The Prospects of Adopting Alternative Staffing Methods in Residential Aged Care in Australia

A thesis submitted in (partial) fulfilment of the requirements for the degree of Doctor of Business Administration.

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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 this thesis is the result of work which has been carried out since the official commencement date of the approved research program; and, any editorial work, paid or unpaid, carried out by a third party is acknowledged.

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Abstract

The Residential Aged Care (RAC) industry is the fastest growing sector of the health care industry in Australia, particularly with the need of people aging eighty five years and over consuming most health care services (Productivity Commission, 2006). This thesis examines the staffing efficiency challenge that is facing the RAC industry in Australia, from the facility managers’ perspectives.

Staffing efficiency is a crucial component in the success of this industry that is labour intensive, delivering complex services twenty-four hours per day and seven days per week. By achieving staffing efficiencies, facility managers would minimise labour cost expenditures; thus, ensuring sustainability and growth of their organisation in the long run. The literature reviewed revealed limited number of scholarly reviews about staffing efficiencies conducted in Australia. Nevertheless, it highlighted a number of available staffing approaches available overseas which could be of promising results if they were adopted to suit the Australian industry and its operational systems.

This thesis explores the prospects of RAC facility managers adopting ‘alternative’ or ‘new’ staffing methods in their facilities as one solution for this staffing challenge. In this study, the researcher refers to alternative or new staffing methods as staffing methods that are not currently utilised in the staffing of RAC facilities in Australia.

Using an Interpretivist research paradigm, 18 semi-structured interviews were conducted with the participating RAC managers in their work environment. During the interviews, a sample alternative staffing tool, developed prior to the study, was displayed. The data generated were analysed in the context of the RAC industry’s environment, operational challenges, and
through the theoretical implication of neo-liberalism. This theory provided a vehicle for the analysis of the data generated on staffing within the context of Australia’s current economic policies. The generated data revealed little chance of such adoption reflected in a number of findings including: 1) Participants’ lack of interest in adopting alternative staffing methods despite their comments on the unsuitability of current tools. 2) Overdependence of the industry on cost cutting measures and monetary performance indicators. 3) Lack of incentives for the adoption of change and 4) Lack of preparedness of RAC facility managers for such change.

Thorough analysis of the findings revealed misinterpretation of free-market principles in the currently utilised staffing tools, which links demand of service to the number of individuals requiring care on one hand, and the supply of services available to the number of staff rostered to provide the care, on the other hand. The application of such a principle on the RAC industry is questionable, particularly with the inconsistency in the elderly residents’ care needs and the staffing skill mix. A new staffing approach that uses the care required by the elderly individuals and the staffing skills available in the facilities as the basis for the demand and supply principles will provide a plausible solution for facing the staffing challenge. A joint venture between the Australian government and the RAC industry to encourage the adoption of such alternative staffing approach is the recommended way forward for improving staffing efficiencies.
Chapter One: Introduction

1.1. Overview:

RAC services in Australia have grown and developed to become a significant industry and a major player in the Australian economy and social infrastructure. The growth of the RAC industry was not accidental. It has accompanied growth in the demographic group of retired persons aged 65 years and above, especially those requiring RAC services. Further, expansion of the RAC industry in Australia and overseas has been accompanied by mounting challenges in terms of resources as well as operational challenges that could threaten the wellbeing of the services, providers and service recipients. The focus of this study is on one of these challenges - staffing.

Staffing is a crucial component of the business of RAC service delivery. It is labour intensive and, therefore, affected by staff availability which is an expensive and scarce resource that requires specialised management and efficient allocation. Unless this process is understood and the challenges it generates attended to, all parties involved in the provision of these services will be drastically affected. This study explores one specific aspect of staffing in RAC in Australia: the prospect for adopting suitable staffing methods capable of assisting the industry in its workforce challenges. This is a concern worth studying because current staffing methods have not met existing challenges and there is a need to explore the RAC industry’s perceptions of investigating alternative staffing methods.

1.2. Background:

Aged Care services in Australia are numerous and multifaceted, ranging from casual assistance provided to elderly persons at home, to extensive long-term and specialised
clinical care, provided in purpose-built residential facilities referred to as RAC services. These services are mainly funded by government subsidies which are indexed every year and increased as per set formulae. In business terms, the gradual changes in demography accompanied by government subsidy, make available a steady flow of consumers for Aged Care service providers and they provide stability of generated income once target clients (e.g. financially advantaged or not) are met or the facilities’ beds are occupied. However, the rapid growth of the industry and the expected financial gains for investors is not guaranteed because of the substantial influence of a number of factors. They include dependence on hard-to-get government funding, reliance on a shrinking labour force, governance by increasingly complex laws and regulations, vulnerability to an opportunistic media, and delivery of highly political and emotionally-infused services affecting the care of frail elderly Australians. These concerns are not unique to the Australian aged care industry. They are experienced by a number of foreign countries especially those with societies that are aging in manner similar to Australia’s: Japan, Italy, United Kingdom and the United States of America. This similarity will become more apparent in the following chapters.

This research focuses on one component of the Aged Care industry, the RAC Industry, and discusses, mainly, staffing challenges and the impact of staffing approaches on the current and future wellbeing of the industry in general and individual RAC businesses specifically. The research, however, does not ignore other challenges. It lists a number of them in the contextual concept chapter because they have critical impact on the efficient running of RAC facilities and the delivery of quality care and services.

This research contributes to the body of knowledge and the body of practice by conduct of an empirical qualitative study involving Australian RAC facility managers, supported by a
national and international literature review. Since the RAC industry has a level of singularity and complexity, this paper dedicates one chapter (chapter 2) to introduction of the industry. It provides an overview of the structure of the industry, the mechanisms that rule the daily operations, a brief history, and relevant recent changes.

1.3. Current and future challenges of the RAC Industry

The literature indicates that two main groups of challenges face the RAC industry: external challenges and internal challenges. External challenges represent all the issues and demands exerted from outside the industry such as funding, regulatory compliance, supply and demand, and workforce. Internal challenges represent all the issues and demands exerted from within the industry such as operational challenges and financial challenges.

1.3.1. External challenges:

External challenges have macro effects on the RAC industry and its members, the service providers. Service providers are organisations licensed by the Australian Government to own and operate the RAC facilities such as nursing homes (high care), hostels (low care), and mixed facilities (ageing in place). Although, the service providers are of different size (in relation to the number of facilities within an organisation), ownership (church, municipal council, commercial) and aim (for-profit and not-for-profit), they share external challenges. A number of the external challenges are:

1- Expansion in demand for RAC services due to rapid change in the Australian demography, especially the ratio of the sixty five plus population to the forty five and
below population (Percival & Kelly, 2003). Most of the growth in the sixty five plus population has been in the segment of those aged eighty five years and older (a growth of 70% between 1997 and 2007). This is the population segment that requires most health care (Productivity Commission, 2008: 26).

2- Mounting pressure on funding provided by the Australian Government, the major financier of the RAC industry. There is increasing imbalance in the ratio of tax payers to non-tax payers and that is expected to decrease the revenue from the Federal budget (National Aged Care Alliance, 2004 -b). Aged Care funding provided by Federal, State and Territory Governments had an annual average increase of 6.1 percent from $4.4 billion in 1996-96 to $8.6 billion in 2006-07 (Productivity Commission, 2008; p: 27).

3- Increased public and government scrutiny of the RAC is shown in continual growth of accreditation and regulatory requirements and in increased media interest in daily issues of the industry. The rise in quality standards has imposed financial and workload burdens on RAC operators and the workforce and exposes them to the risk of incurring fines and attracting negative publicity for any non-compliance (Hogan, 2004 ).

4- Decreased supply of specialised labour brought about by retirement, lack of interest in the RAC industry from qualified nurses, intense workloads, poor remuneration (in comparison to their counterparts in the acute health care sector), and poor management (Access Economics, 2004; ACIL Tasman, 2003; Hogan, 2004 ).

5- Increased competition between RAC firms struggling to attract fee-for-service consumers, and lack of cooperation, and perception that strategies adopted by
Government agencies were designed to divide and conquer. (McCue, Mark, & Harless, 2003; National Aged Care Alliance, 2004-b).

1.3.2. Internal challenges:

The internal challenges are those exerted from within the RAC industry which affect individual firms and their operators. Although these challenges are influenced by the external challenges that influence the entire RAC industry, their effects on individual firms vary from one facility to another under the influence of a number of factors such as a facility’s location, size, and structure.

An example of the influence of location is a facility located in a rural area. On one hand it is isolated from pools of skilled labour. On the other its isolation assists it to attract and retain a loyal workforce because of the limited competition for labour in that locality. The effects of location are reversed for urban localities.

The industry has a number of internal challenges that impinge on the daily running of RAC facilities:

1. Increased operational challenges resulting from the external challenges (funding, quality expectations, staff shortages.) This has led to high staff turnover evident in the escalating high expenditure on casual nursing personnel in a number of RAC facilities (McCue et al., 2003; National Aged Care Alliance, 2004-b).
2. Increased in client/consumer expectations associated with a more educated society, wider knowledge, and increased wealth compared with previous generations, compounded by a rise in industry competition (Hogan, 2004) mainly for fee-for service beds (extra services) and when demand supply exceeds demands (e.g. when a number of new facilities at close proximity open for business at the same time.

3. Increased financial difficulties from the cost of constructing bigger, better, and more easily accessible locations. In turn, this has resulted in high development and real estate costs to meet the rising competition and demands for services (Access Economics, 2004; ACIL Tasman, 2003; Richardson & Martin, 2004).

4. Decreasing workforce skills and reliability is evidenced in decreasing demand for advertised positions in the RACs, high staff turnover, decreased efficiency, and high usage of subcontracted workforce (Chang, 2004; Jeffries, 2002).

1.4. The need to prepare for the industry’s challenges

The serious nature of the preceding challenges has raised a number of calls, in Australia and overseas, to prepare for these challenges. These challenges will neither disappear nor will the RAC industry stop expanding. Naturally, the focus and intent of these calls varies depending on their source and the vested interest of the caller. The Australian Government highlighted the need for equity, efficiency and sustainability (Productivity Commission, 2008). Service providers’ calls focussed on the need to increase funding and provide flexibility in regulations (Ansell, 2008; Stoyles, 2005). Workforce representatives sustained their
demands for equity and fairness (QNU, 1999). User groups’ voices are rarely heard but are destined to emerge sooner or later due to the changes in the population needs, expectations, and demography. Few calls have recognised the importance of staffing challenges, facing an industry that is labour intensive, dependent on the availability of low and high skilled workers and affected by the associated costs. Such vulnerability to staff challenges warrants more attention, especially the methods and processes that contribute to efficient workforce allocation, efficient usage of funds, and to fluctuations in workforce and workloads.

1.5. The current most common staffing methods adopted and their shortfalls

With such vulnerability to staff challenges and staff costs, one would expect that this challenge would be allocated special interest among service providers and would expect to find numerous studies and staffing approaches adopted and used. This is not the case. This study found only one staffing method in use and no other known or published alternative. This staffing method, referred to as the facility manager’s own ‘professional judgement’, emerged frequently in the literature reviewed and in the interviews conducted.

Traditionally, staff allocation in Australian Aged Care facilities has been the responsibility of facility managers or their delegates. The process has been based in the main on RAC facility managers’ judgement guided by predetermined operational budgets set usually by the owner, provider or the corporate financial controller. The process has been influenced also, although to a lesser extent, by traditional (industrial union-prescribed) staff-patient ratios and historic or seasonal trends. Such staffing processes reflect neither residents’ fluctuating care needs nor varying staff skills available to meet those needs and workloads. The result is formulation of staff rosters that are generic, distant (do not meet the needs of the staff), and often
subjective. Rosters formed in this way have operational and financial consequences for the facilities and the industry. Over-staffing increases already expensive operational costs and under-staffing has negative effects on staff morale, turn over, and the quality of care provided (Chang, 2004; Jeffries, 2002).

1.6. The value, aim, and scope of this research

1.6.1. The value:

Staffing approaches that consider staff availability, workload changes, and correct allocation of resources would benefit the RAC industry if the prospectability (the chances of uptake by the industry), applicability (in the industry), validity, and efficiency of the approach/tool were included. The author considers the study of prospectability should occur before any investment in developing or marketing new staffing approaches. The knowledge that emerged from studying the prospectability of adopting alternative staffing approaches would add to the body of knowledge and augment the body of practice in a growing industry dependent on staffing and staffing efficiency. Study of applicability, validity and efficiency of the new staffing approaches may follow knowledge of the prospectability.

The present research reveals the perceptions of a number of RAC managers (participants) on staffing requirements and staffing challenges in Australia. It reveals their own views on staffing challenges and prospects of adopting alternative staffing methods, exemplified by the method demonstrated to participants during interview. The findings highlight the prospects and challenges that would face attempts to introduce alternative staffing approaches to the Australian RAC industry.
1.6.2. The aims:

The primary aim of this research was to explore the perceptions about adopting alternative staffing approaches/ methods among RAC facility managers in Australia. The exploration would assist the industry to meet a number of staffing and efficiency challenges. The secondary aim of this study was to inform the researcher of the prospects for investing in the development of alternative staffing approaches. The tertiary aim was to obtain the perceptions of RAC managers on the above.

1.6.3. The scope:

The study used an interpretivist paradigm reflected in the adopted systematic methodology as the most suitable approach in meeting the exploratory motives and goals of the research (Blaikie, 2003; Collis & Hussey, 2003). Semi-structured interviews following the Interpretivist approach, using abductive research strategies were used to explore prospective users’ opinions on: 1) staffing in RAC, 2); the process of adopting non-traditional/ alternative staffing approaches; 3) a sample alternative staffing module. The study was introduced by a concise literature review of relevant articles, reports, and studies.

1.7. Overview of similar research and studies

A number of studies and reports originating in Australia and overseas have called for a review of the prevalent staffing approach, professional judgement, with a view to consideration of more efficient approaches (Scott, 2002). The literature highlighted a number
of studies that recommended a particular staffing system, including an Australian study by (ACIL Tasman, 2003). Another by a UK-based association the Social Care Association (Social Care Association, 2002 ) has commercially promoted its system among long-term care organisations.

In Australia, a number of studies from various industry stakeholders reported on the looming staff shortage but they stopped short of calling for research on alternative staffing approaches. They focused on staff shortages and the need to promote efficiency and sustainability of the RAC industry (Commonwealth Department of Health and Ageing, 2002; Healy & Richardson, 2003; Richardson & Martin, 2004; Stoyles, 2004). The most notable research and the one which had the most influence in Australia’s aged care service provision was the “Review of Pricing Arrangements for Residential Aged Care ” commissioned and financed by the Australian Federal Government and released in 2005. This project was led by Hogan (2004) whose report was based on a number of detailed studies that reviewed the different aspects of the RAC industry and made short-term, medium-term, and long-term recommendations including staffing, processes, and options (see literature review chapter 3).

Overseas, the New Zealand Nurses’ Organisation highlighted to the Ministry of Health their dissatisfaction with the current staffing processes in Staffing Regulations for Aged Care and Residential Care (2004) and recommended a closer relationship between workloads and nursing hours. In the United States, the Park Ridge Center called for Congressional review of staffing in Long-term Care facilities (2002).

In the United Kingdom, Tousignant, Herbert, Dubuc, Simoneau, and Dieleman (2003) considered alternative funding for long-term care facilities and recommended systems that do
not base funding on the number of beds occupied and the hours of care. Carpenter and Perry (2002), studied the application of and recommended Minimum Data Set Resident Assessment (MDS/RAI) and Resource Utilisation Groups version III (RUGIII) as a funding (staffing) system for the registered nurses in United Kingdom nursing homes.

A study by the Residential Forum in the United Kingdom in 2001 collected data from more than six hundred questionnaires sent to individual authorities. Their study resulted in the development and distribution of an alternative staffing module (Social Care Association, 2002).

Scott (2002) reviewed for the Royal College of Nursing in UK a number of staffing approaches in the health industry but with little reference to the RAC sector. The report recommended neither adoption of one staffing approach nor promotion of a Government directed staffing approach such as the one implemented in the public hospital system in the State of Victoria (Australia) from the year 2000. Scott concluded a single staffing approach does not suit all and nurse managers are best suited to selecting a staffing approach/process that matches the changing needs of their units/organisations.

All the studies located in Australia and overseas have highlighted, mainly, the unsuitability of ‘professional judgement’ as the prevailing staffing system. Few have recommended alternative staffing approaches and none has attempted to explore the readiness of the RAC industry in general to adopt alternative staffing approaches in general any particular model. In Australia, there are no publications or research on alternative staffing approaches in the RAC industry and none on the readiness of the Australian RAC industry for such approaches.
1.8. Relevance of this research

This research has a special value to the author (researcher) for personal and professional reasons. The author was personally exposed to the challenges discussed earlier while being employed as registered nurse, a facility manager for a number of RAC facilities and a RAC consultant. In almost all of those facilities, operational and financial challenges emerged on a daily basis as a result of the absence of a clear formula for staffing that provides operational efficiency while maintaining quality of care. The main questions for the researcher, as nurse consultant, are availability of alternative staffing approaches such as the literature has revealed and readiness of the Australian RAC industry to embrace these approaches. Answering this question would benefit the RAC industry and would support the researcher in developing and promoting alternative staffing approaches to provide and maintain efficiency and quality RAC services.

1.9. Summary of the introduction

The preceding introduction has presented the extent of the challenges facing the RAC industry especially in relation to staffing. The RAC industry’s prevalent staffing method, professional judgement, is unsuitable and will not assist the RAC industry to meet its future operational challenges. The RAC industry has little chance of achieving efficiency and sustainability without investigation and adoption of suitable staffing methods. This chapter has established the need and the rationale for conducting this research with the intended scope, structure, and methodology. This study explores prospective users’ opinions on: current RAC staffing approaches, processes of adopting non-traditional/ alternative staffing approaches and their responses to a sample alternative staffing module. It uses semi-
structured interview and presentation of a model staffing tool. The following chapter/sections include more details, arguments, and analysis with which to unravel complexities of RAC industry staffing and provide RAC operators, policy makers and the body of knowledge with a scholarly paper to support industry progress and initiate further research. With such ambitions, the thesis includes the following chapters:

Chapter one (the current chapter), the Introduction, includes citations and references from several national and international sources followed by the aim of this research, an overview of similar research, and a note on the relevance of the topic to the researcher.

Chapter two, the contemporary context concept chapter, recommended to readers unfamiliar with the RAC industry, provides an overview on the structure of the industry, the mechanisms that rule the industry, a brief history, and relevant recent changes. The chapter introduces and presents an illustration of the sample alternative staffing tool.

Chapter three, the literature review Chapter, lists the literature supporting the aim, arguments, and recommendations and provides supporting evidence from publications within Australia and overseas. It lists a number of studies related to the topic of the present research, overviews current staffing processes and presents a number of currently available staffing methods.

Chapter four presents the research methodology.

Chapter five presents the research findings.

Chapter six presents the data interpretation.

Chapter seven presents the conclusion and recommendations.
Chapter 2-Contemporary Context Chapter

2.1 Background

This chapter presents a general overview of the RAC industry’s history in Australia and its development and position within the Australian economy. It focuses on individual (RAC) facilities in its structure, processes and major staffing challenges. It provides an overview of a number of available alternative staffing methods adopted in the health care and the RAC industry, nationally and internationally. The chapter concludes by providing an overview and an illustration of the sample alternative staffing tool presented in the interviews. It is followed by the literature review chapter which describes, summarises and analyses available publications on the related topics.

2.2 RAC in Australia, a general overview

As in many other Organizations for Economic Cooperation and Development (OECD) countries, the size of the older Australian population is steadily growing. In 2001, people aged 65 and over represented 12.5% of the population, with this proportion expected to increase to around 25% by the year 2051. The proportion of those aged 85 years and over is growing more rapidly than any other section of the Australian population (Grenade, Horner, & Boldy, 2004).

2.2.1 History
There is limited documentation of the history of the RAC industry in Australia. Nevertheless, the information since the Second World War suggests the existence of a limited number of long-term accommodation ‘homes’ with very limited information on government’s role. The Commonwealth Government’s role and involvement increased after 1954 with introduction of a capital improvement subsidy for non-profit organisations topping 1,033 approved grants and accommodating 18,000 people by 1964. These grants covered hostel accommodation only but were extended to cover nursing homes and other accommodation services by 1966. Personal care subsidy was introduced in 1969 covering residents 80 years or above living in hostel-like accommodation but was later extended in 1973 to cover residents of any age as long as they require the care (Madge, 2000).

The Commonwealth Government involvement was manifested in a number of acts and schemes including the Persons Hostel Act 1972, the Nursing Home Scheme, and the Deficit Financed Scheme (both introduced in 1975). The later schemes were introduced mainly to assist in the unmet accommodation and care needs but at the same time, to put in place measures to control the associated rapid cost expansion. Unfortunately the introduced acts, schemes and measures led to the opposite: there was an escalation of unnecessary uptake of services as well as an increase of 47 percent in the number of nursing home beds of the voluntary (not-for-profit) sector and 9 percent in the for-profit ones (Madge, 2000).

The Commonwealth responded with a number of industry reviews and reforms including the ‘Holmes Committee Report’ in 1977 and the ‘McLeay Report’ in 1982 with no apparent relief in the funding or the expanding costs (Madge, 2000). The RAC Structural Reform Package followed, backed by the ‘the Aged Care Act 1997’ did not also provide any
financial relief. The ‘Review of Pricing Arrangements in Residential Aged Care’ by Hogan in 2004 suggested a number of funding and operational changes.

The documents reviewed in the present study indicated that the RAC industry in Australia has been growing exponentially through time in what appears to be a ‘trial and error’ fashion. There has been no clear direction from the Australian Government. A hazy reaction from the industry has added to operational complexities in the industry and in the daily operation of individual RAC facilities. This approach seems likely to continue as the industry expands and its contribution to Australian society and economy grows.

2.2.2 Programs

While the residential and community care industries are the backbone of the Aged Care Program, they are not the only aged care programs provided by Government. The Australian Government supports a number of other services and schemes that are designed to meet the care needs of the aged populations specifically in rural and remote areas. Other programs meet specific needs such as for those individuals with dementia, incontinence, loss of hearing or vision, and the frail aged with severe or profound disability (The Department of Health and Ageing, 2007). These programs and services target elderly persons in the community and are not within the scope of this study. This study does cover the RAC program, which is an Australian Government program that regulates and supports the RAC Industry in Australia. The RAC industry in turn is subdivided into high care (Nursing Homes), low care (Hostels), and special accommodations. (The last category is not considered in this research). RAC services (high and low care) are predominantly financed and regulated by the Australian Government and are mostly provided by the non-Government sector such as religious,
charitable and private sector, and commercial providers (The Department of Health and Ageing, 2007).

2.2.3 Impact on the Australian economy

RAC services in Australia have developed to become an industry with more than $2 billion dollars worth of investment (Stoyles, 2006). It is becoming a major employer and is receiving a large chunk of the aged care funding (estimated at $5.5 billion in 2002-2003 (Clinton, 2004)). Following the demographic changes and the increase in RAC needs, the RAC industry contribution to the economy will continue to increase noticeably in rural and remote areas where the RAC facility is often the largest employer in town (for example, in Violet Town, a small country village in the northeast of Victoria).

Health care, in general, is among the highest expenditures for both State and Federal Governments ($66.6 billion dollars or 9.3% of the Gross Domestic Product GDP) which is less than that of Japan and New Zealand, far less than that of the United States, but similar to that of Canada and France (Stanton, Willis, & Young, 2005). Although most of the health expenditure in Australia is in the acute or the hospital sector, mainly public hospitals and their infrastructure, with about 50 to 80 percent of health expenditure (Stanton et al., 2005), the aged care industry consumes around $5.5 billion dollars of which $4.3 billion is spent on the RAC industry (Clinton, 2004).

Expenditure in the RAC industry is expected to increase as the number of low and high care residents are expected to rise 215 percent between now and 2044-2045 with an increase in the cost of aged care by around 2.6 times more than the growth of GDP over the same period.
This represents a rise from .85 percent in 2002-03 to around 2.24 percent (of GDP) in 2044-2045. It is associated with an increase in Government spending of around 6.5 percent points of GDP which could be only 0.9 percent in the absence of ageing (a reflection of the costs that the RAC industry put on the Government spending) creating tremendous pressure over future Governments (Productivity Commission, 2005). Stoyles (2006) reaffirmed that the RAC industry in Australia, at the end of 2004-2005, has experienced an increase of 3.3 percent in the number of operational RAC places.

Currently, there are over 2872 facilities (30 June 2007) delivering RAC services in Australia and receiving subsidies from the Australian Government (Productivity Commission, 2008). Private non-profit, followed by private for-profit organisations provide the majority of aged care services. These providers originate from large religious organisations, publicly listed companies, small family run businesses and small community based entities (Productivity Commission, 2008). Approximately 2,000 new beds (88 beds per 1000 of people aged 70 years or older) are added to the RAC industry every year requiring all the necessary development, investments and Government funding (Productivity Commission, 2008).

2.2.4 International comparisons

ACIL Tasman (2004) reported residential care services in UK provided 511,300 care home places in 14,753 homes for older people and those with physical disabilities as at April 2002. Two-thirds of the places are for long-stay geriatric hospital patients and 83 percent are provided by the independent sector (private providers). However, between 2000 and 2001 there has been a number of closures with a net loss of 7,700 and 13,100 respectively in the
number of residential care places due to bankruptcies and financial pressures, and regulatory compliance pressures.

The US RAC industry has 17,000 nursing homes providing services for 1.6 million older adults. Similar to UK but unlike Australia, 66 percent of the US beds are run by private for-profit providers, 27 percent by private not-for-profit providers, and the remaining 7 percent are Government owned. The RAC industry in the US is fragmented with the largest provider running a modest 3.5 per cent of the beds (ACIL Tasman, 2004).

Although the Australian RAC industry is much smaller in size than UK and US ones: 1,550 organisations, 3000 Aged care facilities according to Grenade et al (2004) and 135,507 places in 2002 according to the Australian Institute of Health and Welfare (2003), returns in the Australian industry are more profitable. For example, in 2000-2001, the average US operating margin in the industry was 1.4 percent with an average return on equity of 2.2 percent and the average return on assets of 4.2 percent. These rates of return do not compare favourably with those of the Australian RAC industry in the same period. The average operating margin of nursing homes in the US (1 percent) is lower than the Australian nursing homes (4.5 percent) and the American return on equity and return on assets are at best one-third lower than those in Australia. Inadequate funding and strict regulations are thought to have brought about low rates of returns although recent changes have caused a restructuring within the providers and a move away from the threat of bankruptcies (ACIL Tasman, 2004).

2.2.5 Government role

The RAC services in Australia fall mainly under the jurisdictions of the Department of Health and Ageing. Two Ministers are responsible for these services, the Minister of Health and
Ageing and the Minister for Ageing. Other members of the Government also have responsibilities related to Aged Care Services in general, such as the Minister for Veterans’ Affairs and the Minister for Human Services. The Australian Government Federal Departments fill the role of policy making and delegate the management of RAC funding to Medicare Australia (an Australian Government agency responsible for managing a number of health programs e.g., the medical benefits scheme) and monitoring the quality standards to the Standards and Accreditation Agency (a non-Government organisation).

State Governments’ contribution includes the hospital, mental health, dental and community services as well as programs such as Worksafe and the management of limited number of RAC beds. Local government has also a legislated role in the delivery of Health Services (Courtney and Briggs, 2004) such as monitoring food services e.g. meal preparation in RAC facilities.

In other words, the aged care services in Australia are increasing in size, variety, complexity and impact on the economy. As with international aged care services, Australian RAC services have formed large industries with extended lists of stakeholders and substantial budgets.

2.3 The RAC Industry

2.3.1 Background and structure

Limited publications are available on the development of RAC as an industry in Australia. The published literature suggests that the interest in the provision of accommodation services
for the elderly has steadily increased since the 1950s. The bulk of these investments at the beginning of this period were small dwellings and residential homes refurbished to suit the purpose and were operated mainly by individuals with or without clinical backgrounds. Other larger purpose-built facilities and centres were operated by the state governments, for example, Mount Royal Hospital in Parkville, Victoria; by municipal councils; by religious organisations for example The Catholic Homes, Montefiore Homes and community organisations, for example, The Royal Freemasons Homes. The later had greater access to funds, real estate, and management infrastructure. Currently, the Australian RAC industry is comprised of service providers with varying business objectives, levels of investment and locations. According to Ernst and Young (2005), operators in this industry include a high number of small for-profit and not-for profit operators, a number of large private operators and an increasing number of large publicly listed players with the largest operator controlling only 3.5% of beds. Although not-for-profit organisations still hold a larger percentage (63%) of the RAC bed licences (Clinton, 2004), the for-profit sector holds interest and investments in 23% and the remaining 12% are Government owned (Grenade et al., 2004). The balance of ownership of these facilities has changed since the 1950s shifting it gradually towards large financial organisations such as Macquarie Bank, Amity, and Blue Cross (in Victoria).

One of the reasons for the public and private interest in this industry has been mounting access to substantial capital resources, entrance to the share market (Stoyles, 2006), promises of 12 to 20 percent return on investment, and facilitation from the Australian Federal Government. Support from the Government originates from its interest in cutting its own operational costs and responsibilities and follows trends in UK and New Zealand by moving the provision of aged care services to private providers (Stack, 2005).
2.3.2 Stakeholders

The RAC industry in Australia involves a number of stakeholders who interact and cooperate to provide elderly clients with required services and care. Although the role and contribution of these stakeholders vary, all directly and indirectly influence the operational and strategic decision making of every facility. The stakeholders referred to are summarised by the author in Table 1.0.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly residents, current and prospective</td>
<td>Service recipients</td>
</tr>
<tr>
<td>Family and friends of residents</td>
<td>Advocate</td>
</tr>
<tr>
<td>Government</td>
<td>Main financier, regulator, and assessor</td>
</tr>
<tr>
<td>RAC industry</td>
<td>Service provider and main investor</td>
</tr>
<tr>
<td>Facility administrators</td>
<td>Service coordinator</td>
</tr>
<tr>
<td>Workforce</td>
<td>Service producer</td>
</tr>
<tr>
<td>General Medical and Allied Health practitioners</td>
<td>Service supporter</td>
</tr>
<tr>
<td>RAC industry creditors and shareholders</td>
<td>Interest groups</td>
</tr>
<tr>
<td>Industrial unions, industry representatives, public</td>
<td>Other interest groups</td>
</tr>
<tr>
<td>opinion, and the media</td>
<td></td>
</tr>
</tbody>
</table>

Table 1.0 Stakeholders involved in the care of the elderly in RAC settings

2.3.3 Acts and regulations

The RAC industry is one of the most regulated industries in Australia affected by more than a dozen acts and principles including the Aged Care Act, the Drug and Poisons Act, the Occupational Health and Safety Act, Equal Opportunity Act, Privacy Act, etc. The Aged Care Act 1997 is the principal regulation under which the RAC industry operates. There are a number of other federal, state and local regulations that need to be complied with for the industry to operate and receive funding. These regulations, which sometimes overlap, cover
matters such as fire, safety of buildings, food preparation and storage, medications management, consumer protection, privacy of information, occupational heath and safety, equal opportunity, and other matters (Department of Health and Ageing, 2007). These acts, principles, and regulations, introduced to facilitate and regulate the management of the industry, have added to complexity of the RAC industry and the management of its facilities. These sets of laws can be grouped into three main categories: building certification, facility accreditation and a number of other regulations such as the food safety programs, the ‘Hazard Analysis and Critical Control Points’ (HACCP), and the ‘Worksafe’ regulations applied in the State of Victoria.

Building certification is a process through which RAC facilities must pass a number of building standards relating to fire safety, security, access, hazards, lighting, heating, cooling and ventilation. Through this process approved providers must submit an annual fire safety declaration to the Department of Health and Ageing to provide assurance that their facilities have, for the last 12 months, complied with all such laws (Department of Health and Ageing, 2004).

Facility accreditation is a three-yearly quality standards program launched in 1997 with which every RAC facility must comply. It includes four standards and 44 quality outcomes. Failure to comply could lead to cessation of Australian Government funding as well as withdrawal of the licence to operate. This program and the building certification program is the responsibility of the Australian Government.

Other regulations include food services regulations such as the HACCP program (local government responsibility) and the Worksafe programs (state government responsibility).
2.3.4 Funding

In general, funding the RAC Industry is a combined effort between the Federal Government and consumers. Received funding derives from a number of sources: a) Australian Government subsidies provided through an elaborate process (the RCS/ACFI systems); b) residents’ daily fees (monthly rent) paid by the residents and/or their relatives; c) accommodation bonds (deductions and interests); and d) extra services fees (for the participating facilities). Each source, except for government subsidies, is provided by the residents (savings or assets) and, in some cases, their families (Department of Health and Ageing, 2007).

Funding for the RAC industry has undergone a number of changes, the most recent being the introduction of the Aged Care Funding Instrument in May, 2008 which is still to prove its utility and effects on the RAC industry. The literature indicates a focus on cost rationalisation by the Australian Government and the RAC industry. This is superimposed on the cost of service provision and quality of care (Stack, 2005).

2.3.5 Workforce structure

The configuration and the performance of the health workforce are crucial to the structure and performance of the health industry. This is because as in typical service industries 70-80% of health care industry costs are due to labour (Stanton et al., 2005).

The RAC workforce is composed of three major groups: 1) direct care providers comprising nurses and personal care workers; 2) support care workers comprised of general medical and
allied health (physiotherapist, podiatrists, pharmacists) practitioners; and 3) non-care workers, comprising cleaning, catering, laundry, accounting, administration and others.

In this study, only the first group is discussed and referred for a number of reasons: the size of the group comprises between 80-90% of the total staff; its contribution to delivery of care is a labour intensive and specialised service; its unique characteristics of skill; availability and allocation challenges. The second group is too small to influence staffing (e.g., administration) or is composed of professionals such as general practitioners, pharmacists, and physiotherapists that are contracted to facilities. The third group has limited demands on staffing because many facilities outsource cooking, meals preparation, cleaning and laundry. Therefore, only the first group will be discussed. This group is subdivided further into professionally qualified and non-professionally qualified workforce. The qualified group consists of nurses registered in Division One (RN Div1) and enrolled nurses registered in Division Two of the Victorian Nurses’ Board. The non-professionally qualified group consists of Personal Care Attendants (PCA).

Richardson and Martin (2004) reported the results of two surveys, one among Australian RAC facilities and the other among the 6,199 direct care workers the facilities employ, indicating that the workforce of the RAC industry is characterised by the following:

- In 2003 there were 116,000 direct care employees of whom 25,000 were Registered Nurses (Division one), 15,000 were Enrolled Nurses (Division two), 67,000 were Personal Carers and 9,000 were Allied Health workers (mainly diversional and recreational officers).
• The workforce is highly educated with 88 percent with post school qualifications and 29 percent with more than one such qualification.

• 18 percent of registered nurses in comparison to 11 percent of all workers are engaged on a permanent full-time basis. Two-thirds are engaged on a permanent part-time basis.

• A small proportion of workers are subcontracted ‘Agency’ workers with around 3 percent of all shifts filled by such staff.

• 57 percent of the workforce are 45 years or over in comparison with 67 percent of Registered nurses. Ninety-four percent of workers are female.

• Around 75 percent of workers were born in Australia which mimics that the profile of the entire Australian workforce.

• Around 10 percent of facilities report employing a large proportion of their staff from ethnic minorities.

• Only a small minority of RAC workers are employed full-time.

Healy and Richardson (2003) provided another workforce report based on the following sources:
Two surveys, one from RAC facilities (managers) and another from those facilities’ workforces. Each survey was conducted in the second half of 2003.

- The Australian Bureau of Statistics (ABS)
- The National Centre of Vocational Education (NCVER)
- The Australian Institute of Health and Welfare (AIHW)
- Other sources such as the Department of Education, Science and Training (DEST), the Immigration, Multicultural and Indigenous Affairs (DIMIA), the Health Service Union (HSUA), and various State nursing bodies that have carried out their own research on the aged care workforce.

This report highlighted a number of findings (p. 5) including the following:

- There is an increased number of patients per Full Time Equivalent (FTE) of nurses employed, reflected in the decrease in the number of (FTE) nurses employed per 100,000 population throughout Australia (with no decrease in the number of patients).
- There were significant differences in the number of nurses employed in metropolitan, regional, and rural areas as well as between States.
- There was an increase in the numbers of nurses working part-time.
- There has been a significant change in the age profile of students choosing to study nursing with a larger ratio of mature aged undergraduate students.
- The nursing aged care workforce is generally older than the general workforce.
- There are increasing numbers of nurses seeking employment overseas.
- There is a large number of nurses leaving the labour workforce or choosing not to practise in nursing.
• There is a decrease in the number of students commencing undergraduate nursing courses as well as a decrease in the number of student nurses completing their nursing education.
• There is a decline in the number of registered nurses working in the RAC sector.

According to Healy & Richardson (Healy & Richardson, 2003) the above findings were also reflected by those of the Department Health Services (DHS) in South Australia which can be used as a reflection on other States. These include: (p: 43)

• “2,010 registered nurses in private aged care (down 4% on 2001), which was 1,388 FTEs (down 8% on 2001);
• 1,167 enrolled nurses in private aged care (down 7% on 2001), which was 799 FTEs) down 13% on 2001); and,
• 6,736 unregulated care workers in private aged care (up 4% on 2001), which was 4,259 FTEs (up 5% on 2001)” (Healy and Richardson, 2003: 43).

In summary, the workforce of the RAC industry is experiencing two main trends: 1) a gradual shift towards unregulated staff. 2) It is generally older than the overall workforce.

2.3.6 Challenges

Due to the complex nature of providing care to the elderly resident in an overregulated environment, the RAC industry faces a number of challenges. Lewis (2005) attributed these challenges to the industry’s inherent characteristics and structure as well as its role in the Australian economy, politics and community.
2.3.6.1 General Challenges

A number of these challenges include:

1. The industry has no inventory which means that services can not be produced beforehand, stored and used when needed. They have to be produced on the spot.

2. The services produced are not standard as they vary depending on the patient needs, time of delivery and location of delivery (residents becoming sick, have falls, etc.)

3. The industry is labour intensive with no foreseeable options of replacing workforce with feeding or washing robots (for example).

4. The quantity of service provided is limited to the number of staff and time available. Speeding up the service could provide care for more patients but at the expense of quality of the service, patient satisfaction, and staff exhaustion.

5. Quality control of the services provided is impossible as these are produced and consumed on the spot; quality-checking services prior to production or recalling defective ones are not possible with these kinds of services.

6. The perception of quality service is greatly affected by the service provider and the service receiver influenced by expectations, mood, clinical condition, and other unmeasurable variables.

7. The service provided involves the health and wellbeing of the client which has its own set of challenges such as various residents and families expectations.

8. The clients are vulnerable and frail.

9. The facilities are not only businesses but also long-term homes of the customers (Grenade et al., 2004).
10. The organisations are greatly scrutinised not only by various Government levels for political reasons and gains but also by stakeholders especially if the organisation belongs to a community or a religious organisation.

11. The RAC industry is highly regulated by numerous laws and acts.

12. The industry has high potential for growth.

13. A number of the RAC facilities are operated as business ventures (for-profit), creating high expectations in relation to operational costs and return on investment.

Therefore, the services expected and delivered are dependent on a number of variables which are hard to standardize, measure, produce in bulk and store for the time of need.

2.3.6.2 Funding challenges

As the largest financier of the industry, the Australian Government has major influence on the industry’s planning, policy agenda and operation (Stanton et al., 2005). Since the 1980s, the Federal Government’s interest in the development and organisation of the industry has increased. The increased interest is driven by a number of concerns including monitoring, assessment, and consumer rights (Grenade et al., 2004). As the main financier, policy maker, and quality assessor the Australian Government provides the RAC facilities with little room to negotiate when funding disputes arise. The power imbalance between the Government and the RAC industry compounds the challenges listed above.

In such a position, the RAC industry finds it complex to obtain funding adequate for viability and profitability.
2.3.6.3 Workforce challenges

2.3.6.3.1 Attraction and Retention

Attraction and retention of staff is of significance to the RAC industry (Blake, 2004; Grenade, 2004; Grenade et al., 2004; Richardson & Martin, 2004; Stanton et al., 2005).

A number of factors affect attraction and retention of the RAC workforce:

1. Image and value that the community places on nurses working in Aged care nursing in comparison to nurses working in the acute sector (Beadnell, 2006; Stoyles, 2004).
2. Lack of clarity about the role of nurses in the RAC industry (Duckett, 2005).
3. Labour replacement (substitution) with poorly-qualified personal care assistants has added to the experience of stress in existing labour, especially the professionally qualified staff. This is in addition to the effects of emotional labour (a term used by Stanton et al) in the industry (Stanton et al., 2005) which highlights the emotional drive that the workforce have in order to stay in the industry despite its challenges.
4. Failure of service providers to spend government subsidy on staff wages (Beadnell, 2006).
5. Wage gap between the RAC industry and other health care services (Beadnell, 2006; Stack, 2005). There is a differential in pay up to $295 per week between the RAC workforce and their counterparts who are paid according to public sector awards. The differential rose from $85 dollars in 2002 and made remuneration (in addition to job image) a greater hurdle to employing nurses in this sector (Beadnell, 2006).
6. Lack of Government scrutiny the subsidies paid to the service providers in relation to improving staff wages and decreasing the health industry wage gap (Beadnell, 2006).
7. Frequent attempts to cut labour costs (Stack in Stanton, 2005).
8. Increasing average age of nurses (42 years) (Townsend & Allan, 2005).
9. Reduced number of nursing graduates from Australian universities (Townsend & Allan, 2005).
10. Increased number of nurses who are not entering or who are leaving the health industry (Townsend & Allan, 2005).
11. Decline in job satisfaction arising from remuneration, inability to spend sufficient time in providing direct care to residents, and the recruitment of unqualified workforce (Richardson & Martin, 2004; Stack, 2005).
12. Increased demand and decreased supply for RAC workforce (Duckett, 2005; Townsend & Allan, 2005).

The attraction and retention of skilled and semi-skilled staff in the RAC industry is affected by a number of factors. Attending to these diverse factors or at least taking them into consideration is crucial for the industry to continue providing its needed services. Further sections in this chapter and the literature review chapter will discuss a number of these attempts.

2.3.6.3.2 Supply and demand

Issues of supply and demand in the aged care workforce are global in nature, with reports on increasing workforce mobility between industries, states, and even nations creating noticeable shortages and impoverishing industries (Duckett, 2005). Consequently, there is a nurses shortage in Australia (Beadnell, 2006; Stoyles, 2006) with the shortage of 5,000 full time nurses in 2004 estimated to rise to 30,000 in 2006 (Stoyles, 2004) and to 40,000 by 2010.
(Stanton et al., 2005). Stack (2005, P:171) notes a decline in the size of the aged care workforce coinciding with an exodus of qualified nurses not only from the aged care industry but also from the nursing profession as a whole. This short supply of nurses has raised major concerns in the RAC industry and government, both of whom are seeking to locate and recruit adequately qualified staff in urban and rural areas (Richardson & Martin, 2004).

The RAC industry in Australia, then, faces a number of funding and staffing challenges. These challenges affect the industry as a whole, regardless of location, size, business objectives and ownership. The challenge with the most impact is staffing because the RAC industry is a service industry dependent on the availability of a qualified and experienced workforce. Adding to this challenge is that the scarcity of labour supply that is projected to diminish further in the future.

2.4 The RAC Facility

2.4.1 Structure

The RAC Facility (RAC FACILITY) is the single functioning unit of the RAC industry in which clinical and non-clinical services are delivered to elderly residents. Each facility is singular and different from others in the care it provides, its location, size, design, financial investment and a number of other features. This section provides an overview of a number of these features/ characteristics and their effects on the services provided and challenges derived from them.
There are two main categories of RAC facilities in Australia; high level care, traditionally known as Nursing Homes; and low level care, traditionally known as Hostels. While a number of aged care homes continue to specialise in low or high level care, many homes now offer the continuum of care. This allows residents to ‘age in place’ and to receive a higher level of care as their care needs increase. These facilities are referred to as Merged Care.

Nursing homes provide high level care over the 24 hour day. Nursing care is combined with accommodation, support services (cleaning, laundry and meals), personal care services (help with dressing, eating, toileting, bathing and moving around) and allied health services (such as physiotherapy, occupational therapy, recreational therapy and podiatry). High level care facilities require a higher number of staff in general and a higher ratio of professionally qualified nurses to non-qualified staff in their workforces.

Hostels provide low-level care in combination with accommodation, support services (cleaning, laundry and meals), personal care services (help with dressing, eating, toileting, bathing and moving around). Accessibility to allied health services such as physiotherapy, occupational therapy, recreational therapy and podiatry can be also facilitated along with nursing care as required. This is also the case in merged care facilities. The workforce mix in these institutions is less dependent on qualified nurses.

RAC facilities vary also in design and layout as a number are built on a single level occupying relatively large pieces of land while others spread over multiple levels connected via lifts and stair cases (mainly in metropolitan locations). Newly built high care facilities include dual occupancy rooms sharing a bathroom/toilet while low care facilities have maintained single occupancy rooms and amenities since emerging in the 1950s. Four- or
more-occupancy rooms and communal amenities have been disappearing in response to

government legislation. Dining and activities areas vary in size, number, design, and
resources depending on the provider and the size of the facility. Most facility managers
divide facilities into 30-45 bed units each served with its own nursing station, treatment room
where medications are stored and prepared, and utilities. A number of facilities are co-
located and co-managed with other health services such as retirement villages or independent
units (Richardson & Martin, 2004 ).

Rural and regional facilities are generally smaller than those in urban areas and they tend to
provide more low care services. Metropolitan facilities tend to focus more on high care
services (Richardson & Martin, 2004 ).

Extra Services aged care homes offer residents various levels of ‘up-market’ services which
offer more choice and a higher standard of ‘hotel’ type extras in accommodation, food, and
room furnishings; nevertheless, care services provided are standardised among all types of
aged care homes.

Grenade et al. (2004) and Richardson and Martin (2004 ) list a number of r categories by
which the RAC facilities in Australia could be differentiated:

- Care level: high care, low care, and merged care
- Business objective: for profit and not-for-profit
- Provider: religious, community, state and private
- Specialisation: mainstream, ethno specific, dementia specific, psycho geriatric
- Location: metropolitan, rural, and remote
- Size: small (less than 30 beds. Such facilities are usually part of a hospital), medium 30 to 90 beds, Large (more than 90 beds).
- Owner: stand alone (one owner), multi-site (one owner), part of a corporation (State based or national).

In summary, RAC facilities are the smallest functional unit of the RAC industry in which clinical and non-clinical residential care services are provided. Facilities have a variety of characteristics and descriptions. Each of variation creates its own challenges for the operators, workforce and occupants of these facilities. Some of these are discussed in the next section.

2.4.2 Services

RAC facilities provide a number of services for their clients. These activities can be divided in two main categories, ‘care’ and ‘non-care’ activities. ‘Care’ activities could be further divided into clinical/ specialised such as provision of medications and wound care and ‘non-clinical’ activities such as bathing, leisure and assistance with feeding. ‘Non-care’ activities can be further divided into hotel services of catering and laundry and supportive services of as facility management, cleaning and grounds maintenance.

These activities and services, especially the ‘care’ activities, are provided over 24 hour days all year round by a workforce of various qualifications and skills. A labour intensive service, all activities of a RAC facility are provided by a number of staff whose time and availability is carefully scheduled (staffing roster) and whose activities are supervised for quality and suitability. Coordinating these activities and ensuring their quality delivery is the
responsibility of the facility manager who may have a clinical or a non-clinical background. More will be discussed in relation to the RAC facility managers in a later section.

2.4.3 Challenges

Being the smallest operational unit within the RAC industry, the RAC facility is tasked with delivering RAC services to clients in an overregulated industry, constrained by tight funding systems, limited resources, high customer expectations and workforce challenges. These factors generate numerous regulatory, funding, and staffing challenges in all RAC facilities. These challenges are listed briefly below.

2.4.3.1 Regulatory challenges

There are numerous regulatory challenges facing RAC facilities. Accreditation requirements are the most pressing. Accreditation is a three-yearly quality review process in which each RAC facility must be evaluated against a number of standards contained in the Aged Care Act 2007. Achieving accreditation is crucial to continued receipt of monthly government subsidies which constitute the bulk of the facility income. In the accreditation process, facilities are independently assessed. They must demonstrate their compliance with a number of standards. This process involves timely documentation of client care, formal assessment and planning, strict adherence to policies and procedures as well as regular services evaluation (Department of Health and Ageing, 2004). The availability of a capable workforce, sound systems and competent management is crucial for achieving and maintaining accreditation status.
The accreditation process is conducted by an independent third party, the Aged Care Standards and Accreditation Agency Ltd. The Agency is responsible for managing the accreditation processes through conducting spot checks, audits and support contacts (Productivity Commission, 2008).

Achieving and maintaining accreditation is therefore a major challenge as it involves the management of a large number of variables and the effective cooperation of numerous parties which details are beyond the scope of this thesis.

2.4.3.2 Funding challenges

Funding systems and regulations are another factor affecting the daily running of each RAC facility. Management and staff in each facility have to follow strict assessment and documentation processes in order for the facility to receive a monthly Government subsidy. After numerous industry calls and a full industry review (the pricing review in 2005), the Federal Government introduced a new funding tool, the Aged Care Funding Instrument (ACFI) in May 2008. This tool is set to decrease the complexity of the existing funding system (the Resident Classification Scale) and provide more funding for residents requiring higher clinical care. There is not yet much documentation on the success of its introduction and the effects on the subsidies received. Nevertheless, funding will remain a major challenge for RAC facilities as the bulk of their income depends on the ability of staff to meet the requirements of the funding system and effectively reflect the care they provide in the claims
they submit on a regular basis. It is still too early to know if the new funding tool will decrease this challenge on the RAC industry.

2.4.3.3 Staffing challenges

Staffing is another major challenge facing RAC facilities in Australia. Staffing is further complicated by three main factors. First, the services provided by the RAC facilities are heavily dependent on the availability of an adequately trained workforce. Second, there is a workforce shortage, particularly of qualified registered nurses. Third, if available, labour is expensive (Grenade et al., 2004) and hard to manage. Efficient staffing is crucial to residents’ care needs, quality care delivery and efficient resources management. Staffing, staff processes and systems are considered more fully in the following section.

2.5 Staff allocation

Staff allocation is a human resources specialty in its own right. Detailed explanation of various staffing methodologies (the processes and tools used in the health care industry) is beyond the scope of this study. An overview is given to outline the staffing models and the processes available and to give an indication of the complexities involved and their impact on care delivery.

This section gives an overview of the impact of staff allocation on the workforce and the delivery of care. It outlines the staffing process and concludes with an overview of a number of staff allocation systems, care delivery models and workforce planning systems and
classifications. This section is a summary of an extensive national and international search on this topic.

2.5.1 Impact of staff allocation

A number of factors influence the number, the mix and the workforce qualifications of staff allocated within RAC facilities regardless of their characteristics. They include government laws and regulations, customers’ expectations, and workforce wishes and industry work conditions. Other factors are the size and the layout of facilities, number of residents cared for, numbers of shifts to be filled, staff availability, budget constraints, staff leave entitlement, staff turnover, and seasonal variations.

In essence, staff allocation adds to the RAC industry and facilities’ care and business challenges. Service providers (as per Aged Care Act 1997 requirements and service agreement with the Federal Government) need to ensure an adequate workforce is available to meet the clinical and the care needs of their residents. Based on this requirement, facility managers (delegates of the service providers) must allocate their workforce (qualified and unqualified) to meet the clinical and personal care needs of residents around the clock. This challenge begins before the doors of the facility open for the first time, transfers when there is a change in ownership and ends after the departure of the last resident when the facility closes. Taking into consideration the labour intensive nature of the industry, rising labour costs, and the relationship between staffing and quality services, overstaffing or understaffing may expose RAC facilities to expensive and risky outcomes. Profit margins are narrow and quality standards are high (Hurst, 2002).
Staff allocation could have other major impacts on the financial viability and reputation of the RAC facility. Major safety issues would be a possibility if the number and capabilities of the workforce available are below the care needs of the residents. For example, staff with limited or absent skills in pain management, continence care and food and hydration. Financial viability would be compromised if staff numbers and mix exceeded residents’ care needs, as the Australian Government’s financial subsidy would not cover service providers’ costs. Should RAC facilities not comply with federal, state, and local government standards due to poor quality of care, documentation, or unsuitability of staff skills and knowledge their reputations would be damaged and there would be financial implications, including fines and the cost of re-compliance.

Efficiency of staff allocation in RAC facilities is crucial for delivery of quality clinical and care services and accounts for the majority of operational challenges. Efficient recruitment, retention, and allocation could provide the operational efficiency and the competitive advantage required to maintain business and to grow it.

2.5.2 Staff allocation process

Most of the literature noted similarities in the staffing processes followed by RAC facilities regardless of size, ownership, location or care delivered. In essence, once the number of staff required is determined the challenge of allocating or rostering that number emerges and brings with it further steps and considerations (Rosebrook, 1992). They include matching the residents’ number, care needs and shift coverage with available staff numbers and the skill mix of those personnel. Staff allocation needs to consider the budget, staff contracts, shift and secured units (e.g. dementia- specific areas) coverage.
The responsibility for staff allocation or preparing the staff roster can be centralised or decentralised. In a centralised approach, an allocation officer is either located in head office (for a corporation-style organisation) or is part of executive management team. The responsibilities of the officer are to prepare rosters for all staff involved. The advantages of a centralised system are neutrality and cost control. Disadvantages are the geographic and psychological distance of the officer from changes in workloads and staffing. Another disadvantage is the potential for disengagement of the facility/ward manager. In a decentralised approach, the preparation of the roster is the responsibility of the facility manager, ward manager, and at times the shift manager. This approach has its own set of advantages and disadvantages (Rosebrook, 1992) that are the reverse of the centralised approach.

Traditionally, in the RAC industry the task of staff allocation or scheduling is the responsibility of the facility manager who, in many cases, delegates to unit managers, usually Registered Nurses. The staff allocator follows a master roster which prescribes the number, the mix (qualified and unqualified), and hours of contact. This roster is usually developed in accordance with the operations budget, number of hours indicated in the staff employment contracts, facility size, design, and the numbers of residents in care. Changes in the master roster, especially those that result in increases in operation costs, need to be authorised by the service provider or delegate. (This may be the finance department in a corporation). Changes involving daily responsibilities of personnel, staff rotation, and replacement are done by unit and floor managers. All staffing decisions are based on an officer’s professional judgement.
2.5.3 Workforce planning systems

Although the requirements and the process utilised for staffing are similar among the RAC facilities, the literature reveals numerous workforce planning systems in use or available for use for this process. The systems vary in their utility, shortfalls and workforce recommendations. Rosebrook (1992) and O'Brien-Pallas et al. (2004), note there is no magic formula which is reliable enough to calculate the most favourable number of staff for all locations at all times. Rosebrook and O'Brien listed ten of systems: 1) The traditional approach (subjective predeterminations of the staff required); 2) Nursing Hours per Patient Day (NHPD) approach; 3) Nursing Hours per Patient Bed; 4) Patient Census approach (use patients' ratios as the basis of calculating the required staff numbers); 5) Patient Classification Systems (PCS) (quantifies the patient’s average care required as the basis for staff numbers); 6) Nursing Intensity approach (builds upon the PCS approach but adds to it the contributions of nurses with various skills thus adding the staff skill mix factor); 7) Budget Allocation approach (uses historical trends, projected patients’ classifications, and expected income to calculate the average staffing cost per patient per day and then recommend staffing accordingly); 8) Geographic Coverage approaches (considers the geographic/ward constraints to allocate minimum staff numbers regardless of other factors); 9) Award Specification approach (uses industrial agreements as the basis for staff number and skill); 10) Converting Daily Staffing to Annual Requirements approach (uses the contracted and available hours including holidays, sick leave and other leave for various nursing positions as a basis for determining the required staff allocation).

Hurst (2002) categorised the workforce planning systems in five groups including: 1) Professional judgement (Telford) approach (akin to Rosebrook’s traditional approach); 2)
Nurse per occupied bed (NPOB), "top-down method" (akin to Rosebrook’s NHPB approach); 3) Acuity-quality, "bottom-up method" (akin to Rosebrook’s PCS approach). An example of these systems would be “Trendcare” and “PANDA”; 4) Timed-task/activity approach (uses the tasks and activities required by the patient as a basis for calculating the staff required. Example of this approach is the commercially available American-based system “GRASP”). 5) Regression-based system (uses a number of independent variables including the number of beds occupied, days of the week, number of theatre sessions, etc., to conduct regression analysis to establish the relationship between these variables and the staff numbers. The calculated relationship is used to predict number of staff required).

O’Brien-Pallas et al. (2004:22) took a bigger picture by listing four generations of the Patient Classification Systems (PCSs) which are: (for an illustration of these classifications refer to the corresponding figures page 55)

2. Second generation (the 1980s): Basic use of technology and workload measurement (figure 2.0).
3. Third generation (the 1990s): Better use of technology and more advanced workload sensitive approaches (figure 3.0).
4. Fourth generation (future aspiration): Aims to use not-yet-available technology to calculate ‘real-time’ nursing care needs and includes skill mix (figure 4.0).

Although the process and requirements for staffing most RAC facilities are similar, there is a variety of staffing systems and approaches available for use. The challenge rests with the
ability of staffing officers to select the approach most suitable to individual RAC facilities.

Approaches that can best meet an RAC facility’s staffing, financial and quality care challenges should be valued by the facility manager and the stakeholders.
O'Brien-Pallas et al. (2004, 22) Four Generations of Patient Classification Systems (Figures 1.0-4.0):

Figure 1.0: First Generation (N.B. No. : Number)

Figure 2.0: (Second generation)

Figure 3.0: Third generation

Figure 4.0: (Fourth generation)
2.6. Displayed sample staffing tool

A component of meeting the aims and objectives of this study (to explore the perceptions of RAC facility managers in Australia in terms of the prospects of adopting alternative staffing methods), was the display of a sample staffing tool which the author designed to meet the needs of the RAC facilities in Australia.

This RAC staffing tool is original in design, utility and deliverables and could, therefore, be classified as an alternative staffing tool/approach. There are a number of reasons behind display of this staffing method: 1) Inject the study with some implicit originality. No other study, to the author’s knowledge, has used a similar approach in exploring perceptions held on staffing. 2) Bring to the participants the concept of an alternative staffing tool in a concrete and visual manner. 3) Display an alternative staffing method and display its deliverables. The following section shows the relevance of the tool to the daily running of the RAC facility; elaborates on its innovation and deliverables; and displays it, highlighting relevant sections.

2.6.1. Relevance

The sample staffing tool, which will be referred to as SM-1, is a decision supporting tool that is designed to aid RAC facility managers and staffing officers to determine the number, skill mix and location of staff per resident per shift per day. It utilises the currently adopted funding system, the Resident Classification System (RCS), and uses its score in combination with the number of residents cared for as the basis for determining the required staffing hours. The RCS score is a calculated score based on the level of care provided to elderly
residents on a daily basis. This score is required as the basis for a set of eight different Government funding levels. The higher the score, the higher the care required which therefore indicates a higher funding level. This score is readily available and easily calculated at any point in time (for more information refer to the earlier part of this chapter).

Having the ability to calculate the required number of staff hours, their classification, mix and cost is vital not only for the delivery of quality and efficient care but for any strategic or forecasting exercise in a ‘what if’ scenario (e.g., opening a new ward, resident admission, etc.). The process is generally carried out as a subjective process referred to as professional judgement- currently the most adopted staffing method in Australia (refer to chapter 3).

2.6.2. Innovation and deliverables

The SM-1 staffing tool is not unique in its structure but it is innovative in its working and application to the RAC industry. The SM-1 works on delivering Team Nursing, as a care delivery model (section 2.5.3) and is a combination of Nursing Intensity approach, Acuity-quality approach and Time –Task approach staffing systems (Rosebrook, 1992; O’Brien, Abas, Christensen, Nicholls, Le Prou, Hekau, and Vanderpyl, 2003) The SM-1 could therefore be classified under the third generation staffing systems illustrated earlier in the chapter. TrendCare ® and GRASP ® are two examples of staffing systems that adopt one or more of these staffing approaches. The former is designed for acute/hospital care settings and latter is designed for aged care facilities operating in the United States of America. The SM-1 is unique in its application to the Australian RAC industry. It uses the readily available Australian RAC funding system.
The SM-1 tool is a spreadsheet based staffing calculation sheet in which the user keys in the number of residents in care and their combined RAC score in return for the following:

1. Number of staff hours for
   a. Nurse manager
   b. Registered Nurse Division One
   c. Registered Nurse Division Two or Personal Care Assistants
2. Staff hours per shift and ward
3. Cost of staff hours per day, per staff category and per ward.
4. Income generated per score entered.
5. Other costs and income such as bonds, laundry, catering, activities and others.

Simply keying in the number of residents’ per ward, with their cumulative RCS will provide the RAC manager with numerous operational data at any point in time. SM-1 ensures staff hours recommended will not exceed Government subsidy generated from residents. The next section provides an image of this staffing tool.

For example:
The RAC facility manager can key in the number of residents and the residents’ combined RCS score (section C, wing data)
The tool then produces:

1. Number of staff hours for
   a. Nurse manager (section F, Supervisors hrs)
   b. Registered Nurse Division One (section I, Div 1 Direct Care Hrs)
   c. Registered Nurse Division Two or Personal Care Assistants (sections F, Hrs/care)
2. Staff hours per shift and ward (section F, AM, PM and ND)
3. Cost of staff hours per day, per staff category and per ward (blue part of section F and I).
4. Income generated per score entered (section E, RCS income)
5. Other expenditure and income such as laundry, catering, activities and bonds.(section E)
The tool can also be used to carry out a number of other calculations and provide operational data as required by the manager. It can also be customised to the facility regardless of size or level of care provided.

2.6.3. The tool (figure 5.0):
### Staffing Module SM-1

#### Staffing Module SM-1

**Individual Score Calculator:**

- **A:** If RCS Score is: 55

- **B:** Each pt requires: 3.5

  - **C:** Wing Data (Actual)
    - Wing: 7880
    - Scoring: 100
    - Other: N/A

- **D:**
  - $PM allowance: $18.00 per shift
  - $ND allowance: $24.00 per shift
  - $Value/hr: $18.00 Care hr
  - $Value/hr: $28.00 Div 1 hr
  - $Value/hr: $35.00 Super/hr

#### High Care

**For ACF on**

- **E:**
  - Per day: $11,357
  - Per month: $345,430
  - Per year: $4,145,159

- **F:**
  - Income:
    - RCS: $11,357
    - Daily Fees: $3,000
    - Other Income: $753

#### Support Data Table:

- **H:**
  - Extra mins
    - On RCS: 20
    - Other: 0
    - Sick: 30
    - 2 staff: 30
    - Total hrs: 30
  - Req/wing: 30

### Cost/wing:

- **K:**
  - H/C: Scenarios calculator:
    - No. of RCS: 5
    - Average: 63
    - Total: 30
  - L/C:
    - Res/day: Laundry: 5
    - Catering: 16
    - Cleaning: 5
    - Activities: 4
    - $Dollars: 30.00

**Version H 4.0**

by K. Sukkar Copy Right
2.6.4. Utility of the demonstrated staffing tool

The demonstrated tool was constructed and designed to bring maximum utility (and flexibility) for the person responsible for staff allocation and maximum efficiency in linking staffing hours to care needs and available funding. Utility is achieved through the ease of use. The RAC manager needs only to key in two figures, the number of residents cared for and their combined RCS score (readily available as it is used for claiming Government funding). The maximum efficiency is brought through directly linking (via an algorithmic formula) the residents’ care needs, reflected in the RCS score, to the number hours of care required. The link ensures that the hours of care and their associated cost will not exceed the available government funding. N.B. Part of the Government funding is used taking into consideration other operational costs such as cost of continence aides, laundry and fees for the management of beds, . Hours per shift recommendations have another set of algorithmic formulae.

Utilising staffing tools similar to the one demonstrated will aid not only the determination of appropriate staffing but will facilitate staffing for simulation purposes, e.g., commencement of a new ward, mass discharge or multiple admissions and serve as a benchmark between wards and facilities.

2.7. Chapter summary

This chapter has overviewed RAC in Australia — its history, structure, international comparison and contribution to the economy. It has also provided a snapshot of the RAC industry and facilities’; elaborating on the latter’s structure, services and challenges. The chapter has highlighted the level of complexity involved in allocating and rostering
workforce in RAC facilities, tasks vital for the safe and quality delivery of RAC services. The chapter then provided an overview on a number of staff allocation/staffing methods listing the different steps, processes, systems, and approaches involved. It highlighted the value of adopting an appropriate staffing approach that attends to the demands of staffing in a labour intensive industry such as the RAC industry. Finally the chapter has presented an overview of the alternative staffing method demonstrated in the interviews conducted for this study. This chapter has highlighted the following:

1. The RAC industry is growing, reflecting changes in demography and government policy.
2. The RAC industry has a number of challenges that affect it at macro (industry) and a micro (facility) level.
3. These challenges are not unique to Australia.
4. Staffing, financial viability, and regulatory compliance form the majority of these challenges, with no foreseeable relief.
5. Staff allocation is not only a complex process but it contributes largely to the efficient running of RAC facilities and the delivery of safe and quality services.
6. There is a number of alternative staff allocation methods that can be adopted in the RAC industry.
7. The utility of the alternative staffing tool presented during the interviews.

This chapter sets the scene for the study and provides baseline information for use in the following chapters. This chapter is followed by the literature review.
Chapter 3-Literature Review

3.1 Introduction:

In the previous chapter, the Contemporary Context Chapter (chapter 2), the aim was to introduce the RAC industry in Australia, its structure and challenges, as well as to elaborate on the available staffing models and systems. The staffing challenge was highlighted because of its effects on the running of the industry and the quality of service produced. The following concepts have been established.

Australian demography is changing as evidenced in the increase in the number of persons aged 65 plus in comparison with other younger age groups. This age group, within which 5.3% in 2003 (Productivity Commission, 2008) required RAC services, is expected to increase four fold by the year 2050 (Productivity Commission, 2008) requiring an increase in the number of RAC services. The RAC industry, providers of the RAC services, has a number of challenges, with staffing as the most important. The magnitude of the staffing challenge is due to the influence it has on the daily running of the industry, the quality of the services provided and the profitability and sustainability of the industry.

The purpose of this chapter is to conduct a review and critical analysis of the available academic literature relevant to the topic of this research — the prospects of adopting non-traditional staffing approaches in the RAC industry in Australia.
3.2 The Scope, Process and Structure of the chapter

This review is intended to be selective because of the size of the target industry and the abundance of academic and non-academic publications on the topic of aged care and aged care challenges. This review selects and focuses only on publications that are directly related to the topic and are based on empirical research or based on policy based theoretical arguments. The majority of the selected literature has been published post 1997 for two important reasons: first to ensure current relevance and second to capture the effects of the major changes since the introduction of the Aged Care Act in 1997.

This review includes literature from other English speaking countries as well as Australia because there is value in providing comparison between Australian and non-Australian experiences, as aged care challenges are global in nature. Implications are illustrated later.

3.3 Currently adopted Staffing processes in the RAC industry

The literature reviewed on this issue was mainly non-Australian in its origin and did overwhelmingly reveal problems relating to the appropriateness of staff allocation processes for three main reasons: 1), the paucity of staff-related data at the facility level; 2), complexity of staffing processes; and 3), inadequacy of staffing tools in use. In other words, the literature highlighted three management challenges for the operators of RAC facilities. This thesis has a management focus and discusses these challenges and studies the prospects of attempting alternative staffing processes as a potential answer to the challenges. First, availability of staff related data. These vital data are currently available only at national levels and, thus, not suitable at facility or ward levels (2004). Second, the complexity of staffing
processes which not only involves a large number of variables but also have major effects on the care provided and the financial viability of the RAC facility (this concept has been thoroughly discussed and established in the previous chapter). Third, the inadequacy of the currently adopted staffing tools. These tools fail on two counts. They fail to allocate appropriately the number of staff at a facility/ward level and they fail to ensure the provision of quality of care (Chen, Tsai, & Chang, 2007; Takahashi, Kitajima, Dumbaugh, & Reich, 1998).

To elaborate on the inadequacy of the currently adopted staffing tools: current staffing tools are inadequate because the majority are based on a formula which considers ‘number of staff on duty’ as the determinant for allocating the health workforce (Scott, 2000). Setting minimum staff ratios through this formula or enforcing such ratios through laws and policies is burdensome, non-representative and too general. The reason for this is that residents’ needs are not equal, discrediting any staffing approaches of this kind (Mount, 2002). On this, Hyun, Bakken, Douglas and Stone (2008:154) reported that decisions pertaining to staffing fail to consider a number of factors such as nurse experience/education level, fatigue factors, patient condition, skills, and competencies that may have negative effects on the patients’ care outcomes.

According to Stack (2005) and Schneider (1994) further, current staffing tools have a number of competing challenges including: workload-related challenges, work intensification, increased workloads, and difficult work conditions which result in feelings of burnout, high turnover, absenteeism, indifference and poor motivation. In other words, these tools do not respond to internal or external influences on the staff such as demand and supply for workforce, seasonal changes, and the presence of students in the RAC facility.
Another challenge is management induced challenges, such as management over engagement in cost minimisation (Stack, 2005). An example of this is budget driven nursing staff levels in private hospitals in Queensland (QNU, 1999). Such approach to staffing disregards care needs of the patients and assumes all patients have equal care needs which creates high workloads on the nursing staff.

Another challenge is the Australian Government’s promotion of the concept of home-like environment without a matched recognition and promotion of an increase in funding for aged care provision (Courtney, Minichiello, & Waite, 1997; Stack, 2005). For example, Home like environment creates the needs to have private rooms and toilets which increases the size of the RAC facilities thus requiring more staff (larger isolated areas of the facilities require dedicated staff for supervision).

Duckett (2005) notes the fragmentation of responsibility between the four parties that are required to address staffing in the health care industry which include: universities (the provider of education for nursing); health agencies (the provider of employment for nurses); States and Territories (regulator of nurses’ awards and conditions); and the Commonwealth Government (the financier of nurses’ education and regulator of migration intake) is not helping solve this problem.

The findings in the Australian literature were reflected in the literature reviewed from international sources. Research by Mount (2002) found 92 percent of nursing homes in the US fell below the minimum recommended staffing levels. This was mirrored by Chen et al. (2007) who noted that the nurse staffing in Taiwan is inadequate and requires re-evaluation.
In summary, the literature reviewed on the currently adopted staffing processes has highlighted the inadequacy of the current processes in meeting the needs of the RAC industry in Australia and overseas. These staffing processes (and tools used) fail to accommodate residents’ varying needs and staff capabilities and, therefore, fail to contribute to quality residents’ care. Are there any calls for change?

3.4 Calls for change

The literature review on this question revealed a number of calls for change. Some ask for the use and adoption of a specific staffing tool in RAC while others go beyond the tool to more fundamental changes in Human Resources (HR) practices.

In Australia, according to Mount (2002), resident advocates believe that setting minimum staffing ratios is the answer to the nurses’ shortages, a method refuted by nursing home owners for their costs and insensitivity to differences in patients’ care needs. The Queensland Nurses Union (QNU) (1999) and Carroll (2004) advocated the use of Patient Nurse Dependency (PND) Systems.

Overseas, the Canadian Registered Nurses’ Association (2005) called for the use of workload measurement systems (WLMS). Schneider (1994), Kobs (1997), Winkler, Cameron and Flarey (1995) advocated use of resident acuity systems which can estimate nursing services and decrease staff turnover and be used for budgeting purposes. An illness severity-based allocation system was advocated by Chen et al., 2007. Human Resource information systems (HRIS) were recommended by Bortolon, 2003. Redpath (2003) revealed that The RUM
(Resident Use Measure) tool can be a vital tool in service planning for the elderly. O’Brien-Pallas, Thomson, McGillis, Pink, Kerr, Wang, Li and Meyer (2004) argued for the benefits of workload measurement tools. Björkström, Bolinder, Bäckstedt, Heurgren, Johansson and Levenstam (2000) recommended case costing systems listing four main systems: Zebra, Beakta, Rush, and Ril systems. Nilsson (2002) supported the use of case costing tools, mostly used in somatic hospitals in Sweden, listing their efficiency, productivity, forecasting, and benchmarking qualities. According to Carpenter, Ikegami, Ljunggren, Carillo and Fries (1997), the RUG-III, a USA-developed tool, is capable of addressing the care needs of the elderly person. They claim the tool is consistent and has been validated in USA, Spain, Japan, Sweden, England and Wales. Carpenter and Perry (2002) argued for the adequacy of the RUG-III case mix system in determining dependency levels and staffing needs in the long-term care facilities in England. Urquhart, Kenne, Murdoch, Smith, & Lennox, (1999) called for the use of SHRUG Casemix (the Scottish Health Services Resource Utilization Groups (RUG)) as a useful measurement instrument in assessing the resources needed for the elderly people in long-term care. The New Zealand Nurses’ Organisation (2004) in their draft submission to the Ministry of Health on the Staffing Regulations for Aged Residential Care, called for the adoption of a consistent tool that bases daily care hours on clinical needs.

Several studies suggested a number of benefits that could be gained from the adoption of new staffing tools. Dunivan (1991), BordoloI and Weatherby (1999) and Chen et al. (2007) reported that establishing and maintaining optimum staffing and skill mix is crucial to providing cost-effective and high quality care in a highly labour intensive industry. Rosebrook (1992) and Winkler et al. (1995) added that, increasingly, nurse managers are expected to produce staffing plans that are not only sensitive to changing patients’ needs and workload needs but also can be easily substantiated.
Other published reports focused more on changes in work conditions. Kobs (1997), for example, listed the need to match the acknowledged patients’ needs and the design of the hospital with the scope and level of care provided. Kobs added that budgets need to include time, money, people and equipments. Stack (2003) went beyond simple numeric indicators such as absentee rates, to take account of working conditions and employee well-being as fundamental to the 'expected outcome' of quality of care for the elderly. Scott (2000) and Bortolon (2003) added that there is need to improve communication between the employers and employees and equip managers with staff planning and management skills (Scott, 2000). Shullanberger (2000) supported the utilisation of a ‘self-scheduling environment’ with limited nurse management involvement, as a contributor to staff satisfaction in an acute hospital. Townsend and Allan (2005: 204) stressed the importance of work-family flexibilities and called for “experimentation and innovation to improve the quality of working life for nurses”.

Morrissy (2003) agreed with all the above and highlighted the importance of nurses being able to review and contribute to decisions relating to staff numbers and mix in their area of work on a constant basis. Grenade, Horner and Boldy (2004) advocated to link between staff satisfaction in nursing homes with patient satisfaction. The National Aged Care alliance presented three reports (the most recent in 2001 & 2003) on the supply and demands of the aged care sector’s funding. The alliance recommended changes to the use of the indexation tool to make it more care needs focussed rather than wage based (National Aged Care Alliance, 2004 a). The Canadian Registered Nurses Association of Ontario (2005) recommended the adoption of workload measurement systems (WLMS) as nursing interventions are captured to reflect the work involved in professional nursing. According to Stubbings and Scott (2004):
Quality of care measurements must be researched as soon as possible. Nursing roles must be clarified. No longer should nurses be considered by managers and other professional colleagues as cheap, disposable ‘pairs of hands’, readily available to undertake duties other staff want to devolve. Reliable research is essential to ensure that the skill mix necessary for effective quality care is founded on service requirements not financial or political exigencies (Stubbings and Scott, 2004: 190).

In summary, the above review illustrates the overwhelming calls for change. Some recommend the adoption of specific staffing tools and others elaborate on recommendations with benefits exceeding the staffing process. The remainder call for the changes in workplace conditions before any benefits can be achieved from the adoption of new staffing tools. The author noted coherence between the calls for the adoption of alternative staffing tools regardless of the origin (the country) of the literature reviewed. Not much a surprise as RAC challenges (listed in chapter two e.g. society structure, workforce challenges, ageing population etc.) are similar in these countries. Nevertheless, the recommendations to use one tool/system over another varied between tremendously with no clear cause for this variation; This variation in the staffing tools recommended could be an attractive area for future research especially on the benefits and suitability each of these tools provide.

3.5 Research studies relevant to the topic:

The research into the topic revolved around staffing systems, their applicability, their limitations and issues of acceptance and resistance to such systems.

3.5.1 Australian Studies:

Australian studies with relevance to the topic are limited. The three main ones are by Hogan (2004), Duffield (2007) and Shannon, Brand, Ratcliff and Tranter (2007). Hogan headed a
major review on the RAC sector (The Pricing and Productivity Report) funded by the Federal
Government and on which he presented a report in 2005. This review studied the long-term
prospects, sources of funding, and the pricing arrangements of the industry (Hogan, 2004;
Productivity Commission, 2005; The Centre for Efficiency and Productivity Analysis
(CEPA), 2003). The report made twenty recommendations. One was dedicated to the RAC
workforce. The other major study was by Duffield et al. at Sydney University of Technology
(Duffield et al., 2007). This three-year study which commenced in 2003 was not on staffing
in the RAC industry but is of a importance because it aimed at:

1. Collecting empirical evidence on the impact of increased in-patient acuity and
   reduced length of hospital stay (LOS) on nurses’ workload by retrospective data collection
   from NSW Health & Hospital Information Systems;

2. Establishing the relationship between nursing skill mix and models of nursing care
   on patient outcomes, case-mix adjusted by prospective data collection, in a random sample of
   hospitals across NSW. The results, released in October 2007, included a number of findings.
   The most relevant to this study were the effect of skill mix on patient care and the absence of
   a ‘standard’ ward setting.

A study conducted by Shannon et al. (2007: 420) in Tasmania recognised the need to develop
formulae to measure doctors’ workloads and to facilitate their allocation in hospital systems.
Although the study concentrated on the medical profession, it iterated the challenges facing
nursing workloads and allocation. The authors invited replication of their work and research
into the link between clinical staffing and clinical activities in the Australian hospital
systems.
3.5.2 International Studies:

A number of studies linked care requirements to day-to-day workload fluctuations. Others linked staffing levels to quality of care to the safety of the workforce. Hyun et al. (2008) reported that there is some kind of consensus on the relationship between staffing and quality patient outcome.

Winkler et al. (1995) reported on the link between productivity of patient care outcomes and the adverse effects on cost and quality. In which the quality of patient care outcomes improve (maintenance of continence, decrease of falls risk, prevention of bed-sores etc.) overall of quality of care improves and costs on the long run decrease (i.e. costs related to non-compliance with Government accreditation etc.). Takahashi et al. (1998) reported two ‘time’ studies conducted seven months apart in a Japanese gerontology hospital where the effects of burden (patient dependency) and staffing levels on the quality of service were reviewed. In their study the burden was controlled while staffing levels were allowed to vary to measure the effect on quality of service. The one month trial revealed a general decline in the quality of the services delivered (in the low resource period).

Buchan, Poz and Mario (2002) reviewed skill-mix patterns among the health workforce in different countries, sectors and health systems. They recommended adjusting staffing patterns in relation to day-to-day fluctuation of workload. They added that patient dependency is another option for attending to the numerous factors influencing the health industry i.e. relating staffing levels and mixes to the care required by the patient.

Potter, Barr, McSweeney and Sledge (2003) reported the relationship between RN levels (hours of nursing care per patient day) and patients’ clinical outcomes and satisfaction levels.
The study showed positive correlation between patients’ perception of their health status and the RN levels rostered to provide their care. They acknowledged that although they did not identify an optimum level of RN hours of care, they had provided a good indication of the effect of the relationship between the staff levels and care outcomes and perceptions.

Cohen, Village, Ostrey, Ratner, C vitality and Yassi (2004) listed the results of a empirical study in eight independent care facilities in Canada which involved focus groups, systematic observations, care aides-to-resident staffing ratios and in which workload was measured. The study revealed a strong and direct correlation between workload and the number of injuries incurred by staff. Blake (2004) reports on a research showing an increase of one patient per nurse increases burnout by 23% and job dissatisfaction by 15%. The same research has also shown that 43% of nurses experiencing high burnout intend to leave their job in the following twelve months. The Canadian Registered Nurses’ Association of Ontario (2005) studied the multiple roles played and care delivered by registered nurses, outcome of the care, and the associated limited resources. They recommended use of workload measurement systems.

Himmelweirt (2005) reported an inverse relationship between productivity of caring and quality. Chen et al. (2007) reported a significant relationship between work stressors and the total number of residents taken care of by nursing staffs and the number of nursing hours spent. Kane, Tatyana, Mulleller, Duval and Wilt (2007) reported a positive relationship between nursing staffing and quality care. Their report was based on a major study in the United States on the relationship between the two. Lee and Akhtar (2007) reported on the direct relationship between workload and productivity. Their report was based on an empirical study examining the significance of sources of stress on job burnout among a sample of 2267 nurses working in 43 public hospitals in Hong Kong. Multiple regression analysis of the data revealed significant effects of the lack of professional recognition and job
demands on job burnout. Self-efficiency (i.e. to operate with the smallest amount of effort/taking short cuts) was found to be the most effective coping resource.

All the findings of the literature reviewed revealed a direct relationship between staffing levels and quality of care. Complicating this finding is the non-linear relationship between staffing levels and quality of care (Agiliata & Lucier, 2003; Zhang, Unruh, Liu, & Wan, 2006). This means that benefits from any investment in staffing levels would reach a threshold after which further increases would lead to no more care improvements. In other words there is a fine line between overstaffing and understaffing and the implications. Each has implications for financial returns and quality of care. The challenge is to find not only a numeric match between the care required and staff needed, but also a match between the skills required for varying client care needs and changes in health conditions. Accessing and utilising a tool/approach that can match staffing numbers and skills to the care required by the clients would minimise staffing cost (thus increase the returns on investment) and provide the care required.

In summary, national and international literature highlighted the need to review staffing processes adopted in the RAC industry; the relationship between productivity, staffing and quality care as well; the effects of workload on staffing and staff turnover.
3.6 Staffing systems and their applicability:

Research by Bordoloi and Weatherby (1999) revealed the presence of nearly one thousand patient classification systems which vary in function and significance. But, as a Canadian review by the Task Force On Resident/Staff Ratio In Nursing Homes (2002) found, a single resident-staff ratio cannot be applied to all care settings. Several factors contribute to the determination of appropriate direct care staffing levels. These factors include but are not limited to:

- The variety of direct care staff available
- The existence of non-direct care staff available
- The experience and education of staff
- The roles and responsibilities of direct care staff
- The intensity and complexity of resident care needs
- The physical layout of the nursing home
- The availability of time saving equipment and supplies
- The quality of care expected

To cater for such factors, Rosebrook (1999: 60-65) listed eight different types of nursing care models each with their own advantages and disadvantages: 1) ‘functional or task nursing’ (schedule nurses per task performed e.g. medication nurse); 2) ‘specialized or specialty nursing’ (e.g. palliative care team); 3) ‘team nursing’ (e.g. schedule nurses are per defined skill mix); 4) ‘modular nursing’ (focuses on the patient's geographic location for staff assignments); 5) ‘patient assignment or total patient care’ (patients are assigned to one nurse coordinate their care requirements over a extended period such as one week or more); 6)
‘primary nursing’ (assigning care of a group of patients to a nurse who provides all care required); 7) ‘nurse-managed care’ (by a nurse practitioner specific areas such as wound care or diabetes); and 8) ‘case management’ (a nurse coordinate the care to be provided by other providers before, through or after discharge from hospital).

While there is an abundance of staffing systems and nursing care models for adoption by health care managers the challenge lies in locating and adopting the model(s) that best fit their facilities.

3.6.1 Limitations of staffing systems:

A number of limitations in applicability, validity, reliability, and generalisability of the current staffing systems were noted in the literature. Bordoloi and Weatherby (1999) reported that although there are nearly one thousand patient classification systems which succeed in aligning nurses’ numbers and skills to minimize costs, they fail to align nurses’ philosophies with management ones. Arthur and James (1994) concluded that workload measurement systems can be used only to facilitate rather than dictate decisions about nurse staffing levels as no perfect system of such kind would ever exist. Botz, Bestard and Demaray (1993), in a study evaluating the Resource Utilization Groups (RUGs III) as a one stop shop classification method, critiqued three classification systems: the Alberta System (biased towards the less acute patient), the RUGsIII (biased towards the higher acuity rehabilitation patient); and the Medicus (biased towards the chronic category). The systems were found to have noticeably different estimates of the resource requirements, with profound impact on potential users.
Urquhart et al. (1999) commented on the use of the SHRUG CASEMIX tool. The categories of this tool showed just 67% consistency and were able to explain only 35% of the variance in the costs. Carpenter and Perry (2002) reported difficulties in implementing workload analysis in decision-making in relation to staffing. They described such difficulties as focus on the tasks that nurses perform rather than overall care provision; quantification of the nurses’ decision-making process (a difficult task because it is invisible); disregard of environmental factors associated with care (such as geographical location); and discount of nurses’ ability to meet several needs simultaneously when providing care for individual residents and costs involved (i.e. if the tasks that nurses perform simultaneously are costed individually).

There may be limitation in addition to those listed above in the applicability and deliverables of existing staffing modules. Low chances exist for such limitations to be revealed or published for a variety of reasons (Buchan et al., 2002). It is greatly unlikely that the developers, especially of commercial-promoted staffing tools, will reveal its shortfalls.

3.6.2 General resistance to change within the healthcare workforce:

From the literature are gleaned eleven reasons that might affect negatively the adoption of alternative staffing systems:

1. Lack of understanding/uncertainty about the change proposed/fear of the unknown (Borkowski, 2005; Hubboard, Pockneo, & Taylor, 1996).

3. Self-interest/loss of equilibrium and personal power/loss of face/loss of status or ‘personal space zones’ (Borkowski, 2005; Hubboard et al., 1996).

4. Existing skills made less relevant/obsolete (Hubboard et al., 1996).
4. Different perceptions/frames of reference/change is against culture (Hubboard et al., 1996).
5. The addition of extra work (Hubboard et al., 1996).
6. The variation of work importance/value among individuals (lifestyle, part-time/full-time, ...) (Hubboard et al., 1996).
7. The unexpectedness of change (Hubboard et al., 1996).
8. Lack of trust in management (Hubboard et al., 1996; Leggat & Dwyer, 2005).
9. Real or perceived stress (Borkowski, 2005).
10. Reduction in personal need fulfillment (Borkowski, 2005).
11. Successive waves of policy and structural reform, driven by the need for cost containment (Leggat & Dwyer, 2005; Stack, 2003)

There are numerous disincentives for RAC managers to adopt change in general, and to adopt alternative staffing approaches in particular

3.6.3 Resistance to the use of computer-aided staffing tools by nurses:

The Canadian Registered Nurses’ Association of Ontario (2005) reported that nurses will resist computer-aided staffing tools because they will be expected to: 1) Capture workload data accurately without being informed on what basis data is calculated or how it will be used, while continuing with their work responsibilities and without clerical support. Many nurses, lack the computer literacy needed to describe their work properly. 2) Capture and translate their duties/tasks, exposing the systems to collection bias in order to justify cost rationalisation and without involvement in the planning and implementation of the process. Savenstedt, Sandman and Zingmark Sa¨ Venstedt (2006) added that resistance to the use of
information and communications technology applications in Sweden is influenced by the negative attitudes of nurses to such systems. Elliott and Tevavichulada (1999) believed that the lack of training among employees was one possible reason for the scarcity of the integration of computer software with HRM activity and the under-utilization of the information available.

3.6.4 Acceptance of change including the use computer-aided staffing tools:

On acceptance of change in general, Chenoweth and Kilstof (2002) reported that for organizational change to occur in aged care organizations, organizations need to adopt a flat structure and management needs not only to support the process but be seen to be transparent. “Organizational culture and tokenistic support by management are major hurdles for change management to succeed” (Chenoweth & Kilstof, 2002, p:235). Jeong and Keatinge (2004) list four elements — material, environmental, psychosocial and psychological resources — that must be provided for change to be accepted. On acceptance of use computer-aided staffing tools, Dunivan (1991) reported that traditionally, human resources (HR) staff have been late adopters of computers in their operations. Dunivan attributed this to the complexity and cost of such systems, and consideration of HR as a non-strategic imperative to organizations’ business objectives.

Moore’s (1991) principles of the chasm refer to the pragmatist and conservative population (of his model). Moore argues that pragmatists wants ‘whole products’ before any meaningful adoption, and conservatives want simplicity at a low price because they cannot tolerate complexity and are attracted to commodity-like, well established and affordable products.
Applying this model to the RAC industry which is referred to as ‘conservative’ in much of the literature reviewed, cost is an issue, and simplicity is a must.

Hubboard et al. (1996: 280-281) argues the following criteria need to be implemented for the adoption of such systems to be effective:

1. Commitment at the top for major strategic changes (macro)
2. Consensus about the change (augmented by discussions and communication)
3. Communication and involvement (cooperation)
4. Individual behavioural change (which involves tasks, activities, attitudes,..)
5. Attention to details and actions
6. Adoption of small-scale change strategy rather than grand-scale ones
7. Allowing enough time for changes to happen.

Leggat and Dwyer, (2005: 219) added three more factors to streamlining the adoption of such systems:

1. The rate at which an organisation 'learns' to adapt is a factor that determines the rate at which it can adopt change and outperform its competitors.
2. Acceptance of any rising errors and mistakes as system faults without targeting individuals who commit them.
3. Providing psychological safety, a key factor in convincing an employee to take risks without the fear of retribution and negative consequences to self-image, status, or career.
There are a number of national and international studies on the topic of staffing, staffing systems, and the complexities and limitations of these systems. A number of studies discuss issues that lead not only to resistance to the adoption of computerised staffing systems but to resistance to change in general among healthcare staff. Other studies prescribe a number of changes in work conditions and improvements in staff-management to overcome resistance in general and to facilitate the adoption of these systems.

3.7 Theoretical addition: Neo-liberalism

To Blaikie (2000: 141) “a theoretical research is condemned; good research is supposed to involve the use of a theory somehow”. He added that a theory could be used to aid in answering a ‘why’ question; in other words to explain the patterns and themes emerging from the analysis of the data generated in this study. For this reason, this utilises neo-liberalism policies which are the main economic policies adopted in Australia, especially during the Liberal Government of 1996-2007, the time in which this study was conducted.

Neo-liberalism is an ideology contending that free market economies will run smoothly, steadily producing more wealth. State intervention would hinder economic development and thus need to be restricted to other business such as protecting private property and national defence (Harman, 2007). This ideology has dominated the Australian economy since the Second World War. Australia, as a western economy, adopted Keynesian economic principles in the late 1940s then followed the American and British Governments in their gradual adoption of the neo-liberal policies claimed by many as the reason for all the economic growth post war. This embrace became clearer during the Liberal Government between 1996 and 2007 in which the Federal Government worked hard to detach itself as far
as possible from the running of the Australian economy in general and the RAC industry in particular. The Federal Government promoted the adoption of neo-liberal policies that sponsor the principles of free-market, competition and customer’s choice which, in their opinion, promote quality of care (Cook and Beckley, 2001; Braithwaite, 2001; Quiggin, 2002; Cox, 2006).

To Quiggin (2002:10), “the neoliberal ‘new economy’ is the product of specific economic developments of the last quarter of the 20th century, including disillusionment with Keynesian macroeconomics and increasing faith in market solutions to economic problems”. To Cook and Beckley (2001: 10), “Neo-liberals stress the need for a ‘free-market’ system, that is, a market ‘free’ from the control of Government institutions. Given a free hand, the market will regulate itself and wealth will eventually trickle down to everyone in due time”. Nevertheless, there are a number of critics of the theory and the application of its policies in the Australian health and RAC industries.

To Cox (2006), neo-liberal policies adopt highly-structured (Taylorised) contracts which assume one-size-fits all. This was a successful approach after the Second World War when unemployment was high. The objectives were clear and the needs of different countries were similar. For this reason, Cox considers neo-liberal policies to have passed their-use-by date and to be dangerous to the economy because they are the antithesis of the new knowledge-based economy which values human capital. The new economy cannot afford to lose workforce through retrenchment, early retirement and temperamental treatment of qualified workforce. On that Brathwaite (2001: 446) added: “Australia's recent experience shows that to head in the opposite direction (of the new knowledge-based economy) is medically, economically, and politically irrational”. On the promotion of the free market, McAuley
(2007) argues that there is no known place where health care is left entirely to the control of the market. No consumer could plan for their health needs. Consumers, especially frail elderly consumers, have little choice in their admission to RAC facilities and are too frail to vote with his/her feet (Brathwaite, 2001). To Brathwaite also, the RAC industry has little control in the face of the Government, its major financier and quality controller. To Cox (2006) there is even a wrong use of the neo-liberal rhetoric, in that the Government’s current and most recent practices not only undermine consumer choices but are also fairly restrictive to the industry. For example, the RAC regulation and funding guidelines are prescriptive and highly regulated as well as involving harsh penalties for non-compliant RAC facilities.

In summary, the Australian Government in its adoption of neo-liberal policies has not supported the RAC industry in its challenges. It has added to them specifically in the field of the staffing challenges. Because of the relevance of neo-liberal policies to the RAC industry in Australia, Neo-liberalism and the principles of ‘free market’ will be used to aid in the interpretation of the data generated in this study.

3.8 Chapter Summary

The national and international literature reveals clear dissatisfaction with the staffing systems currently in use and calls for change in the processes adopted for staffing. Although a number of authors argued for the benefits obtained from new systems, others cautioned that the systems are not fault-free. The literature revealed resistance within the industry to change to new staffing systems. Resistance is due mainly to the nature of change itself and the ability of the nurses to use computer-based staffing systems. A number of international research projects recommended gradual change and commitment from all organisational levels as a
prerequisite to successful adoption of these systems. In Australia, there is a lack of research on computer-based staffing systems and the effects such systems might have on efficiency, workforce retention and quality care in the RAC industry. This study addresses itself to part of this gap by studying the prospects for adoption of alternative staffing methods (such as computer-based staffing systems) in RAC in Australia. This chapter has included a brief review of the impacts of neo-liberal economic policies on the RAC industry in Australia. Reference to these policies augment the interpretation of the data generated (chapter 6).
4.0 Chapter 4-Methodology Chapter

4.1 Introduction

The purpose of this study is to investigate the prospects of adopting alternative staffing methods in the RAC industry in Australia. This chapter presents the rationale for using an interpretivist research paradigm and discusses the contribution it brings to the central enquiry of this study. The abductive research strategy, that aims “to describe and to understand social life in terms of social actors’ motives and accounts” (Blaikie 2003: 101), was chosen to explore the participating facility managers’ perceptions of adopting alternative staffing approaches. This was possible with the use of semi-structured interviews to generate data specifically related to the topic and to give participants the opportunity to expand on their comments. This type of focused interview facilitates data collection in busy settings such as the participants’ work place, helps minimise the participants’ time commitment and minimises distractions for the participants and interviewers. The methodology provides, through its utilisation of the abductive research strategy, a valuable data generation strategy that can produce data from the comments of the participants which can be not only brief but also exclude business sensitive information. Therefore the choice of the research methodology is the most suitable for the aim of the study, the research question, and the participants’ circumstances.

4.2 Research question and aim

The findings of the contemporary context and literature review chapters were to establish the background to this research on the challenges involved and the options available for the
adoption of efficient staffing methods. The findings have added to the personal experience of the researcher in the RAC industry. The researcher’s involvement in the RAC industry as a facility manager has included daily challenges in staffing and workforce scheduling. This experience is similar to that of other managers in the industry. The absence of research in Australia on these challenges and consequently the lack of recommended staffing approaches do not aid in this process. Developing and recommending useful staffing approaches is important: the prospects of facility managers adopting such approaches is of greater importance. The data generated from exploring the perceptions of the potential users in relation to adoption of alternative staffing approaches is vital for any impending investment for the development of these approaches and in the process required in their distribution. This exploration would add to the body of knowledge and the body of practice in RAC management, change management and policy making. The main motive of the researcher in this study is to explore the prospects of the RAC facility managers (potential users) adopting alternative, more effective, staffing approach/s in their facilities. To facilitate this aim, the researcher presented a sample of an alternative staffing tool (see chapter 2) to first, bring the concept of an ‘alternative staffing tool’ closer to participants and second, to explore participants’ reaction to such a tool that would address a number of the challenges identified by the findings of chapters 2 and 3.

According to Blaikie (2003: 49) the “motives for undertaking research are associated with the type of research, i.e. whether it is basic or theory-oriented research, or whether it is applied or policy oriented research”. Basic research is concerned with exploring, describing, explaining, understanding and predicting a social phenomenon, the reasons behind it or the outcome resulting from it. Applied research is concerned with changing a social situation, evaluating a social intervention or assessing the social impacts of a certain process on the
social structures, processes and / or person (Blaikie, 2003, 74). The present research is concerned with exploring the perceptions of participants within a certain social phenomenon and the prospects of participants adopting alternative staffing processes. As well it is concerned in the implications such perceptions could bring to the RAC industry in solving its staffing challenges. Therefore this research is basic in its intentions and applied in its expectations for further actions and to inform policy.

This research is designed to explore the perceptions of the RAC industry managers on the prospects of adopting non-traditional staffing approaches. According to Blaikie (2003:74) “explanatory research should provide as detailed and accurate a picture of the phenomenon as is necessary to enable the researcher to feel at home and to be able to speak about the research problem with some confidence”. Such a picture and phenomenon, if explored, could assist in determining the prospects of RAC facility managers adopting alternative staffing approaches and, perhaps, their readiness for such approaches.

4.3 Research paradigm

According to Karami, Rowley and Analoui (2006), philosophers interested in science and research methodology had long epistemological debates about the nature of reality being studied and how to access that reality. Their debates revolved around two dominant and fundamentally different schools of thought, the positivist research paradigm and the phenomenological research paradigm. The first is concerned mainly with quantitative data and adopts a deductive pathway to create generalisations via the use of hypotheses. The second adopts an inductive pathway in its understanding of human experience using qualitative data within natural or semi-natural settings. Although the positivist approach has
its strength in relation to applicability and reliability, such strength diminishes as the underlying conditions affecting the data change. The competing phenomenological approach picks up on the in depth/insights of the human experience it brings to the research problem.

According to Broom and Willis (2007:17), “in the context of health care research, a researcher’s paradigmatic positioning relates to their understanding of the nature of knowledge (their epistemological standpoint) and of reality (their ontological standpoint)”. The Interpretivist phenomenological research paradigm supports the notion that knowledge is socially constructed and reality is bound to its beholder. The positivist research paradigm maintains that both knowledge and reality are fixed and can be generated through validated means and methods (Blaikie, 2003; Broom & Willis, 2007; Karami, Rowley, & Analoui, 2006).

In this study, the aim as mentioned earlier is to obtain the perceptions of RAC industry managers in relation to staffing challenges and the prospects of adopting alternative staffing approaches that attend to these challenges. The manager’s view of RAC management in general and staffing in particular is associated with each manager and influenced by his or her experiences, interpretations and situation. Therefore, adopting the Interpretivist research paradigm is suitable for answering the questions and addressing the aim of this study which is to explore the prospects of adopting alternative staffing methods in the RAC industry in Australia.
4.4 The Research strategy

“The construction of meaning is the task of qualitative research and reflects the methods used in the qualitative data analysis process” (Krauss, 2005, p763). The Interpretivist approach to social enquiry has ontological assumptions that view the social world as the social construction of its members. Such a view assumes the presence of multiple realities, relative to the social actor. The epistemological assumption of this research strategy is that knowledge is derived from daily perceptions, associations and socially constructed understandings that expand beyond daily knowledge to encompass circumstances of the social actors; that is to discover and describe the insider’s view of reality rather than imposing an outsider one (Blaikie, 2003, p115). The Interpretivist enquirer also aims to discover why the social actors do what they do by unearthing a large chunk of their embedded tacit knowledge, symbolic meanings, intentions and rules which direct the way they conduct their behaviours. The challenge is then for the researcher to adopt the most suitable research strategy capable of capturing this knowledge and identifying the rules under which the social actors determine what is important and even why it is important.

Abductive research strategy

According to Miller and Brewer (2003 :2) “Abduction refers to the moment of creative inspiration during which the researcher conceives of a hypothetical explanation for some empirical fact”. To Blaikie (2003, p100) this strategy “begins by exploring through everyday language the knowledge that social actors use in the production, reproduction and interpretation of the phenomena under investigation. This is followed by a redescription of this everyday account into special scientific account, and, possibly, into a grounded
explanation”. This is reflected by Schütz 1st and 2nd order constructs (Schütz, 1963). This leads into research techniques of using focused or unstructured interviews to interpret, intersubjectively, the respondents’ meaning.

Ontologically, the abductive research strategy assumes that social reality is the social construction of the social actors. Epistemologically, this strategy assumes that scientific knowledge emerges from the daily concepts and socially-constructed collective knowledge (Blaikie, 2003, 115-116).

4.5 The Research Data

4.5.1 Qualitative verses quantitative

According to Broom and Willis (2007), researchers who choose to conduct their study within the Interpretivist/constructionist research paradigm use qualitative data generated from qualitative research methods such as in-depth interviews, focus groups and ethnographic observations. Such data and research methods are suited to reflect the meaning and knowledge held by the social actors participating in the study. This is the case as the decisions on staffing are made at the facility level and therefore the perceptions of the facility managers as to the likely usefulness of the tool will impact on the likelyhood of adoption. Therefore the data obtained from facility managers are far better suited for the purpose of this research, than quantitative data and quantitative research methods that provide an external description of reality as presented by numbers, averages and graphical displays. To Blaikie (2003: 232):
Quantitative methods are generally concerned with counting and measuring aspects of social life, while qualitative methods are more concerned with producing discursive descriptions and exploring social actors’ meanings and interpretations.

This study pursues qualitative methods to generate qualitative data representing in-depth exploration of the RAC facility managers’ perceptions on staffing, staffing challenges and the prospects of adopting alternative staffing approaches in Australia.

4.5.2 Data settings

One of the characteristics of the Interpretivist paradigm is to generate participants’ meaning at individual level within focused interviews. The research approach is conducted within the natural settings of the social actors (Broom and Willis, 2007). According to Intille, Tapia, Rondoni, Beaudin, Kukla, Agarwal, Bao and Larson (2003), developing products and testing them in unnatural settings, such as in laboratories, often fails when these products are later introduced into natural settings such as homes and workplaces. Human behaviour is strongly affected by their natural settings and by the behaviours of other actors in them (Intille et al, 2007).

In this study, the primary data were obtained from the participating RAC managers and/or directors of nursing in their work environment in the State of Victoria. Conducting the study at the participants’ workplaces supported the naturalistic component of the research paradigm and was intended to create the least distraction and inconvenience for participants.
4.5.3 Sample description

In the RAC industry, officers responsible for the staffing decisions (as identified in chapter 2) are the aged care managers and/or the directors of nursing, referred to in a number of organisations as the director of care. These agents have nursing backgrounds in the main. Their duties extend to cover nonclinical operations such as quality management, hotel services, and financial control. These officers are deemed capable and thus responsible for the staff allocation process. Therefore for the purpose of this study, as identified earlier, the research participants are the RAC managers or the social actors with whom the interviews will be conducted and from whom the data will be generated.

Although RAC managers are responsible for taking staffing decisions within their facilities or organisations, they do not take those decisions in isolation from other factors internal or external to them. The contemporary context chapter as well as the literature review chapter highlighted a number of factors that influence such decisions including: the managers’ knowledge; duties and responsibilities; the size of the agency; business objectives; and the type of services provided. Therefore, to meet the aims of the study in obtaining a representative sample of the industry and to account for the various factors affecting the RAC managers in their staffing decisions, the sample of research participants was drawn based on a number of selection criteria for the participants and their facilities / organisations.

As mentioned above, data were sourced from the administrators of RAC facilities based on their facilities meeting the following criteria:

1) The type of service provided: Administrators were selected to represent the following range of service types: High Care (high dependency residents with a resident classification
score RCS of more than 50, known traditionally as nursing homes); Low Care (low dependency residents with an RCS score of below 50, traditionally known as hostels); and Mixed (facilities with population of residents of both high and low dependencies) as defined in Chapter Two.

2) The affiliation of the facility: Facility administrators were selected to represent the following range of facility structures: One of three facilities (facilities that belong to a group of three facilities owned and operated by one or more owners); part of a group of more than three facilities (as for the first group but the group include more than three facilities); stand alone (when the facility is sole, thus is not part of any group).

3) The size of the facility: Facility administrators were selected to ensure representation of both smaller and larger facilities: 60-beds or less (A) and above 60-beds (B)

4) The business objective of the facility: Facility administrators were selected to ensure representation of both For-profit and Not-for-profit (including charitable) categories

| Table 2.0. The sample selection criteria with the intended number of participating managers |
|---------------------------------|----------------|----------------|----------------|----------------|----------------|
|                                 | High Care      | Low Care       | Mixed          |                |                |
|                                 | For profit     | Not for Profit | For profit     | Not for Profit | For profit     |
| Stand alone                     | 1              | 1              | 1              | 1              | 1              |
| 1 of 3                          | 1              | 1              | 1              | 1              | 1              |
| 4 plus                          | 1              | 1              | 1              | 1              | 1              |

As shown in the table above, the intended number of respondents to be included was 18 RAC managers (one participant for each criterion) to obtain a reasonable coverage of the industry and increase the validity of the data generated.
In total, twenty-two RAC managers were invited (more than the eighteen initially required as per table 2.0) to participate to increase the representativeness of the sample and the validity of the data generated, but four declined. In one facility, the request was for the interview to be conducted by the deputy director of nursing rather than the director as he is the person responsible for staffing. Another RAC manager declined, recommending instead the human resource manager in the head office who also declined. Two more facility managers were invited to participate but they also declined giving no reason. In total eighteen managers agreed to participate and they were interviewed in their workplaces. In these interviews the participants’ perceptions on the topic studied were explored. According to Blaikie (2003) qualitative research is about studying the social reality inhabited by the participants rather than reconstructed reality using demographics. Table 3.0 below provides a description of the participants, their professional background, duties in their organisation, and the type of organisation they represented. It is worth noting that the RAC facilities managers’ background was not targeted unlike the facilities’ characteristics. The backgrounds of RAC facility managers were of various educational levels and from two main professional disciplines, nursing and accounting. Although the mix of educational levels and professional disciplines is a reflection of the variety of facility managers’ background in the RAC industry, RAC facility managers share the same responsibilities for ensuring efficient staffing in their RAC facility/s.
### 4.6 Data generation method

#### 4.6.1 Semi-structured interviews (& rationale for use)

Semi-structured focused interview method data generation was selected because it met the aims and the motives of the study. Semi-structured focused interview is considered to be well able to create an understanding of the participants’ lives and their perceptions on the topic researched (Broom & Willis, 2007). Blaikie (2003: 234) stresses the value of in-depth

<table>
<thead>
<tr>
<th>Interview No.</th>
<th>Title/ Role of the interviewee</th>
<th>Gender</th>
<th>YOE</th>
<th>Services provided</th>
<th>Beds in Facility</th>
<th>Total beds in the Organization</th>
<th>Business objective</th>
<th>Ownership</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Financial Manager</td>
<td>M</td>
<td>3</td>
<td>HC &amp; LC</td>
<td>147</td>
<td>2000 beds</td>
<td>FP, Private</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Regional Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>320</td>
<td>2000 beds</td>
<td>FP, Private</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Financial Manager</td>
<td>F</td>
<td>5</td>
<td>HC &amp; LC</td>
<td>70</td>
<td>2000 beds</td>
<td>FP, Private</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>DON/ Manager</td>
<td>F</td>
<td>3</td>
<td>LC</td>
<td>50</td>
<td>50 beds</td>
<td>NFP, Church</td>
<td>Standalone</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>DON</td>
<td>F</td>
<td>7</td>
<td>HC</td>
<td>60</td>
<td>200 beds</td>
<td>NFP, Com</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Clinical Care Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>131</td>
<td>700 beds</td>
<td>FP, Private</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>DON</td>
<td>F</td>
<td>1</td>
<td>HC</td>
<td>30</td>
<td>250 beds</td>
<td>NFP, Church</td>
<td>Multisite</td>
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</tr>
<tr>
<td>8</td>
<td>Executive DON</td>
<td>F</td>
<td>10</td>
<td>HC &amp; LC</td>
<td>700</td>
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<td>FP, Private</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>DON/ Manager</td>
<td>F</td>
<td>5</td>
<td>HC &amp; LC</td>
<td>90</td>
<td>210 beds</td>
<td>NFP, Council</td>
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<td>F</td>
<td>4</td>
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<td>NFP, Church</td>
<td>Standalone</td>
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<td>Multisite</td>
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<td>M</td>
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<td>Standalone</td>
<td></td>
</tr>
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<td>13</td>
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<td>M</td>
<td>2</td>
<td>HC &amp; LC</td>
<td>88</td>
<td>88 beds</td>
<td>NFP, Com</td>
<td>Standalone</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Quality/ Clinical Care Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>130</td>
<td>130 beds</td>
<td>NFP, Church</td>
<td>Standalone</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Manager</td>
<td>F</td>
<td>2</td>
<td>LC</td>
<td>75</td>
<td>600 beds</td>
<td>FP, Private</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Nursing Coordinator</td>
<td>F</td>
<td>5</td>
<td>HC &amp; LC</td>
<td>495</td>
<td>495 beds</td>
<td>NFP, State</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Clinical Nurse Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>100</td>
<td>495 Beds</td>
<td>NFP, State</td>
<td>Multisite</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Residential Care Manager</td>
<td>F</td>
<td>6 weeks</td>
<td>HC &amp; LC</td>
<td>495</td>
<td>495 Beds</td>
<td>NFP, State</td>
<td>Multisite</td>
<td></td>
</tr>
</tbody>
</table>

**HC**: High Care, **LC**: Low Care, **NFP**: Not for Profit, **FP**: for profit, **Com**: community, **YOE**: Years of employment at current employer.
interviews as they assist the researcher to “get close to the social actors’ meanings and interpretation of the social interaction in which they have been involved”. Collis and Hussey (2003) highlight a number of benefits for interviews as a research method including the ability to understand the constructs on which participants based their opinion, and the ability to ask follow up questions; this provided a clear support for achieving confidence in the replies of the participants.

According to Broom and Willis (2007) the semi-structured interview is one research method utilized by an Interpretivist paradigm which pursues ‘understanding’ with a focus on subjective meaning and interpretation as negotiated inter-subjectively in a social context. It gathers qualitative data from the subjects in their natural settings, with attention focused on in-depth analysis rather than inference.

4.6.2 Suitability of the instrument

The choice of this instrument is influenced by the nature of the research topic and had insightful implications on the design (Miller & Brewer, 2003 ). The semi-structured interview was chosen for its capability to capture the prospects of participating RAC managers address themselves to the research question of the study. This instrument can generate qualitative data by creating an opportunity (the interview) that allows a respondent the time and scope to talk about their opinions on a particular subject. In the interviews conducted, the objective was to understand respondents’ points of view rather than make generalisations about their behaviour. This instrument, through its use of open-ended questions, provided the researcher with the data required to identify the participants’ knowledge on staffing, of alternative
staffing systems as well as their perception on the likelihood of adopting alternative staffing models in their organisation.

4.6.3 Design of the instrument

The research instrument included ten open-ended questions set from a general to specific order to limit the effect of what is sometimes referred to as a ‘part-whole effect’. This effect usually occurs when the reverse order is implemented leading the respondents into focused responses and neglecting the valuable bigger picture answers (Miller & Brewer, 2003). The instrument includes general technical terminology assumed to be known by the respondents due to their duties and responsibilities.

The research instrument was pre-tested in the first three interviews resulting in changes to the order of the questions. Initially, the responses of the participants to the first questions were very concise. The interviewer felt that the interviewees had some difficulty starting to elaborate on operational efficiency and its connection to the RAC industry. Therefore, question 10 which was intended to be a summary question was brought forward (and question 1 was placed last) and succeeded in introducing the interviewees to the theme of the interviews and thus generated data with better flow and value. (A copy of the instrument used in the interviews is included as appendix B).

4.6.4 Data generation process

Interview preparation was followed by the researcher contacting the participants to introduce himself, the university through which he was conducting the study, the topic, and the expected contribution of the participant. The researcher requested permission for an interview at a time suitable to the interviewee. When permission was granted, an interview was scheduled and an invitation letter was sent by mail to each of the participants. This letter
(see appendix D) included a formal invitation, a summary of the topic being researched, the expected contribution of the participant, as well as an overview of rights of the participant and the names of the contacts he or she could contact to verify the researcher’s claims and requests.

Eighteen interviews were conducted at the participants’ workplaces, during which a set of interview questions was asked and a sample of an alternative staffing module was presented (see chapter 2). Prior to starting each interview, the researcher reminded the participant of the topic, the aim, and his/her rights as per the letter of invitation. Each interview was conducted over 45-60 minutes in full, allocating 15 minutes for the concept questions, 15 minutes for the module presentation and 15 minutes for the interviewees’ opinion on the module. All the comments generated during the interviews were recorded using a Dictaphone (tape recorder). Data transcription for each interview and all questions including any observations by the interviewer, were completed in the same day or the next at the most. The reason for the speed in completing the data transcribing was to avoid the loss of any vital observation or comment (data) during the interviews. The comments were then transcribed, grouped, and reduced for analysis.

4.7 Data reduction and analysis

Analysing the data generated from the semi-structured interviews conducted at the participants’ workplace was the next logical step to take. To meet the aim and the motives of the study, that is, to explore the prospects of RAC managers adopting alternative staffing approaches, the qualitative data generated preserved the meaning of the interviewees and concepts were then developed. According to Blaikie (2003: 240-241), “methods of
qualitative analysis differ in the extent to which they attempt to ‘retain the integrity of the phenomenon’. That is, the extent to which the researcher remains close to the language, the concepts and meanings of the social actors rather than imposing their own concepts and categories on lay accounts”. Blaikie added that there are two choices for the researcher to choose from, a ‘high stance’ choice and a ‘low stance’ one when developing concepts from data analysis. In the former, the researcher imposes his/her concepts (or concepts derived from the literature reviewed) and in the latter the concepts are drawn from the social actors themselves through the data generated. To Blaikie, abductive research strategy, such as the strategy adopted in this study, involves a low stance one as the researcher plans to develop his concepts from the comments provided by the participants in their own plain language.

This study adopted a ‘low stance’ approach in its data analysis processes for three key reasons. First, the interest was in exploring the RAC managers’ perceptions of adoption of alternative staffing approaches (please refer to chapter 2); Second, the researcher did not aim to impose external concepts on participants such as those highlighted in the contemporary context and literature review chapter. Third, the researcher wanted to avoid imposing his own concepts and perceptions as derived by his knowledge and experience in the RAC industry. Therefore, the adoption of a ‘low stance’ approach in the data analysis was the most appropriate in accordance with the abductive research strategy utilised and the exploratory nature of this research.

Consequently, the data generated from the interviews was coded in preparation for data analysis. According to Blaikie (2003: 239) “the central activity in qualitative data analysis is a special form of coding. Such coding can facilitate description, but is also used for analysis and theory generation”. Coding comprises two main stages, open coding and axial coding.
The first involves breaking down and grouping the data into categories and subcategories dissecting each observation, comment or group of words and providing them with a name that represents a concept or a phenomenon. The second involves finding relationships between the categories and the sub-categories, upon which core categories are formed and narrative descriptions are constructed. In other words 1st order and 2nd order constructs were formed. In the first, the meaning was generated by the participants and in the second, the meaning was derived from the researcher’s description (Miller & Brewer, 2003; Schütz, 1963).

In other words, the researcher took the following steps in data reduction and analysis:

**Step one:** Personal collection of the data generated from the semi-structured interviews using a Dictaphone. Data transcription took place on the day of collection and included addition of researcher’s observations and any relevant notes. From this the researcher developed an individual log for each interviewee which included the details of interviewee, the facility s/he works for and facility and any other relevant information.

**Step two:** First order constructs were developed based on the meanings given by the participants. ‘Open coding’ techniques were used to reduce the data generated. This process included dissecting the comments collected into the smallest meaningful notions, counting occurrences, and studying the effects of the interviewees’ backgrounds, their facilities’ characteristics and then re-grouping these categories under condensed or distilled concepts. As a result, second order constructs were formed (Schütz, 1963).
Step three: Analysis of each of the newly-formed categories using ‘axial coding’ techniques. In this step, the researcher searched for relationships between the various categories, interviewees’ characteristics and facility descriptions; thus, rebuilding themes and concepts which is a crucial step to reveal meaning and relationships (Collis and Hussey, 2003). In this step the researcher generated meaning and concepts without imposing any external experiences or concepts (including the researcher’s).

Step four: Analysis of the data generated, taking into consideration the relationships surfacing between the categories formed and themes noted, the structure and the challenges of the RAC industry (as listed in the contemporary context chapter), the displayed sample alternative staffing tool and the findings of the literature review chapter. The data analysis took into consideration neo-liberal policies adopted not only in Australia but also in the majority of the western economies (Harman, 2007).

4.8 Methodological limitations

This study has exploratory aims and motives that are to explore the prospects of RAC facility managers adopting alternative staffing approaches. For this reason, the researcher adopted an Interpretivist research paradigm obtaining qualitative data through the use of semi-structured interviews. This research methodology raises a number of limitations which mainly revolve around issues of reliability and validity and those of generalisability (Broom and Willis, 2007). On the first, Blaikie (2003: 36) comments: “the social world is already interpreted before the social scientist arrives”, and on the second no efforts or claims will be made on the generalisability of the findings on the RAC industry in Australia. In fact generalisability is
irrelevant as the study is looking for the range of meanings, not the statistical representation of a generalised population. Furthermore, the researcher has put all efforts to follow objectivity and uniformity in conducting the interviews, recording the comments, and analysing the data. This was done by following the list and the sequence of the questions (except in the first 3) as well as transcribing the data collected on the same day or the following day to capture and put into context the participants’ non-verbal cues and any other relevant notes or circumstances.

4.9 Ethical Considerations

As included in the data generation section, before commencing the study, the researcher requested the approval of the university and the participating aged care providers’ ethics committee (if required). The researcher also prepared the participants in an introduction letter mailed to them (Appendix D), informing them with a brief overview of the topic being researched, the sections of the interview, their right to ask questions, the right to withdraw from the interview at any time, as well as the confidentiality of the discussions and data collected. The above was re-emphasised (and taped) at the beginning of each interview. The participants were given at the interview the choice to sign an informed consent explaining purpose and the benefits of the research (appendix D). However, no one opted for this choice.

Strict confidentiality was adhered to with the information obtained as the participants will remain anonymous. The findings and data collected have been reported anonymously. The researcher and the main supervisor were available to answer questions and inquiries regarding any aspect of the study.
4.10 Summary of chapter

This chapter discussed the research question, research paradigm, the research methodology and the research tool adopted in this study, its relevance to the topic of study, the process followed, and a brief overview on the research methodology limitations and ethical considerations. This chapter forms a crucial step in this study as it elaborated the research methodology adopted to explore the prospects of RAC facility managers in Australia adopting alternative staffing approaches. The next chapter reports the research findings of this study.
Chapter 5  
Research Findings

5.1  Introduction

This chapter presents the findings of the data generated in the semi-structured interviews conducted for the purpose of exploring the prospects of Australian RAC managers adopting alternative staffing approaches (the research question). This chapter presents participants’ comments in categories and themes then discusses the relationships highlighted by the data analysis. To aid the data presentation, relevant summary tables and direct quotations from the participants are included.

It is worth noting that, as an Interpretivist study, this study seeks the range and depth of meanings held by the RAC facility managers represented by the participants rather than provision of a definite answer on the prospects of adopting alternative staffing approaches. To meet this purpose and the objectives of adding to the body of knowledge and practice in the area of RAC staffing, the researcher presents the data (findings) then analyses the data generated. Data are analysed utilising a non-quantifying method of qualitative data analysis, open and axial coding to develop higher concepts and models. This method has been explained in the previous chapter and involves “examining and reflecting on perceptions in order to gain an understanding of social and human activities” (Collis and Hussey, 2003: 13) as well as categorising the data generated into groups, concepts and later on linking them at a higher conceptual level, an overall paradigm model in congruence with the research study (Collis & Hussey, 2003). Blaikie (2003: 239) states: “the central activity in qualitative data analysis is a special form of coding. Such coding can facilitate description, but is also used for analysis and theory generation”.

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5.2 Results

In this section the author presents the findings of the 18 semi-structured interviews conducted in the participants’ workplaces. The findings from the data generated are as follows: (To explore the source of the comment, please match the number following with the participants’ number and characteristics included in appendix B).

5.2.1 Industry Challenges

When the participants were asked to list the challenges and concerns that are currently facing the RAC industry in Australia, the majority of the responses included the following categories: ‘declining qualities of staff’ and ‘staff shortages’ followed by ‘staffing challenges’, ‘staff management’ and ‘poor staff incentives’. ‘Declining Government funding’ and ‘inflexible systems’ followed as well as ‘internal financial challenges’, ‘increased customer expectations’, ‘low image among the public’, ‘building design’, ‘fluctuation in residents’ dependency’ and ‘poor stakeholder commitment’ where also listed but by fewer participants (Appendix C, table 5.0).

Comments on industry challenges include:

*It is bottom line driven (1)*

*Competition in the future will be service driven, staff level driven (2)*

*It is going to be harder in the health industry in relation to staff, we have reached the stage we said five years ago we are not going to reach (3)*
Funding will be very different, more user pay system, targeting a different market, different care needs, self-funded retirees will be paying for their care. (3)

I think the industry is in a shambles, you cannot run an aged care business; it is very hard to operate an investment in RAC, there very few people making money (5)

RNs are becoming more and more gate keepers, one or two in each facility due to wage costs. (5)

They are not there for their resident, they do their hours then they expect to go home.(6)

The Government funding (7)

Finding people committed to aged care (8)

Recruiting is a huge challenge (9)

We are over regulated; there is a requirement to be registered to obtain funding (8)

We are always the poor sister of acute care (16)

I feel politicians are making decisions for the facilities without actual knowledge on the work required at a facility level (17)

5.2.2 Operational efficiency

When the interviewees were asked to elaborate if their organisation is at a level of operational efficiency, seven of the interviewees did not answer, four said “yes” and the other four said “no”. Only one interviewee elaborated on her answer (no) by saying that her facility has been recently bought by a new corporation and they need further time to reach operational efficiency (for a list of the responses refer to Appendix C, table 6.0).

Some of the participants’ comments on operational efficiency were:

When the manager possesses the right skills (1)

Using your resources efficiently to have a better outcome for your business (3)
You have met the expected budget (11)

The money that comes is all we can use; we cannot have any more (13)

To have the right levels of staff, to have the right systems and processes and for the staff to follow the system (18)

Looking at the participants’ comments related to their interpretation of operational efficiency from a higher level, the majority listed bottom line-related factors followed by the existence of established systems and capable staff. Half of the interviewees listed multiple measures.

5.2.3 Operational efficiency and staffing levels

Further on, the participants were asked to comment on the nature of the relationship between operational efficiency and staffing levels. The answers to this question were inconsistent. One-third of interviewees gave no answer, one half said that there is a relationship, four reported direct relationship and three indirect relationships. Three participants said that there is no relationship between operational efficiency and staffing levels (Appendix C, table 7.0).

A number of the participants’ comments on operational efficiency included:

When the facility is well designed so that the staff could work comfortably with the residents (1)

To obtain your business objectives with minimum staff (5)

High levels of staff does not necessarily equate with high level of quality. (6)

There are a number of variables, the skills and the abilities of nurses make a big difference (11)

5.2.4 Staffing system adopted:

When asked about the staffing approach or rostering system utilised in their facility/organisation, the most prevalent method listed was “staff ratios” followed by “trial and error” and “budget driven”. Half of the respondents listed one staffing method, the other half listed
two or more, one participant listed six methods and one other participant did not answer (Appendix C, table 9.0).

Participants’ comments on the above included:

We start from the absolute minimum then we build up (1)

I do not follow a staffing model in particular (3)

You start your master roster from the budget and then you match your roster from what you are allowed (5)

We observe and take decisions, and by trial and error (10)

EBA (enterprise bargaining agreement with the union) guidelines (17)

5.2.5 The effectiveness of the staffing system adopted:

When the researcher enquired if the staffing system adopted in the participants’ organisation meets their operational goals, financial targets, quality requirements, staff wishes, the residents’ needs and in what way, more than half of participants answered “yes” but only one gave a justification for the answer. More than one-third said “no” with only two providing justifications for their answer listing for example: “there is a lot to meet”, “the system is designed to meet the budget and the staff availability first before anything else” and “we don’t have the data to prove it”. One interviewee neither gave an answer nor a justification (Appendix C, table 12).

Participants’ comments on the above included:

No, it doesn’t, there are flaws in it. (1)

Not so much. (2)

Yes, (on the financial targets) it comes from the organisation as they have set targets on how much they should make on the money they invested and on each licence.(3)
It seems so; we don't have a data to prove it. (4)

Yes, we are well resourced by all types of staff skills; we have staff that have been here for years (9)

I think ratios do not work; we need a better system (16)

5.2.6 Familiarity with other staffing systems:

When the participants were asked if they were familiar with staffing systems or tools other than the one/s currently utilised in the participant’s facility, three interviewees answered “yes,” each listing one system including “benchmarking to RCS mix”, “staff ratios” and “split shifts”. Nearly two-thirds of the participants answered with “no” and one-fifth did not answer (Appendix C, table 10.0).

Participants comments on the above included were mostly a “yes” or “no” but the ones who elaborated said:

Not that I am aware of any (12)

Yes, for example split shifts but that was many years ago and was based only on full time staff, flexibility, family friendly (13)

Not very many (14)

Sharing staff among facilities (15)

5.2.7 The likelihood of adopting a different staffing system

Following this, the participants were asked if they would adopt a staffing system that could meet the industry challenges and their organisation’s goals. They were also asked to comment and elaborate on the rationales for their decision and the characteristics of such staffing system (Appendix C, table 11).
Some of the interviewees’ comments included:

No comments. (1)

“I am very open; you need to be a brave person to put your hand up”. (2)

No comments. (3)

“I would be always interested, for best practice”. (4)

“Certainly, if somebody can come up with a better idea”. (5)

“The system currently used is entrenched in our management company (name omitted)”, “(name omitted) are still learning and they are open for suggestions, and they do listen to their staff”, “Changing people is very hard, it takes energy, enthusiasm, and change, but I am working on it, I don’t have a recipe yet but I have the ingredients for it”, “a system that is flexible, a small change on person working on other days”, “A system that provides incentives”, “a system that provides remunerations for extra duties and skills”.(6)

“A system that allows flexible rostering”.(7)

“The system that allows the staff to have some say over rostering, a staff driven, allows a flatter organisation, a system that allows input from the residents”.(8)

“A system that allows spreading your hours across the twenty-four hours, able to determine when your peaks and troughs are, able to utilise the staff in the peaks and the troughs, if you do not need a RN overnight but only at ten and seven, so you only roster an RN only at these times.”. (9)

“I don’t think computers will help me in staffing. I prefer my own judgement”.(10)

“Flexibility, ability to meet the residents’ care-outcomes, staff needs, budget”. (11)

“ We need to know what qualifications the staff need to be, how many staff we need to have, the residents’ needs, the time that is needed to meet these needs, the expectation of the staff member to meet these needs, if that system exist it be worth looking at”. (12)

“you need to identify your needs, to provide care to residents more flexibly for example the seven to nine showers, so if you set flexibility in the input, try to match the staff to the residents’ needs, a good EBA, listen to staff and the residents’ wishes, the attitude that you take, no blame approach”. (13)

“It catches the needs of the residents, the types of the residents, skills staff mix, the personalities, and flexibility as staff requesting leave, and having a good bank/casual system, the staff preference for the shift (long/short/early/late/…))”.(14)

“Flexible system, I don't like a ratio system”. (15)
I would like a flexible method, a one without staff ratios based on the level of care needs, reviewed on a daily basis. As care need change staff numbers change. (16)

Yes I would. Others will as well unless there are unions or other hurdles. The current systems are black and white not flexible. (16)

A system that is flexible and meet the care needs of the residents, it has to be however be ratified by the union first, it is not the numbers it is the flexibility. (17)

I do not know if there is a market for such system, there is a shortage of staff, could a system help with that? The solution is not a new staffing system. It is a two pronged action attracting staff and a new staffing system. Actually it is three pronged: better documentation system, attracting staff and have workforce planning for them and a new staffing system. (17)

No, we can not in this organisation we are bound by the EBA. (18)

In summary, most participants listed a number of features/deliverables that they would like to see in an alternative staffing approach. In general they were positive but gave no clear indication of the likelihood of adopting such staffing system if it existed. As for listing the features of this system, ‘flexibility in rostering’ was the feature most requested.

5.2.8 Demonstration of an alternative staffing method

Further on the interviewer demonstrated an example of an alternative staffing system that is not currently used in the RAC industry and different from the staffing systems listed earlier and currently used by the participants.

The participants during this demonstration expressed a number of comments; these included:

It is too hard

I have seen similar programs before (!) (10)

It is a good guide (10)

My Gosh, my Gosh, I like it. (14)I don't agree with you that feeding requires 10 mins only (8)

What is the benefit of this model with so much fluidity? (8)
It does not allocate work it only gives blocks (12)

How can I get access to this? Good, wow, it would have taken you a lot of time, excellent (13)

5.2.9 Evaluation of the demonstrated staffing method

When the participants were requested to list the strengths and the weaknesses of the system presented earlier, most of the interviewees listed a number of strengths and weaknesses except two who each listed one. More than one-third of the respondents had more weaknesses than strengths, one-third had equal number of strengths and weaknesses, and less than one-third had more strengths than weaknesses. (Please refer to Appendix C, table 11.0)

One, of the four participants who expressed no weaknesses for the presented system, had doubts about the applicability of the system. All the other (more than two-thirds) had doubts about the applicability of such system.

Participants’ comments on the above included:

It is a good base unlike anything I have seen before (1)

Setting up is a shortfall (2)

It is a control tool for the user; it highlights the hours required (3)

It needs to be tested (5)

Some ‘old’ Directors of Nursing might have difficulties with computers, but a number of the new DONs will be alright (11)

Very flexible, it gives even the financial costs. (16)

It is good to show the cost incurred. Good data on completion. As for the negatives, lot of data entry, it is not suitable for an organisation like others in which we have multiple departments running different services and we have EBA. (18)
5.2.10 Prospects of adopting the demonstrated staffing system in the participants’ facilities (refer to chapter 2 section 2.6.3):

Finally when asked if they would adopt this system when staffing their facilities, a little less than one-third of the participants said “yes”. The same number did not answer (although two of them in the previous question gave more strengths than weaknesses to the presented system), and nearly half said “no”, providing a number of reasons (please also refer to the Appendix C, table 12.0):

**Participants’ comments on the above included:**

*Yes, but not this format, in my current organisation it is not possible, it is done in head office (3)*

*In such an environment, I would not as I would like to keep in touch with my staff and thus use my personal judgement (5)*

*If I work from head office or from a distance I would. Good for benchmarking others would say yes, especially financial managers (4)*

*I don’t think managers will have any difficulty using it (4)*

*Cost would be an issue, the size of the facility, the distance from the floor (4)*

*It can not be assumed to be applied for everybody (8)*

*It does not allow for the peaks and troughs, especially if an emergency occurs at certain times (8)*

*Yes, I would. Managers who refuse to use would be the ones that do not like to think outside the box, not used to change. (16)*

*I guess the question has always been that we nurses know what is best for our patients and colleagues. How can a calculator or system tells us what to do? The other issue we have a bottom line that we have to meet, the staffing system can advice us on the numbers but we have to allocate according to the budget. I will give it a go, other managers will do too, and then I will massage it to suite my facility. (17)*

*No, we can not do it because of the EBA; it dictates what staff hours we have. But the EBA is not such a bad thing, as we have higher staff hours than others in the RACI. (18)*
5.3 Data analysis

The previous section listed participants’ replies, comments and answers generated from the semi-structured interviews conducted at the participants’ workplaces. In this section, the author analyses the data generated describing the sample characteristics then the findings in the form of themes. The data generated, pass through a number of stages transforming it from raw information to concepts, then to knowledge. During this process the researcher adopts a ‘low stance’ approach utilising the abductive research techniques in its purest form (Blaikie, 2003). There was no use of any data analysis software in the analysis or the grouping for the data generated.

5.3.1 Data description

This section reduces the data generated listing occurrences, patterns, and points of similarities.

The participants expressed a number of perceptions and comments on the challenges facing the RAC industry. They included comments on staff quality, staff shortages, staff management, staff incentives, funding challenges, financial challenges, systems challenges, increased customer expectations, residents’ care requirements challenges, poor industry image, and building design challenges. Those comments were grouped into three main categories: Staffing challenges (half of the reported challenges), financial challenges (one-fifth of the challenges), and other challenges (one-third of the challenges).
The respondents’ perceptions on operational efficiency included ‘bottom line’ (by two-thirds of the respondents) and the presence of ‘quality systems’ (by little more than one-third of the respondents) as the two major measures of operational efficiency. On the other hand, ‘good staffing’, ‘good leadership’, and ‘quality care’ were listed by one to three respondents only. Hence, these comments could be grouped into two major groups, ‘financial efficiency’ and ‘system efficiency’. The other responses are grouped under the category of ‘other’ (including staffing and quality care).

Respondents’ comments on the relationship between operational efficiency and staffing efficiency are grouped into four categories, one large category (including one-third of the responses) and three relatively equally-sized small categories. The large category is the one that includes a ‘no’ response from the participants and the other three smaller categories are the ‘direct relationship’, the ‘indirect relationship’ and the ‘no relationship’ categories.

The comments expressed on the staffing method adopted by the participants’ facilities may be grouped in different ways. The first is by the number of staffing methods reported and the second is by the type of method adopted. In the first, two categories emerge: ‘single method’ (nearly half of the respondents) and ‘two or more methods’ (one-third of the respondents). In the second three major categories emerge, ‘staff ratio’ (half of the respondents), ‘trial and error’ (one third of the respondents), ‘budget driven’ (less than one-third of the respondents). One major note from these responses is that three of the respondents listed that they use three or more staffing methods in their facility/organisation.

The value perceived by the participants on their adopted staffing method could be grouped in two categories: the ‘yes’ (more than half of the respondents) and the ‘no’ (one-third). Two
further categories could be created for the rationale: 1) ‘Not given’ (the majority of respondents) and ‘given’ (three respondents). 2) No relationship between the ‘yes’ and the ‘no’ answers from one side and providing the rationale from the other.

The participants’ knowledge of other staffing systems generated two categories: ‘no other system’ (the majority of respondents) and ‘one other system’ categories (three respondents only).

Participants’ comments on the likelihood of adopting a newly-developed staffing method that met all the challenges they listed earlier were as diverse as the attributes of the participants and the characteristics of their facilities. There are two groupings possible; One group who did not answer or said ‘no,’ and one group that said it is possible but gave a vague answer.

The comments of the participants on the displayed sample staffing system could be grouped in two major groups: those who expressed doubt on the applicability of such a staffing tool to RAC (majority of the respondents) and those who expressed no doubts about the applicability of such tool (three respondents only).

Comments on the likelihood of adopting a staffing system/tool similar to one the presented in the interview could be grouped in three main groups: a large group (half of the respondents) who responded with the “no” answer, and two equal groups, the one that provided the “yes” answer and the last which did not provide an answer.

At this level of data analysis, the open coding method of data reduction produced a number of categories for use in the process of exploring the prospects of adopting alternative staffing
approaches in the RAC industry in Australia. At this level of the data reduction, the researcher’s main aim was to appreciate the participants’ understanding of staffing, its relationship with operational efficiency (within the RAC facilities) as well as their readiness to embrace change in this area. The categories generated are utilised for further mapping and analysis to develop an understanding of the phenomenon under study. This occurred at the next level of data analysis in which the relationships and inter-relationships between these categories was studied to build higher concepts, frameworks and knowledge from the question researched. The following level of data analysis involves the formation of themes through the use of axial coding techniques.

5.3.2 Themes and frames

In this section, the data analysis continues through efforts to extract the meaning from the categories previously identified. Using axial coding techniques, the researcher explored the relationships between the various categories identified in the previous level of data analysis. Based on the relationships identified, the data were presented in the form of themes which were reviewed in the context of the industry structure, the literature reviewed and the aim and objectives of this study. The identified themes are, therefore, based on comments and perceptions expressed in response to the structured interview questions designed to explore the prospects of adopting alternative staffing approaches in the RAC industry. The four main themes are:

1st theme: Dominance of financial measures in influencing the staffing methods utilised.

This theme was developed from the comments of the participants on operational efficiency, challenges facing the industry and staffing methods adopted. There were clear relationships
between the various categories and subcategories. A general consensus among the participants was the link between operational efficiency and financial efficiency; stressing the greater importance of meeting financial goals over listing ‘bottom line’ as the abundant efficiency measure. Also highlighted was the influence of ‘the budget’ on the day-to-day running of the facilities.

2nd theme: Dissatisfaction with the currently adopted staffing methods and distrust in their capability to deal with the overwhelming staffing challenges.

This theme was developed from the participants’ comments on the size of the challenges facing the industry, their perceived value of the currently adopted staffing methods and the list of characteristics they would like to have in any alternative staffing method.

3rd theme: Limited knowledge in staffing and HR management.

This theme emerged explicitly from the participants’ comments on operational efficiency, the relationship between the operational efficiency and staffing efficiency, currently adopted staffing methods, knowledge of staffing options including available staffing tools, alternative staffing systems and implicitly from the participants’ general inability to provide rationales or explanations for their comments.

4th theme: Hesitancy to adopt new staffing methods.

This final theme emerged from the participants’ comments on the challenges facing the industry, the comments on the displayed staffing method and the comments on the likelihood of adopting the displayed method in their facility. The comments generated provided explicit and implicit connotations of a general disinterest in change. There was also an expressed
sense of hopelessness and inability to change the existing systems, with a common expectation of things getting worse.

5.5 Chapter summary:

This chapter has presented and analysed the comments generated from participants during the semi-structured interviews conducted at the participants’ workplaces. The author, through the use of open coding techniques, reduced the data and grouped it into categories and sub-categories. This process was followed by a higher level of data analysis which involved studying connections and the relationships between the categories and sub-categories from which were formed four main themes. The themes revealed the dominant influence of financial measures on the staffing processes, dissatisfaction with the currently adopted staffing methods, the limited knowledge of the participants in the area of staffing, and general reluctance to adopt alternative staffing methods. The next chapter includes data interpretation and discussion.
Chapter 6- Data Interpretation

6.1. Introduction

In this chapter, the author analyses the data generated from the semi-structured interviews as presented in the previous chapter, the data generation chapter. The interviews referred to were conducted in the workplace of 18 RAC facility managers who agreed to participate in this study. This study has included an innovative research approach aimed at supporting the research methodology through the display of a sample alternative staffing tool, designed by the researcher, during the interviews. The comments provided by the participants on this tool are used to support the data interpretation.

The data generated from the participants’ comments highlighted a number of issues relating to the participants’ facilities, the RAC industry, and RAC workforce staffing. This research, which aims to explore the prospects of RAC facility managers adopting alternative staffing approaches, has revealed four common themes which emerged regardless of participants’ background, expertise, position, years of engagement with the employer and other factors. The emergence of these themes was also not influenced by the facilities’ characteristics, such as size, care provided and business objectives as the data obtained from the participants and later grouped into themes had no relation to the characteristics of neither the participants nor their facility. This chapter elaborates on each of these themes and interprets the data with consideration of the industry’s structure and challenges as listed in the contemporary context chapter and the findings of the literature review chapter. The study also utilises the neo-liberal policies in the data interpretation due to its relevance and application to the Australian economy in general and the RAC industry in particular. As mentioned earlier, the Australian
Government’s initiatives, policies and regulations greatly influence the RAC industry: It is the primary source of funding and issuer of licenses to practice. The licences are conditional upon facilities’ compliance with Australian Government acts and regulations. The chapter progresses to discuss data generated from the perspectives of the individual RAC facility managers, the RAC facility service providers, the RAC industry and finally the federal government at the policy level. Following this discussion, the author describes the implications of findings on the industry and the changes required. A final and brief discussion on the limitations of the findings follows. The data interpretation presented in this chapter builds on previous chapters, particularly data generation and results, and is followed by the study summation and recommendations, in the concluding chapter.

6.2. Relevance of the findings in context of the published literature

In light of the literature reviewed, there were similarities and differences between the comments of the participants in this study and the work of other authors. The comments of a number of participants were similar to the findings of the literature reviewed in three main areas: 1) the challenges facing the Australian industry (possibly a result of such challenges being experienced on a daily basis by the participants); 2) the inadequacy of the currently adopted staffing processes and tools, although not expressed clearly by most participants; and, 3) the reluctance of the participants to endorse change or even express supportive comments towards it.

On the other hand, there were differences between the comments expressed by the participants and the literature reviewed. The differences were in two main areas: First, the lack of acknowledgement of the relevance of staffing processes to the efficient running of RAC facilities. This was a clear divergence from national and international published
literature which stressed the direct connection between the two. One reason for this difference
may be the limited knowledge and experience of the participants in RAC management or
management in general. The second area is the limited interest expressed for the adoption of
alternative staffing tools and processes. Again, this is a clear divergence from national and
international published literature most of which advocates the need to adopt alternative
staffing approaches.

6.3. RAC managers’ perception of the staffing methods

As presented earlier, during the process of data generation and data analysis, transcription
and coding, a number of issues kept emerging which were grouped into four main themes.
The emerging themes and the underlying comments that led to their formation were
considered as representations of the participants’ perceptions of the area under study. To
explore these perceptions, the author analyses each of the four themes and comments on them
taking into consideration the influences of neo-liberal policies on the Australian economy, the
structure of the RAC industry and utilising personal practical experience as a RAC facility
manager, quality assessor and professional consultant.

6.3.1. Dominance of financial measures in influencing the staffing methods utilised

Explicit and implicit comments from all participants, related to the financial challenges
and/or budgetary expectations, caused this theme to emerge. The comments were given
irrespective of the topics discussed in the interview. Examples of these comments include:

(N.B. to track the source of the listed participants’ comments ‘in italics’, please compare the
following number with the list in appendix B)
Yes, (on the financial targets) it comes from the organisation as they have set targets on how much they should make on the money they invested and on each licence (3)

To obtain your business objectives with minimum staff (4)

You need to start at what level of profit margin is acceptable and you go up from there (5)

You have met the expected budget (11)

An example of an implicit comment that refers to financial challenges would be the comment from participant (4) listed above. Other comments were as explicit in their reference to financial challenges as the ones from participants (3, 5 and 11). A number of reasons could be posited for the large number of participant references to financial challenges. Some are listed below.

1) The adoption of neo-liberal policies in the Australian economy highlights the principles of free market and monetary measures. Meeting financial targets of the RAC facilities is part of the participants’ responsibilities as operational managers. They have financial goals to meet and financial viability is non-negotiable. These expectations are common to all Australian RAC facilities regardless of size, location, ownership or business objective (for-profit, not-for-profit, religious, community, or privately-owned). In support of this, Stack (2005) reports the Federal Government direction, demonstrated in establishment of a range of performance management systems to support funding arrangements with service providers and, indirectly, to link profitability, efficiency, and viability with cost control measures rather than with quality services provision.

2) The RAC industry, being a service industry, is labour intensive (Lewis, 2005). All of its services are dependent on the physical presence of and direct interaction between carers (e.g., nurses and non nurses), support workers (e.g., kitchen and laundry staff), and residents. The
corresponding budget for the RAC workforce could reach up to 70-80% of the operational cost (Stanton et al., 2005). This is a typical service industry scenario made worse when costly replacement staff are required for occasional holiday periods and staff relief.

3) The RAC industry avenues for revenue are regulated by Government legislation (The Department of Health and Ageing, 2007; Stanton et al. 2005) and intense competition from service providers for the high-end side (only) of the market. Unless a facility has been categorised by the Federal Government to provide extra services and it is able to attract elderly customers with certain levels of assets, it cannot charge more than a set daily fee determined by the Government and indexed yearly according to gross domestic profit (Department of Health and Ageing, 2007). Any efforts to charge ‘extra fees’, under the exempt extra services category, requires substantial investments in building and infrastructure. Such investments incur financial burdens, loan repayments and maintenance costs. It is worth noting that adoption of extra services status decreases the subsidies received from the Federal Government (WestWoodspice, 2003).

4) Revenue is one of the few measures available to assess facility success as a business in the absence of other quality measures. The revenue per bed is one measure to determine the financial efficiency of RAC facilities. This measure is applied when facilities are listed for sale or are seeking additional bed licenses. (The Australian Government will fund facilities only according to bed licences.).

The unexpected finding of the study was the displayed staffing tool’s failure to attract participants’ attention. The tool is designed to support financial decisions and to ensure
staffing cost does not exceed Government subsidies. This finding is discussed in the 4\textsuperscript{th} theme (6.3.4) listed below.

In summary, the emergence of this theme came as no surprise to the researcher. As revealed in the literature reviewed, the Australian Government has commissioned recently two major reviews based solely on financial measures; 1) ‘The Review of Pricing Arrangements in Residential Aged Care’ by Hogan in 2004; and 2) ‘The Productivity Commission’ in 2008. Meeting the financial goals for each facility manager is a fundamental key performance indicator, a necessity for sustainability, and a reasonable expectation for service providers who entered the market lured by the return on investment the RAC industry promises. Nevertheless, influences of neo-liberal policies on the RAC industry with its free market principles are based on supply and demand can have serious implications on the industry as will be shown in the following themes and analysis.

6.3.2. Hesitancy to adopt new staffing methods (see literature review 3.6.2, 3.6.3)

Unlike the first theme, hesitancy to adopt new staffing methods emerged only when participants were asked to comment on the prospects of adopting such staffing approaches as the sample staffing tool. This hesitancy was apparent in the perceptions of the participants. Participants also expressed explicitly and implicitly their disinclination to adopt alternative staffing approaches and/or the one presented. This was highlighted further when the participants were shown the sample staffing tool which encompasses a number of the ‘ideal characteristics’ they stated that they wished to see in alternative staffing tools. Examples of an explicit refusal are comments from participants (11), (12) and (15) all of whom said: “No”
and the comment by participant (4) whose comment was: “others would, especially financial managers”. Examples of implicit refusal/hesitancy are found in the following comments: “It needs to be tested. Not all nurses, DONs, Care manager, feel comfortable with numbers and technology” and “Yes, but not in this format” from participants (3) and (5) respectively.

There are a number of possible explanations for hesitancy to adopt alternative staffing approaches:

1) Lack of financial incentives and rewards for the adoption of innovation in the RAC industry. The Australian Government provides no reward to facilities and organisations adopting innovative processes (besides a ‘shy’ listing in the Standards and Accreditation Agency’s regular newsletter). No innovation is required to attract consumers. Elderly residents and their families usually seek facilities mainly based on need, location and affordability.

2) Innovation is risky, as is adoption of new processes. This is particularly the case when a process deals with the costly staffing process and carries with it uncertainty for the manager and the employing organisation. The literature revealed at least eleven reasons that will hinder adoption of change in health care settings. These are listed with relevant references in section 3.6.2 in the literature review chapter.

3) Fear of an industrial backlash. The RAC industry is under the influence of several nurses’ and workers’ industrial unions. The history between them is tainted by mistrust, claims and counterclaims between the unions, individual organisations and industry representatives. A brief review of news letters sent by the unions representing the RAC industry workforce and
the ones representing the RAC industry would show the conflicting interests and non-conciliation approach each are following. The author could not verify the size of the industrial representation in the Australian RAC industry.

According to Richardson and Martin (2004) one in five nurses has to be replaced each year-by their current employer, if not by the whole industry. This makes turnover of the workforce an issue that needs to be managed by the industry. Beadnell (2006) note there is a nurses’ shortage in Australia. Any attempt to relate staffing to workload could be interpreted as an effort to decrease staffing levels and may lead to expensive industrial actions that could result in time consuming arbitration, loss of productivity, and negative publicity for a service provider and an individual manager.

4) Fear of resistance, from the staff, on the adoption of change especially from the senior staff. The average age of the RAC workforce in Australia is 45 plus for unqualified carers and 50 plus for qualified ones (Healy & Richardson, 2003; Richardson & Martin, 2004). Accordingly, such age groups, who are not as computer savvy as their younger counterparts, have not been exposed to technology, raising issues of adoption of change, in general, and adoption of technology-based systems and processes, in specific. In support of this, The Canadian Registered Nurses’ Association of Ontario (2005) and Savenstedt, Sandman and Zingmark Sa”Venstedt (2006) commented on nurses’ resistance to the adoption of computerised staffing methods. The RAC industry could be considered ‘conservative’ and even ‘late adopters’ as per Moore’s (1991) principle of the chasm. N.B. All of the participants were above 45 years of age, were mainly female and mainly of nursing background. This snapshot reflects the demography of RAC industry managers.
5) Changes in the industry have usually been driven from outside the industry such as the changes initiated by the Federal Government. Examples of this are the introduction of the RAC standards in 1997 and the introduction of the new funding tool, the aged care funding instrument (ACFI). Although such changes involved some industry consultation, they were mainly put together by the Australian Government which made it mandatory for the RAC industry to change their systems and processes.

6) There is no robust alternative staffing system that has been researched empirically for its applicability and validity in the industry by a research institution such as a university or an independent research centre. The literature review conducted did not yield any recommended staffing method for the Australian RAC industry.

7) Fragmentation of the RAC industry (Ernest & Young, 2005) has brought about a state where no role model facility/organisation has emerged with an alternative staffing method that can be adopted in other facilities. The industry does not generate ‘early adopters’ following Moore’s principal of the chasm.

8) The influence of the Neo-Liberal policies plays a major role in the reluctance of RAC managers to adopt alternative staffing approaches. Applying the principles of demand and supply gives the false impression that meeting the demands of RAC services is a simple formula that links residents’ numbers to staff numbers and there is no need to develop or adopt alternative staffing approaches.
In summary, there are numerous explanations for RAC managers’ hesitance to adopt a new staffing approach. The most serious of the explanations is the final one, as the following themes and data analysis explain.

6.3.3. Limited knowledge in staffing and HR management

This theme has been developed from the comments of a number of participants on the topics related to knowledge of existing staffing approaches, relationship between staffing and operational efficiency and experience with staffing approaches other than the one/s adopted in their facilities. Knowledge in staffing and HR is crucial for facility managers, especially in a labour-intensive industry such as the RAC industry where allocation of skilled staff on a shift by shift basis has major effects on the operational costs and the quality of care delivered. It is worth mentioning that a number of large, multi-site RAC organisations are at an advantage by having the input of a HR manager, located at corporate head office. Nevertheless, this advantage is limited because HR knowledge is required more at a facility level where care requirements and staff availability change frequently. Changing care requirements are a normal response to residents’ changing health conditions and the natural process of ageing. However, being conversant with this knowledge can be difficult for a number of reasons.

1) Undergraduate general nursing programs, where the bulk of nurses are prepared for professional practice, do not steep students in the disciplines of staffing and HR. The same applies to registered nurses who, formerly, were prepared in hospital-based programs. Now this preparation is in the tertiary education sector. A quick review of the curriculum of two
undergraduate nursing programs (registered nurses division one) and two certificate four nursing programs (enrolled nurses) revealed no management or HR component.

2) Formal knowledge and proficiency in staffing and HR is rarely requested when facilities seek to hire new RAC facility managers. A simple review of the currently advertised positions (printed and electronic) would highlight the absence of management or HR in selection criteria given in short advertisements and position selection criteria.

3) There are no legislative government requirements for RAC managers to possess such skills. Therefore the RAC organisations are not obliged to adopt or to seek them.

There was a clear deficiency of formal staffing and HR knowledge among the sample participants. This finding is not a surprise because such knowledge is neither provided for nor expected of RAC facility managers. The finding does generate its own questions: In the absence of formally acquired management and HR knowledge and skills, on what basis did participants question the validity of the current staffing approaches? Did participants understand the relationship between care needs and efficient staffing? Were participants ready to consider alternative staffing models? Unfortunately, none of these questions were answered by this study. Similarly, the literature reviewed did not answer such question or did it refer to any study that did. A clear gap exists in this area.

6.3.4. Dissatisfaction with the currently adopted staffing methods and distrust in their capability to deal with the overwhelming staffing challenges
Forming this theme was not easy as half of the participants’ comments explicitly indicated satisfaction with the currently adopted staffing methods and the other half were either dissatisfied or did not provide a clear position. Only three participants elaborated on the contribution staffing methods make to their organisations’ operational efficiency. It questions the participants’ self-reported satisfaction with the tools in use. There are two main reasons for the dissatisfaction with existing staffing approaches:

1) Current staffing approaches are based on the principles of the free market (neo-liberal policies) which treat staff members as numbers required to be available at certain places, to produce a certain number of tasks within a defined period of time. These staffing approaches which work on the neo-liberalist principles ‘one size fits all’ (Cox, 2006) are no longer suitable. Not only are RAC staff (especially the professionally qualified sector) more knowledgeable, they are working on a part-time basis, and experience abundance of work opportunities in an industry where demand for labour outstrips supply. Unless the staffing approaches accommodate the above changes, these approaches will be a hindrance rather that a support to the operators of the RAC facilities.

2) Most currently adopted approaches are based on the principles of the “free market”. They are staffing approaches that base staffing requirements on demands hypothetically required by the number of residents in an RAC facility. Since the number of residents varies little in RAC facilities (hence long-term care) one might assume that a single formula (which varies between RAC managers) would serve every facility at all times. Although such a formula has not been published nor has it been explicitly expressed by any of the study participants, it is considered to be the basis of the corporate and/or the facility manager’s professional
judgement. This term occurs frequently in the literature and was noted in participants’ comments.

The ‘professional judgement’ staffing formula fails on at least two counts: First, it fails to accommodate the residents’ different and fluctuant care needs. Fluctuation is a product of residents’ movements (in and out of the facility) and of their changing health conditions. Second, it fails to vary according to staff knowledge, skills and capabilities. It falls short of contributing to quality of residents’ care and exposes facilities to the risk either of under staffing or the costly overstaffing. There was considerable evidence for this in the national and international literature reviewed in section (3.3) in the literature review chapter.

‘Budget driven’ and ‘corporate decision’ as staffing methods are equally insensitive to residents’ dependencies and staff capabilities/skills. ‘Trial and error’ as a staffing method need not be discussed. As shown in the literature reviewed; “Staffing decisions that lack all relevant factors (nurses’ knowledge and capabilities and residents’ care needs) may result in poor patient outcomes” (Hyun et al., 2008:157).

Therefore, linking staffing or staff numbers to resident numbers (supply and demand) has neither been successful in solving the RAC industry challenges nor has it been popular among RAC managers. The staffing formula used by the RAC industry has been based on numbers of residents rather than the care needs of residents. The industry considers ‘demand’ to be resident numbers. In fact, ‘demand’ is the care needs of residents. On the ‘supply’ side, the industry considers numbers of staff available, rather than the pooled skills of the available staff. Hence, residents’ care needs and staff skills/ mix must be quantified for any ‘staffing formula’ work efficiently.
There are numerous reasons for the themes to emerge from the RAC managers’ comments. The highlighted themes and the reasons behind them reflected commonly known issues: reliance of the RAC industry on financial measures; dissatisfaction with the currently used staffing tools; and clear hesitancy to adopt alternative staffing tools. The study has demonstrated an unexpected theme; the extent to which RAC managers lack knowledge (as reflected by the sample interviewed) of basic staffing principles and management. Such lack of knowledge is amplified when a wrong, or at least inappropriate, ‘staffing formula’ has been used to staff RAC facilities in Australia. This ‘formula’ has failed to attend to staffing challenges and has compounded the challenges by creating dissatisfaction, lack of trust in the industry, and producing sub-optimal care.

6.4. The prospects of adopting alternative staffing methods

Based on the participants’ perceptions expressed through their comments, formed themes, literature reviewed and the implications of neo-liberal policies in Australia, what are the prospects for adopting alternative staffing methods in the RAC industry in Australia?

6.4.1. For the individual RAC manger

Participating RAC managers have little staffing/HR knowledge to promote operational efficiency in their facilities. If they did have the knowledge, they would be hesitant to apply it to adoption of new staffing methods for a number of reasons: Their knowledge and intentions may threaten their peers and others more senior to them. Success in the RAC industry is measured in finance and regulation compliance metrics, not in innovation. Innovation is considered risky and is unrewarded. The factors in combination point to a poor
prospect for Australian RAC managers to adopt alternative staffing methods/approaches. Although RAC managers are responsible for staffing decisions made in their facilities, most lack the staffing knowledge, authority and influence to change established financial measures and incentives driving the RAC industry.

6.4.2. For the organization/service providers

Although the study did not aim to explore the prospects of RAC service providers (the owners of the RAC facilities which are the employers of the RAC facility managers) adopting alternative staffing methods, this section will attempt to infer such prospects from the data generated from the participants as well as the literature reviewed. Unlike RAC managers, RAC service providers have more incentive to investigate and invest in alternative staffing methods. Such incentives are numerous. Service providers, the legal owners of the RAC facilities, unlike RAC facility managers, would not risk their employment if the application of alternative staffing method failed to yield improvements in efficiency. Application of new staffing methods would be merely a controlled business venture that could be stopped or reversed at any time. To improve operational efficiency and decrease the cost of labour, the largest operational cost, is the RAC service providers’ only available option. Government funding is capped, residents’ contributions in daily fees and bonds are indexed and the high-end market experiences strong competition. Indirect benefits from better staffing methods include would be staff-friendly rosters and workloads. Flow-on from such benefits would be decreased staff turnover, increased retention and decreased burn out of qualified staff. Alternative staffing methods could operate within an environment of free-market principles
or even neo-liberalist policies if these are translated to the structure and the processes of the RAC industry.

In the absence of current staffing approaches being rectified to consider residents’ care needs and staff skills and capabilities, there is little prospect of achieving staffing and operational efficiency in the RAC industry. Although it is not a topic specifically studied in the present work the work points to higher prospects of RAC service providers adopting alternative staffing methods than RAC managers. Service providers have the means to obtain professional advice on interpretation of free market principles in staffing their facilities and incentives to do so.

6.4.3. For the industry

The RAC industry’s prospects of adopting alternative staffing methods warrant discussion. The industry, consisting of individual organizations of various sizes, locations, business objectives and affiliations, has been conservative in operation and adoption of change. No published evidence of any innovation or change in the way RAC facilities are run or staffing is allocated in Australian facilities, was located or cited in the scholarly literature, the general media or government-sponsored communication. The study found no evidence of aged care initiatives emerging from within the industry apart from the scattered calls for increased government funding or for changes to accreditation and funding processes. Most changes in funding, staffing, quality outcomes or service delivery are generated outside the industry. Their sources are the Australian Government, industrial unions and formal requests or complaints from individual residents. The RAC industry is disjointed. It is heterogeneous in ways and forms. The only factors common to players in the RAC industry are the funding
system and the regulatory requirements. The industry has no flagship organisation or role model whose lead other organisations could follow in the adoption of innovative practices. Despite the potential benefits for the industry from the investment in and adoption of alternative staffing processes, it is most unlikely that the RAC industry, as one group, would initiate or adopt alternative staffing methods in the near future.

6.4.4. For the Federal Government

This leaves the Federal Government, the final industry stakeholder and the major financier of the RAC industry in Australia (N.B. there are numerous other stakeholders, such as general practitioners and residents’ families but they do not influence staffing decisions). The federal government has a major responsibility and a major role to play in the area of staffing. On the topic of responsibility, the Australian Government, through its adoption of neo-liberalistic policies, has not helped in the systems or the processes through which staffing is allocated in the RAC industry. There are no recent indications of change in the near future. The Government’s adoption of neo-liberal policies with their assumption that they apply to all industries, including the RAC industry, have caused many of the operational challenges that the industry is facing. There is lack of guidance on operational matters that promotes competition based on infrastructure rather than care, and failure to introduce minimal staffing level guidelines. At the same time, the government has taken a hard line. It uses a policing approach (accreditation visits and limiting of subsidies), to detect and reform non-compliance with the rules and regulations. The result is an environment in which innovation is difficult and risky.
On the Australian Government’s role in the area of staffing guidelines, there is room for a stewardship role in assisting the RAC industry in translating free market policies into more informed operational and staffing processes that accommodate the needs of the elderly, the nature of the service required and the staff skills available. RAC managers lack the required HR and management knowledge, service providers lack incentives and the industry lacks the efficient organisational role models to initiate and adopt changes in staffing and operational processes.

The Federal Government has the interest and the means to encourage the industry to invest in alternative staffing methods. This could be verified by the Government’s numerous calls to improve efficiency within the industry. *The Intergenerational Report 2002-2003* and *The Intergenerational Report 2007* raised the need to improve efficiency within the Industry (The Commonwealth of Australia, 2002 & 2007) and the Federal Government, Department of Health and Ageing dedicated a website to this matter ([http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-econnect.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-econnect.htm) accessed 16-01-09). Historically, the Australian Government has been able to induce change in the industry through the consecutive introduction of acts and regulations, different funding and accreditation schemes as well as through subsidising a large number of studies and research projects related to workforce and the adoption of change (e.g., those related to pricing and productivity). It has also, on a number of occasions; taken control of RAC facilities when its agents considered quality care has not been delivered.

Adoption of alternative staffing methods by the RAC industry could mean, for the Federal Government, an increase in operational efficiency, an increase in the appeal of the industry
for the health workforce, a decrease in staff turnover, improvements in service delivery and other positive changes which have been related, in the national and international literature, to the availability of an adequate, qualified and stable workforce.

Therefore, for any change to occur in the investment and adoption of alternative staffing processes, the Australian Federal Government needs to take the lead in reviewing its application of economic policies to the RAC industry, in increasing its engagement with the RAC industry, and encouraging adoption of innovation through political rhetoric and financial incentives and public recognition.

6.5. Implications for organisations and management practice

Based on the above themes and the analysis provided, and taking into consideration the context of the RAC industry in Australia, a number of implications arise.

1) The need to adopt an alternative staffing formula or process that works within free market principles of demand and supply but taking into consideration variables of care needs and staffing skills. Such a formula/ process would have a number of benefits including drawing attention to the value each staff member brings, highlighting the training and education required and better matching services (care) required to the services provided. This would improve efficiency. Furthermore such process would work within the RAC funding system (the existing RCS system and the forthcoming ACFI system) to link funding to care given/required.

2) There is need for the Australian Government to support and encourage RAC service providers to adopt an alternative staffing process. The government could achieve this through
financial support and facilitation of change, especially in managing possible backlash from industrial unions and the media. It could promote the achievements of organisations which undergo such change as producing flagships/role models for other RAC organisations. After all, improving operational efficiency in the RAC industry brings benefits such as improvement in financial performance, quality of care, image and recruitment and retention of staff.

3) There is need to improve the knowledge and the skills of RAC managers so that they can assist with the above. The knowledge and skills could be improved through funding, training provision, and encouragement and support of RAC managers in the acquisition of skills. Management of RAC facilities would be enhanced by improved human resources management, management of change, basic financial management for small to medium size business and by introduction of a registration process/ competences required for RAC managers. Such competencies or minimum requirements would be the minimum requirements for managers to be licensed to administer RAC facilities. This would give a system similar to that in other industries and professions in which for example, a car driver may not drive a truck or a generalist medical officer may not carry out a surgical procedure without appropriate training and formal credentialing. The question that arises here is why a person would be allocated the role of a manager to run organisations which directly influence the well being of numerous elderly residents (in many case more than 100 per facility), employees and sizable investments, because he/she has background in nursing (and in numerous cases not even with that). Would that be not considered strange in an over-regulated industry or is it also part of the Government neo-liberal policies of “no interference” with the internal business of the industry?
6.6 Limitations of the findings

The findings of this study, although informative, have two main limitations. The first is the characteristics of the participants and the facilities they represent. The second is the sample itself: consisting of only RAC managers with no representations of the other RAC industry stakeholders such as service providers, Australian Government, the workforce and their industrial representatives.

The characteristics of the sample participants involved in this study included the roles of the participants, size of the facility they manage, business objective (for profit or not-for-profit), delivering high or low care, being part of single or multi site organization and the owner organization (private, community, government or church). Characteristics that the study may have included are extent of participants’ RAC experience and their higher education, the location of the facilities (country, metro and regional) and history of facilities’ compliance with the accreditation standards. The additional descriptors of RAC managers and facilities may have added more value to the data and themes developed, albeit at the expense of additional complexities in sampling and data analysis.

The size of the sample was limited to 18 participants. This was due to the difficulty in recruiting participants and interviewing a representative sample of Australian RAC facilities (shown in table 2.0) for which 18 varieties were to be considered. The choice of RAC managers to the exclusion of the other stakeholders, as sole sample group, was based on the assumption that RAC facility managers are the agents generally responsible for the day-to-day staffing decisions in their facilities and for dealing directly with workforce and care
issues. The assumption was verified by many of the themes that emerged. Inclusion of representatives of the service providers, government, facility staff and industrial unions may have added more value to the results. It would have added, also, complexity beyond the scope, funding and capabilities of the researcher. Each limitation was intentional and was made for the sole purpose of controlling the study’s scope and decreasing its complexity. Further studies with a different sample of participants would add different values and highlight different aspects of the topic.

6.6 Chapter Summary

This chapter interpreted data from the study into the prospects of RAC facility managers in Australia adopting alternative staffing methods. It listed the four themes that emerged from the data. Highlighted themes were the folly of imposing the principles of free market on staffing and the need for government to support change and to regulate the position of RAC managers, which is a crucial role within the industry. The next chapter includes the study conclusions and the recommendations.
Chapter 7 - Conclusion and Recommendations

7.1 Research Summary

This is the final chapter of this thesis is reporting on the prospects of RAC managers in Australia adopting alternative staffing methods. The aim derived from rapid expansion in size and in impact of the Australian RAC industry in Australia as the ratio of persons aged 65 plus to the rest of the population increases. Expansion of RAC services brings challenges of staffing and sustainability. The literature indicated that staffing processes have direct links with efficiency and sustainability in RAC settings. This is the case as the RAC in general is labour intensive and costly. Attraction and retention of an adequately trained workforce is critical to the success of the industry and the facilities within it. The literature revealed currently adopted staffing methods to be not only ineffective but also to be adding to the challenges the industry faces. Key reasons for this ineffectiveness are that these methods do not take account of the residents’ care needs or the workforce capabilities. As well, currently adopted staffing methods focus only on financial measures and outcomes, which reflects the influence of neo-liberal policies in the western world in general and Australia, in particular.

The RAC industry faces a number of related challenges. The suitably qualified workforce, such as student registered nurses has declining interest in joining the industry. Attractive and financially more rewarding opportunities lie outside the RAC industry. A well prepared workforce, attracted to the industry, is crucial for RAC industry survival and for service provision. Other challenges facing the industry include limited financial return and industry fragmentation. The prospect of improvement under these conditions is slight. Australia is
an ageing society. It suffers from staff shortages, high standards of living and limited government resources.

For these reasons, the study considered the staffing challenge within the RAC industry and its facilities. Staffing is a vital operational process that has the potential to influence business efficiency and care and work quality. Staffing involves the daily allocation and coordination of the workforce to meet the care needs of elderly residents according to quality standards and consumers’ expectations. Available Australian and international literature that deals with staffing, staffing challenges and staffing suggestions was reviewed. The literature revealed a strong need to adopt adequate staffing methods as a crucial step in allocating staff efficiently and improving work conditions of the RAC workforce.

To meet the aim of this study, perceptions of a number of RAC facility managers from a variety of RAC facilities in the State of Victoria were elicited. The approach aimed to delve into the perceptions of persons at the ‘front line’ who allocate and coordinate the workforce in RAC facilities. In many cases, this group is the most qualified. They are expected to provide guidance not only to their staff but also to their employers. Facility managers were the most appropriate group of people to gauge the needs of RAC facilities and to identify the most suitable staffing approach.

Eighteen RAC facility managers, working for various organisations and of various backgrounds and characteristics, agreed to participate. The participants were asked a number of questions. The questions were structured to explore facility managers’ comments and perceptions on the RAC industry, its challenges, relationship between operational efficiency and staffing, their satisfaction with currently adopted staffing method/s and the prospects of
their adopting an alternative staffing method. Comments were tape-recorded, coded and analysed following a qualitative research method. The findings that emerged from the interviews and data analysis revealed four main themes: 1) an over emphasis on financial measures; 2) a general dissatisfaction with the currently adopted staffing methods; 3) limited staffing and human resource management knowledge; and 4) a general reluctance to adopt alternative staffing methods; despite their dissatisfaction with and the inadequacy of currently adopted staffing methods.

Further analysis of the data highlighted a number of possible reasons for the emerging results including:

1) Australian Government policies which: a) advocate ‘free market/ demand and supply’ principles and which influence the criteria upon which the industry is measured for efficiency; b) take a punitive approach to non-compliance; and c) lack support for innovation.

2) Inadequate staffing processes based on RAC facility managers’ professional judgement consider the number of residents requiring care and the number of staff available to provide that care. Staffing processes do not consider the care required or the skill required to provide that care. The basis of such professional judgement/staffing formulae is the assumption that the care needs of residents are equal as are the skills that the staff possess. This is a false assumption.
3) The managers and Director of Nursing currently running Australian RAC facilities have limited management and HR knowledge and skill, restricting their contribution and openness to adopting alternative staffing approaches.

The literature and this study have highlighted the complexity involved in the conduct of Australian RAC facilities in Australia, compounded by shortage of qualified staff, heavy workloads, and increased demand for RAC services.

This study has highlighted that the Australian RAC industry needs to review its staffing methods and the role of staffing methods in order to optimise efficient operation and quality care. It adds two main findings. Readiness to adopt alternative staffing methods is a far-off objective. Any efforts to investigate and adopt alternative staffing approaches should be a joint effort between the Australian Government and RAC service providers.

**7.2 Recommendations**

There are a number of recommendations derived from the study. The responsibility for implementing these recommendations should be a joint effort between the RAC industry, the Australian Government and the academic institutions (universities being an independent and respected partner in care). These recommendations are:

1. To commission further research into the role and contribution of workforce allocation processes and systems in the daily operation and management of RAC facility in Australia.
2. To study and develop a more suitable staffing model that takes into consideration residents’ care needs and staff skills in the context of free market principles and industry context. Tertiary

3. To broaden the scope of such studies to include a larger sample and factors such as facility location, knowledge and experience of RAC managers, and other stakeholders such as service providers, staff and industrial unions.

4. To conduct empirical trials of a number of currently adopted international staffing methods within Australian RAC facilities.

5. To undertake further study into the role, knowledge and skills required to manage Australian RAC facilities. This work might lead to the development and enforcement of a mandatory registration of ‘RAC facility manager’ licence. In this way a minimum requirement of skill and responsibility among RAC facility managers in Australia would be ascertained.

6. To promote collaboration between the RAC service providers, government and workforce industrial representatives on approaches to ensure that workforce allocation processes work in favour of all stakeholders.

7.3 Contribution to the body of knowledge and practice

This study has added to the body of knowledge in the area of staffing in the RAC industry, an area that lacks studies and suitable resources. It has added weight to claims for review of
staffing processes and methods in Australian RAC facilities. It has demonstrated the potential contribution of such methods to the efficient conduct of RAC facilities. It has shown that a selection of staffing systems and methods adopted overseas is ready to be trialled in Australia for suitability and benefits. The study has elaborated on the inadequate interpretation of the impacts of ‘free market’ principles on staffing and operational efficiency in the RAC industry. It has shown the need to review the skills and preparation required to managing Australian facilities. Finally, it has shown need to initiate intra-industry cooperation to measure and explore perceptions of all RAC industry stakeholders on the adoption of alternative staffing methods in the RAC facilities in Australia.
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Brisbane, Australia: School of Economics, University of Queensland.


# Appendix A Interview Questions

<table>
<thead>
<tr>
<th>Type</th>
<th>Questions</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception Questions:</td>
<td>As an Aged care facility manager, Do you have an interpretation of operational efficiency? Is your organisation at this level? Why?</td>
<td>Based on their experience and their organisational goals, the participants will be encouraged to list their and their organisation’s interpretation of operational efficiency, operational goals, and how they measure them.</td>
</tr>
<tr>
<td></td>
<td>From your experience, what is the relationship between operational efficiency and staffing levels?</td>
<td>Participants will identify their understanding of the degree staffing levels contribute to operational efficiency and reflect that on their organisation’s goals.</td>
</tr>
<tr>
<td></td>
<td>What staffing approach or rostering system do you use in your facility?</td>
<td>Participants will reveal the staffing approach and system they currently use.</td>
</tr>
<tr>
<td></td>
<td>Does this system meet your organisation’s operational goals, i.e. financial targets, quality requirements, staff wishes, and residents’ needs? How?</td>
<td>The participants will be challenged to evaluate their organisation’s staffing system in meeting the staffing levels required to satisfy the operational goals of their organisation.</td>
</tr>
<tr>
<td></td>
<td>From your experience, have you encountered or used systems or tools other than the staffing system you currently use?</td>
<td>The participants would reveal the depth of their knowledge of staffing systems and approaches and/or past successes or failures with other staffing systems (if any).</td>
</tr>
<tr>
<td></td>
<td>Now after you have listed your operational goals and identified how they are reflected in your staffing levels and the staffing system you use, Would you consider using other types systems that would better meet your organisation’s goals? Why?</td>
<td>Assuming the participant is internally convinced of the limitations of his/her staffing system, the participant would be challenged to validate any resistance to change or prepare to take the staffing module’s presentation seriously.</td>
</tr>
<tr>
<td>Demonstration</td>
<td>Demonstration of the staffing module (via the interviewer’s computer screen)</td>
<td>To present the module’s features and deliverables.</td>
</tr>
<tr>
<td>Opinion Questions:</td>
<td>Using your knowledge and experience in the industry, what do you think the strength and weaknesses of such system?</td>
<td>The participant would evaluate the system, recommend improvements, and pinpoint shortfalls.</td>
</tr>
<tr>
<td></td>
<td>Would you use such system in your facility?</td>
<td>The participant is challenged to reflect the demonstrated system on his/her organisation, and give a validated evaluation of it.</td>
</tr>
</tbody>
</table>
Appendix B (Table 3.0)

<table>
<thead>
<tr>
<th>Interviewee No.</th>
<th>Title/Role of the interviewee</th>
<th>Gender</th>
<th>YOE</th>
<th>Services provided</th>
<th>Beds in Facility</th>
<th>Total beds in the Organization</th>
<th>Business objective</th>
<th>Ownership</th>
<th>Size</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Financial Manager</td>
<td>M</td>
<td>3</td>
<td>HC &amp; LC</td>
<td>147</td>
<td>2000 beds</td>
<td>FP</td>
<td>Private</td>
<td>Multisite</td>
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<tr>
<td>2</td>
<td>Regional Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>320</td>
<td>2000 beds</td>
<td>FP</td>
<td>Private</td>
<td>Multisite</td>
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<tr>
<td>3</td>
<td>Financial Manager</td>
<td>F</td>
<td>5</td>
<td>HC &amp; LC</td>
<td>70</td>
<td>2000 beds</td>
<td>FP</td>
<td>Private</td>
<td>Multisite</td>
</tr>
<tr>
<td>4</td>
<td>DON/Manager</td>
<td>F</td>
<td>3</td>
<td>LC</td>
<td>50</td>
<td>50 beds</td>
<td>NFP</td>
<td>Church</td>
<td>Standalone</td>
</tr>
<tr>
<td>5</td>
<td>DON</td>
<td>F</td>
<td>7</td>
<td>HC</td>
<td>60</td>
<td>200 beds</td>
<td>NFP</td>
<td>Com</td>
<td>Multisite</td>
</tr>
<tr>
<td>6</td>
<td>Clinical Care Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>131</td>
<td>700 beds</td>
<td>FP</td>
<td>Private</td>
<td>Multisite</td>
</tr>
<tr>
<td>7</td>
<td>DON</td>
<td>F</td>
<td>1</td>
<td>HC</td>
<td>30</td>
<td>250 beds</td>
<td>NFP</td>
<td>Church</td>
<td>Multisite</td>
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<tr>
<td>8</td>
<td>Executive DON</td>
<td>F</td>
<td>10</td>
<td>HC &amp; LC</td>
<td>700</td>
<td>700 beds</td>
<td>FP</td>
<td>Private</td>
<td>Multisite</td>
</tr>
<tr>
<td>9</td>
<td>DON/Manager</td>
<td>F</td>
<td>5</td>
<td>HC &amp; LC</td>
<td>90</td>
<td>210 beds</td>
<td>NFP</td>
<td>Council</td>
<td>Multisite</td>
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<td>10</td>
<td>Clinical Care Manager</td>
<td>F</td>
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<td>LC</td>
<td>45</td>
<td>45 beds</td>
<td>NFP</td>
<td>Church</td>
<td>Standalone</td>
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<tr>
<td>11</td>
<td>DON</td>
<td>F</td>
<td>8</td>
<td>HC</td>
<td>30</td>
<td>600 beds</td>
<td>FP</td>
<td>Private</td>
<td>Multisite</td>
</tr>
<tr>
<td>12</td>
<td>A/DON</td>
<td>M</td>
<td>3</td>
<td>HC &amp; LC</td>
<td>122</td>
<td>122 beds</td>
<td>NFP</td>
<td>Com</td>
<td>Standalone</td>
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<tr>
<td>13</td>
<td>DON</td>
<td>M</td>
<td>2</td>
<td>HC &amp; LC</td>
<td>88</td>
<td>88 beds</td>
<td>NFP</td>
<td>Com</td>
<td>Standalone</td>
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<tr>
<td>14</td>
<td>Quality/ Clinical Care Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>130</td>
<td>130 beds</td>
<td>NFP</td>
<td>Church</td>
<td>Standalone</td>
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<td>15</td>
<td>Manager</td>
<td>F</td>
<td>2</td>
<td>LC</td>
<td>75</td>
<td>600 beds</td>
<td>FP</td>
<td>Private</td>
<td>Multisite</td>
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<tr>
<td>16</td>
<td>Nursing Coordinator</td>
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<td>5</td>
<td>HC &amp; LC</td>
<td>495</td>
<td>495 Beds</td>
<td>NFP</td>
<td>State</td>
<td>Multisite</td>
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<td>17</td>
<td>Clinical Nurse Manager</td>
<td>F</td>
<td>4</td>
<td>HC &amp; LC</td>
<td>100</td>
<td>495 Beds</td>
<td>NFP</td>
<td>State</td>
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<td>18</td>
<td>Residential Care Manager</td>
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<td>HC &amp; LC</td>
<td>495</td>
<td>495 Beds</td>
<td>NFP</td>
<td>State</td>
<td>Multisite</td>
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HC: High Care, LC: Low Care, NFP: Not for Profit, FP: for profit, Com: community, YOE: Years of employment at current employer.
Table 4.0: Challenges facing the RAC industry:

<table>
<thead>
<tr>
<th>Poor Staff Quality</th>
<th>Staff Shortages</th>
<th>Staff Management</th>
<th>Poor Staff Incentives</th>
<th>System</th>
<th>Funding</th>
<th>Financial</th>
<th>Customer Expectations</th>
<th>Public Image</th>
<th>Public In &amp; Dependency</th>
<th>Dec. in dependency</th>
<th>Stakeholder Commitment</th>
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Table 5.0: Participants’ interpretation of operational efficiency

<table>
<thead>
<tr>
<th>Q 1 Interviewee</th>
<th>1st Part of the question</th>
<th>2nd Part</th>
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<tr>
<td>1</td>
<td>Bottom Line</td>
<td>Staff Rel (4)</td>
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<tr>
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<tr>
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<td>Bottom Line (3)</td>
<td>Systems (2)</td>
</tr>
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<td>?</td>
</tr>
<tr>
<td>8</td>
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</tr>
<tr>
<td>9</td>
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<td>Leadership</td>
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<td>Staff Rel (2)</td>
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<tr>
<td>13</td>
<td>Bottom Line(2)</td>
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<td>14</td>
<td>Systems</td>
<td>Leadership</td>
</tr>
<tr>
<td>15</td>
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<td>Staff Rel</td>
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<td>Staff Rel</td>
</tr>
<tr>
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<td>Systems</td>
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### Table 6.0: Relationship between operational efficiency and staffing levels

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<tr>
<th>Interviewee</th>
<th>Comments of the relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not Expressed</td>
</tr>
<tr>
<td>2</td>
<td>Direct relationship</td>
</tr>
<tr>
<td>3</td>
<td>Indirect Relationship</td>
</tr>
<tr>
<td>4</td>
<td>Not Expressed</td>
</tr>
<tr>
<td>5</td>
<td>Indirect relationship</td>
</tr>
<tr>
<td>6</td>
<td>Indirect relationship</td>
</tr>
<tr>
<td>7</td>
<td>Direct relationship</td>
</tr>
<tr>
<td>8</td>
<td>No Relationship</td>
</tr>
<tr>
<td>9</td>
<td>Not Expressed</td>
</tr>
<tr>
<td>10</td>
<td>No Relationship</td>
</tr>
<tr>
<td>11</td>
<td>No Relationship</td>
</tr>
<tr>
<td>12</td>
<td>Direct relationship</td>
</tr>
<tr>
<td>13</td>
<td>Direct relationship</td>
</tr>
<tr>
<td>14</td>
<td>Not Expressed</td>
</tr>
<tr>
<td>15</td>
<td>Not Expressed</td>
</tr>
<tr>
<td>16</td>
<td>Direct Relationship</td>
</tr>
<tr>
<td>17</td>
<td>No Relationship</td>
</tr>
<tr>
<td>18</td>
<td>Direct relationship</td>
</tr>
</tbody>
</table>

### Table 7.0: Staffing approach/system adopted in the participants’ facilities

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>1st level coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Staff Ratio</td>
</tr>
<tr>
<td>2</td>
<td>Care needs</td>
</tr>
<tr>
<td>3</td>
<td>Budget driven</td>
</tr>
<tr>
<td>4</td>
<td>Benchmarking</td>
</tr>
<tr>
<td>5</td>
<td>trial &amp; error</td>
</tr>
<tr>
<td>6</td>
<td>non-staff ratio</td>
</tr>
<tr>
<td>7</td>
<td>Staff Ratio</td>
</tr>
<tr>
<td>8</td>
<td>Reg compliance</td>
</tr>
<tr>
<td>9</td>
<td>Corp decision</td>
</tr>
<tr>
<td>10</td>
<td>Budget driven</td>
</tr>
<tr>
<td>11</td>
<td>Corp decision</td>
</tr>
<tr>
<td>12</td>
<td>Budget driven</td>
</tr>
<tr>
<td>13</td>
<td>Reg compliance</td>
</tr>
<tr>
<td>14</td>
<td>Staff Ratio</td>
</tr>
<tr>
<td>15</td>
<td>Our Experience</td>
</tr>
<tr>
<td>16</td>
<td>Trial &amp; error</td>
</tr>
<tr>
<td>17</td>
<td>non</td>
</tr>
<tr>
<td>18</td>
<td>Trial &amp; error</td>
</tr>
</tbody>
</table>

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Table 8.0: The effectiveness of the staffing system adopted:

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>1st L coding</th>
<th>2nd L coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>no</td>
<td>not-given</td>
</tr>
<tr>
<td>2</td>
<td>no</td>
<td>not-given</td>
</tr>
<tr>
<td>3</td>
<td>yes</td>
<td>given</td>
</tr>
<tr>
<td>4</td>
<td>no</td>
<td>given</td>
</tr>
<tr>
<td>5</td>
<td>no</td>
<td>given</td>
</tr>
<tr>
<td>6</td>
<td>no</td>
<td>not-given</td>
</tr>
<tr>
<td>7</td>
<td>no</td>
<td>not-given</td>
</tr>
<tr>
<td>8</td>
<td>?</td>
<td>not-given</td>
</tr>
<tr>
<td>9</td>
<td>yes</td>
<td>not-given</td>
</tr>
<tr>
<td>10</td>
<td>yes</td>
<td>not-given</td>
</tr>
<tr>
<td>11</td>
<td>yes</td>
<td>not-given</td>
</tr>
<tr>
<td>12</td>
<td>yes</td>
<td>not-given</td>
</tr>
<tr>
<td>13</td>
<td>yes</td>
<td>not-given</td>
</tr>
<tr>
<td>14</td>
<td>yes</td>
<td>not-given</td>
</tr>
<tr>
<td>15</td>
<td>yes</td>
<td>not-given</td>
</tr>
<tr>
<td>16</td>
<td>no</td>
<td>given</td>
</tr>
<tr>
<td>17</td>
<td>no</td>
<td>given</td>
</tr>
<tr>
<td>18</td>
<td>yes &amp; no</td>
<td>given</td>
</tr>
</tbody>
</table>

Table 9.0 Familiarity with other staffing systems:

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>1st level coding</th>
<th>2nd level coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>unknown</td>
<td>?</td>
</tr>
<tr>
<td>2</td>
<td>no</td>
<td>risky</td>
</tr>
<tr>
<td>3</td>
<td>unknown</td>
<td>?</td>
</tr>
<tr>
<td>4</td>
<td>possible</td>
<td>If recommended</td>
</tr>
<tr>
<td>5</td>
<td>possible</td>
<td>If recommended</td>
</tr>
<tr>
<td>6</td>
<td>possible</td>
<td>If recommended</td>
</tr>
<tr>
<td>7</td>
<td>possible</td>
<td>F, T, I</td>
</tr>
<tr>
<td>8</td>
<td>possible</td>
<td>F, PH</td>
</tr>
<tr>
<td>9</td>
<td>possible</td>
<td>F</td>
</tr>
<tr>
<td>10</td>
<td>no</td>
<td>risky</td>
</tr>
<tr>
<td>11</td>
<td>possible</td>
<td>F, S, R, B</td>
</tr>
<tr>
<td>12</td>
<td>possible</td>
<td>S, M</td>
</tr>
<tr>
<td>13</td>
<td>unknown</td>
<td>F, M, S, R</td>
</tr>
<tr>
<td>14</td>
<td>unknown</td>
<td>R, S, M, F, P</td>
</tr>
<tr>
<td>15</td>
<td>no</td>
<td>risky</td>
</tr>
<tr>
<td>16</td>
<td>possible</td>
<td>F</td>
</tr>
<tr>
<td>17</td>
<td>no</td>
<td>?</td>
</tr>
<tr>
<td>18</td>
<td>no</td>
<td>?</td>
</tr>
</tbody>
</table>

Table 10.0 The characteristics of the participants’ ideal staffing tool and the possibility of them adopting such tool/s.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Possibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>personality attributes</td>
</tr>
<tr>
<td>F</td>
<td>Flexibility</td>
</tr>
<tr>
<td>S</td>
<td>Staff wishes</td>
</tr>
<tr>
<td>M</td>
<td>Accounts for Staff mix</td>
</tr>
<tr>
<td>R</td>
<td>Residents needs</td>
</tr>
<tr>
<td>B</td>
<td>Budget conscious</td>
</tr>
<tr>
<td>I</td>
<td>Incentives Based</td>
</tr>
<tr>
<td>T</td>
<td>Task Oriented</td>
</tr>
<tr>
<td>PH</td>
<td>Accounts for peak hours</td>
</tr>
</tbody>
</table>
### Table 11.0: Prospects of adopting the demonstrated staffing system in the participant’s facility

<table>
<thead>
<tr>
<th>(Q9) Interviewee</th>
<th>Would you use this system?</th>
<th>pos Vs neg comments received</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>yes</td>
<td>100/0</td>
</tr>
<tr>
<td>2</td>
<td>no answer</td>
<td>50/50</td>
</tr>
<tr>
<td>3</td>
<td>no</td>
<td>50/50</td>
</tr>
<tr>
<td>4</td>
<td>no</td>
<td>20/80</td>
</tr>
<tr>
<td>5</td>
<td>no</td>
<td>30/70</td>
</tr>
<tr>
<td>6</td>
<td>yes</td>
<td>40/60</td>
</tr>
<tr>
<td>7</td>
<td>yes</td>
<td>50/50</td>
</tr>
<tr>
<td>8</td>
<td>no</td>
<td>50/50</td>
</tr>
<tr>
<td>9</td>
<td>no answer</td>
<td>50/50</td>
</tr>
<tr>
<td>10</td>
<td>no answer</td>
<td>100/0</td>
</tr>
<tr>
<td>11</td>
<td>no</td>
<td>15/85</td>
</tr>
<tr>
<td>12</td>
<td>no</td>
<td>0/100</td>
</tr>
<tr>
<td>13</td>
<td>no answer</td>
<td>70/30</td>
</tr>
<tr>
<td>14</td>
<td>yes</td>
<td>100/0</td>
</tr>
<tr>
<td>15</td>
<td>no</td>
<td>0/100</td>
</tr>
<tr>
<td>16</td>
<td>yes</td>
<td>100/0</td>
</tr>
<tr>
<td>17</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>no</td>
<td>30/70</td>
</tr>
</tbody>
</table>
Appendix D  Invitation letter for participation in the study

RMIT University
Graduate School of Business

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT
PROJECT INFORMATION STATEMENT

Date

Dear participant

You are invited to participate in a research project being conducted by RMIT University. This information sheet describes the project in straightforward language, or ‘plain English’. 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 the investigator.

Project Title:
“Care needs and/or staff ratios”:
A new approach in Residential Aged Care staffing in Australia

Investigators:
o  Mr Khalil Sukkar (Doctorate of Business Administration degree student)

Supervisor:
Dr Erica HalleBone (Project Supervisor: Associate Professor, Graduate school of Business, RMIT University, erica.hallebone@rmit.edu.au)

Dear …

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

This research has been developed to study the value of developing and promoting a staffing module/approach that attends to staffing in aged care facilities from the care needs perspective rather than from a staff-resident ratio one. The benefits of such approach will not only contribute to process of staffing but also to staff retention and quality residents care. This research aims first to highlight the challenges pertaining to staffing and operational efficiency as perceived by the aged care providers and administrators and then will seek the participants’ comments and suggestions for a proposed staffing module as a possible answer for the raised challenges and obtained perceptions.

This research is being conducted as part of a Doctorate degree in Business Administration and has been approved by the RMIT Human Research Ethics Committee. This research is self funded by the researcher with no other source of funding and no other interested party.

Why have you been approached?

You have been selected as a representative of an aged care provider/administrator due to your responsibilities, exposure, and experiences in dealing with staffing processes and the demands of operational efficiency. Thirty six participants will be selected and invited from a variety of facilities in the State of Victoria each with a wealth of experience and a variety of responsibilities.
What are the questions being addressed?

The interview is constructed into three sections: first section include questions about staffing process, staffing challenges, and operational efficiency, section two includes a presentation of staffing module, and section three includes discussions about the presented module and its relation to issues raised in section one.

If I agree to participate, what will I be required to do?

In the scheduled interview, if you decided to participate, you would be expected to answer a number of questions giving your perceptions, suggestions and comments based on your past experiences, knowledge, and recent and past responsibilities as there is no right or wrong answers. You will also be required to attend on a presentation of a newly developed staffing module (part of the interview) then to give your comments and suggestions. The interview is constructed to last between forty five to sixty minutes and it will be tape recorded to facilitate the flow of your comments and to efficiently capture the issues discussed.

What are the risks or disadvantages associated with participation?

Give an honest assessment of any risks associated with participation. In this research there are no perceived risks outside the participants’ normal day-to-day activities. The only possible issue would be that during the interview the participant would find his/her participation distressing or has the desire not to respond to one or more question due to sensitivity of the answer or due to the position and responsibilities of the participant. If such to occur, feel free to refrain from answering the question, or withdrawing your participation or even contacting the supervisor Professor. Erica HalleBone on : 99251348. Your discussions and concerns will be dealt with and followed-up professionally and confidentially.

What are the benefits associated with participation?

Participating in this research would facilitate your:

- Contribution to the body of knowledge in general and the RAC Industry in specific with your valued opinion, comments, and suggestions.
- Contribution to the efforts exerted and planned to relief the difficulties and challenges facing the industry in relation to staffing and operational efficiency.
- Review your own knowledge and rethink some of the issues you face on a day to day basis.
- Exposure to a newly developed staffing approach.

What will happen to the information I provide?

Strict confidentiality and anonymity will be adhered to with all the information provided and the data generated as no reference to the participant and his/her workplace is planned for or is required for the purpose of the research. The data will be only seen by the researcher and his supervisor and will be kept securely at RMIT for a period of 5 years before being destroyed. Only the analysis of the collective data generated may be published ensuring that under no circumstances the responses of any particular participant or his/her details will be disclosed to any third party.

What are my rights as a participant?
In this research you have the right to:

- Withdraw your participation at any time, without prejudice.
- Have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- Have any questions answered at any time.
- Request that the taping of my interview be stopped at any stage of the interview.

**Whom should I contact if I have any questions?**

If you have any question or issue please contact me on (03) 95619792 or the supervisor for this research Dr. Erica HalleBone on 99251348 or the Chair, Portfolio Human Research Ethics Sub-Committee, Business Portfolio, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 5594 or email address rdu@rmit.edu.au.

**What other issues should I be aware of before deciding whether to participate?**

Nil unless you have a question or inquiry please call me on (03) 95619792 or my mobile on 0412 337987 or on my e-mail address khalil@mudeer.com.

Yours Sincerely

**Erica Hallebone**

B.A (Honours), PHD
Associate Professor
RMIT University
Graduate School of Business

**Khalil Sukkar**

RN.BSN.MSHLSc
Doctor of Business Administration
Student
RMIT University
Graduate School of Business
Appendix E  Consent form

Prescribed Consent Form for Persons Participating in Research Projects Involving Interviews, Questionnaires, Focus Groups or Disclosure of Personal Information

PORTFOLIO OF
SCHOOL/CENTRE OF  
Name of Participant:  
Project Title:  

“Care needs and/or staff ratios”: A new approach in Residential Aged Care staffing in Australia

Name(s) of Investigators:  
(1) Khalil Sukkar Ph: 0412 337987  
(2) Ph: 0395619792

1. I have received a statement explaining the interview/questionnaire involved in this project.  
2. I consent to participate in the above project, the particulars of which including details of the interviews or questionnaires have been explained to me.  
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.  
4. I give my permission to be audio taped:  ☐ Yes ☐ No  
5. I give my permission for my name or identity to be used:  ☐ Yes ☐ No  
6. I acknowledge that:  
(a) Having read the Plain Language Statement, I agree to the general purpose, methods and demands of the study.  
(b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.  
(c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.  
(d) The privacy of the information I provide will be safeguarded. However should information of a private nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.  
(e) If I participate in a focus group I understand that whilst all participants will be asked to keep the conversation confidential, the researcher cannot guarantee that other participants will do this.  

If I participate in a focus group I understand that whilst all participants will be asked to keep the conversation confidential, the researcher cannot guarantee that other participants will do this.  

Participant’s Consent  
Name:  
Date:  

(Participant)  
Name:  
Date:  

(Witness to signature)  

Where participant is under 18 years of age:  
I consent to the participation of ____________________________ in the above project.  

Signature:  
(1) ☐ ☐ Date:  
(2) ☐ ☐  
(Signatures of parents or guardians)  

Name:  
Date:  

(Witness to signature)  

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Chair, Portfolio Human Research Ethics Sub-Committee, Business Portfolio, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 5594 or email address rdu@rmit.edu.au. Details of the complaints procedure are available from: www.rmit.edu.au/council/hrec.