Key competencies, skills, and attributes required of leaders in the residential aged care services

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

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Dedication

This thesis is dedicated to my parents who have always loved and supported me throughout my learning journeys. To my father, George Nelson Irving (1930 – 2013), who would have been beyond proud to have witnessed this achievement and who would have revelled in telling everyone he knew (and didn’t know)! To my mother, Barbara Elizabeth Irving, who has continued to encourage (and push) me to reach this milestone, knowing how important an accomplishment it is. Thank you both always.
Abstract

“Leadership is one of the most observed and least understood phenomena on earth.” Burns (1978 p.2)

“We need to recognise and plan for this increased need for health service provision. This is an urgent and critical challenge for Australia: if we don’t provide properly for aged care, we will have a human rights disaster on our hands.” Susan Ryan, Age Discrimination Commissioner (2014)

This thesis focuses on the skills and attributes required by Chief Executive Officers (CEOs) and senior staff as leaders and managers in the residential aged care services (RACS) sector. It makes a significant contribution to this field of inquiry by utilising original research to examine the capabilities needed to meet the challenges faced within this industry sector.

The sector is beset by many complexities that are characterised by four main issues. Firstly, the need for effective leadership is essential. Prominent theorists claim that a paucity of research has been conducted regarding leadership in RACS. The second issue relates to demographic complications related to Australia’s ageing population and workforce and the increasing demand for quality services and staff within budgetary and other constraints. The third issue involves the intricacies of government policies that are an added obstacle. Fourthly, RACS are affected by major complications regarding human resource management (HRM) issues, including poor working conditions and complexities recruitment, attraction and retention.
This study employs a qualitative research methodology, underpinned by constructivism and thematic analysis. In-depth interviews with eighteen CEOs and senior managers within the RACS explored the nature of leadership within the sector, identified key leadership capabilities and investigated the potential HRM strategies that could be developed to address the sector's needs.

Based on the research, this thesis provides a detailed understanding of what skills and competencies are required of leaders to be successful in RACS and what the major constraints and factors that impact on their ability to utilise these attributes effectively. The thesis argues that there is an urgent need for Australia to develop a rigorously evaluated and strategically integrated national policy approach to the aged care health workforce. Strategies are needed to enhance working conditions, improve leadership and facilitate workforce innovation. A key component of these strategies is the need for qualified, skilled and dedicated leaders within the RACS who exhibit and implement the complex skills, competencies and attributes found by this research to be essential to successful aged care leadership.

Keywords: Leadership, Residential Aged Care, Skills, Government, HRM, Demographics
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Chapter 1 - Introduction to the research

This thesis is a study of the competencies, skills and attributes required of leaders within the complex field of residential aged care services (RACS).

This chapter introduces the study by setting the context, then outlining the focus of the study and the importance of this research. The key research question is identified and stated below. The overall structure of the study is outlined comprehensively by providing a brief overview of each chapter of this thesis including the research methodology that is employed.

1.1 Statement of the Problem


“The successful twenty-first-century organisations will be the ones with leaders that not only have the knowledge, skills and abilities to operate
effectively but also possess the relational capabilities to partner with others to realise their vision and goals.

The academic and general literature plus government reports, newspaper articles and media commentary about residential aged care services (RACS) presents RACS as an industry sub-sector that faces enormous complexities (Productivity Commission 2011, King, Mavromaras, Wei, He, Healy, Macaitis, Moskos, Smith & Wei 2012). It is in urgent need of effective leadership to navigate the difficult terrain on which it travels (Jackson, Mannix & Daly 2003, Timo, Fulop & Ruthjersen 2004, Masso & McCarthy 2009, Productivity Commission 2011). This and much more as will be demonstrated by a wide array of literature throughout this study. The key problems which this research is concentrating on include four broad areas which emerged as being significant while undertaking a comprehensive review of the available literature: leadership, government policies, regulations, demographic issues and human resource management (HRM) challenges. From the outset, it needs to be stated that the leaders are not necessarily a problem, but leadership is problematic given the array of complexities that beset RACS as an industry subsector in health (Treasury 2010, Productivity Commission 2011, DoHA 2012, Millane 2013c & 2014).

These four themes were originally selected because they are highlighted in the Productivity Commission Report into the status of the aged care industry in Australia, entitled “Caring for Older Australians” (2011). Subsequent research and the collection of data from informants in this study reinforced these issues as being significant influences in the ability of leaders in RACS to be effective and successful (Treasury 2010, Productivity Commission 2011, DoHa 2012).
This research will show that each of these issues is a major problem being confronted by Australian society (Spoehr & Barnett 2008, Treasury 2010, Productivity Commission 2011, King et al.. 2012, DoHA 2012, Millane, 2013a, 2013b, 2013c & 2014). Firstly the literature review undertaken in this research, in tandem with in-depth interviews, demonstrates that leaders in RACS have an extremely complex role and are often ill-prepared for such a role (Treasury 2010, Productivity Commission 2011, DoHA 2012, King et al.. 2012, Millane 2013c & 2014). Secondly, from a demographic perspective, the ageing population is a major problem that is placing pressure on this industry sub-sector and the economy at large (Treasury 2010, Productivity Commission 2011, Treasury 2015). The demographic issue also extends to the workforce that has a mean age well above all other industries and is rapidly ageing (Productivity Commission 2011, King et al.. 2012). Thirdly the complexities and problems that arise regarding government regulations, finance and policies are well documented in the Federal Government’s reports (Treasury 2010, Productivity Commission 2011 and DoHA 2012), yet are designed and implemented by the government and their representatives. This leads to the final problem which is HRM. This sector needs to replace ageing staff in a field that is paid poorly, highly casualised and the overall working conditions are not seen as attractive as other industry sectors seeking talented staff (Treasury 2010, Productivity Commission 2011, King et al.. 2012, Millane 2014). The literature review, in-depth interviews and findings present parallel research themes in these four key areas to demonstrate the dimension of the problem.

The Problem:
A common theme that exists across the aged care industry is that there is inadequate preparation for people transitioning into management and leadership roles. Management and leadership roles are complex, and they are hindered by an ageing population and workforce, complex and stringent government regulations and constrictive HRM conditions. Developing effective leadership and management teams in the aged care sector is critical for sustainability and effective continuity of the industry. This thesis aims to address the leadership challenges within RACS by exploring the four themes impacting on effective leadership in this sector and by establishing what skills, competencies and attributes are required by leaders in RACS to maintain a high quality of care and the long-term economic viability of RACS organisations.

1.2 Objectives of the thesis

The objectives of this thesis are multiple. The overall aims of this major study are to research a complex field using an array of research skills to advance potential solutions to the major problems faced by Australian society for RACS. The objectives extend to:

1. developing a ‘critical understanding of a substantial and complex body of knowledge at the frontier’ (Australian Qualifications Framework {AQF} Council, 2013, p. 12) of this field of research to contribute to knowledge that may have an impact improved leadership in RACS leading to more effective overall organisational outcomes.

2. ‘develop, adapt and implement research methodologies to extend and redefine existing knowledge … and disseminate and promote new insights’ AQF Council, 2013, p. 12) relating specifically to the skills, attributes and competencies that will most successfully serve RACS
leaders, and to identify and isolate the challenges, specific to their role, that influence the requirement for these abilities.

3. ‘generate original knowledge and understanding to make a substantial contribution’ (AQF 2013, p13) through original research to add academic commentary to the body of knowledge in the field to work towards a resolution of major challenges that this society is now facing due to an ageing population and an overwhelmed and underequipped aged care industry.

This study will address the overall objectives by specifically researching and providing commentary on the complexities and challenges facing RACS as they endeavour to meet the needs of ageing Australians in the four main areas as listed in the preceding section. These include:

- Determining and commenting on the skills competencies and attributes that are required of leaders in RACS to effectively manage the government policy, demographic and HRM and issues that inhibit the successful and sustainable provision of aged care
- Analysing the demographic issue which has two problematic dimensions. The first is the well-reported ageing of the Australian society; the second is the rapidly ageing workforce employed within RACS with large numbers facing retirement in the next decade (Productivity Commission 2011, DoHa 2012, King et al. 2012).
- Investigating the impact of government policy on the effectiveness of the aged care industry and its ability to effectively care for our ageing population.
• Identifying the HRM complications currently facing RACS and examining the issues that prevail in this industry sub-sector

These objectives emerged as significant themes in the Productivity Commission Report on aged care in Australia (2011), from within the literature, and subsequently during the in-depth interview research. The thesis, using these themes, provides new insights into RACS and the significant problems this sector faces regarding the provision of aged care, in an environment where the population is ageing, and the pool of potential aged care workers is shrinking. There is limited research on the skills, competencies and attributes required of leaders in RACS (Jeon, Merlyn and Chenowyth 2010, Jeon, Glasgow, Merlyn and Sansoni 2010, Buchan, 2004, Dwyer 2011). This study provides research regarding the requirement for effective leadership in this sector, as well as outlining the necessary leadership competencies, attributes and skills which must be identified and developed to sustain the successful continuation of this industry sector, and to fill the gap left by the scarcity of research in this field (Jeon, Merlyn and Chenowyth 2010, Jeon, Glasgow, Merlyn and Sansoni 2010, Buchan, 2004, Dwyer 2011). Thus, this thesis aims to make a significant contribution to the body of literature on this key research issue.

1.3 Significance and Justification of the Research

This research investigates the significant leadership and policy development that is required to address the needs of RACS in Australia. The significance of the research lies in analysing the complexities of residential aged care and the difficulties faced by RACS leaders, which impinge on their ability to effectively lead and manage in a complex sector. These issues include attracting and
retaining staff, determining significant changes required in the direction and practices modelled by senior management in this industry, along with the evolution of more relevant and targeted government policy (Productivity Commission 2011). A key factor is the establishment of improved working conditions, wages and salaries, training and career pathways for aged care workers who are crucial now to providing adequate care for ageing Australians but this issue is destined to become more critical without significant change (Productivity Commission 2011).

Australia's ageing society presents many problems. There is a shrinking pool of people to recruit to provide care for older Australian people (Productivity Commission 2011, King et al. 2012). This problem is further exacerbated as workers in RACS are generally older than the average age of workers in other fields and significant numbers of staff who will retire in the next decade presents as a major problem (Productivity Commission 2011, King et al. 2012). This problem is aggravated by the complications faced by RACS in attracting and retaining skilled workers (Productivity Commission 2011). Considerably more than half of RACS' employees (58 per cent) were aged over 45 years of age in comparison to 38 per cent of workers in all other industry sectors (King et al. 2012). In the ten years from 2000-2001 to 2010-2011, those aged over 55 years working in RACS increased significantly from 11 per cent of the workforce to 27.3 per cent (King et al. 2012). Clearly, this manifests as a substantial problem for the industry, ageing Australians, and society in general as demonstrated by landmark studies in this field (Productivity Commission 2011, DoHA 2012, King et al. 2012). The higher age category of aged care employees serves to intensify the current and predicted labour shortages in this industry which will further
impact RACS regarding recruiting and retaining staff (Productivity Commission 2011). Each year a minimum of 250,000 Australians turn 50 years of age and by 2020, there will be another two million new seniors, while Australia’s fertility rate has been diminishing since 1961, and life expectancy has been growing for over a century (Treasury 2010).

RACS and the aged care industry in general, are considered to be a complicated, multifaceted system, with specific and complex challenges that make it unique to lead and manage. A number of factors intensifies this opinion. Firstly, there is the social reinforcement of the aged care sector’s low standing in comparison with the acute and community care sectors, which transpires via the perception of insufficient resource allocation, employment of predominantly low-skilled care workers and lower incomes for qualified nurses (Hegney, Eley, Plank, Buikstra & Parker 2006, Productivity Commission 2008, Jeon, Merlyn & Chenoweth 2010). These imbalances, subsequently accompany high levels of administrative compliances and management accountabilities, which lead to greater levels of staff dissatisfaction, burnout and turnover (Eley et al., 2007, Productivity Commission 2008, Jeon et al.. 2010). This significantly influences the issues within RACS that their leaders are expected to resolve, in a complex atmosphere of high staff mobility, while managing and caring for vulnerable individuals and groups of people with diverse and complex care issues (Jeon et al.. 2010, Dwyer 2011, Stockhausen & Mowbray 2015). It is recognised in the literature that leadership in aged care nursing is complex and unique (Hegney et al.. 2006, Productivity Commission 2008, Eley et al.. 2007, Jeon et al..2010, Productivity Commission 2011, Dwyer 2011, O’Keeffe 2014), as it must include managing and leading for; “human resource and care management, wound care, pain
management, dementia, guardianship, polypharmacy, and palliation that demands sound knowledge, relevant expertise and clinical skills to care for low to highly dependent residents” (Stockhausen & Mowbray 2015, p.1). Finally, there is an ongoing challenge for RACS to encourage future and aspiring leaders to graduate into senior roles, as it is such a compliance-driven sector still operating under multiple layers of regulation. This compliance and regulatory burden not only deter potential leaders from taking a more senior role but also results in a lack of opportunity for current leaders to be bold and innovative, to address the complex issues with which they must contend (Productivity Commission 2011, O’Keefe 2014).

These problematic issues can thwart the effectiveness of organisations operating in this sector as many recent reports have argued (Speohr and Barnett 2008, Treasury 2010, 2010a, Productivity Commission 2011, King et al.. 2012 and Millane 2014). Therefore, this thesis argues that pioneering approaches are needed by leaders in both aged care and the government, to resolve the human resource management needs that prevail in the RACS, to reduce the compliance burden and encourage innovation and sustainability, and to meet the challenges these major problems pose. To develop and interpret what approaches are required to meet this challenge, there must first be an understanding of the aged care sector and its environment, and the skills, competencies and attributes required of leaders to successfully guide their RAC organisations to a sustainable outcome that meets the needs of Australia’s ageing population.

1.4 Delimitations

The research in this thesis focuses on Victorian RACS only due to time and
funding constraints. Further, Victoria provides a good representation of the aged care industry in Australia, as it is home to the highest percentage of privately owned facilities and government-owned facilities in Australia (Australian Institute of Health and Welfare 2012). This means that there is a large variety of care facilities from which to select a wide diversity of participants.

This research concluded by interviewing eighteen participants only, as the information gleaned via the in-depth interviews was becoming repetitive and no new themes or information were forthcoming. According to Alvesson and Ashcraft, (2012), participant numbers may depend on the balance between the representativeness of the phenomena being studied and the quality of responses in achieving sufficient information. If the goal of the research is to describe a shared perception, belief, and behaviour among a relatively homogeneous group, data saturation is more likely to occur as early as after twelve interviews (Guest, Bunce & Johnson 2006). This research selected a mostly homogenous group of leaders in RACS, however the added inclusion of a few leaders who were in the aged care industry but not specifically in RACS, and who reinforced the views and perceptions of the leaders in RACS, allowed the assumption of data saturation to be made earlier, rather than later. This fits nicely with Bernard’s (2012) recommendation that to further enhance data saturation, one should include the interviewing of people that would not normally be considered as part of the homogeneous group.

1.5 Definitions

1.5.1 Leadership
As the question this thesis seeks to answer is regarding the key competencies, skills and attributes required by leaders in RACS, it is firstly important to determine the meaning of the key terms that are central to this question – leadership, skills, competencies and attributes. As mentioned previously, leadership is a much-contested term, but while it is often used interchangeably with the term management, it is generally accepted to be a different concept (Kotterman 2006, Maccoby 2000, Zaleznik 1998, Kotter 1990). Despite the varied approach to defining leadership, much of the research around leadership and its meaning has focussed on their influence over their followers. For example, Bass (1990) asserts that leader legitimacy is dependent on the recognition and approval of their subordinates. Yukl (1989) emphasises the perception of followers in defining leadership, which concurs with Eden and Levitan (1975), who determined that leadership is legitimised in the mind of the follower. However, more recent conceptualisations of leadership propose that leadership may be shared not only between formal leaders and other expert leaders but by team members as well (Ciulla 1998, Avolio, Bass & Jung 1999,). In essence, team members who are neither a formal or expert leader can also engage in leadership behaviours (Xioa, Seagull, Mackenzie & Klein 2004). Further, Barnes and Kriger (1986) observed that leadership does not rest with a single individual but is pluralistic and fluid, as in a volatile world, no one person can lead at all times and in all situations (Hollander 1992, Lichtenstein, Uhl-Bien, Marion, Seers, Orton & Schreiber 2006). The role of a leader should be assumed by the person or group best positioned to guide a specific decision and should be shared and emerge from the given context (Torres & Reeves 2011). As such, a useful definition of general leadership for this thesis is as follows:
“Leadership is something that people do (it is a behaviour), not a position or job title, and it helps other people solve difficult problems. (Bailey, Docherty, Adams, Carthron, Corazzini, Day, Neglia, Thygeson & Anderson 2012, p.2)

1.5.2 Management

Due to the frequently implemented interchangeable use of the terms leadership and management, it is almost impossible to define leadership effectively without also referring to the concept of management. Management is often described as being a function, and Gardner (1990) suggested that the term manager usually relates to someone who fulfils a directive position within an organisation, who organises functions, distributes resources, and effectively utilises staff.

Early management theorists like Fayol, (1930, p.6) established the role of a manager is “to forecast and to plan, to organise, to command, to coordinate and to control”. Similarly, Koontz (1961, p.175) describes management as being “the art of getting things done through and with people in formally organised groups” (Koontz, 1961). For this thesis, we will turn to Peter Drucker, commonly known as the father of modern management theory, and his definition of management:

“management is a function, a discipline, a task to be done; and managers are the professionals who practice this discipline, carry out the functions, and discharge these tasks”( Drucker 2012, pg 10).

Despite the much-discussed distinction between leadership and management, however, there is some doubt as to whether they are quite as separate as this in practice. Kotter acknowledged that both are essential for “success in an increasingly complex and volatile business environment.” (Kotter, 1990, p103)
Bolden (2004), argues that the different functions allocated separately to ‘management’ and ‘leadership’ are a fundamental part of the same job. He reasons that people are commonly hired into ‘management’, rather than ‘leadership’, roles and are expected to undertake a variety of responsibilities that range from day-to-day planning and implementation, to the creation of a longer-term vision and staff motivation (Bolden 2004). This duality of roles is acknowledged in this thesis, particularly as leaders of smaller RACS facilities, by necessity, must be both a manager and a leader. However, the focus is on leadership because of the need of leaders in RACS to inspire, motivate and influence their stakeholders in a complex, challenging environment.

1.5.3 Competencies

The focus of this thesis is on ascertaining the skills, competencies and attributes of leaders in RACS. It is important, therefore, to indicate what is meant by these terms as they relate to leadership. Even though the plethora of leadership theories have thus far proved unsuccessful in isolating a conclusive set of leader characteristics, the competency approach to leadership development and assessment has shown to be effective in a number of instances (Overby & Suvanujasiri 2012, Harris, Clemmer 2014, Mathur, Anthony & Gottlieb 2016). The basis of management development and review processes is now often formed by specific organisational or industry leadership standards, qualities and competency frameworks within most large organisations (Bolden 2004, Clemmer 2014, Sebastian, Fulop, Dadich, Fitzgerald, Kippist & Smythe 2014, Welch & Hodge 2017). The current notion of competencies can be traced back to the work of psychologist David
McClelland (1973). He proposed that competencies could be defined as relevant measures of knowledge, skill, abilities, and traits which should be embraced as a more valuable method for measuring aptitude (McClelland 1973). The Cambridge Dictionary (2018) defines competency as an important skill that is required to do a job. It is proposed that competencies are generic and apply to most managers or workers, regardless of function or type of organisation (Spenner 1990, Parry 1998, Ledford 2002, Garman & Johnson 2006). Many organisations will tend to refer to the same competencies again and again, such as time management, setting goals, making decisions – all of which are general requirements that relate to most organisational occupations. For this thesis, the following definition, taken from the Government of Western Australia website, has been utilised as it encompasses both the universality of competencies and their contribution to the success of an organisation, which is a key concept regarding leadership:

“Competency is the capability to apply or use the set of related knowledge, skills, and abilities required to successfully perform ‘critical work functions’ or tasks in a defined work setting. Competencies often serve as the basis for skill standards that specify the level of knowledge, skills, and abilities required for success in the workplace as well as potential measurement criteria for assessing competency attainment. Competence is a measure of both proven skills and proven knowledge.” (Government of Western Australia n.d.)

1.5.4 Skills

Excessively high levels of ongoing unemployment from the mid-1970s and the revolution of ICT which has made permanent, irrevocable changes to production processes, have forced the notion of skill and its acquirement to the epicentre of discussions on apposite employment policies for reforming modern
economies (Rigby & Sanchis 2006). Frequently, however, in these discussions, the concept of skill is presumed and its complexity is neglected. It is important to understand what comprises skills so that the essential skills for leadership in RACS can be identified, as well as being able to foster these in education and training systems and recognise them in current and potential employees.

While competencies are generic and universal regardless of function or type of organisation, skills tend to be situational and specific (Parry 1998). Mumford and Peterson (1995, p.4) define skill as a set of general procedures that trigger the effective acquisition and application of knowledge in different areas of endeavour. Guthrie (1952) found that skill involves having the ability to produce results with maximum certainty and a minimum expenditure of energy and time.

The definition used in this research for the term skill is as follows:

“the ability to perform given tasks or to master various techniques, whether manual dexterity or cognitive skills.” (Green, Machin & Wilkinson 1998, p.166)

1.5.5 Attributes

According to Gonczi, Hager & Oliver (1990), a competent and proficient professional can be defined as a person who has the attributes necessary for job performance to the appropriate standard. As the final piece of the puzzle to determining what makes an effective and successful leader in RACS, it also important to understand not only the skills and competencies they possess but the personal and professional attributes. Although personal characteristics are the most subjective of the components, a growing significant body of research links specific personality traits to successful individual and organisational performance. (Carson, Ranzijn, Winefield & Marsden 2004, Maxwell & Knox
2009, Hodowski 2011). A succinct definition of an attribute for this thesis can be taken from Wuim-Pam (2014):

“Attributes are properties, qualities or characteristics of individuals that reflect one’s unique personal make-up and are considered to have been innately developed or attained from a person’s amassed life experiences (p.51)”.

1.6 Background

This section will provide a brief overview of issues that are confronting the RACS in general terms. It is an overview of relevant issues that present problems for the RACS in the context of the complexities leaders face in providing a residential service to Australia’s elderly citizens. More comprehensive research from secondary sources is outlined in the Literature Review, and primary research from empirical data gathered from in-depth interviews and outlined in the Findings chapter.

1.6.1 Residential Aged Care Services

The term residential aged care services (RACS) refers to non-hospital facilities that ‘provide accommodation and aged care as a package to people requiring ongoing health and nursing care due to chronic impairments and a reduced degree of independence in activities of daily living (Productivity Commission 2011,p. XIX). RACS provide residential aged care accompanied by a range of services that may include nursing, managing or other issues related to the personal care required by the RACS residents. RACS are specifically designed establishments where the principal service components are ‘long-term care and services are provided to people with moderate to severe functional restrictions’ (Productivity Commission 2011, p. XIX).
The aged care sector is defined as:

A range of services required by older persons (generally 65 years and over or 50 years and over for Indigenous Australians) with a reduced degree of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on help with basic activities of daily living. Aged care is frequently provided in combination with basic medical services (such as help with wound dressing, pain management, medication, health monitoring), prevention, re-ablement or palliative care services. (Productivity Commission 2011, p XVI)

Previously there were two principal forms RACS could take - low care and high care. Low-level care comprises the delivery of accommodation and associated services which include cleaning, laundry and meals, along with personal care services such as assistance with eating, toileting and dressing (Productivity Commission 2011). High-level care incorporates accommodation and associated services, nursing and personal care services (Productivity Commission 2011). Changes to government policy in 2014 means that these two levels of care no longer apply (My Aged Care 2015). These categories have been removed so that RACS clients can be provided with more flexibility according to their changing needs, without having to change care facilities as their needs become more demanding (My Aged Care 2015).

Australia’s RACS are characterised by being extensively regulated with regard to quality, quantity and price, regulated by the Aged Care Act 1997 and accompanying legislation (Productivity Commission 2008, Australian Institute of Health and Welfare 2012). Added research conducted by the organisation known as Grant Thornton (2012) showed that on 30 June 2009, there were
approximately 160,000 people in RACS in Australia, with near 72 per cent of the clientele requiring high-level care. Population estimates advise that there will be four million people aged between 65–84 years in Australia by 2022 with rapid acceleration of some age groups (over 65, over 85) over the next decade, and over eight million in this age group by 2057, as shown in figure 1.1. This will provide an enormous challenge to the capacity of RACS to provide care for the amount of people requiring it (ABS 2008).

There is also a perception that Aged care is over-regulated and successive governments have implemented many requirements which duplicate other more appropriate regulation, confuse compliance and quality, remove an older person’s rights and dignity of risk and monopolise the care time of aged care staff as they spend substantial time meeting and reporting on regulatory
requirements (ACSA 2010, De Boer 2010). The aged care workforce is ageing and there is substantial anxiety among policymakers and RACS providers in regard to attracting and retaining care staff to RACS as demand is expected to exceed supply over the next 30 years (Productivity Commission 2008, De Boer 2010). Also, aged care employees receive some of the lowest wages in Australia, and the issue of suitable remuneration for workers in RACS has been systematically unresolved, despite warnings from industry, unions and employees (Productivity Commission 2008, ACSA 2010, De Boer 2010). These all comprise significant challenges for the aged care industry, Government and RACS leaders.

RACS, as a sector within the health industry, is unique and this poses complexities for leadership and management (Productivity Commission, 2011). RACS have patients with dementia who may have major difficulties communicating or recognising staff from one day to another (Productivity Commission, 2011) Low salaried staff within confined budgets results in high staff turnover and the need for ongoing recruitment and training which are costly (Montague, Burgess & Connell 2015). Deaths are common; so too are complexities with caring relatives, which requires high-level interpersonal skills at all levels – particularly senior levels (Productivity Commission, 2011 Cash, Hodgkin, & Warburton, 2013). RACS are also subjected to extensive regulations and laws (Hussein & Manthrope 2005, Fujisawa & Colombo 2009, Chenoweth, Jeon, Merlyn, Brodaty 2010, Hebson, Rubery & Grimshaw 2015, Baines & Cunningham 2015 ACSA 2010, Productivity Commission, 2011). Added burdens are experienced due to a shortage of people willing to work in the sector, further exacerbated by an older workforce who are developing health
ailments themselves and many are nearing retirement (Montague et al., 2015). Each of these factors makes this a unique industry to lead and manage but also one of the most complex from a leadership and management perspective (Productivity Commission, 2011).

1.7 **Key Themes**

After completing a literature review and examining the data from the qualitative interviews, four key themes emerged. These included

A) Leadership

B) Demographics – of the workforce and wider society

C) Government Policy

D) Human Resource Management (HRM) Complexities

1.7.1 **Leadership**

According to Alquist and Levy (2011), the concept of leadership remains hazy, disputed and much defined. For example, a Google Scholar search of articles and books on leadership on 11 June 2015, presented approximately 2.69 million results in less than a second (see figure 1.1). In general terms, it appears that many researchers agree that leadership is a practice of social influence, which maximises the efforts of others, to voluntarily work towards the achievement of an agreed goal (Handy 1992, Hersey and Blanchard 1993, Yukl 1994 Kouzes and Posner 2002, Anderson 2003, Dowton, 2004).

*Figure 1-2 Google Scholar Search on the Concept of Leadership*
There is also a growing body of literature recognising that there is a difference between the leadership required in the aged care and related healthcare sector and leadership of other organisations and industries (Horner and Boldy, 2006, Jeon, 2013). In the constantly shifting bureaucratic and economic setting of the aged care services sector, those working in leadership roles at times must be able to fuse two professions, which are based in both clinical care practices and effective management practices (Wyszynski, 2000, Angus, 2009). In particular, depending on the size of the organisation, leaders may have to operate both as the medical director and the senior strategic manager of a smaller facility that doesn’t have the resources to separate the clinical manager from the administrative manager (Angus 2009, Jeon 2013). Leadership in smaller sized RACS is as intricate as it is varied, as they must the individual impact of ageing, as well as the assumptions of both their clients and their representatives, about care needs (Nay & Closs 1998, Dwyer 2011). They are compelled to provide leadership and direction in care advice, provide training and development opportunities to team members and aid residents in making informed decisions, predominantly on matters about treatment choices, palliative pathways and end-of-life issues (Aberdeen & Angus 2005, Dwyer 2011). These multi-faceted leadership requirements and complexities will only increase in the coming decades as new sets of skills and attributes will need to emerge to meet the
anticipated changes in our aged care sector due to the increasing development of technology and the knowledge economy, changes in care models and a significant growth in demand for aged care services (Porter-O'Grady 2003, Davidson, Elliott & Daly 2006).

According to Jeon et al. (2013), leadership in aged care is an expansive term with a varied scope of functions which depend on the position and job requirements of the respective leaders and/or managers. Therefore in an aged care setting, the preferred definition of leadership in this context and for the purposes of this research is embodied in Ciulla (1998, 2014 p.xv):

Leadership is not a person or a position. It is a complex moral relationship between people, based on trust, obligation, commitment, emotion, and a shared vision of the good.

The use of this as a definition in aged care is supported by Duncan and Boldy’s (2004) research which revealed the importance of constructing a leadership team in an aged care setting, as well as creating a values-based perspective of leadership, based on principles of trust, integrity and respect. Further, in Jeon, Glasgow, Merlyn and Sansoni (2010), they identified effective leadership in an aged care setting as necessitating good communication, and professional expertise in cultivating respect and recognition and enabling a team building outlook within an organisation.

1.7.2 Demographics – the Australian Society and the Workforce in RACS
As with many other western countries, Australia's total population is ageing, and older people represent a growing proportion of society (ABS 2016). Australia currently faces a multifarious mix of long-term challenges, including an ageing and growing population, escalating pressures on the health system and significant demographic changes over the next few decades (Australian Treasury 2010, Australian Treasury 2015). By 2051, over 25 per cent of Australia’s population will be aged over 65 (Guest & McDonald, 2001, Australian Treasury 2010). The fastest rate of growth will occur in the over 85 category, which is expected to triple in the next 50 years to comprise 2.3 million Australians (O’Connell & Ostaszkiewicz, 2005, ABS, 1999). The population of Australian citizens aged over 85 years is projected to increase from the 2014 figure of 400,000 to 1.8 million over the next 36 years (Morcom 2014). Around 68 per cent of females and 48 per cent of males will require a form of care after attaining 65 years of age, with anticipated increases as medical advances continue to extend lives (Morcom 2014).

This explosion in Australia’s ageing population will result in a reduction in the proportion of people working and paying taxes to support persons aged over 65 years of age. The prediction was that by 2050, a mere 2.7 people of working age would be supporting each Australian aged 65 years and over in contrast compared to five working aged people per aged person in 2009: in 1970 the figure

1 Also referred to as the *Intergenerational Report 2010*

2 Also referred to as the 2015 *Intergenerational Report*
was 7.5 (Australian Treasury 2010). This issue is of relevance as RACS already need to compete for staff in contemporary times but in the future added vigour and improved working conditions will be needed to attract and retain staff in a competitive environment (Productivity Commission 2011). The complexity of attracting and retaining staff to work in RACS is significantly compounded by consequences in terms of economic growth and government finances. The Intergenerational Report (2010) claimed that the rate of improvement in average living standards is projected to fall, which places pressure on Australia’s capability to fund the expenditure demands associated with an ageing population, predominantly in terms of health spending. Based on the research outlined and identified in the Productivity Commission Report (2011) a key question and problem are whether RACS as a sub-industry sector can fund more attractive working conditions unless users are asked to pay more and taxation enables added flexibility and expenditure through the federal government’s budgetary framework and associated policies?

An ageing population necessitates central social, economic and organisational challenges for future aged care. In the next decade, the ageing of populations globally will challenge every nation’s ability to provide the leadership needed to reshape and develop systems for the care of the aged (Aberdeen & Angus, 2005; Christensen, Doblhammer, Rau, & Vaupel, 2009; Kinsella & Phillips, 2005; OECD, 2009; Public Health and Aging, 2003). The World Health Organization has identified leadership as one of the areas that need to be focused on if the needs of these ageing populations are to be met (WHO, 2015), making the connection between the ageing population and effective leadership significant. To meet the challenges of an ageing population, healthcare providers need to
respond proactively to develop health and aged care services that will meet this
demand head-on, and take into account some of the unique characteristics and
challenges faced by aged care providers and the limited body of knowledge on
leadership in aged care communities, particularly, leadership for change
(Aberdeen & Angus, 2005, Horner & Boldy, 2006, Productivity Commission
2011). Substantial investment by organisations is essential in developing
appropriate leadership and management abilities to build an affirmative
workplace culture, develop the quality of care outcomes and guarantee the
readiness of RACS to be able to meet future challenges (Productivity
and 2014). Mark Butler (former Minister for Ageing, under the Gillard
Government) was cognisant of, and expressed concern at, the severe problems
the sector faced: the escalating calls to improve RACS was clearly identified, and
problems such as ‘underinvestment in new and refurbished facilities, incoherent
financial arrangements, and workforce issues were some of the main policy
challenges he [as the responsible Minister at the time} needed to confront’ (Sloan
2013, p. 12). This demographic deficiency will continue to escalate as a problem
as baby boomers age, bringing with them very different expectations regarding
how their aged care should be delivered (MENA Report 2016).

1.7.3 Government Policy – Regulations

The Australian Government funds RACS and other public care services which
include caring for those who require it, in their home. In the 2014-15 financial
year, the Australian Government contributed approximately 0.9 per cent of GDP
for total government aged care expenditure, while the State governments
supplied a small percentage of less than 0.1 per cent (Treasury 2015). Since 1975, spending by the Australian Government on aged care has almost quadrupled (Treasury 2015). Because of the increase in those aged over 70 years of age by 2055, government spending on aged care is projected to approximately double again (Treasury 2015). Under the ‘proposed policy’ scheme, spending is projected to increase from 0.9 per cent of GDP in 2014-15 to 1.7 per cent of GDP in 2054-55, and from $620 to $2,000 in real, per person terms (Treasury, 2015).

An ageing Australian society poses a series of problems requiring dedicated policy intervention by government as proposed by two major government bodies (Treasury 2010, Productivity Commission 2011). With more than one quarter of Australia’s citizens being older than 65 years of age by 2050, the contribution of significant resources is critical to Australia’s ageing society, which must be led by comprehensive and far-reaching government policies that provide for quality aged care (Treasury 2010, King et al. 2012, Millane 2014). It is inevitable that large numbers of older Australian citizens will become increasingly frail, which will produce an increase in the requirements for care and support (Treasury, 2010, Productivity Commission 2011, Treasury 2015). The substantial growth in older people in Australia will lead to ‘a significant increase in both demand for aged care services and spending on aged care’ (Productivity Commission 2011, p. 2).

The multiple problems facing aged care in Australia, along with the profusion of reports and academic commentary confirm a number of weaknesses and concerns that must be addressed with exigency (Treasury 2010). The following
reports, which include the Hogan Reviews (2004a, 2004b), the National Health and Hospitals Reform Commission Report, (NNRC 2009) the Henry Review (Henry, Harmer, Piggott, Ridout & Smith 2010), The Intergenerational Report (Treasury 2010) and the Caring for Older Australians, Report No. 53, Final Inquiry Report (Productivity Commission 2011) all indicated that there is a requirement for significant government policy reform in the aged care industry. A major finding of this research is that needed changes, despite multiple recommendations from the plethora of reports listed in the preceding sentence, has not occurred within the RACS involved in this thesis.

1.7.4 Human Resource Management

... human resource management (alternatively, ‘employee relations’ or ‘labour management’) includes the firm’s work systems and its models of employment. It embraces both individual and collective aspects of people management. It is not restricted to any one style or ideology. It engages the energies of both line and specialist managers... and typically entails a blend of messages for a variety of workforce groups.

(Purcell and Boxall 2003 p. 24)

The term human resource management (HRM) can be an ambiguous and intangible concept - not least because it seems to have an assortment of meanings with an extensive range of meanings and models (Purcell and Boxall 2003, Nankervis, Baird, Coffey, Shields, 2014). Purcell and Boxall (2003) defined HRM as the programs and processes required to effectively manage the employment relationship within an organisation. Minbaeva (2005) enhanced this definition to describe HRM practices as a set of organisational processes designed to manage human resources by enabling the development of
organisational specific competencies, generating and managing complex social relationships and creating and maintaining organisational knowledge to establish and maintain a competitive advantage. More recently, interest in the employees’ well-being component of HRM has been driven partly by a growing awareness of its importance. Wellbeing is a pivotal factor in both individual and organisational performance (Chartered Institute of Personnel and Development {CIPD}, 2007, Nankervis et al. 2014). For “cash-strapped” industries like RACS, staff wellbeing initiatives provide a viable HRM alternative to the use of monetary rewards to attract and retain workers (Productivity Commission 2011).

Leadership is relatively under-researched in the aged care sector: there is limited sector-specific research on HRM practices in this industry sub-sector (Buchan, 2004). Over the last decade significant resources have been devoted to investigating the connection between human resource management (HRM) and organisational effectiveness; however, very few studies have been focussed on the health, and therefore the aged care, sector (Harris, Cortvriend and Hyde, 2007). Cooke and Bartram (2015) suggest that despite growing academic interest in the past two decades in HRM in health care, the interest in relation to elderly care has been to a far lesser extent. While the Productivity Commission (2011) has drawn together a noteworthy body of research on the aged care sector as a whole, and clearly identified the HRM complexities the industry faces, it is not supported by other significant research on HRM practices in RACS. The report (2011) provides an extensive array of recommendations are made to government to address the problems in aged care, including in relation to HRM. However, some research indicates (Millane 2014) that these recommendations are not being adopted and there is no longer a specific Minister for aged care in the
federal government to develop policies recommended by government reports. Therefore, personal experience and personal mental models remain as the instrumental approaches used to inform and mould the HRM practices in the health and aged care sector as espoused by (DePrins and Hendrickx, 2007) as opposed to the support needed by collective professional and academic expertise underpinned by improved policies called for within the Productivity Commission report (2011).

While research focussing on HRM in the aged care field has been limited, a study by Buchan (2004) emphasised that a "fit" between the HRM methods and the organisational attributes, environment and objectives is crucial. A collection of connected and synchronised HRM processes are more likely to accomplish continuous improvements in organisational effectiveness than ad hoc or non-strategic HR activities (Buchan 2004). In a more recent study, Clarke and Hill (2012) argued that in an aged care setting, as in other industries, employee wellbeing is directly related to the quality of care and service delivery, as well as overall business success. HR processes and procedures that focus on matters like employee involvement, training and development and workplace health and safety will significantly contribute to heightening and sustaining employee wellbeing (Clarke and Hill 2012). Nica (2013) further supported this premise by her findings that claimed aged care managers can enhance the care experience by cultivating employee satisfaction and retention and that the quality of the work environment for all employees forms a significant predictor of highly effective aged care organisations.
1.8 **Key Research question**

The key question for this study is: What are the competencies, skills, and attributes needed by leaders in the complex residential aged care service industry sector?

1.8.1 **Subsidiary questions**

What are the future development needs of senior managers in RACS to innovatively meet the complex challenges facing RACS?

What challenges are posed by Australia’s current and projected demographics in regards to the continued provision of aged care to older Australian citizens?

What is the impact of government policy on the effectiveness of the aged care industry and its ability to effectively care for our ageing population?

What are the major human resource management (HRM) issues facing RACS and what are the possible solutions?

1.9 **Thesis Structure**

This thesis will evaluate and analyse the recurring themes of demographic issues, government regulations and human resource management and as they relate to leadership competencies, skills and attributes in RACS. There are four chapters following this opening chapter. In Chapter 2, an assessment of the related literature is outlined and analysed in relation to the key research themes. In Chapter 3, the methodology and theoretical framework underpinning the research is outlined and discussed. In Chapter 4, findings from the semi-structured
interviews are presented. In Chapter 5, a discussion of findings obtained from the semi-structured interviews, as well as the associated literature is undertaken. Finally, in Chapter 6, a conclusion of the research study is developed and recommendations for further research are provided.

1.9.1 Literature review

The literature review will outline a thematic, theoretical framework for this research and will define key terms, and pertinent terminology. Research supporting the topic will be identified to define further and consolidate the area of study. The key points of a literature review are to identify what the research in the field is saying on the topic and to uncover any relevant themes that emerge during this process. Four clear themes became apparent during the examination of the literature and also coincided with four key themes within the Productivity Commission Report (2011). The literature review is therefore aligned with the four key thematic areas that materialised, which are Leadership, Demographics, Government Policy and Human Resource Management. The literature review chapter will comment on the aspects of the research that are outstanding, deficient or missing in context with the major themes. This chapter will firstly provide a thorough analysis of the literature related to both the aged care sector and leadership, with particular emphasis on research undertaken regarding leadership in the aged care sector. The literature review will examine the research already undertaken in this field. It includes a critical analysis of the correlation amongst different bodies of work and researchers and reflects a theoretical framework and rationale for this research study which is underpinned by recurring thematic analysis on the four key themes outlined above. The literature review also draws out particular themes that provide a structure to analyse the data
collected and will serve to support the argument/proposition behind this thesis topic by using evidence drawn from experts and specialists in the aged care and leadership fields. It specifies the link between the introduction of my research question and the presentation of the original contribution embodied in this research.

1.9.2 Methodology

The thesis will then move to discuss the methodology used in gathering data and justify the reasons for utilising a qualitative data collection method. A constructionist/interpretivist approach underpins this proposed study (Denzin and Lincoln 2011). Constructionism proposes that there is no independent reality to be determined, but instead, we construct significance of diverse experiences through our interpretation of life events and situations, and my methodology reflects this via the use of semi-structured interviews (Denzin and Lincoln 2011). I have interviewed senior people in 18 RAC organisations using semi-structured interviews, as particular subject areas needed to be investigated as part of the interviews. Nevertheless, the precise wording of the interview questions and order in which they were delivered was kept flexible to enable adaptability and to explore any peripheral issues that added value or clarity to the data collected (Schmidt 2004, van Teijlingen 2014). Ethics approval was sought and received to select and contact participants, inviting them to take part, via an in-depth interview, in this study.

The qualitative method used is an interpretivist/constructivist approach (Denzin and Lincoln 2011) supported by the recurring inductive thematic analysis of the
key issues that are outlined in the Literature Review chapter above underpinning this research (Boyatzis 1998, Thomas 2006, Braun 2006). The methodology is comprehensively explained in Chapter 3.

1.9.3 Findings

In Chapter 4, I will present the preliminary findings from the semi-structured interviews are presented reflecting the recurring thematic themes. These results will be presented in a way that will provide acceptable evidence of my research to the reader and will be categorised into the designated recurring themes of analysis, including Leadership, Demographics, Government Regulations and HRM.

The results presented in the Findings section will be drawn together and discussed in relation to previously published data, giving information on the advances made and presenting conclusions. Possible theoretical or practical significance of the results will be discussed and areas for possible future research will be highlighted. The purpose will be to bring the various findings together in an interpretative manner and discuss these in relation to the research question and also to the results of any previous research in the field. In particular, the findings will be evaluated to determine where they do and do not reinforce the current literature regarding the recurring themes of Leadership, Demographics, Government Regulations and HRM.
1.9.4 Discussion

In Chapter 5, I will integrate and discuss the key findings of this research. Consequences for both theory and practice are emphasised and interpreted, succeeded by a discussion of the current research’s methodological and theoretical limitations. This chapter provides the basis for a model of leadership for RACS developed from the ensuing discussion and presented in Chapter Seven.

1.9.5 Conclusion

According to Evans and Gruba (2002), the conclusion of a research study must indicate how your research outcomes fulfilled the aim statement of your research project, which was stated, in your introduction. In this research study, the conclusion will integrate the key issues covered in the body of the thesis and comment upon its meaning to the aged care industry. In summary, the concluding chapter will provide the following:

1. Tie together, integrate and synthesise the key issues raised in the discussion section, while providing linkages to the key thesis statement
2. Provide answers to the thesis research questions
3. Identify the theoretical and policy implications of the research concerning the current aged care leadership practice
4. Highlight the study limitations
5. Examine the results in light of acknowledged theoretical models and paradigms of leadership and specify the overall significance of the research to the field of aged care leadership, making recommendations for future practice and research.
### 1.10 List of Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACAA</td>
<td>Aged Care Association Australia</td>
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<tr>
<td>ACLCF</td>
<td>Aged Care Leadership Capabilities Framework</td>
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<td>ACSA</td>
<td>Aged and Community Services Australia</td>
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<td>AQF</td>
<td>Australian Qualifications Framework</td>
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<td>ASQA</td>
<td>Australian Skills Quality Authority</td>
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<tr>
<td>CCT</td>
<td>Compassion Cultivation Training</td>
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<tr>
<td>DEEWR</td>
<td>Department of Education, Employment and Workplace Relations</td>
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<tr>
<td>DOHA</td>
<td>Department of Health and Ageing</td>
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<tr>
<td>EI</td>
<td>Emotional Intelligence</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HLA</td>
<td>Healthcare Leadership Alliance</td>
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<td>HRM</td>
<td>Human Resource Management</td>
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<td>LASA</td>
<td>Leading Aged Services Australia</td>
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<td>LLLB</td>
<td>Living Longer Living Better</td>
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<td>NACA</td>
<td>National Aged Care Alliance</td>
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<td>NACWCS</td>
<td>National Aged Care Workforce Census and Survey</td>
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<tr>
<td>NCHL</td>
<td>National Centre for Healthcare Leadership</td>
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<tr>
<td>NNRC</td>
<td>Neuroscience Nursing Research Centre</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<tr>
<td>PCA</td>
<td>Personal Care Attendant</td>
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<tr>
<td>PRCS</td>
<td>Prudential Regulation and Compliance Section</td>
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<tr>
<td>RACS</td>
<td>Residential Aged Care Services</td>
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<tr>
<td>VET</td>
<td>Vocational Education and Training</td>
</tr>
<tr>
<td>VUCA</td>
<td>Volatility, Uncertainty, Complexity, Ambiguity</td>
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2 - Literature Review

2.1 Introduction

Despite the plethora of research, writing and educational information on leadership, the skills of Australian managers regarding this discipline still appears to leave much to be desired. Karpin (1995) reported to the federal government on actions to improve management development and business leadership and acknowledged the need to improve managers’ interactive, strategic, and innovation skills as part of the new leadership approach to international competitiveness. As recently as 2007, Chhokar & House, as part of their Global Leadership and Organizational Behaviour Effectiveness Research Program found that Australian leaders have a perception of practising egalitarianism yet, in reality, Australian organisations are very stratified & hierarchical in structure. A significant finding in a 2006 SEEK survey; was that employees were concerned that current managers are “all talk no action” and that the in general, management quality continues to provide the lowest level of staff satisfaction in the Australian workplace. A key concern was that the respondents to the survey scored management lowest on leadership ability and their capacity for following up words with actions (Seek, 2006).

The need to understand leadership development in Australia was confined to the Residential Aged Care Sector (RACS) industry – a sector that is both newsworthy and struggling to meet the needs of its clients and the wider Australian society. Aged care is one of the fastest growing sectors of the Australian economy, with the largest growth being seen in the private residential aged care sector (Aged and Community Services Australia {ACSA} 2008). The number of beds provided
by private providers over the decade preceding 2008, rose from 24 per cent to 32.5 per cent, with 29.5 per cent of beds being supplied by religion-based organisations, 32.5 per cent by private organisations, 14.5 per cent by community-based organisations, 16.0 per cent by not-for-profit organisations, and State, Territory and local governments supplying the residual 7.5 per cent of beds (Aged & Community Services Australia, 2008). The government’s more recent approach advocates a ‘user pays’ or self-funding model for residential care and the privatisation of related services (Timo, Fulop & Ruthjersen, 2004, George, 2008). This has resulted in a large increase in the numbers of private aged care providers (Timo et al., 2004, George, 2008). As the baby boomers (those born between the years 1946 and 1964) begin to retire in increased numbers and subsequently require care services, RACS are expected to continue to grow over the next few decades, particularly in the private sector (Treasury 2010, Treasury 2015).

This chapter provides background information and definitions on RACS for context. The chapter then continues the focus on thematic analysis that will be reflected in the methodology, findings and discussion chapters. According to Daly, Kellehear, & Gliksman (1997), thematic analysis refers to the exploration for themes that appear as being significant to the narrative of the phenomenon being examined. The key themes that underpin the complexity of providing leadership in RACS emerged prominently from the analysis within the literature and fieldwork interviews and included:

- The concept of leadership
- Leadership in RACS
- HRM issues
• Demographics (population and workforce)

• Government Regulations

2.2 RACS – Background

2.2.1 The Aged Care Industry Australia

Over one million older Australians obtain some form of aged care support, which can include aid with health and personal care, as well as everyday living (Productivity Commission, 2011). While some needs are met by family, neighbours and friends, a considerable proportion of the care will be the responsibility of paid workers in elderly citizens residences or in dedicated residential facilities (RACS) (Productivity Commission, 2011). In 2010, 215,000 people were recipients of long-term residential care with high-level care provided to 70 per cent of care recipients (Productivity Commission, 2011). Over the past ten years, permanent residents receiving high-level care increased significantly (Fitzpatrick, 2012). Between 2010 and 2030, it has been reported that $51 billion will need to be invested in the aged care sector to meet demand (Young, 2010).

The aged care system in Australia is largely funded by the Commonwealth Government, though contributions are also received from other levels of government and individuals receiving care (National Seniors Australia, 2010, Productivity Commission, 2011). The mainstream types of care funded by the government are:

• Residential care, which offers long- or short-term stays in an aged care facility
• Home care (Home Care Packages Program), which provides different levels of aged care services for people in their own homes
• Home support (Commonwealth Home Support Programme), which provides entry-level support at home. (Department of Health 2017)

Across Australia on 30 June 2017, 902 organisations were providing residential aged care through 2,672 services, 702 organisations providing home care services and 1,523 organisations were funded to provide home support through 3,308 services (Department of Health 2017). The government also funds other flexible care services that target particular communities and acknowledge that the needs of aged care recipients may require a different care approach than that provided through mainstream residential and home care. Flexible care consists of:

• Transition care, which provides short-term care to restore independent living after a hospital stay
• Short-term restorative care, which expands on transition care to include anyone whose capacity to live independently is at risk
• Multi-purpose services, which offer aged care alongside health services in regional and remote areas
• Innovative Pool, which pilots new approaches to providing aged care
• The National Aboriginal and Torres Strait Islander Flexible Care Program, which provides culturally-appropriate aged care at home and in the community. (Department of Health 2017)
The healthcare system in Australia is presently struggling to ensure that the healthcare workforce has adequate staff numbers with appropriate skills to meet the health requirements of an ageing population. Aged care clients increasingly hold high expectations for healthcare provision, adding complexity to the demands for appropriate staff, given the diversity of Australian labour market locations and the variations in available workers (Scott, 2009, King et al. 2012). According to the Productivity Commission (2011), this problem is not new within Australian society. As far back as 1987, Newman warned that as the aged population continues to intensify each year, a growing number of people will need care facilities with the expertise to meet their increasingly specialised needs. Along with other socio-demographic developments including increasing numbers of women participating in the labour force, increasing geographic distance between immediate family members, declining family size, the swelling numbers of elderly citizens in Australia mean that the informal care, customarily delivered by family members will decrease, placing massive pressure on aged care facilities (Csesko & Reed 2009).

The urgency of staffing that Newman (1987) signalled two decades ago remains a key problem as shown by the findings of the Productivity Commission (2011). This report identified that the three key problems exacerbate challenges to the aged care sector: the increasing numbers and expectations of older people; a relative fall in the number of informal carers; and the need for more workers in the industry (Productivity Commission 2011). It has been predicted that by 2050, an average of over 3.5 million Australian elderly citizens is expected to use aged care services annually (Productivity Commission, 2011, Senate Community Affairs Committee 2017).
Unfortunately, the aged care system suffers key weaknesses as it provides restricted services, it is difficult to navigate, there is currently a perceived over-regulation of service supply and quality is inconsistent (Productivity Commission, 2011, Grant Thornton, 2012). Ongoing problems include labour force shortages intensified by low wages, poor working conditions a primarily casualised workforce and poor branding of the sector (Martin & King 2008, Grant Thornton 2012, Montague, Burgess and Connell 2015). The Department of Education, Employment and Workplace Relations (DEEWR) identified registered nurses, nursing support and personal care workers, and aged and disabled carers as the RACS’ occupations most frequently classified as hard to fill in 2009/10 (DEEWR 2010). According to a DEEWR survey of employers’ recruitment patterns confirms that in 2009-2010 RACS found recruiting appropriate staff challenging and complex. Among 86 per cent of employers surveyed almost all (97 per cent) of this subgroup cited staff turnover as the key reason for recruiting new staff (DEEWR 2010). This was supported by Mavromaras, Knight, Isherwood, Crettenden, Flavel, Karme, & Wei (2016) in their Research for National Aged Care Workforce Census and Survey–The Aged Care Workforce.

The high level of staff turnover in this sector is a clear outcome of the low salaries paid to staff (Productivity Commission 2011, Charlesworth 2012, King et al., 2012, Millane, 2014). Poor retention is a result of poor wages and insecure, unpredictable working hours, according to Charlesworth (2012), who also noted a direct relationship between government funding and low wages in the sector. Moreover, Charlesworth (2012, p. 113) observed that ‘... despite the direct link
between inadequate government funding and low wages, there has been a remarkable reluctance by governments at all levels to take any responsibility for wage outcomes in the sector.’ This has been a recurring problem over many decades (Productivity Commission 2011). The wages and conditions that service providers in the industry can offer to staff has been a constant cry among major reports for inducing struggles for RACS on attracting, recruiting and retaining aged care employees for the past three or more decades (Aged and Community Services in Australia: Discussion Paper 2005. Treasury 2010, Productivity Commission 2011, Charlesworth 2012, King et al.. 2012, Mavromaras et al.. 2016, Senate Community Affairs Committee 2017). There is evidence to suggest that RACS employers themselves are continuing to take a familial approach to care whereby aged care work is both low-skilled and the natural domain of women, therefore not worthy of greater pay levels (Palmer & Eveline 2012). Other reports verify the claim that there is a requirement for significant government policy reform in relations to HRM wages and conditions in the RACS (Hogan 2004a, 2004b, NNRC 2009, and Henry et al.. 2010, Mavromaras et al.. 2016, Senate Community Affairs Committee 2017, Tune 2017). Clearly, these issues have a significant impact on the ability of leaders within RACS to effectively manage their organisations. With an entrenched culture of low wages and unpredictable working hours, they are struggling to recruit, retain and motivate appropriate staff to sustain RACS in the long-term, making the task of leadership even more complex and challenging (Productivity Commission 2011, Palmer & Eveline 2012, Charlesworth 2012, King et al.. 2012).

The aged and community care system has also been significantly underfunded by subsequent governments (ACSA 2011). Under the current system, the
government pays for residential and community aged care through general tax revenue. However, according to Aged and Community Services Australia (2005), the industry has been leached of funding and resources as a result of the failure of government financial support to maintain abreast of the cost related to ensuring the provision of quality aged care services. The Living Longer, Living Better Strategy Policy (LLLB), released by the Government on 20 April 2012, (DoHA 2012) attempts to address some of the funding issues in the aged care sector. However, a considerable segment of the funding of this reform package was based on alterations to the residential aged care funding instrument, which had been developed without the use of all-inclusive data on the cost of delivering aged care (Grant Thornton 2012). For example, rural and remote providers face additional costs in providing aged care including, for example, the cost of food, travel costs and staff remuneration and training costs. These additional costs are not adequately factored into government funding which results in an inequitable system, as consumers in these communities receive less care compared to consumers with similar aged care needs, living in metropolitan communities (ACSA 2016, Tune 2017). The in-kind provision of aged-care services also creates economic inefficiencies, as services are provided directly as an explicit, narrow range of goods or services rather than money (Access Economics 2010). Cash is generally preferred over the provision of goods and services so that people can effectively and efficiently direct their funds towards the care services and goods that are most required by them. However, as the Government is currently the ‘price setter, price taker and price controller with complex regulation and controls’ (Deloitte, Touche and Tohmatsu 2010, pg 3), inefficiency (and inequity) also arises from the need to restrict access to goods, services and funds in order to protect Government interests (Access Economics 2010, Deloitte
Touche Tohmatsu 2010). This means that leaders in RACS must have intricate knowledge of the funding instrument and how best to manipulate it to ensure the effective management of their organisation. This is yet another distraction to the effective provision of leadership and care to RACS staff and residents.

The aged care industry in Australia is perceived as being heavily regulated. There are many different systems of regulation with broadly similar requirements that duplicate other more suitable regulation (Productivity Commission 2011). Some of these requirements, such as the Complaints Investigation Scheme (CIS) and the Accreditation Agency, confuse compliance and quality, while other requirements, such as compulsory reporting, remove an older person’s right to self-governance and dignity (ACSA, 2005 & 2010). A substantial amount of time is spent by aged care specialists on meeting and reporting on regulatory requirements including “aged care specific ones (e.g. CIS, funding) and generic ones (e.g. OH&S, privacy, food safety)” (ACSA, 2010, p. 9). This perceived over-regulation of the aged care sector means that it is highly constrained in quantity, quality, location and price and instead of the relationship being primarily between the service provider and the person requiring care; it is between the Government and the service provider (Grant Thornton, 2008). These regulations have far-reaching consequences for the industry which include:

- Diminishing the extent of competition between providers and reducing the ability of prospective providers to enter the market
- Limiting customer choice and reducing their capacity to bargain over entry conditions
- Restraining innovation in service design and delivery, while adversely restricting business mix and investment in the sector (Hogan, 2004, p.2)

There is also a pervasive lack of coordination over a number of levels in the aged care sector (ACSA 2005, Hugo 2007, Charlesworth 2008, Dwyer & Eager 2008, Treasury 2010, Productivity Commission 2011, Martins & Isouard 2014, Millane 2014). The allocation of resources is coordinated within the Commonwealth aged care program but not with related external services such as disability, mental health, housing and income support (ACSA 2005, Reynolds 2009). Furthermore, the formula for allocating aged care program resources does not include State managed programs, and there are incomplete and overlapping interfaces within and between different jurisdictions (Productivity Commission 2011). The efficient coordination of services to particular individuals is seen as being achieved despite the 'system' rather than because the system is effective (ACSA 2005, Reynolds 2009).

The Productivity Commission (2011) outlined that consumers faced a complex and confusing array of entry points into the aged care system and multiple sources of information about ageing and recommended establishing a central gateway for older Australians to find out about and access aged care services. The government supported the recommendation and in response established an aged care gateway, now known as My Aged Care. My Aged Care is designed to create a single pathway into, and through, the aged care system. Following significant expansion in 2015, My Aged Care now includes a contact centre and website, central client records to facilitate the collection and sharing of information, holistic needs assessment through a nationally standardised
assessment form, online referral management and web-based portals for clients, assessors and service providers. However, while a step in the right direction, customers continue to have issues around accessibility of the system, timeliness of assessment, and the consistency and quality of assessment processes (Richards 2016, Tune 2017).

Service delivery in the residential aged care industry has been characterised by a sizeable number of moderately small organisations, which is seen by many as a weakness in the aged care system (ACSA 2005). However, there is also significant rhetoric about, and expectations that, residential aged care will provide a ‘home-like’ environment for their residents and considerable effort by is expended by RACS to simulate this (ACSA 2005, ACSA 2013). These divergent views create potential tension between industry amalgamation and the preservation of easily accessible and individualised services for the elderly. The reality is that the economics of service provision are encouraging larger and larger facilities and the realities of ‘zoning’ often create a congregation of aged care services on large, single sites (ACSA 2005, Uniting Care 2010). This may be good for coordination and achieving economies of scale but will mean that the care that is obtainable will become less individually focused and therefore less “home-like” (Gray and Heinsch 2009, Uniting Care 2010, Access Economics 2010, CEPAR 2014). In fact, it is more probable that care recipients will have to share rooms and be clustered for efficacy purposes, rather than having their individual needs and preferences met in their own room, and that staff will have less personal contact with residents, a trend which is already occurring (Uniting Care 2010, Productivity Commission 2008, Access Economics 2010). This will
impact considerably on the quality of life experienced by residents and place significant pressure on leaders regarding ensuring quality care in a homelike environment.

Regardless of the high level of regulation in RACS, all-inclusive evaluation, monitoring and national benchmarking of the quality of aged care in Australia continues to be of concern (National Aged Care Alliance {NACA}, 2012). The Productivity Commission (2011) has also recognised the difficulty of evaluating, monitoring and improving the quality of aged care. This is further supported by Courtney, O’Reilly, Edwards and Hassall (2007), who suggested that the quality of aged care is not an easy concept to delineate as at least part of it is an abstract, however it is an important concept that needs clear definition, so that the criteria for healthcare facilities can be quantitatively assessed and compared. While four broad standards are generating 44 aged care outcomes, the standards are expansive to cover all facets of care delivery (Quality of Care Principles 2014). Each standard also has a number of broad outcomes, which can apply to the diverse levels of care requirements in any Australian aged care organisation (Ranasinghe and Miller 2006, Quality of Care Principles 2014). The process of inspecting RACS and ranking them as compliant with the standards is both qualitative and subjective and relies heavily on the experience and opinions of individual assessors (Ranasinghe and Miller 2006). This has inexorably led to inconsistent views on what comprises a satisfactory or quality RAC (Productivity Commission 2011, Ranasinghe and Miller 2006, Courtney et al.. 2007). According to NACA (2012, 2014), Ranasinghe and Miller (2006), Courtney et al. (2007) and the OECD (2013), the Residential Aged Care Accreditation Standards currently offer a process of monitoring care without strong emphasis on clinical
outcomes and simply signify the level below which no service provider should fall, rather than best practice quality of aged care. The original aged care reforms in 1986 delivered specific funding for staffing and provision of care under an acquittal system (Ranasinghe & Miller 2006). The 1997 reforms outlined in the Aged Care Act 1997 removed this system of checks and balances, with the expectation that adequate and appropriate staffing and care would be guaranteed through focusing on quality outcomes and continuous improvement fixed in the accreditation process, (Nay, Fethrestonhaugh & Garrett 2010). The implications for leadership as a result of this system are enormous, as more than many other industries, they are subject to a confusing combination of standards and regulations, with no clear definition of ‘quality care’ (Wilde, Larsson, Larsson & Starrin 1995, The Public Advocate 2018). This has forced many RACS leaders to reshape their roles out of both compulsion and the need to safeguard the continuance of important care services to their residents, amidst constricting but subjective regulations, funding challenges and a growing call for high quality aged care (Hogan, 2004, Venturato & Drew 2010)

Aged care leaders face a number of planning and infrastructure issues (ACSA 2005). Infrastructure investment decisions are significantly inhibited by regulation (Access Economics 2010). A ratio establishes the number of residential care services and community care packages. Before the abolishment of high and low care distinctions, the ratio provided 40 high-care residential places, 50 low-care residential places and ten community care packages for every 1000 people aged at least 70 years old (Hogan 2004, Access Economics 2010). On 30 June 2016, there were 113.2 aged care places per 1,000 people aged 70 years and over in Australia (Department of Health 2017). The Fourth report on the funding and
financing of the aged care sector (Aged Care Financing Authority 2016) set targets for future aged care provision in Australia, considering the projected increase in demand for services and the goal of keeping people in the community longer. The targets include an aged care provision ratio of 125 places (80 residential, 45 community) per 1,000 people aged 70 years or over by 2021–22 (Aged Care Financing Authority 2016). The demographic and economic determinants of demand do not influence the supply of residential aged care infrastructure. Instead, it is determined by the number of people aged 70 or over in a region (Hogan 2004, Department of Health 2017, PWC 2018). Further, current calculations do not take into account the need to rebuild existing stock of aged care facilities (PWC 2018). The Aged Care Financing Authority estimates that over the next decade, 25 per cent of the current stock would need to be rebuilt (Aged Care Financing Authority 2015). Instead of linking planning ratios to people aged 70 or over, the ratios would be better linked to the population aged 85+, which is growing much faster than the current planning benchmark (Access Economics 2010). There is also the potential for using predictive analytics and risk stratification, which are tools that could help identify people that are at risk and the areas in most need of aged care services (PWC 2018). There has been, at a comprehensive level, significant underinvestment in building infrastructure as well as information and communication technologies infrastructure that might increase effectiveness, productivity and capacity in RACS (ACSA 2005, PWC 2018). The LLLB reforms have worked in some way towards facilitating investment in aged care infrastructure (Tune 2017), and it is important that policy planners continue to prepare for a large expansion of RACS places and community packages to ensure sufficient future supply for Australia’s ageing

There has not been complete inaction by the government in regard to reforming aged care. The LLLB reforms included:

- additional support and care to help older people remain living at home
- additional help for carers to have access to respite and other support
- establishing a gateway to services to assist older Australians to find information and to navigate the aged care system
- changes to means testing in home and residential aged care
- changes to improve services for people with dementia
- additional funding for the aged care workforce.

However, a number of these areas have been insufficiently addressed or implemented by this strategy (Gray & Lewis 2017, Tune 2017). According to the Legislated Review of Aged Care Report (Tune 2017), further reforms are needed in information, assessment, consumer choice, means testing, and equity of access.

2.3 The concept of leadership

There are numerous definitions of leadership documented by many researchers. There were 239,000,000 results in one popular search engine, Google, when the term leadership was entered on 14/10/14. While this is not an academic source, it provides some idea of the variety of definitions and approaches and the ongoing interest in defining leadership. Most of the early theories of leadership are inclined to concentrate on the characteristics and behaviours of successful leaders, while
later theories start to contemplate the part played by followers and consider the contextual qualities of leadership (Bolden, Gosling, Marturano, & Dennison 2003). Each of these early theories views leaders via an individual lens and focuses on leadership as a set of personal attributes, traits or behaviours (Bolden et.al 2003, Spicker 2011).

Preliminary research into leadership produced the view that to comprehend the nature of leadership and to develop an appropriate definition of leadership, it is essential to understand and define the larger philosophies of leadership and management (House 1971, Bass and Stogdill 1990, Bolman and Deal 1991). Most research proposes that these terms should be contemplated as distinct philosophies and concepts (Bass and Stogdill 1990, Bolman and Deal 1991, Bush 2003, Kotterman 2006, Kotter 2008, Toor and Ofori 2008). Yukl (1989) defines leadership as ‘influencing task objectives and strategies, influencing commitment and compliance in task behaviour to achieve these objectives, influencing group maintenance and identification, and influencing the culture of an organization’ (p 253). Leadership can also be defined as the ability to inspire confidence and support amongst those who are required to achieve organisational goals. (Bartol et al.. 2003, Du Brin 2007). ‘Leadership isn’t something you do to people. It’s something you do with them’ (Blanchard 2007, p.1). A leader requires followers, who they are able to influence in the right ways (Daft 2005, Du Brin 2007). While management produces order, consistency, and predictability, while leadership produces change and adaptability to new products, new markets, new competitors, new customers, and new work processes (Zaleznik 2004, Kotter 1990). According to Kotter (1990), managers must be able to lead as well as manage. Effective leaders have to be good managers themselves or be supported by effective managers (Mintzberg 2008). Undoubtedly, over time there
has been a tendency to colonise leadership by using distinct managerial concepts and frameworks as competencies (Carroll, Levy & Richmond 2007). However, by its very nature, leadership and management have a quality of elusiveness and intricacy, which creates disquiet and uneasiness in an organisational context that values prudence, control, precision and rationality (Townley 2002, Wood 2005, Carroll et al. 2007).

There is growing support for a move away from competency frameworks, models and instruments defining and influencing leadership, and a change towards examining leadership-as-practice (Carroll et al. 2007), leadership as a process (Wood, 2005) and leadership as a relationship (Uhl-Bien 2006, Cuncliffe & Eriksen 2011). The increasing popularity of defining and disputing the meaning of, and approach to leadership, as evidenced above, has served only to reinforce theoretical confusion and widespread elusiveness (Carroll et al. 2007, Alvesson & Spicer 2012, Spicker 2012, Johnson, Bainbridge & Hazard 2013) In order to address this uncertainty, Alvesson and Spicer (2012) propose three general sets of paradigmatic assumptions reinforcing leadership research and exploration: functionalist, interpretive and critical.

A functionalist approach to leadership has an overriding commitment to organisational success (Mabey 2013). This viewpoint regards leadership as a detached phenomenon that is open to systematic inquiry, and as a reasonably static entity that can be uncovered and analysed by using the appropriate diagnostic methodology (Burrell and Morgan 1979, Alvesson and Spicer 2012). The functionalist approach identifies with the trait theories of leadership, as they attempt to evaluate the physical and psychological characteristics and behaviours of successful leaders (Hartley 2010, Mabey 2013). The functionalist
approach contributed to many of the early leadership theories, including the Trait, Transformational and Situational theories (House and Aditya, 1997, Bass, 1985, Hersey & Blanchard 1969). From the late 1970s leadership researchers began to question the validity of the functionalist approach as it had been unsuccessful in discovering a practical, commonly acknowledged and broadly applied model of leadership (McCallum & O’Connell 2009 Alvesson & Spicer 2012).

A change in emphasis from individual leadership skills and capabilities has since occurred, which expanded the view of leadership to give greater attention to the relational framework within which leadership transpires (Day and O’Connor, 2003). This led to the interpretive paradigm which involves viewing leadership as something that is a socially and culturally constructed phenomenon (Stewart & Manz 1995, Fairhurst and Grant, 2010, Alvesson & Spicer 2012) whereby leaders construct their identities through interaction and dialogue, which has greater influence and authority than the physical and psychological characteristics of leaders (Alvesson & Willmott, 2002, Baxter 2015). Interpretive leadership paradigms attempt to bring to light the diverse approaches to leadership with the objective of creating a shared meaning of leadership (Alvesson & Spicer 2012).

Critics of the interpretive approach, however, posit that it does not take into account the concepts of power and domination and only emphasise the positive aspects of leadership (Morgan 1984, Spillane, Hallett & Diamond 2003).

To confront these limitations, a small number of researchers have begun to develop critical approaches to leadership (Alvesson & Spicer 2012, Alvesson and Sveningsson 2012, Harding, Lee, Ford & Learmonth 2011). Critical leadership theorists do not simply aim to comprehend how leadership is given meaning in various situations but aspire to delve further, by scrutinising the sequences of
power and supremacy connected to leadership and correlate it with wider conceptual and institutional conditions (Alvesson & Spicer 2012, Mabey 2013). This approach challenges the orthodox interpretation of leadership, which relies on the flawed notion that successful leaders must change the behaviours and perspectives of others as a means to their ends – this being a morally indefensible assumption (Sinclair 2007). It seeks to query the generally accepted concept that leadership is an overpoweringly constructive and required entity (Ford & Harding 2011, Collinson 2011)

Leadership is to date, ‘a politically sensitive, culturally complex and institutionally embedded’ phenomena (Mabey 2013, p.359) and debate over how leadership should best be clarified and evolved means that dependence on only one perspective is both potentially limiting and particularly inappropriate in this research.

2.3.1 Leadership in the Aged Care Sector

It has been acknowledged that leadership is a much-disputed term in the general context, meaning that to define it clearly and specifically to aged care, makes it a difficult task. However, for this research, leaders in RACS have been identified as those in senior positions with high-level decision-making capacity. While not making the definition of leadership more definite, it serves to focus our leadership definition, so it is relevant to the role being undertaken and examined in this thesis.

The overview of the various concepts of leadership, as identified by various researchers, seeks to provide a basis for which a relevant and appropriate explanation of leadership specific to RACS, can be developed. As previously
discussed, the concept of leadership is much contested, and there are numerous other leadership styles and theories within the literature, not least of which include: “strategic leadership” (Finklestein and Hambrick, 1996, Ad Abdallah, C. and Langley 2014), "environment leader" (Carmazzi, 2005) “full range leadership” (Avolio and Bass, 2002), “charismatic leadership” (Weber, 1905), “primal leadership” (Goleman et al., 2002), follower-leader (Kellerman, 2008) to name but a few. Many of these leadership approaches contradict other conceptualisations of leadership, and despite the plethora of research and theoretical concepts of leadership, we are no nearer to evolving a coalescence of understanding regarding leadership (Carroll et al., 2007, Johnson et al., 2013, Forsyth 2015). Moreover, although leadership has been comprehensively researched concerning the advent and efficacy of leaders, there is an absence of understanding regarding how a person’s leadership approach is cultivated (Forsyth 2015), and the inclination has been to emphasise a single, preeminent leader and the individual competencies and attributes within whatever leadership approach is being touted (Lord & Hall, 2005). What limited research that has been undertaken in aged care has found that there is great importance placed on the effectiveness of the leadership group, not any single leader and that there is a need for evidence of appropriate leadership behaviour, rather than role or accountabilities (Boldy 2006, Jeon et al., 2013). Therefore to adequately determine the leadership competencies, skills and attributes required of leaders in RACS however, it is important to identify a relevant ontology and epistemology of leadership that will be effective in this industry. However, as a consensus of what constitutes leadership has not been achieved, pinpointing an approach of leadership that works for RACS is complicated. To do this, a brief overview of the development and evolution of leadership theory is essential.
As mentioned previously, to define leadership is difficult, and there is a vast amount of literature offering some definitional and analytic guidelines about what constitutes leadership. Leadership is generally recognised as the process by which a person influences others to accomplish a goal and who guides the organization and those in it, in a way that makes it more unified, consistent and effective (Kalpana, 2009, Schreiber and Carley, 2007 in Livingston and Lusan, 2009, Zaccaro & Klimoski, 2001). However, according to Alquist and Levy in their 2011 research on what leadership means, the concept of leadership remains hazy and much disputed. The many schools of thought that have evolved around leadership theory are varied in both their understanding and approach to leadership. Classical research on leadership underlined the concepts of power and legitimacy (Dowton, 2004 in Daly, Jackson and Nay eds, 2009, Yukl, 1989, Giddens and Held, 1982, Wren and Bedeian, 2009, Weber 1968); the “functions of the executive” (Alquist and Levy, 2011 p.3), which includes defining relevant goals, outlining how they are achieved and managing the exchanges between leaders and their followers (Daly, Jackson and Nay eds, 2009, Selznick 1957 in Washington, Boal and Davis, 2007, Weber, 1968). Power has often been defined in terms of the ability of one to adjust the activities, approaches, opinions, behaviour, requirements, and ideals of another (Rahim, 1989, Rahim, Antonioni & Psenicka 2001). This definition therefore infers that exploration of power is restricted to the influence of one individual over another individual (Rahim et al., 2001), and is a notion particularly being confronted by a more critical approach to leadership theory (Alvesson & Spicer 2012, Alvesson and Sveningsson 2012, Harding, Lee, Ford & Learmonth 2011).
Later leadership theories evolved to discuss leadership origins within the leader-follower relationship, and emphasise leadership arising from the specific features of the relationship rather than the particular partners in the relationship (Livingston and Lusin, 2009). The collective locus includes those theories where leadership is presumed to arise from the interconnected relationships of people within a specific group of individuals (e.g., work teams) and is based on an understanding of leadership as a long-term relationship between leaders and group members (Daft et al.. 2010, Graen and Uhl-Bien, 1995). This is of particular importance to RACS as the concept of leadership being the premise of various individuals, and the importance of developing effective relationships in this complex sector is regarded as a key to leadership success in preliminary research (Elvira and Davila 2012, Etherton-Beer, Venturato and Horner 2013, Jeon et al.. 2013). Despite the study of leadership spanning over many years and incorporating the work of thousands of researchers, there is still no clear and agreed upon explanation of what constitutes leadership and the methods for its accomplishment. Stogdill (1974, p.259) concluded that there are “almost as many definitions of leadership as there are persons who have attempted to define the concept” and according to Graen and Uhl-Bien (1995), despite the numerous theories developed to explain leadership, there is little consistency between these theories, making it difficult for a clear understanding of leadership to be developed.

During the last decade, leadership tended to be analysed as a social construction (Tullberg, 2003 in Furaker and Nilsson, 2010), in other words, a phenomenon that is developed between a leader and those they are leading. From a social construction perspective, the way management and leadership are defined and
expressed are critical to gaining an understanding of the entities, as from this perspective, ‘reality’ is constructed through language (Grint, 2005). Furthermore, as with similar concepts such as ‘love’, ‘justice’ and ‘pleasure’, leadership is open to subjective understanding, as people tend to create their own innate explanation of leadership, depending on past experience, education, culture and theoretical perspective, making it difficult to identify one simple and universally held definition (Bolden, 2004). This reflects Alversson and Spicer’s (2012) interpretive paradigm, which they describe as an approach to leadership as a socially and culturally constructed phenomenon through which leaders construct their identities via interaction and discourse.

The psychodynamic approach to leadership increases the areas to be considered when assessing and developing leadership theories, such as ascertaining which psychological aspects are significant in driving people to be either a leader or a follower, and isolating what characteristics of groups, organisations and societies validate the perception of ‘leadership’ (Bolden 2004). This leadership approach accentuates the significance of the development of emotional intelligence and relationship management, as well as an understanding of the transactional nature of the relationship between leader and followers (Stech, 2004). In this approach, It is important therefore, to understand concepts such as authority, leadership, responsibilities and limitations, combined with the relevant organisation practices and control in workplaces, in order to recognise the role participants play in developing and reinforcing the types of organisations in which they work (De Jager, Cilliers and Veldman, 2003).
To date, leaders and leadership within RACS have functioned somewhat as toothless tigers. Australia’s aged care system has evolved over many decades. It is not a single service but comprises a range of programs and policies, large and small, which together are intended to meet a wide range of care needs. As previously mentioned, the aged care space is a complex and unique system, which provides distinctive and complicated challenges to its leaders. Dealing with issues such as inadequate resource allocation, employment of primarily low-skilled care workers, offering lower incomes for qualified nursing staff, high levels of administrative compliances and management accountabilities and a significant regulatory burden, makes leading in aged care an onerous role (Hegney, Eley, Plank, Buikstra & Parker 2006, Productivity Commission 2008, Jeon, Merlyn & Chenoweth 2010). This is combined with managing and caring for vulnerable elderly customers with diverse and complex care issues and simultaneously addressing the concerns, complaints and emotions of their families (Jeon et al. 2010, Dwyer 2011, Stockhausen & Mowbray 2015). These leadership challenges are well documented (Jeon et al. 2010, Treasury 2010, Productivity Commission 2011, King et al. 2013, Edvardsson, Sandman & Borell 2014, O’Keeffe 2014), yet leadership has been area sorely neglected in the reform of the aged care industry. There has been the development of the Health LEADS Framework (2013), which aimed to provide a shared approach to health leadership that would be relevant across all sectors of the health system and influence health leadership training and development across the Australian health system (Health Workforce Australia 2013, Sebastian, Fulop, Dadich, Fitzgerald, Kippist & Smythe 2014, Shannon 2015). There has also been the establishment of the Aged Care Leadership Capability Framework (2017), which identified the knowledge, expertise and capabilities that are required of
leaders across the Aged Care industry (CS&HISC 2015) and provided a framework intended to help current and potential leaders in Aged Care to more successfully manage their staff and customers and to carry out strategic planning and enable innovation (CS&HISC 2015, Department of Industry 2014). While both models were advised by leaders in the health and aged care industry at the time, it was apparent that while aware of what needed to be done to improve RACS leadership, little was actually being achieved by those in leadership positions, both in RACS and other representative bodies (Australian College of Nursing 2016, Carnell & Paterson 2017). Currently, there needs to be more active leadership in aged care, more collaborative relationship development and greater agency in pushing to develop a collective force that can enact positive change in the industry. Aged care leaders need to be pivotal in reconstructing the role of leadership in the aged care industry. The complexities of the aged care system necessitate that leaders in aged care be flexible, effective communicators, have professional expertise in nurturing respect and recognition and empowering team building capabilities (Thyer 2003, Jeon et al.. 2010). They should also demonstrate a range of attributes of individual leadership that include openness, enthusiasm, respect, consideration, mentoring, supportiveness, motivational, emotional intelligence and organisational agility and political astuteness (Jeon et al.. 2010). The following review of the leadership literature will focus on leadership theories that are most appropriate to support these proposed characteristics required of aged care leaders.

While these are only some of the leadership theories on offer and provide a basis for determining a definition of leadership suitable for RACS, it is important to
acknowledge the leadership skills and attributes specific to the healthcare and aged care industries. The health industry has been traditionally dominated by a scientifically based medical model of leadership, which is administered by a male-dominated profession, entrenched and enclosed by a rigidly hierarchical structure (Thyer 2003). Healthcare organisations are currently controlled by leaders who utilise an out-dated transactional leadership style to manage within intrinsically stagnant organisational hierarchies (Schwartz & Tumblin 2002). However, increasingly as the bureaucratic and fiscal environment of RACS appears to be constantly in flux, staff in leadership roles must have the capacity to combine two occupations which are founded in both healthcare and management practices. Leaders in the RACS need to sufficiently demonstrate emotional intelligence and ethical behaviour, as well as technical capabilities (Wyszynski 2000, Angus, 2009, Schwartz & Tumblin 2002). Furthermore, aged care leaders in the coming decades will require a new set of skills and attributes to meet such changes in our aged care sector (Davidson, Elliott & Daly 2006). Porter-O’Grady (2003a) notes that a number of these changes will emerge due to the increasing development of technology and the knowledge economy; changes in care models and significant growth in demand for aged care services. Therefore, the qualities that characterise a RACS leader must include proficient medical skills, patient-focus, vision, resilience, innovation, drive, self-assurance, altruism, decisiveness and cooperation with other health specialists (Mahoney 2001, Borbasi & Gaston 2002, Davidson et al. 2006). This means that the traditional medical leadership approaches need to be challenged and transformed to convert RACS organisations into successful, innovative learning organisations that are employers of choice for appropriate job seekers.
According to Pearson Schultz, and Conroy-Hiller (2006) and Jeon, Glasgow, Merlyn & Sansoni, (2010), with some exceptions, residential aged care is not characterised by the use of the best available leadership knowledge and there is a paucity of research that has been conducted in regard to leadership in the residential aged care sector (Boldy and Horner, 2006 and Daly, Jackson and Nay in Garratt and Nay Eds. 2009). Although a number of studies recognise the role of effective management to meet the care and quality needs in the aged care sector, there is little written on the importance of leadership in the aged care sector (Stanley, 2013). Yet, healthcare and in particular, aged care creates exceptional leadership challenges because of the intricacy of healthcare organisations. Traditionally, physicians tend to possess certain traits and have received training experiences that do not predispose them to collaborating with others, or for readiness to receive and follow orders or advice from others (Taylor, Taylor & Stoller, 2008). In a study of academic chairs of Internal Medicine undertaken by Lobas in 2006, it was found that the criteria for promotion to leadership in academic institutions often place more emphasis on academic and clinical accomplishments than on being skilled in the leadership competencies listed above. This was supported by Jennings, Scalzi, Rodgers and Keane (2007) and Bassett, Ramsey and Chan (2012) as part of their respective studies into senior medical personnel recruitment and selection processes. These researchers (Jennings et al.. 2007, Bassett et al.. 2012) found that recruitment panels for such leadership roles are usually concerned with selecting a person who has the pertinent credentials and clinical skills, with little regard for their ability to collaborate with other professionals or any talents that would contribute to organisational success.
Many RACS employ the hybrid clinician manager approach to managing their organisations, which is typified by doctors or nurses working as both people managers and clinicians. (Taylor, Taylor & Stoller, 2008, Ferlie and Shortell, 2001; Braithwaite and Hindle, 2001; Fitzgerald and Ferlie, 2000). Medical professionals and management specialists have different perspectives and different approaches for dealing with staff issues in RACS. Management practitioners utilise an approach based on their experience of the business of health, which is centred on cost reduction and efficiency, while medical practitioners base their management approach on maximising individual patient care (Kippist and Fitzgerald 2009). This can lead to role dissonance where, for example, hybrid clinician managers might place priority on clinical work, to the detriment of organisational decision making and people management (Kippist and Fitzgerald 2009). There is also a lack of management education and training implemented in RACS to deal with the challenges of undertaking dual clinical and managerial roles (Musson and Helmreich 2004). These consist of confusion regarding professional identity when leaders have a medical view of management, implementing individualistic decision making, lack of understanding of other positions and practices in the organisation and inadequate communication with other colleagues (Lobas 2006, Kippist and Fitzgerald 2009 Jennings et al.. 2007 and Bassett et al.. 2012).

It is a generally accepted notion that compassionate caring is central to high-quality care for residents and families, as well as for job satisfaction for staff (Dewar & Nolan 2013). In encouraging high-quality care, one of the fundamental elements is the facilitation and establishment of growing facilitating and developing aged care towards increasing person-centredness in aged care.
Person-centredness entails a focus on the person instead of the disease, respecting and including the person’s experiences, values, preferences and needs in all aspects of care, relationships and environment (Kitwood 1997, Brooker 2004, Edvardsson et al. 2008b). Person-centredness links closely to the concept of compassion. Compassion is a contested term but there is some agreement that about it concerns the quality of the relationship between carers and care recipients, it is about relating to the needs of others and preserving their integrity, and recognises and empathises with suffering and vulnerability (Schantz 2007, Schulz, Hebert, Dew, Brown, Scheier, Beach,... & Gitlin 2007, Dewar 2013). Furthermore, compassion in regard to care for the elderly is currently at the vanguard of national and international aged care policy, practice and educational debates (Benetas 2010, Cummings and Bennett 2012, O’Keefefe 2015). This would suggest that compassion is a requirement for leaders in RACS.

According to a study by Boyatsis, Smith & Blaize (2006), when leaders exhibit compassion, they experience psychophysiological effects that restore the body's natural healing and growth processes, thus enhancing their effectiveness. A additional study by Dutton, Frost, Worline, Lilius & Kanov (2002) found that when leaders exhibit compassion in their leadership, it not only decreases the immediate suffering of those directly affected by stress and distress, emotions frequently found in RACS, it empowers them to recuperate from forthcoming setbacks more rapidly, and intensifies their connection with their colleagues their organisation. Further, they found that those who observed or took part in acts of compassion, discovered their own resilience and attachment to the organisation increased, suggesting that compassion in an aged care leader would be a clear
contributor to employee, resident and family satisfaction and an obvious attribute essential to RACS leadership (Dutton et al. 2002).

However, according to Gamroth, Semradek, & Tomquist (1995), the atmosphere within long-term healthcare facilities has been one that is dehumanising and promotes dependence and subjection in staff, predominantly because the constitution, ambience and structure of such organisations have been based on the medical leadership model. Furthermore, leaders in contemporary professional and service organisations often continue to focus on a hierarchical view of leadership as a part of a mechanical view of organisations, whereby an organisation is viewed as a machine in which all parts can be understood in detail (Dowton, 2004, Edmonstone and Western, 2002). This view is firmly rooted in early management theory which sees power, control and outcomes emerging through the division of labour and delineation of job task known as the command and control model (Wren and Bedeian, 2009). According to Dowton (2004), considerable parts of healthcare systems in Australia remain locked in this antiquated and ineffective paradigm. Furthermore, the perennial demands of government licensing and regulation with which RACS need to comply, mean that senior leaders, as well as middle management, are often ensnared in a succession of processes to meet accreditation standards, compete for funding opportunities and deal with the issues associated with severe skill shortages, leaving little opportunity or motivation to pursue professional leadership development (Jeon Jeon, Glasgow, Merlyn & Sansoni, 2010 et al. 2010).

There is no real agreement regarding what constitutes an effective leader in RACS. As mentioned previously, there has been limited development of
leadership theory in an aged care context, particularly in relation to RACS, which has ensued in the embracing of leadership models sourced from business management framework (Jeon et al.. 2010). The transformational leadership model, which promotes a vibrant, inspirational leader, able to inspire followership by motivating and empowering their employees, seems to be most supported by evidence up to now (Thyer 2003, Arnold, Turner, Barling, Kelloway & McKee 2007). Nevertheless, it is also acknowledged that this type of leadership fits uneasily into a more intricate healthcare setting, in which the use of collaborative, interdisciplinary teams are the norm (Hartley & Hinksman 2003, Jeon et al.. 2010). Furthermore, entrenched management policies and practice and organisational leadership may have a strong influence on both the effectiveness of specific aged care operators and on their workforce and care quality outcomes limiting the effectiveness of any leadership style (Jeon et al.. 2013). Some writers suggest that shared governance can be an effective principle for management (Ellis et al.. 2006, Buchanan et al.. 2007, Cartwright et al.. 2008, ASLaRC Aged Services Unit, 2013). As aged care work is complex, involving staff in planning, providing them with decision making power and encouraging independence, can mean that staffing and quality issues are dealt with in a more flexible, distributed, and proficient way (Jeon et al.. 2013). This view extends beyond the boundaries of a set of qualities, actions or goal-orientated behaviour, to recognise that leadership is a relationship which must be navigated effectively to lead to desired collective behaviour (Capriles 2012). It emphasises the need for sustainable leadership to influence shared goals and outcomes, and provides a basis for defining viable leadership attributes that are based on moral relationships between all stakeholders in RACS, with the aim of achieving effective leadership for the current challenges and to meet the needs of future organisational
generations (Elvira and Davila 2012). This is supported by Etherton-Beer, Venturato and Horner (2013) who found, while reviewing evidence regarding organisational culture and leadership, that leadership styles focussing on people and relationships were linked with more positive outcomes than leadership styles focusing primarily on tasks.

Leadership also plays an essential role in ensuring ethical care and for the establishment of caring workplace cultures – understanding that ethics are of collective concern and fundamental in all professional healthcare situations (Gustafsson & Stenberg 2017). The literature is clear that leaders in all healthcare are required to implement ethical decision-making to ensure fairness and justice in regards to the needs and wellbeing of the individual, the organisation and staff, and society (Pava & Primeaux 2000, Conroy 2009, Murphy & Fillatre 2009). Fairness, integrity, independence and beneficence, combined with professional ethical standards and guidelines, are the most universally acknowledged ethical principles (Murphy & Fillatre 2009, Gustafsson & Stenberg 2017). These concepts align closely with authentic leadership. Authentic leaders demonstrate extraordinary integrity, a profound sense of purpose and a commitment to their personal values. They foster trusting relationships and design organisational structures and systems to enshrine core values and uphold ethical standards (Livingston & Lusin 2009). Many pressures, such as the push to decrease costs, guarantee service and access, meet growing need with a smaller workforce, and manage a growing regulatory and compliance burden, embody only a few of the fundamental demands that intensify the intricacy of leadership ethics in healthcare, authentic leadership presents a valid option for modelling leadership strategies in RACS (Fine 2001, Murphy & Fillatre 2009, Laschinger 2012, Tuckett
According to the literature, by incorporating and enacting behaviours that nurture morality and ethics, healthcare leaders who practice an ethical leadership approach are more able to promote a strong ethical resolve amongst their care staff, as well as encouraging teamwork, collaboration and a desire to provide quality care (Katz-Buonincontro 2011, Mannix et al. 2015). Studies have shown that health care patients, care staff and families reacted positively to an ethical leadership approach when it is focussed on fairness, integrity and doing the right thing in care situations (Gallagher & Tschudin 2010, Xu, Fu & Shi 2011, Mannix et al. 2015).

There is some available research that Servant Leadership (Greenleaf 1970, 1977) is also an effective form of leading staff in a healthcare setting. Servant Leadership is a ‘holistic and altruistic approach of leadership that focuses on the commitment to serve other people’ (Pekerti & Sendjaya 2010, p.754). Greenleaf introduced this new servant leadership model, under the inspiration of servant leadership, as displayed by Jesus (Sendjaya & Sarros, 2002, Amadeo 2008). As an ethics-based theory of leadership, servant leadership accentuates service to others, along with a focus on spirituality in leadership, and the characteristics of trust, integrity, humility and compassion are reflected in servant leadership (Greenleaf 1977, Sendjaya, Sarros & Santora 2008).

Servant leadership incorporates a potent skill base that delivers care by effectively implementing a team approach (Neill & Saunders 2008, Trastek, Hamilton & Niles 2014). Similar to distributed leadership, this framework
promotes the professional development of care workers, and at the same time
stimulates the delivery of quality care to clients, by encouraging and supporting
shared decision making, integrative team collaboration, and ethical behaviour
(Neill & Saunders 2008). Recent research regarding leadership in healthcare, has
indicated that the most effective and appropriate model for this sector is servant
leadership, because of its focus on trust and enablement of both clients to
influence their own healthcare, and also care worker teams that provide their care
& Niles 2014). Servant leadership is also clearly linked to organisational
characteristics that include service and justice, along with the employee qualities
and attributes of job satisfaction and engagement (Vanderpyl 2012,
Gunnarsdottir 2014).

Shared or distributed leadership would appear to provide a very good foundation
for beginning to understand leadership in aged care. One of the most frequently
cited explanations of shared or distributed leadership is that of Pearce & Conger
(2003, p1), who define it as: “a dynamic, interactive influence process among
individuals in groups for which the objective is to lead one another to the
achievement of group or organisational goals or both. This influence process
often involves peer, or lateral, influence and at other times involves upward or
downward hierarchical influence”. To further explain this approach to leadership,
distributed or shared leadership moves away from the single figure hero as a
leader (Badaracco, 2001, Loetze 2011), to a universal viewpoint where
leadership becomes a collective social process that materialises through the
(2011), if leadership is dispersed, accountability will be shared by a number of
individuals, who together provide a comprehensive range of skills, abilities and knowledge. This is supported by Bennett, Wise, Woods, & Harvey (2003 p.7), who propose that distributed leadership views leadership as an “emergent property of a group or network of interacting individuals”, which diverges from leadership as an occurrence arising from an individual. This view builds on Gronn’s (2002) work on distributed leadership as a concertive action, whereby people work together pooling their initiative and expertise, to produce an outcome which is superior to the sum of their individual actions. The premise behind distributed (or shared) leadership, is that leaders empower their followers to lead (Orazi, Good, Robin, Van Wanrooy, Butar Butar, Olsen, and Gahan 2014). Leadership is regarded as an activity or purpose that is shared and delegated to others, rather than a specific role (Orazi et al. 2014). As such, followers are not simply the beneficiaries of leadership, but they are the colleagues or co-producers of leadership (Jackson & Parry, 2008).

The distributed leadership model is particularly relevant to a RAC setting, and this is recognised in the recently developed Australian Aged Care Leadership Capability Framework (ACLCF) (Department of Industry 2014). The ACLCF proposes that leadership capabilities particular to aged care include; the need to effectively articulate the organisational mission, while paying special attention to the importance of human connection and the development of relationships (Department of Industry 2014). It also recognises that there is a movement towards person-centred, or consumer-directed, care services which require inclusive and democratic leadership via sharing roles among followers, providing them with the opportunity to take the initiative and lead others (Orazi et al. 2014). This model also supports the condition of compassion, discussed earlier as a key
leadership requirement for RACS leaders, as clearly and deliberately distributing a leadership obligation to every person within an organisation, is fundamental for constructing the style of distributed leadership which can cultivate a healthcare culture in which high-quality, compassionate care can be delivered (McCauley 2011, West, Eckert, Steward & Pasmore 2014).

The following figure 2.2, outlines the enablers of shared leadership as being shared purpose, social support, team trust and voice. This model sees leadership deviate from the traditional hierarchical management approach to one in which employees have greater involvement in the decision-making processes and managers take on a facilitative, as opposed to a controlling role (Scott and Caress 2005, Carson, Tesluk, & Marrone 2007). Using this approach, managers must ensure that that teams and their team members have a clear and shared understanding regarding their direction and purpose. They must encourage and create team norms that foster participation and contribution to team activities and decisions. Finally, leaders must strive to generate and nurture a positive team environment where members encourage and identify each other’s’ various, important contributions (Carson et al.. 2007). According to Scott and Caress (2005), Jeon et al.. (2013), Buchanan, Caldwell, Meyer, Storey & Wainwright (2007), shared leadership in a healthcare setting can utilise staff skills to improve care quality, create a reflective culture that enables continuous improvement and promotes a learning environment, while enabling a workplace culture in which staff feel valued and therefore work together to provide the best patient focussed care.

*Figure 2-1 Shared Leadership Enablers (Carson et al.. 2007)*
The emergence of distributed or shared leadership reflects not only disenchantment with heroic models of leadership, but also the need for organisations in health and social care to address what are termed as ‘wicked issues or problems’ (Rittel and Webber 1973, Heifetz 1994). These issues or problems can be categorised as damaging, vicious, tricky and aggressive (Gillin & Hazelton 2015). Ageing well for the populace and resultant care of the elderly is an excellent illustration of a ‘wicked problem’. Ageing individuals are understandably anxious regarding the who, what, where and how they will be cared for, families and friends are increasingly concerned about the quality and accessibility of aged-care services at all levels, and community culture, genetics, gender and government policy will also have a potential impact on healthy ageing (Gillin & Hazelton 2015). Adaptive leadership also offers a potential solution to such wicked problems by attempting to diminish follower dependence on one leader by enabling them to take on leadership themselves, thereby enacting ‘adaptive’ leadership (Heifetz 1994, Currie & Lockett 2011). Similarly to distributive leadership, adaptive leadership theory fits well into the aged care space. It proposes the idea that leadership is not a job or based on authority but
it is a practice that can be done by anyone and in doing so, may foster cooperative and ethical practice, and avoid the disaffection associated with lack of power by those positioned as followers (Currie & Lockett 2011, Gronn 2002; Hodgkinson 1991).

The significantly different challenges faced in aged care which earn the term ‘wicked problems’, include technological changes, new models of service delivery and funding models, greater diversity, new models of engagement and increasingly complex issues in their sector and within the community (Productivity Commission 2011, Creyton 2014, Rural Health Workforce 2016, Hesta 2017). These challenges have no clear technical solution because they are adaptive, and therefore require a fresh approach to leadership. Adaptive leadership theory distinguishes between technical and adaptive leadership challenges that arise in an organisation (Lichtenstein et al., 2006; Uhl-Bien, Marion, & McKelvey, 2007).

Technical challenges are complications or concerns that are effectually addressed through the application of specific expertise, resources, or tangible technical skill and generally entail the somewhat straightforward matching of the right proficiency to the problem (Corazzini, Twersky, White, Buhr, McConnell, Weiner & Colón-Emeric 2014). Adaptive challenges are challenges that have no recognisable, distinct solution, which is more challenging to isolate and define, and necessitate reviewing current norms and belief sets (Torres, Reeves & Love 2010, Corazzini et al., 2014). Adaptive leadership encourages embracing uncertainty and adopting innovative tactics to successfully manage in turbulent conditions and maintains that the best solution arises through learning and adapting to change (Torres et al., 2010, Yukl & Mahsud 2010). Finally, unlike any model of leadership that can be captured by a list of personal characteristics, or
an anticipated set of processes and techniques, the best analogy for adaptive leadership is where the leader appeals to their followers to learn, originate, and be responsible as a group for their workplace decisions and circumstances (Argyris, 1976; Heifetz, 1994, Heifetz 2006, Currie & Lockett 2011 ). This has been shown to be a successful leadership approach to addressing “wicked” problems in aged care organisations (Currie & Lockett, 2011, Bailey et al. 2012, Sturmberg, O'halloran & Martin 2012).

While the distributed leadership, adaptive leadership, authentic leadership and servant leadership models can be appropriate for RACS, they comprise only part of the leadership skills, competencies and attributes that are required by successful leaders in this sector. Winning the hearts and minds of RACS employees is only part of the battle faced by leaders. This must be combined with business skills, strategic thinking and effective change management proficiency (ACSA 2015, Jeon et al. 2014, Department of Industry 2014). The concepts of shared, adaptive, authentic and servant leadership are appropriate for leading staff within RACS, however, it is important not to forget that leadership in this context needs to encompass strategic capability along with more ambiguous attributes such as innovation and vision, as well as the confidence to utilise these much-needed skills and abilities (ASLaRC Aged Services Unit, 2013, ACSA 2015). While there has been some research linked to these leadership approaches and the eliciting of innovation, problem-solving and creativity in health organisations, the development and implementation of day to day management skills that are part of leadership, are not generally referred to in the relevant leadership literature (Vanderpyl 2012, Yoshida, Sendjaya, Hirst & Cooper 2014). However, adaptive leadership’s separation of the technical and
adaptive issues that must be addressed by leaders, does recognise the existence of the more transactional element of leadership (Corazzini et al., 2014).

These more practical skills and attributes are closely linked to Boyatzis’ (2011) Managerial and Leadership Competencies, which provides a model for discerning specific skills and competencies required of leaders in RACS and allocating them to specific leadership dimensions. What limited research that has been undertaken on this topic has found is that leading and managing in aged care involves not only leading staff and caring for a vulnerable group within society, but also involves managing budgets, planning strategic initiatives and making multifarious decisions after evaluating budget restrictions with client needs (Meissner and Radford 2015, Sankaran, Dick, Shaw, Cartwright, Davies, Kelly, & Vindin 2014). This is combined with the strict regulation and high level of requirements embedded in the aged care sector, whereby successive governments have developed and implemented numerous requirements that replicate other more relevant regulation and confuse compliance and quality (Department of Health and Ageing 2008, ACSA 2010). Furthermore, changes facing the aged care sector in Australia are of such a scale and scope that leaders are charged with the task of not only managing effectively, but also thinking inventively and strategically, adapting their organisations to ever-changing demands of the community, government and staff, driving creativity and innovation, and engaging and cooperating with stakeholders and their workforce as they lead change (Department of Industry 2014, Sankaran et al., 2014). With an increase in the average lifespan, the retirement years have increased and the years for which supported care is needed has also grown significantly, and according to Jeon et.al (2014) organisational and industry-wide change is
currently both anticipated in the future and ongoing at the present in RACS. Organisational leaders are seen as being responsible for leading change, by modifying organisational culture to support sustainable change and progress in regard to quality outcomes. Even though there is broad consensus on the need for change, there has been limited investigation or debate regarding how change can be effectively managed in the current demographic, economic and regulatory environment (Shanley 2007, Jeong and Keatinge 2004). In fact, the process by which managers actually confront organisational and regulatory change as a regular occurrence has not been explored in great detail, although there is a growing body of literature on the use of adaptive leadership in aged care organisations which involves changing behaviour in appropriate ways as the situation changes and is becoming more important for most managers and administrators as the pace of change affecting organizations (Burke & Cooper, 2004, Yukl & Mahsud 2010). Unfortunately, the focus on compliance and regulation in aged care appears to limit the opportunity for leaders to be able to reflect and focus on all of the required components of effective aged care leadership.

2.3.2 Leadership Frameworks

As there is only emerging research and empirical evidence on this subject, there are only some recently developed and as yet, untested aged care specific frameworks that clearly express the required leadership and management competencies, skills and attributes for this industry (Jeon et al. 2013, Department of Industry 2014, Jeon, Conway, Chenoweth, Weise, Thomas and Williams 2015,
Meissner and Radford 2015). There has been a number of health and general industry leadership models developed that may offer some ability to be adapted to RACS. The National Centre for Healthcare Leadership (NCHL, 2004) implemented a research-based competency modelling process to develop a competency model defining 26 competencies as vital for effective healthcare leadership (Calhoun, Vincent, Baker, Butler, Sinioris & Chen 2003, Calhoun, Dollett, Sinioris, Wainio, Butler, Griffith & Warden 2008). These competencies are structured into three categories, which include transformation, execution, and people, and comprise skills and characteristics such as team leadership, accountability, community orientation, and strategic orientation. The Healthcare Leadership Alliance (HLA), which is comprised of six key professional medical membership organisations, utilised data obtained from their individual accreditation processes to propose five competency areas mutual to all of their practising healthcare managers (Garman & Johnson 2006, Stefl & Bontempo 2008). These areas of competency were as follows: (1) communication and relationship management, (2) professionalism, (3) leadership, (4) knowledge of the healthcare system, and (5) business skills and knowledge (Healthcare Leadership Alliance 2010). Boyatzis’ (2011) Framework also provides a good foundation for developing a leadership framework for RACS, which includes three clusters of competencies that distinguish exceptional from average leaders globally and include: cognitive competencies, such as systems thinking and pattern recognition; emotional intelligence competencies, including self-awareness and self-management competencies; and social intelligence competencies, including social awareness and relationship management competencies, such as empathy and teamwork (Goleman 1998, Goleman, Boyatzis, and McKee 2002, Boyatzis 2008, Boyatzis 2011).
Finally, worthy of mention is the VUCA model of leadership. The acronym VUCA (Volatility, Uncertainty, Complexity, Ambiguity) has been utilised to refer to the instability and disorder inherent in the contemporary world of work (Stiehm and Townsend, 2002). In a VUCA defined world, organisations must be able to react quickly in response to change and effectively vary and adjust what they do and how it is done (Horney, Pasmore & O'Shea 2010). Human knowledge is short-lived in an environment so beset by change, and technology has made specialised knowledge far more widely accessible to more people than it has previously been. This has made the concept of personal and organisational knowledge less important but has instead made critical, behaviours focusing on technical, cognitive and personal agility and the individual attributes sustaining those behaviours (Johansen & Voto 2013, Ross, 2014). This is particularly relevant in the aged care industry, in which people and practices face regular challenges presented by the rapidly changing environment in which they must operate (Jeon et al., 2010, Bennett & Lemoine, 2014).

A VUCA environment is confronted with accelerated change, constant disruptions and distinct challenges (Hartely, Allen & Sargent 2007, Armstrong, Gillespie, Leeder, Rubin & Russell 2007, Brodtik 2017). A VUCA world encompasses circumstances that are (i) volatile and experience riotous change; (ii) uncertain due to the disruption of certainty which triggers fragile practices and services; (iii) complex as a result of addressing both confusion and hectic changes; and (iv) ambiguous because of the nebulous and indistinguishable implications of the changing conditions (Hall & Rowland 2016, Brodtik 2017). VUCA work environments change rapidly, produce volatility, and comprise of contextual
dynamics that can either support or impede effective performance (Baran & Scott, 2010). In this context, nimble leadership is critical in ensuring that the rapidity and force of the changes in their organisations and environment are managed effectively to ensure sustainability and viability going forward (Horney, 2015; Hall & Rowland 2016).

The VUCA Model or Prime can be regarded as the scale and variety of skills that leaders can cultivate to navigate leadership in a VUCA environment and can be implemented as a skills and capabilities blueprint when constructing leadership development plans. (Lawrence 2013). In using the VUCA model of leadership, volatility, uncertainty, complexity and ambiguity all have countering dimensions that can address the challenges inherent in a chaotic, changing environment (Kinsinger & Walch 2012, Lawrence 2013). In the VUCA paradigm, volatility is moderated by “vision,” which must be a clearly communicated as an explicit declaration of where an organisation is headed, because vision is even more vital in turbulent times (Kinsinger & Walch 2012). Uncertainty is answered with understanding, which involves the capacity of a leader to stop, look, and listen further than their functional areas of expertise (Johansen 2012, Livingstone 2014). Complexity can be contradicted with clarity, which is the ability to see through confusion and contradictions to a future not yet seen by others. (Johansen 2012, Manders 2014). Finally, ambiguity can be countered with agility, the aptitude to communicate across an organisation and to work swiftly to develop and implement resolutions (Kinsinger & Walch 2012, Shukla, Pattanaik & Maity 2015).
All of these frameworks can offer much to the development of leaders in RACS, however, none specifically encompass the intricate and complex blend of skills, competencies and attributes that are required to successfully lead in such a multifaceted environment, which faces such a specific combination of influences including demographics, government regulation and serious HRM issues.

2.3.3 Aged Care Leadership Frameworks

The Health LEADS Framework and the Aged Care Leadership Capability Framework (ACLCF) are both recent initiatives that explore and delineate leadership competencies for the broader health industry and then the aged care industry. The Health LEADS Framework, developed by Health Workforce Australia (2013) in consultation national health stakeholders, aimed to provide a common language about health leadership that would have relevance across the health system and inform health leadership syllabi at all levels across the Australian health system (Sebastian et al., 2014). The goal of the framework is ‘Leadership for a people focussed health system that is equitable, effective and sustainable’ (Health Workforce Australia 2013, p. 5). It has five areas of focus which include: Leads self, Engages others, Achieves Outcomes, Drives Innovation and Shapes Systems (Health Workforce Australia 2013). Health leaders need awareness and skills relating to all five areas to be effective in creating and sustaining advancement in healthcare (Health Workforce Australia 2013). The Health LEADS Framework is based on the distributed leadership model, which supports the approach to leadership being used by this research, so can, therefore, provide a reference point for evaluating the findings in this thesis.
The Health LEADS Framework was followed by the (ACLCF) which was established via a strategic partnership between Aged and Community Services Australia (ACSA), Leading Aged Services Australia (LASA) and the Community Services and Health Industry Skills Council (CS&HISC). The ACLCF was presented after the research for this thesis had been completed and provided many complementary findings to the information and themes that emerged during this research process. Consulting with over 300 aged care leaders, as well as other senior people within the industry, the aim was to identify the underpinning knowledge, skills, abilities and attributes that are required of leaders across the Aged Care industry (CS&HISC 2015). This framework was developed, along with tools and resources, which form part of the Aged Care Leadership Development Centre. They are intended to assist Aged Care leaders and managers to manage their workforce, clients and other stakeholders effectively and to undertake strategic planning and drive innovation in the face of the significant changes confronting the industry (CS&HISC 2015, Department of Industry 2014). The framework provides a good roadmap for aged care leadership development and reflects the authentic, adaptive and transformational leadership approaches as being appropriate to aged care.

This research both takes from and adds value to both of these frameworks as it evaluates the skills, competencies and attributes required of leaders in RACS, which align closely to the dimensions outlined in these frameworks, as well as taking into account the very specific issues facing leaders in RACS, which include government policy, demographic and HRM challenges. It recognises that a more collaborative relationship is required among and between leaders in RACS and that greater agency is required to develop a collective force that can reconstruct
leadership from within the industry and work to enact positive change in aged care.

### 2.4 Demographics

#### 2.4.1 Australian Society

In contrast to many other countries, Australians' life expectancy is increasing, and many retain good health with decent access to health and welfare support services. Nonetheless, incidences of chronic disease and multi-morbidity are growing exponentially, in line with an extended lifespan, placing increasing pressure on the Australian aged care sector to provide appropriate care for ageing Australians (Jeon, Glasgow, Merlyn & Sansoni, 2010). The highest users of aged care and health services in Australia comprise older people with chronic ailments instigating an extreme burden on these services to provide for the needs of older and infirm Australians, along with a rising population of migrants (Jeon, Merlyn & Chenoweth, 2010).

The ageing of Australia's population is one of the most persistent and demanding issues influencing the next three decades (Australian Treasury 2010, Henry 2010, Hugo 2007). High numbers of post-world war two immigration, along with the ageing of the baby boomer generation, will result in those Australians aged over 65 amounting to 6.4 million by 2051, as opposed to only 2.3 million in 1999 (Healy 2004). While improved healthcare, diet and a longer life expectancy indicate that Australia's older generation are becoming healthier and longer-lived, it is an immutable fact that illness and disability increase with ageing. Therefore the medical advances that prolong our lives will, in fact, mean that greater
ongoing medical intervention will be needed to ensure quality of life for the ageing (Hugo, 2007). Consequently, with the growing requirement for aged, disability and dementia care in the Australian community, there will be an even greater need for licensed medical and health workers to plan, coordinate and supervise a range of care services for this health population (Chenoweth, Jeon, Merlyn & Brodaty 2010, Intergenerational Report 2010).

From 2009-10 to 2049-50, real health spending on those aged over 65 years is expected to increase around sevenfold. Over the same period, real spending on those aged over 85 years is expected to increase around twelve-fold. (Australian Treasury 2010)

The issues cited above have led to a considerable change in the aged care workforce profile. Aged care services are more commonly staffed by personal care workers who are less qualified than degree qualified nursing staff (Pearson, Nay, Koch, Ward, Andrews and Tucker 2001). Vagaries in Australia’s labour force profile have also led to a decrease in the managerial level staff available to oversee and act as leaders within the aged care sector (Jeon et al. 2013). Shortages of available workers, minimal investment in employee training and education, low levels of skills specific to understanding aged care, and limited career opportunities for employees in RACS, compared with their acute and other allied health colleagues, all combine to impact the provision of quality care in RACS. These pressures are not limited only to Australia (Hussein & Manthrope 2005, Fujisawa & Colombo 2009, Chenoweth, Jeon, Merlyn, Brodaty 2010, Hebson et al. 2015, Baines & Cunningham 2015).
2.4.2 General Workforce

The generation of Baby Boomers will gradually retire from the workforce over the next ten to fifteen years, taking with them difficult to replace levels of workplace knowledge, skills and experience (Centre for Strategic and International Studies {2000}, Corporate Leadership Council {2002a, 2002b}). Simultaneously, reduced fertility rates will negatively impact the numbers of younger people entering the workforce to replace those who have left (Access Economics 2001). Since 1976, the total fertility rate for Australia has been below replacement level, with the average number of babies born to a woman being insufficient to replace herself and her partner (ABS 2012). Assuming current immigration levels, this drift is anticipated to result in a persistent workforce shortage over the next few decades, as there will be a severe drop in new candidates joining the workforce, with only 125,000 new entrants predicted to enter the Australian employment market between 2020 and 2030 (Access Economics 2001). This prognosis diverges sharply with the annual rate of 170,000 new entrants in 2001 (Hugo 2007).

The average age of the Australian workforce has been swelling at a rate faster than the average age of the general population, resulting in a higher number of older workers remaining in the workforce (Shacklock and Shacklock 2006). As a result of the ageing population, the labour force participation rates are projected to drop from the level of 63.5 per cent in 2005 to about 56.3 per cent by 2044-45 (Productivity Commission 2005, Treasury 2010). Australia’s population pyramids (Figure 2) demonstrate the progression of our ageing population pictorially, culminating with an inverted pyramid by the year 2044, whereby the number of over people over 60 years old will outstrip those under 18 years of age for the
first time (Treasury 2010). The median age of Australia’s population is also increasing, from 38.2 years in 2010 to 45.2 years in 2050 (ABS 2008).

Australians are now living longer than ever before, with current life expectancy exceeding 80 years for a male and 84 years for a female (ABS 2014), increasing to 95.1 years for men and 96.6 years for women by 2055 (Intergenerational Report 2010). Ageing commonly causes a drop in workforce participation rates as older people tend to play less of a role in the labour force, by either reducing working hours or leaving the workforce before their sixties (Shacklock and Shacklock 2006). As an example, in 2003 the majority of men (90.2 per cent) and women (74.2 per cent) aged 45 to 54 years participating in the labour force. In contrast, men and women aged 55 to 64 years, during that same period, had a participation rate of only 66.7 per cent of men and 43.7 per cent of women (Australian Bureau of Statistics 2005a). These figures coupled with reduced average working hours as a result of the relative growth in part-time work, and the on-going tendency for Australian workers to take early retirement, means that
the available pool of skilled labour is likely to be insufficient for future needs (Australian Bureau of Statistics 2004a, Productivity Commission 2005). For example, in 2014, 25per cent of employed Australians aged 25-64 worked part-time in comparison to 21per cent in 1992, with the percentage of men working part-time increasing from 6per cent to 11per cent over the same period (Australian Bureau of Statistics 2015b). Figure 2-4 below demonstrates the greater growth in part-time jobs versus full-time jobs over the past seven years in Australia.

*Figure 2-3 Full-time versus part-time employment growth*

In addition, the younger population in Australia is steadily decreasing (Australian Bureau of Statistics 2014). From 1994 to 2014, the percentage of the people in Australia aged under 15 years of age has diminished from 21.6 per cent to 18.8 per cent and people in this age group are entering the workforce later with the expectation that they will stay in education longer becomes the norm (Australian Bureau of Statistics 2014). These figures have significant implications for the government, researchers and RACS. The fundamental issues that must be addressed include: growing the participation in the labour force of older people by prolonging their working lives; reducing and removing age discrimination;
addressing the negative pigeonholing of older workers as less attractive employment options by employers; growing the acceptance and implementation of flexible working arrangements; providing enhanced incentives for working; improving financial options via the Australian taxation, pension and superannuation systems; and increasing immigration to meet labour force needs (Department of the Treasury 2004a, Encel 2003, House of Representatives Standing Committee on Health and Ageing 2005, Keating 2004, Patrickson 2003, Patrickson and Hartmann 2001, Platman 2004b, Productivity Commission 2005, Reday-Mulvey and Taylor 1996, Sheen 1999, 2000, 2001). If these issues are not sufficiently addressed, with little change in the retirement age and an increase in the average lifespan, the retirement years will continue to increase and the years for which supported care is needed will also continue to grow significantly. Our older population is not only larger, but it is also living longer.

2.4.3 Aged care workforce

The composition of the Australian health workforce has altered considerably during the last five years. It has grown in both size and structure but will require even more alterations if Australia is going to be ready to address the health challenges and the demographic evolution of our future population (Australian Treasury 2010, Wilson 2010). Currently, there are meaningful shortages documented for most health professionals (DEEWR 2010, Skills Australia 2010). The greatest crises are represented by dementia and aged care, and the demand for registered nurses is extremely high within Australia’s healthcare system (Australian Treasury 2010, Productivity Commission 2005 & 2011). There is also likely to be continuing shortages in the General Practitioners’ (GPs) population given to the growing number of women comprising that workforce, and their
propensity to require part-time working conditions, as well as the imminent withdrawal of the baby boomer GP generation (Joyce, McNeil & Stoelwinder, 2006, Skills Australia 2010). It will be crucial for this industry that the supply of those qualified in the health sector be able to keep up with the growing demand. The ageing of the population combined with reducing fertility rates mean that the general workforce in Australia is currently under significant pressure in this decade and beyond (Australian Treasury 2010), and one of the most significant sectors of the workforce in which labour and skills shortages will continue to remain a problem, is aged care (Fine 2007, Skills Australia 2010, DEEWR 2010, King et al. 2012).

Regrettably, the type of work which is generally required throughout the aged care sector, along with the negative image which plagues both the job and the industry, and the hurried pace of structural change in the sector, has resulted in the aged care workplace being epitomised by high turnover, low worker satisfaction and growing absenteeism (Stein, Heinrich, Payne & Hannen, 2000). Staffing in aged care is a compound issue that is impacted by numerous factors, which include the international shortage of nurses, lower levels of remuneration and demanding working conditions (Venturato, Kellett, & Windsor, 2006). In fact, working in aged care is, by and large, seen as an unappealing alternative for nurses, and nursing students have shown that they find the prospect of caring for older people unattractive and exhibit minimal inclination towards working in this sector after they graduate (Robinson, Andrews-Hall, Cubit, Fassett, Venter, Menzies & Jongeling, 2008). Moreover, nurses working in RACS are paid at least 10 per cent less than their colleagues in the acute care sector, with the wages gap becoming worse depending upon the location (Access Economics, 2009,
George, 2008), which indicates that RACS is the key health sector most likely to be negatively impacted by the growing skills shortages in this industry. Traditionally, as an occupation exemplified by low pay, around one-third of RACS workers are migrants from non-English speaking backgrounds (King et al., 2012). This can create care situations embedded with communication and service difficulties (George, 2008). Furthermore, while boosting the aged care workforce through increased immigration and recruitment of migrants might be regarded as a solution to workforce shortages, competition from other industries for human resources is likely to increase to unparalleled levels. This means that the involvement of migrants in the aged care workforce will need to increase many times if the demand for an adequate workforce is to be met (Howe, King, Ellis, Wells, Weiz & Teshuvas 2012, Fine & Mitchell 2007).

In the next few decades of this century, the worldwide ageing of most developed countries will challenge the economic capability of government and industry to cultivate, educate, retain and replace leaders who are practised and capable health professionals and managers to adapt and advance the delivery of quality healthcare (Aberdeen & Angus, 2005, Angus, 2009). There is significant verification that links the employment and retention of qualified, professional health care providers and leaders to excellence in patient outcomes (Venturato & Drew, 2010, Zhang, Unruh, Liu, & Wan, 2006). However, contemporary healthcare is currently underpinned by demand issues that prevail oversupply (Venturato & Drew 2010, Martin & King 2008), and there remains much to be understood about how this relationship is explained in the aged care context. Even less is understood about the schemes and policies that have been implemented to encourage successful leadership in the aged care sector in
regard to staff turn-over patterns, decisions by employees to depart or remain working in the private residential aged care environment, as well as the impact of workforce turnover on the standard and quality of resident care (Jeon, Merlyn & Chenoweth 2010).

In Australia, the aged care sector is one of the most highly regulated workplaces with the Commonwealth setting accreditation standards and outcomes, registration fees, nursing home fees, governance and funding (Australian Productivity Commission 1999). It is fair to say that the strict regulation and high level of requirements embedded in the aged care sector are not conducive to the development of innovative and effective leadership skills in the aged care sector. The Aged Care Industry is governed by legislation including the Aged Care Act, 1997 and the Home and Community Care Act, 1985 (Department of Health and Ageing, 2008). The Aged Care Act governs issues inclusive of the “planning of services, the approval of service providers and care recipients, payment of subsidies and responsibilities of service providers” (Department of Health and Ageing, 2008, p.10). As well as being regulated under the Aged Care Act 1997, residential aged care facilities are regulated by the associated Aged Care Act 1997 principles, which present guidelines and structure to care delivery (Dawbin & Rogers, 2006).

2.5 Government Regulations and Policy

Research undertaken both in Australia and internationally has indicated that apprehension about ensuring quality of aged care has resulted in a plethora of government-led regulations tightly controlling RAC behaviour, in order to improve quality while also reducing unit costs (Hussein & Manthrope 2005, Fujisawa &
Colombo 2009, Chenoweth, Jeon, Merlyn, Brodaty 2010, Hebson et.al 2015, Baines & Cunningham 2015 ACSA 2010, Productivity Commission 2011, EY 2017). There have also been concerns from the government regarding the financial risks attached to government expenditure which has led to regulations restricting access for older Australians to aged care (ACSA 2010, National Aged Care Alliance 2010). Government regulation of RACS is also subject to a conflict of interest predominantly regarding complaints and quality assurance, as the government has a specific interest in protecting political and administrative reputations as well as monitoring compliance and resolving complaints to the satisfaction of the parties involved (ACSA 2010).

Within the aged care industry, there is a perception of over-regulation. Successive governments have developed and implemented numerous requirements that replicate other more relevant regulation and confuse compliance and quality (ACSA 2010). Aged care workers spend a large amount of time on complying with, and reporting on, both aged care specific and generic regulatory requirements (ACSA 2010, Productivity Commission 2011). Many stakeholders believe that the current regulatory system must be overhauled to ensure client safety and security, and to guarantee accountability for public resources, while at the same time eliminating superfluous and duplicative requirements (ACSA 2010, Productivity Commission 2010, Treasury 2010, DoHa 2012, EY 2017). Industry bodies such as ACSA have constantly promoted the removal of “certification and extra service status requirements, an open accreditation system operating under the JAS-ANZ framework, and the modification of compulsory reporting, police check legislation and aspects of prudential requirements” (ACSA 2010 p.9). The LLLB Reform Package (2012)
stated that the highly regulated aged care system currently in play, comprises controls on supply and price, restricts competition, choice for consumers and inducements for innovation and efficiency.

One of the policy recommendations from the LLLB (2012) involved enhancing the consistency of aged care regulation. The report proposed that from 1 July 2014, a single agency, the Australian Aged Care Quality Agency would be established, assuring a more streamlined system and a higher quality of residential and home care services. The aim was to create a more flexible and seamless aged care structure that allows greater choice and access to the complete collection of aged care services (LLLB 2012, Hough & McStay 2012). It was envisioned that progressively, the level and mix of aged care services would be more customer driven and involve less government regulation, with government’s role placing greater focus on simply protecting equity in access and quality of service (LLLB 2012).

The Intergenerational Report (2010) determined that failure by the Australian government to address intergenerational concerns immediately, especially those pertaining to aged care, would cause damaging, economic, financial, and social consequences. Treasury (2010) openly identified the requirement for major and effective policy intervention. Currently, in Australia, the ageing population has been used to rationalise existing and prevalent ideological viewpoints that seek to minimise public sector intervention and maximise the use of the private health sector (Coory 2004, Dela Rama, Dalton, Edwards & Green 2010). In relation to the delivery of aged care services, the fundamental view is that governments should aim to reduce public expenditure on such services while publicising the
benefits of competition between both private and non-profit aged care providers (Dela Rama et al., 2010). The reform agenda, based on a neoliberal New Public Management context, emphasises market-based reforms which include reducing funding levels, standardising work through regulation and compliance and potentially creating conditions whereby smaller community-based organisations are marginalised in the marketplace (Cunningham & James, 2011, Baines & Cunningham, 2015). This approach acts to reduce government costs and move the provision of care to the private sector (Davies, 2011, Baines & Cunningham, 2015). Furthermore, negativity and disinterest regarding population ageing and its impact has quelled productive debate and restricted the policy options that are being considered (Coory, 2004).

According to Millane (2013a) ageing and aged care have been overshadowed by the Social Services portfolio, of which it is now only a part, having been relegated to the outer ministry by the current government (O’Keeffe, 2017). Despite the fact that the Intergenerational Report (2010) and the Productivity Commission (2011) both identified an urgent need for the development and implementation of effective policies to address the specific and varied challenges of RACS and the aged care sector, subsuming aged care into part of a greater portfolio, signifies that it does not appear to be a priority for the incoming federal Abbott government (Millane, 2013a). According to Millane (2013d), Australia was previously at the forefront, amongst other countries worldwide, in caring for its aged citizens. Currently, Australia only ranks in 14th place on the first Global Age Watch index, lagging behind the USA, the UK and Ireland (Millane, 2013d). It appears that there has been a nonexistence of clear, rational policy development in recent decades.
regarding aged care, despite the significant evidence pointing to rapidly deteriorating circumstances.

The problems that surround aged care as identified by major reports such as the Productivity Commission (2011), The Intergenerational Report (2010), LLLB Report by DoHa (2012), demonstrate that significant policy development is required into the future. These policies must be supported by all political parties to ensure an uncontested commitment to address the array of problems identified by previous research (ACSA 2010, Productivity Commission 2010, Treasury 2010, The Intergenerational Report 2010, Productivity Commission 2011, DoHa 2012). Aged care policy, in particular, must cultivate workforce strategies that address and solve the crucial issues negatively impacting the aged care sector. These include the payment of fair and competitive wages, the facilitation of employee access to quality education and training, the development of clear career pathways, the identification and improvement of leadership and management skills and abilities and the extension of scopes of practice and the reduction of regulatory burdens (Productivity Commission 2011). The government also must ensure that applicable staffing levels, compensation measures and relevant skill development occur so that RACS can effectively compete with other industries for staff (Productivity Commission 2011). Recent media reports demonstrate that this is not currently occurring and instead indicate that nursing homes are reporting that they are caring for a greater number of high-care residents, however, the time spent caring for residents fell seven per cent over the past year (Allard 2016). Furthermore, despite the perception of over-regulation in other areas of aged care, there is a growing proportion of aged care workers who are not adequately qualified to care for Australia’s ageing
population. This is demonstrated by Health Department figures that revealed the fraction of registered nurses working in aged care fell nearly 30 per cent between 2003 and 2012 (King et al. 2012, Lee 2016). During the same period, the number of personal care attendants grew from 57 per cent to 68 per cent (King et al. 2012, Lee 2016). According to a study by Palmer and Eveline (2012), care workers are often carrying out the skilled work of the more qualified nurses that they have replaced. In addition, in 2015, average hours worked by care staff, which includes nurses, care assistants and therapists, decreased from over 42 hours per fortnight to just under 40 hours per fortnight, calling into question the safety of both residents and staff in some RACS (Allard 2016).

The effective training and development of staff are limited by aged care facilities’ financial constraints which impede providers’ ability to develop capability and to allow staff to undertake necessary professional development (Productivity Commission 2011). Training and development for staff require an organisation to provide paid time off to carry out the required educational activities’ (Productivity Commission 2011). This is particularly difficult for aged care providers in rural areas, as it can be both challenging and costly to replace staff, as well as absorbing the considerable costs accompanying the attendance of training by employees in an alternative location (ACSA 2013). This gap is imperative to address as career development has constantly been discovered to be a crucial driver in the retention of healthcare employees globally (Shen, Cox & McBride 2004). Moreover, adequate tertiary nursing and healthcare management places must be established to meet the projected demand from the aged care sector, to ensure that nurses and managers are available and readily equipped to enter and be effective in these critical aged care roles (Productivity Commission, 2011).
In summary, the funding models implemented by the Australian government in the aged care sector, have created employment conditions marked by low pay, part-time work arrangements and work intensification (Cunningham, Baines and Charlesworth 2014). The predominant opinion that governments should aim to decrease public spending on aged care services, peddling the benefits of competition between both private and non-profit social-service providers, has not been the balm to care services it has been predicted to be (Hancock 2002, Dela Rama et al. 2010). Many commentators believe that the neoliberal policy options for aged care, which see care providers increasingly motivated by profit, have contributed to an growing absence of 'human-ness' in caring for residents, families and staff, and has contributed to the continued low pay and poor conditions in the sector (Morrow, Bartlett & Silaghi 2007, Gray & Heinsch 2009, Dela Rama et.al 2010, Montague, Burgess & Connell 2015). The Productivity Commission (2010) further, confirmed that insufficient funding weakened service quality in aged care and limited the capacity of providers to respond to fluctuating client needs, while also decreasing their capability to recruit, develop and retain staff effectively. The current 10 per cent gap in remuneration for employees in aged care, as opposed to those in acute care and other healthcare organisations, tends to outweigh the preparedness of care workers to exchange inferior wages and conditions for opportunities to contribute to the well-being of older Australians (Cunningham et al. 2014). The Legislated Review of Aged Care (Tune 2017) found that some of the LLLB reforms had been implemented to improve ease of access and information, such as the MyAgedCare website, changes to classification and funding of residential aged care and the removal of a number of restrictions on accommodation payments. However, in submissions to the
Review, aged care industry representatives remain concerned that the current aged care system remains over-regulated, which increases costs and stifles innovation. They ascertained that a more flexible, less-regulated system would enable providers to increase the range and scope of their services and that regulations should be used solely to ensure safety and quality, protect the vulnerable and address market failures (ACSA 2016, Tune 2017). The Review of Aged Care legislation which provides for the regulation and protection of Refundable Accommodation Payments in Residential Aged Care (2017) undertaken by Ernst and Young for the Department of Health, also found that the compliance burden was still a significant issue with RACS, and that government needed to strengthen the available tools, resources and capability in the department’s Prudential Regulation and Compliance Section (PRCS) to enable it to improve its compliance function and ease the compliance encumbrance for providers. There are clearly important concerns for policy-makers as depleted resources, worker dissatisfaction and over-regulation of RACS threaten to undermine the ability of the sector to meet the challenges of the ageing population and growth in future demand for aged care services.

2.6 Human Resource Management

“Since all healthcare is ultimately delivered by and to people, a strong understanding of the human resources management issues is required to ensure the success of any healthcare program.” Kabene, Orchard, Howard, Soriano & Leduc (2006)

The emphasis of human resource management (HRM) is on managing people effectively within the employment relationship (Stone 2013). HRM recognises the
‘human resources’ of an organisation as assets and views workforce management as a strategic variable that can have a significant influence on effective organisational performance (Balnave, Brown, Maconachie & Stone 2009). Essentially, HRM represents employees as human resources who are fundamental organisational assets who possess knowledge, abilities, aptitudes and future potential. Employees command cohesive and complementary management strategies enacted via job design, successful attraction and retention practices, performance management and reward packages and workplace health and safety procedures so that they can individually and collectively contribute effectively to the accomplishment of organisational goals and objectives (Nankervis, Baird, Coffey and Shields, 2014).

The provision of quality aged care services is conditional on the ability of organisations to recruit and retain qualified, experienced, and motivated employees, supported by relevant HRM practices and processes that will guarantee the required level of care is delivered to residents (Clarke and Rao Hill 2012). The Department of Health and Ageing (DoHA 2012) has indicated that unless remuneration and employment conditions are significantly altered HRM problems will probably deteriorate for RACS in the future as a result of competition with other higher paying industry sectors. The major problem facing aged care is that innovative approaches to people management must be effected in line with sound HR strategic planning to address the prospective problem of more people leaving the labour force in the next few decades than will enter it (Spoehr and Barnett 2008, Treasury 2010, Treasury 2015). As mentioned previously, the Baby Boomer cohort are scheduled to retire over the next twenty years, meaning that there will be major labour shortages emerging in RACS if
HRM strategies designed to enhance the aged care workforce participation rates are not developed and implemented – providing yet another challenge for leaders in RACS (Spoehr and Barnett 2008).

There has been a number of studies in recent years examining the relationship between HR practices and organisational performance to identify and understand the policies and strategies that will lead to high performing workplaces and excellence in service delivery (Nankervis et al. 2014, Guest 2002, 2006, De Prins and Hendrickx 2007). Most studies have stated that there is a positive relationship between HR practices and organisational performance (Becker & Gerhart 1996, Wilson et al. 2004, Clarke and Rao Hill 2012). Unfortunately, the performance of Australia’s public healthcare organisations, including RACS, is a major concern for governments (Locock 2003, Productivity Commission 2011). The sector has not adapted efficiently and expediently to management practices that involve sound HRM practices, such as employee participation in decision-making, paying staff competitively, fostering a rewarding working environment and providing further opportunities for skill development (Bartram et al. 2007, Productivity Commission 2011). In a sector where labour costs comprise approximately 70 per cent of healthcare budgets, there has been surprisingly limited research into HRM strategies that encourage recruitment and retention of employees in aged care settings (O'Donoghue, Stanton and Bartram 2011, Hodgkinson, Haesler, Nay, O'Donnell & Mcauliffe 2011). This lack of exploration of what HRM strategies are effective in RACS creates significant challenges for leaders, particularly as they struggle to recruit and retain skilled employees (Fleming & FitzGerald 2009, King et al. 2012, Millane 2013, Productivity Commission 2011).
One of the foremost contributors to difficulties in recruiting appropriately skilled staff, as well as inordinately high turnover in RACS, is the low wages that are characteristic of the aged care sector compared to acute health and other health sectors (Millane 2013, King et al. 2012, Charlesworth 2012, Productivity Commission, 2011). Research by King et al. (2012) shows that a considerable percentage of the direct care workforce in RACS regard low pay as a drawback for working in this sector, which makes it a clear issue for workforce recruitment, planning and development. The Productivity Commission’s Report (2011) proposed that the aged care sector requires improved employment conditions, represented most notably by increased wages, to build a larger source of workers in RACS. They found that the low wages combined with the disparity between wages paid to workers in the aged care sector and those in other health sectors were a significant determinant of recruitment and retention difficulties (Productivity Commission 2011). Data shows that aged care workers are not only not well paid but that gender has been found to play a clear role in determining earnings in this sector (Meagher 2006, King & Martin 2007). Caring as an occupation is regarded as both the domain and burden of women and gender inequalities are apparent in the wage rates of aged care workers at all levels of proficiency (Meagher 2007, Martin 2007, Kaine 2012a, Palmer & Eveline 2012). Unfortunately for leaders in RACS, this wage inequity means that qualified carers can increase their incomes by changing occupations into non-caring community service roles, highlighting what Meagher (2007, p.160) describes as ‘evidence of a ‘care penalty’ in paid carers’ wages’. While the LLLB reforms outlined the provision of additional funding, called the Workforce Supplement, to deliver higher wages, targeted to areas of greatest workforce pressure (LLLB 2012). Following the change of government in September 2013, the Workforce
Supplement was terminated but funds were redirected to include an increase of 2.4 per cent in funding to aged care providers and a twenty per cent increase in funding to aged care services in rural and remote areas to assist with the extra cost of delivering services in those areas (Tune 2017). However, despite the increase in funding, pay differences between aged care workers and those in other sectors has not closed since the implementation of the LLLB Reforms (ACSA 2016, Tune 2017). According to the 2016 National Aged Care Workforce Census and Survey (NACWCS), total remuneration still is still prominent as being the workplace factor with which residential aged care workers are least satisfied (Mavromaras et al. 2017).

Burnout and stress play a significant role in the current care workplace (King 2007). As care work has moved from a welfare state approach to a more market-oriented approach, productivity and managerialism have reconceptualised the nature of, and the work environments under which, care is provided (Knijn 2000, Baines & Cunningham 2015). This change has produced a work setting in RACS that is characterised by growing levels of casualisation, increased work stress and dissatisfaction, and high rates of burn-out and care worker ill-health (Knijn 2000, King 2007). The principles above, which emphasise efficiency, competition, greater performance expectations and accountability have contributed to a sense of conflict and frustration within care workers, as they believe there is insufficient time to provide quality care for residents under these conditions (Cameron & Brownie 2010). This lack of time to provide care needed to residents, as well as demanding and exhaustive work that intrudes into home life and the feeling of not being able to live up to the expectations of clients, families and management contribute significantly to emotional exhaustion and burnout in RACS workers.
According to research by King (2012), leaders in RACS play a pivotal role in assuaging such conflict and frustration, by creating the right work environment. Leaders need to allow, as part of their human resource strategy, care workers to have comparative autonomy regarding their caring and enable them to create a perception of professionalism in their role as carers construct themselves as professional carers providing high-quality care (King 2012). King’s (2012) research demonstrated that leaders who provided such conditions, as well as facilitating their carers in managing their emotions and developing emotional resilience, both eased workers’ frustration, and improved job satisfaction and staff retention. If leaders in RACS are unable to address these issues in the workplace effectively, it can result in job dissatisfaction and a recurrent motivation for leaving the aged care sector, as well as contributing to greater leadership challenges.

Research has also found that care workers consistently rated a lack of available career opportunities in the sector as a significant factor prompting them to leave employment in aged care (Radford, Shacklock & Bradford 2015). While career advancement has been found to be an important factor regarding job quality, there are few structured pathways of learning and development for careers in aged care (Leschke, Watt & Finn 2008, Clarke 2009, Dwyer 2011). Furthermore, the existing flat career structure provides limited opportunity to develop and apply more complex skills in RACS or to have such skills acknowledged and suitably rewarded (Clarke 2009). A study by Pearson et al. (2001) found that there is a clear need for a recognised career structure within the aged care sector to increase levels of recruitment and retention. Radford et al. (2015) further support this in their research, which found that employers need to invest in leadership.
training for those in supervisory roles, as well as having clear succession management plans in place if they are to attract and retain skilled care workers.

Job satisfaction has increasingly been recognised as an important influence on service and care quality, as well as retention and job commitment in RACS (Chou, Boldy & Lee 2002, Edvardsson, Fetherstonhaugh, McAuliffe, Nay & Chenco 2011). Studies have shown that job satisfaction with work in healthcare is influenced by the environment in which the nurse or a care worker is employed and the personal attributes of the nurse or care worker (Taylor et al. 1999, Tovey & Adams 1999, Hegney, Plank & Parker 2006, Brownie & Nancarrow 2013). The implementation of effective HR strategies such as flexibility of hours, good terms and conditions regarding leave arrangements, salary packaging, effective rewards programs and relevant training and development opportunities are important components of an effective work environment (Venturato, Kellett & Windsor 2007, Clarke & Hill 2012). However, some research shows that the accreditation and documentation requirements enforced by government regulation, impact how aged care staff and their leaders can allocate their time, and this works to obstruct the development and implementation of effective HR strategies in RACS, as leadership focus and attention is forced elsewhere (Venturato, Kellett & Windsor 2007, King, Wei & Howe 2013, Cooke & Bartram 2015)

Finally, the Productivity Commission (2011) has identified effectual training, not only for management but general staff also, as being critical to creating and retaining an effective and sustainable aged care workforce. The provision of quality care for patients who are at the end-of-life care and in a palliative state
can only be delivered by staff in RACS if they are appropriately trained and resourced (Productivity Commission 2011). According to Phillips, Davidson, Jackson, Kristjanson, Daly & Curran (2006), there is growing scope for both leaders and their staff in RACS to become practiced in the management of chronic and multifaceted resident care, as well as being able to effectively and perceptively interact with families, expedite advance care planning, and assist with the management of palliative care needs in RACS. These services are aged care fundamentals and appropriate aged care training should include this as a key competence for all aged care staff. However, this training is not conducted in a suitable or respectful manner by either the sector itself or by the government (Productivity Commission 2011, Howe et al. 2012, King et al. 2012 Millane 2013a, 2013b, 2013c. 2013d and Millane 2014). Yet, providing quality care for older Australians is of major importance to a compassionate and functioning society, and in light of this, appropriate training is essential. If RACS’ staff can confidently provide effective care to elderly people as a result of effective training and development, staff turnover would be significantly reduced (Productivity Commission 2011). A number of Registered Training Organisations (RTOs) are not delivering properly accredited courses that provide adequate training to the quality standard required by RACS (Productivity Commission 2011, Howe et al.. 2012, Millane 2013d and 2014). To ensure that staff are adequately trained and developed content and delivery of vocational education in aged care programs must be reviewed and reformed (Productivity Commission 2011).

The LLB Reforms did acknowledge the need for better training and development in the aged care industry, as well as recognising that the turnover rate for aged care staff is also higher than other sectors, leading to a loss of productivity and
higher training costs due to training new staff (LLLB 2012). They also identified a lack of career development within the sector and the need for qualifications, competency standards and skill sets to be updated (LLLB 2012). As part of their recommendations, the LLLB reforms aimed to refocus remaining aged care training and development resources to support the execution of their Workforce Compact, part of which was to provide targeted training and educational opportunities and support aged care career pathways and workforce planning (LLLB 2012, Murphy 2012). According to the Tune Legislated Review of Aged Care (2017), there are still significant gaps and deficiencies in current education and training systems. The aged care sector, in conjunction with government, still needs to consider how to build and extend the skill sets, competencies and knowledge needed in the aged care workforce, including developing specific requirements for on-the-job training and ongoing professional development, and encouraging and participating in the expansion of ageing and aged care as a specialisation in post-secondary education (Tune 2017).

Effective human resource management plays a crucial role in enabling a positive workplace culture in RACS (Jeon et al. 2010). This leads to enhanced outcomes for staff stability and productivity, as well as improving care quality and budget management, better preparing the aged care sector for the challenges ahead (Jeon et al. 2010, Clarke & Rao 2012). The implications for leaders in RACS are clear, as HR practices and strategies are connected closely to the overarching philosophy and strategy of an organisation in general (Eaton 2000). Therefore, by reforming key HRM practices such as improved staffing ratios, implementing effective teamwork, training and employee participation, both staff retention and job satisfaction increase, leading to higher care quality and better organisational
This chapter covered some of the available literature on the themes being explored by this thesis. It included an overview of the major leadership theories, a review of the Australian ageing population and workforce, an examination of the literature available on HRM in RACS and a synopsis of the major government policies and related issues regarding ageing in Australia and RACS. Finally, it presented a review of leadership theories, the limitations imposed by the aged care industry and its environs on leadership; overviewed some of the leadership frameworks for relevance and applicability to aged care; and finally focused on shared/distributed and adaptive leadership as the most appropriate leadership models to best reflect the culture and climate of RACS. The models of shared and adaptive leadership support the approach to leadership for this research. Therefore, a leadership definition to provide the context for leadership in RACS is taken from Ciulla’s (1998) ethics-based definition of leadership, incorporates Bailey et al.’s (2006) definition of leadership in general and adopts Lichtenstein, Uhl-Bien, Marion, Seers, Orton & Schreiber’s (2006) characterisation of adaptive leadership, as follows:

Leadership is not a person or a position. It is a complex moral relationship between people, based on trust, obligation, commitment, emotion, and a shared vision of the good (Ciulla 1998, pg xv). It is a complex interactive dynamic sparked by adaptive challenges (Lichtenstein et al.. 2006, p.4)

The next chapter focusses on outlining and explaining the chosen methodology for data collection and the theoretical framework used for analysis.
Chapter Three – Methodology

3.1 Chapter Overview

This chapter provides an overview of the methodology used in this research, the rationale behind the choice, and the study design.

This thesis comprises of exploratory research that examines perceptions of leadership within the RAC sector, as well as perceptions of what is needed to lead within the sector. These perceptions were obtained by undertaking in-depth interviews with eighteen participants in senior leadership roles in RACS. The research questions in this study lend themselves to a qualitative approach, and given that this research is about exploring the construction of these concepts within aged care, a subjectivist approach was deemed to be a good starting point to address the following key question:

- What are the competencies, skills, and attributes needed by leaders in the complex residential aged care service industry sector?

The methodology also needed to address the four supplementary questions outlined below that underpin the key question within an analytical framework. These supplementary questions were designed to link through an appropriate methodology that analysed the data to provide insights into the characteristics, capabilities and competencies required for leadership development to effectively manage RACS in light of the major challenges faced in 2013-2015 and in the coming decades.

The supplementary questions are:

- What future development is required for senior managers in RACS to innovatively meet the complex challenges facing RACS?
• What major human resource management (HRM) issues are facing RACS and what are their possible solutions?
• What challenges are posed by Australia’s current and projected demographics in regards to the continued provision of aged care to older Australian citizens?
• What is the impact of government policy on the effectiveness of the aged care industry and its ability to effectively care for our ageing population now and in the future?

The key and supplementary questions, and overall research objectives are based on a subjectivist ontology and a constructivist epistemology that leads to a qualitative methodology.

This chapter is structured as follows: firstly, a discussion and justification of the theoretical framework that is implemented in this research are outlined. Subsequently, the research design, sample and participants, as well as the data collection methods and instruments are discussed, along with reliability and validity evidence. Finally, a discussion of ethical concerns involved in this study closes this section.

3.2 Theoretical Perspective

The theoretical framework is the design for the whole thesis study. It acts as the foundation on which the study is built and developed, and also specifies “the structure to define how you will philosophically, epistemologically, methodologically, and analytically approach” the entire research thesis (Grant
and Osanloo 2014, p.12). The theoretical framework influences and impacts every decision made by the researcher during the research progression (Mertens, 1998). Therefore, the theoretical framework comprises the theories underpinning how and why a researcher has understood and planned their research topic, along with the identification of the concepts and definitions from the selected theories that are relevant to the topic (Grant and Osanloo 2014, Lysaght 2011). Applying and developing a theory for a research thesis should be appropriate, well comprehended and compatible with the topic and questions being researched (Lovitts 2005, Mackay, 1993). For this research, a subjectivist approach is being taken, under the belief that individuals construct their reality, and concepts of leadership are part of this construction. Therefore the researcher can only really know how the participants perceive leadership and what they value in leaders – leading us to a qualitative methodology that explores individual perceptions and views and values the lived experience of leadership.

3.3 Subjective Constructivism

Ontology is the philosophical study that examines the nature of reality (Blaikie 2010). Ontology is related to a key argument which examines whether social entities should be observed as objective or subjective (Dudovskiy 2016).

Objectivism asserts that “social entities exist in reality external to social actors concerned with their existence” (Saunders, Lewis & Thornhill 2012, p.110). Alternatively, subjectivism identifies that truth is constructed from the awareness and resultant activities of individuals and that true reality does not exist separate from perception (Bryman 2012). Subjectivism is, therefore, an ontological position which emphasises that social phenomena and their meanings are
constantly being revised to create a reality (Saunders, Lewis & Thornhill 2012,).

This is often allied with the term social constructivism which asserts that to be able to understand the views and perceptions of individuals, it is first essential to examine the subjective implications that motivate their actions (Bryman 2012, Dudovskiy 2016).

Constructivism was initiated as an approach to be utilised for explicating the ‘formation of natural knowledge without engaging in assessment of its truth or validity’ (Golinski 1998, pg.7). Constructivism as an explicit perspective emerged towards the end of the 19th century, and is regarded by some as a response to the swiftly growing utilisation of vastly abstract theories and methods of proof in the field of mathematics (Troelstra 1991). Generally, however, the western constructivist approach can be traced back to the French philosophers, Jacques Derrida and Michael Foucault, whose opinions attained eminence amidst the French social upheaval occurring in the late 1960s (Matthews 2003). Other major sources during this time gave new life to construction and ‘meaning-making’ in the 1960s and 1970s, which included: Goffman’s seminal sociological publication in 1959 and Berger and Luckmnann’s (1966) book, The Social Construction of Reality (Jost & Kruglanski 2002, pg.170). These independent works succeeded in renewing general awareness of questions about mutual subjectivity and the social construction of cultural practices, as well as highlighting the micro-sociological developments in which specific meanings of reality are suggested, tested, and discussed during face-to-face interactions (Hamilton 1994, Jost & Kruglanski 2002).

The constructivist approach affirms that people experiencing the same event can construct different meanings despite sharing the same social phenomena (Crotty,
Several assumptions regarding constructivism were acknowledged by Crotty (1998) which are central to this research. These are: (1) meaning is constructed by people as they interact with others and the environment that they are interpreting, so qualitative research implements semi-structured questions in order to encourage interviewees to openly share their insights; (2) human beings participate within their sphere of interaction and interpret it based on their historical and social perspectives; (3) the basic generation of meaning is permanently social and arises both in and out of interface with other human beings (Crotty 1998). The research explanations and outcomes in qualitative research are therefore specific to the context of the participant and their experiences. Constructivism is apt as the theoretical framework for this research study. Lincoln and Guba (2000, p.165) stated that constructivism represents "local and specific constructed realities." Stake (1995) defined constructivism as a belief that knowledge comprises largely of social justifications of incidences rather than awareness of an external reality.

This thesis's research is based on the interpretations of senior managers working in RACS regarding their current experiences in this role and their views concerning the challenges for themselves and other RACS leaders in the future. The study’s participants constructed reality based on their individual and shared experiences.

The assemblage of qualitative data in analysis is a common tool, however, awareness about stratagems for proficient and defendable procedures for evaluating qualitative data is less common (Thomas 2006). One method for the synthesis and analysis of findings of qualitative research is called 'thematic
synthesis’ or thematic analysis (Thomas and Harden 2008). Thematic analysis can be viewed as one of the foundational methods for qualitative analysis (Braun and Clarke 2006). While thematic analysis is a poorly demarcated and rarely acknowledged, analytic method, it is widely used to effectively and accurately evaluate qualitative data (Boyatzis, 1998; Roulston, 2001). In terms of this inquiry, the thematic analysis provided a framework for construing how leaders in RACS interpreted and made meaning of the particular issues they face as leaders in this challenged industry.

This research was specifically interested and focussed on discovering what senior managers in RACS understood as the major challenges to the industry, the possible solutions and skills and attributes they required as leaders to steer their organisations into the future. The interpretive convention allows that the researcher to commence by investigating the framework that is to be studied and developed via both action and inquiry, rather than employing predisposed hypotheses (Braun and Clarke 2006). According to Strauss and Corbin (1998), the researcher starts with an area of study and enables the theory to emerge from the data. In other words, thematic analysis links comprehensive evaluations of raw data to develop themes, concepts or a model from the interpretations by the researcher (Thomas 2006).

Fundamentally, interpretive analysis epitomises the notion that the researcher wants to understand how contributors to the research create meaning from a situation or experience (Braun and Clarke 2006, Thomas 2006). This approach means that the researcher’s philosophies and perspectives underpin the core of the research project and that the researcher is as much a part of the study as the objective of the research and the research method implemented (Piantanida &
Garman, 1999). Interpretive analysis utilises an inductive strategy and produces a descriptive outcome (Merriam 2002). The two methodologies of constructivism and interpretive analysis accept the concept that all social reality is created, assembled or adapted by persons and groups interacting in a social system (Ireland, Tambyah, Neofa & Harding 2009, Gray 2013). The epistemological notion of the interpretive-constructivist researcher implies that “findings are literally created as the investigation proceeds” (Guba & Lincoln, 2005 p.111). They unequivocally identify that to comprehend social reality one must also understand how processes, values and perspectives are shaped and learned by people and the language and tacit norms they share as part of their common experiences. (Orlikowski & Baroudi 1991, Andrade 2009). In light of this perspective, this research used an interpretive-constructivist paradigm to examine and understand senior staff’s perceptions and experiences about the leadership challenges they face in RACS. Interpretive-constructivist researchers hold that people make sense of their world individually, therefore personally construct their own reality (Gubrium & Holstein, 1997; Jones, 2002, Williamson 2006). Therefore by investigating in-depth the experiences and perspectives of senior managers in RACS, through use of semi-structured questions, the aim was for the researcher to understand and construct meaning from their perceptions and experiences within the aged care sector.

3.4 Qualitative methods or methodological approach

Qualitative research is appropriate when there is limited knowledge available about a topic (Denzin & Lincoln 2011). While there is a growing body of literature addressing the leadership skills and competencies required of leaders in RACS, there is certainly not yet a compelling quantity of literature shedding light on the
issue of leadership in the complex area of RACS. Moreover, qualitative research has the benefit of capturing intricacy in a research study by clarifying not only what people do, but also why they do it (Wertz & Charmaz 2011). Qualitative research claims a lengthy and renowned place in researching human disciplines, involving examining phenomena in their normal situations and endeavouring to interpret, this phenomenon regarding the values and significance people attribute to them (Denzin & Lincoln 2008). Qualitative research includes any type of enquiry that yields outcomes that have not been derived from using statistical measures or other quantitative processes (Strauss & Corbin, 1998). In particular, in the healthcare field, qualitative methodologies are frequently utilised to explore intricate occurrences that are faced by nurses, other health practitioners, policy makers, and patients (Denzin & Lincoln 2011).

3.5.1 Justification of the methodological approach

I have undertaken qualitative research using a constructivist methodology and implemented the technique of thematic analysis, for a number of reasons. Generally, qualitative research methods are particularly valuable in determining the sense that people give to the phenomena they experience (Bogdan & Biklen, 2003; Denzin & Lincoln, 2011). Constructionism also holds that there is no objective truth to be discovered, but that we construct the meaning of various phenomena through our engagement with life experiences and situations (Lehmann and Coady 2008). Qualitative research has increasingly gained legitimacy within health research and in particular with granting agencies, who are indicating a growing interest in the perspectives of the participants within healthcare settings (Morse 2015). It is progressively being recognised that
relevant peoples’ perspective should not be ignored and that ethically and essentially, the humanistic facets of healthcare must be included in research and analysis if effective care is to be attained (Sofaer 2002, Speziele, Streubert & Carpenter 2011, Morse 2015). In comparison to quantitative research, qualitative interviews are reasoned to provide greater ecological validity, offering rich discerning interpretations and the capacity to help comprehend complex organisational truths (Eby, Hurst and Butts, 2009, Saunders & Townsend 2016).

Conger (1998) claimed that solely using quantitative research cannot produce a worthy appreciation of leadership, due to “the extreme and enduring complexity of the leadership phenomenon itself” (p. 108). Leadership exhibits a vigorous character, comprises of various levels of phenomena and has a symbolic component which is better understood by implementing with qualitative research methodologies (Conger 1998). Qualitative research on leadership not only leans towards giving greater attention to the ways in which leaders and their approach to leadership are responsive to particular circumstances, but it expands upon the quantitative research emphasis on vision, charismatic leadership, and transformational leadership to also recognise the significance of more mundane instrumental forms of leadership behaviour, such as ensuring the need for adequate resources for followers to get the job done (Bryman 2004). Qualitative researchers are also more likely to accentuate the importance of the sector within which leadership is being performed for determining effective styles of leadership and are inclined to be more receptive to the impact and requirements of particular environments on leaders and their leadership style (Alvesson, & Sveningsson 2003, Bryman 2004).
In contrast with quantitative research, which is deductive and tends to investigate phenomena regarding trends and occurrences, qualitative research aims to understand the meaning of such phenomena via narrative and description. The aim of qualitative research is to develop concepts that can help us understand social phenomena in natural settings, emphasising the meanings, experiences and views of the participants (Mays & Pope 1995, Ospina 2004, Al-Busaidi 2008). According to Patton (2002), there are a number of conditions that are appropriate for qualitative research, including queries regarding people’s experiences; investigation into the meanings people infer from their experiences; evaluating a participant in their work environment and research where there is a previous lack of knowledge on the phenomenon. This supports the premise of this research, which has found that there is an absence of comprehensive research into leadership in RACS (Pearson Schultz & Conroy-Hiller 2006, Jeon, Glasgow, Merlyn & Sansoni 2010, Jeon et al.. 2013, Jeon et al.. 2015) and therefore by examining the in-depth experiences and perspectives of senior leaders in RACS, it can contribute to the development of a distinctive leadership framework. Qualitative research methods are therefore most suitable for this research because of the emphasis specifically on leaders in RACS’s lived experience and the importance of locating the meanings they place on the events and practices in their environment, as well as their perceptions and assumptions, to theorise effectively about the nature of leadership as a social influence process, in the residential aged care environment (Miles 1994, Parry, Mumford, Bower & Watts 2014). Finally, research has demonstrated that qualitative research is appropriate to the research of leadership, as it draws out the contextual influences on what passes for effective leadership, and takes into account the impact of norms, legitimating principles, historical legacies, and other institutional factors on the

3.6 Setting

The context of the research setting is pivotal for understanding the social sphere, so researchers involved in implementing qualitative data collection techniques highlight the importance of this social framework. According to Shenton (2004, pg.69), ‘thick description of the phenomenon under scrutiny’ should be undertaken. Comprehensive description in this region can be an imperative provision for encouraging reliability and integrity as it aids in conveying the authentic circumstances that have been scrutinised, as well as the frameworks that surround them, enabling the audience of the final thesis to conclude the magnitude of which the overall findings appear relevant (Shenton 2004).

The research for this study was conducted in Melbourne, Victoria, a metropolitan area with a population of around 4.5 million people in 2013 (Australian Bureau of Statistics 2013). The Australian aged care system provides a range of services that support older people in both a residential and community setting. People who are no longer able to be supported in their homes are those provided with residential aged care. In Victoria, there were over 47,000 people receiving services from RACS in 2011 (DoHA 2006, 2008, Australian Institute of Health and Welfare 2012). There were previously two types of aged care provided in residential aged care facilities; low-care or high-care, depending on the assessment of the individual’s needs (DoHA 2006, 2008). A person receiving low-
care would require housing and personal care, whereas residents who received high-care necessitate 24-hour nursing care, as well as the low-care services they receive (Australian Institute of Health and Welfare 2012). However, the conditions of allocation for residential aged care places were amended to remove the distinction between low care and high care residential aged care places from 1 July 2014 (Australian Government 2014). Aged care assessment teams (ACATs) comprehensively evaluate the care needs of frail people [who are generally older citizens] in order to aid them in accessing the services most appropriate to meet their care needs, and will take into account a number of factors including, physical, medical, psychological, cultural and social requirements during an assessment (Australian Institute of Health and Welfare 2012 p.vii).

Australian Residential aged care services are supplied by providers from various sectors, which include private, government (local and state government) and not-for-profit (comprising religious, community-based and charitable) providers (Australian Institute of Health and Welfare 2012, Department of Social Services 2013–14). In 2017, not-for-profit and private organisations provided most of the residential aged care services nationally, including 37 per cent and 54 per cent of facilities, respectively (Department of Health 2017). However, Victoria had the highest proportion of privately owned facilities within Australia (54 per cent) and government-owned facilities (10 per cent) and the lowest proportion of not-for-profit facilities (37 per cent) (Department of Health 2017).

3.7 Recruitment of Participants and Sampling Method

According to Marshall (1996), selecting a research sample is a significant stage in any research project as it is seldom practical, effectual or ethical to examine
entire populations. In qualitative research, the method of sampling implemented is selected by the methodology being used and the topic being examined, not by the requirement to generate generalisable findings (Patton 2002, Higginbottom 2004). Samples for qualitative research tend to be small, as a suitable sample size for a qualitative investigation is one that can effectively answer the research questions (Marshall 1996, Maya & Pope 2000). Furthermore, it is understood by qualitative researchers that some potential participants are 'richer' than others and therefore are more inclined to offer greater awareness and understanding of the topic for the researcher (Coyne 1997). This process, identified as purposeful or judgement sampling, is where the researcher actively chooses the most relevant and qualified sample to address the research topic (Marshall 1996, Cresswell & Plano Clark 2011, Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood 2015).

In this study, the sampling unit is the company or organisation, and sampling frame is the list of the not for profit and for profit RACS in Victoria sourced from the Internet. To be eligible for participation, participants had to be considered as an aged care expert through current employment within the aged care sector and having relevant knowledge and experience in aged care regarding clinical practice, management, service delivery, policy, research or education. This is because, according to Sargeant (2012), the subjects sampled must be able to inform important facets and perspectives related to the phenomenon being studied. Potential participants identified as meeting the eligibility criteria were purposefully sampled from searching aged care internet directories such as villages.com.au, myagedcare.gov.au and www.agedcareguide.com.au. The researcher had no relationship with any of the participants beyond the initial
contact and interview. The participants were selected according to their role in the organisation, which indicated their potential knowledge and experience regarding leadership and leadership issues facing the aged care sector, and RACS in particular.

The sample size at the completion of the research phase was eighteen participants. It is generally thought that for a phenomenological study such as this, between five and twenty-five interviews is acceptable (Kuzel 1992, Morse 1994, Creswell 1998) More recent research by Saunders and Townsend (2016) suggest that between sixteen and sixty participants provide a more reliable sample size in qualitative research. The research sample is deemed sufficient when additional interviews or focus groups do not result in the identification of new concepts and reach an end point called data saturation (Sargeant 2012). After eighteen interviews, the point of no new data was reached, no new themes were emerging; therefore, data saturation was deemed to have occurred and the interview research was concluded. Interviewing followers or clients would have gained an even richer insight into leadership in RACS, however, this was beyond the scope of this research. Besides investigating the skills, competencies and attributes required of leaders in RACS, this research also aimed to identify and isolate the particular challenges, specific to their roles that impacted the necessity of having or acquiring these capabilities. It was important, therefore, to select those acting in a variety of relevant roles as senior leaders in RACS so that their specific perspectives and experiences of the phenomenon of leadership in their context could be discovered.
Following ethics approval through appropriate channels at RMIT University, senior leaders within a number of RACS providers and related aged care industry bodies were contacted by both phone and email to obtain consent for as interview participants and research informants. Once the participants had agreed to take part in the study, the researcher formulated a schedule with agreed dates and times to interview each of the senior managers at their workplace. The senior managers interviewed were employed in a variety of roles, including facility manager, human resources manager, CEO, chief medical practitioner and director of nursing. All had high-level decision-making roles within their organisation and strong knowledge of both the industry and the issues impacting on their workplaces and RACS in general as an industry sector.

3.8 Stage 1: Data Collection

3.8.1 A constructivist approach to interviewing

I interviewed eighteen senior managers working in various Victorian RACS. In-depth interviews were utilised as the format allowed for significant probing via two-way communication that provided detailed descriptions of the questions and topics being discussed. In-depth and semi-structured interviews examine participants’ previous experiences and the significance they assign to them (Tong, Sainsbury & Craig 2007). Using this approach, researchers encourage informants to discuss what they think is relevant to the research question by asking open-ended queries. This open-ended, semi-structured approach allows the interviewer to rephrase, re-order or simplify the questions, enabling them to probe in more depth themes presented by the participant (Legard, Keenan & Ward 2003, Tong et al.. 2007). The methodology of utilising in-depth interviews
are often used in qualitative health research, to study the understandings and implications of personal and sensitive themes (Pope, Van Royen & Baker 2002). In-depth and semi-structured interviews can also help to identify factors within healthcare that can potentially be changed and adapted for the enhancement of healthcare delivery (Wright, Holcombe & Salmon 2004).

In this research, single participant, one-on-one, qualitative interviews provided significantly more data around a particular topic than written questionnaires. Denzin and Lincoln (2011) suggest that when individuals were interviewed on a face-to-face basis, there was an increased likelihood of them saying things they were unlikely to document in a survey. The interviews were semi-structured to provide the opportunity to explore particular themes or responses to probe and clarify further. A semi-structured interview does not limit respondents to a set of pre-determined answers (unlike a structured questionnaire) and can be utilised to allow respondents to discuss and raise issues that the interviewer may not have considered (Denzin & Lincoln 2011). The semi-structured interview provides interviewers with some choice in how they present each question and allows for the amplification of thought-provoking and significant issues raised by participants (Hutchinson & Skodal Wilson 1992, Denzin & Lincoln 2011). The semi-structured interview is also appropriate for exploring attitudes, values, beliefs and motives and is especially effective when discoursing on sensitive issues (Nay-Brock 1984, Treece & Treece 1986, Barriball and White 1994, DiCicco-Bloom & Crabtree 2006). Finally, in-depth semi-structured interviews allow the interviewer to probe further and shed light on inconsistencies within participant’s responses and can assist them in recalling information where
memory is required to respond to the questions (Smith 1992, Barriball & White 1994, DiCicco-Bloom & Crabtree 2006, Tong, Sainsbury & Craig 2007).

This process of data collection via semi-structured interviews was an interpretive study guided by a constructivist paradigm, which accentuates understanding the multiple meanings people make of the phenomenon under study (Al-Saggaf & Williamson 2004). A differentiating characteristic of constructivism is the significance of the interaction between the researcher and the participant (Mills, Bonner & Francis 2006a, Mills, Bonner & Francis 2006b). Deeper meaning is only able to be discovered via this interaction and the researcher and participants cooperatively create or co-construct outcomes from their interactive discourse and interpretation (Mills et al. 2006a, Mills et al. 2006b, Charmaz, 2006, Pidgeon & Henwood, 1997 Guba & Lincoln, 1989). Interviews generally averaged approximately 60 minutes and were audio recorded and then transcribed verbatim for analysis. In addition to the recordings, the researcher took written notes. Engaging multiple methods, such as interviews and recordings is found to lead to more valid, reliable and diverse construction of realities (Golafshani 2003).

The questions asked of the participants were as follows:

- What are the competencies, skills and attributes that you believe are required by senior employees in the RAC to be effective leaders?
- Is there a shortage of qualified people to work in senior positions in the residential aged care sector?
- What are the skills and attributes that you believe are required by senior employees in the RAC to be effective leaders?
- Is there too much emphasis when appointing senior staff in the RAC on clinical experience and academic qualifications as opposed to leadership
and management skills? Can you please explain your thoughts on this approach?

- Looking at this industry sector broadly, what leadership skills gaps exist in RAC from your perspective commenting on your colleagues?
- What are the major changes occurring in the RAC and what specific leadership skills are required to address these changes?
- Circumstances from my research indicate that difficulties are experienced in recruiting and keeping staff in this sector. Does this test your leadership skills? If so how?
- What major strategies are your organisation currently employing to resolve recruitment and retention problems regarding senior employees?
- Do you believe the government is providing effective leadership regarding the issues facing the aged care sector? Please explain your answer?

The transcribed data from the responses to these questions were arranged for investigation by tabulation. The interview data was first structured into a table with the columns labelled as interviewee pseudonym, interviewer question and interviewee response. Each row represented a single question and full response. The data was then further systemised and classified into primary themes based on the topics from the interview agenda, the literature previously examined and any common themes that emerged from the participant interviews. In utilising this type of interview and categorisation of themes approach, validity and reliability hinge on ensuring that the equivalence of meaning from each response is conveyed appropriately during the evaluation process (Denzin 1989).
3.9 Stage Two: Data Analysis

3.9.1 Extracting the main themes from the data

To draw out the main themes that arose in the interviews, the data were analysed at two levels. This was done without using software, as coding procedures can frequently lead to two problems that are not easily solved, namely an overload of codes and an overload of texts.

According to Welsh (2002) with the intention of understanding how the different themes interweave to form a whole, individual themes should first be analysed. This is difficult to achieve using Nvivo because to be able to connect each particular theme to other ideas; the researcher also needed to be able to examine and compare the themes with any notes taken during the two different analysis phases (Welsh 2002). The first phase was a descriptive analysis of the data based on the interview transcripts. For this, all the data were tabulated according to the responses of each participant to their respective semi-structured interview questions and commonalities within the responses were highlighted. The resulting information was helpful in making sure that all of the high-frequency words and patterns were included in the analysis to identify common themes from the data. This was utilising the inductive coding method of thematic analysis, which allows for the recognition of important moments in the research data and encoding it as a theme, before then interpreting the main concepts and themes that emerged from the data (Boyatzis, 1998).

In the second stage, a more interpretive approach took place where the transcripts were reviewed again and tabulated according to how each interview
response correlated to each of the four themes being examined. This stage identified where participants constructed similar or different significances or implications from similar questions in similar contexts. This stage supports the constructivist approach, which asserts that people undergoing the same experiences, can construct different meanings despite sharing the same phenomena (Crotty, 1998, Morrow 2005).

3.9.2 Thematic analysis as a qualitative technique of analysis

Thematic analysis was utilised in this thesis to analyse the interview transcripts from the eighteen participants in the research study. According to Daly, Kelleheah, and Gliksman (1997) and Aronson (1995), thematic analysis comprises searching for identifiable themes that materialise as being significant in explaining the social phenomenon being explored in the research study. It involves identifying themes from the transcripts through careful and thorough examination of the data collected (Rice & Ezzy, 1999). This approach to data analysis relies on pattern recognition within the collected data and the emergent themes that formulate the categories for evaluation (Fereday & Muir-Cochrane 2006). Thematic analysis is, therefore, a technique for isolating, describing, evaluating and recording themes and patterns within a data set in rich detail (Braun & Clarke, 2006). Thematic analysis is a widely used, yet somewhat poorly documented qualitative method (Boyatzis, 1998; Braun & Clarke, 2006), but it was integrated into the framework for this research study because of its ability to tell an interpretative story about the data in relation to a research question. (Braun & Clarke, 2006, Braun & Clarke 2014). Thematic analysis is also related to phenomenology in that it focuses on the human experience subjectively (Fereday & Muir-Cochrane 2006, Guest, MacQueen & Namey 2012). As phenomenology
emphasises the participants’ perceptions, feelings and experiences as the dominant object of the research, this allows them to talk about the research topic in their own words, free of restrictions imposed by the fixed-response questions typical of quantitative studies (Schutz 1967, Schutz 1970, Schutz 1973, Fereday & Muir-Cochrane 2006). A potential limitation of thematic analysis is that it is a poorly documented methodology, which is open to interpretation, particularly in higher-level analyses (Braun & Clarke, 2006). Nevertheless, the aforementioned benefits of utilising thematic analysis as the methodology for this research overshadowed this limitation.

There are two principal means for identifying themes or patterns in thematic analysis: by utilising an inductive approach and a theoretical deductive approach (Braun & Clarke, 2006, Joffe 2012). In the former approach, the researcher seeks to code raw data without trying to use a theoretical framework or the researcher’s analytic presumptions (Joffe 2012). Using this approach, the thematic analysis provides a comprehensive depiction of the data set as it relates to the general research question, and enables the more specific research questions to develop via the coding process (Braun & Clarke, 2006). In other words, the construction of key concepts emerges from the participants’ words and perceptions and they are participating in the research process as they drive the development of key concepts; allowing the researcher to recognise the value and importance of their construction of, and live experience of, leadership. Using the deductive approach, the analysis is more overtly driven by the researcher and focuses on a more meticulous evaluation of certain facets of the data, which are coded for each particular research question (Braun & Clarke, 2006). In summary, thematic analysis is employed to develop a description and seeks to explain various
themes within the research findings and is often related to preceding studies which align key themes and issues embedded in the literature review (Braun & Clarke, 2006).

In this research, a combination of approaches to thematic analysis was chosen. Firstly Boyatzis’ (1998) data-driven inductive approach was utilised to draw on the naturally occurring themes which emerge from the data itself (Joffe 2012). Secondly, a deductive approach, based on an analysis of theory and prior research which was outlined by Crabtree and Miller (1999), was employed to reach a further level of interpretive cognition. The inductive approach allowed for themes to emerge directly from the interview data using inductive coding. The inductive coding method required recognition of an important moment and encoding it as a theme before using a process of interpretation (Boyatzis, 1998). In this approach, the themes that were identified bear little relation to the actual interview questions being asked, and are also not motivated by the researcher’s theoretical interest or bias related to the field of inquiry (Braun & Clarke 2006). It must be noted here that it is impossible for the data to be coded in an epistemological void, as researchers are unable to completely disassociate from their previous theoretical and philosophical perspective (Braun & Clarke 2006). Moreover, it is essential to regard each set of data with awareness of prior findings in the research area to avoid ‘going over old ground’. Also, new knowledge can only be identified and examined by understanding and evaluating all findings that do not correlate with previous research and theoretical frameworks and have the potential ability to transform current knowledge of the research topic (Fereday & Muir-Cochrane 2006, Joffe 2012). Therefore, also using a process of deductive coding via the interview question themes, derived
from the literature review, assists in organising the data to isolate and develop themes. In this combination approach, the researcher can examine the data with certain predetermined categories derived from a theoretical framework and is also able to remain receptive to new concepts that materialise. According to Boyatzis (1998), a theme can be defined as a pattern within the data that at a minimum level outlines and categorises the potential interpretations of the data, and at best illuminates facets of the occurrence. This combined perspective enhanced the research questions by permitting the principles of social phenomenology to be central to the practice of deductive thematic analysis while still enabling clear themes to materialise directly from the information collected using the process of inductive coding (Fereday & Muir-Cochrane 2006, Joffe 2012).

After careful consideration, thematic analysis was considered to be the appropriate method for evaluating the data in this research grounded on a number of pertinent elements. Primarily, a review of the relevant literature resulted in a finding that there was a dearth of information on the skills and attributes required of leaders in RACS and the impact of HRM processes, workplace demographics and government policies on shaping these required skills and attributes. Secondly, the major theme of this thesis is to explore what senior managers, as leaders at the coal face of RACS, regard as being the greatest challenges for leadership in RACS and what expertise and abilities are required to meet these specific challenges, which cannot be accomplished by employing traditional quantitative methods of surveys and or quantitative analysis. Thematic analysis enables the garnering of information regarding the meaning made of the phenomenon under study by the groups studied and
provided the necessary groundwork for establishing valid models of human thinking, feeling and behaviour (Joffe 2012, Corbin & Strauss, 2008). Furthermore, if little is known about a topic and there are limited theories available to elucidate or forecast a group’s behaviour, thematic analysis is amongst the most organised and transparent research strategy available, in particular because it embraces the importance of the pervasiveness of themes, without forfeiting depth of analysis (Braun & Clarke 2006, Joffe 2012). Most importantly, thematic analysis allows researchers to access the workplace and speedily obtain an empirically based understanding of social occurrences, and analyse these occurrences without depending on existing theory, but by allowing theory to emerge through the recognition and analysis of themes which are important to the phenomena (Fereday & Muir-Cochrane, 2006).

In this study, methodological procedures follow the doctrines proposed by Britten (1995) in her study on qualitative interviewing in the medical field. However the analysis of the data will follow the practical data analysis suggestions in Braun and Clarke (2006) particularly in relation to their step by step guide for generating codes and then creating a thematic map of the analysis, which allows the defining and naming of themes for the final analysis. As per Table 3.1, Phases of Thematic Analysis, Braun and Clarke (2006) set out guidelines for creating codes, finding and reviewing themes that establish the properties and dimensions of the final themes that will be analysed.
This is very similar to Boyatzis’ (1998) model for transforming qualitative information into themes and codes below:

Figure 0 Transforming qualitative information: thematic analysis and code development, Boyatzis 1998

**Thematic Analysis**

While this research relied primarily on the accounts of individuals participating in the study, developing an understanding of how their individual views fitted within
RACS meant the analysis has to encompass more than one person’s experience alone. As the research concentrated on socially constructed findings based on the individual interviewee’s perception of required leadership attributes and skills, along with factors impacting the execution of those skills, thematic analysis was utilised to analyse the data for this research. Thematic analysis of the interview transcripts emerged as being the most useful and realistic method for analysing the data for this thesis. The reason for this is because the information elicited in a semi-structured interview with time constraints does not provide enough detail to interpret the interviewees’ explanations in a more narrative, case study style (Smith and Eatough, 2007; Storey, 2007). Consequently, to best utilise the data from the participants, thematic analysis of the interview transcripts was used to most effectively extract the shared patterns and themes.

As mentioned previously, thematic analysis is grounded on the work of Boyatzis (1998), Braun and Clarke (2006) and Fereday and Muir-Cochrane (2006). Thematic analysis was selected as the tool for analysis because it is a flexible, straightforward procedure, which not only enabled the research process to be informed by using a theoretical framework but was also able to identify and produce new insights. This technique was appropriate for recapitulating the major ideas within the data, countering the research questions, and allowing the evaluation of the different perceptions regarding the leadership of the various participating aged care leaders and managers.

Thematic analysis has been used effectively as a qualitative analysis tool (Boyatzis 1998). Thematic analyses seek to unearth the themes salient in a text at different levels (Attride-Stirling 2001) and are utilised by researchers from a
number of different academic fields, to enable them to gain understanding and awareness regarding their qualitative research data. Braun and Clarke (2006) advocate that thematic analysis is compatible with both essentialist and constructionist models and via the theoretical freedom it allows, thematic analysis is a flexible and expedient research tool, that can provide a rich, comprehensive and complex explanation of data. Boyatzis (1998) defined thematic analysis as a method for viewing, and a practice for converting, qualitative information to realistic conclusions via the use of codes and themes. According to Braun and Clarke (2006), a theme denotes a pattern found within data. To further explain this, Ryan and Bernard (2003, p.87) posit that themes “are abstract (and often fuzzy) constructs that link not only expressions found in texts but also expressions found in images, sounds, and objects”.

Stage Two – Data Analysis implemented a combined approach of inductive and deductive approaches to analysing the data. A basic analysis of the results from the interview process had been completed before they occurred via the literature review, which informed the questions to be asked during the interview phase. Unavoidably, this prior analysis will have impacted which patterns or themes took significance within the data. This supported by Braun and Clarke’s (2006) and Bendassolli’s (2016) observations that themes don’t simply materialise from the data, as they suggest that the researcher will actively identify these during and after the interview process. However, when analysing the interview transcripts, the objective was to identify any themes directly from the transcripts, rather than slot the data into already defined patterns. Regardless of that aim, it is to be expected that presumptions and biases from previous research and theory would influence the process of coding the information and determining the relevant
themes. However, as Braun and Clarke (2006) argued, data are never coded in a vacuum and researchers cannot free themselves of their theoretical and epistemological commitments. As outlined by Braun and Clarke (2006) in Table 3.1, during the thematic analysis process, the researcher fluctuates between the data collected, the coded pieces of data they have extracted and analysed at the time and the final analysis being formed.

Cognisant with the process outlined in Braun and Clarke’s (2006) table, the themes that emerged and were collected during this method were compared and contrasted with the patterns and themes that were discovered within the literature on leadership in RACS. While a more meticulous approach could have been taken by employing multiple researchers to undertake the data coding and developing the themes via dialogue with these researchers, the nature of a PhD study does not lend itself to this measure of collaboration and perspective.

3.10 Ethical considerations

3.10.1 Ethics and consent

In comparison to surveys and structured interviews, there is possibly a higher level of ambiguity and insecurity for research participants when participating in semi-structured, in-depth interviews (Di Cicco-Bloom & Crabtree 2006).

The National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council 2015) recognised that there are three predominant scientific rules that should oversee all research relating to humans. These include: (1) respect for persons – respecting personal autonomy and
protecting those with diminished autonomy; (2) beneficence – doing no harm and maximising good; and (3) justice – safeguarding non-exploitative procedures and ensuring unbiased distribution of any costs and benefits (National Health and Medical Research Council 2015).

In line with the RMIT University Human Research Ethics Guidelines, ethics approval was sought and approved by the Human Research Ethics Committee to undertake this research project. Furthermore, informed consent was provided and agreed to by all participants before the interview process. This included providing a copy of the interview questions prior to the interview itself; explaining how the interview process will progress and that new questions, deviating from the interview script may be asked based on the responses from the research participant, and as awareness of the phenomena in which you are concerned about is cultivated. Participants were also reassured that they have the right to withdraw from the interview process at any time. With reference to principle two, the probability of participant harm as part of this research was minimal due to the research focus, however, the guaranteed anonymity of the participant and their organisation acted to ensure that no repercussions from information divulged would occur for the participant. A mindful approach which confirmed this protection for the participants from such harm was nonetheless an important consideration. In terms of principle three, there are no real costs or benefits directly related to participation in this research that cannot be protected by the assurance that the researcher will: avoid undue intrusion, not use of deception, preserve anonymity, afford participants the right to check and modify a transcript and ensure the confidentiality of any personal opinions.
3.11 Limitations of the Methodology

There are some limitations regarding qualitative research. In this study, the limitations that can be identified include responder bias, researcher bias and effectively addressing these issues contributes to the trustworthiness of the research. There are no automatic or simple solutions to limit the possibility that there will be limitations in qualitative research, however, there are various ways of improving validity, each of which requires the exercise of judgment on the part of the researcher. Trustworthiness or rigour of research refers to the degree of confidence in data, analysis and techniques implemented to ensure the quality of the research (Pilot & Beck 2013, Connelly 2016). The most common measures used to gauge qualitative research are those proposed by Lincoln and Guba (1985). To cultivate trustworthiness in qualitative research, Lincoln and Guba (1985, 1994) offered five criteria: credibility, dependability, confirmability and transferability. Credibility refers to the idea of internal consistency and rigour in the research process (Lincoln & Guba 2004). Transferability is the extent to which the reader can generalise the findings of a study to her or his own context and dependability refers to the way in which a study is conducted is consistent across time, researchers, and analysis techniques; and confirmability is based on the recognition that research is never objective. (Gasson 2004).

In qualitative research, the researcher takes on a principal role in data collection and interpretation and must, therefore, be aware of any potential personal bias that may be applied when guiding a study (Yin, 2009). Along with the sifting of the data, the researcher’s own biases and assumptions can twist the result and weaken the internal validity of the research (Merriam 1998, Fraenkel & Wallen 2003). Creswell (2003) suggests that by disclosing the researcher’s biases, a
more open and honest description of the study’s results can be reported (Creswell, 2003). Reflexivity means sensitivity to how the researcher and the research process have moulded the collected data, which includes the role of prior assumptions and experience. Personal and intellectual biases need to be made plain during the research report to enrich the trustworthiness of the findings. A potential bias the researcher brought to the study was the experience of undertaking previous research regarding skill shortages in the aged care sector. Issues impacting leadership were raised by participants in this previous study, meaning there was some anticipation by the researcher regarding the concerns that might be raised by the participants and the problems they were facing. To address this, the researcher undertook a rigorous review of the literature and media commentary regarding the aged care industry and the challenges within it, which supported her initial thoughts regarding the challenges facing leaders in RACS. The methodology, however, did not extend to presenting findings to the participants for added commentary and observations. It is an acknowledged limitation in this research due to time constraints.

Eisenhardt and Graebner (2007) further suggest that a technique used to control for researcher bias is through the use of highly cognisant informants and preserving comprehensive ties to the appropriate literature. Van Maanen (1983) and Shenton (2004) also recommend the use, as a form of triangulation to address both researcher and responder bias, of a wide range of informants. This enables single viewpoints and experiences to be verified against others and, eventually, a rich picture of the attitudes, wishes or activities of those under analysis can be constructed based on the contributions of a range of people (Shenton 2004). These suggestions were considered and implemented
throughout the data collection process, with senior and experienced leaders in RACS, as well as leaders within the broader aged care industry, were utilised to provide both expertise and variety of informants in the study. Finally, across the interview process, the informants spoke with one voice in many respects and their views on leadership in RACS clearly reflected the findings in the ACLCF study, enhancing the trustworthiness of this thesis.

This chapter has described the research methodology, as well as the sample, data collection methods and data analysis involved. It has also outlined the ethical considerations relevant to the data collection and analysis. The following chapter will present the research findings.

**Chapter Four – Findings**

4.1 Introduction

The preceding chapters have described the background and literature review of this PhD research, evaluated the relevant literature, and outlined the methodology of the research.

To reiterate the purpose of this study was to answer the question: “What are the key competencies, skills, and attributes required of leaders in the residential aged care services”

The researcher used this study to discover whether there were any significant skills and attributes specific to the residential aged care leadership and what the complexities were regarding recruiting and retaining senior staff with those skills.
The research questions for this study were developed to elicit responses regarding four key themes that emerged within the research topic when undertaking a review of the literature. These were:

1. Leadership Skills
2. Industry Demographics
3. Government Regulations

The order of the four themes in this list reflects the order in which each theme was addressed to compile the data via the semi-structured interview questions. Within each of these key themes, certain patterns emerged resulting in a clarity regarding outcomes.

Eighteen participants in residential aged care or related roles participated in the research project. To preserve privacy, aliases were assigned to each participant. The participants all held high-level leadership positions at their respective Residential Aged Care Facility or were the senior leaders of their department or division. The participants were in charge of RACS that managed facilities or a number of facilities ranging from less than 100 beds to over 1000 beds. A table outlining the profile of the participants is below (Table 4.1)

<table>
<thead>
<tr>
<th>Participant Alias</th>
<th>Role</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ben</td>
<td>Manager Aged Care Facility – stand alone</td>
<td>40 years in journalism, publishing and Public Relations</td>
</tr>
<tr>
<td>Cherise</td>
<td>Manager Aged Care Facility – Local Government</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Charlotte</td>
<td>Manager Aged Care Facility – stand alone</td>
<td>Registered Nurse</td>
</tr>
</tbody>
</table>
The participants all had a wide and varied range of experience in the aged care sector, some with over thirty years specifically in aged care and others who were relatively new to the sector and had minimal aged care or health sector experience. The majority of participants, however, had a minimum of five years’ experience working in RACS. The experience of the informants is important to
understand as it speaks to their qualifications regarding being able to comment on leadership in RACS and to draw meaning from their own personal experiences as leaders, who see and deal with the leadership issues in aged care on a regular basis. The types of leadership positions were also significant because, despite the variety in leadership roles and experiences, data saturation still occurred by the time eighteen participants were interviewed. There is also a heavier reliance on the words of one or two participants, such as Ivan and Andrea, because of their experience in different roles across the aged care sector. They spoke with greater authority on some issues because of their roles in and across leading aged care organisations.

This Chapter will discuss the four themes related to leadership attributes and skills required of leaders in RACS that emerged in the descriptive analysis of the data: Leadership Skills, Industry Demographics, Government Regulations and Human Resource Management. This will be followed by an interpretive analysis of the data, which revealed eight additional sub-themes, or patterns within the themes, that materialised as key points of either similarity or clear difference, within the responses of the participants regarding like experiences and contexts.

4.2 Findings and Themes that emerged from the data

4.2.1 Leadership Skills

According to Fiedler (1996), the effectiveness of a leader is a key determining factor regarding the success or failure of an organisation. It has been argued that training and developing good leaders is paramount if organisations are to be able
to survive the growing unpredictability and instability of the external environment (Bernstein, 2014; George, 2007; Hennessey, 1998). Furthermore, there is an abundance of observational data in existence regarding the influence of effective management and leadership skills on the workforce, work environment, and care quality (Jeon et al. 2013). A continuing upsurge in the number of elderly Australian a needing aged care services requires an amplified need for the effective management of RACS (Productivity Commission 2011). As a result, there has been a greater recognition that effective organisational leadership capabilities must be identified and developed, given their effects on care quality, staff and client safety and employee productivity (Jeon et al. 2013; Productivity Commission, 2011; Meissner and Radford, 2015).

While this study followed a combined deductive/inductive thematic analysis approach (Boyatsis 1998, Clarke and Braun 2006, Bendassolli 2016), the narrative was also used within the constructivist tradition (Crotty 1998) to gather the participants’ stories of leadership, to construct meaning from their experiences. Steeves (1994) referred to the narrative as representing the —world in motion (p. 23), therefore, the first interview question was formatted in narrative form, asking for the participants’ story of leadership to provide a more dynamic quality to the interview. The responses to this were many and varied.

The background and experience of the participants fell into three different categories; those who came from a medical background with nursing qualifications, those who came from a health background without nursing qualifications and those who came from a completely unrelated vocational or industry background. Three of the participants with nursing qualifications had
worked in the acute sector in earlier parts of their career and entered the aged care sector as either a vocational change. As described by Chloe, “my background is in the acute sector I used to manage an operating theatre and I wanted a change in career” or because of changes to their circumstances as Charlotte (2014) explains, I “…did nursing and things happen in your life and I was married to a guy, we lost the business so I went back to school… [and got into aged care], or a specific interest in dementia, as Laura explained,

\begin{quote}
Well, I've been nursing for nearly 30 years. I've been in aged care for about 25 of that and within that time my pathway has taken me to dementia care, dementia specific care as an area of need, an area that has been neglected for a very long time and required someone to be the advocate for people that no longer can be for themselves. (Laura 2014)
\end{quote}

The participants who came from the health industry but were not qualified nurses, like Julia, had varied experience in health-related roles:

\begin{quote}
So my background is I’m an occupational therapist by trade. And I've worked in the public health sector in Victoria, and then spent 14 years at the Transport Accident Commission doing more claims related work and perhaps more disability focussed. And then spent three years at Australian Unity in their private health insurance business, and then came here. (Julia 2014)
\end{quote}

Andrea had a similar diverse background in health-related roles before entering the aged care sector:

\begin{quote}
I came through from a policy and a health, general health I guess, or hospital background. So started through the government. So ten years in government, then I went into private health insurance,
\end{quote}
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and then a couple of years consulting, and I went into Red Cross, so in the blood service side. (Andrea 2014)

Ivan was another participant with significant health industry experience with slightly different role focus and skill:

I have over, well almost 30 years’ experience in the health and aged care and community services sector; I come from a background as an industrial relations advocate that developed a workforce and HR planning, and strategic planning for associations, for government, and also as, for the unions, for the trade union movement, and also as a consultant. (Ivan 2014)

Finally, the third category of leaders, those with no health industry experience, came from the retail and retail logistics industry, journalism and public relations and consulting. It is important to understand the background and experience of each of the participants, as according to the constructivist approach, their historical and social perspectives will shape their interpretations of their current experiences regarding leadership (Crotty 1998).

The interview questions asked by the researcher that elicited the following responses were designed to focus the participants on the types of leadership skills they believe are important in RACS. There was a clear recognition by all participants that effective leadership skills are required within their organisation, if they are to be successful in the delivery of quality care and client satisfaction, as well as attracting and retaining a skilled workforce. When the participants in this study were asked what skills and attributes that they believed are required by senior employees in the RAC to be effective leaders, there were a variety of responses. Very few of the participants identified leadership skills that were
agreed upon unanimously by them all and many different skills and requirements for an effective leader in the RACS industry were acknowledged.

Communication
The one theme that all of the eighteen participants believed was important was that communication skills are an extremely important leadership trait in RACS. The ability to listen as well as to communicate effectively with staff, residents and their families were noted critical communication skills that were needed by leaders. In the words of, the CEO of a smaller boutique RAC:

> Communication. It’s basis of the whole thing. Yeah, problem-solving. They’ve (CEOs, Facility Managers) got to be smart, really, really smart, and be on the front foot with that stuff. But the communication stuff doesn't matter whether it’s, where it is, whether it’s with the department or whether it’s with the resident, or whether it’s with the staff, right across the board. If they’ve got really good effective communication skills that’s one of the biggest problems right across the whole industry.
> (Charlotte 2014)

This was expanded upon by Ivan (2014), Senior Manager in an Aged Care Industry Association, who stated:

> It’s about being a good relationship manager as well to those people that can sometimes be quite anxious and hostile and demanding, and sometimes they forget that there’s a lot of emotional input from relatives and friends and supporters and loved ones to the frail older person with the service that is being provided. (Ivan 2014)
One senior HR Director, with fifteen years’ HR experience in the Health Sector, Smiley (2014) commented that what she would consider “…HR management skills, first and foremost. So good communication, HR management skills…” are those that are especially important in RACS. She also indicated that this was a skill often lacking leadership roles, especially regarding dealing with family guilt at placing a family member into care, saying:

…because putting Mum and Dad into residential aged care is extremely difficult….. and I don’t think managers have got good skills in being able to have those conversations (Smiley 2014)

This was echoed by Cherise (2014)

A lot of the relatives have a lot of guilt about putting their loved ones there because they were supposed to look after their mum and dad… they get really upset so the manager has to sit them and talk to them so they’re more or less looking after the families too.

Glen (2014) remarked that leaders had to communicate effectively to so many stakeholders including ‘family members that you’re trying to keep happy, plus your residents’.

Karina (2014) commented in a similar fashion saying that as a leader in a RAC, ‘you’re not only dealing with that person, you’re dealing with the family’.

Learning to communicate with all of the stakeholders involved in RACS is seen as a difficult skill to learn by Julia (2014) who said:
You’ve got to be able to learn to take on that authority, to be able to talk to families, to be able to talk to general practitioners, with a sense of authority - and I think that’s a really tricky thing for people to learn.

Andrea concurred with this view, saying:

I think what you’re going to need is you’re going to need managers that are more able to deal with families and manage their relationships

Being able to communicate sensitively with family members of residents was a particular theme that has not been covered to a great extent within the limited literature on aged care leadership. There have been some studies (Kellett 1999, Pillemer, Suitor, Henderson, Meador, Schultz, Robison & Hegeman 2003, Edvardsson, Fetherstonhaugh & Nay 2010) regarding the impact of effective communication between family members and residential care staff. However, there has not been any significant research regarding the importance of a RACS leader’s ability to successfully communicate with residents families, and the impact this has on their leadership effectiveness. The concentration on communication as being an important attribute for RACS leaders has generally been focused on their ability to communicate effectively with staff and residents in the literature and has assigned the importance of communication with resident’s families to the paid caregivers.

Another senior facility manager, Laura (2014), noted that communication is essential in motivating others to work together, but is an area in which many RACS managers are lacking:

If you can’t communicate and inspire others, no matter who they are, nothing is going to move forward, there’ll be no growth. So you need to have those type of skills and there’s
lots of managers that have no communication skills.
(Laura 2014)

Compassion

Another attribute that was widely regarded as critical to good leadership in RACS is being caring and compassionate. A director of an aged care facility will be involved in handling situations with residents, their families, staff and contractors. According to Ben (2014), a facility director,

I think you need to have compassion, an attitude that the residents and their wellbeing come first above everything else... (Ben 2014)

This was echoed by Bart (2014), the CEO of a large aged care organisation, who said: “We probably need more compassion, more caring, more understanding of older people…”. Sarah (2014) confirmed that compassion is a required attribute in aged care leadership, saying, “You have to be compassionate and you have to have a passion for what you’re doing.” Laura (2014) expanded on this by explaining, “to truly lead then it’s about inspiring these people to want to make a difference and believe in your dreams.”

Louise (2014) elaborated even further, implying that the residents were owed compassion at this stage in their life:

“I always come back to compassion and empathy, I guess, that’s a big one. Because these people have gone through their whole life, and they’ve all got a story to tell. And you know, where they’re at now at the end of life, you know, it’s not very nice having a nurse run in there and giving them what for and pushing them through everything.” (Louise 2014)
Emotional intelligence

Despite the consensus regarding the need for compassion in a leader, interestingly, only two participants cited the need for a leader in a RAC facility to have emotional intelligence. Emotional intelligence (EI) refers to “…knowing and handling one’s own and others’ emotions.” (Salovey and Mayer in Boyatzis, Goleman and Rhee, 2000, p2.). According to Freshman and Rubino (2002), healthcare is an industry that should be synonymous with having leaders with high EI, particularly in RACS, as they face some of the most significant problems facing health-related organisations. This includes having to provide safe and high-quality service to their ailing residents, often with limited financial and human resources available. Ivan (2014), who named EI as a required quality in RACS leaders, said the following:

One of the first things you notice when you come into this industry is that people need a very high level of emotional intelligence because of their interface with very vulnerable people who are frail and older people, some of them from culturally diverse type of communities and the workforce as well. It’s pivotal and essential that these people have a high level of emotional intelligence. Part of their leadership skills in their toolbox, they also need to be able to engage, and relate, and deal with conflict resolution at a very early stage. (Ivan 2014)

This was supported by Cherise (2014), who stated:

When it comes to leadership skills it’s not managing others, it’s almost, sort of, managing oneself. One self’s time, and be able to sit back and look at it and analyse it, and not, and the emotional intelligence is really important; when to respond, how to respond, or when not to respond, when just to listen. Be supportive to staff no matter what happens so that they can come to you, and they will come to you. At the same time, you have
to listen to families no matter what they say about your staff. (Cherise 2014)

It is interesting that only two participants felt compelled to regard this as a required skill, as in recent years, research has paid growing attention to the part of relationship management proficiency and emotions in organisational effectiveness and health leadership (Skinner and Spurgeon, 2005). This may be because there is unfamiliarity regarding naming the concept of EI or it may actually something that people in the industry don’t think is important. This may come back to the issue referred to in the literature review, of not recognising certain skills because they are done by women and are seen as innate, like compassion, rather than something that can be learned and adopted (Cortis & Meagher 2012). It may also mean that the participants use the concept of compassion in place of EI and of which compassion is a key component (McQueen 2004). Moreover, while there have been studies concerning the emotional competencies and abilities that are required for future leaders in healthcare organisations, along with the requisite balance between clinical skills and sound emotional intelligence attributes, there has so far been a limited application to the aged care sector (Bass and Alvolio 1990, NHS, 2003, Weiszbrod 2015, Crowne et al. 2017).

**Strategic Vision**

Seven participants (Bart, Cath, Liza, Ivan, George, Ben & Charlene 2014) referred to having a vision as an essential leadership attribute. There has been a growing interest in the notion of organisational vision, particularly regarding effective leadership and as a demonstration of leadership capabilities (Larwood,
Falbe, Kriger & Miesing 1992, Boyatzis, Rochford & Taylor 2015). This was echoed by Bart (2014), who mentioned that good leadership is

“…I think largely it’s being able to create and sell a vision. And whether that’s in charge of an organisation or whether it’s in charge of a department or whether it’s in charge of a home – being able to create the vision to be able to enthuse people…”. (Bart 2014)

Cath (2014) noted that in addition to compassion and communication skills, leaders need to take into account that “…there’s a vision for the organisation also, so you build on that vision…” to be effective and inspire your staff. Liza (2014) augmented this point of view by saying “the daily workload is often such that people either are not aware of the need to kind of step back and think of the bigger picture” and most don’t have “the skill to be able to see that that’s necessary as a leader and a manager and then act to create space to look for the bigger picture”.

**Strategic Thinking/Planning/Innovation**

The next question addressing leadership skills and attributes asked what leadership skills gaps exist in RAC as an industry. Many of the responses echoed the skills and attributes they had previously cited as being essential for leaders in RACS, suggesting that current leaders in this industry do not, in general, possess the relevant skills (Charlotte, Ivan, Laura, Julia, Ben, George, Liza, Madeleine & Bart 2014). There was a sense that vision and strategic thinking were lacking within the current industry leadership, as stated by Charlotte (2014):

_They’re reactive managers. They’re not strategic thinkers. They’re not strategic, they don’t know. You’ll talk to an aged care manager running a facility, there is no strategic thinking at all._ (Charlotte 2014)
This was further elaborated upon by Laura (2014), who said:

“if I was actually to pick one thing, and when I go to meetings, when I hear people talking, people are just too narrow and I think outside the square.”
(Laura 2014)

Ivan (2014) also indicated that this was an issue when talking about the skills needed but not necessarily possessed by leaders in RACS:

“they’re conflict resolution skills, the emotional intelligence skills; there’s a real lack of being able to manage and blend those tactical skills that are so essential in delivering care and services to older Australians with those strategic leadership skills; having a head for strategy.” (Ivan 2014)

The need for vision and strategic thinking was a significant requirement for leaders of smaller organisations, as voiced by a number of the participants (George, Cherise, Ivan, Laura, Madeleine, Sarah & Charlotte 2014). These participants were of the firm belief that the small, independent aged care facilities are being forced to close because of rising costs and an inability to compete with the bigger groups moving onto the market, for qualified staff, infrastructure and capital. They see strategic thinking and vision as a requirement to survive in this climate where aged care services are being rationalised. This was expressed by Ivan (2014) as follows:

*It’s important that they have a good strategic head about the market going forward, their place in that market, where they’re situated, what partnerships of mergers, acquisitions, collaborations that they can enter into to ensure their survival.* (Ivan 2014)

George (2014) added:

“We certainly found small providers who were the most likely targets for amalgamation being worried that they would lose their, they were
essentially set up by communities and they thought they would lose the whole community focus. At the same time, they were absolutely struggling and bleeding and had dysfunctional boards” (George 2014)

Cherise (2014) expanded on this:

“The changes, I would say one of the things that I noticed are these large players from overseas coming in. So they run it more like the factory business. They’ve got the pink carpets and the pink curtains and the number of staff. So we have to compete with them, and that there is no capital allocations. (Cherise 2014)

Ivan (2014) summed this situation of smaller homes requiring strategic thinking and vision to survive in this manner:

I think we’re going to see some of them struggle to find a niche market for their facility. We are concerned that it is important that businesses prepare themselves during this time of reform, and reposition and realign. We’ve told our members that they really need to consider their collaboration strategies and working with other organisations within the region, understand the market at which they’re going out to older Australians to, for their facilities (Ivan 2014)

While it was recognised that vision and strategic thinking were areas where skills gaps existed, many of the participants also went on to explain that in many cases because the industry is so compliance driven, that there is no room for vision and innovation (George, Liza, Karina, Charlotte, Ivan, Bart, Ben & Cherise 2014). This was outlined by Karina (2014):

“it is so compliance-driven, it’s actually strangling any innovation and any innovation in leadership that I see.” (Karina 2014)

Liza (2014) echoed Karina’s viewpoint regarding the stifling of vision and innovation by industry workload and compliance:
“The pressure of the daily task, the daily workload is often such that people either are not aware of the need to kind of step back and think bigger picture, or they're just unable to find that space.” (Liza 2014)

Julia (2014), who is in a leadership position in the head office of a larger RAC organisation, reinforced this view, saying of the facility leaders:

“in order for the business to survive there’s the innovation, the project work, the best practice, and I think sometimes there’s a sense of “Well my job is to manage the site, and you guys can worry about the future” (Julia 2014)

General business management and budgeting skills were other areas highlighted as essential skills for leaders in RACS (Ivan, Julia, Laura, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014) and also an area where there are skill gaps, as outlined by Julia (2014):

“I think that there are gaps definitely in the business area. And that’s not so much, as I said before, about being an accountant and being able to read the reports, but really just about understanding that at the end of the day even in a big organisation like this we expect each of the sites to be able to operate financially on their own, and that being able to be flexible about the way you work is actually an important thing.” (Julia 2014)

These business management and innovation skills also include the ability for RACS leaders to promote their organisations to potential staff and clients. Smiley (2014) commented on this saying:

“the other element that’s probably missing quite significantly for residential aged care is sales and marketing, is to be able to market the services to external people” (Smiley 2014)

Cath (2014) echoed this view:
“leaders are going to have to have some sort of innovation type and marketing skills as well” (Cath 2014).

The development of leaders with these skills is a key challenge for the sector as it transitions from a government-provided service sector to a marketised sector, as business skills have not traditionally been required in this sector but, with such changes, are now increasingly in demand (Weerawardena & Sullivan-Mort 2001, Booth, Roy, Jenkins, Clayton & Sutcliffe 2005, Jeon et al. 2015). In particular, strategic thinking is a concept applied to business as a tool for seeking a competitive edge (Haycock, 2012). Karina (2014) pointed out in the face of competition and change that exists in today’s aged care industry, it is important that leadership “becomes then more about strategic focus, business development, business improvement, those sorts of things, where you’re always putting the value back into your business”, if a RAC facility is going to move forward toward a new and more successful future.

Financial Skills
A significant skill that was mentioned quite frequently by participants was the ability to budget and manage financial and commercial aspects of an aged care facility (Ivan, Julia, Laura, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014). This appears to be expertise that has not previously been as important to leadership in RACS until more recently. As Julia (2014) pointed out:

“There’s the business side of things, and I think that’s where the difference has been over the last five to ten years, is that there’s a much greater emphasis on the commercial realities of running a site, and I don’t think that that matters if you’re a standalone small place or part of a larger organisation. That’s the reality of it. So it’s not about even coming with an aged care background, although I think that helps if people have had some
exposure to it, if they’re at a site level. But it is about being able to understand what the things are that will make a difference. Not necessarily to be accountants but they do need to be able to read some basic documents. And they need to know that if they do or don’t do certain things it will have an impact on the financial viability of a site.” (Julia 2014)

This was further supported by Laura (2014), who stated:

*You need to have financial business skills. So you would need to be able to look at frontline management, you know, and leadership in regards to running a business. If you don’t have that you can’t possibly run a business like this because there are too many aspects vital to you being able to maintain a building, provide everything that is required in regards to living, like eating, drinking, you know linen, all those types of things, wages, you know management of staff, all those types of things.* (Laura 2014)

Charlotte (2014) echoed this sentiment:

*“Very little understanding of finances, how finances work. They’ll know, like a nurse will know the recurrent funding, they’ll know the recurrent funding, but they don’t realise the worth of it. They don’t, they hear you talking in millions of dollars, but there’s lack of that education because they don’t understand budgeting. They think it all runs on love.”* (Charlotte 2014)

It appears from the number of participants who cited finance, business and budgeting skills as a required skill for leaders in RACS, that this is a clear area of skill development for the future, as they believe it is currently lacking in their organisations.
Managing Change

Finally, the ability to manage and implement change was highlighted by eight out of the eighteen participants as essential skills for leadership in RACS (Ivan, George, Liza, Ben, Cath, Andrea, Laura & Charlene 2014). This is an interesting outcome because all of the participants referred to changes that were and would be occurring in the aged care industry, but not all recognised the need for leaders to be able to manage this process!

Ivan (2014), however, regarded this as an extremely important skill as follows:

“the ability to help an organisation get through and thrive and change and re-form and make the most of the changes that were occurring and navigate their way through just the labyrinth of regulatory and market structural changes and just the changing expectations of consumers or customers and all of the other things, so dealing with change and lifting their organisations to help, transforming them from being nursing homes into something that was far wider and far deeper in its services.” (Ivan 2014)

Charlene (2014), who is the facility manager for a local government RAC also recognised change management as a required skill for leaders, and said when recruiting other facility leaders “we looked at their leadership skills and their ability introduce change and looked at the culture of the environment…” (Charlene 2014)

Human Resource Management

Ten of the participants pointed out that Human Resource (HR) and people management skills were also required but not generally held by leaders in RACS (Smiley, Andrea, Cherise, Charlotte, Greg, Liza, Charlene, Cath, Ivan & Ben 2014). As Smiley (2014) pointed out there are:
“...huge gaps in terms of true capability people management skills to be able to manage the day-to-day issues that come up.” (Smiley 2014)

Andrea (2014) also supported this viewpoint by stating:

“And so I think what you’re going to need is you’re going to need managers that are more able to deal with families, manage relationships, manage a business”. (Andrea 2014)

Cherise (2014) expanded on this, by explaining that people management skills were important for managing both staff and residents’ families in RACS, but were lacking in the industry:

“So those skills, I think the people management skills. So in some ways, it is how to deal with people and how to manage people. Because that’s what you do. You’re managing people who are doing the work. And that’s the gap.” (Cherise 2014)

Clinical Skills

An interesting finding that emerged from asking participants about the required leadership skills and current skill gaps, was that there was a clear divergence regarding whether it was imperative for a leader in RAC to have clinical skills, as well as management skills.

Almost half of the participants were of the view that recruiting leaders based solely on their clinical skills meant that vital management skills, which are now being required in this industry, were missing and this would have a negative effect on RACSs (Charlotte, Cherise, Cath, Ben, George, Liza, Madeleine, Ivan & Charlene 2014). As Julia (2014) put it:
If I just start by saying some of the more senior people who’ve got a clinical background are old school nurses, and therefore their leadership style is like what you remember from your childhood with those movies with the matron and the big white triangular hats walking down the corridor, and much more of a hierarchical way of working. (Julia 2014)

There is a view that the medical model of management often practised by nurses managing and leading in aged care is outdated and ineffective, as mentioned by Ivan (2014):

“This is not acute where one stays for a week there is care to the resident’s illness rather that the whole person, we look at holistic care. Somebody who is depressed may have a wound, you know that’s not healing but you look at, have to have a look at the depression also. Whereas those in the acute concentrate on the wound care first and tend to treat that first without looking at the whole person. So we have to retrain them and we don’t want a medical model where they are giving pills for this and that. “ (Ivan 2014)

George (2014), a leadership consultant in the aged care industry agreed with this view, stating:

Yeah, they’re clinicians. They’re managing the clinical area but they don’t have the capabilities that we need for the more general management roles. (George 2014)

This was further supported by Cherise (2014):

“So they tend to look at people who hone in on nursing and clinical skills and making sure we meet the standards. But that’s not about management. Management is a lot more than that. Management is managing. And that means people managing and issue managing and service managing. So you need somebody who need[s] to manage all
that, and that means people who’ve got leadership skills. Because leadership skills help people manage everything.” (Cherise 2014)

Cath (2014) also pointed out that there were changes in the industry that have driven a need for an emphasis on management skills over nursing skills in RAC leaders:

“If you’re looking at the involvement of aged care and leadership, it’s generally been, not so much, definitely not now, but the leadership, it was driven by the unions a lot too. Because a nursing home had to be run by a director of nursing. And a director or nursing was anybody you could get who’s a registered nurse, and we just elevate them. So that leadership component really wasn’t an emphasis. It certainly is now. Because you may have a nursing home, you may be running 90 beds, but your manager may not be a nurse at all. But that’s working okay because most people have a care manager, which replaces. So the care manager is in charge of care. The manager is in charge of the site.” (Cath 2014)

Ben’s (2014) experience in coming into a leadership position in his RAC facility echoed Cath’s views:

“Members of the committee were aware of my management background, and since they were unable to secure the services of appropriate industry professionals (who were probably, and rightly, unsure of the home’s future and, therefore, reluctant to put their hands up for the job) felt that anybody with a high level management background, even outside the aged care sector, would be better than having no manager at all. The Director of Nursing at the time refused the invitation to take up the role. For me, I quickly learnt not having a nursing or healthcare background wasn’t as much a disadvantage as most people thought. Being able to identify the right individuals for the right jobs was more important, and the quality of the team behind you is critical.” (Ben 2014)
There appears to be a pattern evolving whereby the larger organisations are ensuring that they have leaders with management skills leading a facility or department but are supported by staff with relevant clinical skills as pointed out by Charlotte (2014):

“We’ve got the nurses look after the care, and I’ve got a business person that looks after all of the other hotel services. Yeah. And admissions and sales, and yeah. So it’s a flat structure. Aged care, … in big organisations you won’t find it but in smaller organisations like this you will find it where they’ve, one person [who] could be holding four or five portfolios.” (Charlotte 2014)

While some participants roundly supported the need to have leaders with management skills rather than clinical skills, almost half disagreed with this completely (Laura, Andrea, Bart, Karina, Sarah, Gary & Julia 2014). According to Andrea (2014), much of this view is based on minimising risk:

It’s often brilliant clinicians who have been pushed into management roles. And it’s almost like we hold on to wanting that clinical experience because a lot of the risk around running a facility is around clinical risk. And so I think we think it’s better to have someone who has clinical knowledge in those roles, even if they’re not delivering direct care, just so they can manage the risk around clinical care. (Andrea 2014)

She added:

There’s a sense that if you put somebody in a role like that that doesn’t have aged care experience and you’re putting them in a management role, or they don’t have clinical experience, that you potentially could be seen to be not acknowledging the responsibility by not putting people with those sort of skill levels in there. (Andrea 2014)
Laura (2014) believes that leaders need to have clinical skills so that they can model correct care:

Well, you need to be definitely a registered nurse because if the majority of your staff are personal care workers, ENs and RNs obviously you need to be the one that’s able to lead them and direct them and give them the skills and the tools to enable the quality to be provided. If you don’t have that yourself how can you possibly support, guide and advise your staff (Laura 2014).

Laura (2014) further elaborated this viewpoint by saying:

Really if somebody’s coming into it just from the business perspective you’re going to lose your resident focus. And you’re going to have staff that you cannot educate in regards to that clinical side of it which is vital. You know if you can’t perform the basic care needs of each person and if your manager doesn’t even understand them because they’re not even a nurse or have a clinical background, there’s no possibility that that’s going to be successful (Laura 2014).

This observation was further supported by Karina (2014), who works in a large RAC organisation and oversees a number of facilities:

They have to be a registered nurse. That is part of our selection criteria because it is all about the care. And in order to do that we actually, some are, you know, different. It would be interesting if you spoke to [a large for-profit organisation] because I know they trialled a model of service managers or facility managers and they, some of the groups have looked at non-clinical and have looked at more of the hotel type of manager. That might have been okay now but we can see what’s happening with the residents that are coming in and they are becoming more of an acute setting, which is why we believe they do need to be a registered Division One Nurse. (Karina 2014)
Ivan (2014) summed up the clinician-management skills dilemma as follows:

> Now there is a cohort that’s grown of recent times that are not clinicians and they have a clinical care coordinator; there’s been a mixed reaction to that type of leadership in aged care facilities. Some are astoundingly good business leaders, but they have to have someone there that gives them the clinical context to deliver care and services to the client in aged care facilities. So one of the things that we’ve discovered, the essential part is being able to demonstrate business leadership, but also clinical leadership. So the framework has to be able to accommodate clinical governance, principles, as a leader, as well as business principles to be able to run a business in age care. So you’re running, what we describe in HR parlance as a “juggler”, are juggling a whole range of portfolios or responsibilities, of clinical responsibilities plus also HR responsibilities, plus leadership responsibilities.

Madeleine (2014), a GP to aged care facilities added to this view by saying:

> Larger, more corporate organisations will be able to get away with employing managers with no clinical skills as they can afford to also employ staff with clinical skills to advise them, but smaller organisations must have a manager with clinical skills to be able to provide the growing levels of medical care required in aged care homes” (Madelaine 2014)

This argument appears to be as much about organisational culture in RACS and the requirement to maintain a culture of care as the industry is being pushed to operate more like a business (Baines & Cunningham 2015). This is a crucial aspect of leadership in this sector that arises out of the changing pressures on the sector and is regarded as an irreconcilable difference within the industry. It is also a clear point of difference with other leadership roles in other sectors.
The participants were also asked what major changes are occurring in RAC and what specific leadership skills are required to address these changes, which elicited a variety of responses.

**Dementia Knowledge**

One of the major changes creating challenges for leaders has been brought about by the government’s “Ageing in Place” strategy. This means that people are remaining in their homes longer and according to some of our participants (Sarah, Karina, Charlotte, Gary, Julia, Ivan, Bart & Laura 2014), coming into a RAC service solely for end of life care. This links clearly back to evidence from the literature review, which found that due to better health and longer life expectancy, elderly citizens are entering aged care facilities at a later age and with a greater likelihood of having developed serious illnesses such as dementia (Intergenerational Report 2010). According to Sarah (2014):

*When someone goes into an aged care facility the time is now a lot shorter from that until death. So we know staying in a person’s home, buying in those services, whether it’s shopping services, cleaning services, just general going in and looking after mum and dad, if all the family are at work during the day, is much better for them mentally and preventing the onset of dementia earlier by staying in their own home. ... because they’re coming in sicker and sicker and that’s going to get worse and worse. So actually what they’re doing is they’re coming into what needs to be more of an acute setting than an ageing in place* (Sarah 2014).

Laura (2014) supported this viewpoint:

*My pathway has taken me to dementia care, dementia specific care as an area of need, an area that has been neglected for a very long time and required someone to be the advocate for people that no longer can be for...*
themselves…so interventions that we put in place are different to the norm and allowed that higher level of care to be provided but also to enable the people living with dementia to continue to live their life in a way that is fulfilling for them but also allows them to thrive and not deteriorate. (Laura 2014)

This is an important consideration for current and future leadership in RACS, as leaders are perceived to not only require leadership and management skills in terms of successfully operating an organisation, they are also regarded by stakeholders as needing to have the requisite skills for effectively dealing with dementia residents and their families, as part of their leadership skills package (Etherton-Beer, Venturato & Horner 2013). The increase in RACS residents requiring specialised dementia and other acute illness care is serving to change how stakeholders construct the ideas and skills of leaders in aged care. Person-centredness of care has more recently been defined as a central theory for dementia and aged care and as a gauge of high-quality care (Edvardsson, Winblad & Sandman 2008b, Brooker 2004). Therefore, the link between high-quality care, person-centredness and dementia has resulted in aged care stakeholders to construct a need for RACS leaders to lead the way towards implementing a person-centred philosophy and practice of care, using a model of shared or distributed leadership (Backman, Sjögren, Lindkvist, Lövheim & Edvardsson 2016)

**Palliative Care Skills**

Charlotte (2014) also shared this view and explained that there will be a greater need for palliative skills and skills for coping with grieving families in RACS:
I think what you’re seeing, I think we need to become palliative care experts. And that’s where I see the nursing side going, into becoming palliative care experts. I think where you will be able to buy that much stuff to stay at home, what you’re going to, people are going to push and push and push, and use all that money to stay at home before they come into care, so I think the turnover in care will be as little as six months. [So people will be] coming in to die. Yeah. And so I think the whole focus on what we currently provide in this environment is going to be hotel type services but in an environment that is so comfortable, and it’s going to invite all of the families. Because you’re talking about mass grieving (Charlotte 2014).

Challenge of the Baby Boomers

Another change that had participants expressing concern and highlighting as a challenge for leaders is the commencement of baby boomers coming into RACS and the differences they will have regarding expectations of care (Bart, Andrea, Charlotte, Ivan, Laura & Charlene 2014). According to Bart (2014), there is a major challenge in providing the type of care environment they will demand, as well as being able to deliver safe and appropriate care:

With the Baby Boomers coming through......how are you going to meet those needs, how is the organisation going to caring for them? The expectations of the workforce, the expectations of relatives, and the clients are expecting a high quality, and it’s the environment that they’re looking at five star type accommodation, but how you design care and services in five-star accommodation when there’s very, very limited money. And there’s also requirements to ensure that it’s the workplace, so......you know, you’ve got to be careful and you can’t design it like a hotel because you have to deliver care and services in there (Bart 2014).
This was further elaborated upon by Andrea (2014), who highlighted that baby boomers will want quality care but delivered in a very different way than how it is currently delivered:

So on site, I think the way aged care is going now is there’s going to be a much greater emphasis on business skills, but also on customer service. On focus on families and not just on that clinical care. I think the change in the sector with the Baby Boomers coming through, so they are 64 plus, when they come through they’re going to expect a level of care which is, they’re going to expect the clinical care that we give now, without a doubt, but they’re going to expect it to be delivered in a very different way. And so I think what you’re going to need is you’re going to need managers that are more able to deal with families, manage relationships, manage a business than you are needing real people with really heavy clinical skills. That’s my general sense of what’s coming (2014).

Charlotte (2014) reiterated this view:

Those who are coming in now are looking at the whole patient, how they big is my room, you know do I have to share with somebody, what’s the en-suite like, what is the rest of the place like, is there computers, you know because they are paying for that service. So it’s becoming more like a user pays system. So, therefore, those who want, you know the pink carpets and the television will also pay for that plus the nursing care which is funded. And the families nowadays too are demanding much more than the basic model of care, which is a room, and you know a bed, so that they are expecting more (Charlotte 2014).

This leads into the next theme within this thesis, that of government regulations and funding.
4.2.2 Demographics

Ageing Population

Australia’s ageing population is a well-recognised challenge for those currently in public policy-making roles. Nevertheless, an understanding of this issue does not necessarily convert to an appreciation of its consequences for both government and Australian society. In fact, it is clear from the participant responses above, that the aged care sector and subsequently its workforce, have not received adequate responsiveness from government to ensure that policy consideration is directed towards improving leadership within aged care and guaranteeing the creation and retention of a suitably skilled workforce to ensure care needs of older Australians are adequately met (ACSA 2016. Productivity Commission 2011).

According to ACSA (2016, p.5.), “aged care is a ‘people business’ that involves people providing care and support to other people”. The ageing population also points to a relative decline in the ratio of working age people to those requiring care. Furthermore, as the Australian populace grows older, inevitably the requirement for appropriately skilled workers increases, in order to be able to deliver care and support to growing numbers of ageing Australians, adding yet another dimension to the skills and attributes required by leaders in this industry.

Ageing RACS Workforce

According to Montague, Burgess & Connell (2015), employees aged over 45 years old comprised 58 per cent of workers in the industry, compared only 38 per cent of workers in all other industries. The numbers of RACS care workers aged 55 years and over has also grown considerably in last decade, from 11 per cent of the workforce in 2000-2001, to 27.3 per cent in 2010-11(King, Mavromaras,
Furthermore aged care nurses now have an average age of approximately 50 years, and as a result of skills shortages and growing numbers of aged care clients, they are progressively more likely to have to supervise more residents and more employees as part of their role, regardless of being paid ten per cent less than nurses in the acute public sector (Willet 2012). Interestingly, the participants interviewed for this thesis generally did not recognise the potential impact the ageing population and workforce will have on their ability to lead their organisations. Only three of the interviewees (Ivan, Laura & Andrea 2014) referred the ageing population as being a concern.

Ivan (2014) pointed out that the current workforce in aged care is also ageing:

_We’re an ageing workforce; we look after older people but we also, the predominance of people that work in the aged care industry are over 48, they are female_ (Ivan 2014).

Laura (2014) indicated that many of the aged care organisations and the government were not prepared for the ageing workforce and its impact:

_But as an ageing population and a growing population we all know elderly people, we’re all going to be elderly eventually, we’ve all got parents that are getting elderly, the baby boomers are coming to the forefront, I think that they do need to look at that and prepare themselves better for it and ensure that we are prepared for it as well_ (Laura 2014).

Andrea (2014) acknowledged that her organisation’s workforce was ageing and that aged care was regarded as an end, not a start, to a career!

_We seem to get them at their end of career coming into aged care or we see people that have been sort of kicked out of the acute sector and think, “Oh, I’ll give aged care a go”_ (Andrea 2014).
Skills and Staffing Shortages

Not only is the RACS workforce ageing, but the aged care sector faces significant competition regarding recruiting skilled workers, with the growing skill shortages in this industry expected to worsen (Productivity Commission 2011, Montague 2011). According to Spoehr and Barnett (2008), the aged care sector faces the dual stresses of being faced with a significant increase in demand as the population ages, during a period when recruiting and retaining staff is becoming more challenging as more people are forecast to retire from the workforce than join it. Furthermore, there are major threats to the future supply of nurses in RACS, with falling enrolments in nursing undergraduate programs worldwide, and this is a worldwide phenomenon, and an ageing nursing workforce (Fletcher 2001, Daly, Jackson & Mannix 2003).

The participants recognised in many instances that there is a skills shortage and many struggle to recruit appropriately qualified workers. Ivan (2014) explained as follows:

We’ve got a critical shortage of nurses, so we are really looking to underpin our leaders at the moment. We’re an ageing workforce (Ivan 2014).

Andrea (2014) regards the issue of having enough skilled workers to maintain an effective aged care sector as critical:

Fundamentally the way that the industry is positioned generally from a workforce perspective that’s where we’re going to fail. Even if they put money into buildings, even if they give us more funding, if they don’t address the workforce shortage and the perception, it’s not going to change (Andrea 2014).

Cherise explains that this skills shortage extends to senior employees as well:
There appears to be a shortage in the sense that we need those who just don’t know clinical care but they need to be good managers and managers of people, human resources management. We find nurses who have gone up the ladder are, you know they’ve gone to unit managers and in charge of a ward or a wing and then become directors of nursing but we just interviewed six, seven people for a manager’s position here, we found that they had pockets of skills or expertise but as a total we’ve found there was a lack (Cherise 2014).

Gary (2014) agrees that there is a shortage of appropriately qualified senior staff available to recruit for RACS:

Yeah. I think, yeah, senior staff, it’s hard to get, senior staff that we want, well I’d like, nursing staff from my senior staff, just because they got the background knowledge of everything that happens (Gary 2014).

Charlotte (2014) confirms this view that there are not only skills shortages within the normal care workers but nurse leaders as well:

If you could find a nurse who has got excellent leadership skills, that can marry care and leadership together, I’m telling you it’s worth heaps, gold. People would pay gold for it (Charlotte 2014).

Some of the other participants emphasised that it wasn’t a lack of available applicants that was a problem, but getting those with the right skills, capabilities and personality traits that was the real issue for them.

According to Julia (2014):

I would say it has taken a long time for me to recruit some roles. Now that doesn’t necessarily mean that you don’t get applicants. Part of my issue is about the quality of the people coming through. And I don’t think I set particularly high standards (Julia 2014).

This was supported by George (2014), who believes while skilled workers are hard to find, the pay is a deterrent:
I don’t think there’s a shortage so much. It’s just, maybe there’s a shortage of skilled workers I guess, of finding skilled workers, but I think they’re out there. I just think that the pay is so low, the pay’s at a lower grade, nobody wants to do it (George 2014).

Ben (2014) believes that there is a shortage of the right people and that people are not being appropriately qualified by the educational institutes:

I do believe there is a shortage of suitably qualified people to work in the sector. The tertiary institutions are churning out ‘qualified’ individuals but these qualifications are largely academic, seldom practical and often irrelevant as the educational institutions themselves are often under-resourced (Ben 2014).

Migrant/Overseas Workers

Cath (2014) described how the workforce that has been available to aged care is increasingly comprised of overseas students, who are generally good care workers but are limited regarding their working availability due to student visa conditions. This creates significant employment difficulties for RACS.

But what we’re getting into the market now or into our pools, is a lot of overseas people with limited visas. Which means they can only work 20 hours a week. And then because they work, they might do 20 hours here, they may work somewhere else. There’s a sort of, it’s really hard to keep a tab on that. So, and the other thing is if you want to employ somebody, at the moment I’m trying to get someone for a night shift. Well, that’s a nine and a half hour shift. It’s a long shift. So if a person can only work 20 hours a week, they can only do two shifts for me, and I’ve got four. So either I say okay, but these people, they’ve got their own two shifts, they’re
not flexible enough to work anymore because they can’t. They’re willing to but they can’t (2014).

She also added that, while they are good workers, the language barrier can be an issue in an aged care setting:

And as you know, most overseas with students’ visas, they’re encouraged to do aged care. So we’re getting a lot of those ones. And with those is a challenge in itself, because their English isn’t that good. And our residents are frail, if they can’t understand, we can’t understand them sometimes more or less, you’re speaking to them in English and they can’t understand you, you’ve got no hope if they’ve got an accent (Cath 2014).

Charlotte (2014) expands on this view, finding that the culture of some of the migrant and overseas workers doesn’t match with the culture within her RAC:

I’m telling you I’d have 50 applicants from India, with maybe two Aussies in there. So I’m not saying they’re not skilled, but that’s not the cultural fit for what I’m looking for (Charlotte 2014).

Andrea (2014) confirmed that her organisation also has problems when employing overseas carers:

We recruit, you know, there’s been a history of recruiting, you know, Indian engineers into carers’ roles that really do not want to do the hands-on care - because there’s no-one else (Andrea 2014).

These views correlate to the research reviewed and to more recent data indicating that the percentage of foreign-born aged care employees has increased from 33 per cent in 2006 to 37 per cent in 2011 and grew more quickly over this period than did Australian-born carers (Negin, Coffman, Connell & Short 2016). Managing such a diverse workforce creates significant challenges for
leaders in RACS. This challenge is exacerbated by the fact that long-term care comprises some of the most intimate of services over an extended period (Walsh & Shutes 2012). Therefore, good communication and a sympathetic and understanding relationship between the resident and care provider are essential to quality care (Redfoot & Houser 2005). Language barriers are the most obvious cultural problems when employing a migrant workforce. Moreover, cultural preferences concerning care can be impediments to effective relationships if the care provider does not understand and manage the preferences of their care patients (Brush, Sochalski and Berger 2004, Johnstone and Kanitsaki 2008, Xu 2008). Leaders of RACS must contend with the language barriers and cultural preferences of both their workforce and clients if they are employing large numbers of migrant care workers. While there is limited research on relationship dynamics between elderly care recipients and migrant care providers, the perception of older care residents of migrant care workers has also been shown to influence the development of the care relationship. Negative attitudes, which include occurrences of discrimination against overseas care providers and their non-acceptance by older people has been documented, adding to the complexity of leadership (Browne, Braun & Arnsberger 2006, Cuban 2008, Doyle and Timonen 2009).

4.2.3 Government Regulations and Funding

As referred to earlier in this thesis, significant time is expended by aged care specialists on meeting and reporting on government monitoring requirements which include aged care funding applications, compliance reporting, OH&S, privacy and food safety, to name a few (ACSA, 2010, Treasury 2010). The level of regulation of the aged care industry has been perceived to have contributed
to the constraint of quantity, quality, location and price in RACS, and reduced the relationship from being principally between the service provider and the care recipient, to being focused on the Government and the service provider (Grant Thornton, 2008, Treasury 2010, ACSA 2010). This increase in regulation is associated with the substantial marketisation of the aged care industry in Australia over the past thirty years, which was brought about as a result of Neo-liberal detractors who regarded the traditional provision of government-funded aged care as an inefficient government monopoly with minimal scrutiny of their performance (Davidson 2011). Making government funding for RACS more contestable, was meant to allow high-quality new providers into the sector and result in the departure of inferior providers, as well creating enticements for behavioural change within the industry and improving service quality, equity of access, productivity and responsiveness, and diversity of services, while ensuring care providers more answerable to both clients and the government via significant regulation and compliance requirements (Le Grand 2007, Davidson 2011).

**Government Regulation Issues**

This view was strongly supported by most of the participants interviewed (Cath, Ivan, Gary, Smiley, Sarah, Louise, Andrea, George, Liza, Madeleine, Gary, Ben, Charlotte, Cherise & Charlene 2014) and was summed up by Sarah (2014), who stated:

> the aged care accreditation standards, by all means, don’t make it easy at all for aged care providers to run a facility, you know, sort of at a best practice level I guess. Because regarding compliance there’s four
standards and within that there’s 44 outcomes that they have to achieve (Sarah 2014).

Ivan (2014) espoused a similar viewpoint, saying:

Most leaders find it very, very difficult to acquit the huge amount of compliance about, obviously signing on care plans and ACFI and everything’s got forms; the lack of time that you and your team are able to interact with the client where you’re, the administrative burden becomes huge in the compliance burden under the Aged Care Act. We do understand that of course, there needs to be some documentation of the care and services that are being given; it’s not just a free for all, you can’t have a free rein on being able to do that. However, when the compliance burden deters from or impedes your ability to interact with the client and provide quality services, there’s a problem (Ivan 2014).

According to Cath (2014), “there’s more paperwork here for one resident than you would [need] to have open heart surgery!"

George (2014) believes that government regulatory and funding requirements make the aged care leadership a very difficult role:

[You have] low wages, the skill shortage, but then so many compliances. You’ve got your accreditation, you’ve got your applications for your funding, and then you’ve got your family members that you’re trying to keep happy, plus your residents (George 2014).

This was echoed by Smiley (2014), who said:

And there is outside of work hours expectations, so there is quite a lot that happens outside of work. Keeping on top of the Aged Care Act, keeping on top of where the government is or isn’t with funding and how much, to what value and even the reading is extraordinary, it’s just ridiculous to be able, you couldn’t keep on top of it if you tried (Smiley 2014).
This view was, to a certain extent, mitigated by Ivan (2014) who admitted that
government regulations and workplace safety constraints were an extremely
important requirement, but needed to be more balanced:

“A resident has a right to a room, to enjoy a home-like environment. And
that sometimes can be in conflict with the Occupational Health & Safety
requirements of the employees when they’re lifting someone out of bed,
and because the room’s cluttered or it’s designed in such a way that it
becomes a bit of a Health and Safety risk. So it’s about not trading off
rights and responsibilities and entitlements and obligations, but balancing
and managing all those expectations, both as a resident’s place where
they live and as a workplace, and that can sometimes be very, very
difficult, because sometimes they’re in conflict and you have to get
somehow some synthesis of those two different paradigms (Ivan 2014).

Insufficient Funding and Support
There also appears to be a distinct view that the government is doing too little in
regard to ensuring the survival of the aged care industry and that the funding is
inadequate for the survival of some RACS (Ben, Cherise, Charlotte, Andrea,
Julia, Ivan, Gary, Bart, Cath, Sarah, Karina, Liza, George, Charlene, Smiley,
Madeline, Louise 2014). Cath (2014) explained this as follows:

An enormous amount of money goes into aged care and welfare payments
and now disability. But every sector and every place that’s going to get
funding are going to fight for their little patch. And then you have to, as an
organisation, or a manager, work out the best way to spend your little pot
of money and the most appropriate, to get the outcomes that your
customer wants. And meet al.l the regulations that you have to meet (Cath
2014).
Ben (2014) also held quite a vehement view on the government’s funding approach and the impact it will have on smaller providers, particularly regarding their ability to pay staff and coordinate funding applications:

*The main problem right now is pay scales – the disparity between the pay scales in aged care and other areas of healthcare. Small, independent facilities cannot afford to pay more – and the bigger organisations contain their costs through economies of scale, and that often means the responsibilities of senior staff are spread across a number of facilities instead of one. For instance, Group XWZ that has six facilities in the southern region of Melbourne employs one ACFI (Aged Care Funding Instrument) Manager, with perhaps one assistant, to coordinate ACFI submissions for all six rather than each facility having its own ACFI manager. It doesn’t take any more knowledge of ACFI to coordinate the submissions of six facilities as it does for one but the economies of scale means Group XWZ can pay its ACFI Manager say 30 per cent more than the ACFI Manager of a small 50-bed facility (Ben 2014).*

Julia (2014) holds the view that the government’s approach to aged care funding is rhetorical and insufficient to meet the growing needs of RACS:

*...the rhetoric is all there. But it hasn’t been matched with the dollars. And I can, I also understand that you just can’t create a whole new bucket of money and that it’s not, you can’t just do it all in one go. So I think that the concern even with the latest announcement that just happened about the workforce compact was that it was you give with one hand and you take away with the other. [Laughing] So we’ll give you this but you have to do that as well, and you can’t, I don’t have a problem with the principle of it, but in terms of bottom line and the dollars, it doesn’t actually make sense. It doesn’t allow the industry to grow in order to support this supposed tsunami coming forward (Julia 2014).*

Karina (2014) also embraced this view of government funding:
The funding is all driven through, you know, the ACFI and it’s just atrocious. They’re lucky they have Catholic providers who actually see this as a mission, that want to give back. Because there’s some providers out there that are cutthroat, that I’m glad I don’t have a parent in aged care (Karina 2014).

Interestingly, Laura (2014) was a lone voice regarding Government funding and she had this to say:

The subsidies are fine. Everybody that says that we don’t get enough is talking crap because it’s all based on our evidence, our claims for every single resident per day, what they require, is based on the amount of care that they receive. If you have the evidence to back their high care needs you get the top subsidy per resident per day which means you can pay for everything that you need to be able to still make a profit. I pay for everything and still make a profit. So that’s a load of rubbish. They do provide us plenty it’s just everybody who’s in the management seat crying about the fact that they have to work a little bit harder to collect the evidence to back up their claims and that’s all it is (Laura 2014).

Wages

Apart from Laura (2014), all participants considered that the lack of government funding has contributed to the extremely low wages in the aged care industry, which provides a significant challenge for aged care leaders. There appears to be a clear link between the regulatory environment and the current low wages and conditions in residential aged care, particularly as the capability of traditional labour law to provide the best wage outcomes for RACS employees is restricted by poor levels of collective representation, as well as funding constrictions within the industry (Kaine 2012b). This is further associated with changes to the
centralised bargaining system of the past which included ingrained gender pay disparities, but provided some safeguards for female-dominated industries, such as aged care, that tended to have limited bargaining capacity (Frances and Nolan, 2008, Ravenswood & Harris 2016). Changes in this system to a less centralised bargaining approach has removed these safeguards, as it has eliminated state awards within the private sector and emphasised organisational level collective bargaining, which has shown to be most effective in industries with high unionisation and high levels of full-time employment and are generally male-dominated (Cooper 2010b, Kaine 2012b). Ivan (2014) provided his analysis of the funding as it relates to wages in the aged care industry:

The second thing I want to talk to you about is the wages and conditions; we do know that the wages are pretty low in this industry. I have an inkling that it’s because of the industrial might; it would come from fundamentally, as an industrial relations analysis [RACS] is a cottage industry where it’s female-dominated, where the industrial power to lift the wages and conditions has not been strong. So therefore we have, and government and society have relied on the goodwill of a generous workforce of predominantly female workers (Ivan 2014).

Gary (2014) put the low wages into further perspective by stating:

“At the end of the day, somebody working on the [aged care home] floor is earning less than somebody working at McDonald’s pretty much. The government needs to recognise the work that the people are doing for probably their family members. A few people that I’ve known have left to go work in say Safeway and that, and they are getting more money than working in aged care.” (Gary 2014)
Andrea (2014) also expressed concern at the lack of regard the government appeared to have for the aged care sector workers and their lack of understanding of its needs:

I think the government is well aware that it’s going to become a really big issue in the next ten years. The leadership has been in our experience has been very much that the government is focussed on regulation, financing, and trying to put things in place to give the customer a better voice but it hasn’t been done with a lot of depth of knowledge. So fundamentally I don’t think the government has a good handle on what are the expectations of the Baby Boomers because they are very focused on the Baby Boomers (Andrea 2014).

Cath (2014) suggested that because of the low wages, it was difficult to expect the kind of professionalism leaders would like in RACS:

“You’ve got to be careful because you can’t expect professionalism for a person that’s getting $20 an hour. Being able to sort of lead them at the level they’re at, encourage ongoing personal development, that sort of thing. But that is a challenge.” (Cath 2014)

This was strongly supported by Cherise (2014) who said:

I’ve known a lot of managers in the industry, who have actually gone up and become cleaners. Because you can get $25 an hour to clean a house, and you clean for 2 hours and you walk away with cash in hand. Or gone to Myers, work for their husbands, and doing home, what do you call it, office work, where they feel that they have a lot of family time. This is 24/7, the demands are there. And not everyone is wanting or willing to be working 24/7. (Chersie 2014)

Palmer & Eveline (2015) explain the approach above in their study, by finding that employers of RACS have traditionally kept labour cheap by asserting that it is unskilled despite the recognition that the “really unmeasurable things of care
are actually a set of accomplished skills” (p.264). In other words, women working in the care industry possess a certain indeterminate quality that serves as an alternative for professional skill and therefore does not need to be rewarded at the same level (Knijn 2000, Palmer & Eveline 2012). They also assert that employers assume that women who work in RACS are financially supported and therefore will have less need to demand higher pay and development opportunities and also that their experience in providing care for their family makes them an ideal employee whose “life skills” are sufficient for them to undertake a caring role (Palmer & Eveline 2012, Ravenswood & Harris 2016).

Smiley (2014) reasoned that the lack of funding for wages and salaries was also limiting the pool of good leaders in RACS, as they can’t compete with other industries:

*The funding is just not there. But again, I’m talking at the executive level. But at the executive level they also don’t have, there are quite significant caps in public sector in terms of what you can and can’t offer, so that does make it more challenging I think, and the complexity, when you work in an aged care that’s inside the public health system there is another layer of complexity that’s added to that, so I think that’s, and reputation and brand, I think from the public system (Smiley 2014).*

Bart (2014) agreed saying:

*They’ve got a really complex role because they have to try to balance money when you can’t sustain the staff that you have, because there’s not enough money. So, in other words, the lower amount of money that the government puts in actually induces problems in the sector.*
Andrea (2014) also supported this view, adding that that the government is not only providing insufficient funding but not addressing the workforce issues that are going to have a big impact on the aged care sector in the near future:

*I think it’s they’re definitely under-investing. They definitely are not addressing the workforce issues, and the challenges we’re going to find. Fundamentally the way that the industry is positioned generally from a workforce perspective that’s where we’re going to fail. Even if they put money into buildings, even if they give us more funding, if they don’t address the workforce shortage and the perception, it’s not going to change. We’re going to have the same issues they had, they have with trying to attract nursing staff as well* (Andrea 2014).

Finally Ben (2014) summed up this viewpoint in his statement, which refers to the importance placed by successive governments on aged care:

*In my opinion, RAC – certainly in this country – has not been able to attract the type and level of management and care talent it needs primarily because it has been treated almost as a “second cousin” in healthcare. For instance, nurses in aged care are paid much less than those working in both private and public hospitals. For what they do, PCAs are grossly underpaid compared with other health workers. In summary, the disparity in wage structures has by and large discouraged many talented people from entering the industry* (Ben 2014).

The issue of wages is clearly a significant challenge for leaders in RACS as social support for the aged care sector’s lower status, in comparison with acute and community care, is enhanced via the perception of insufficient resource provision by the government, which is regarded as encouraging the employment of low-skilled carers and inferior wages for qualified nurses (Pearson et al. 2001, Jeon et al. 2010). Combined with high levels of regulatory and
compliance requirements, these issues produce greater levels of staff and leader dissatisfaction, burnout and turnover, contributing significantly to the challenges accompanying the recruitment and retention of appropriately skilled care staff and considerably complicating the role of leadership in RACS (Pearson et.al 2002, Stack 2010, Jeon et al. 2010).

Training and Education

This links closely to the view by some of the participants that the government is doing little to ensure well-qualified leaders, with appropriate skills, are being prepared for the aged care industry through relevant training and qualifications (Ben, Gary, Charlotte, Cath, Bart & Ivan 2014). Ben (2014) stated the following:

> On the macro level, I believe there is a strong case for government funding for tertiary institutions to develop aged care-specific Executive Leadership courses as well as degree courses in aged care management. Right now no such course exists. (Ben 2014).

He added:

> The tertiary institutions are churning out ‘qualified’ individuals but these qualifications are largely academic, seldom practical and often irrelevant as the educational institutions themselves are often under-resourced. (Ben 2014).
Gary (2014) concurred with this point of view and advocated the need for leadership or management qualifications in aged care to be developed to create better career paths in RACS:

“You can do like nursing in aged care and PCA in aged care, but they should have senior management in aged care, where it takes you down the track, and it’s recognised. That would also allow people to see that there are career paths in the industry and…” (Gary 2014).

Charlotte (2014) added further to view regarding the lack of government leadership in training and development in RACS, by opining that even the funding that is earmarked for education in the sector is wasted because of the quality of training courses available:

“The other thing that they do is I think one of the things that puts the industry very much at risk, is that you’ve got a lot of funding out there where you can get $4,000.00 from the Government, get some funding, to have a whole lot of Cert III, Cert IVs or whatever training. That, you can’t throw somebody into school, do 120 hours, and then you’re qualified. There’s not enough work put into, just not enough, that course is just, you just sort of stand there when you see some of the things that they do and you think “What were you taught?” I honestly, I would really, really like to see training come back, the basic training.” (Charlotte 2014).

Cath (2014) supported the general opinion that accredited training for aged care Personal Care Attendants was not adequate to equip those coming into aged
care with the right skills to care for residents adequately, and that government was not doing enough to address this.

I’ve done a lot of courses where you got people standing up there talking and you think they’ve got no idea what they’re talking about. Aged care doesn’t work like that. And so the course content doesn’t line up with what’s happening. I think RTOs [registered training organisations] that are out there spruiking courses where people can do assignments based on what they’ve got, what’s happening in the workforce, so they’ll pick up a manual that’s been developed at the workforce, put that in as they’re work and they’d get a credit for it, that’s got to go (Cath 2014).

Concern over User-pays Model

There is also concern amongst the participants regarding the move of the government towards a more user-pays model and type of care that will result for those from lower socio-economic conditions (Andrea, Karina, Charlene, Ivan, Charlotte & Smiley 2014). Andrea (2014) expressed this as follows:

So the government haven’t really looked, what, the way the industry is going is it’s going to be very much user pays. And part of me says “Yeah, okay, well if you can pay, great, but what about the people who can’t? What are their choices going to be like?” It’s like anything isn’t it? They won’t have the same choice, they won’t have the same range (Andrea 2014).

Karina (2014) also shared this view:

I say to people looking at going to the acute sector, “Don’t give up your private health insurance”, and “Thank God Mum’s got a home because,
you know, you can sell it and, you know, you’d be able to have a, you’ll get a decent bond so she’s got a, he or she, have got a chance of getting in somewhere (Karina 2014).

Charlene (2014) expanded on this perspective, indicating that there would be vast differences in care provided to those who could afford a user pays system and those who couldn’t:

There is also a change that the previous government introduced, and the current government is carrying on, that there’s a user-pay model. So if someone has a lot of money, they can choose the place of their choice, and they can negotiate what it is they want, more like a hotel service. So you have to do a lot more to be attractive to offer that so called five star service, to then attract the kind of clients you want. Otherwise, you will be a pensioner-type facility where there is very little extra money, other than to meet the cost (Charlene 2014).

Industry Image and Government Leadership

There is a strong sense that the government does not understand and is not working hard enough to help change the reputation and promote the aged care industry as one that is valued, positive, important to our society and a viable industry sector in which to build a respected career (Charlotte, Ben, Gary, Andrea, Sarah, Liza, Cherise, Louise & Laura 2014. Charlotte (2014) encapsulated this view by stating that the aged care portfolio was not seen as important or significant in its own right by government members:

It’s not a significant portfolio to have as a candidate in politics. But it’s not a bad stepping stone. It’s not sexy. It’s never going to be sexy, and I think they need to chuck that word right out of aged care. (Charlotte 2014).
Participants believe that the government needs to provide leadership regarding improving and promoting the image of the RAC as an industry in which to work and receive excellent care. This construction of leadership by the participants adheres closely to the transformational leadership model, whereby leaders empower followers to be motivated and encompassed by the vision they create (Thyer 2003, Arnold et al. 2007). It is clear from the responses that some of the participants regard the role of government in RACS as one that must inspire stakeholders (the public, care workers, government departments, leaders in RACS) with their vision for a strong and attractive aged care industry. Ben (2014) considers the government to have given too much focus on regulating the industry but has not really assisted with improving its image:

Aged care has not had a good “image” in the past. What most people knew about aged care centred on bad press about old aged homes abusing the elderly and sucking them dry of their money etc etc etc. While in the past decade or so, with state and federal governments ‘cleaning up’ the sector by adopting regulated standards and accreditation processes, the public perception is changing, nevertheless, it is not a sector that is immediately attractive to young people looking for work in the healthcare sector (Ben 2014).

Andrea (2014) agreed with this view and pointed out that the disability sector has had far more effort put into improving its image than aged care and argues:

But I think people have a perception about nursing homes particularly, or residential care, that is very right. Run down, smell, poor food. That’s where the government are not addressing the in-built, we all have a fear of ageing. We all do. And it isn’t nice at the end. And it isn’t nice when people are really old and frail. But if the government don’t start to
address some of those issues we are so far behind the disability sector it's not funny (Andrea 2014).

Gary (2014) concurred with this viewpoint by saying:

That's the other thing, aged care for media and government-wise only gets a negative impact. There's never anything positive about it on the TV. Which is a shame. And I mean to me, but I don’t know what you think, but I think that’s, I mean that’s an issue, that’s a gap in government leadership, that they’re not taking the reins and driving it and developing a more positive image (Gary 2014).

Sarah (2014) made these comments regarding the lack of government focus on promoting the aged care industry, and how her organisation had to take on this activity instead:

So, you know, we need to work more on an advocacy role trying to promote aged care. We promote it at the nursing expos, with our public hospitals. We try and promote it through our RTO, promote it through the schools, promote it through with ACU. We try and look at all those different arrangements to try and attract that worker (Sarah 2014).

Even the “lone voice” participant who was reluctant to be critical of government leadership and funding regarding the aged care sector, Laura (2014) said:

“I think that they need to put out, it would be nice to see some positive information being put out there. Having said that though how many people are really interested in it until they get to the stage where they have to look into aged care (Laura 2014).

RAC Survival and Corporatisation of Care

The question of RAC survival and corporatisation of care was an area of concern for a number of the participants, who also revealed that they believed that single
facility organisations would cease to exist and that large corporate organisations would dominate the RAC industry, if the government didn’t act to assist smaller homes (Charlotte, Ivan, Laura, Julia, Ben, George, Liza, Madeleine, Sarah, Cherise, Charlene & Bart 2014). Ben (2014), from a small religious RAC, stated:

Firstly, there is a rationalisation of the industry that is going on. Small, independent aged care facilities like ours are closing because of costs, the inability to compete with the bigger groups for qualified staff, ageing facilities and the lack of adequate capital to carry out the major renovations necessary to get them to a “competitive standard” being just some of the reasons. Secondly, the ‘privatisation’ of council-owned, state-owned homes has further hastened the rationalisation of the industry. Both developments have seen the bigger groups like Blue Cross and BUPA grab market share. (Ben 2014)

Laura had a similar view saying:

A standalone with 30 beds they’re not going to make enough to be able to care for their, the people within their care. It’s just not viable. There is too much involved in running places like this. Organisations that have a number of facilities and more beds are going to be better off because of the profit margin and that’s the only way to maintain your buildings. It’s the only way to actually provide environments that are safe and secure etcetera. If you’re just basing it on one facility with 30 residents that are getting a little bit of government subsidy every day it’s not, you know, where are you going to get the money when you need to re-pipe, where are you going to get the money when you need to put air conditioners in everywhere, you’re just going to keep running at a loss and it’s going to fall apart or they’re going to cut corners and people will be neglected (Laura 2014).

There was also a view that while the smaller facilities were not strategically equipped to compete with the larger corporate organisations, there would be a
loss of community focus if they were bought out by a more corporate operation, as pointed out by Liza (2014):

There’s pros and cons of course and we certainly found small providers who were the most likely targets for amalgamation being worried that they would lose their, they were essentially set up by communities and they thought they would lose the whole community focus. At the same time, they were absolutely struggling and bleeding and had dysfunctional boards etcetera, etcetera. But, yeah they were very worried. I think what you get in those circumstances, at least you’d get a viable facility working, but it might not be, it might not have all the attributes that the community wanted (Liza 2014).

The view that the influx of larger corporate RACS would lose the community focus and home-like environment was echoed by Charlene (2014):

I would say one of the things that I noticed is these large players from overseas coming in. So they run it more like the factory business. They’ve got the pink carpets and the pink curtains and the number of staff. So we have to compete with them, and that there are no capital allocations. So, and the funds we been receiving through bonds need to be used smartly (Charlene 2014).

Overall, there was a general view that the government has very little understanding of the needs of the aged care industry as identified by Cherise(2014):

I don’t think governments understand some part of it. I believe they are there to put out policies and procedures that often is politically modulated it’s not necessarily what’s best for the industry. I’m not sure whether they’ve got the right advisers to tell them what is needed in the industry.
So in my opinion, no. I don’t think they’ve shown leadership (Cherise 2014).

To sum up, the views of the participants regarding government funding, regulation and leadership in regards to aged care, Liza (2014) said:

Talking with CEOs of three facilities that were actively contemptuous of what government was or wasn’t doing for them and just, yeah and that wasn’t an uncommon effect. DOHA was rarely described in anything other than pejorative terms. There’s a strong sense that they don’t understand us. They have no insight into what we do, they don’t yeah, both on a basic operational level and a strategic level (Liza 2014).

This final damming statement by Louise (2014) sums up the extremely disdainful of views held regarding government behaviour and action addressing the RACS to date:

“Dear me, there’s nothing supportive about the government at all. I think they want to take support, even more support away as well, so that’s just, it’s like paddling up a creek without a, you know, that’s like being up a creek without a paddle.” (Louise 2014)

4.2.4 Human Resource Management Strategies

Recruitment and Retention

According to ACSA (2014), the current image of the aged care sector acts as a deterrent to the attraction and recruitment of skilled workers in RACS. To attract and recruit bigger numbers of competent staff, the aged care sector needs to both improve its image and promote its value to the community. Recruitment costs in RACS are high and as skill shortages grow, there will be increasing competition
for staff over the next decade, which will amplify the challenges of recruitment for RACS (ACSA 2014, Productivity Commission 2011).

Retention is another issue faced by the aged care sector, and a crucial phase for influencing both job satisfaction and retention success is within the first twelve months of engagement (NILS 2012, ACSA 2014). Research has shown that the aged care sector has not been effective in developing and implementing HR practices in their organisations to foster a rewarding work environment and to retain competent, highly skilled employees within their employ (Bartram et al. 2007, Productivity Commission 2011, Clarke and Rao Hill 2012). This is despite the fact that numerous studies have shown that the provision of quality services in all organisations, is provisional on the organisation being able to attract and retain qualified, expert, and motivated employees, who are reinforced by appropriate HRM practices and procedures that will ensure the requisite level of service is delivered to clients (Huselid, Jackson & Schuler 1997, Kepes & Delery 2006, Clarke and Rao Hill 2012). This provides a significant challenge for aged care leaders, who must ensure the provision of quality and compliant care to their residents while dealing with the problems created by staffing shortages. These staffing deficiencies not only compromise the quality of care provision but even further undermine ongoing staff retention, as it creates greater work intensification and deteriorated employee welfare, therefore generating a vicious circle, to which RACS leaders must constantly find a solution (Rafferty, Clarke, Coles, Ball, James, McKee & Aiken 2007, Jourdain & Chenevert 2010, Cooke & Bartram 2015).
There have been mixed views regarding the development and implementation of HRM strategies amongst the participants who were interviewed. Most interviewees did understand the importance of good HRM strategies to the recruitment and retention of qualified employees, and had made attempts to introduce these strategies into their organisations as far as funding and capacity allowed them (Louise, Ivan, Julia, Laura, Karina, Sarah, Ben, Gary, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014).

In regard to recruitment of senior managers and leaders in aged care, most found it very difficult to recruit appropriately qualified and experienced senior staff (Bart, Louise, Ivan, Julia, Laura, Karina, Sarah, Ben, Gary, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014). Numerous studies (Nay 1998, Pearson et al. 2001, Aberdeen & Angus 2005, Venturato 2007, Chenoweth et al. 2010, Dwyer 2011) have pointed to the devalued image of working with elderly people, the lack of education for professional development, the fact that role delineation and limitations of responsibility are clouded by issues of compliance and limited available funding, as well as long hours and low salaries.

According to Cherise (2014), it is very difficult to find the right person to lead a care facility effectively

_It was difficult, we had been through this exercise twice before; we thought we got a very experienced and older manager, but she’s lasted about 2 years. She was somebody who was very good at her clinical skills, but as a leader and managing a group of people she struggled. So staff numbers, they couldn’t cope. And then we again, recruited another manager who appeared to be competent and capable but within 6 months we had to let her go because she lacked in management skills and leadership skills_ (Cherise 2014).
George (2014) agrees, saying:

Well, I’d like, nursing staff from my senior staff, just because they got the background knowledge of everything that happens. The problem with that is that not all of them have management skills obviously. And then trying to find a good mix of that, by the time you get that most people are just burnt out and out of aged care. Want to come out of it. So, yeah, it’s difficult to find the right person at the right time (George 2014).

Ben (2014) echoed this sentiment, saying it was hard to find senior staff to work in RACS because:

Nurses in aged care are paid much less than those working in both private and public hospitals (Ben 2014).

Andrea (2014) talked about the difficulty, particularly in recruiting qualified registered nurses into senior positions:

We struggle to attract registered nurses into aged care as you would know. We’re competing with the acute sector primarily (Andrea 2014).

Laura (2014) believes that there are enough nurse leaders in the health sector but that they simply do not want to work in aged care:

I think there’s plenty of nurses that are leaders however the ones that are leaders a lot of them don’t come into aged care unfortunately so that’s where the lacking is (Laura 2014).

The issue of low wages and limited career opportunities inherent in the industry was also cited as a problem in regard attracting and retaining good staff (Louise, Ivan, Julia, Laura, Karina, Sarah, Ben, Gary, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014).
As Cherise (2014) said, HRM strategies are extremely important to her organisation for attracting and retaining good staff because of the hard work and low salaries:

*I’ve known a lot of managers in the industry, who have gone to Myers, work for their husbands, and doing home, what do you call it, office work, where they feel that they have a lot of family time. This is 24/7, the demands are there. And not everyone is wanting or willing to be working 24/7. And emotionally, you always thinking of somebody who’s rather ill or a new staff member on the floor who doesn’t know. So they have to have methods of to, how to make it better and easier and build a team within a very constrained environment* (Cherise 2014).

Cherise (2014) also pointed out that the lack of funding to train and pay good managers in team building and other HR practices limits their ability to employ and build good teams:

*People who work at the facilities say “Look, if you want me to come and learn X, Y and Z, you need to bring me on board after hours.” And there is no funding for that. And I don’t think anybody’s going to give us a bucket of money and say “Here you go. This is for you to build a team.” No one’s going to do that, in fact, what’s happening is money being taken away because there isn’t money in the federal budget* (Cherise 2014).

George (2014) summed the general views about this issue up by saying:

*For accreditation, you’ve got to have a certain amount of nursing staff to do certain duties. But the nurses aren’t coming to aged care. Why would you? You earn three times as much in the public sector with no responsibility* (George 2014).

Many of the participants also saw training and development opportunities as being critical to attracting and retaining staff. Liza (2014) commented on the
difficulty in retaining staff and training them to be leaders, particularly in smaller aged care organisations:

mostly in larger organisations where there was in-house learning and development, HR areas that were focussed on leadership which sort of just makes sense from the perspective of you know, an area to focus. But, I don’t think in the small and medium organisations there wasn’t a lot of that because people just didn’t have the resources really to put into it (Liza 2014).

However, George (2014) indicated, this is a strategy that has been successful in his boutique RAC facility:

We like, well the more, we encourage everyone to do lots of training because the more that they gain knowledge the better it is for them, but more so the better it is for the resident. But other than training, yeah, well it’s the lot I guess. Yeah, training and the family atmosphere I’d say (George 2014).

This links to the opportunity for developing a career path in aged care, which Andrea (2014) sees as an important HRM strategy to retain workers:

We’ve got two managers here which are called our Business Development Managers for Residential. So ten managers report to them. And they would have been a facility manager before, so they’ve got a career path in here, and then from there they might be general manager – it’s important (Andrea 2014).

Karina’s (2014) organisation also regards this as an important attraction and retention strategy, as many of their clients’ families would not want their children working in aged care as they regard as an industry without a career path. She said that her organisation appreciates that it is important to:
people a career in aged care, creating pathways for school students to come in and get placements (Karina 2014).

These views were supported by Radford’s (2016) study, which found that while pay is a central factor in RACS long-lasting recruitment and retention problems, job satisfaction and security, positive work culture and opportunities for training and career development were also key factors influencing worker retention. Those providers who can pay above award rates and provide training and development opportunities have been found to also report fewer issues with attracting and keeping staff (O’Keeffe 2017). Aged care leaders tend to blame the sector’s low wages and lack of career opportunities on the government, for setting the level of funding providers receive too low in many instances to provide adequate pay and conditions and to create an effective workplace environment that will attract and retain skilled staff (O’Keeffe 2017, Radford 2016). Another factor blamed for the low wages and limited career prospects in RACS is the concept of lower wages being applied to work involved in providing care, as mentioned previously regarding government funding for RACS. Referred to as a wage penalty (England, Budig & Folbre 2002), this is where workers in occupations such as care workers, receive a lower hourly pay than would be expected, given the characteristics of their jobs, including skill demands and the qualifications required to undertake the job. This is often linked to gender and what is considered predominantly ‘female work’ (Palmer & Eveline 2015) and was recognised amongst the informants only by Ivan (2014). The problem of having limited opportunities for pay, training and career progression is a challenge for RACS leaders, as it prevents the development of good leaders within the industry.
at all levels and makes it difficult to retain good potential leaders (Dwyer 2011, Jeon et al., 2010).

**Employee Burnout and Stress**

The issue of executive and staff burnout was another theme that resonated strongly from the participants (Ivan, Smiley, Gary, Bart, Charlene, George, Liza, Andrea, Louise, Cherise, Kate, Sandra & Charlotte 2014). There is a strong view that people don’t last long working in aged care because the hard work and long hours with low pay lead to them becoming burnt out and leaving the industry.

As George (2014) pointed out earlier, his experience regarding staff and burnout has been that by the time people develop a good level of experience and management skills, they are burnt out and tend to leave the industry. This means RACS not only lose care staff but potential leaders as well.

Even those organisations who believe they are competitive pay-wise cite burnout as a problem, as espoused by Smiley (2014):

*I would say two years is probably the average; that would be my rough estimate, the burnout rate. And the burnout rate is, because it’s long hours, and whilst the remuneration for us is quite competitive it is still incredibly long hours* (Smiley 2014).

A large part of the stress causing burnout appears to come from the government accreditation process that has been highlighted previously as being so burdensome for RACS employees. According to Bart (2014):
And I recognise the need to do the accreditation, but as I said it’s incredibly stressful for those people that have to go through it on a day to day basis (Bart 2014).

This is regarded as a major cause of turnover in the industry, as said by Ivan (2014):

We see a turnover of facility managers time after time, after… just prior to or after a visit by the Standards Accreditation Agency, because it’s such a stressful thing (Ivan 2014).

Smiley (2014) confirmed the high turnover in the industry of senior staff due to high levels of stress. She explained that turnover for senior management in the industry is around 20 per cent and that managers need a high level of resilience to be able to withstand the long hours and lack of funding and staff availability. She acknowledged that people with these qualities, as well as the very specific and comprehensive skill set required of leaders in aged care, were very hard to find:

So finding those skills in leaders that can sustain that is incredibly difficult, but it’s not, and that’s why clinicians become leaders is because you know that clinically, intrinsically they’ve got those altruistic skills; why else would you be a clinician? So that’s why clinicians become leaders. But then you’re disillusioned often because you can’t make a difference directly (Smiley 2014)

Job Satisfaction and HRM

These circumstances mean that many of the participants recognised the need for good HRM strategies to mitigate what are often seen as the negative aspects of working in RACS, referred to previously. To moderate the stressful conditions, participants such as Cherise (2014) generally recognise the need to provide a workplace that works to alleviate this problem in some way:
I think all approved providers have to create an environment where leaders too can grow and to avoid unnecessary stress or unnecessary burden so that leaders can lead. Because anybody can be snowed under and you get burnt out (Cherise 2014).

Bart (2014) believes that the RACS offer a lot of benefits to potential employees, but that the sector does not promote these effectively:

I think we undersell the sector, and I think what we don’t do is we don’t sell some of the major benefits and some of the major attractions, some of the major rewards that come from working in aged care. So I think the sector, like I’ve heard people in the past apologise for aged care and the fact that we don’t pay a very big wage. So rather than sort of focusing on the positives they actually focus on the negatives. Most of the people that come and work in aged care don’t come because of the dollars. They actually come because the satisfaction they get from the job, and some of the other benefits, some of the flexibility benefits (Bart 2014).

This view clearly links to the feminist debates that argue that the love of the job and the innate desire to care for others is used as a justification for low wages (Palmer & Eveline 2012, Hebson et al. 2015, Ravenswood 2016). Research has demonstrated that work related to the care of, or interaction with, others tend to be female-dominated and are generally paid lower wages than similar jobs (Meagher 2016). Not valuing occupations involved in the care of others occurs as a result of the persistent and traditional relationship between care work and the historical roles of women (Palmer & Eveline 2012, Charlesworth, Bain & Cunningham 2015, Ravenswood 2016, Meagher 2016). As these care roles are generally not afforded financial value in society, the skills linked with them are also diminished or rendered insignificant (Hebson et al. 2015, Meagher 2016).
This provides a challenge for RAC leaders as they struggle to attract skilled workers to an industry apparently consigned to continued low pay and undervaluation.

According to Sarah (2014), the HRM strategies are the only way their organisation can achieve any competitive advantage regarding attracting and retaining staff because of the poor wages:

_The culture in aged care, because it’s hard work and it’s poorly paid, the things, the absenteeism, those sorts of things, as a manager create a lot of challenges. The only benefit that we offer our staff is that we can salary package. So that does add some, you can compete a bit better commercially. So we have, so basically what we allow people to do is package up so if they’ve got a mortgage or school fees, or computers or whatever they can package it up…_(Sarah 2014).

Consistent with Sarah, Andrea (2014) believes that maximising the HRM strategies within her organisation is the only way they can compete with the acute sector and other industries regarding staffing.

_[Organisation name], while we might not have the best pay rate in the whole wide world, have reasonably good conditions. Flexibility of hours, and shifts, wherever possible. We’ve got good terms and conditions of leave arrangements and salary packaging, and we’ve got good rewards programs, we try to have organised social things, so we’ve got a social club that’s started up. We have functions and family day. So trying to make it a good place to work_(Andrea 2014).

Ben (2014) agrees with this and outlines how his organisation uses HRM strategies as their competitive advantage to retain workers:
I guess it’s not a case of finding it hard to recruit senior staff – but what is more relevant is the difficulty recruiting the appropriate, qualified and skilled senior staff. The main problem right now is pay scales – the disparity between the pay scales in aged care and other areas of healthcare. What we aim to do is to create and maintain an “irresistible” working environment – to make working a happy experience. Coupled with our training and education program, we provide our senior personnel much more autonomy than they would have if working for, say, [other organisation name omitted] (Ben 2014).

One of the HRM strategies that Cath (2014) finds works in her RAC facility is the implementation of quality circles to share information and increase workplace participation.

*We have quality circle meetings, now a quality circle, have you heard of them? I think [Organisation Name] were the first ones to ever have them. So we have quality circle meetings locally and we have quality circle meetings at head office. So what’s fed at locally goes up to that other group. So we don’t have union troubles and that. And [Organisation Name] is known within the industry as a great place to work. Within the accreditation agency, we run great facilities. So you know, it’s a nice place to be, you’re proud to work here. You’re actually very proud to work here* (Cath 2014).

Charlotte (2014) acknowledged the need to implement good HRM processes and also believes that the industry as a whole needs to change its attitude from a medical management model, which is seen as paternalistic, inhumane and reductionist to a management model where staffing and quality issues are dealt with in a more flexible, dispersed, and capable way:
One of the major, major, major changes that I want to see before I retire, is that we move away from the medical model. And we move away from the seven till three, three to 11, 11 to seven model. There’s a whole workforce out there who are mums with kids. That if I was a young nurse and I was looking to come back into the workforce, give me school hours. I’ve got a few staff here that work nine till either 2:30 or three o’clock and guaranteed every school holiday off (Charlotte 2014).

Currently, the aged care industry characterises paid aged care work as unskilled and expected as a female role and therefore not deserving of higher pay (Palmer and Eveline 2012). Many participants portray the workplace as one plagued by dissatisfied workers who deal with workplace issues such as inadequate staffing, heavy workloads, lack of sufficient support staff and the restrictive wages. Ivan (2014) sums up the current workplace in many RACS as follows:

Highly casualised, predominantly part-time, but there is a, to fulfil your need, often people work over the hours that are allotted, so that causes a bit of a problem. It is hard work delivering services to older people. We have to find a way to develop innovative and new models of care. There is a need to really look at what we’re doing and focus on taking the pressures and stresses of a workforce, it’s labour-intensive delivering care and services to older Australians, and I think that we have to change our models of care and the way we do work. It’s been very Tayloristic in my view, and the work has been, the command and control structures from a military type thing where health services came from originally, and those things do have to change! (Ivan 2014)

In this chapter, I presented the findings of the study. These findings are based primarily on analysis of the semi-structured interview transcripts, and are supported by reviewed literature and other research examined during this study. The findings discussed in this chapter help us to understand the complex mix of skills required for leaders in RACS. This includes the significant issues they face
in regard to government regulations and funding, the ageing of both the population as a whole and the workforce in particular and the need for good HRM policies and practices to mitigate the long hours, hard work, poor salaries and negative industry image.

Some of the key issues identified via the semi-structured interview process include:

1. There is currently no formula for the type of experience and skills currently held by senior managers in leaders in the aged care industry. Work experience and capabilities are eclectic and varied. However, participants had clear views on what they regard as required and desirable skills of successful RAC leaders.

2. There is also a strong sense that the ability to be strategic, innovative and communicate a vision for RACS is a skill that is lacking among current RAC leaders, and that the medical model of leadership, with a clinician at the helm, is no longer necessarily a requirement for RACS to be successful.

3. Participants believe that successful RAC leaders will be able to manage budgets and finances, effectively market and promote their organisations, communicate a clear vision for the future to their staff, clients and families, as well as being able to compassionately manage the palliative care of residents and effectively communicate and support their families at the same time.

4. The assessment of the government and their leadership and support of RACS is generally negative, with all participants acknowledging that the regulatory requirements are burdensome and counter-productive to an effective and efficient RAC facility.
5. Government funding is insufficient for many organisations to operate effectually, as it reinforces an industry afflicted with low wages, a casualised workforce, limited autonomy and overwhelmingly populated by women and people of non-English speaking backgrounds. It was clear from most of the interviews that within RACS, the government is viewed as ineffectual, misguided and not fulfilling their role regarding funding and supporting aged care.

6. Interestingly, while Australian demographics and our ageing society have been cited by the government, media and numerous researchers as contributing to the “aged care crisis” in Australia, the participants did not overwhelmingly recognise this as a key problem for leaders. In particular, very few referred to the impact of the ageing population of aged care workers as impeding good leadership and also a complexity that significantly thwarts the ability of leaders who struggle to recruit and retain skilled workers in RACS effectively.

7. The analysis of the semi-structured interviews also shows that human resource practices are taking on growing importance in RACS and have a relationship with increased employee satisfaction and retention in RACS. They recognise that because they can’t compete with the acute sector on wages and workload, so offering good HRM strategies such as salary packaging, flexible work hours, training and development are integral to being able to attract and retain their staff. There is also a view that many people employed in aged care are not attracted by money but the opportunity to care for others, so rewards such as those above are more valuable anyway.
8. The corporatisation of aged care is placing at risk the continued existence of smaller and rural RACS, as large providers see the opportunity for profit in the growing residential aged care sector. They believe this will lead to a loss of community focus and quality care.

9. Generally the skills, attributes and competencies indicated by the informants as being requisite for effective leaders in RACS align with the competencies prescribed in the Health Leads and ACLCF. However, these frameworks do not acknowledge the potentially negative impact of Government Regulations, Demographics, such as the ageing population and RACS workforce, and other HRM issues discussed, on RACS leaders being able to utilise these competencies and provide effective leadership outcomes.

The key findings from the research findings are as follows:

1. A key leadership attribute for leaders in RACS has been found to be the condition of being compassionate and caring about the staff, residents and their families. While there is no reference to compassion or a similar adjective in the ACLCF, the Health LEADS Framework does echo this finding and refers to compassion being an important attribute of health leaders to influence the quality of care.

2. Creating and communicating a sustainable and inspiring vision for RACS is another key leadership quality established through this research. While this should be an obvious leadership requirement, it is clear from the views of the informants, that it is not a usual occurrence in current leadership behaviour.

3. There is a clear division between participants regarding the need for clinical skills in RACS leaders.
4. A surprising finding in this research was that the informants did not clearly and resoundingly refer to the complexity of the role as a leader in RACS. This finding placed in context, demonstrates that leaders in this industry sector, despite being faced with an enormous number of complex challenges, are either not recognising or naming this as an issue unique to their industry.

4.3 Conclusion

The informants' views were generally supported by the observations of the 2017 “Review of Aged Care legislation which provides for the regulation and protection of Refundable Accommodation Payments in Residential Aged Care”, which commented on the need for government to make changes that limited the compliance burden on Aged Care Providers (EY 2017). Like the EY Review (2017), they generally believe that government must develop a framework that minimises cost and administrative burden for Approved Providers.

The Legislated Review of Aged Care Report (Tune 2017), further underpinned some the views of the participants, including:

- the opinion that aged care requires further reform to become a more client/consumer-centred system;
- it must provide access to care for all older Australians and ensure that affordability does not create a barrier to access;
- that low wages in the sector are an ongoing source of concern for both employees and the sector more broadly;
- there is a need for stronger education and training;
• there is a requirement to improve the adequacy of entry-level qualifications; and
• problems with the performance of some training providers

Chapter Five discusses the themes that emerged from this study and recommends future practice and research. In the discussion, based on the findings, we are looking for a leadership framework that encourages and fosters leaders at a younger age because we understand that the industry requires leaders with complex skills and experience, has an image problem that must be overcome, has limited resources and a recruitment problem and a retention problem. This means a leadership framework must be developed that is so robust that it targets all these different issues and challenges that RACS and their leaders have to face.
Chapter Five – Discussion

5.1 Introduction

This discussion chapter is based on the interviews with informants and compares and contrasts the information gained with what has been documented in the literature review isolating contrasting and comparative commentary. The theoretical constructs within the concept of leadership are itemised with new findings regarding issues, ideas and knowledge that have emerged from this research and are highlighted (Evans and Gruba 2002).

The thematic approach continues to compare and contrast the findings with the literature using the recurring key research themes that permeate this study.

A) Leadership
B) Demographics – of the workforce and wider society
C) Government Policy
D) Human Resource Management (HRM) Complexities

As stated in the Methodology Chapter, the research procedure adopted was applied within a qualitative framework guided by constructivism and thematic analysis (Thomas, 2006, Clarke and Braun, 2006). It is important to reiterate that the choice of theoretical framework selected by a researcher is not uninformed and reflects important understandings about the nature of knowledge, how it exists regarding the research subjects, and the possible tools which will consequently be selected by the researcher in their study (Lysaght 2011). The research tool for this project was thematic analysis linked to constructivism. This chapter, like other chapters, reflects a thematic system and complies with the recommendations by Boyatzis, (1998), Clark and Braun (2006) Thomas (2006).
Previous research has demonstrated that qualitative research methods are important when attempting to understand and analyse the interpretations and meanings that people attribute to the occurrences they experience about a particular situation, topic or occurrence (Bogdan & Biklen, 2003; Denzin & Lincoln, 2011, Beuving and de Vries 2015). Constructivist theory contends that individuals construct the significance of experiences and events, meaning that people construct “realities” based on their experiences (Charmaz, 2006, Lehmann and Coady 2008, Lauckner, Paterson and Krupa 2012). Accordingly, this research has aimed to comprehend how the informants within the research constructed their specific and shared meanings around the phenomenon of leadership, demographics of the workforce and wider society, government policy and HRM complexities, within their organisations and their broader industry sector. Also, constructivism has the particular characteristic whereby the researcher also constructs meaning through their interpretation of the studied phenomenon (Mills, Bonner and Francis 2006a, Charmaz, 2006, Pidgeon & Henwood, 1997 Guba & Lincoln, 1989). This means that research must be undertaken by implementing a transparent and insightful approach which involves thinking about what one is doing and why, as well as exploring the way that the theoretical, cultural and political context of the researcher affects the interpretation of both what is being researched and the responses of the research participants ( Alvesson & Sköldberg, 2000, Mills, Bonner, & Francis, 2006).

This mounting acknowledgement of the need for a reflective and transparent process when implementing a constructivist approach highlights the value of synthesising this type of primary qualitative research so that effective and
appropriate practice and analysis ensued. In light of this, thematic analysis was utilised as one of the underpinning methods for organising and synthesising qualitative analysis (Braun and Clarke 2006, Thomas and Harden 2008). A combined approach to thematic analysis was implemented, allowing the researcher to examine the data within certain predetermined categories derived from a theoretical framework, and also to remain receptive to new concepts that arose from the data.

Qualitative research is appropriate to this research focus on leadership in RACS and reflects the theoretical approach recommended by Biggart and Hamilton (1987), Bryman and Stephens (1992) and Grobler & du Plessis (2016). The contextual influences on effective leadership has been reflected in this study and taken into account the impact of norms, legitimating principles, historical legacies, and other institutional factors on the leadership setting and the final leadership outcomes again complementing the theoretical approach outlined by Biggart and Hamilton (1987, Bryman and Stephens (1992) and Grobler and du Plessis (2016). The findings are discussed in the context of RACS using the key themes and this discussion includes consideration of how this study links with current research and knowledge with the prominent academic literature used in the literature review as recommended by Evans and Gruba (2002).

Leadership development is a crucial role that influences the successful performance and sustainability of an organisation (Bass & Avolio 1993, Ogbonna & Harris 2000, Zaccaro and Klimoski 2001, Blanchard 2010). Too few RACS are appearing to recognise and plan strategies to directly address their leadership development needs (Jeon et al., 2010, Productivity Commission 2011). While
there are health leadership competency models available, these competency models are not industry, organisation, and role specific to the RACS. Theory development in aged care leadership is also inadequate and almost unavailable, which has led to the acceptance of models sourced from business management fields (Boldy 2006, Aberdeen and Angus 2007, Shanley 2007, Jeon et al. 2010, Jeon et al. 2013, Jeon et al. 2015, Meissner and Radford 2015). For a leadership model to be successful and have impact, they must be aligned with the organisation’s strategic goals and priorities, and clearly distinguish the ideal skills and attributes that will be required of successful future leaders (Jeon et al. 2010a, Jeon et al. 2010b). Given the significant complexity of the economic, demographic and workforce challenges intensified by our ageing society, it is clear that we need increasingly capable leadership to help guide RACS into a sustainable future (Boldy 2006, Aberdeen and Angus 2007, Shanley 2007, Jeon et al. 2010, Productivity Commission, 2011, Jeon et al. 2013, Jeon et al. 2015, Meissner and Radford 2015). It is, therefore, a key finding that substantial work needs to be done to build a leadership model that can define leadership requirements and prepare the effectiveness of leaders to meet and resolve these future challenges. The aim is to provide important insights into how this can be achieved as a result of this important research.
5.2 Discussion of Research Findings

5.2.1 Leadership

This section provides information where the informants agreed or were at variance partly or predominantly with the prominent literature cited in this study. The first interview question of this study asked of informants was: *What are the future development needs of senior managers in RACS to innovatively meet the complex challenges facing RACS?* The interview questions addressing this research question focussed on the skills and attributes required of effective leaders. More recently, research on effective leadership has drifted away from focussing on transformational leadership, toward placing greater emphasis on a shared or distributed leadership model (Pearce and Conger 2003 and Uhl-Bien 2006), which focusses on a collective, relational, and universal viewpoint that identifies the interaction between leader and follower as key elements in the effectiveness of the leadership process (Van Dierendonck 2011, Avolio, Walumbwa, & Weber, 2009). This premise is further supported by Clutterbuck and Hirst (2002), whose research demonstrates that there is little agreement in the literature regarding what makes a good leader, but that almost all research agrees that good leaders are good communicators. This was reflected in the responses by all of the 18 informants for this study. All agreed that communication was a significantly important skill for leaders in RACS but, as with the literature, there was no universally agreed view regarding effective leadership on the whole.

Effective communication is an intricate collection of dimensions, which include openness, precision, timeliness, empathy and satisfaction (Scott-Cawiezell,
Schenkman, Moore, Vojir, Connolly, Pratt & Palmer (2004). Communication can be defined as the relational process of creating and interpreting messages that elicit understanding and a response between a sender and a receiver (Griffin 2006). Communication seldom results in complete understanding because of the many environmental and personal barriers to effective communication (Robbins, Judge, Millett, & Boyle 2011). Not only are leaders in all organisational contexts expected to be effective when communicating but communication skills are arguably their most pivotal management tool (Scott-Cawiezell et al., 2004). In the aged care sector, the key to effective organisational communication with clients, families, co-workers and other healthcare professionals is via the use of authentic dialogue that delivers straightforward and open messages throughout all levels of an organisation in all directions (Arnold and Boggs, 2015). RACS that practice and apply good communication skills are expected to have better performance than RACS that experience and implement poor communication processes among their stakeholders (Scott-Cawiezell et al., 2004, Jeon et al., 2010). This view is confirmed by the responses of the participants who strongly proposed that effective and excellent communication is a key leadership requirement.

**Communication**

It is important to emphasise that communication was an area where all the informants reflected the importance of communication as a critically important skill in the armoury of an effective leader. The comments from informants comprehensively reflected the theoretical view that communication is a crucial leadership skill – each stating that one of the key skills required by effective leaders in RACS was excellent communication (all Informants, 2014). Leaders in RACS must deal on a daily basis with a plethora of stakeholders, all with different
needs, interests and abilities (all Informants 2014, Boyatzis 2015, Jeon et al., 2010 Chenoweth et al. 2014). RAC leaders must be able to manage relationships that can be difficult and fraught with anxiety and hostility, from both the residents and their families, as well as being able to communicate professionally and compassionately with staff, who face constant challenges in the day-to-day care of elderly residents (Ivan, Smiley, Laura & Charlotte 2014). Participants (Laura, Andrea & Ben 2014) outlined the importance of using communication effectively to inspire their staff so that their organisation can continue to grow, develop and meet future challenges reflecting the positions adopted by Brownie & Nancarrow 2013, Jeon et al., 2010, Scott-Cawiezel et al.. 2004). Despite all informants being senior leaders, the comments from numerous informants (Charlotte, Smiley, Laura, Gary, Cherise 2014) was that communication, being an essential leadership skill, was not practised as effectively within their RACS. Again this perspective matches comments by the Productivity Commission (2011) Jeon et al., (2010). While the topic of effective communication having a positive relationship with leadership, in general, has been well-researched (Tovey, Uren & Sheldon 2010, Nankervis et al. 2014 2017, Bratton and Gold 2012, 2017) there is limited support in the literature on leadership in RACS on this key aspect interpersonal, or soft skills (Dwyer 2011). The importance of aged care leaders being able to communicate their vision and strategy is supported by Jeon et al. (2010) and in Dwyer (2011) in their research into leadership in the aged care sector, however, there is limited aged care specific literature available to provide greater weight to this contention. The present research supports Tovey, Uren & Sheldon (2010), Nankervis et al. (2014, 2017), Du Brin (2013) in regard to effective communication being an essential attribute of successful leadership, and adds evidence concerning the importance of leader communication in RACS.
regarding the achievement and sustainability of collaborative relationships with stakeholders other than staff and residents. This study further found that leaders must also be able to sensitively and empathically communicate with residents' families, who were often experiencing a feeling of loss of control, being disheartened and feeling guilt, sorrow and liberation simultaneously. This is an added facet of communication not required of leaders in many other industries of positions, and which contributes to the complexity of RACS leadership. In the words of Charlotte (2014), a RACS leader must “look after the client, consider the family and run a business”! This links adroitly with the attribute of compassion as a requirement for leaders in aged care discussed next.

**Compassion**

A new finding raised by informants was the issue and importance of compassion. This was in stark contrast to the literature as there was an absence of academic commentary about compassion as an important aspect of leadership in aged care. All of the 18 informants raised this issue prominently, but to emphasise again in the context of the literature on leadership in RACS the concept of compassion was notably absent.

Compassion is difficult to define, and not simply sympathy or pity (Fien 2003, Bramley and Matiti 2014). One definition explains compassion as the emotion that arises in perceiving another's suffering and subsequently stimulates a desire to provide aid or assistance (Lazarus 1991, Nussbaum 2001, Goetz, Keltner and Simon-Thomas 2011). Compassion can also be defined as having three components, which include empathy or understanding and sharing the feelings of another, caring for another person, and preparedness to respond appropriately
to another’s feelings (Boyatzis, Smith, and Blaize 2006). A compassionate leadership is one who has made a positive difference to their environment over time and who pursues the greatest good for the organisation and each individual within the organisation (Briner & Pritchard, 1997). Further, a compassionate leader senses the discomfort of others and attempts to guide and support them in reaching their goals, ambitions and visions (Briner & Pritchard, 1997; Boyatzis, Smith, & Blaize, 2006). Being compassionate and caring about the staff and residents was another leadership attribute that was espoused by all the 18 informants (2014) as being critical for leaders in RACS. This is characteristic of leaders in RACS does not gel with the literature researched in this paper as the term compassion among leaders was not isolated as a needed attribute within the academic commentary within the key literature cited in Chapter Two. This is a new finding in the view of the researcher as the terms leadership, aged care and compassion were listed in the cross-search function in the RMIT library online database, and while sixty items were identified, none of these actually related to leadership compassion in aged care.

Understanding and describing compassion (or to use synonyms such as sympathy, empathy, kindness and consideration), and how it is learned and taught is confounding for many, due to its intangible nature (Liaschenko and Fisher, 1999). There is a considerable commentary on the need for compassion amongst medical and caring staff in the health industry (Dewar and Nolan 2013). Relational knowledge and relational practices are necessary for achieving compassionate care in the regarding the health sector (Dewar and Nolan 2013). The concept of “care” was defined by Gaut (1983) as a feeling of concern for others and being the essence of helping relationships. Benner and Wrubel (1989) and Noddings (1984) propose that caring is central to assessing and intervening
on behalf of another. According to (Bassett 2002, p. 8), care in nursing can be defined as a ‘prime example of emotion, thought and action coming together to provide comfort, both physical and emotional, for another individual’. Francis (2013) and Johnston (2013) assert that the best leaders of highest quality healthcare organisations behave as role models for the principles and philosophies that underpin compassionate, person-centred care. Much research has been undertaken concerning the need for compassion and compassionate care in hospitals, and in regard to nurses in residential aged care (Phillips, Davidson, Ollerton, Jackson and Kristjanson 2016, Dewar and Nolan 2013, Cameron and Brownie 2010, Tuckett, Hughes, Gilmour, Hegney, Huntington & Turner 2009). However, there is a lack of investigation in the literature regarding the need for leaders in RACS to demonstrate compassion and caring, as the role models and mentors of their care focused organisations. This does not support the views of the informants, who clearly indicated that compassion is a key and critical requirement for leaders of RACS (all 18 informants 2014). There is also some dispute in regard to whether compassion can be taught or whether it is an innate characteristic (Pence 1983, Dougherty & Purtilo 1995, Wear & Zarconi 2008, Jazaieri, Jinpa, McGonigal, Rosenberg, Finkelstein, Simon-Thomas, Cullen, Doty, Gross & Goldin 2013), which has implications for future leadership development training in RACS. If compassion is a major requirement for RACS leaders then it needs to be determined if and how it can be taught to potential aged care leaders.

**Emotional Intelligence**

Goleman defined emotional intelligence as ‘a ground-breaking, paradigm-shattering idea,’ as well as one of the most influential business ideas of the
decade (Goleman 2005, p. xii): surprisingly only two interview participants (Ivan and Cherise 2014) identified EI as a required skill for leaders in RACS. Emotional Intelligence (EI) is generally regarded as a modern day, fundamental talent for developing harmonious workplace relations, as well as being a key leadership and managerial competency (Cooper and Sawaf 1997, Goleman, Boyatzis, & McKee, 2004, Goleman 2013). As some of the most significant problems facing society are health-related, leaders in healthcare would naturally benefit from having high EI (Freshman and Rubino 2002). Leaders in healthcare and therefore aged care, must struggle with the ability to provide excellent, high-quality and safe services to their clients, during a period where they are fragile, and also being served by an industry that is has both limited financial and human resources (Freshman and Rubino, 2002, Anderson, Davidson, Hilberman and Nakazono 2000). Further, because aged care, as a human services industry, so comprehensively involves people and relationships, as well as technology and business practices, it would seem relevant that EI would be a germane construct in this study (Brunetto, Farr-Wharton & Shacklock 2012, Weiszbrod 2015)

While, the pressing need for developing skills to deal with the complex situations above was highlighted by many of the participants (Charlotte, Smiley, Meredith, Bart, Julia, Charlene, Karina, George, Liza, Ben 2014) , it is interesting then that only two (Ivan & Cherise 2014) actually named EI as one of the attributes a leader in RACS must possess. This is a thought-provoking phenomenon given the well documented premise that effective leaders possess the ability to motivate others, communicate successfully and be able to manage and resolve conflict situations (Morrison 1993, Rosete & Ciarrochi 2005, Kerr, Garvin, Heaton & Boyle 2006, Goleman, Boyatzis & McKee 2013, Du Brin 2013). These attributes are all
representative of someone who is emotionally intelligent. However, existing research demonstrates that people possessing and exercising these skills are not conspicuous in the care industry (Bellack 1999, Cadman & Brewer 2001, Freshman & Rubino 2002, Freshman & Rubino 2004, Cox & Gray 2015) and that limited research has been undertaken to establish the relationship of emotional intelligence with competencies in the healthcare industry (Dries & Peperman 2007, Hopkins & Bilimoria 2009, Ledlow & Coppola 2013). Empathy and the ability to understand and share the feelings of others is a key focus of EI but studies have demonstrated that empathy is an attribute that can be under-utilised in the nursing and healthcare sector, as healthcare workers can experience a tension between having to manage increasing workplace demands and maintaining compassion and empathy towards their clients. (Wheeler and Barret 1994, Reynolds 1998, Cameron & Brownie 2009). It appears, from both the responses of the participants and the available literature that, while they understand that caring and compassion are requisite attributes for RAC leaders, there is a not a clear recognition that the skills that contribute to the various components of EI are essential prerequisites to the development of compassion and care. This may be a result of the fact that those in the sector construct the key issue as compassion and empathy rather than EI.

**Strategic Vision**

A fundamental requirement of leadership is to create and communicate the vision for collective effort within the organisation to achieve organisational progress (Zaccaro and Banks 2001, Roswell and Berry 1993). Furthermore, it has been established in this thesis that the aged care industry in Australia faces many significant changes, which require leaders to plan for and attain major
organisational evolution and growth (Davidson et al., 2006, Commission 2011, Department of Industry 2014, Sankaran et al., 2014).

In light of these challenges, there has been a need identified to replace the transactional style leader with a more transformational leadership style which encompasses the promotion and delivery of a strategic vision (Jeon et al. 2010, Pearson, Laschinger, Porritt, Jordan, Tucker & Long 2007). The role of a transformational leader is to accomplish substantial changes in the present circumstances of an organisation and lead them to improved conditions and outcomes (Burns 1978, Bass 1985, Luzinski, 2011, Ayoko, and Muchiri, 2014).

Importantly, leaders who wish to be transformational must be more focused on creating change rather than on an exchange. More importantly, this leader with his/her vision for the organisation must lead followers both inside and outside of the organisation to embrace that vision. Yukl (2006, p. 295) defined vision as being “simple and idealistic, a picture of a desirable future” that “should appeal to the values, hopes and ideals for organisational members and other stakeholders whose support is needed. The vision should emphasise distant ideological objectives rather than immediate tangible benefits”.

Seven of the informants in this study (Bart, Cath, Liza, Ivan, George, Ben & Charlene 2014) were cognisant of the need for leaders who can create and implement a vision for RACS. While not actually referring to the term ‘transformational leader’, these participants outlined the requirement that leaders in RACS require a capacity to create and sell a vision to their staff, clients and the community, in order to be able to meet the challenges besetting the industry, and to inspire their staff to meet these challenges (Bart, Cath, Liza, Ivan, George, Ben & Charlene 2014). This complemented the information on leadership in the
general academic commentary but was significant due to its sparsity in literature about RACS.

These participants (Bart, Cath, Liza, Ivan, George, Ben & Charlene 2014) also recognised that the day-to-day demands of the job did not provide leaders with the time or ‘headspace’ to examine the ‘bigger picture’ and create a vision to embrace it. They saw the leadership role as being so compliance-driven, that it strangled the development of organisational vision and innovation. It appears that the lack of acknowledgement of the importance of vision to organisation effectiveness in aged care, as embodied by Yukl’s (2002) transformational leader, is not restricted to those working in the sector. There is limited research in the literature regarding the ability of leaders in RACS to construct and market a vision for their organisation as a vital skill in this industry.

Thyer (2003) examined the need for leaders to communicate the vision of the organisation, the direction it wishes to take, and the future it sees for its success, as well as involving staff in the decision-making process if the vision is to be successful. Jeon et al. (2010) cited that a key driver of a positive workplace culture was the ability of leaders in RACS to communicate a long-term vision and build staff commitment to it. In a study on leadership in faith-based RACS, Shaw et al. (2014) found that high performing leaders were those who were able to share a clear vision for the future direction of the organisation with their employees, and were then able to bring those staff along with them to achieving the vision. Finally, the ACLCF (referred to in the Literature Review, 2.3.2) indicates that there is an urgent need in aged care for transformational leaders with vision, who can “inspire, challenge, stimulate, motivate and support followers to lift them to higher levels of performance and greater job satisfaction”
These comprise only a few sources in the literature that examine the requirement of leaders in RACS to possess vision as a major leadership attribute despite an extensive literature search. Therefore, while almost half of the participants (Bart, Cath, Liza, Ivan, George, Ben & Charlene 2014) clearly cited skills related to transformational leadership, such as creating and selling a vision, as being of significant importance to successful leadership in RACS, there is limited research available that has investigated this phenomena. This may be because the aged care industry is still experiencing a transition from a cottage industry supported by families, volunteers and the community, to operating as a viable and competitive business. Consequently, aged care leaders and researchers are only just recognising the need to be strategic, innovative and adaptable regarding their business models, to sustainability and growth for the future (Jeon et al.. 2010b, Department of Industry 2014).

**Strategic Thinking/Planning/Innovation**

In responding to the question regarding skills gaps in leaders of RACS, it was in the areas of vision, strategic thinking, innovation and financial skills that around half of the participants highlighted as requiring attention (Charlotte, Ivan, Laura, Julia, Ben, George, Liza, Madeleine & Bart 2014). There is a sense that many RACS leaders are reactive and non-strategic, but that for the business to survive innovation, continuous improvement and best practice processes must be adopted (Ivan, Laura, Julia, Ben, George & Liza 2014). This indicates that these participants either support or regard as inevitable, a more marketised aged care sector. Chandler (1962, p. 13), author of Strategy and Structure, which is the classic study regarding the connection between the strategy and the structure of
an organisation, defined strategy as “the determination of the basic long-term goals and objectives of an enterprise, and the adoption of courses of action and the allocation of resources for carrying out these goals.”. Strategic planning, therefore, assists in determining the direction and scope of an organisation over a long period, and plans for corresponding organisational resources to the changing environment, which includes its markets, consumers and clients, so that stakeholders’ needs can be effectively met (Johnson and Scholes 1993, Ad Abdallah and Langley 2014).

This is supported to a limited extent in the literature (Productivity Commission 2008, Department of Industry 2014, Goldsworthy 2016). Michael Goldsworthy (2016), cites two key drivers instigating leaders in RACS to adopt a more strategic approach to their management practices, which includes the emergence of customer choice, and the establishment of a highly competitive marketplace where private, public and community organisations all vie for clients and funds. This is an outcome of the neoliberal policies of the recent federal government which leaves a reduced role for public organisations in the provision of aged care services, as discussed in the literature review (refer to Coory 2004, Cunningham & James 2011, Davies 2011, Baines & Cunningham 2015). The policy emphasis on for-profit delivery of aged care services has been exemplified by the extension of the private sector into aged care service provision, to the extent that for-profit providers are now major influencers in this sector, with whom not-for-profit organisations must compete (King & Meagher 2009).

The Aged Care Leadership Capability Framework (Department of Industry 2014) stated that size and range of changes within the aged care environment will drive
leaders to adopt strategic and inventive thinking as well as piloting innovative practices and adapting their organisational approach to meet shifting customer requirements. Leaders must, therefore, ensure that they work in partnership with stakeholders and employees to lead key strategic changes to ensure their organisation’s survival and success (Department of Industry 2014). However, in reality, the opportunity to achieve these strategic outcomes is at risk of being constrained by external factors beyond the control of RAC leaders, many providers, particularly smaller or single facility operators, insist that the possibility of achieving greater competitiveness through strategic changes within their organisations has already largely been exhausted due to the growing regulatory burden (Productivity Commission 2008). This also links with the view amongst the following participants that the large RACS will continue to grow larger and the smaller organisations will need to become boutique or specialist organisations….or cease to exist (Charlotte, Ivan, Laura, Sarah, Julia, Ben, George, Liza, Madeleine, Cherise, Charlene & Bart 2014).

Financial Skills

A noteworthy ability that was revealed quite regularly by most participants was the capacity to be able to budget and manage financial and commercial aspects of a residential aged care facility (Ivan, Julia, Laura, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014). While these particular skills may be considered as being pertinent to managers rather than leaders, in the Literature Review it was acknowledged that there is a view that managers must be able to lead as well as manage, and that effective leaders must also be good managers (Kotter 1990, Mintzberg 2008). There has been a tendency to isolate leadership from management by defining distinct managerial concepts and frameworks as
competencies, however, both roles are of fundamental importance to an organisations' well-being (Carroll, Levy & Richmond 2007). According to DuBrin (2013), a leader sets the direction of the organisation, while the manager undertakes the planning and budgeting. In many smaller organisations like RACS, the senior staff member must take on the roles of leader, manager, figurehead, entrepreneur and spokesperson, to name a few (d'Amboise & Muldowney 1988, Jeong & Keatinge 2004, Jeon et al. 2010, Dwyer 2011). However, managing commercial and financial interests appears to be expertise that has not previously been as important to leadership and management in RACS until the past decade (Shanley 2007, Productivity Commission 2011). In particular, this attitude can be attributed to the aged care industry developing from previously being a cottage industry based on the care and compassion of family members and the community and not profit, as indicated by one informant (Ivan 2014). Many RACS still operate under a not-for-profit position, which can generate added and distinctive challenges for leaders within such organisations (Shaw et al. 2013). Clients often view not-for-profit RACS as preferred providers because this status indicates that they are strongly committed to a specific mission or faith and that any profits will be re-invested into improving client care, which generates pressure on leaders in regard to both meeting the service quality anticipations of customers and families, and guaranteeing the sustainable operation of their business (Hearn 2011, Weerawardena and Sullivan-Mort 2001, Sankaran et al., 2010). Sankaran et al. (2010) found in their research that leaders in not-for-profit RACS required the ability to implement financial reporting and operating processes, to budget effectively without adversely affecting operations and staff, and to manage complex financial structures. However, the current standard of
performance expected of leaders in not-for-profit organisations is far higher than previously, and expectations that they will both meet the demands of market forces, while maintaining their community values and ethos means that many leaders do not possess a clear understanding of the financial management role (Sankaran et al. 2010; Connelly 2004).

This view in the literature was supported by a number of participants (Ivan, Julia, Laura, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014). According to Cath (2014), the practice of many of the smaller facilities employing nurse managers as leaders has meant that they provide excellent clinical care but do not necessarily have budgeting and management skills required. This was further elaborated on by Charmaine (2014) who considered that many leaders in aged care do not understand budgeting and believe that their organisations “run on love”. It appears from the number of participants who cited finance, business and budgeting skills as a required skill for leaders in RACS, that this is a clear area of skill development for the future (Ivan, Julia, Laura, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014). Only two of the few studies that have been undertaken regarding leadership skills in RACS, which was commissioned by Community Services & Health Industry Skills Commission, Aged and Community Services Australia and Leading Aged Services Australia (Cooke 2014), found that financial management was one of the key leadership capabilities required for successfully managing an aged care organisation. The recently developed Aged Care Leadership Framework (Department of Industry 2014) also recognised the need for leaders in aged care organisations to develop sound financial management capabilities, including budgeting, accounting and strategic use of financial resources to remain competitive and sustainable. Unfortunately, there
appears to have been limited research undertaken which specifically examines the capability of leaders in RACS to effectively manage the financial and competitive activities required of them in today’s competitive, changing aged care environment.

Managing Change

All of the participants interviewed for this research referred to the significant changes troubling the aged care industry and the RACS, and the ability to manage and implement change was highlighted by eight out of the eighteen participants as an essential skills for leadership in RACS (Ivan, George, Liza, Ben, Cath, Andrea, Laura & Charlene 2014). The Productivity Commission Report, (2011) stated that the ability of organisations to successfully meet and manage substantial changes to the aged care industry would rely profoundly on the capacity of aged care managers to successfully lead change within their organisations. According to ACSA in their report on the aged care workforce (2015) and the Productivity Commission (2011), the rate of change in the aged care industry will increase in the coming years, which will elevate the opportunities, as well as the challenges for RACS. To emphasise, one of the participants, Ivan (2014) echoed these predictions, warning that RACS required the ability to “.. get through and thrive and change and re-form and make the most of the changes that were occurring..”. He believed that in order for RACS to steer effectively through the web of regulatory and market structural changes, as well as meeting the changing expectations of consumers or customers, their leaders must be able to successfully manage the change process and raise their organisations from simply being nursing homes into something that offers so much more to their clients (Ivan 2014).
This view was identified in previous but limited research that has been undertaken regarding managing change in RACS. Cook (2001) suggested that healthcare leadership must focus on continuous improvement through persuading their staff to ‘buy in’ to change and that to do this, leaders must be adept at understanding the process of how to lead change. In a study by Pearson, Schultz and Conroy-Hiller (2006), it was found that there is a need for leaders in aged care to be able to continuously assess the external environment and develop appropriate solutions for their organisations to continue to be effective and competitive. The study also determined that RACS had not, at that time, been the subject of research eliciting the best available knowledge and data in regard to change and change management which was an issue that Pearson et al. (2006) had raised almost a decade earlier and was key issue raised in the Productivity Commission report (2011). Further studies by Shanley (2006), Jeon et al. (2015) and Meissner and Radford (2015) found that leaders in RACS regard changes within their industry as constant and inescapable, but that few of these leaders have actually engaged in analysing or discussing how they can most effectively manage this changing environment. This would in some way explain why leaders interviewed for this study recognised the significant changes underway in their industry but that few acknowledged change management as a required skill for effective leaders, therefore supporting the limited literature available on this topic.

**Human Resource Management**

Human Resource (HR) and people management skills were another capability area that some participants felt were highly required capabilities in the current environment but were not generally held by leaders in RACS (Smiley, Andrea, Cherise, Charlotte, Greg, Liza, Charlene, Cath, Ivan & Ben 2014). The
participants (Smiley, Andrea, Cherise, Charlotte, Greg, Liza, Charlene, Cath, Ivan & Ben 2014) believed that people management skills were important for managing both staff and the residents’ families, during what is often a difficult, pressurised and sensitive time. However, it was an area that was also highlighted as significantly lacking in the industry. Jeon et al. (2010a) found that the implementation of good HRM procedures in aged care organisations through practices such as coaching and mentoring, career development, emotional support and positive feedback systems, until recently has been significant by its absence. While stating that a dearth of rigorous research has been previously undertaken in this area within Australian RACS, Jeon et al.. (2010a) found that a deficiency of supportive workplaces, combined with poor staffing levels and skill mixes, was evident. This view from Jeon et al. (2010a) was corroborated by several commentators in this field (Cooke and Bartram 2015; Kaine 2012a; Clarke and Rao 2012). This situation exacerbated the limited career opportunities, in the industry which caused difficulties in attracting and retaining aged care staff, as well as inducing low workplace morale and self-esteem (Jeon et al.. 2010a).

Cooke and Bartram (2015) found in their research, that the role of HRM within the wider health sector has been strongly researched in Australia, and that well developed HRM policies and practices within this industry, can contribute to better healthcare outcomes for clients, as well as improving the job satisfaction and working experiences of clinicians, management and other care staff. In the aged care sector, HRM skills and capabilities within management have not yet been sufficiently researched and have had no real outcomes recorded (Cooke and Bartram 2015; Kaine 2012a; Clarke and Rao 2012). In reviewing the limited
research that has been undertaken into the implementation of people management skills in aged care facilities, Dwyer (2011) found that there was a lack of professional support, specific education focused on leadership and management and a lack of structured pathways for learning and development regarding careers in aged care. Many leaders in RACS are not well prepared for their role and are deficient in people management and HRM skills, making them unready and ineffective in undertaking the multifarious leadership role they hold in aged care (Dwyer 2011, Jeon et al.. 2010a, Aberdeen and Angus 2005). There was insufficient access to education programmes available for nurse leaders to advance their professional capabilities and ongoing development of both their clinical and HRM skills (Dwyer 2011, Carryer, Hansen and Blakey 2010). The research participants (Smiley, Andrea, Cherise, Charlotte, Greg, Liza, Charlene, Cath, Ivan & Ben 2014) clearly supported the limited literature available regarding the need for well-developed HRM and people management skills in RACS leaders and recognised that it has been lacking in aged care leadership to date. So half of the informants (Smiley, Andrea, Cherise, Charlotte, Greg, Liza, Charlene, Cath, Ivan & Ben 2014) agree with the view espoused by the authors cited above who had commented on this problem Cooke and Bartram 2015; Kaine 2012b; Clarke and Rao 2012, Dwyer 2011, Carryer, Hansen and Blakey 2010, Jeon et al.. 2010a, Aberdeen and Angus 2005).

**Clinical Skills**

There was a clear divergence amongst participants regarding the need for leaders in RACS to possess clinical, as well as management skills to be effective. Almost fifty per cent of the participants interviewed held the view that engaging leaders simply based on their clinical skills led to vital leadership and
management skills being overlooked, resulting in negative outcomes regarding RACS leadership (Charlotte, Cherise, Cath, Ben, George, Liza, Madeleine, Ivan & Charlene 2014). This view is supported by Radford (2016), who found in her research into employee turnover in aged care that staff tend to be promoted into management roles as a result of their clinical rather than leadership skills, but that leadership training and development for such staff is not readily available. Furthermore, Aberdeen and Angus (2005) found in the case of residential aged care, those with management experience and qualifications are underrepresented in leadership roles and that clinicians in leadership roles hold few effective managerial skills. They found that they tend to be overly beholden to the regulations and compliance expectations of the role and the sector, and that this has the effect that even experienced nurse managers rapidly cease to utilise the management and leadership skills previously learned and practised in other roles (Angus and Aberdeen 2005, Jeon et al. 2010a, Jeon et al. 2010b).

The diverging view of the participants regarding the need for clinical skills in leaders is a significant new finding. While there is some literature outlining the need for the development of leadership and management skills in RACS leaders (Dwyer 2011, Jeon et al. 2010a, Carryer, Hansen and Blakey 2010, Aberdeen and Angus 2005), nearly all of the research focuses on developing clinical leadership skills, without taking into account the emergence of leaders in RACS who do not have a background in the health-related industry sector. Jeon et al. (2013) undertook the development and testing of an innovative aged care leadership program, specifically aimed at improving RACS managers’ clinical leadership aptitudes, to ensure the delivery of quality care in Australian RACS. A clinical leader was defined by Harper (1995, p. 81) as “one who possesses clinical
expertise in a speciality practice area and who uses interpersonal skills to enable nurses and other healthcare professionals to deliver quality patient care”.

Research has demonstrated that a key driver in a healthy workplace culture is the ability of clinical leaders to communicate lasting organisational vision, create staff satisfaction and build organisational commitment (DuBrin 2013, Gilmartin & D’Aunno 2007, Anderson 2003). Pearson et al. (2006) argued that an investment in developing clinical leaders in regards to researched-based interventions and activities, along with skills in evidence transfer and change management are also required. Kitson, Silverston, Wiechula, Zeitz and Marcoionni (2011) concurred with (Pearson et al., 2006), proposing that changes to leadership in aged care need to focus on developing clinical nursing leaders in regards to assisting them to introduce new knowledge, processes and vision into their practice. So while clinical leadership is an important focus of the aged care leader, there appears to have been a scarcity of research undertaken into the leadership skills required for leaders of RACS regarding both clinical and business management capabilities.

Much of the evidence from the participants focussed on RAC leaders needing clinical skills, but that the medical model of management, often practised by nurses managing and leading in aged care, is outdated and ineffective (Ivan, Charlotte, George, Liza, Laura, Andrea, Sarah & Karina 2014). After acknowledging this point, the participants were divided regarding the process for addressing the medical management inadequacies. Approximately half of the participants were adamant that to manage risk, RACS leaders must have clinical skills and develop other key management and leadership skills, becoming all things to all people (Laura, Andrea, Sarah, Karina, Louise, Julia, Bart & Smiley
This view reflects the research of Davidson et al. (2006, p. 182), who found that current economic, environmental and political challenges necessitated the emergence of vigorous nurse or clinical leaders who are capable of shaping and guiding clinical activities so that the best patient outcomes are achieved, and who demonstrate “...mentorship, supervision, clinical excellence, support of colleagues, a positive orientation and inspiration to others.”. As current general healthcare sector frameworks are becoming more interdisciplinary and less dependent upon hierarchical, medical leadership, there is a growing opportunity for nurse managers to become pivotal in directing and guiding healthcare services, including aged care, as well as quality clinical process development (Dwyer 2011, Jeon et al., 2010, Davidson et al. 2006). There is a strong view in the available literature that it is nurses who are essential in administering leadership and direction in care provision, being responsible for employee learning and development and assisting patients and families in making informed decisions, regarding their care, treatment and palliative pathways (Dwyer 2011, Venturato & Drew 2010, Venturato et al., 2006 and Davidson et al. 2006). This ties in closely with the views of (Laura, Andrea, Sarah, Karina, Louise, Julia, Bart & Smiley 2014), who believe that leaders in RACS must be both nurse/clinical managers as well being responsible for all of the other day-to-day management tasks, rather than operating specifically in a leadership role only.

The remainder of the participants, however, believed that business management and people management skills were a far more important attribute in successful RAC management and that access to clinical advice when required, was sufficient (Charlotte, Cherise, Cath, Ben, George, Liza, Madeleine, Ivan & Charlene 2014). There was a view that in the past unions drove the requirements
for leadership in RACS to be predominantly comprised of Directors of Nursing – who could be anyone qualified as a registered nurse elevated to a leadership position, and that in this model, the leadership component was not particularly important to the role (Cath & Ivan 2014). The informants believe that today’s conditions require a care manager to manage the care, and leader to lead, motivate, inspire and manage the business elements of the facility or organisation (Charlotte, Cherise, Cath, Ben, George, Liza, Madeleine, Ivan & Charlene 2014). This is supported by Gilmartin & D’Aunno’s (2007) research that found aged care leadership needed to be collaborative, communicative and flexible but cognizant of the systematic communication protocols and procedures inherent in a health organisation, and also effectively addressing the range of staffing variables which impact job satisfaction, retention and recruitment. To highlight, one participant, Ben (2014) supported this view as he learned that not having a nursing or healthcare background was not a disadvantage, and that being able to identify the right individuals for the right jobs was more important, as well as that ensuring that you have a quality team behind you is critical to success. There has not been any available literature to support further this view at this stage, which leads to a claim that this represents an added new finding in the view of the researcher.

At the time of writing, the Health LEADS Framework and the ACLCF were both recent frameworks that investigate and outline such leadership capabilities for both the health industry and the aged care industry. Although these leadership frameworks are designed respectively for the whole health and whole aged care systems, they aim to embed leadership capabilities into clinical health professionals’ undergraduate and postgraduate curricula, to provide earlier and explicit engagement with leadership behaviours and to heighten their leadership
effectiveness (Sebastian et al., 2014). Both of the frameworks outline leadership competencies and capabilities specific to a leader in the health and aged care industries’ roles that can be embedded with or without clinical skills. They, therefore, provide a good basis for the development of leadership training and development specifically tailored to RACS.

**Dementia Knowledge**

As discussed throughout this thesis, a consequence of the economic boom after the Second World War was a change in the demographics of developed countries (Productivity Commission 2011, Australian Treasury 2010, ACSA 2016, ABS 2016). The birth of the baby boomers after World War II, combined with the increasing life expectancy as a result of improved medical technology, research and treatments, along with the subsequent decrease in birth rates in these same countries, has meant that Australia’s population is ageing significantly (Productivity Commission 2011, Guest & McDonald, 2001, Australian Treasury 2010). This change in demography, in conjunction with structural changes to families and shifting social beliefs, has resulted in an enormous growth in demand for care for older Australians (Sparrow and Sparrow 2006, Productivity Commission 2011, Guest & McDonald, 2001, Australian Treasury 2010). In light of these changes and the impact they have had on RACS, the participants also commented on the major changes that are occurring in their RACS and the specific leadership skills they believe are required to address these changes. One of the major changes generating substantial challenges for RAC leaders has been elicited by the government’s “Ageing in Place” strategy, which planned elderly people to remain in their homes longer and consequently coming into a RAC purely for the end of life care (Karina, Charlotte, Gary, Julia & Laura 2014).
Numerous participants made comments that reflected the demographic complexities well covered in the literature. Many identified the big issue facing aged care over the next few decades being linked to an increase in elderly people with dementia (Sarah, Karina, Charlotte, Gary, Julia, Ivan, Bart, Karina & Laura 2014). While some of the major killers in society such as heart disease, stroke, cancer and musculoskeletal disorder are declining due to improvement in medical treatment, the onset of dementia in elderly Australians, despite medical advancements, is growing (Bruen 2005, Abbey, Froggatt, Parker, & Abbey 2006, Alzheimer’s Australia 2017). To date, there has been no real evidence that dementia can be successfully treated or delayed, and as older people live longer due to effective treatment and prevention of other diseases, general incidence of dementia-related illness is increasing (Jeon et al., 2010, Angus 2009, Bruen 2005 Alzheimer’s Australia 2017). This circumstance, combined with growing numbers of elderly people in the Australian community, means RACS are facing an immense challenge regarding providing effective care for people with a disease or condition for which there is no real remedy or prevention (Australian Treasury 2010, Productivity Commission 2005 & 2010, Bruen 2005, Abbey et al.2006, Alzheimer’s Australia 2017).

The result of a growing cohort of aged persons in Australia with untreatable conditions means that leaders in RACS require even more specific skills than those already attributed to aged care leaders (Charlotte, Sarah, Kate, Ivan & Laura 2014). According to Sarah (2014), aged care leaders will require a greater understanding of age-related mental illnesses and also be able to effectively train and lead those who are charged with their care. Currently, while there is
recognition of, and treatment provided for, dementia-related illnesses in older people living in RACS, this is challenged by the dearth of leaders and care staff trained in this area (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003; Moyle, Hsu, Lieff and Vernooij-Dassen 2010). In Australian RACS, most of the care staff are lower skilled personal care workers (PCWs) whose key emphasis is on maintaining residents’ activities of daily living. PCWs do not have adequate training in caring for people with mental illness (Montague et al. 2015, Moyle et al. 2010; Beeber, Zimmerman, Fletcher, Mitchell and Gould 2010, Doyle and Ward 1998). In more recent times, there has been a growing belief stated in the literature that person-centred care for people with dementia is a method of patient care grounded in the conviction that personal identity and individuality can be preserved despite intellectual and rational deficiency (Stein-Parbury, Chenoweth, Jeon, Brodaty, Haas & Norman 2012). This view finds support from Brownie and Nancarrow (2013), who found that some RACS in Australia are now replacing the clinical model of care to one that utilises person-centred care as the main standard of practice for dealing with the growing number of residents with dementia-related illnesses. This was acknowledged by only a handful of participants (Sarah, Karina, Charlotte, Gary, Julia, Ivan, Bart & Laura 2014), who referred to the need for a more person-centred approach to aged care and in particular dementia care.

There have been some Australian Federal Government initiatives that have been founded to encourage the development of better leadership and management in RACS, which embrace dementia-related education and training (Jeon et al. 2010a, Productivity Commission 2008). These include the ‘Bringing Nurses back into the Workforce’ program; the Aged Care Nursing Scholarship Scheme, which
provides postgraduate scholarships for community aged care nurses; the Support for Aged Care Training Program, which focusses on training in rural and regional zones; dementia-related education and training; and the Community Aged Care Workforce Development and the ‘Better Skills for Better Care’ programs (Jeon et al. 2010a). However, the purpose of these initiatives has been to recognise and benefit only a small number of RACS leaders or homes for service excellence, or for the education and training of direct care staff (Jeon et al. 2010a, Productivity Commission 2008). None of these programs has the purpose of providing a logical and tactical direction for strategic and clinical leadership development for leaders of RACS (Productivity Commission 2011, Jeon et al. 2010b, Sankaran, Shepherd, Cartwright & Kelly 2006). Once again, most of the literature surrounding the development of skills that successfully implement person-centred care related to the growth in aged care residents suffering from dementia is related to nurses and care workers, rather than those in leadership positions in RACS. Addressing dementia means not only working with those suffering from the disease but also managing relationships with families affected by watching loved ones deteriorate while being in care (Edvardsson, Featherstonehaugh & Nay 2010). A very recent study found that leaders of RACS are instrumental in leading by example in conveying affirmative organisational and professional attitudes towards the care of people with dementia and their families, therefore indicating that there a need for them to have some knowledge of the disease and its manifestations (Edvardsson, Sandman & Borell 2014). This is an area for further investigation in the view of the researcher, as while only some of the informants (Sarah, Karina, Charlotte, Ivan, Bart & Laura 2014) and limited commentators from the literature commented on this attribute, those that did,
clearly indicated that it was an important leadership requirement for RACS, not simply confined to the realm of nursing expertise, which bears further exploration.

**Palliative Care Skills**

Palliative care assists people to live their life comfortably and as normally as possible despite living with a life-limiting condition or terminal illness. Palliative care recognises and treats symptoms based on individual needs and may include physical, emotional, spiritual or social aspects. One participant, Charlotte (2014), believed that because of the increase in dementia-related illnesses and people in need of aged care later in life, leaders in RACS must become knowledgeable in palliative care as well as providing an appropriate level of caring and compassionate service to families of those ending their life in aged care facilities – adding even further skills to their list of leadership requirements. This was more pertinent to the smaller RACS where leaders needed to be across wider care issues. In the past, many RACS exhibited a limited focus on palliative care and received restricted support from external providers, which combined with a perceived obligation to provide a home-like care setting, may have restricted leaders’ capacity to create appropriate processes and models that effectively delivered sensitive and compassionate palliative care (Dwyer 2011, Phillips, Davidson, Jackson & Kristjanson 2008).

There is a continuously growing scope for staff in RACS to become practiced in the management of chronic and multifaceted resident care, as well as being able to effectively and perceptively interact with families, expedite advance care planning, and assist with the management of palliative care needs in RACS (Phillips, Davidson, Jackson, Kristjanson, Daly & Curran 2006). Furthermore, the
Productivity Commission (2011) advised there is likely to be a heightened need for aged care residents to receive specialised nursing care and benefit from the skills of specialist health teams who can provide clinical leadership and care management, chiefly in areas such as palliative and end-of-life care, as well as in the area of behavioural management expertise. Finally, a study by Davis, Byers, Nay & Koch (2009), found that visionary leadership and inventiveness, along with open and cooperative approaches to care were most effective in ensuring dementia and end-of-life friendly environments in RACS.

It is imperative that leadership within RACS play a key role in empowering and inspiring aged care nurses and care assistants to develop skills outside the scope of simply gerontology and become themselves expert in the provision of effective care to palliative patients and their families (Phillips et al., 2008, Productivity Commission 2011). To date, only a limited amount of research has been undertaken to focus on the need for leaders in aged care to develop these skills, which gels with the findings of this research, with only one informant (Charlotte 2017) citing this as a required leadership attribute. The key issue is that only one person form 18 experts interviewed commented on this looming change given the vast increase in elderly Australian citizens.

**Challenge of the Baby Boomers**

A final challenge referred to by some participants listed below was the concern over the commencement of baby boomers coming into RACS and the differences they will have regarding expectations of care. Participants regard this as a major challenge for leaders regarding providing the type of care environment baby boomers will demand, in combination with safe and appropriate care designed to
address baby boomers’ particular health needs (Bart, Andrea, Charlotte, Ivan, Laura & Charlene 2014). These participants are of the view that the baby boomers will have significantly different care requirements than the current generation current in RACS, and will expect a much higher quality of care, that is far more flexible and less hospital-like, all provided with limited funding (Bart, Andrea, Charlotte, Ivan, Laura & Charlene 2014). While almost half of the participants held this view regarding the challenge of the baby boomers and their expectations, it was not widely supported by the available literature. A comprehensive search of the accessible databases found that there was a scarcity of research addressing the expectations, strategies and arrangements of baby boomers for their elderly years (Quine & Carter 2006, Hunter, Wang & Worsley 2007, Gray & Heinsch 2009).

The Productivity Report (2011) devoted a significant level of commentary to the demands that the baby boomers will present to RACS and there is some research published on work, income and social expectations of the baby boomers regarding their care expectations. However, the issue of accountability for baby boomers’ health, well-being and care in old age was largely uncharted, and recent literature comprises opinion rather than empirical results (Quine & Carter 2006, Hunter, Wang & Worsley 2007, Gray & Heinsch 2009) again with the important exception of the Productivity Commission Report (2011). While this is not a new finding, it supports the largely unsubstantiated and unexplored view, that there is further research required regarding the care expectations of baby boomers when they become clients of RACS Productivity Commission Report (2011).
Ethical Behaviour

Health and aged care workers face regular ethical challenges in the delivery of high-quality care (Ulrich et al., 2010, Productivity Commission Report, 2011). As discussed in the literature review of this study, ethics is the bedrock of leadership because the actions of leaders generally have a greater impact on a greater number of people, than the actions of other individuals in organisations (Cuilla 2004, Cuilla 2013). Furthermore, it is the role of a leader to combine and address the welfare of all parties in an organisation to ensure success and prosperity for all stakeholders (Ciulla 2004, Derr 2012, Ciulla 2013). In an aged care setting, it would appear even more important that a component of good leadership is the ability to manage stakeholder relationships and care, based on high ethical standards (Lloyd 2004, Oliver 2006). Central to the whole concern for those in aged care is ‘respecting their dignity of the aged, their life stories, their social situation, their feelings, their spirituality, and their integrity, in spite of their diminished physical and intellectual capacities’ (Wade 2001, p. 6). Given the nature of the healthcare industry and the reliance of individuals on its staff for care, issues such as end-of-life care, medical errors, patient privacy and autonomy over decision making are common and frequent ethical concerns in RACS (Doran, Fleming, Jordens, Stewart, Letts & Kerridge 2015).

Interestingly, not one of the participants in this study referred to the issue of ethics in aged care and the concept of ethical leadership. This is reflected in the research as a similar search of the literature was undertaken using the terms aged care ethical leadership, and it appears that there has been limited research undertaken regarding the important issue of ethical expectations of leaders in aged care.
5.2.2 Demographics

Ageing Population

To recap briefly the demographic statistics that will impact on RACS being the age of the residents and staff the following is used to place this issue in context again, although it is covered with greater intensity in the Literature Review Chapter (2).

By the year 2050, the average life expectancy in Australian is expected to reach 92 for females and 88 for males (Australian Bureau of Statistics, 2010). Additionally, there has been a decline in the proportion of children from 35 per cent to 20 per cent of the total Australian population and an increase in the proportion of the population aged over 65 years from 4 per cent to 13 per cent over the last century (Australian Treasury 2015, Australian Treasury 2010, Hodgkin 2014, Warburton & Hodgkin, 2012). Estimates that predict as far as 2056, calculate that the proportion of people aged 65 years and over will grow by roughly 40 per cent, and will then account for 25 per cent of the total population in Australia (Australian Bureau of Statistics, 2009).

Ageing RACS Workforce

A report by Australian Treasury (2010a) has identified that this fundamental problem of ageing population growth that will occur significantly over the years to 2050, will bring about a smaller quantity of workers to support the number of potential retirees. In effect, according to Speohr and Barnett (2008), there will be more people retiring from the workforce than entering it by 2050. This prediction is even more alarming for the aged care sector, as the aged care workforce is not
young and only 5 per cent of the workforce is aged 16-24, compared to the rest of the Australian workforce, where they comprise 20 per cent (Fleming & FitzGerald 2009). Furthermore, when compared with the rest of the Australian workforce, the aged care sector encompasses only 12 per cent, of the share of workers aged 25-34, with the majority of their workforce being over 45 years old, and having 17 per cent being over 55 years old (Fleming & FitzGerald 2009, King et al. 2012). As identified earlier in this thesis, and stated by Richardson and Martin (2004, p.28) “The typical worker is female, Australian born, aged about 50, married, in good health, has at least 12 years of schooling and some relevant post-school qualification and works 16-34 hours per week. She is likely to be a personal carer, working a regular daytime shift. The post-school qualification is likely to be a Certificate III in Aged Care. “

Interestingly, the ageing population is a topic which most of the participants interviewed for this thesis generally did not regard as a problem. Perhaps participants did not realise the potential negative impact the ageing population will have on their ability to manage and run their organisations in the future successfully. This lack of recognition of this important issue is a concern, as RACS are increasingly going to be required to respond to the escalating demand for residential care services, as Australia’s population ages (Productivity Commission 2008, Productivity Commission 2011, King et al. 2012). Therefore they must be developing strong workplace policies and strategies to attract and retain an effective workforce that encompasses the necessary flexibility to provide apposite care for older Australians, in an environment where the work is demanding and labour intensive and will face growing pressures to entice workers to meet these needs, given the anticipated decrease in workforce growth.
As noted in the findings chapter, only four participants referred to the ageing of the workforce as being an issue for leadership and organisational success (Ivan, Laura, Andrea & Cath 2014).

**Skill and Staffing Shortages**

The aged care sector faces significant competition for skilled workers and the growing skill shortages in this industry are expected to deteriorate (Productivity Commission 2011, Montague et al. 2015). While there are skill shortages across all of the roles within the aged care sector, 49 per cent of RACS reported deficiencies in regard to PCWs, 63 per cent reported shortages of registered nurses and 33 per cent reported a lack of enrolled nurses (ENs) (LASA 2016, ACSA 2016, King et al. 2012). This skill shortage is not likely to be alleviated in the future as the number of people of working age is decreasing while the number of those retiring grows (Treasury 2010, Productivity Commission 2011). Those in the shrinking workforce are unlikely to be attracted to filling the skills shortages in RACS, as they are many other working options with better pay and conditions (Productivity Commission 2011, Montague et al. 2015). A recent study into the wellbeing of nurses by Monash Business School, found that one third of nurses are thinking of leaving the profession as they feel overworked, undervalued and in danger of burnout (Holland, Tham & Gill 2016) Furthermore, nurses in the aged care sector, reported higher levels of emotional labour, decreased level of management support in the workplace and greater workload issues (Holland et al.. 2016). Given that staffing in aged care is already an issue that is impacted by a number of elements, including a shortage of registered nurses, inferior rates of remuneration and challenging working conditions (Venturato, Kellett, & Windsor,
2006), it can be inferred that the impact of the loss of one third of nurses to the health sector overall will significantly affect the RACS.

Furthermore, as presented in the Intergenerational Report (Department of Treasury 2015a), the configuration of Australia’s population is changing, which also has significant repercussions for the demand for aged care services. In 2010 each Australian aged over 65 years was sustained by five people of working age, however, by the year 2050, this proportion is projected to drop to only 2.7 workers participating in the workforce for every person over 65 (Treasury 2010, Productivity Commission 2011, Millane 2013d). To re-emphasise, this significant point - Australia is confronting a future where those in retirement outnumber the population of workers and potentially needing care (LASA 2016, CS&HISC 2013, Productivity Commission 2010).

Much of the research (Productivity Commission 2011, Montague 2011, King et al. 2012, LASA 2016, ACSA 2016) purports that it is difficult to employ staff in RACS, however, in this study, some of the participants did not regard being able to employ people as the problem. Some felt that being able to employ people, at all levels of the organisation, with the appropriate skills, abilities and attributes, was perceived to be the challenge for RACS leaders. A mere five (Julia, George, Ben, Cherise & Charlene 2014) of the 18 persons interviewed expressed this, which was very surprising given the enormity of the problem as outlined in key research commentary her and also within the literature review. This is supported by Millane’s (2013) research, which found that new graduate and trainee carers commencing in RACS without the suitable knowledge and abilities to deal effectively with difficult conditions like dementia. This supports the contentions previously discussed regarding lack of
government attention to ensuring the appropriate provision of quality training to
total and current aged care workers. Despite the fact that the overwhelming
majority of aged care workers are well-intentioned regarding their role, an
extremity exists in terms of variable level of skills and capabilities brought by
them to their jobs because of the variation in accredited training quality that is
While this research supports the general view that the aged care sector has,
and will continue to experience, staffing and skill shortages, the focus of the
informants’ responses was firmly of the view that the shortage was in regard to
relevant skills only rather than the actual ability to find willing staff. This aligns
fairly well with some of the emerging literature discussed above and in the
Literature Review, Chapter 2.

**Migrant/Overseas Workers**

Some participants raised the issue that many of the workers currently working
and willing to work in RACS were migrant workers, often on student visas (Cath,
Ivan & Andrea 2014). This is supported by a report of the National Institute of
Labour Studies (2015) which stated that a substantial number of immigrants
worked in the aged care industry in Australia and has been rising steadily over
the past two decades (Goel & Penman 2015). Aged care workers born outside
of Australia currently comprise 35 per cent of the workforce and the proportion
is increasing (King et al. 2012). While the recruitment and training of the
overseas workforce can be regarded as one strategy to address aged care
workforce shortages, worries have also been expressed by aged care leaders
cited within the literature, regarding their suitability to working in an aged care
environment (Aged and Community Services Australia 2011). Many managers
of aged care facilities expressed concern as employees whose primary language is not English struggle with the effective and proficient completion of required documentation (Martin & King 2007). Client communication is also challenging due to the hearing difficulties and dementia accompanying ageing making it difficult for elderly clients to understand overseas workers’ accents (Martin & King 2007). While staff born outside of Australia presently constitute just over one third of the current aged care workforce, they are not evenly dispersed through the workforce, and most are concentrated in metropolitan areas and therefore not servicing the rural areas where staff shortages were more acute (Fine & Mitchell 2007, Productivity Commission Report, 2011). Over the next fifty years, there will be a growing need for sustained recruitment of overseas workers within the RACS workforce, requiring further research and greater consideration in regard to policy and employment questions related to migrant staff in the aged care workforce (Hugo 2009, Fine & Mitchell 2007, Productivity Commission Report, 2011). While the subject of migrant workers was raised by only a few of the research participants (Cath, Ivan & Andrea 2014), being at odds with the literature, it appears that there is a need for leaders in RACS to be more aware of the potential for migrants to fill skill gaps and employment requirements in their organisations, and for governments to acknowledge this requirement and develop policies accordingly. It is notable that a more diverse workforce can have advantages in meeting the needs of an ageing population, that is becoming more culturally diverse in some developed countries like Australia (Productivity Commission Report, 2011). It is an interesting finding that the RACS leaders interviewed for this research did not recognise the potential benefit of workforce diversity to the provision of better services in RACS with residents of different cultures, noting only three (Cath,
Ivan & Andrea 2014) considered this to be a prominent leadership and human resources management issue for leaders to focus upon.

### 5.2.3 Government Regulations and Funding

This thesis also asked participants the following question; *do you believe that the government is providing an appropriate level of leadership in regard to aged care policies and strategies?* All of the participants (2014) agreed that the aged care system is restricted by high levels of government intervention and accompanying regulation. Thirteen of the eighteen informants (Cath, Ivan, Gary, Smiley, Sarah, Louise, Andrea, George, Liza, Madeleine, Gary, Ben, Charlotte, Cherise & Charlene 2014) believed that the intricate and innumerable regulations governing aged care have not only led to a lack of understanding by consumers but have acted to stifle the all-important factor of leadership innovation that is so desperately required in the industry. Leadership is quite complex, as traditionally managers implement procedures and leaders need to be innovative (DuBrin 2013). In aged care, given the strict regime of regulations, leadership is quelled. Research has demonstrated that there is limited coordination between the controlled components of the aged care regulatory system and the informal support networks, making it extremely challenging for older Australians to plan and be responsible for their care choices and decisions and for the leadership of aged care providers and to facilitate this (Productivity Commission 2011, Grant Thornton, 2008, Treasury 2010, ACSA 2010). Government regulations and funding present a key issue where the majority of informants align with the literature.
Government Regulation Issues

According to many of the participants, one of the major outcomes of the enormous regulatory burden is the impact it has on the quality of customer care (Cath, Ivan, Gary, Smiley, Sarah, Louise, Andrea, George, Liza, Madeleine, Gary, Ben, Charlotte, Cherise & Charlene 2014). Ivan (2014) summed this up particularly well by explaining that while leaders in RACS understand that there needs to be some documentation of the care and services that are being given, they not only find it very difficult to document and acquit the huge amount of compliance required by the government, but this administrative burden significantly detracts from the time that leaders and their teams can interact with the residents and their families and provide quality services. In a study by Tuckett et al. (2009), it was found that thirty-five per cent (35 per cent) of the aged care staff interviewed, were overwhelmed by the time they had to spend on paperwork related to residential aged-care facility government accreditation and funding. The study also established that this “paperwork-accreditation funding nexus – a cause, is inextricably linked to (un)available time to care – an effect” (Tuckett et al..2009, p. 2006). In many RACS there is a view that care is being replaced by paperwork to gratify the growing government requirements (Productivity Commission 2011). More explicitly, managers and care workers in RACS believe that the amount of paperwork they are required to complete prevents them from supporting the needs of the residents and does not provide sufficient time to deal with the queries and requirements of the residents’ families, which in turn means that leaders are not able to provide appropriate leadership and management support for their nurses and personal care workers (Tuckett et al.. 2009, Productivity Commission 2011). A key residual impact of this regulatory burden on facilities is the sense of conflict and resentment that RACS leaders and care
staff feel when they are prevented from providing adequate levels of care to their residents and this is inextricably linked with emotional exhaustion and burnout among this cohort (Cameron and Brownie 2010). This is supported by the Productivity Commission Report (2011) which found that excessive regulatory burdens that are linked to the accreditation process, acquittal mechanisms for funding and mandatory reporting requirements were regularly branded as decreasing job satisfaction and thwarting improved productivity.

It is important to mention at this point, that according to a recent study by Holland, Tham & Gill (2016), aged care nurses often have to work with a large number of residents with complex medical conditions, as well as dementia, with just two nurses available. This is able to occur because, despite the reported high level of regulation taking nurses away from caring activities, there are also no mandated minimum staff/resident ratios across the aged-care industry, just a vague reference in the Aged Care Act 1997 (p.246), requiring “an adequate number of appropriately-trained staff”, which is open to interpretation and abuse (Simpson 2016, Holland et al.. 2016). A residual outcome of the absence of regulated minimum staff ratios is that managers are under pressure to meet revenue objectives, and can ensure this fiscal result by reducing staff, which places vulnerable elderly citizens at risk (Aged Care Crisis 2015, Belardi 2016). Another option frequently adopted by RACS to meet profit targets is to select the most economical staffing option by employing a higher number of lower-paid workers such as personal care workers rather than the higher-paid enrolled or registered nurses (Stack 2003, Belardi 2016). The subsequent supervision of these lessor qualified staff members places additional constraints on the time available for the more qualified nurses to care for residents (Stack 2003). Notably, there are
mandated staffing levels in childcare centres, kindergartens, schools and hospitals, which also cater for vulnerable people with different levels of need, calling into question the value government and society place on caring for our elderly citizens (Aged Care Crisis 2015).

This may link with the growing belief by aged care advocates, along with the emergence of data, that the sectors’ lack of resources is actually driven by aged care providers who are more concerned with making a profit than delivering care (Fedele 2015, Russell 2016). This view is supported by Simpson (2016), who found that while customer expectations are escalating and a growing number of older Australians are making the conversion to care or higher levels of care, larger providers are attempting to ascertain ways to reduce costs and increase revenue in order to safeguard their margins and profitability, and lower staff ratios may be one method of achieving this. The research generally demonstrates that there is a positive relationship between staffing numbers and care outcomes (Dunton, Gajewski, Klaus & Pierson 2007, Spilsbury, Hewitt, Stirk & Bowman 2011, Shin & Bae 2012, Willis, Price, Bonner, Henderson, Gibson, Hurley, Blackman, Toffoli & Currie 2016). Further research supports the premise that lower staffing levels are linked to care being likely to be missed or delayed, particularly in regard to unscheduled tasks such as answering call bells, taking residents to the toilet and attending to their social needs (Knopp-Sihota, Niehaus, Squires, Norton & Estabrooks 2015, Zuniga, Ausserhofer, Hamers, Engberg, Simon & Schwendimann 2015, Henderson, Willis, Xiao & Blackman 2016, Willis et al. 2016). Interestingly, this particular issue was not one that was referred to by the research participants, indicating that senior managers in RACS either do not find that they have a staff to patient ratio problem, because they provide
appropriate care staff to meet patient demands, or do not provide adequate staff to patient ratios and are not aware of the workload and care pressures it places on their staff. It may also be ignored, because as the research outlined by Fedele (2015), Russell (2016) and Simpson (2016) claimed, it can positively impact on a RACS’ budget if staffing ratios are not required. This is a significant finding given the rhetoric around the regulatory burden placed on aged care, yet the lack of staffing ratios are not considered an issue by the informants, which does not gel with the literature in the field.

The majority of informants align with prominent literature commenting on the negative impact of regulatory burdens on RACS, but the key point here is that the lack of ratio of caring staff to residents in RACS has not been highlighted as an issue by the informants. None of the participants mentioned that childcare centres, kindergartens, schools and hospitals and hospital have regulated staff to client ratios: none mentioned that elderly citizens seemed to be forgotten in terms of adequate staffing levels to care for their needs. The new knowledge here is that it is surprising that the staff, many of whom were overworked, did not make this extremely important, if not obvious observation. Profits, and government funding and care for Australia’s citizens was prominently outlined as a concern by the Productivity Commission (2011) but oddly was not remarked upon in this context of carer ratios by informants. While the question of staff to client ratios was not specifically asked of the participants, so as not to lead them, and in order to gain an understanding of what issues struck them as being significant to leaders in RACS, it is interesting that despite recent literature indicating this is a significant problem – the participants working and leading organisations in the field did not cite it as one.
Insufficient Funding and Support

Among all of the participants in this research, bar one, there also appears to be a perception that the government is not taking sufficient action to ensure the continued existence of the aged care industry and that the funding is insufficient for the viability of some RACS (Ben, Cherise, Charlotte, Andrea, Julia, Ivan, Gary, Bart, Cath, Sarah, Karina, Liza, George, Charlene, Smiley, Madeline, Louise 2014). In fact, there was a belief that the government's approach to aged care funding smacks of rhetoric and is insufficient to meet the growing needs of RACS (Ben, Cherise, Charlotte, Andrea, Julia, Ivan, Gary, Bart, Cath, Sarah, Karina, Liza, George, Charlene, Smiley, Madeline, Louise 2014). According to research by (Chomik & MacLennan 2014), their analysis indicates that RACS with higher levels of profitability are those that are for-profit, high-care, city-based and single-service providers, while smaller, government and regional RACS are not managing as efficiently. Submissions to the Productivity Commission by the Aged Care Association Australia (ACAA) (2011) and Deloitte (2011) noted that financing arrangements were not sufficient to support the growth in supply that is required for future need. The ACAA (2011), Deloitte (2011) and Treasury (2010) believed that as aged care funding is provided from tax payments, the ageing of the population will mean that there will be a significantly lower proportion of tax paying Australians to those requiring aged care funding. The views of the informants overwhelmingly supported the investigated literature regarding this issue. From more recent research, circumstances indicate that funding levels have not improved greatly, but the government appears to be providing growth funds proportionate to growth need (Cranston & Lenaghan 2016)
Wages

This lack of government funding and support was also regarded by nearly all of the research participants as contributing to the extremely low wages infamous in the aged care industry (Ben, Cherise, Charlotte, Andrea, Julia, Ivan, Gary, Bart, Cath, Sarah, Karina, Liza, George, Charlene, Smiley, Louise 2014). The average wage for a personal care attendant in a RAC facility was AU$19.77 per hour in 2016, and wages for this role have not been shown to increase significantly despite experience (Payscale Human Capital 2016, Aged Care Award 2016). People who work in this role rarely have more than 10 years’ experience, so have had limited opportunity to progress from what is a relatively flat pay scale (Payscale Human Capital 2016). The inability to pay more competitive salaries for nursing and care staff provides a significant challenge for aged care leaders. Many of the participants expressed that they had high levels of staff turnover from their organisations because staff could potentially earn more at Woolworths or McDonald’s (Ivan, Bart, Ben, Gary & Cath 2014). The literature concurs with the informants view regarding low wages, and a study by job search engine Adzuna, found that the average salary of aged care workers in Australia was $83,326, but this included all aged care positions including trainees, clerical jobs, personal care attendants, registered nurses, clinical managers, regional/operations managers and was therefore heavily skewed by managerial roles, which ranged between 80k and 220k (McKenna 2016). Yet, while Australia continues to age, and demand for aged care workers continues to grow, as shown in Figure 5.1, more than 50 per cent of jobs in this industry pay less than $60,000 per annum (McKenna 2016). The average national wage gap between aged care and other health sectors is increasing, the average wage of a worker in RACS is $41 000 per year which is less than the average wage, industry-wide in Australia by
$19 000 according to the Australian Bureau of Statistics (2016). One of the participants, Ben (2014) maintained that RACS have not been able to attract the type and level of management and care talent it needs because it has been regarded as of secondary importance in overall healthcare. He supported this by citing that nurses in aged care are paid much less than those working in both private and public hospitals and believes that personal care workers in RACS are grossly underpaid in comparison with other healthcare workers (Ben, 2014). This disparity in wages and salaries has dissuaded many talented people from entering the aged care industry (Ben 2014, McGowan, 2016, Productivity Commission, 2011). The opinions of the informants significantly supported the key literature regarding wages in aged care.

Figure 0-1 Pay Distribution in Aged Care

![Pay Distribution in Aged Care](image)

(McGowan 2016)

Training and Education

The provision of education and training for aged care leaders and their employees needs added support. There appears to be some level of unanimity among the
informants regarding the view that the government needs to play a much larger role in ensuring that well-qualified leaders and care workers, with appropriate skills, are being developed for the aged care industry through relevant training and qualifications (Ben, Gary, Charlotte, Cath, Bart & Ivan 2014). Not only is there is a large variation of management skills between different RACS, but numerous complaints have been levelled by members of the aged care industry that some of the vocational education and training (VET) sector graduates are not appropriately qualified after completing their various courses and that standards of training are inconsistent (LASA 2016, Cooke & Bartram 2015, ACSA 2011).

The government needs to focus on developing and implementing an aged care leadership and management education and training model on a national basis, not only to develop leadership skills, but capabilities that are specific to the philosophy of person-centred care and the unique attributes of the RACS workforce and industry (Cooke & Bartram 2015, Jeon 2011). Jeon (2011) asserted that while there are papers and articles that outline preferred leadership characteristics and principal competencies, they are broad-based and have no empirical evidence that supports the effectiveness of such attributes in an aged care setting. There is also no developed approach for determining how to best cultivate the effective leadership and management skills that are so essential to drive a successful and effective aged care industry (Jeon 2011). While appropriate instruction and preparation are essential for cultivating the required skills and capabilities to provide high quality aged care, instruction is not sufficient to transform aged care culture or the attitudes of RACS leaders, managers and care staff (Jeon 2011). This is because they are entrenched in a system of minimum care as a result of operating in a “marketised” environment that leads
to working with reduced resources and lower wage levels in comparison to other nursing and care fields (Jeon 2011).

Six participants said that the funding for education in the aged care sector is wasted because of the lack of quality of training courses available (Ben, Gary, Charlotte, Cath, Bart & Ivan 2014). According to Belardi (2015), a survey by the South Australian government showed that almost 50 per cent of aged care providers found that less than half of graduates of the Certificate III in Aged Care were appropriately skilled to be employed in RACS. Montague (2011) found that some RACS managers will not use certain aged care training providers as they are renowned for poor quality graduates – one, in particular, delivered a Certificate III qualification in personal care with a total of just 13 hours of face-to-face training. Similarly, a study by Booth et al. (2005) found that some RACS managers have determined that the Certificate III standards do not reflect the complexity of the personal care worker’s job role, and that if they are to provide a high quality of care in the changing aged care environment workers must also possess generic ‘employability’ skills, which are not being taught as part of the qualification. These issues were prominently identified by the Productivity Commission (2011) but as the informants were still highlighting this disturbing aspect, it appears little has been done to address this problem.

A further review of training for aged care exposed many training programs as being too brief and providing inadequate workplace experience for trainees to develop appropriate skills, also finding that RTO leadership and trainers had limited knowledge and command of the national standards for aged care and struggled to properly assess the competency of their trainees (Montague et al..)
2015, Simpson 2014, Productivity Commission 2011, Aberdeen, Leggat & Barraclough 2009, Thomson, Saunders, and Foyster, 2001). A strategic review of vocational education being undertaken by the Australian Skills Quality Authority (ASQA) for the Department of Education and Training (2016) highlighted assessment within aged and community care training programs as an area requiring more attention to result in the establishment of quality training and development. Emphasis was required in this sector, as an incompetent graduate that is deemed competent could have a negative impact on employers and the workplace or seriously affect public safety, including endangering individuals or older citizens gaining assistance within community-based care structures (Department of Education and Training (2016). These views of the participants regarding the lack of quality education and training currently being delivered to potential and current aged care workers are reflected comprehensively in the literature.

**Concern over User-pays Model**

There is also concern amongst the participants regarding the move of the government towards a more user-pays model and type of care that will result negatively for those from lower socio-economic conditions (Andrea, Karina, Charlene, Ivan, Charlotte & Smiley 2014). The participant referred to as Charlene (2014), advocated the hypothesis that those who have adequate financial resources will be able to choose the RACS accommodation of their choice, and will be able to negotiate the service they wish to receive, whereas those who do not have the available finances will have limited choice and be pushed into a care facility that is inferior in quality, possibly not local to their friends and relatives and
where there is very little extra money available, other than to meet the basic care costs. In Australia, financial concerns connected to the ageing of our population have subjugated government policy, and driven subsequent governments to embrace a range of neo-liberal strategies that aim to encourage ageing Australians to become more economically autonomous (Cash, Hodgkin, & Warburton, 2013). In addition, the aged care industry has been faced with the constriction of entry into RACS, as well as the introduction of national eligibility criteria, the restriction of available care beds and the establishment of a user pays system (Lenaghan 2016, The Lamp 2011, Gargett 2010, Setterlund, Wilson, & Tilse 2006). According to the government (Australian Treasury 2015) these changes to legislation, that include daily care fees at RACS being means tested on assets and income, including the family home, are intended to provide older Australians with a choice regarding their care and how they fund their care. However, in 2011, the Australian Government devoted only 0.8 per cent of GDP on aged care funding, while countries such as Norway expended 2 per cent, the Netherlands 3.5 per cent and Sweden 3.6 per cent (The Lamp 2011). The Productivity Commission (2011) predicted that by 2050, Australia's aged care outflow would be 1.8 per cent of GDP, which is only half of Sweden's current aged care expenditure (The Lamp 2011). This suggests that both the cost and provision of care for older people has been increasingly moved away from being a government responsibility and placed more heavily onto individuals and families (Hodgkin 2014).

Changes in government support for aged care are believed, by both the research participants and the literature, to be detrimental to a fair and just system of care being available to elderly people, and in many cases will require them to either
sell their home or apply for a reverse mortgage to fund their care (The Lamp 2011, Hearn 2011, Andrea, Karina, Charlene, Ivan, Charlotte & Smiley 2014). This is a very interesting finding, given the previous lack of apparent concern by participants regarding the absence of staff to patient ratios requirement in RACS (in 5.2.3.1), signifying that RACS either do not require a staff to patient ratio to provide appropriate care to meet patient demands, which is unlikely, or actually do not provide sufficient staff to patient ratios, placing unwanted pressure on their staff and negatively impacting their quality of care. Thus the participants’ concern over the impact of the user pays model and care quality is at odds with their lack of concern over the mandated provision of adequate staffing ratios to patients. This is another significant finding, once again in light of the rhetoric around the impact of the marketisation of aged care on care quality, yet the lack of staffing ratios are not considered an issue.

**Industry Image**

Perceptions of aged care and working in RACS are formed via the negative images many people have of this industry, which is often reinforced by the media (Venturato et al.. 2007). Many of the participants in this study also believe that the government must take some responsibility for this poor image, and is not working hard enough to help change negative perceptions (Charlotte, Ben, Gary, Andrea, Sarah, Liza, Cherise, Louise & Laura 2014). The government should be providing leadership by promoting the aged care industry as one that is respected, progressive, vital to the general public and an industry that prospective employees can find meaningful work and appropriate career opportunities. The image of the aged care sector has been tarnished over the past three decades
by accusations of exploitation and mistreatment of the occupants of aged care facilities in Australia. Recent reactions by successive Australian governments to these adverse scenarios have resulted in improvements in the required standards of care for RACS residents (Chenoweth & Kilstoff 2002, McCallum & Gieselhart 1998). Nonetheless, it is the comparative helplessness of RACS employees in regard to achieving acceptable working wages and conditions, which would encourage the maintenance of good quality care principles, that has not been adequately confronted or resolved in the plethora of government-commissioned reports and investigations into RACS services (Pearson et.al 2006, Gibson, Braithwaite, Braithwaite and Makkai 1992). Research has found that negative images associated with ageing and the care of older people are ideological constructions that are reinforced by failure of the government to identify the value of the industry by ensuring there is both sufficient reward and recruitment of staff (Chenoweth et al. 2002, Moyle & Kellett 1996, Nay & Closs 1998). These negative images are further strengthened via the expansion of a progressively controlled and inflexible system of care that serves to limit experts in regard to their decision making capability and flexibility, while simultaneously asserting that they encourage personalised care and professional independence (Venturato et al. 2007, Carr & Kazanowski 1994, Nay & Closs 1998). Yet, research has shown that negative views of aged care tend to subside when leadership is appropriately flexible and effective to engage with families regarding their loved one’s care planning and also to take part in their life within the RAC facility (Marquis, Freegard & Hoogland 2004). In addition, earlier investigations have shown that negative perspectives of the aged care industry impact the attitudes of nursing undergraduates, by reinforcing the viewpoint that working in aged care nursing is not a valued role and therefore adversely influences their employment decisions.
regarding working in the industry, as well as negatively impacting the morale of those already working in RACS (Happell 2002, Cheek, Ballantyne, Jones, Roder-Allen & Kitto 2003). Finally, Cheek et.al (2003) affirmed that it is a clear responsibility of Governments (Federal and State), in conjunction with other industry representatives, to work cooperatively together to instigate a concentrated and unified marketing campaign that actively endorses a positive image of RACS to both the public and potential nurses and care workers. This research from the literature, therefore, supports the views of a number of the informants (Charlotte, Ben, Gary, Andrea, Sarah, Liza, Cherise, Louise & Laura 2014) regarding this issue.

**RAC Survival and Corporatisation of Care**

A key concern that emerged from the interviews was that there is a clear sense amongst RACS that smaller providers will not survive government, industry, economic and demographic changes unless they are niche market type establishments, utilising a smarter, more strategic management model (Charlotte, Ivan, Laura, Julia, Ben, George, Liza, Madeleine, Sarah, Cherise, Charlene & Bart 2014). A study by (Chomik & MacLennan 2014) for the ARC Centre of Excellence in Population Ageing Research, found that a noteworthy trend within RACS is their consolidation from single providers into larger facilities, reflecting a perception amongst providers that they must achieve significant economies of scale to survive. During the 1990s, RACS with up to forty beds were considered the norm but the trend towards larger providers and consolidation of facilities has meant that RACS accommodations of this size are now amongst the least common (Chomik & MacLennan 2014). Keryn Curtis (Australian Ageing Agenda 2013) stated that magnitude and scale of the
organisation in the RACS would be a significant factor from a government policy perspective, and that sustainability of smaller aged care providers is at risk in the coming years due to a lack of competitiveness. A report by the Australian Institute of Company Directors (2015) supported this view. Their research found that 40 per cent of boards of not-for-profit aged care organisations had conferred with other aged care organisations regarding possible mergers during 2014, and that half of those engaged in the discussion believe such mergers will proceed. Nonetheless, this process of merging with other organisations or growing the scale of current operations may not be practical for those smaller RACS not considered as desirable merger propositions for larger operators or for those organisations operating in rural and fringe locations (Hogan 2004, Productivity Commission 2008). The literature clearly aligns with the views of the participants (Charlotte, Ivan, Laura, Julia, Ben, George, Liza, Madeleine, Sarah, Cherise, Charlene & Bart 2014) regarding the survival of smaller RACS facilities.

RACS are labour intensive, do not operate in a high tech environment and require their services to be specialised to some extent to the needs of their clients, meaning that the opportunities for RACS to develop and implement productivity enhancements are limited (Productivity Commission 2008). Some of the participants (Charlotte, Ivan, Laura, Julia, Ben, George, Liza, Madeleine, Sarah, Cherise, Charlene & Bart 2014), commented that while the smaller facilities were not able to implement solutions to enhance productivity and therefore compete with the larger corporate organisations, there would be a loss of community focus and potentially the loss of personalised care quality if they were bought out by a more corporate operation. According to Weerawardena and Sullivan-Mort (2001), the rapidly growing aged care cohort, which includes clients with
potentially higher discretionary incomes than in the past, has attracted increasing numbers of commercial providers into the market, subsequently forcing smaller RACS to embrace a competitive operational position and to hunt for innovative methods of service delivery in order to survive. In line with this argument, research by Sappey, Bone and Duncan (2010), showed that the fragmented industry structure of the smaller community-based RACS, which to date have been funded through asynchronous and fragmented state and federal funding programs, means that they struggle to meet the growing requirement for aged care services. In particular, those providers in regional and urban fringe markets will find that competitive tensions will increase between smaller providers and larger commercial providers, as they compete for federal and state funding, as well as scarce labour in an ageing labour market, already beset with significant skill shortages (Sappey, Bone and Duncan 2010). Research by Grant Thornton (2015) reveals that while Not for Profit providers currently form the majority of RACS operators, in the last five years, 92 per cent of the purchasers of Aged Care facilities have been for-profit organisations. Corporate investors have been attracted to the RACS sector due to the high growth forecasts, caused by our growing aged population and their escalating care needs (NAB Health 2015, Lie 2015). The implementation of the Government’s LLLB policy will also inspire further private investment into RACS, as it provides opportunities for facility operators to receive added income by providing extra services via a “user pays” system, and increasing their cash flow to enable to expansion of their facilities by being issued Refundable Accommodation Deposits to eligible residents (Grant Thornton 2015). This is an issue for RACS leaders, as previous studies into the corporatisation of the health-care systems, has shown that corporate interests are focussed primarily on meeting market priorities rather than patient care and
subsequent market obligations prompt practitioners to attend to their business mission at the cost of duty of care to their elderly clients (Dela Rama et al.. 2010). This supports an earlier reference to the growing evidence that RACS’ lack of resources is actually exacerbated by aged care providers, who are more focused on making a profit than delivering appropriate care, and that the rising number of older Australians who require care, means that larger, corporate providers are attempting to ascertain ways to reduce costs and increase revenue, in order to safeguard their margins and profitability, rather than ensuring quality care (Fedele 2015, Russell 2016, Simpson 2016). This more recent research clearly gels with the views and concerns of the informants on the topic of the survival of smaller RACS and the subsequent impact on care quality. However, it is an interesting finding that the informants do not associate inadequate capital within for-profit organisations, with their corporate owners not passing on profits, but instead lay the blame primarily with the government as providing insufficient funding. It is an area that urgently requires more research to direct government policy and funding in RACS.

5.2.4 HRM

Recruitment and Retention

Recruitment and retention of appropriately skilled workers have been clearly established as a significant problem facing leaders in RACS and the aged care industry Australians (Fleming & FitzGerald 2009, Productivity Commission 2011, King et al. 2012, Millane 2013, Montague et al.. 2015). Evidence has shown that the industry has been subjected to major problems in attracting and retaining appropriately qualified and knowledgeable employees to provide for the care needs of older Australians (Fleming & FitzGerald 2009, King et al.
2012, Millane 2013, Productivity Commission 2011). This is linked to the problem that the aged care workforce is itself ageing and consequentially typical turnover rates are intensified by ageing workers retiring from what is considered a physically challenging setting (Hugo, 2007a; Segal & Bolton, 2009). Moreover, there was difficulty filling advertised registered nursing positions in aged care nurses from 2003 to 2007, and almost 40 per cent of these advertised positions have taken over one month to fill (Martin & King 2007). Nothing has altered, it seems. According to the Australian Nursing Federation, there is a pressing need for 20 000 nurses to be employed in aged care (Goel & Penman 2015). Most participants who were interviewed on the subject of the development and implementation of HRM strategies in RACS facility agreed with the evidence outlined in the literature examined (Louise, Ivan, Julia, Laura, Karina, Sarah, Ben, Gary, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014). Most interviewees agreed that good HRM strategies were required to ensure the recruitment and retention of qualified employees in a difficult industry beset by low wages and tough working conditions, and many were working to introduce effective HRM strategies into their organisations insofar as funding and capacity allowed them (Louise, Ivan, Julia, Laura, Karina, Sarah, Ben, Gary, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014). They also agreed that registered nurses were a key category that they experienced difficulty in recruiting and retaining because of the working pay and conditions facility (Bart, Louise, Ivan, Julia, Laura, Cherise, Charlotte, Cath, George, Liza, Julia & Smiley 2014).

One of the major contributors to recruitment difficulties and high turnover in RACS is the low wages that are inherent in the aged care sector compared to the acute health and other employment sectors (Millane 2013, King et al.. 2012,
The salaries paid to care workers in the aged care industry have been a problem since the industry’s inception (King et al. 2012), and the Productivity Commission (2011) has recommended that any reforms to the aged care sector must include revision of wages and salaries so that they are both fair and competitive. Kaine (2012b) and Charlesworth (2012) contended that the traditional regulation of wages and conditions through awards and collective bargaining agreements has been unsuccessful in producing tolerable or justifiable wage outcomes for aged care workers. Ongoing low wages are worsening employment supply concerns, which is perturbing given the exponential growth that is going to occur in the aged care sector over the coming decades (Kaine 2012b, Productivity Commission 2011, Martin & King 2008). The public funding via government that supports RACS has a substantial effect on the operational budgets of providers of RACS and therefore limits their ability to offer better wages and conditions to their workers (Kaine 2012b, Productivity Commission 2011). This means that the most significant problem facing RACS - the development of wages and conditions that produce a sustainable stream of aged care workers - cannot be adequately addressed (Charlesworth 2012, Kaine 2012b). Given that the sector is highly feminised and has a large percentage of part-time, casual employees and increasingly, overseas-born workers, it can be argued that both the government and aged care employers aggressively ‘reproduce a familial logic of care that represents paid aged care work as unskilled and natural for women and therefore not deserving of higher pay’ (Palmer & Evaline 2012, p.254). Interestingly, only one participant (Ivan 2014) recognised the issue of gender as influencing low pay in aged care, perhaps implying that the expectations of the workers in the industry are embedded within traditional gender bias that
because caregivers are predominately female, their wages will remain unimportant in comparison to those who are employed other occupations with similar requirements and work settings (Nelson 1999, Palmer & Evaline 2012).

As a result of the pressures within the aged care industry, that pushes for both cost reduction and the requirement for high-quality care, effective leadership and the development of good HRM strategies that create job satisfaction and organisational commitment in care organisations is critically important (Cooke & Bartram 2015). While the issue of low pay is largely out of the hands of many RACS leaders, a lack of available career opportunities in the sector was consistently rated by care workers as a significant factor prompting them to leave employment in aged care (Radford, Shacklock & Bradford 2015). Concern about career paths is a key influencer of decisions not to commence or continue working in the aged care sector: many nurses, in particular regard aged care being an endpoint in their career, because there are no recognisable pathways or assistance regarding the development of a career in the sector (Abbey, Liddle, Bridges, Thornton, Lemcke, Elder & Abbey 2006). A study by (Wray & McCall 2007) on nursing students, found that most of the participants viewed the aged care sector in a negative light and not something they would consider as a career path, because they viewed the work as dirty, which links back to the participants’ arguments that government and the industry are not doing enough to try and counteract this negative industry image. The absence of career paths was a point made by both Andrea (2014) and Cath (2014) during the semi-structured interview process. Both Andrea (2014) and Karina (2014) were the only participants whose organisations were developing strategies to implement career paths for their employees. There is a clear
disconnect between the experiences and understandings of the informants and what has been established in the literature. This is an interesting finding as, despite recognition of the need for career paths in the Productivity Commission Report (2011), it is clearly not something being strongly perceived as an important issue for leaders in RACS to tackle.

**Employee Burnout and Stress**

The connection between job satisfaction and engagement and employee burnout and stress has been well documented (Jeon, Luscombe, Chenoweth, Stein-Parbury, Brodaty, King & Haas 2012, Beck and Vogelpohl 1999 & Evers et al., 2002). Workplace or occupational burnout is characterised by “exhaustion, lack of enthusiasm and motivation, feelings of ineffectiveness, and also may have the dimension of frustration or cynicism, and as a result reduced efficacy within the workplace” (Ruotsalainen, Verbeek Mariné & Serra 2014), and was appended to the mental health vocabulary during the 1970s (Maslach 1982). Burnout is frequently utilised to determine work-related anxiety, stress and well-being (Jeon et al.. 2012). According to Stack (2003), burnout, stress and exhaustion can be issues that produce behaviours in caregivers that are counter to the ethos and purpose of the aged care vocation. These conditions can result in those providing care to elderly patients to behave in a manner that is remote from their patients, to dehumanise and demonise them, to develop cynical attitudes and to treat their charges in ways that are demeaning (Scott, Aiken, Mechanic & Moravcsik 1995), which appears to be contradict the act of providing ‘care’ (Stack 2003). Causes of burnout and stress have been levelled at the lack of time nurses and care staff have to spend providing care to their clients, due to the overwhelming workloads they often carry, the compliance
and administrative burden, inadequate resource allocation, the employment of often inadequately skilled care staff and low wages (Jeon et al., 2010, Glasberg, Eriksson & Norberg 2007). The conflict inherent in providing care and receiving wages for undertaking this task can often cause frustration and emotional dissonance in care workers (King 2012). Research demonstrates that this is a significant contributor to job dissatisfaction and a collective stimulant for nurses and other caregivers leaving RACS or working part-time to manage the stress associated with their work experience (King 2012, Cameron & Brownie 2010, Moyle, Skinner, Rowe & Gork 2003, Stein 2002). The clear view of the participants supports this research, that burnout and stress on staff at all levels is a cause of turnover in their organisations, and has the added issue of being counter-productive to the care they are trying to provide (Ivan, Smiley, Gary, Bart, Charlene, George, Liza, Andrea, Louise, Cherise, Kate, Sandra & Charlotte 2014).

**Job Satisfaction and HRM**

Contemporary literature has promoted the concept of employee wellbeing as an essential factor contributing to both employee and organisational performance (Clarke & Rao 2012, CIPD, 2007, Guest 2002). There are a number of negative outcomes that have found to be the result of poor employee wellbeing, including absenteeism, poor performance, sick leave and turnover (Renee Baptiste 2008, Cotton & Hart 2003). Importantly, the lack of employee wellbeing in RACS is likely to lead to poor quality care delivery, meaning that substantial benefits could be achieved from implementing good HRM strategies to encourage workplace health and wellbeing (Clarke & Rao 2012). Perceptions of care staff regarding the level to which their supervisors and managers show concern
about their wellbeing and value their contribution to the organisation has been shown to have a positive correlation to job satisfaction and retention (Cavanagh, Fisher, Francis & Gapp 2012).

Aged care organisations, along with unions and others in society are seeing a need to lift wages and to recognise and reward care staff appropriately to induce retention of people in the industry (Ivan 2014). Most of the participants’ organisations demonstrated that they understood this viewpoint and that they were attempting to encourage staff recruitment and retention, by trying to provide “an irresistible workplace” (Andrea 2014). This included implementing and offering HR strategies such as flexibility of hours, and shifts, wherever possible, good terms and conditions regarding leave arrangements, salary packaging, good rewards programs and training and development opportunities.

The participants and their organisations are starting to explore both new models of care and new models of staff interaction. In the future health and aged care workers will be empowerers, advocates and enablers, rather than caregivers (Ivan 2014, King 2012, Chenoweth et al., 2002). This approach aimed at increasing retention by improving job satisfaction and organisational commitment, as well as improving practice and care standards, is well-supported in the literature, demonstrating that while still in the early stages of development, RACS recognise the need for solid HRM strategies to sustain a skilled and appropriately resourced workforce (Chenoweth 2002, Kuokkanen, Leino-Kilpi & Katajisto 2003, Phillips et al. 2008). Participants (Ivan, Smiley, Gary, Bart, Charlene, George, Liza, Andrea, Cherise, Kate, Sandra & Charlotte 2014) also acknowledged the limitations placed on their ability to implement
certain HR strategies as a result of the regulations placed on them by the government. The compliance burden impedes both the type of HR strategies that can be implemented and the delivery of these strategies, which in turn also inhibits crucial aspects of quality care, intensifies the prospect of burnout and absenteeism, and in the long run increases employee turnover in RACS (Productivity Commission 2008, Stack 2003). The views of the informants regarding this issue clearly coincided with the available literature on the same topic.

5.3 Conclusion

An unusual, though unique finding in this research was that the informants did not claim that the role as a leader in RACS was extremely complex. While they acknowledged the different requirements and demands of the leadership role in RACS, only four participants (Andrea, Smiley, Bart and Ivan 2014) actually highlighted how uniquely complex the aged care leadership role is to perform. This represents a new finding and to place it in context, leaders in this industry sector are beset by an enormous array of encumbrances. These include, staffing issues, regulations, complexities with relatives, death, health issues amongst the elderly patients and elderly staff, funding problems, staff turnover, skills shortages, an environment seen as having poor working conditions – and the list can be extended beyond this lengthy inventory. Each of these factors was identified in the landmark Productivity Commission Report (2011) but the informants were unusually quiet on this issue. Few industry leaders face the broad array of complexities that those who guide RACS experience. Leadership
in RACS is extremely complex given the abundance of stakeholders and government regulations.

The purpose of this research was to examine the skills, competencies and attributes required of leaders in RACS and examine how the complexities of the industry, within the themes of government policy and regulation, population and workforce demographics and Human Resource Management Strategies, impact the ability of leaders to manage in this sector effectively. From this, it aimed to identify what, if any, are the development needs of current and future leaders to meet these challenges successfully. This research has identified and contributes to knowledge in the field of leadership skills, attributes and competencies that are required for developing current and future organisation leaders in RACS. While many of the information provided by the informants clearly coincides with the available literature, there are also new findings that should contribute significantly to the understanding of the RACS industry in Australia.

These key findings include:

1. A key leadership attribute for leaders in RACS is compassion, which is not widely referred to in the available literature and is something that is often regarded as being innate rather than learned. This needs further research to determine the ability to teach compassion to potential RACS leaders.

2. Creating and communicating a sustainable and inspiring vision and strategy for RACS is another key leadership quality established through this research. This is supported by findings from the ACLCF (2014), which also indicates that leaders in RACS must be able to inspire and motivate employees if they are to achieve greater performance and
improved job satisfaction. While this should be an obvious leadership requirement, it appears to not be a usual occurrence in past and current leadership behaviour because of the limitations placed on their role by issues such as government regulation, an ageing workforce and other HRM issues. It could also be surmised that the lack of morale and resources, heightened emotional challenges and job burnout in RACS, creates a more significant need for an inspiring as well as a sustainable vision.

3. The argument regarding the necessity of having clinical skills to be successful as RACS leaders appear to be an issue that is emerging as the sectors grows, corporate providers infiltrate and a corporate business model replaces medical models regarding leadership and the operation of the aged care sector. This needs greater research to determine whether the sector should move, or will be forced to move, towards a dual leadership approach whereby business issues and clinical issues are approached and led separately, by implementing a more corporate business model.

What was not said by the participants

An important part of undertaking qualitative research is that researchers can access tacit knowledge not only by taking note of what is said, but also by what is not said (Tracy 2010). There were some unexpected subjects not mentioned by the participants that were either significant in the literature or current topics within the media.

4. A surprising finding in this research was that the informants did not clearly and resoundingly refer to the complexity of the role as a leader in RACS. This finding, placed in context, demonstrates that leaders in this
industry sector, despite being faced with an enormous number of complex challenges, are either not recognising or naming this as an issue unique to their industry.

5. What also emerged as a key finding after comparing the literature with the findings from the interviews was the issue of staff to client ratios. The lack of regulated staff to client ratios has been highlighted in the media and the literature over recent years, as having a negative impact on quality of care in RACS. However, it is an interesting finding that the informants do not consider this as one of the factors impeding leadership and care excellence in RACS.

To sum up this chapter, twelve research questions were formulated to guide semi-structured interviews, and each question focused on a particular aspect of leadership in RACS within one of the four themes. Discussions focused on an analysis of the participants' interview responses which were summarised in Chapter Four, in conjunction with an integration of the relevant literature found in Chapter Two. The next chapter explains the RACS Leadership Framework developed from the findings of this research.
Chapter Six - Building a framework for RACS Leadership

This study explored leadership in RACS from an integrative viewpoint, with the intention of creating an all-inclusive framework for understanding, recruiting, developing and retaining RACS leaders. Due to the complex nature of the aged care environment and role requirements, the framework has been established based on the findings from the current literature on leadership in RACS, findings from this study, and on Bass and Avolio’s (1993) Transformational Leadership Theory, Boyatzis’ (2011) Managerial and Leadership Competencies Framework (Health Workforce Australia 2013, Department of Industry 2014), Pearce and Conger’s (2003) and Uhl-Bien’s (2006) vision of shared or distributed leadership and Greenleaf’s (1991) Servant Leadership and incorporating Ciulla’s (1998) definition of leadership, stated in the Introduction chapter (p.13). It has built on the ACLCF and the Health LEADS Frameworks, as relevant models to inform leadership behaviour and development in aged care.

The RACS Leadership Framework (see figure 6.1) is based on three leadership dimensions; Attributes, Skills and Competencies. The first dimension - attributes - concerns the characteristics of relational leadership, which includes developing attributes, understandings, and behaviours that reflect transformational leadership qualities (Bass & Avolio 1993). The first dimension also extends to shared or distributed leadership qualities (Pearce & Conger 2003, Uhl-Bien 2006), and includes elements of Greenleaf’s (1991) servant leadership and Ciulla’s (1998, 2014, p.xv) evocation that ‘trust, obligation, commitment, emotion, and shared vision of the good’ embody effective leadership. The second dimension of skills is based on the specific academic qualifications, proficiencies
and abilities that RACS Leaders should possess according to the findings from the participants and on the limited research that has been undertaken in regard to the knowledge and aptitudes for RACS leaders (Jeon et al. 2010, Sankaran et al. 2010, Shaw et al. 2012, Department of Industry 2014). Finally, the dimension of competencies is also based largely on the findings from the participants and on the narrow research that has been undertaken in regard to these skills for RACS leaders (Jeong et al. 2004, Shanley 2007, Grant Thornton, 2008, Jeon et al. 2010, Treasury 2010, ACSA 2010, Productivity Commission 2011). This dimension includes ethics and skilled ethical decision making, which was not cited by participants and is neglected in aged care leadership literature – but is deemed critical to the development of a successful RACS leader (Jeon et al. 2015). The three dimensions also draw on the capabilities outlined by the ACLCF (2014) and the Health LEADS Frameworks (2013). The ACLCF and the Health LEADS share many similarities, most significantly is the articulation of leadership capabilities across five domains (Marles 2017). Health LEADS Australia incorporates their five domains of leadership as follows: leads self, engages others, achieves outcomes, drives innovation and shapes systems, while the ACLCF delineates a series of capabilities around their five domains of self, others, purpose, business and change (Health Workforce Australia 2013, Department of Industry 2014). Table 7.1 below indicates how the domains of the Health LEADS and the ACLCF link to those in the RACS Leadership Framework’s Skills, Attributes and Competencies dimensions. While the capabilities in each of the dimensions or domains are not all the same, numerous capabilities are similar within the three frameworks.
At the centre of the leadership skills, attributes and competencies are three tenets which this research has found to be critical to effective aged care leadership – care, compassion and communication. These three characteristics form “the heart” of all of the leadership requirements exposed by the participants and some of the literature examined in this thesis, and are important factors in the creation of moral relationships in aged care, as per Ciulla’s (1998) ethical leadership approach. Compassion, care and communication are cornerstones of shared or distributed leadership in a healthcare context (Bass & Steidlmieier 1999, Brown et al., 2005, Dewar & Cook 2014) as well as the enactment of servant leadership (Crippen 2004, van Dierendonck & Patterson 2015). Finally, exceptional communication of organisational vision, direction and care expectations are an integral part of inspirational encouragement and exemplary influence in a RACS transformational leader’s role (Berson & Avolio 2004). Without these qualities, a RACS leader will not fulfil their leadership potential (Wieck, Prydun & Walsh 2002, Deutschman 2005, Large, Macleod, Cunningham & Kitson 2005, Scalzi, Evans, Barstow & Hostvedt 2006, Skills for Care 2006, Jeon et al., 2015).
In contrast to the ACLCF and Health LEADS, the RACS Leadership Framework recognises the impact of external and internal influences on the ability of the leader to implement and enact all of the skills, abilities and behaviours required within the role, and to be able to apply appropriate HRM strategies to ensure the attraction, recruitment and retention of engaged, competent staff (Fleming & FitzGerald 2009, King et al. 2012, Millane 2013, Productivity Commission 2011). The ability to implement these strategies effectively contributes to the effective operation of RACS and the achievement of their organisational goals (Cooke & Bartram 2015). Organisation size also impacts on the use of strategic HRM as smaller organisations need to rely more on informal, innovative, low-cost policies and practices that improve working conditions for employees, promote teamwork and social relations and increase employee motivation (Marlow & Patton 2002). Larger organisations, on the other hand, can offer higher wages and greater career pathway options, so can to an extent “buy” their employees loyalty and suffice with implementing more formularised HRM processes (Marlow & Patton 2002, Bartram, Stanton, Leggat, Casimir & Fraser 2007).

Finally, the RACS Leadership Framework reflects the important impact that government policy and decision making regarding aged care have on the ability of RACS leaders to achieve successful organisational outcomes. A range of factors combine to negatively influence the capacity of leaders to successfully lead their staff, residents and other stakeholders (O’Keefe 2016). These factors include the significant burden of compliance and regulation requirements, the standard of registered training and development available to RACS staff, low wages that are endemic in the industry and linked to insufficient government funding overall (O'Keefe, 2016, Productivity Commission, 2011).
Demographic problems such as skills shortages and an ageing workforce have led to the increased employment of migrant workers in aged, which adds an extra complexity to aged care leadership (Hugo 2009, Fine & Mitchell 2007, Productivity Commission Report, 2011). The RACS Leadership Framework identifies that these government policy and demographic factors influence the types of HRM strategies a leader will need to implement within their organisations, to ensure they recruit and retain competent employees, as well as impacting their ability to effectively apply appropriate strategic HRM processes in their organisations. This leadership framework also recognises that while appropriate clinical skills are of vital importance in effective and safe care (Jeon et al. 2010b, Venturato & Drew 2010, Dwyer 2011), the size of the organisation will determine whether it is the leader who must have these skills, or a non-leader with a dedicated clinical role.

To sum up, based on this research it can be concluded the skills, attributes and competencies in the framework reflect and support the capabilities within the ACLCF and the Health Leads Frameworks, and are supported by the foundation qualities of aged care leadership – compassion, communication and care. This framework, however, takes the ACLCF and the Health LEADS Frameworks further, by recognising that the acquisition, learning and implementation of these skills, attributes and competencies must be complemented with, and may be compromised by, a recognition and understanding of the other significant factors that impact the effectiveness of leadership in aged care. These must be acknowledged and addressed by both RACS leaders and government to provide a fair, equitable and effective residential aged care system for all.
Figure 6.1 RACS Leadership Framework

- Leader Skills, Competencies & Attributes
  - Trust
  - Guidance
  - Emotional Intelligence
  - Motivation
  - Conflict Management
  - Teamwork
  - Exemplary Influence
  - Inspirational
  - Encouragement
  - Consultation
  - Embrace Diversity

- Clinical Skills
  - Communication
  - Care and Compassion
  - Ethical Decision Making
  - Managing Ambiguity
  - Managing Change
  - Strategic Thinking
  - Problem Solving
  - Innovation
  - Strategic Vision
  - Reward

- Size of Organisation
- HRM Strategies

- Effective Outcomes
  - EMPLOYEE:
    - Attraction
    - Retention
    - Motivation
    - Engagement
    - High Quality Care
    - Safety
    - Commitment
    - Problem Solving
    - Team Membership
  - ORGANISATION:
    - Sustainability
    - Effectiveness
    - Competitiveness

- Government Policy & Regulation
  - Regulatory Burden
  - Education & Training Standards
  - Low Wages
  - Insufficient Funding & Support

- Ageing Population & Workforce
  - Skill Shortages
  - Migrant/Overseas Worker
Chapter Seven – Conclusion

7.1 Introduction

To conclude this thesis, this closing chapter covers the following sections:

(1) the introduction itself outlines the study rationale, aims and outcomes, and methods and methodology;

(2) the implications of the research;

(3) significance of the study;

(4) the new knowledge;

(5) the theoretical contribution;

(6) the limitations of the research;

and (7) major conclusions and recommendations for further research;

This study examined the skills and attributes required of leaders in RACS and scrutinised how the complexities of the industry, within the themes of government policy and regulation, population and workforce demographics and human resource management strategies, impacted upon the ability of leaders to manage in this sector effectively. The study also focussed on the development needs of current and future leaders to meet these challenges successfully. Currently, the development of leadership theory is inadequate, and virtually non-existent in RACS, as leadership theories and models being adopted from other industry sectors and disciplines. This approach of forcing a ‘square peg into a round hole’ fits awkwardly into the far more intricate and complex environment of RACS. Therefore, the rationale behind this thesis has been to develop an understanding of the specific leadership skills and attributes required of leaders in RACS and to
develop an aged care leadership model to propose a guide to the recruitment, training and development of current and future RAC leaders.

The research involved twelve core questions underpinned by semi-structured interview questions focussing on specific aspects of leadership in RACS within one of the four themes. The research aimed to uncover enhanced knowledge through the following questions:

- What are the skills and attributes needed by leaders in the complex residential aged care service industry sector?
- What are the future development needs of senior managers in RACS to innovatively meet the complex challenges facing RACS?
- What are the major human resource management (HRM) issues facing RACS and what are the possible solutions?
- What challenges are posed by Australia’s current and projected demographics regarding the continued provision of aged care to older Australian citizens?
- What is the impact of government policy on the effectiveness of the aged care industry and its ability to effectively care for our ageing population?

This thesis utilised thematic analysis to scrutinise the views and insights of the senior aged care management participants regarding the requirements for leadership in aged care and the impact of the four themes on the role of the leader, and focussed on constructing meaning from what the participants communicated in their semi-structured interviews. The evaluation of the interviews was systematic, focused and comprehensive while also exposing an
understanding of the impact the informant's past experiences and attitudes had in shaping their views.

7.2 Summary of Research

This qualitative research study was undertaken using constructivism underpinned by thematic analysis and collected data from semi-structured interviews with 18 senior aged care leaders regarding their perceptions of leadership in RACS. Research participants were recruited via a series of phone calls and emails requesting their participation and were selected from various sized RACS in Victoria. All of the interviews were conducted in a face-to-face setting and the participants worked in a variety of senior roles within RACS and the aged care industry associations. All the participants were located in Victoria and had varying degrees of experience in the health sector, with 12 being employed previously in a nursing or health-related role.

The conclusion has been developed following the four themes used throughout this thesis:
1. Leadership,
2. Government Regulation and Policy,
3. Demographics, and
4. HRM Strategies.

The first category of leadership involved the competencies, skills and attributes required of leaders in RACS, along with any determined skills gaps evident in current RACS leaders, as well as an enquiry regarding the need for clinical skills in leaders of RACS. The second classification concentrated on the impact of government policy and regulation on the ability of RACS leaders to be effective
and the limitations they placed on their job. Demographics was the third category, which focused on the influence of the ageing population and the ageing RACS workforce regarding the effectiveness of leaders and their responses to these challenges. The final category examined the major HR issues and the implementation and impact of HRM strategies on attracting and retaining a skilled workforce in the face of demographic, government regulation and policy and image problems within the aged care sector.

7.3 Implications of this Study

This section describes the understandings and outcomes that emerged from this qualitative research, semi-structured interview process. These perceptions and experiences were identified by participants responses to questions asked of them regarding leaders and leadership in RACS, and the influence of government policy and regulation, population and workforce demographics and HRM issues and strategies, in the eighteen RAC facilities in this project. These views and insights were compared with current and available literature, that was overviewed in the literature review. The implications follow from these viewpoints and experiences, as well as the literature, by providing suggestions for the future development of aged care leaders and managers, potential changes to aged care policy and regulation by government and the implementation of certain HRM strategies designed to alleviate the attraction, recruitment and retention issues faced by RACS.

7.3.1 Leadership

Key leadership characteristics required by leaders in RACS according to both the interview participants and the literature include; being able to effectively
communicate and collaborate with staff, residents and their families, develop, communicate and implement a strategic vision for their organisation to staff, be able to successfully manage finance and budgets and be able to manage change within the industry and their organisations (All participants 2014, Jeon et al. 2010, Sankaran et al. 2010, Shaw et al. 2012, Department of Industry 2014). The participants highlighted these skills as being gaps within leadership and they also expressed that a leader should inspire their staff and clients to achieve organisational vision, which fits more closely with Bass and Alviolo’s (1993) Transformational Leadership Model, which focuses on a leader creating change and communicating a vision for the organisation, while leading followers both inside and outside of the organisation to achieve that vision. This viewpoint, is supported by McKee, Charles, Dixon-Woods, Willars & Martin’s (2013) research that found while many care workers saw a role for distributed leadership in promoting team work and collaboration between managers and clinical staff, they also expressed concern that it could lead to confusion about who was in charge, create mixed messages and contradictory expectations and requirements in the workplace.

Compassion was another key attribute emphasised by participants as being crucial to successful and effective leaders in RACS and is a new finding in this research. The concept of compassionate leadership fits within Greenleaf’s (1991) “Servant Leadership” approach, which considered the leader’s role to involve sharing power, placing the needs of others first and helping people develop and perform as highly as possible. Two of Greenleaf’s (1991, in Schwartz & Tumblin, 2002 p. 1421) prescriptions for an effective servant leader is to ‘accept individuals and have empathy for them and live out an ability to
exert a healing influence on individuals and institutions’. Effective servant
leaders have been linked to outcomes such as extra effort, satisfaction,
organisational effectiveness and leadership trust (Barbuto & Wheeler 2006,
Joseph & Winston 2005). While the issue of whether or not compassion can be
learned was outside the scope of this study, it is important to note that research
has demonstrated that through Compassion Cultivation Training (CCT)
programs, as well as sharing care 'stories' with colleagues, compassion can be
taught and learned, but it is an entire system, a social and professional network
that develops and reinforces compassionate ideals (Pence 1983, Wear &
Zarconi 2008, Shea & Lionis 2010, Jazaieri et al. 2013). This clearly requires
further research regarding the ability and success of training RACS leaders in
compassion.

7.3.2 Demographics
While the senior aged care managers interviewed recognised that the ageing
population is going to place significant pressure on their ability to offer quality
care for all those who require it in the future, there was a limited appreciation
that the workforce is also ageing. The participants interviewed tended to focus
on their inability to employ skilled employees because of poor working
conditions, inadequate training programs, poor worker attitudes and the
negative image of the RACS, rather than also attempting to understand the
added complexity of their own ageing workforce. Many participants admitted to
being reliant on overseas student workers to fill vacancies but were clearly only
utilising such people as a stop-gap rather than attempting to provide training,
development and career path opportunities to retain them as high-quality
workers in their organisation. This is in part due to the requirement that employees on overseas student visas only work twenty hours per week, however, there was a lack of recognition of the benefit that can be provided by utilising international workers to fill skill gaps and the possibilities of lobbying government for exemptions to this regulation in their industry. This points to the lack of strategic vision and management skills that have been indicated by the participants and supported to an extent by the literature. Furthermore, this is a solution that is complex and requires active commitment from government, educational facilities and aged care leaders to implement a strategic approach to use migrant and overseas student workers to fulfil skill gaps in RACS.

7.3.3 Government Regulations

Overall, participants expressed that government(s) in Australia have little understanding of the aged care industry and need to work considerably harder to support its real needs adequately. This sentiment appears to be reflected in recent government cuts to the aged care funding instrument for aged care homes, as well as the Aged Care Education and Training Initiative, and the Aged Care Vocational Education and Training professional development programs (MENA Report 2015). Government does not make it easy for older Australians requiring care to obtain access to the advice, support and care services they need, as the system is fractured and complex, affording no easy points of contact and frequently offers too few resources to meet needs in certain areas (Reynolds 2009, Department of Health, 2018). Such concerns have been prominent in the media as a special two-part investigation of the failings in aged care was aired by a Four Corners Program (ABC, 2018). On Sunday 16 September Prime Minister Scott Morrison announced the
Government's decision to establish a Royal Commission into the aged care sector (Department of Health, 2018)

In addition, aged care peak bodies, as well as senior managers in the RACS, believe that government are sending mixed signals to the industry as they champion a move to a consumer-led and market-based system, but also stifle investment and grind down business confidence through their ongoing regulatory intervention (O’Keeffe 2016). There is a general view amongst participants that the government needs to find the correct balance between cost, consumer choice, supply and demand of care places, but also implement fewer, less complex regulations that still enforce required accountability for RACS. While there has been limited research undertaken regarding these issues, participants believe that government leadership in training and development in RACS is lacking, and that funding for education in the aged care sector is wasted as there is a deficiency of appropriate training courses available. It is clearly important that government act to ensure that RTOs offer the same quality of training in aged care as those delivered via TAFE and mend this current discredited model of accredited training and development (Fedele 2015, ASQA 2014, Simpson 2014). On the other hand, while many of the research participants and reports advocate that government funding is insufficient for the provision of adequate care, there is growing evidence that the larger aged care organisations are intensifying care insufficiencies by inadequately staffing their organisations to protect and increase their profits, which have risen by 40 per cent over the last twelve months (Russell 2016, Health Department, 2018). Participants appeared unaware, or unwilling to admit, that despite the lack of government funding, there is growing evidence that the larger aged care organisations are intensifying care insufficiencies by
inadequately staffing their organisations to protect and increase their profits. This supports the previous finding that ethics and ethical behaviour among RACS leaders are both poorly researched and recognised.

### 7.3.3 HRM

The implementation of HRM policies and strategies has been slow to develop, limited in application and there has been minimal qualitative research completed to determine exactly what current or potential employees want from a career in aged care (Clarke & Hill 2012, Clarke 2015, Ravenswood & Harris 2016). With the growth of the for-profit organisations operating in the aged care industry, there has been the introduction of HRM concepts, compelling the smaller and/or not-for-profit organisations to consider the development of their own HRM processes. Most of the people management strategies provided by these smaller RACS include the potential for workplace and shift flexibility and the provision of a family like atmosphere, meant to instil a feeling of belonging and therefore loyalty. To attract and retain their employees, larger organisations can offer salary packaging, leave buy back and career paths. The overwhelming message from the participants regarding the implantation of effective HRM strategies was that they are limited in what they can offer because of insufficient funding, excessive regulations and the necessarily hierarchical nature of care work. The participants, however, were again reticent regarding the option of lobbying government for better qualifications, higher wages and improved funding to implement successful HRM programs designed to encourage career paths within the industry and attract workers who will stay.
7.4 Significance Of The Findings

This study has made a contribution to the current research on leadership in aged care. In this study, the significance of the findings largely rests on the contribution to theory development, with the four themes providing an understanding of what is required of leaders to be successful in RACS and what are the major influences on their ability to utilise these attributes effectively. This study can contribute to refining leadership development for current and future leaders in RACS, both practically and theoretically. This study may be constructive to the government, training providers and higher education institutions, and those designing curriculum related to aged care and RACS leadership. By understanding the skills, competencies and attributes of successful leaders in RACS, the process of designing training and educational qualifications will be based on a theoretical foundation. This study has identified the issues and complexities that impede the implementation of successful RACS leadership behaviours and provides recommendations to government and the aged care industry regarding the development of policy and practice to alleviate these impediments. This study aims to serve as a contributory reference for researchers about leadership in RACS.

The research contribution can be viewed from two different perspectives: (1) a contribution to the body of knowledge and to RACS; and (2) a contribution to government policy. The key findings are as follows:

7.4.1 New Knowledge

The following are considered new findings regarding the existing body of knowledge regarding RACS.
Key Finding

1. A key leadership attribute for leaders in RACS has been found to be the condition of being compassionate and caring about the staff, residents and their families. This characteristic of leaders in RACS does not align with the literature researched in this paper, as the term compassion was not isolated as a needed attribute among leaders within the researched academic commentary. Compassion is difficult to isolate and define, yet it is a concept overwhelmingly regarded as important when leading an organisation that cares for vulnerable people in, what should be, a home-like environment. Compassion is difficult to teach, not traditionally applauded in leaders and previously perceived as being “soft” or making oneself vulnerable, but it is indubitably an attribute that is a cornerstone of RACS leadership (Nouwen, McNeill & Morrisson 1982, Von Dietze 2000, Grant 2008). According to Grant (2008, p.76), in ‘times of confusion and pain leaders demonstrate acts of compassion which influence a response by others to be compassionate in the organisation’. In other words, the concept of behaving compassionately as care staff must be modelled by the organisational leader, if it is to become a valued and practised convention within RACS. The literature on compassionate leadership in RACS was silent; the voice of the participants on this was directly the opposite.

Other Key Findings

1. The concept of having a vision for an organisation has been found to be a fundamental requirement of leadership, along with the ability to create and communicate this vision throughout the organisation to achieve organisational growth and success (Roswell and Berry 1993, Zaccaro and
Banks 2001, Kay 2005, Cable 2011, Kish, Troyer & Watkins 2016, Srivastava 2017). The capability to create and communicate a sustainable and inspiring vision for RACS is another key leadership quality established through this research. This aptitude comprises only a few sources in the literature currently presented by the academic community. Again, the informants held the opposite view.

2. A finding of significant interest was the division between participants regarding the need for clinical skills in RACS leaders. Half of the participants were adamant that a RACS leader must also be a clinician to be successful (Laura, Andrea, Sarah, Karina, Louise, Julia, Bart & Smiley 2014). This view is supported to some extent by the literature, which focuses on developing leadership skills in clinical leaders (Anderson 2003, Pearson et al. 2006, Gilmartin & D’Aunno 2007, Jeon et al. 2014). The other half of the participants, however, advocated that today’s challenging conditions require a care manager to manage the care, and a leader to lead, motivate, inspire and manage the commercial aspects of the organisation (Charlotte, Cherise, Cath, Ben, George, Liza, Madeleine, Ivan & Charlene 2014). There has not been any available literature to support further this view at this stage, which sees this as another new finding in the view of the researcher.

Findings to note for further exploration

3. An interesting finding in this research was that the informants did not clearly and resoundingly refer to the complexity of the role as a leader in RACS nor did they distinguish between the roles of a manager as opposed to that of a leader. This new finding placed in context demonstrates that
leaders in this industry sector, despite being faced with an enormous number of complex challenges, are either not recognising or naming this as an issue unique to their industry. These extremely complex challenges were identified in the ground-breaking Productivity Commission Report (2011), so it is both interesting and puzzling to find that the informants were unusually quiet on these two issue. This warrants further research.

4. The issue of staff to client ratios has been highly promoted in the media and by United Voice – the primary union responsible for the aged care sector – yet the informants did not consider this as one of the factors inhibiting effective leadership and care quality in RACS. This is of note because the absence of prescribed staff to client ratios has been emphasised in both the literature and media as having a negative impact on quality of care in RACS.

5. This research study introduces the RACS Leadership Model (Figure 6?.1), which combines the necessity that leaders in RACS possess certain technical, relationship and critical thinking skills. It acknowledges that the need for clinical skills and the type of HRM practices to be implemented are contingent on the size of the organisation and the impact of issues such as Government Policy & Regulation, the Ageing Population & Workforce, Education & Training Standards and Migrant/Overseas Worker Readiness. The RACS Leadership Model outlines the skills and attributes required of leaders in RACS, and encompasses elements of transformational leadership model whereby a leader inspires, empowers, and stimulates followers to reach organisational goals (Bass & Avolio 1993) but recognises the need for a transactional paradigm of incentive and reinforcement (Jeon et al.. 2010).
It also proposes a distributed or shared leadership approach that moves away from the solitary leader (Badaracco, 2001, Loetze 2011), to a more collective perspective, where leadership becomes a communal, social process that supports individuals to work collaboratively in teams, thereby sharing decision making and accountability for outcomes (Uhl-Bien, 2006, Bolden 2011, Loetze 2011). Finally, the RACS Leadership Model takes into account the factors that impact or impede the successful implementation of desired leader behaviours and competencies, to create greater awareness for leaders of RACS, government and policy makers. Servant leadership

In conclusion, this research aimed to support RACS leaders in conceptualising their leadership by combining both a compassionate approach with strategy and vision, to lead and inspire their staff, their residents and other stakeholders, and to achieve successful organisational outcomes in a challenging environment. The research is also intended to instigate government action and guide subsequent policy decisions, regarding the causes of the significant challenges faced by RACS leaders, named in this study as the ageing demographics, government regulation and policy, and related HRM issues.

7.4.2 Contributions to the Field of Study

This research has offered insights into the efficacy of different types of leadership attributes and styles and the associated impact of Australian demographic trends, government policy, and HRM on leadership effectiveness.
The findings identified in this thesis may potentially act as an impetus to direct further research in these areas, in the following ways.

1. Firstly, previous research has suggested that EI is an important leadership characteristic in leaders (Melita Prati, Douglass, Ferris, Ammeter & Buckley 2003, Goleman, Boyatzis & McKee 2013, Maamari & Majdalani 2017). Yet, while the participants in this study identified compassion as a required attribute for leaders in RACS, they did not recognise that the skills that contribute to the various components of EI are essential prerequisites to the development of compassion and care (Rankin 2013). As mentioned in the Discussion Chapter, this may be because the informants themselves construct the key issue as compassion and empathy rather than EI. However, it may be a timely cue for a greater focus on the development of EI in leadership positions in RACS and greater research into the impact of leaders with EI skills in improving outcomes in the aged care sector.

2. Secondly, while there has been underlying acceptance regarding the importance of leaders being able to think and plan strategically in successful organisations (Jeffries & Annulis 2012, Spurgeon, Mazelan & Barwell 2012, Morrill 2013), few researchers have defined or explored this as a specific leadership skills in regard to aged care leadership (Cartwright, Sankaran & Kelly 2008, Shaw et al. 2014). While almost half of the informants outlined that leaders in RACS must be able to generate and promote a vision to their stakeholders, (Bart, Cath, Liza, Ivan, George, Ben & Charlene 2014), only three identified strategic planning as a requisite skill (Ivan, Charlotte & Karina 2014). This
indicates that the informants construct the idea that while leaders must be transformational in creating and selling a vision, actually possessing the skills to plan and implement the vision is not something they have given consideration. In developing a theoretical description of the skills and attributes required of leaders in RACS, it is recommended that researchers consider the concept of strategic thinking and planning, as a critical skill in ensuring effective organisational structure and performance.

3. Many of the research participants (Ben, Cherise, Charlotte, Andrea, Julia, Ivan, Gary, Bart, Cath, Sarah, Karina, Liza, George, Charlene, Smiley, Madeline, Louise 2014) and recent governmental reports (Productivity Commission 2011, Treasury 2015, ACSA 2016, LASA 2016) identify that government funding is insufficient for the provision of adequate care. There is growing evidence that the larger aged care organisations are intensifying care insufficiencies by inadequately staffing their organisations to protect and increase their profits, which have risen by 40 per cent over the last twelve months (Allard 2016, Russell 2016). All participants, except for Laura (2014) appeared unaware, or unwilling to admit, that this is occurring. This may indicate that their particular organisations are either sacrificing profit to ensure quality care, that funding is not appropriately targeted to those organisations that most require it. The implications for future research, and for the government, is that there needs to be a more thorough investigation regarding how aged care funding is being spent, and in ensuring that funding is targeted more appropriately to ensure RACS can
provide adequate care.

4. Linking to this previous contribution to the field, while participants appeared unconcerned regarding the impact of potentially insufficient staffing ratios on care, they were very alarmed about the impact of the user-pays model being introduced by the government into RACS. Both the informants and any examined literature cited in this thesis agreed that the introduction of a user-pays model to aged care might significantly impact those from lower socio-economic conditions negatively (Andrea, Karina, Charlene, Ivan, Charlotte & Smiley 2014, Hodgkin 2014, The Lamp 2011, Hearn 2011, Productivity Commission 2011). These participants (Andrea, Karina, Charlene, Ivan, Charlotte & Smiley 2014) asserted that this model means that those who do not have the accessible finance will face a limited choice and may be forced into a care facility that is inferior in quality and remote from their local surroundings and services. This concern is at odds with their lack of anxiety over the non-existence of required adequate staffing ratios to patients, and the significant negative impact that may have on care. This supports the previous implications for research and government regarding the investigation into how aged care funding and finances are managed and distributed.

5. Caring for and caring about people with dementia requires specific skills and while there is recognition of, and treatment provided for, dementia-related illnesses in older people living in RACS, this is challenged by a lack of leaders and care staff trained in this field (American Geriatrics
Society and American Association for Geriatric Psychiatry, 2003; Moyle, Hsu, Lieff and Vernooij-Dassen 2010, Productivity Commission, 2011).

The literature surrounding dementia care skills relates is too focussed on the care and nursing staff rather than those in leadership positions in RACS, despite this research demonstrating that it may also be a critical skill required of leaders in RACS. Some of the participants (Sarah, Karina, Ivan, Bart & Laura 2014) expressed knowledge of dementia was an important skill for RACS leaders, to assist them in dealing with and catering for, both elderly residents with dementia, their families and carers, which indicates that this may be an emerging area of skills development for leaders and requires further inquiry.

6. The ageing population and its predicted impact on the aged care industry is a topic well discussed in the academic literature (Joyce, McNeil & Stoelwinder, 2006, Fine 2007, Skills Australia, DEEWR 2010, Australian Treasury 2010, Wilson 2010, Productivity Commission 2005 & 2011, King et al. 2012). Interestingly, the participants interviewed for this thesis generally did not appear to regard this phenomenon as a problem for their organisations. It was obviously not a forefront issue in the minds of the informants, which was quite puzzling. This may be because the participants did not understand the full impact that the ageing of our population will have on their ability to lead and operate their organisations in future decades effectively. Only four participants referred to the ageing of the workforce as being an issue for leadership and organisational success (Ivan, Laura, Andrea & Cath 2014), indicating that further
research on RACS leader’s awareness regarding workforce availability and future staffing trends may be beneficial.

7. Over the next five decades, there will be an increasing need for continuous recruitment of overseas workers into the RACS workforce to alleviate the loss of the currently ageing RACS workers to retirement (Hugo 2009, Fine & Mitchell 2007). The entry of the Baby Boomers into the RACS market will mean a change in expectations of care delivered. While the subject of migrant workers was raised by only a few of the research participants (Cath, Andrea, Bart & Ivan 2014), it appears that there is a need for leaders in RACS to be more aware of their potential to fill skill gaps and employment requirements in their organisations, and for governments (state and federal) to acknowledge this requirement, and develop policy accordingly. This signals that RACS leaders and government must work together to redress the education and training issues currently facing the aged care industry, as well as the problem of limited working visas for overseas students, who are currently critical to the RACS workforce (Fine & Mitchell 2007). This research, therefore, encourages additional and widespread examination of current education and training options and offerings for aged care, as well as greater research into the need for overseas workers to meet staffing challenges and the changes to government policy required to facilitate their ability to work in Australian RACS.

8. This links to a final contribution to current aged care research, which is the issue of career development for care workers in RACS. Research
has established that the absence of career opportunities in RACS was regularly rated by aged care employees as a substantial factor stimulating them to leave employment in aged care (Abbey, Liddle, Bridges, Thornton, Lemcke, Elder & Abbey 2006, Leschke, Watt & Finn 2008, Clarke 2009, Dwyer 2011, Radford, Shacklock & Bradford 2015). In this research, however, only two of the participants acknowledged that the lack of career paths was an issue for leaders in aged care and their ability to attract and retain staff (Andrea & Cath 2014). In addition, only two of the participants interviewed had implemented strategies in their organisations to commence the development of career path options for their nursing and care staff (Andrea & Karina 2014). There is a clear disconnect between the experiences and understandings of the informants and what has been established in the literature. This is a new finding as, despite acknowledgement that there is a need for some career structure for RACS staff in the Productivity Commission Report (2011), it is clearly not an issue that has been recognised and acted upon by leaders in RACS. This study, therefore, encourages further and comprehensive investigations into the key HRM issues that provide complex challenges for RACS leaders, along with the establishment of effective strategies, such as career path development, to alleviate these complexities.
To sum up how this thesis has met the objectives of the research, the following table provides a clear and succinct outline of the aims, objectives and outcomes of the study:

Table 7.1 – Summary of Aims, Objectives and Outcomes

<table>
<thead>
<tr>
<th>Overall Aim</th>
<th>Objectives</th>
<th>How achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contribute to new knowledge that positively impacts leadership outcomes in RACS</strong></td>
<td>To contribute to knowledge that may have an impact on improved leadership in RACS leading to more effective care outcomes.</td>
<td>The RACS Leadership Framework builds on the ACLCF and the Health LEADS Framework by finding support for the health and aged care leadership capabilities indicated in their research. It also builds on these capabilities by determining the impact of government regulations, ageing demographics and other institutional factors on the leadership setting and the enactment of leadership.</td>
</tr>
<tr>
<td><strong>Identify skills, attributes and abilities required.</strong></td>
<td>To ‘develop, adapt and implement research methodologies to extend and redefine existing knowledge … and disseminate and promote new insights’ relating specifically to the skills, attributes and abilities that will most successfully serve RACS leaders</td>
<td>Using the qualitative research methods of constructivism and thematic analysis, this research was able to elicit a new account of participants interpretation of leadership. Using semi-structured interviews enabled the further probing of certain thoughts and experiences of the participants, and in particular, established the concept of compassion in RACS leadership. While compassion in a care role is not a new concept, it has not been isolated as a required attribute among leaders within the researched academic commentary. The research also establishes that underpinning good RACS leadership is the characteristics of compassion, communication and care. Further research is required to determine if and how these characteristics can be taught to potential future leaders in RACS.</td>
</tr>
</tbody>
</table>
| **Provide original knowledge to assist in meeting the challenges of the ageing population in Australia.** | A key aim is to add academic commentary to the body of knowledge in the field to work towards a resolution of the major challenges that this society is now facing due to an | This was achieved identifying the key impediments to good leadership in RACS, being:  
- Regulatory Burden  
- Education & Training Standards  
- Low Wages  
- Insufficient Funding & Support |
ageing population and an overwhelmed and underequipped aged care industry.
• Ageing Population & Workforce
• Skill Shortages
• Migrant/Overseas Worker availability/abilities
By clearly naming these issues, many of which have been identified in other research, this can assist in guiding future government policy regarding RACS and RACS leadership.

7.4.3 Limitations of the Research

The research in this thesis focused only on RACS in Victoria as a result of time and funding restrictions. A research study incorporating a variety of RACS from all states and regions in Australia would provide a more in-depth and wide-ranging perspective. This research concluded by interviewing eighteen leaders in RACS only – lower level staff, residents or their families were not interviewed for this research. As with expanding the geographical scope of the research, broadening the range of participants, and their experiences, would also enhance the validity and reliability of this research. The limitations and disadvantages of qualitative research has been debated, however qualitative research can extract the contextual influences on what is regarded as effective leadership. This is consistent with a proposition by Biggatt and Hamilton (1987, p. 437), that research should begin with essential hypotheses ‘that postulate the impact of norms, legitimating principles, historical legacies, and other institutional factors on the leadership setting’ – which is what this research has focussed upon. Further, a quantitative method might have verified the authors’ previous ideas about leadership in RACS and their concerns, but it probably would not have captured the significance of qualities like compassion as a vital characteristic for leaders, without being able to utilise the semi-structured interview process to draw out these responses.
7.5 Major Conclusions and Recommendations for Further Research

There are major proposals I make based on the findings of this study.

- **There is an urgent need for** Australia to develop an acceptable, rigorously evaluated and strategically integrated national policy approach to the aged care health workforce. This must include a re-evaluation of funding levels, regulations, accredited training and development standards and the aged care industry marketing and promotion.

- **There must be reform** that is enhanced by improved working conditions, better leadership and workforce innovation, underpinned by change and strategic thinking and planning.

- **This must be guided by** qualified, skilled and dedicated leaders within the aged care who exhibit and implement the complex skills, competencies and attributes found by this research to be essential to successful aged care leadership.

- **The RACS Leadership Model** should be considered as a guide for developing the skills and abilities of leaders in RACS and also for defining the particular skills and abilities required by individual organisations according to their size and operational requirements.

- **There must be further research into** the notion of compassion as a key leadership attribute for RACS, and how this term can be defined and quantified as a capability that can be developed by future leaders.

- **Education and Training must incorporate** the teaching and training of competencies that enable the skills for creating and communicating an organisation vision, as well as managing budgets and finance. Other skills, such as the management of residents with dementia and providing quality end-of-life care should be further studied and developed as competencies.
in accredited training and development for RACS leaders, so that they can competently manage and develop successful organisations.

- **The concept of ethics** as a crucial characteristic of aged care leaders must be further researched and developed as competence or skill to be included in aged care qualifications and training.

- **Government and RACS must combine** to examine the issue of the ageing RACS workforce and the potential use of greater numbers of migrant workers to assuage the skill deficiencies that will be left in this industry, as the current ageing workforce retires. They must collaborate to develop standards for training to ensure appropriate care, and develop policies that allow the employment of enough migrant workers, over enough hours, to fulfil need.

- **A Royal Commission into aged care in Australia is long overdue.**

- **Finally, it is a key finding that** substantial work needs to be done to build a leadership model that can define leadership requirements and prepare the effectiveness of leaders to meet and resolve these future challenges.

The findings of this present study advocate that research should continue to explore the concept of leadership, relevant Australian demographics, government policy, HRM strategies and other contextual factors. This is needed to clarify the required characteristics and behaviours of leaders in RACS, to develop strategies that ensure leadership effectiveness in the complex aged care sector. In developing theoretical explanations for the role of leaders and leadership in ensuring a successful future for the aged care industry, researchers are encouraged to contemplate more comprehensively, the wide array of multifaceted characteristics specific and distinctive to the aged care industry.
Attention must be focussed on the contribution of compassion as a key attribute required in RACS leaders, the development of strategic vision as a critical leadership skill and the role of servant and shared leadership as preferred leader frameworks for RACS. The function of ethics and being ethical, as a critical element of leadership in RACS, is an area that requires a comprehensive study, given its vital yet unacknowledged role in this and other aged care leadership research.

In conclusion, this research has contributed both the theory and practice of leadership in RACS and has provided the groundwork for further research. The constructivist methodology and evaluation of findings using thematic analysis enabled several new contributions to the understanding of leadership skills, attributes and competencies in RACS, the development of future government policy and regulation and the prospective improvement of education and training qualifications and outcomes for aged care leaders. Areas for future research have been identified and while research was piloted within the context of RACS, the results have the potential for application in the wider aged and community care sector.

At the end of the day, we as humans, want to be cared for in a manner which ensures dignity, enshrines compassion and nurtures the individual, while having care needs considered and met, in an environment that is both comfortable and comforting, and in which we can end our days valued and respected.
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Appendix 1 - PhD Interview Questions

1. Can you tell me/us about your experience and career in the residential aged care sector please?
2. Is there a shortage of qualified people to work in senior positions in the residential aged care sector?
3. What are the skills and attributes that you believe are required by senior employees in the RAC in order to be effective leaders?
4. Is there too much emphasis when appointing senior staff in the RAC on clinical experience and academic qualifications as opposed to leadership and management skills?
5. Looking at this industry sector broadly, what leadership skills gaps exist in RAC from your perspective commenting on your colleagues?
6. Could you comment on your learning curve that you experienced as a leader in the aged care sector?
7. What are the major changes occurring in the RAC and what specific leadership skills are required to address these changes?
8. Circumstances from my research indicate that difficulties are experienced recruiting and keeping staff in this sector. Does this test your leadership skills? If so how?
9. What major strategies is your organisation currently employing to resolve recruitment and retention problems in regard to senior employees?
10. Can you give an example of the major strategies that are required to address leadership skill development in this sector? What is and isn’t being done, in your view?
11. Can you comment on the leadership demonstrated by government in regard to the residential aged care sector?
12. Is there anything else that would like to share from your experience?
Appendix 2 – Sorting the Responses

1. Can you tell me/us about your experience and career in the residential aged care sector please?
2. Is there a shortage of qualified people to work in senior positions in the residential aged care sector?
3. What are the skills and attributes that you believe are required by senior employees in the RAC in order to be effective leaders?
4. Is there too much emphasis when appointing senior staff in the RAC on clinical experience and academic qualifications as opposed to leadership and management skills?
5. Looking at this industry sector broadly, what leadership skills gaps exist in RAC from your perspective commenting on your colleagues?
6. Could you comment on your learning curve that you experienced as a leader in the aged care sector?
7. What are the major changes occurring in the RAC and what specific leadership skills are required to address these changes?
8. Circumstances from my research indicate that difficulties are experienced recruiting and keeping staff in this sector. Does this test your leadership skills? If so how?
9. What major strategies is your organisation currently employing to resolve recruitment and retention problems in regard to senior employees?
10. Can you give an example of the major strategies that are required to address leadership skill development in this sector? What is and isn’t being done, in your view?
11. Is there anything else that would like to share from your experience?

Lit Review

Table 1

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<tr>
<th>Themes</th>
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<th>Source – Catholic Homes</th>
<th>Source – Charmaine, Kow Gardens</th>
<th>Integration (noting the notable hits but not all)</th>
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<tr>
<td>1. Can you tell me/us about your experience and career?</td>
<td>Goodness, I’ve been nursing for 13-14 years now. I guess. Like, here I came back to.</td>
<td>I have been a resident services manager that overlooked all Catholic Homes facilities.</td>
<td>Look I mean I entered the workforce at 17, doing nursing. And I was just lucky. I think for me</td>
<td>Nursing graduate originally.</td>
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Appendix 3 - Thematic analysis data coding sample

Key:
- Healthcare
- Nurse Manager dichotomy
- Training
- Industry image
- Flexibility
- Performance appraisals
- Extension

<table>
<thead>
<tr>
<th>Key</th>
<th>Sample</th>
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<tbody>
<tr>
<td>SMT</td>
<td>When I was in Adelaide we, certainly in Anglicare and one of the first in South Australia to be appointed as a manager, not having come through a nursing background. So he was actually a chef, and so that was... not only was a chef but he was male, where 90% of the population were female. So it was a bit of a break in the tradition. Here we haven’t done anything quite that radical but we’ve got a manager who is an EN, rather than an RN.</td>
</tr>
<tr>
<td>LG</td>
<td>I think the other thing with residential aged care, it’s incredibly highly regulated. Incredibly, a lot of pressure, people live in fear of two things. One that someone will die and they will have a coronal inquiry. We’ve got one that’s coming up now. And the second in charge of the area is off on stress leave, just worrying about the fact that it’s coming up. So that’s one, and the other is when the accreditors come around we’ll fail the accreditation. You know they’ll find fault on one of the 43 points and normally it’s not, well in our situation it’s normally not about whether we’re providing a good level of care. It’s whether we’ve actually remembered to</td>
</tr>
<tr>
<td>SMT</td>
<td>But I think we undervalue the sector, and I think what we don’t do is we don’t sell some of the major benefits and some of the major attractions, some of the major rewards that come from working in aged care. So I think the sector, like I’ve heard people in the past apologise for aged care and the fact that we don’t pay a very big wage. So rather than sort of focusing on the positives they actually focus on the negatives. Most of the people that come and work in aged care don’t come because of the dollars. They actually come because the satisfaction they get from the job, and some of the other benefits, some of the flexibility benefits. A lot of our workforce are part time.</td>
</tr>
</tbody>
</table>
Appendix 4 – Ethics Application, Participant Information

Statement and Agreement

Application for Review of Negligible and Low Risk Research by the College Human Ethics Advisory Network (CHEAN)

About this form:

This application form should be used by researchers seeking ethics approval from the CHEAN for human research projects that have been assessed by the RMIT HREC Checklist for negligible and low risk research as presenting no more than low risk to research participants (i.e. risk that is no more than discomfort).

The completed checklist must be attached as a cover to this form

Attachments:

You need to include with this application the following supplementary documents (where applicable)

- A completed checklist (either negligible risk or low risk checklist as appropriate)
- Participant Information sheet/plain language statement (see Applying for HREC approval that gives you a guide for completing the Information sheet)
- Informed consent form distributed to participants statement (see Applying for HREC approval that gives you the consent form template)
- Questionnaires or any survey instruments
- Any other documents required for the research project (for example, approvals from other organisations to conduct research)

Submitting the application form:

Submit your original and signed application form as well as any supplementary information to your relevant CHEAN secretary. Please go to your college website to ascertain where to send your documents and how many copies you will be required to submit. All initial correspondence about your application should go through the CHEAN secretary.

You must not commence data collection until you receive written approval from the CHEAN

---

3 It is recognised that there are some questionnaires or survey instruments that can’t be attached because of their size and type. In that case, you must provide a full description and citation
Please remove this cover page before submitting your application
Application for Review by the CHEAN of Negligible and Low Risk Research

<table>
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<th>Approval Date (office use)</th>
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1 Project Title
Leadership in Residential Aged Care

Section 2: Researchers

**Principal Investigator – Staff Research**

<table>
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Discipline/School/College

**Other Investigator/s**

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Add rows as required

**Principal Investigator – Student Research Degree**

<table>
<thead>
<tr>
<th>Title</th>
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Ms Jacqueline O'Toole
Degree: PhD
School of Management

**Senior Supervisor**

<table>
<thead>
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</table>

Dr Alan Montague

**Other Investigator/s**

<table>
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<tr>
<th>Title</th>
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<th>email</th>
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</thead>
</table>

Add rows as required

**Corresponding Investigator**

| First name, family name | E-number / Student number | phone | email |

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4 Adapted from Queensland Government, Queensland Health “Application for review (HREC or Non-HREC) of low risk research” 2008 and “low impact research”, SET Portfolio, 2008

5 Use your student email address only – not your personal email address
3. Project details

3.1 Proposed duration of the whole research project

<table>
<thead>
<tr>
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<th>To:</th>
</tr>
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<tbody>
<tr>
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<td>28 February 2015</td>
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3.2 Proposed duration of the data collection phase of the research project

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 December 2011</td>
<td>10 December 2012</td>
</tr>
</tbody>
</table>

Please note: Annual/final reports of your project must be submitted and are due during December for all research projects that have been approved by the CHEAN. The necessary form can be found at annual final report form.

3.3 Executive summary of the research project

See NHMRC National statement on ethical conduct in human research (2007), section 1

Briefly outline, in simple terms, the scope of your research project, the project aim(s), target population(s) method and possible outcomes. (150 – 200 words)

The proposed study focuses on the skills and attributes of leaders in the residential aged care (RAC) sector in Victoria and the capabilities required to meet the challenges faced by this industry sector from 2011 to 2020, due to growth in demand for quality services, due to demographics and increased government regulation (Kendig & Duckett 2001; Hugo 2007, Productivity Commission 2008, 2010, & 2011, Australian Treasury 2010, Jeon, Merlyn, & Chenoweth 2010) the competition for quality and qualified staff, in a sector many prospective recruits find unattractive to work in with low salaries and other budgetary and regulatory constraints (Productivity Commission 2010).

This study will employ a qualitative research method underpinned by constructivism, and use a longitudinal multiple case study design, to generate data in relation to the professional skills of leaders in the residential aged care (RAC) sector.

The proposed study intends to use a sample of sixteen RAC facilities and their staff in Victoria to examine the required skills in leaders in this industry sector. The sample seeks to address maximum variability in participant informants’ backgrounds and work locations. In doing so, the study will seek to provide a comprehensive understanding of complexities faced by leaders in aged care. The proposed study will use multiple methods of data collection over a twelve-month period including an intensive examination of relevant literature in relation to leadership and management as well as information on the challenges facing this sector in terms of demographics, an ageing workforce, skills shortages and the image of this field. Data obtained from primary sources will be compared and contrasted with the data from primary sources to “construct” the research outcome being the leadership skills required in the residential aged-care sector, in relation to challenges in terms of change.
creativity, innovation, and fulfilling responsibilities to residents, employees and the public?

I intend to collect data through in-depth interviews with senior staff working in the sector, and integrate research material emanating from other research studies in the field, commentary by other researchers at conferences or in the media (podcasts, newspaper articles and blogs). The proposed study will contribute to knowledge in the field in numerous ways. A primary aim is to provide commentary on effective leadership in this sector that may have particular relevance for other industries. This will also include an increased understanding of the required leadership in RAC and an analysis of skill gaps and development needs. Secondly the study aims to provide a demographic overview of the array of complexities that confront an ageing Australian society and its institutions drawing in added issues concerning government policy and strategic planning. A third aim is to comment on the impact effective leadership can contribute to greater employee job satisfaction, lower staff turnover and higher quality care is an added key issue within this study. Overall the research will endeavour to develop a framework for leadership development in the RAC sector to add to knowledge that may enable the implementation of successful change in the sector, improve outcomes for staff performance and contentment, and guarantee quality care and an improved sector image.

3.4 Research aims and significance

State the research objectives, key research questions and significance of the project. Where relevant state the specific hypothesis to be tested or in the case of qualitative research state the specific topic of inquiry to be investigated. Comment on its potential to contribute to existing knowledge and why your research should proceed and an explanation of any expected benefits to the community. It is expected that reference will be made to key literature informing the research project and to any relevant projects. (approximately 300 – 400 words)

Through the proposed research, the aim is to develop systemic and critical understanding of the complex issues and body of knowledge required for CEO Managers and leaders in the aged care industry sector.

The overall aim is to develop research skills and methodologies which systematically and independently engage in critical reflection, synthesis and evaluation to redefine existing knowledge and professional practice. An added aim is to disseminate and promote new findings to peers and appropriate people connected to the aged care sector, to contribute substantially to the body of knowledge in the area of professional practice within aged care management and leadership, and link government policy and practice as an issue of symbiotic importance with associated commentary.

The aim is to demonstrate the application of knowledge and skills developed within the PhD study using initiative and creativity to foster further learning through original research in an area of crucial importance to Australian society.

To be more explicit - the proposed study aims to explore and place in context the growing crisis within the private residential aged care sector in regard to the attraction, retention and training of skilled staff, meeting the healthcare needs of a growing number of older Australian residents, providing quality care to current clients and developing a positive public image within the community. The proposed study aims to develop theory about the current role and future development needs of CEO - managers and leaders - in the private (for profit) and not-for-profit residential aged care
sector in meeting these complex challenges. The following research question will guide the proposed study:

| What are the leadership skills required in the residential aged-care sector, in relation to challenges in terms of change, creativity, innovation, and fulfilling responsibilities to residents, employees and the public? |

3.5 Research methodology

Provide a summary of the proposed method/s including the number of participants required. Give a justification of your proposed sample size, including details of statistical power of the sample where appropriate or, in the case of qualitative research, the number of participants anticipated to be required in order to attain data saturation. Outline the inclusion / exclusion criteria for the sample and how these have been established, and how the data will be analysed. (approximately 150 – 200 words)

Interviews allow the researcher access through words to an individual's constructed reality and interpretation of his or her own experience (Fontana & Frey, 2000; Minichiello, Aroni, Timewell & Alexander, 1995). In-depth interviews enable the researcher to seek an understanding of participants’ perspectives of their experiences or situations through repeated face-to-face encounters (Taylor & Bogdan, 1984).

This proposed study intends to gather data through in-depth interviews which are semistructured. The semi-structured interview has specific topic areas that need to be covered during the course of the interview, however the order of the questions and the exact wording of the questions are left (noting ethical considerations and approval) to the discretion of the interviewer (Bryman, 2001; Hessler, 1992).

This enables the researcher flexibility to respond immediately to issues raised by participants, ask probing questions and to allow participants to discuss issues considered to be important to them. The interview guide, however, remains focussed on collecting data to ensure that the research question(s) can be answered (Minichiello et al., 1995) and seeks to ensure cross-case comparability (Bryman, 2001).

In this proposed study, data will be collected according to the following schedule:

I will interview at least 2 senior people in 16 RAC organisations using semi-structured interview has specific topic areas that need to be covered during the course of the interview. However the order of the questions and the exact wording of the questions will be left fluid to enable flexibility and to explore any peripheral issues that will add value or clarity to the data being collected. There will be eight for profit and 8 not for profit RACs used in the sample size to provide a richer comparison of findings as part of engaging in critical reflection, synthesis and evaluation of the data.

Interview questions will be provided to each participant several days before each interview to enable each participant to reflect upon their experiences and prepare for the interview.

Interviews will be approximately 60 minutes in length and will be conducted on a face-to-face basis at each participant’s workplace. Permission to tape-record each interview will be sought from each participant. Interview transcripts will be emailed back to each participant for verification. Individual RAC organisations will be approached to formulate a list of potential respondents/informants for this research. The respondents
will be senior managers in the RAC sector and fall into the “low risk” category. All respondents will be unidentifiable.

Interviews will be constructed at a convenient location to respondents. Interviews will be recorded and transcribed and coded thematically for analysis and copiling the data into a useful framework for systemic analysis (Bodgan & Biklen 1992, Hessler 1992, Wolcott 1994, Denzin and Lincoln 2000)

A draft copy of the interview questions are attached in Appendix A.

3.6 What data collection technique(s) will be used? [Tick as many as apply]

- Survey questionnaire (attach a copy, or if a copy can’t be attached, provide details including a citation)
- Web-based survey (you need to complete the document “are you planning a web-based survey” available on the HREC website)
- Interviews or focus groups (attach a question schedule or list of topic areas)
- Observation of participants with their knowledge
- Photographs of interviewees or events with their knowledge and consent
- Audio-recording of interviewees or events with their knowledge and consent
- Video-recording of interviewees or events with their knowledge and consent
- Use of equipment that records biosignals from the body surface and uses an electrical supply in any form (e.g. electroencephalography, electrocardiography, feedback audiometer)
- Accessing student data base (IExplore or other)
- Other (Please give details. Use no more than 50 words):

3.7 Based on your responses to 3.6, detail the tasks that participants will be asked to participate in. What exactly are participants being asked to do? The description should be provided in sufficient detail so as to enable a research assistant, with minimal familiarity with the research area, to explain the procedure to a potential participant and to then enact the procedure with the participant. (Up to 200 words)

Participants will be asked to participate in a face-to-face interview for no more than one hour. Participants will be contacted prior to interview via letter and email, with a follow up telephone call. Contact letters will include a plain language statement.

The researcher will organise and attend the participant’s workplace at a time that is convenient to the interviewee. At the commencement of the interview the participant will be taken through the plain language statement again. The purpose of the research as well as their rights as participants will be fully explained. The participant will then be asked to sign a consent form. Participants will be asked if they will permit recording of the interview, and advised that this is not compulsory. If permission for recording is
declined, extensive notes will be taken by the interviewer. The researchers will also explain the importance of the confidentiality of the interview. The semi-structured interview schedule will then be followed (see attachment).

3.8 Provide a list of the references that have been used in this application (Up to 20 references)

Bogdan, R.C. & Biklen, S.K. (11192) Qualitative Research in Education: An Introduction to Theory and Methods, Allyn & Bacon, Boston.
Department of Education, Employment and Workplace Relations (2010) Lists of State and Territory Skill Shortages
Joyce, M., McNeil, J. & Stoelwinder, J.???????????????????????, (2006), MJA, Volume 184, Number 9


Thyer, G. L. (2003), Dare to be different: transformational leadership may hold the key to reducing the nursing shortage. Journal of Nursing Management, 11: 73–79. doi: 10.1046/j.1365-2834.2002.00370.x

Williams, C., & McWilliams, A. (2010) MGMT Cengage Sydney


4. Researchers’ qualifications, experience and skills

For each of the researchers listed in section 2.1 and 2.2 list their academic qualifications and briefly outline experience and skills relevant to this project (50 words for each investigator)

Jacki O’Toole (BA, Grad Dip Comm, MBus)
Current Position: Research Assistant, School of Management

Summary of experience and relevant academic activities
Jacki has been involved in teaching and program development in Organisation Behaviour, Employment Relations, Leadership and Management and Work Integrated Learning. Key aspects of her role at RMIT have involved contributing to educational development and delivering learning outcomes across international boundaries including Malaysia, Hong Kong and Singapore. She has also undertaken a number of roles in Federal, State and Local Government agencies involved the extensive formation of numerous partnerships with wide ranging bodies in the community, education and industry sectors. She has also been involved a high level of policy development, as well as having a strong understanding of business development, strategy and management.

5. Participant Details

5.1 Participant data

Identified □  Potentially identifiable (coded)6 □  non- identifiable/anonymous7 □

5.2 Target participant group

Students of this University □  Students of one or more other universities □

A specific target group (please identify in section 5.3) □  People under 18 years (please detail in section 5.3) □

No special characteristics □  Persons on a data base that has been sourced with permission □

Other (please give details – up to 50 words):

5.3.1 Number, age range and source of participants

Provide the number of participants; indicate how many groups will be used and describe the characteristics of each group. Do you have any exclusion criteria?

---

6 This means that you, as investigator, know who the participant is – even though when you report on your research project, the report does not use research participant names

7 This means that you, as investigator, do not know the names (or any personal identifying features) of your research participants
<table>
<thead>
<tr>
<th>Phase</th>
<th>Participants</th>
<th>Total Number</th>
<th>Type</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview</td>
<td>One CEO and one senior manager in 16 aged residential care facilities</td>
<td>32</td>
<td>Semi-structured interviews</td>
<td>All over 18 years</td>
</tr>
</tbody>
</table>

5.3.2 Age range of your research participants

**Adults aged over 18 in the workplace**

5.3.3 Source of your research participants (i.e. what group of people do you intend to approach to participate in your research?) (up to 50 words)

As part of the research team on the *Study into Key Policies within Aged Care Services-Research in Labour Market Complexities and Solutions*, I have established a sound relationship with the Aged Care Association of Australia (ACAA) as well as with a number of interview participants from RACs in Melbourne. Approaches will be made to individuals in numerous RACs to gather informants. No problems are anticipated in this area as my work as a research assistant on another research project has provided many potential informants at senior levels.

5.4 Explain how you will recruit your participants and invite them to participate

*Include in your explanation the precise details of the recruitment method (e.g. direct approach, networking, advertisements/flyers, accessing a database (are you authorised), talking to a group) – up to 200 words*

Direct approaches to the CEOs and senior managers will be undertaken. Other interview participants that have been part of the *Study into Key Policies within Aged Care Services-Research in Labour Market Complexities and Solutions Project*, have already asked to participate when the topic of my PhD was raised informally.

5.4.1 Explain, if applicable, the steps to be taken to ensure that participation will be purely voluntary and not influenced by, for example, the teacher/student, doctor/patient, manager/subordinate relationship (where there is a dependency relationship between the researcher and participant). *Up to 200 words*

At all stages it will be made clear to all potential informants that the process is purely voluntary and that they are at liberty to withdraw from the process at any stage.

5.4.2 Detail, if applicable, the steps to be taken to ensure that the conduct of the research will not interfere with the primary teaching role of the class, provision of normal clinical care or conduct of normal business. *Up to 200 words*
The participants will be asked to identify convenient times and locations suitable to the operation of their organisation.

5.4.3 Include any steps that may be necessary to respect the cultural sensitivities of participants. (up to 200 words)

In all circumstances, sensitivity to local cultural context will be a major concern to the researcher throughout the study. The researcher will adopt interview techniques to suit the cultural context in which the study is taking place.

5.5 Are you seeking to recruit children as participants?
Yes ☐ No ☒

If Yes, have the relevant members of the research team completed a Working with Children Check?
Yes ☐ No ☐

If Yes, please attach a photocopy of each Working with Children Check card. If No, please explain why a Working with Children Check is not required.

For further information on the Working with Children Check please refer to Victorian Department of Justice website.

6. Research into teaching practice

6.1 Is this research project specific to research into university teaching practice?
Yes ☐ No ☒

If YES, please go to 6.2. If NO, please move to section 7

6.2 Have you sought permission to recruit students for your research from the course co-ordinator, program director (co-ordinator) or Head of School? 
(Please note: it is important to consider the degree of exposure of students to staff research into teaching practice activities)
Yes ☐ No ☐

6.3 Do you intend to use class time to undertake your research activities?
Yes ☐ No ☐

6.3.1 If yes, please explain why this is necessary and detail how much class time will be taken to complete research activities. (up to 100 words)

---

8 Please note: Final approval will only be given when appropriate approvals have been provided to the CHEAN
6.3.2 Have you received written permission from your Discipline Leader or Head of School to use class time to conduct your research activities? 
Yes ☐ No ☐

6.4 Do you intend to use student assessment grades as part of your data? 
Yes ☐ No ☐

6.4.1 If yes, you must ensure that students are aware that you will access their assessment grades as part of your data. You must explicitly state, in the Information sheet, that student progress will NOT be affected by their participation / non-participation in your research. 
*Please detail the steps you have taken to ensure that students are aware that their participation / non-participation in your research will not affect their assessment scores or progress through their program of study. (up to 100 words)*

---------

6.5 Do you intend to use student assessment tasks, or any other forms of activity, or participation in them, as part of your data? 
Yes ☐ No ☐

*If you answer YES, you must respond to 6.5.1 and 6.5.2*

6.5.1 If yes, you must ensure that students are given an opportunity to “opt-in” to the research-associated assessment task or other forms of activity or contribution. Are students given the option to opt-in to the research associated assessment task or other forms of activity or contribution? 
Yes ☐ No ☐

6.5.2 If you answered YES to 6.5.1, please describe the strategy you will use to allow students to “opt in” to the research associated assessment task. Note too that this information must be included in your information sheet (plain language statement) *up to 100 words.*

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6.5.3 A second strategy is that the student is given an opportunity to consent to the use of information associated with their assessment task. Are students given an opportunity to consent to the use of information associated with their assessment task? 
Yes ☐ No ☐ Not applicable ☐

---

*Please note: Final approval will only be given when appropriate approvals have been provided to the CHEAN*
6.6 Do you intend to access RMIT student databases (e.g. IExplore\textsuperscript{10}, Learning Hub email system / or similar) as part of your data collection or as a method to recruit students for your research?\textsuperscript{11}

Yes ☐ No ☐

6.6.1 Are you authorised to access the specific database for the purposes of your research project?

Yes ☐ No ☐

If you responded yes to section 6.6, you must explicitly state this in the Information sheet.

*Does the Information sheet explicitly state that you have / will access RMIT student databases as part of your data collection or as a method to recruit students for your research?*

6.7 Do you intend to use CES data as part of your research data?

Yes ☐ No ☐

6.7.1 If YES, you must inform students that their information will be used for research purposes.

*Does the Information sheet inform students that their information will be used for research purposes as well as for quality assurance purposes?*\textsuperscript{12}

Yes ☐ No ☐

6.8 Do you intend to use student Blogs / Wikis or any other interactive IT conversational tool as part of your data collection method?

Yes ☐ No ☐

6.8.1 If YES, you must use the RMIT “statement to be included on blogs” at the front end of your IT interactive conversational tool. Have you accessed and used, or will access and use, the RMIT “statement to be included on blogs”?

Yes ☐ No ☐

*Please note: Students must be informed if their participation will form part of aggregated data, and advised that before any individual contribution is quoted, specific permission will be sought from them.*

\textsuperscript{10} Data from IExplore can only be used for legitimate purposes – and such use must be consistent with the “rights and responsibilities” for using these data. IExplore must not be used to obtain lists of cohorts of students having specific characteristics – e.g. students of a specific ethnic origin.

\textsuperscript{11} Please note that the university does not permit the use of global emails for research purposes. This system is for the purpose of communicating official RMIT information. “MyRMIT”, the student portal can be used for research purposes.

\textsuperscript{12} Note if you are only collecting CES data you may not require a Information sheet – but you are still required to complete this ethics application.
7. Participant information, informed consent and advice of project outcomes

7.1 Information sheet (plain language statement)

Participants will be given an information sheet that contains all items listed in Attachment A:

Yes ☒ No ☐

*Please attach a copy of your information sheet and completed Attachment A if applicable.*

Special arrangements are required when seeking informed consent from specific groups, e.g., children, people with an intellectual disability, or where interpreters or third parties will be involved – see Section 4 of the National Statement.

7.2 Consent form

Consent form not required ☐

Participants sign a consent form ☒

Consent assumed if participants return a questionnaire ☐

*If using a consent form, please attach copy.*

8. Privacy and confidentiality

8.1 Data storage

Data will be stored in a secure location

Yes ☒

Where will the data be stored? All soft copy data will be stored on a secure password protected server. All transcripts will be located in a secure file within a locked office at RMIT.

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13 This means that research participants are in no way known to you (either by name or appearance); an example here is observing human activity in a public place. You are not approaching any individual.

14 If you require a signed consent form you will be collecting personal data (research participant name). You now also have an ethical issue of confidentiality – you must protect the privacy of your research participant; this includes storing the data securely. You must complete section 8 of this application form.

15 All electronic data should *normally* be stored on University Network systems. These systems provide high levels of manageable security and data integrity, can provide secure remote access, are backed up on a regular basis and can provide Disaster Recover processes should a large scale incident occur. The use of portable devices such as CDs and memory sticks is valid for archiving, data transport where necessary and some works in progress. The authoritative copy of all current data should reside on appropriate network systems; and the principal investigator is responsible for the retention and storage of the original data pertaining to the project for a minimum period of five years.
Detail security arrangements for storage of data.  

Data will be stored for 5 years after publication of research findings

Yes

Only the researchers will have access to the data

Yes

Data will only be used for the purposes described in the participant information sheet

Yes

If any of these boxes is not checked, please explain the arrangements that will apply.


8.2 Adverse events relating to the inappropriate release of personal information

Are procedures in place to manage, monitor and report adverse and/or unforeseen events relating to the inappropriate release of personal information during its collection, use or disclosure? Examples include: collecting the wrong information about an individual, collecting information about the wrong individual, receiving identified information (or access codes for coded information) when the information was supposed to be received in a de-identified form, loss or theft of laptop containing identifiable information.

Yes ☒ No ☐

Give details.

All precautions will be taken to maintain security. In the unlikely event of any other adverse event relating to the collection, use or disclosure of information, the nature of the event will be reported to the College Human Ethics Advisory Network for advice on further procedures.

The principal researcher is responsible for reporting all adverse events of this nature to the HREC as soon as possible.

8.3 REPORTING PROJECT OUTCOMES

Hard copy data must be archived at the university. Each school is responsible for ensuring that appropriate archiving facilities are available. During data collection and analysis hard copy data may be stored in a place with appropriate security provisions – i.e. locked filing cabinet, locked office.
(a) Will the project outcomes be made public at the end of the project?

☑ YES ☐ NO  

(If YES, give details of how the results will be made public (eg in journal articles, book, conference paper, the media, working papers, university / library data archive facility or other). If NO, explain why not. Project outcomes will be made public via thesis, journal articles and conference papers.

(b) How will you protect the privacy of individuals in any report / publication arising from this project?

Individuals will be provided with pseudonyms and no identifying data will be used in any report or publication arising from the project.

(c) Will a plain language report of the project outcomes be available to participants at the end of the project?

☑ YES ☐ NO  

(If YES, give details of the type of report and how it will be made available. If no, explain why not.

NB These details should be included in the Participant Information Sheet

In the event of the thesis being passed and admission as Doctor of Philosophy is assured a copy of the final thesis will be provided in PDF form where no amendments or changes can be made to the text or data for participants

9. Funding and finance

Researchers should include any source of funding (e.g. departmental, commercial, non-commercial, government.). See National Statement section 5.4.

(a) Has this research received any research funding or is this submission being made as part of an application for research funding

Yes ☐ No ☑

If yes, what is the source of funding up to 50 words

(b) Will the researcher receive any remuneration and/or in kind funding to perform this research?

Yes ☐ No ☑

If yes, give details up to 50 words

(c) Will participants receive any payment or expenses for participation in the research?

Yes ☐ No ☑

If yes, give details up to 50 words
10. Other approvals

Is this protocol being submitted or has it been previously submitted to another ethics committee?

Yes ☐ No ☒

If yes, give details of other institutions involved; the approval status and details of required amendments up to 20 words
## Declaration by researchers

I/We have read the NH&MRC National Statement on Ethical Conduct in Human Research (2007), and accept responsibility for the conduct of the research detailed in this application in accordance with the principles contained in the National Statement and any other conditions laid down by the relevant RMIT Human Research Ethics Sub-Committee.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacqueline O’Toole</td>
<td>24.10.11</td>
</tr>
<tr>
<td></td>
<td>(Signature of Principal Investigator)</td>
</tr>
</tbody>
</table>

Name: Alan Montague  
Date: 24/10/2011  
(Signature of other investigator or senior supervisor if applicable)

Copy, paste and complete additional signature boxes to enable all co-investigators to sign.

### Declaration by the Supervisor (if not an investigator)

I have informed the student of their responsibility to undertake this research in a manner that conforms with the NH&MRC National Statement on Ethical Conduct in Human Research 2007, and any conditions of approval of this research by the RMIT College Human Advisory network.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Alan Montague</td>
<td>24/10/2011</td>
</tr>
<tr>
<td>(Signature of Senior Supervisor)</td>
<td></td>
</tr>
</tbody>
</table>

### Declaration by the Head of School:

The project set out in the attached application, including the adequacy of its research design and compliance with recognised ethical standards, has the approval of the School. I certify that I am prepared to have this project undertaken in my School/Centre/Unit.

Name:  
Date:  
(Signature of Head of School or approved delegate)

School/Centre:  
Extnt:
# PARTICIPANT INFORMATION SHEET

**The information sheet:**

1. is printed on College / University letterhead as required
2. includes clear identification of the University, the School(s) involved, the project title, the principal and all other researchers (including contact details and qualifications of investigators), and the study level if it is a student research project.
3. states the aims of the research project
4. advises that the project has received clearance from the HREC
5. advises why the participant has been approached (random, sampling method, specific target group, whether their contact details have been obtained from another source and who provided permission for this)
6. provides details of what will be required of participants (e.g., involvement in interviews, completion of questionnaire, audio/video-taping of events), and estimated time commitment
7. outlines any risks/benefits to participants involved
8. states that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied
9. includes a clear statement that involvement in the project will not affect ongoing assessment/grades/treatment
10. provides advice about what will happen to the information provided including arrangements to be made to protect confidentiality of data and secure storage of data
11. provides advice as to whether or not data is to be destroyed after a minimum period
12. states how privacy of the individual will be protected in any publication of the information (i.e. protecting the anonymity of participants)
13. provides advice regarding inherent risks associated with participation in research that uses web-based surveys
14. provides in the footer, date and version of the information sheet, and the project HREC number when approved
15. includes **contact details** if participants have any complaints about the conduct of this research project

*Please attach a copy of your information sheet to your application*
INVITATION TO PARTICIPATE IN A RESEARCH PROJECT
PARTICIPANT INFORMATION

Project Title:

Investigators:

- All investigators, including supervisors and consultants must be listed as investigators
- Include name, qualifications, RMIT email address and RMIT phone number
- Do not use personal contact details

Dear <<>>,

You are invited to participate in a research project being conducted by RMIT University. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

- This research project is being conducted by Ms Jacqueline O’Toole, PhD Student, School of Management, RMIT University
- This research is being undertaken part of a PhD Thesis and aims to undertake a qualitative investigation into residential aged care to identify the complex issues & bodies of knowledge are needed for leaders in the aged care sector to keep the industry operating effectively to meet the needs of their current stakeholders and what are their future development needs in order to meet the complex challenges facing the residential aged care sector.
- This project has been approved by the RMIT Human Research Ethics Committee.

Why have you been approached?

You have been approached as a leader in the aged care sector in Victoria.

What is the project about? What are the questions being addressed?

- This project aims to identify the leadership skills present in RAC and the leadership skills and attributes which are required to be a successful leader in the aged care industry. I also intend to develop an understanding of organisational change, the role of change agents in successful change and the significant changes facing the aged care industry. From this I will attempt to determine how leaders must manage these changes and the skills and attributes they will require to do so successfully.

- This will help me to provide a well-researched thesis that promotes new insights to industry and the community and also to generate original knowledge and understanding that will make an important contribution to the aged care industry, as well as education/training providers for developing leadership & management skills to build a positive workplace culture, improve care quality & outcomes & ensure the preparation of the private residential aged care sector for the enormous challenges now and just over the horizon

- I intend to interview 32 people in senior aged care positions.
The key research questions of this project include:

1. Can you tell me/us about your experience and career in the residential aged care sector please?
2. Is there a shortage of qualified people to work in senior positions in the residential aged care sector?
3. What are the skills and attributes that you believe are required by senior employees in the RAC in order to be effective leaders?
4. Is there too much emphasis when appointing senior staff in the RAC on clinical experience and academic qualifications as opposed to leadership and management skills?
5. Looking at this industry sector broadly, what leadership skills gaps exist in RAC from your perspective commenting on your colleagues?
6. Could you comment on your learning curve that you experienced as a leader in the aged care sector?
7. What are the major changes occurring in the RAC and what specific leadership skills are required to address these changes?
8. Circumstances from my research indicate that difficulties are experienced recruiting and keeping staff in this sector. Does this test your leadership skills? If so how?
9. What major strategies is your organisation currently employing to resolve recruitment and retention problems in regard to senior employees?
10. Can you give an example of the major strategies that are required to address leadership skill development in this sector? What is and isn’t being done, in your view?
11. Can you comment on the leadership demonstrated by government in regard to the residential aged care sector?
12. Is there anything else that would like to share from your experience?
If I agree to participate, what will I be required to do?

You will be asked to participate in a semi-structured, interview addressing the following:

- Leadership skills and attributes required in RAC,
- Leadership skill gaps identified in RAC,
- Current and future challenges to RAC,
- The strategies that can be developed at the workplace, enterprise and industry level to improve leadership skills and also recruitment and retention of effective leaders across RAC, and
- The critical problems in regard to leadership skills and RAC which need to be understood and addressed to allow the development of successful policy intervention

This should take approximately 1 hour of your time on one occasion only.

- If you wish to receive a copy of the interview questions prior to the interview, we would be happy to provide them to you. Participants have the right to request that audio recording is stopped at any stage during the interviews.

That are the possible risks or disadvantages?

There are no known risks associated with being a participant in this project. However if you are unduly concerned about your responses to any of the questionnaire items or if you find participation in the project distressing, you should contact the Ethics Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is <<>>.

What are the benefits associated with participation?

The project will provide suggestions for enhanced solutions and reforms through practical options for the development of leaders in this sector, and will identify policy strategies to support skills development, quality work, quality service delivery and the development needs required to meet future challenges.

What will happen to the information I provide?

The information will identify the leadership skills and attributes required in RAC and will provide a recommendation for policies that may improve leadership development, recruitment and retention in RAC. Confidentiality will be strictly maintained. This information will be published a PhD thesis and may be published in academic journals or conference proceedings and may be utilised in public policy submissions to support advice and policy formulation for key stakeholders in the residential aged care industry.

If you would like a copy of the transcript of the interview please ask for one after the interview or you can call me on the number listed below if you decide you would like a copy at a later date.

Your name and location will be substituted to protect your privacy; all data collected will remain confidential. Interviews will be digitally recorded and stored on password-protected compact disks which will be stored in a locked filing cabinet. Similarly transcripts of interviews will be stored in password-protected computer files and hard copies will be stored in a locked filing cabinet. All materials will be held for 5 years after the completion of the project, after which time it will be securely disposed.

The researcher will organise and attend the participant’s workplace at a time that is
convenient to the interviewee. At the commencement of the interview you will be taken through the plain language statement again. The purpose of the research as well as your rights as participants will be fully explained. You will then be asked to sign a consent form. You will be asked if you will permit recording of the interview, and advised that this is not compulsory. You have the right to request that audio recording is stopped at any stage during the interviews. If permission for recording is declined, extensive notes will be taken by the interviewer. The researcher will also explain the importance of the confidentiality of the interview.

Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission.

**What are my rights as a participant?**

This process is purely voluntary and you are at liberty to withdraw from the process at any stage. In all circumstances, sensitivity to local cultural context will be a major concern to the researchers throughout the study. The researchers will adopt interview techniques to suit the cultural context in which the study is taking place, drawing upon the cultural diversity within the research team and the expertise of the team which has a strong background in cultural literacy and intercultural research.

You are able to request at any time for recording of their interview to be discontinued. You can also request the withdrawal of your interview data at any time prior to the completion of the project. Individuals will be provided with pseudonyms and no identifying data will be used in any report or publication arising from the project.

**Whom should I contact if I have any questions?**

If you have any questions regarding this research, you should contact the PhD supervisor, Dr <<>>, Lecturer, School of Management, RMIT University on <<>> as soon as convenient. Dr <<>> will discuss your concerns with you confidentially and suggest appropriate resolution.

**What other issues should I be aware of before deciding whether to participate?**

There are no other issues that need to be considered when deciding whether or not to participate in this project.

Yours sincerely

Jacqueline O'Toole

PhD Student, School of Management, RMIT University
PARTICIPANT’S CONSENT

Not required if consent is implied e.g. return of an anonymous survey

1. I have had the project explained to me, and I have read the information sheet

2. I agree to participate in the research project as described
   I agree to [insert appropriate words] See Agrees to particular tasks, procedures or processes see examples on the Preparing the Participant information and consent form page

3. I acknowledge that:
   (a) I understand that my participation is voluntary and that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied (unless follow-up is needed for safety).
   (b) The project is for the purpose of research. It may not be of direct benefit to me.
   (c) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   (d) The security of the research data will be protected during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to ............... (researcher to specify). Any information which will identify me will not be used.

Participant’s Consent

Participant: ____________________________ Date: _______________

(Signature)

Witness:
[only required if research is assessed as more than low risk; otherwise please delete]

Witness: ____________________________ Date: _______________

(Signature)

Any complaints about your participation in this project may be directed to the Ethics Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 2251.

Details of the complaints procedure are available on the Complaints with respect to participation in research at RMIT page

Participants should be given a photocopy of this PICF after it has been signed.
Semi-structured interview questions

1. Can you tell me/us about your experience and career in the residential aged care sector please?
2. Is there a shortage of qualified people to work in senior positions in the residential aged care sector?
3. What are the skills and attributes that you believe are required by senior employees in the RAC in order to be effective leaders?
4. Is there too much emphasis when appointing senior staff in the RAC on clinical experience and academic qualifications as opposed to leadership and management skills?
5. Looking at this industry sector broadly, what leadership skills gaps exist in RAC from your perspective commenting on your colleagues?
6. Could you comment on your learning curve that you experienced as a leader in the aged care sector?
7. What are the major changes occurring in the RAC and what specific leadership skills are required to address these changes?
8. Circumstances from my research indicate that difficulties are experienced recruiting and keeping staff in this sector. Does this test your leadership skills? If so how?
9. What major strategies is your organisation currently employing to resolve recruitment and retention problems in regard to senior employees?
10. Can you give an example of the major strategies that are required to address leadership skill development in this sector? What is and isn’t being done, in your view?
11. Can you comment on the leadership demonstrated by government in regard to the residential aged care sector?
12. Is there anything else that would like to share from your experience?