embrace the opportunity to develop her supervisory and managerial skillset further for the benefit of new staff, her employer, and herself.

It is also notable that the profile of residents and their daily living needs are changing. Over the decade to 2020-2021, a higher proportion of people have high care needs for activities of daily living (rising from 36% to 59%), which grows to 69% for people living with dementia (Australian Institute of Health and Welfare 2022b). Significantly, it estimated that up to 472,000 Australians were living with dementia in 2021, with the number projected to more than double by 2058 (Australian Institute of Health and Welfare 2022a). These numbers highlight the importance of having the necessary skills to support these growing populations. As highlighted by Charlotte and Anthea, staff require professional development and training to assist in mitigating challenging situations and helping people living with dementia:

I think sometimes staff maybe if they don't get enough training, like in dementia, or if they really stressed and overwhelmed, can start to shut down a bit [and dehumanise residents]. And that that can be where perhaps an age, ageist attitudes can come out.
(Charlotte [social and spiritual support])

You have people that work specifically in the dementia ward because they're trained to deescalate. They're not going to go and punch that patient or go and give them extra drugs to knock them out. That's not how you deal with it. You need to look at the behaviour before it escalates and then you, you intervene. It's not like we're treating them like they're crazy and they don't have any control, that's not the case. We do have control by monitoring the behaviour and being cued to go, okay, something, someone is rambling, [so go] sit with that person (Anthea [Caring, nursing and allied health]).

There are a range of training programs and courses that are available to fulfil training gaps. Notably, the University of Tasmania offers two Massive Open Online Courses (MOOC) - *Understanding Dementia* and *Preventing Dementia* - which are free educational courses on dementia including the different forms of dementia, dementia risk, and protective factors. These free courses have multiple intakes per year, are asynchronous, and are completely online (see https://mooc.utas.edu.au/). The University of Tasmania also offers undergraduate and postgraduate qualifications in ageing and dementia, again which are online and asynchronous (see https://www.utas.edu.au/wicking). Aged care providers could provide incentives for staff who successfully complete courses such as these.

In addition, a wide range of people from different cultures, ethnicities, and identities, and with a lifetime of experiences, live in RACFs. For example, the 'Forgotten Australians' is demographic of people who were placed in out-of-homecare institutions in the 20th century (Browne-Yung et al. 2021). This demographic of people experienced often severe childhood trauma as result of their institutionalisation. As they approach older age, this group of people is fearful of re-entering institutions and, as such, the people and systems of a RACF could trigger traumatic reactions related to their childhood experiences (Browne-Yung et al. 2021: 171). This type of response could be mitigated by training staff in the practise of trauma-informed care, which could also respond to staff traumas.

Trauma-informed care is framework that prioritises the assessment of trauma and its effects, and changes procedures to account for the triggers that produce automatic responses (Cations et al. 2020: 425). This can be used to positively support recovery in all people with a history of trauma and reduce the chances of distress and re-traumatisation, and has been used effectively in hospital wards for older people for these purposes as well as reducing responsive behaviour changes (Cations et al. 2021). Significantly, trauma may also be in response to coronavirus pandemic both in residents and staff, particularly those with a history of trauma, due to a sense of powerlessness or feeling overwhelmed (Skatssoon 2021). For some of the participants, the trauma of working in RACFs during the coronavirus pandemic in addition to the existing workload pressures, had influenced them to leave the industry (some had left at the time of the interview while others later reported that they had left).

Engaging in personal development and training is an opportunity create a workplace environment that is safe, attractive to work in, encourages community, and can provide quality care. Investing training and hiring staff

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with skills in person-centred care is a crucial component of this strategy (see Recommendation 4). Scheduled training enables newly hired and existing employees to do their job effectively as well as the opportunity to acquire new knowledge, skills, and abilities. By supporting personal development and training, it enhances an employee's value by ensuring they gain new knowledges and skills; all which benefit their employer as well as those living in RACFs. Investing in training can also contribute to the improvement of morale, avoid burn out, reduce labour turnover, and improve organisational flexibility (Thapa et al. 2022).

In thinking about professional development opportunities, we suggest the following:

- Renumerate or reward staff to attend professional development opportunities, which may include providing staff with a list of available opportunities that will be recognised by the aged care provider (see Recommendation 3).
- Provide multiple opportunities at different times, or asynchronous offerings, for staff to engage with professional development opportunities.
- Explore introducing trauma-informed practice/care training and policies (for example, see Australian Government, Department of Health and Aged Care 2021. This also aligns with Recommendation 74 from the Royal Commission into Aged Care Quality and Safety 2021).

- Train staff (specifically, staff in management and care roles) in person- and relationship- centred care models (see Recommendation 4).
- Support staff to seek dementia-specific training, particularly those working closely with residents who are living with dementia.
- Explore initiatives to reduce ageism within the aged care workforce, such as the free Advocates Training offered by EveryAGE Counts (https://www.everyagecounts.org.au/advocates_training) (see Recommendation 1).

Recommendation 9: Support the mental health and wellbeing of residential aged care staff and residents

The coronavirus pandemic brought an unprecedented range of mental health challenges for residents, family members and aged care staff. Lockdowns, close contact regulations, facility isolations and the cessation of non-essential activities (such as visitors, volunteers, lifestyle activities, and communal eating) were implemented. To achieve this, residential aged care staff assumed extra duties in supporting residents and their families. As noted by Gemma, when residents were separated from their families, staff members became their primary source of social and emotional support:

Oh yeah, you see them [residents] getting very, very depressed. A lot of them just cried, just didn't understand why they couldn't see their families. And a lot of them aren't phone savvy, don't know how to FaceTime. Something [... that] could have done with them, ring their family, put them on FaceTime or you know, just a bit extra support would have been nice for them. And that's why I spent extra time as well. I don't have it, but I spent as much time as I can with the residents when they don't have family. Because, you know, we're the only interaction they had for the whole day.
(Gemma [Hospitality services])

Residents experienced an array of adverse effects from the coronavirus pandemic that included disruptions to their daily living routines, social isolation and, in some cases,

difficulty in adapting to technologies. Although recent research by Curran et al. (2022) found no evidence of exacerbated symptoms for residents already living with mental illness during first two waves of COVID-19, research by Brydon et al. (2022) and Leontjeas et al. (2021) found that residents experienced an increase in loneliness, agitation, anxiety depression, and irritability. Furthermore, while some residents had family or friends that they could contact remotely, others did not. For those without family or friends, other residents (as well as staff) are their only forms of social contact and interpersonal relationships. It was clear that many of our participants made significant efforts to alleviate the hardships experienced by residents and provide emotional support, when and where possible. This coupled with limited resources, resulted in mental exhaustion and burnout for staff (Corpora et al. 2021; Dobson et al. 2020). Staff workloads expanded to include - in addition to factors we mentioned in Recommendations 3 and 4 - managing the distress of family members unable to see their relatives. Sophia notes:

Like when in 2020, everyone had to have the, they had to have a flu vax to visit. Some people had never had a flu vaccine in their lives, and this was a deal breaker. How dare, you know, you asked me to do that. But that wasn't from us. That's, again, from the Feds [federal government], but we [residential aged care staff] have to wear this because we are the face

that they [visitors] see. So that was really, really challenging.
(Sophia [Caring, nursing and social support; Management and supervisor])

Staff were often required to inform visitors and family members about government mandates, infection control measures, and explain how it impacted on them (for example, visitations) and their loved ones. This not only required staff to be up to date with current policy, but to also have the skills to manage often distressed and occasionally aggressive people. Staff are positioned and the 'relational bridge' (Heyn 2016) between residents, families and RACFs, who translate needs and perspectives of all sides. The circumstances of the coronavirus made this extremely difficult to manage, as conversations revolved around the enforcement of restricted visits, vaccinations, and unique challenges of end-of-life. These conversations required an enormous amount of compassion, diplomacy, and tact to settle conflicts and to maintain the necessary alliances between residents, families, residential aged care staff and RACFs. Amongst the participants, the extra emotional load was mentioned as influencing whether they remain in the aged care sector or not, as Heather comments:

[Exacerbated sigh] The whole process of putting someone into care, is, as some individuals have said, it's the hardest decision they've ever had to make. Then you throw COVID in, it's just terrible. And, and it was, and my role, in that role was a really emotional job, anyway. And that, and that's one of the reasons why I left, it just broke me [...] And, you know, the staff really struggling, you know, with not having

enough staff, and then things not happening that should of happened. And it just weighs you down. [...] I'm surprised more people didn't break.
(Heather [Social and spiritual support])

Notably, an overburdened and emotionally exhausted workplace drastically reduces the quality of organisational performance (Stone 2014). Our research indicated there is a clear need to invest in more mental health mechanisms to support residents and aged care staff. Many of the participants noted how useful this would be for residents as well as themselves:

But someone who's a psychologist, I think would be really beneficial for the residents if that were just an in-house one. Even pre-emptive things so like not just getting an issue when it's an actual issue, but just preventing mental health issues from arising for them as well. I think it's important.
(Felicity [Social and spiritual support])

I'd get someone that could talk to in there, if they wanted to talk [referring to staff]. Because there is, somethings you do see, you, you can't take home with you, and you'd rather get it out before you go home. Anything, so, like, somewhere they could sort of, or someone they could talk to, to get it off their chest, too. It helps them, sort of thing.
(Annie [Hospitality services])

To support the mental health and wellbeing of residential aged care staff and residents, we recommend that residential aged care providers engage in proactive prevention measures and interventions to reduce the risk

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of mental health injuries and to support mental wellbeing. These include:

- Introduce workplace policies that promote a culture of work-life balance and self-care. Having a healthy work life balance and practicing self-care has been shown to assist staff to manage their obligations and work demands, as it emphasises the importance of balancing personal needs and the needs of others (Søvold et al. 2021).

- Employ onsite psychological services, particularly during times of increased workload or challenging working conditions (such as emergencies and pandemics). An option could be a psychologist who is employed across different sites of an aged care provider (for example, at *x* RACF on Mondays and Tuesdays, and at *y* RACF on Thursdays and Fridays) or, with an agreement, shared between aged care providers within a local government area.

- Reduce the stigma of mental health and expand and promote the use of employee assistance programs (EAPs). Research has shown that using an EAP is an effective mechanism for assisting people with their mental health. However, the stigma associated with mental health, and negative perceptions of trustworthiness and confidentiality, deter people from using these services (Matthews et al. 2021). Partnering with an EAP and promoting their use will help encourage staff to access these services.

- Employ more staff. This will reduce the pressure of excessive workloads and empower staff to focus on their duties and the care of residents. Most participants mentioned feeling under resourced and overworked, and spoke of being disengaged or demoralised, which impacted their ability to cope and perform (in addition, see Recommendations 3 and 4).

Summary

"Nurses and nursing assistants working in nursing homes are invaluable members of society and work in care environments in which many others are unwilling to work. The key message for policy makers is that we need to bring to the forefront the critical role of leaders and their capacity to effectively lead in nursing homes, which are complex environments. During this unprecedented time in our history, we should be thankful for all staff working in nursing homes. They are the de-valued work force and, in some countries, the forgotten. A reckoning of how we treat staff working in nursing homes is required" (McGilton et al. 2020: 965).

A large portion of interviewees said that they enjoyed working in RACFs as they drew a lot of job satisfaction from the relationships and connections they established with the residents. We found that nursing, caring, and allied health staff form relationships with the residents, as do staff working in hospitality, management, and supervision roles. When our participants were asked about what type of changes they would like to see in their workplace, their responses often focused on more staff, improved work-life balance (due to overtime and double shifts), more resources, more time to spend with residents, reduce administration requirements, and better support and recognition. While participants mentioned problems they had with wages, it was clear they were not always nor exclusively motivated by wages or benefits. They had intrinsic motivations to fulfil their caring roles and responsibilities, and the pleasure that is derived from helping in people living in RACFs.

Unfortunately, most participants described struggling to meet these personal sources of satisfaction and organisational goals. As noted by Leah:

[...] even though I quite like it, a few times I've said that I want to leave, [but] I don't think I ever could. Not without a very good reason, because like I enjoy spending time with the residents, I enjoy the staff for the most part, I enjoy the work. Like on a good day, the job's fine. And I'm definitely someone that thrives off routine. So being in a routine base job is really good. It's always, it's always different. You never know the stories you're going to hear from residents just as you're bringing in their cups of tea, they'll stop and tell you about a tidbit that I was thinking of at the time. Yeah, it's amazing [...].
(Leah [Hospitality services; Management and supervisor])

Under the conditions highlighted in this report, most participants expressed feeling exhausted, undervalued, and were considering alternative forms of employment. Indeed, during this project, some of the participants left the residential aged care sector to pursue work in other industries.

Governments and residential aged care providers have an opportunity to invest in aged care to improve the perception of residential aged care in the community, the quality of care that residents receive, and to increase workplace satisfaction and organisational commitment of aged care staff. They can do this

by developing their workplaces into attractive employer of choice; an organisation that focuses on meaningful work, employee development and recognition, tailored communications, and developing targeted initiatives such as community engagement (Branham 2005). By doing so, this can attract, create, and retain a loyal workforce, which will enable management to focus on business strategy and growth rather than being consumed by staff turnover and the associated challenges. While we understand that it might not be fiscally possible to address all the recommendations presented in this report (or at least, not all at once), we believe that working with the wider community, local government, and with those in individual RACFs (residents and staff), progress can be made towards making RACFs more durable to manage future crisis and emergency situations while also improving the work experience for residential aged care workers and the quality of care that residents receive.

Limitations and Strengths

There are limitations to this research. First, this research was undertaken in Tasmanian RACFs, which did not experience significant coronavirus outbreaks prior to 15 December 2021. Nevertheless, some of the Tasmanian RACFs were under similar restrictions to RACFs in other Australian state/territories that were experiencing and managing coronavirus outbreaks. In addition, some Tasmanian RACFs are managed from other Australian states/territories, and therefore their coronavirus rules and regulations reflected what the aged care provider was doing in these contexts (that is, a 'one size fits all' approach that was not contextually responsive). In addition, Tasmanian RACFs began to experience coronavirus cases and outbreaks following the opening of the Tasmanian borders to interstate and international visitors from 15 December 2021. As mentioned in the *Research Process* section of this report, data were collected prior to and following this time.

Consequently, the Tasmanian context can reflect on issues experienced nationally and internationally, but it does not reflect the challenges in managing the coronavirus pandemic as it impacted on the Australian community and RACFs in states such as Victoria and New South Wales during 2020 and 2021.

Second, all participants in this project worked in not-for-profit providers. This was not unexpected given the profile of aged care providers in Tasmania. In 2020-2021, it was reported that 83% of aged care providers in Tasmania are not-for-profits, which is significantly higher than the national average of 57% (Australian Institute of Health and Welfare 2022c). Therefore, the participant profile of employment in the not-for-profit aged care sector, heavily reflects the aged care industry within Tasmania. In addition, ten participants worked for the same aged care provider. Most of these participants, however, worked across

at least two sites of this provider (which, at times, had different rules and procedures), and some also worked for other aged care providers. This did not detract from the findings as the themes generated, and the recommendations provided, were common across the experiences shared by the participants collectively. It should again be noted that the participants worked for nine different aged care providers and across 21 different RACFs (see *Research Approach* earlier in this report).

Third, as the project was qualitative, it did not seek to achieve a representative sample of the residential aged care workforce in Tasmania. However, all findings presented in this report have emerged from the shared experiences of participants, for which examples have been provided in each recommendation. Each recommendation was only made when it reflected the experiences shared by multiple participants. In addition, data saturation was reached after nine interviews (see *Research Approach* earlier in this report). Therefore, we believe our recommendations would be of interest to the residential aged care sector broadly and would reflect the experiences of many residential aged care workers. As a result, our research findings could be generalised and potentially transferred to other contexts (for example, see Smith 2018 on generalisability from qualitative research). In addition, undertaking a qualitative research project allowed us to examine in detail the lived experiences of residential aged care staff during the coronavirus pandemic, and provided them the opportunity to voice and explore this in their own words. This allowed participants to raise issues that were important to them rather than what the interviewer and research team presumed would be relevant. This would not have been possible with survey-based research, which would have used pre-determined questions that respondents would not have been able to modify and add to including clarifying or explanatory details. Furthermore, due to the lack of research exploring the impacts of the coronavirus pandemic on aged care staff, a survey was not possible because it is not known what to ask survey respondents. Future research could use the findings presented in this report to create and test a survey instrument.

In addition, all residential aged care staff who participated in this project reflected all roles in the residential aged care industry (except for administration), and therefore the data can be taken as a reflection of the distribution of the experiences of Tasmanian residential aged care staff during the coronavirus pandemic. Furthermore, all interviews were video or audio recorded. This allowed transcripts to be very detailed - they were transcribed verbatim and included notes on the participant's oral or body expressions. In addition, each interview involved building trust between the interviewer and the interviewee, which facilitated long interview times and open and honest conversation. As a result, the data collected in this project is rich and in-depth, and therefore strongly reflects and captures the experiences of those who worked in Tasmanian RACFs during the coronavirus pandemic.

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