Working in Aged Care: Medication Practices, Workplace Aggression, and Employee and Resident Outcomes

Report prepared for the Australian Nursing Federation

Victorian Branch

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Executive Summary

This report contains the findings from a survey of 1038 members of the Australian Nursing Federation (Victorian Branch) working in public, private for profit and private not for profit aged care facilities conducted in 2007. The study finds that workers are under significant stress stemming from excessive workloads, cost cutting, a hostile work environment, and competing role demands. There appears to be few differences across job or facility type. It is noteworthy that participants said that they were not committed to their facility, were emotionally exhausted and almost a third of them were thinking about leaving their job. This is of concern because it suggests that they are disengaged from their organisation and are experiencing symptoms associated with 'burnout'. On the positive side it appears that perceptions of facility satisfaction, resident care, safety and staff responsiveness were quite high. There does however, appear to be some concern with medication errors, particularly in private for profit and private not for profit facilities. There appear to be no major concerns with scope of practice, though public sector participants (both Division 1, 2, 3, and 4) would like more training. In general, more training, rigorous recruitment and selection practices, performance management and grievance procedures led to better resident and worker outcomes.

Registered nurse to resident ratios ranged from 1:5 to 1:53 across public, private for profit and private not for profit facilities. Analyses revealed that in public facilities, as compared to private not for profit and private for profit facilities, there were fewer residents for each registered nurse to care for. This probably reflects that within the public sector there are legally enforceable nurse to resident ratios in high-care facilities. In facilities where each nurse had to care for fewer residents there were significantly better outcomes in relation to employee turnover intentions, fewer medication errors, resident safety, facility satisfaction and better overall resident care. Not surprisingly, the ability of staff to respond to resident needs in a timely fashion was also significantly related to registered nurses to resident ratios. For all shifts the more residents each registered nurse had to care for the poorer resident safety was and the more frequently medication errors were reported as being made. For more detailed information on these findings please refer to section 3.2 (pages 16-19) of the report.

In relation to ***medication practices*** most registered nurses reported that they felt they had received adequate training in relation to the changes to their scope of practice concerning the administration of medications (Division 2 endorsed nurses) or the supervision of medication administration by others (Division 1,3 and 4 nurses). Over 25% of the sample reported that on average residents at their facility either missed their medication or received it at the wrong time once, or twice a month. Eight per cent of participants also reported that dose administration aids (DAAs) were found to be incorrectly filled at least once or twice a week, suggesting these repackaging systems are potentially unsafe. The study's findings also indicate that medication errors are likely to happen more frequently in situations where levels of role conflict, co-worker aggression and resident quality of living cost-cutting are high. Medication errors are likely to happen less frequently if the organisation has good grievance procedures and training practices. For more detailed information on the findings in relation to the medication practices examined please refer to section 3.3 (pages 19-36) of the report.

Executive Summary

Two forms of ***workplace aggression*** were assessed in the study; co-worker aggression towards residents and aggression from residents towards employees. Forty per cent of participants had seen a co-worker yell at a resident one or more times and 15% had seen a co-worker push, grab, shove, or pinch a resident one or more times in the past 6 months. The frequency with which participants' experienced resident aggression varied based on the type of aggression. Eighty six per cent of workers reported being yelled, shouted or sworn at and subjected to verbal aggression by residents at least once in the past six months and 64% had a resident try to hit them with something at least once in the past six months. Those who worked at public facilities tended to experience aggression from residents more frequently than those from private not for profit or private for profit facilities. For more detailed information on the findings in relation to workplace aggression please refer to section 3.4 (pages 36-47) of the report.

The seven key ***work, psychological and physical health outcomes*** examined in the study were job satisfaction, turnover intentions, organisational commitment, emotional exhaustion, social functioning, depression and, physical symptoms. Overall participants across the sample reported that they were somewhat satisfied with their current job, with individuals who worked at private for profit facilities reporting significantly lower levels of job satisfaction compared to individuals who worked at public or private not for profit facilities. Of note is the fact that over 30% of participants said that they were likely to leave their job, with those who worked at private for profit facilities more likely to report an intention to leave compared to those participants who worked in public or private not for profit organisations. Consistent with this finding, participants also reported relatively low levels of commitment to their current organisation. Significantly, 70% of participants reported feeling emotionally exhausted as a result of their work at least monthly; with 30% reporting being emotionally exhausted daily, a few times a day or weekly. Consistent with these findings in relation to emotional exhaustion, on average participants also reported that they had experienced five physical health symptoms in the past month. Further analysis of the study's findings also revealed that overall participants who worked in facilities where there were heavy workloads, high levels of role conflict, resident aggression, and staff and resident quality of living cost cutting were more likely to report more negative work related attitudes and poorer health outcomes. Effective grievance procedures and training were found to be important in minimising poor health outcomes for the study's participants. For more detailed information on the findings in relation to the work, psychological and physical health outcomes examined please refer to section 3.5 (pages 47-68) of the report.

The six key ***resident outcomes*** examined in the study were facility satisfaction, staff responsiveness, resident safety, resident care, resident sleep quality and, medication errors. Overall 81.2% of participants reported being satisfied with their facility and 70.8% of participants reporting that staff at their facility were responsive to resident needs. Fifty four per cent of participants felt that resident safety was a high priority at their facility, with 79.2% of participants reporting that resident care at their facility was of a high standard. However, those participants who worked at private for profit facilities reported significantly lower levels of resident safety than those participants who worked at public or private not for profit facilities. Participants in public facilities reported significantly higher levels of resident sleep quality than individuals from private not for profit or private for profit facilities. Additional analyses revealed that participants who worked in facilities where there were high levels of role conflict, co-

worker aggression towards residents and, staff and resident quality of living cost cutting were also more likely to report poorer outcomes for residents. In contrast, participants who worked at facilities with well developed grievance procedures and performance appraisal practices were more likely to report more positive outcomes for residents. For more detailed information on the findings in relation to the resident outcomes examined please refer to section 3.6 (pages 68-83) of the report.

The majority of participants were married females, working part-time as registered nurses, with average tenure in their occupation of 17 years and 9 years in their current job. Just under half were employed in private facilities. More detailed information on the key characteristics of the study's ***participants*** and their ***workplaces*** can be found in sections 3.1 (pages 11-16) and 3.2 (pages 16-19) of the report, respectively.

1. Introduction

This report presents data from the first survey conducted as part of an ongoing research project based on surveys of Victorian aged-care workers. The current study builds on a project which we conducted in 2005 (reported in October 2006), but the current project is a separate one which involves a longitudinal research design comprising three surveys. The ongoing program of research is concerned with how, in an environment which is placing increasing pressure on aged-care provision, working arrangements are affecting quality of working life for aged-care workers and the quality of care which they are able to provide to residents. Accordingly, as well as providing descriptive data on the characteristics of aged-care workers and their working lives, we explore links between job design, work organisation and human resource management practices on one hand and employee and resident outcomes on the other. Our central motivation in conducting the research is to provide a solid empirical basis to inform practices within aged-care facilities, as well as government policy, in pursuit of favourable outcomes for aged-care residents, employees and providers.

The rapidly-ageing population in Australia is placing unprecedented pressure on aged-care provision and it seems likely that this pressure will continue to increase over coming decades. In addition, the passage of the Commonwealth Aged Care Act (1997) brought changes in funding arrangements. An additional key contextual change concerns the scope of practice for staff, with endorsed Division 2 Registered Nurses now permitted to administer medication under supervision. These contextual changes all pose significant challenges for the aged-care industry. These challenges relate both to the quality of care which can be provided to residents of aged-care facilities and the quality of working life for staff, in an environment of increasing pressure.

The data presented here are based on 1038 responses from ANF (Victorian Branch) members working in aged-care in Victoria, surveyed in September-October 2007. The report provides a “snapshot” of our respondents, their workplace characteristics, work practices, management practices and of worker and resident outcomes. In addition, it presents analysis of links between a range of these aforementioned factors, allowing inferences to be drawn about the impact of specific practices on the quality of working life and resident care.

The report is divided into four sections. In the section that follows, we set out the method employed in the study. In Section Three we present our findings. This section commences with overviews of the participants and of their workplaces, then turns to the, medication practices and workplace aggression. The section concludes by presenting data on quality of working life for respondents and quality of care provided to residents. Finally, the key findings of the study are summarised in section four of the report.

2. Methodology

2.1. Study Design

This was a cross-sectional study carried out in October 2007. The study forms the first wave of data in a three year study of the quality of working lives for nurses and personal care workers in aged care. Based on the award of an Australian Research Council linkage grant, two additional rounds of data will be collected in 2008 and 2009. This will be the first large scale longitudinal study of work organisation in Australian Aged Care.

The study consisted of a series of scales relating to the quality of work organisation (e.g., scope of practice, work stressors) in aged care along with several outcome measures relating to facility functioning and resident quality of care (including medication errors) as well as work (e.g., job satisfaction, turnover intentions) and employee well-being outcomes (e.g., social functioning, physical symptoms, emotional exhaustion).

2.2. Study Population

A questionnaire was mailed to 3102 individuals randomly selected from the membership roll of the Australian Nursing Federation (Victorian Branch) who were working in an Aged Care Facility either as a registered nurse (Division 1, 2,3, 4) or a personal care worker. The questionnaire was mailed out by the ANF to preserve the anonymity of participants. Completed surveys were returned directly to the researchers at University of Melbourne. One hundred and one questionnaires were excluded because the respondent had ceased working in aged care or the address was incorrect. In total there were 1038 useable and completed questionnaires (a 35% response rate).

It is important to make clear that our unit of analysis is the employee. When we report data on workplace characteristics, these are based on the employees' reports of the characteristics of their workplaces, not on data collected from a sample of workplaces. Consequently, we cannot draw any inferences about the population of aged-care workplaces in Victoria, but only the reported characteristics of workplaces in which our respondents worked. Thus, for example, when we report that 46.3%of respondents worked in private for profit facilities, it is important to be clear that this does not mean that 46.3%of Victorian aged care workplaces are in the private sector.

Analyses were conducted to assess the representativeness of our sample relative to the Victorian aged care nursing population. On three demographics (average age, gender and average work hours per week) that we were able to compare, the sample characteristics were statistically different from those of the Victorian aged care nursing labour force (Australian Institute of Health and Welfare, 2005). Unfortunately there are no available statistics for 2007 so we used the 2005 statistics and as a consequence the statistical differences we found between our sample and the population need to be interpreted with caution. Registered nurses are working fewer hours than in 2005 (28.7 hrs per week vs. 31.1 hrs per week) and are older (50.6 yrs vs. 49 yrs) though this is not surprising given the comparison is between 2007 and 2005. There were also slightly fewer males who are registered nurses in the sample

(5.1 % vs. 5.6 %). It is noteworthy that we were unable to find any population level data on personal care workers.

2.3. Study Measures

Below a brief description of the scales used to measure the variables examined in the study is provided. Where possible existing scales with well established high levels of reliability and validity were used. All scales used in the study demonstrated acceptable levels of internal validity. For a full listing of the items used in each scale please refer to Appendix A.

Medication Practices

Scope of Practice Training Div 2s
The five items in this scale asked Division 2 Registered Nurses (only) to reflect on changes to their scope of practice that now enabled them to administer medications under supervision. Participants were asked to indicate whether they felt they had received adequate training to administer medications, whether their organisation had clear polices and procedures in relation to medication administration, and whether they received adequate and appropriate supervision when administering medications. An example of an item used is “I have received training which has given me a good understanding of which medications I can administer and which I cannot.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree).

Scope of Practice Training Div 1,3,4s
The six items in this scale asked Division 1, 3 and 4 Registered Nurses (only) to reflect on the recent changes to scope of practice that now enabled them to supervise Div 2s administering medications. Participants were asked to indicate whether they felt they had received adequate training to supervise the administration of medications, whether their organisation had clear polices and procedures in relation to medication administration, and whether they had read and understood the Nurses Board of Victoria (NBV) code for the administration of medications. An example of an item used is “I have received training which has given me a good understanding of my responsibilities when supervising Division 2 Registered Nurses as they administer medication. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree).

Medication Administration Self-Efficacy
Those participants who administered medications as part of their role were asked to reflect on how confident they felt in obtaining consent from residents, identifying different medications correctly by name, administering medications, and monitoring residents for potential adverse reactions. Division 1, 3 and 4 RNs were also asked how confident they felt in assessing the qualifications of another staff member when delegating medication administration. In total there were four items in the scale. An example of an item used is “Indicate the extent to which you feel confident you can correctly identify different medications by name.” Participants were asked to record their responses using a scale which ranged from 1 (Totally Unconfident) to 9 (Totally Confident).

Medication Administration by Non-Endorsed Div 2s & Personal Care Workers (PCWs)
This single item asked whether they had seen non-endorsed Div 2s and PCWs administering medication from a Dose Administration Aid (DAAs) (e.g., blister packs)

without supervision at their facility. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).

Medication Errors
The seven items in this scale asked participants to indicate the frequency with which a series of different medication errors were made at their facility. An example of an item used is “In the past 6 months how often has a wrong dose been given to a resident?” The response scale participants were asked to use ranged from 1 (Less than once per month or never) to 5 (Several times per day).

Workplace Aggression

Co-Worker Aggression towards Residents
The four items in this scale assessed how frequently in the past 6 months participants had witnessed co-workers behaving in an either verbally or physically aggressive way towards residents. An example of an item used is “In the past 6 months how often have you seen other staff push, grab, shove, or pinch a resident.” Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times).

Resident Aggression
The five items in this scale assessed how frequently in the past 6 months participants had personally experienced either verbal or physical aggression from residents. An example of an item used is “How often in the past 6 months have you been yelled at, shouted at, or sworn at by a resident?” Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times).

Job Stressors

Workload
The five items in this scale assessed how frequently participants felt that in their job there was often a great deal of work to be done and that they had little time to get things done. An example of an item used is “How often does your job leave you with little time to get things done?” Participants were asked to record their responses using a scale which ranged from 1 (Rarely) to 5 (Very Often).

Role Conflict
The eight items in this scale assessed how frequently participants felt that they received incompatible requests and/or inadequate equipment or staff in executing their job tasks. An example of an item used is “I work with two or more group who operate quite differently.” Participants were asked to record their responses using a scale which ranged from 1 (Rarely) to 5 (Constantly).

Interpersonal Conflict
The four items in this scale assessed how frequently participants got into arguments with co-workers or had co-workers be rude to them. An example item used is “How often are co-workers rude to you at work?” Participants were asked to record their responses using a scale which ranged from 1 (Never) to 5 (Very Often).

Staff Cost-Cutting
The five items in this scale assessed the extent to which participants felt their facility had fewer and/or less qualified staff on shifts than previously in an attempt to cut costs. An example of an item used is “My facility focuses on cost saving by reducing staffing levels at the expense of resident care.” Participants were asked to record

their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).

Resident Quality of Living Cost-Cutting
The seven items in this scale assessed the extent to which participants felt their facility had lowered the quality of things like residents' meals and dressings in an attempt to cut costs. An example of an item used is "My facility has reduced the nutritional quality of food for residents to save money." Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).

Management Practices

Grievance Procedures
The eight items in this scale assessed the extent to which participants felt their facility had clear and effective procedures for resolving disputes or complaints between residents, staff and/or management. An example of an item used is "My organisation has clear and effective policies and procedures in place for resolving complaints by staff". Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree).

Recruitment & Selection Practices
The two items in this scale asked participants about how rigorous they felt the employee selection processes were in their organisation. An example of an item used is "How rigorous is the employee selection processes for a job in this organisation (e.g., Does the process involve tests, interviews etc?)? Participants responded using a scale which ranged from 1 to 7.

Performance Practices
The five items in this scale asked participants to indicate how much effort went into measuring and assessing employee performance in their facility. Items in the scale also asked participants to indicate how closely job performance was tied to pay in their facility. An example of an item used is "How often is performance discussed with employees?" Participants responded using a scale which ranged from 1 to 7.

Training
Three questions were used to assess the amount of training the participant's employer had paid for them to undertake in the last 12 months and the extent to which they felt that overall they had received sufficient training to do their job. An example of an item used is "To what extent do you agree or disagree that you get the training needed to do your job effectively?"

Work, Psychological & Physical Health Outcomes

Job Satisfaction
The three items in this scale assessed the extent to which participants were satisfied with their current job. An example of an item used is "All in all, I am satisfied with my job." Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree).

Turnover Intentions
The three items in this scale assessed the likelihood that participants would leave their current job and/or how much they would like to get a new job. An example of an item used is "How like is it that you will look for a job outside of this organisation

during the next year?" Participants were asked to record their responses using a scale which ranged from 1 to 7.

Organisational Commitment
The six items in this scale assessed the extent to which participants felt committed or emotionally attached to their current organisation. An example of an item used is "I do not feel a strong sense of belonging to my organisation." Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree).

Emotional Exhaustion
The nine items in this scale assessed how frequently participants felt emotionally drained and fatigued as a result of their work. An example of an item used is "How often do you feel emotionally drained from your work?" Participants were asked to record their responses using a scale which ranged from 1 (Never) to 7 (Every Day).

Social Functioning
The four items in this scale assessed how frequently over the past few weeks participants had felt able to enjoy their life and capable of making decisions and dealing with problems. An example of an item used is "Have you recently been able to enjoy your normal day-to-day activities?" Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time).

Depression
The four items in this scale assessed how frequently over the past few weeks participants had felt unhappy and unable to cope. An example of an item used is "Have you recently been feeling unhappy or depressed?" Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time).

Physical Symptoms
This scale was designed to assess out of a total of 18 possible physical symptoms how many the participant had experienced in the past 30 days. Examples of physical symptoms listed include backache, headache, chest pain, and an upset stomach or nausea.

Resident Outcomes

Facility Satisfaction
The twelve items in this scale assessed the extent to which participants felt that residents' rooms and nutrition were of a high standard. The privacy of residents and the extent to which family and friends were welcome to visit residents were also assessed. An example of an item used is "Family and friends are welcome to visit residents and be involved in their care." Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).

Staff Responsiveness
The ten items in this scale assessed how responsive participants felt staff were able to be to the different needs of residents. An example of an item used is "How responsive are staff to a resident requesting assistance using their buzzer or call system." Participants were asked to record their responses using a scale which ranged from 1 (Very Unresponsive) to 7 (Very Responsive).

Resident Safety

The nine items in this scale assessed the extent to which participants felt resident safety was a high priority at their facility, with the extent to which management provided the resources, procedures and training needed to ensure resident safety also being assessed. An example of an item used is “Management provides a working environment that promotes resident safety.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).

Resident Care
The six items in this scale assessed the extent to which participants felt residents were able to talk to staff as needed; staff showed a real interest in residents and residents in the facility were provided with appropriate care by staff. An example of an item used is “The nurses and personal carers have the skills to provide appropriate care.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).

Resident Sleep Quality
The two items in this scale assessed the extent to which participants felt residents were able to sleep free from noise and interruptions at night. An example of an item used is “The amount of noise disrupts residents’ sleep.” Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).

2.4. Data Analysis

Data were analysed using SPSS 15.0. The results section of the report contains information on both the descriptive statistical analyses and, inferential statistical analyses (specifically regression analysis) conducted on the different measures. More specific information on the analyses conducted for each measure is provided in the results section of the report.

2.5. Limitations of the Data

In a number of instances items are negatively skewed, for example resident aggression. For these reasons we have provided the dispersion of responses to the statement rather than relying solely on means and standard deviations. *Missing data* was treated as such and was not imputed.

3. Results

Please note where participants did not respond to an item this has been reported as *missing data*.

3.1. The Participants

Table 3.1.1

Age (Mean[1])	**Total Sample**
Years	50.5
Gender (%)	
Female	93.8
Males	4.3
Missing Data	*1.8*
Relationship Status (%)	
Single	7.6
Widowed	3.5
Married	65.3
Divorced/Separated	14.3
De facto relationship	7.0
Missing Data	*2.3*
Job Title (%)	
Managers	7.8
RNs	71.3
Div 1	32.8
Div 2	37.8
Div 3	0.4
Div 4	0.3
Personal Care Workers (PCWs)	20.9
Missing Data	*2.9*
Overtime worked per week (Mean)	
Hours	6.0

[1] A mean is an average and is calculated by summing the responses of all the participants and then dividing this total by the total number of participants.

Table 3.1.1 (cont)

Number of Jobs (%)	
1 job	78.5
2 jobs	18.8
3 jobs	2.2
4 jobs	0.3
5 jobs	0.1
6 jobs	0.1
Div 2s Endorsed to Administer Medications (%) as a percentage of all Div 2s in the sample	
Yes	34.1
No	63.1
Missing Data	*2.8*

Group Comparisons – Job Type

The following table presents the data for those participant variables where there was a significant difference between the three job categories; management (Managers), registered nurses (RNs) and personal care workers (PCWs). On all of the remaining participant variables (not listed) there were no significant differences between the different job categories.

Table 3.1.2

Highest Nursing Qualification (%)	Managers	RNs	PCWs *[2]	Total
Hospital Trained	39.2	38.0	0.9	26.0
Certificate III Aged Care/Nursing	0.0	1.1	67.3	22.8
Certificate IV Aged Care/Nursing	5.1	1.7	21.8	9.5
Advanced Certificate in Nursing	7.6	39.1	5.2	17.3
Bachelor of Nursing	21.5	11.2	0.5	11.1
Graduate Certificate/Diploma in Nursing	24.1	6.2	0.5	10.3
Masters of Nursing	2.5	0.6	0.0	1.0
None	0.0	0.0	2.4	0.8
Missing Data	*0.0*	*2.1*	*1.4*	*1.2*

[2] Those groups marked with an asterisk (*) were statistically significantly different from the other job types. For example if there is an asterisk next to the PCW column it means in relation to that particular item PCWs were significantly different from managers and registered nurses.

Table 3.1.2 (cont)

Employment Status (%)	Managers *	RNs	PCWs	Total
Full-time	49.4	14.6	9.0	24.3
Part-time	48.1	78.6	84.8	70.5
Casual/Temporary	0.0	5.7	4.3	3.3
Fixed Term	0.0	0.3	0.0	0.1
Missing Data	*2.5*	*0.8*	*1.9*	*1.8*
Hours worked per week (Mean)	**Managers ***	**RNs**	**PCWs**	**Total**
Hours	37.9	28.7	30.2	32.3
Time working in occupation (Mean)	**Managers**	**RNs**	**PCWs ***	**Total**
Years	18.3	19.2	9.4	15.6
Time working at current organisation (Mean)	**Managers**	**RNs**	**PCWs ***	**Total**
Years	7.7	9.4	6.0	7.7
Working shifts less than 2 hours (%)	**Managers**	**RNs**	**PCWs ***	**Total**
Yes	2.5	4.2	8.5	5.1
No	86.1	88.6	77.3	84.0
Missing Data	*11.4*	*7.2*	*14.2*	*10.9*
Desire for full-time employment by participants currently employed on a part-time or casual basis (%)	**Managers**	**RNs**	**PCWs ***	**Total**
Yes	3.8	14.6	24.2	14.2
No	91.1	82.1	68.2	80.5
Missing Data	*5.1*	*3.3*	*7.6*	*5.3*

Group Comparisons – Organisation Type

The next table presents the data for those participant variables where there was a significant difference between the three organisation types; public, private not for profit and private for profit. On all of the remaining participant variables (not listed) there were no significant differences between the different organisation types.

Table 3.1.3

Time working in occupation (Mean)	Public *[3]	Private Not for Profit	Private for Profit	Total
Years	19.2	16.7	16.4	17.4
Time working in organisation (Mean)	**Public**	**Private Not for Profit**	**Private for Profit ***	**Total**
Years	10.0	9.1	7.7	8.9

Summary: The Participants

Overall the majority of participants were married females who were working part-time as registered nurses. On average participants had been working in their current occupation for 17 years and for their current organisation for 8.6 years with the majority of participants not working short-shifts. Overall, very few of the participants desired full-time employment or more hours. Of the Division 2 nurses in the sample 34.1 % were endorsed to administer medications.

In the job type comparisons significant differences were found in the level of qualifications held by managers, registered nurses and personal care workers. A higher percentage of managers worked full-time as compared to registered nurses and personal care workers who both predominantly worked part-time. On average managers and registered nurses had worked significantly longer in the occupation as compared to personal care workers. Personal care workers tended to work more short shifts than managers and registered nurses, and also reported a greater desire for full-time employment than these two other groups.

In the organisation type comparisons participants who worked in public facilities reported working in the occupation for significantly longer than those participants who worked in private not for profit or private for profit facilities. Individuals working at private for profit facilities had worked at their current organisation for significantly less time than individuals employed at public or private not for profit facilities.

[3] Those groups marked with an asterisk (*) were statistically significantly different from the other organisation types. For example if there is an asterisk next to the public column it means in relation to that particular item public facilities were significantly different from not for profit and private facilities.

3.2. The Workplace

Table 3.2.1

Facility Ownership (%)	Total Sample
Public	21.8
Private Not for Profit	27.9
Private for Profit	46.3
Missing data	*3.9*

Mean Registered Nurse to Resident Ratios

The next series of tables and graphs depict the mean registered nurse to resident ratio based on the type of care provided by the facility (low, mixed or, high), the type of organisation the facility is (public, private not for profit or, private for profit) and the timing of the shift (am, pm or, night). There was only a very small number of participants (N=13) working at low care facilities in the sample so the below figures should be interpreted with caution.

Table 3.2.2 Low Care Facilities

Shift	Organisation Type		
	Public	**Private Not For Profit**	**Private for Profit**
AM	1:5	1:20	1:27
PM	1:5	1:16	1:26
ND	1:11	1:53	1:27

Figure 3.2.1

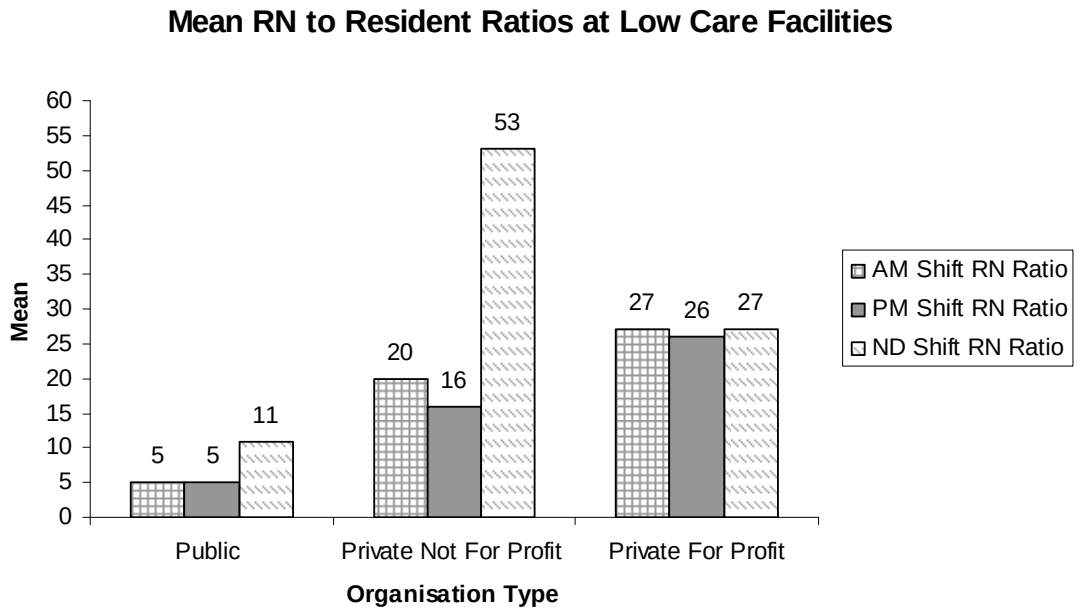


Table 3.2.3 Mixed Care Facilities

Shift	Organisation Type		
	Public	Private Not for Profit	Private for Profit
AM	1:13	1:22	1:22
PM	1:15	1:31	1:32
ND	1:19	1:37	1:39

Figure 3.2.2

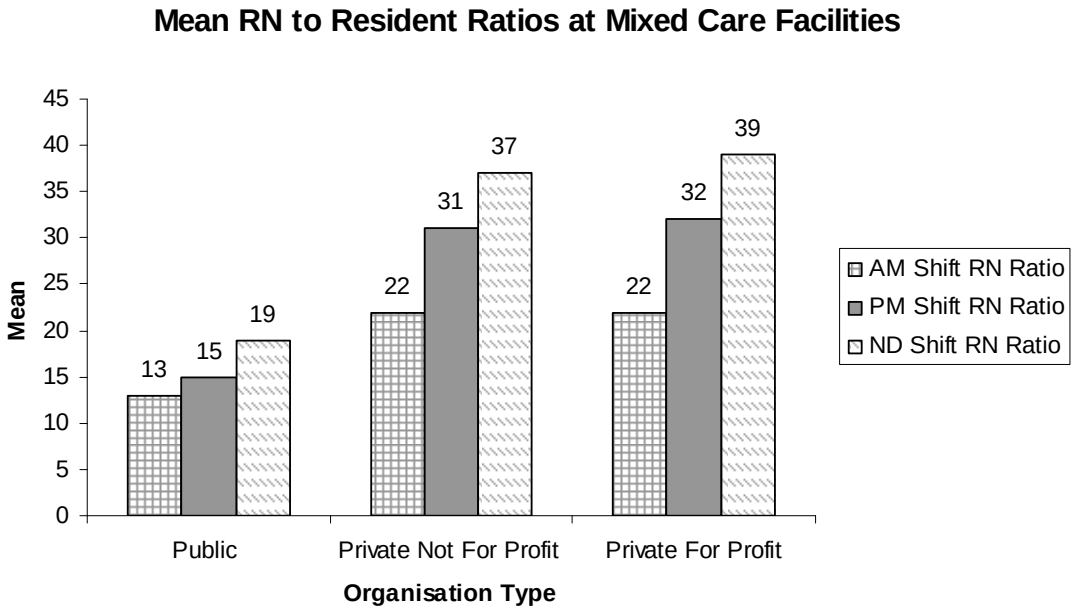
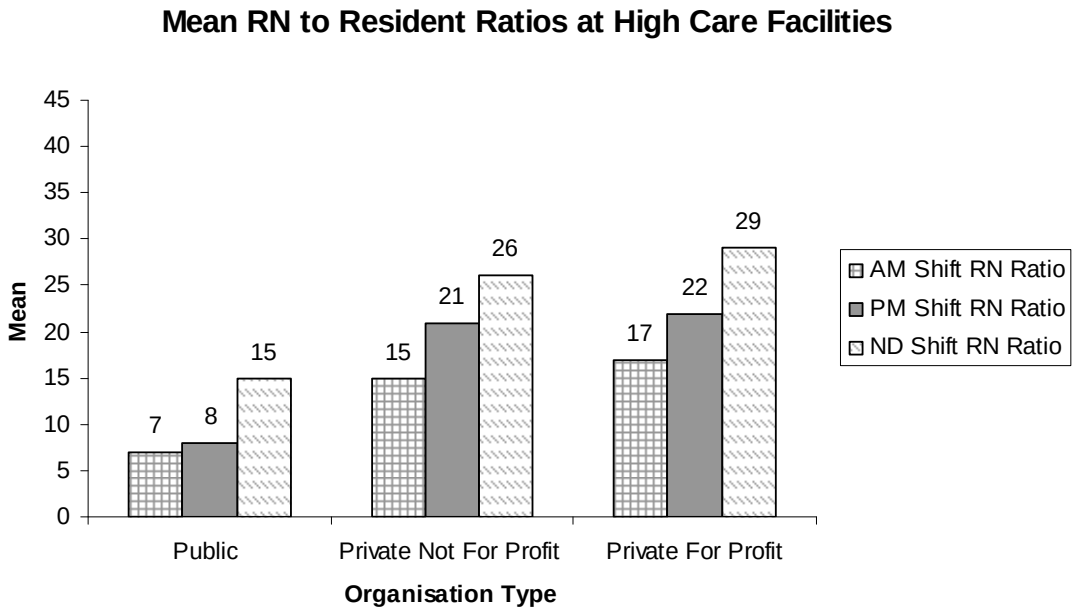


Table 3.2.4 High Care Facilities

Shift	Organisation Type		
	Public	Private Not For Profit	Private for Profit
AM	1:7	1:15	1:17
PM	1:8	1:21	1:22
ND	1:15	1:26	1:29

Figure 3.2.3



Group Comparisons – Organisation Type

Analyses revealed that across the three different types of care provision (low, mixed, high) in private not for profit and private for profit facilities each registered nurse had more residents to care for as compared to the public facilities where each registered nurse had to care for fewer residents.

Group Comparisons – Type of Care Provided

Analyses revealed that across two different types of care provision (mixed, high; low care facilities were excluded due to the low numbers of these facilities (N=13) in the sample) there were significant differences in relation to only two of the job stressor variables examined. Participants from high care facilities reported significantly higher workloads and levels of staff cost-cutting as compared to participants from mixed care facilities. These significant differences are depicted in the graph below.

Figure 3.2.4

Registered Nurse to Resident Ratios as Predictors of Outcomes

A set of statistical analyses (regressions) were conducted to determine the extent to which the average registered nurse to resident ratios for each of the shifts (averaging across the different organisation types and types of care provided) predicted worker, organisational and resident related outcomes. As part of the analyses the possible influence of a number of employee/facility variables were also controlled. The analyses revealed that registered nurse to resident ratio levels on the AM shift significantly predicted turnover intentions, levels of emotional exhaustion and number of physical symptoms experienced by participants. The greater number of residents there were for each nurse to care for during night duty the more likely individuals were to intend to leave their current job.

In relation to resident outcomes the registered nurse to resident ratio across all three shifts was a significant predictor of resident safety and medication errors. For all shifts the more residents there were for each registered nurse to care for the poorer resident safety was and the more frequently medication errors were reported as being made. Both the registered nurse to resident ratio on the AM shift and the night shift were also significant predictors of facility satisfaction and resident care. Analyses revealed that where there were more residents for each registered nurse to care for, individuals were less satisfied and felt the resident care at their facility was poorer. The registered nurse to resident ratio on the AM shift and the PM shift also significantly predicted resident sleep quality, with more residents per registered nurse being associated with poorer resident sleep quality. Finally, the registered nurse to resident ratio on the night shift also significantly predicted how responsive staff were to residents' needs. The more residents each registered nurse had to care for on the night shift the less responsive staff were able to be to residents' needs. Overall, the data indicates that having poor registered nurse to resident ratios on the night shift results in the most negative outcomes for residents.

Summary: The Workplace

Forty-six per cent of the participants were employed at private for profit facilities. Registered nurse to resident ratios ranged from 1:5 to 1:53. A number of the participants commented on their questionnaire that they felt staffing levels were

inadequate. In the words of one participant *"It does not matter where you work; staffing levels are inadequate to meet resident's needs and regulatory compliance"*. In the organisation type comparisons significant differences were found in relation to registered nurse to resident ratios, such that public facilities (across the different types of care provision) had significantly fewer residents for each registered nurse to care for. This probably reflects that within the public sector there are legally enforceable nurse to resident ratios in high care. Registered nurse to resident ratios emerged as significant predictors of both employee and resident related outcomes. In particular, the ratios seemed particularly important for predicting resident outcomes. This seemed to especially be the case for the registered nurse to resident ratio on the night shift with this ratio being a strong predictor of staff responsiveness, resident safety, facility satisfaction, resident care and medication errors. In all cases the more residents each registered nurse had to care for the poorer the reported resident outcomes.

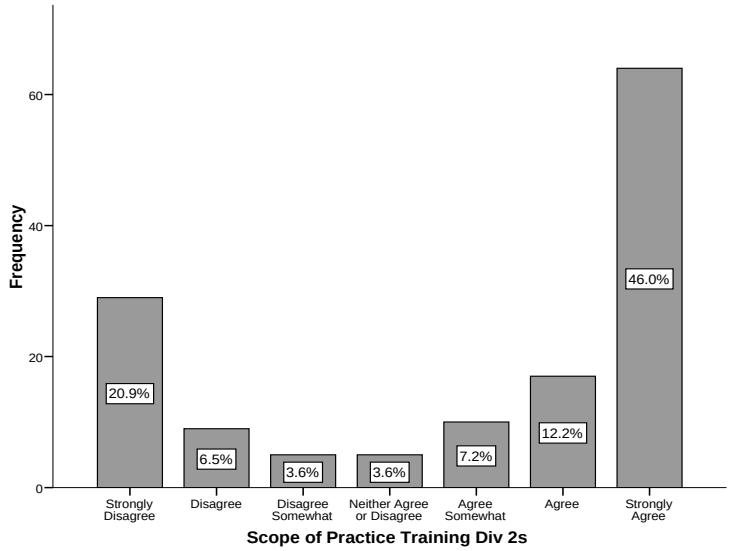
3.3. Medication Practices

In order to assess the effect of recent changes to the administration of medications to residents this section of the survey asked participants to think about the practices related to medication administration in their facility and how they felt about the recent scope of practice changes. Below a summary in relation to each of the different scales used in this section of the survey is provided. A bar chart for each scale indicating the dispersion of responses based on the entire sample is also provided. This is followed by comparisons for each of the scales across different job (Managers, Registered Nurses, & Personal Care Workers) and organisation types (Public, Private Not for Profit, Private for Profit). Appendix A provides the individual items for each of the different scales.

Scope of Practice Training – Div 2s

Total Sample
This scale asked Division 2 Registered Nurses (only) to reflect on the changes to their scope of practice that now enabled them to administer medications under supervision. Participants were asked to indicate whether they felt they had received adequate training to administer medications, whether their organisation had clear polices and procedures in relation to medication administration, and whether they received adequate and appropriate supervision when administering medications. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). The higher the score the more adequate participants felt the training they had received had been. Appendix A provides the individual items for the scale. The proceeding graph indicates the dispersion of responses based on the entire sample for the item.

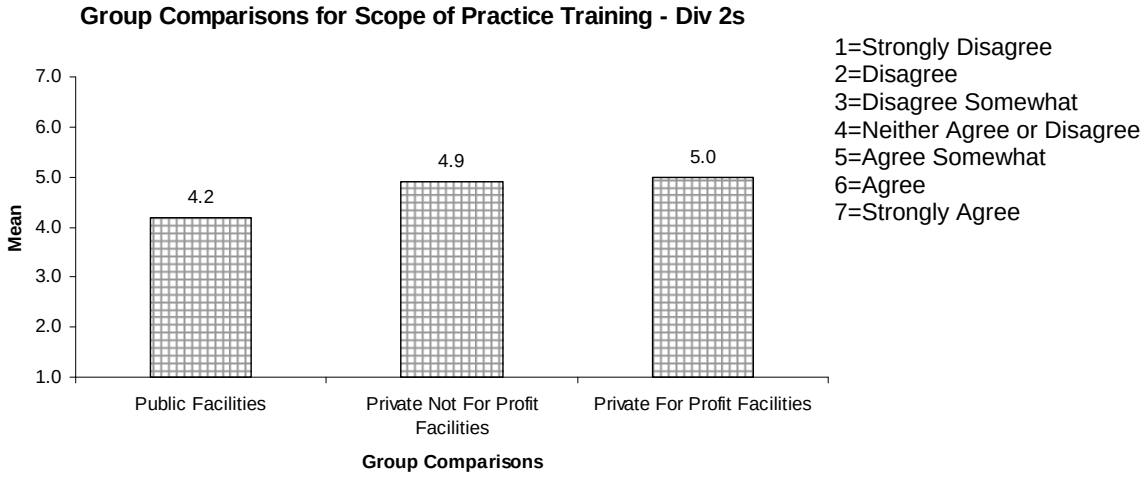
Figure 3.3.1



Group Comparisons

The following graph presents means for scope of practice training for DIV 2s for the different groups based on organisation type. The higher the score the more adequate participants felt the training they had received had been. Overall division 2 registered nurses working in public facilities reported significantly lower levels of training as compared to those participants who were working in private not for profit or private for profit facilities.

Figure 3.3.2



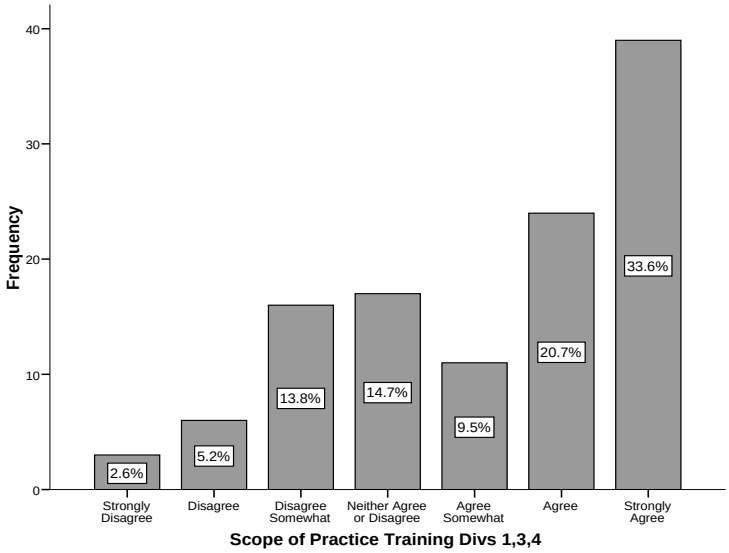
Scope of Practice Training – Div 1,3 and 4s

Total Sample

This scale asked Division 1, 3 and 4 RNs (only) to reflect on the recent changes to scope of practice that now enabled them to supervise Div 2s administering medications. Participants were asked to indicate whether they felt they had received adequate training to supervise the administration of medications, whether their organisation had clear polices and procedures in relation to medication administration, and whether they read and understood the Nurses Board of Victoria (NBV) code for the administration of medications. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly

Agree). The higher the score the more adequate participants felt the training they had received had been. Appendix A provides the individual items for the scale. The proceeding graph indicates the dispersion of responses based on the entire sample for the item.

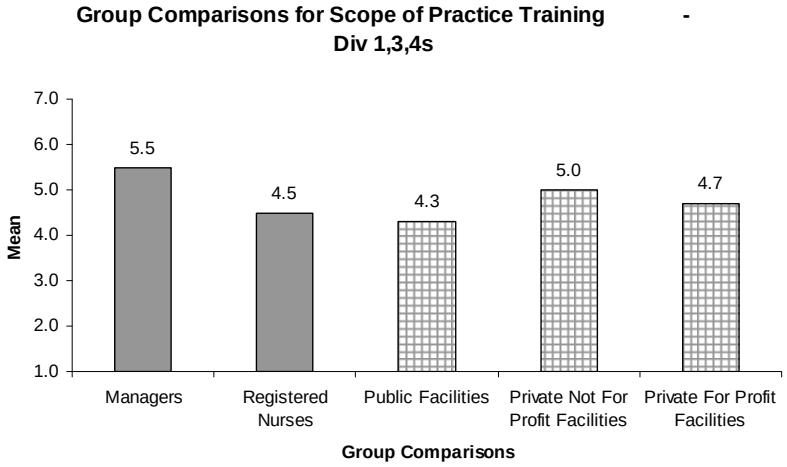
Figure 3.3.3



Group Comparisons

The following graph presents means for scope of practice training for Registered Nurses DIVs 1, 3 and 4 for the different groups based on job type and organisation type. The higher the score the more adequate participants felt the training they had received had been. In relation to the job type comparisons managers reported significantly more positive perceptions in relation to the scope of practice training they had received as compared to registered nurses. In relation to the organisation type comparisons participants working in public facilities reported significantly lower levels of satisfaction with the training they had received as compared to participants working in private not for profit or private for profit facilities.

Figure 3.3.4



1=Strongly Disagree
2=Disagree
3=Disagree Somewhat
4=Neither Agree or Disagree
5=Agree Somewhat
6=Agree
7=Strongly Agree

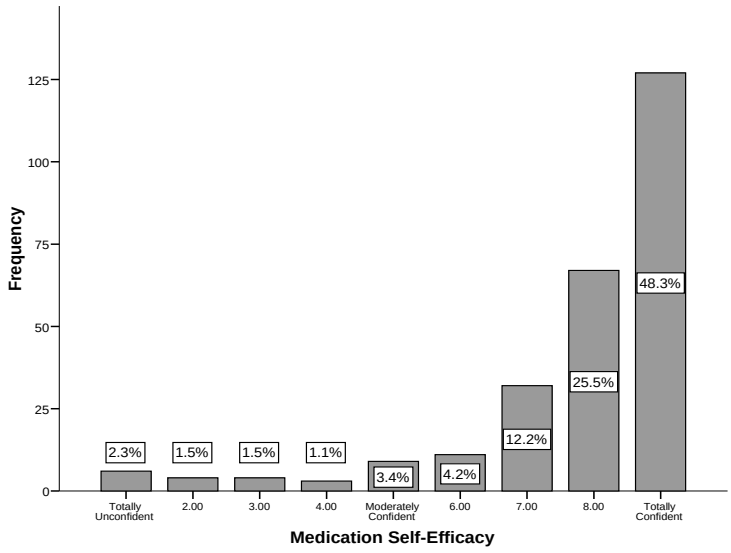
Medication Administration Self-Efficacy

Total Sample

Those participants who administered medications as part of their role were asked to reflect on how confident they felt in obtaining consent from residents, identifying different medications correctly by name, administering medications, and monitoring residents for potential adverse reactions. Division 1, 3 and 4 RNs were also asked how confident they felt in assessing the qualifications of another staff member when delegating medication administration. Participants were asked to record their responses using a scale which ranged from 1 (Totally Unconfident) to 9 (Totally Confident). Higher scores indicate greater levels of confidence in relation to the administration of medications. The proceeding graph indicates the dispersion of responses based on the entire sample for the scale. See Appendix A for full details of the items which make up this scale.

Figure 3.3.5

Mean: 7.5
SD: 1.6

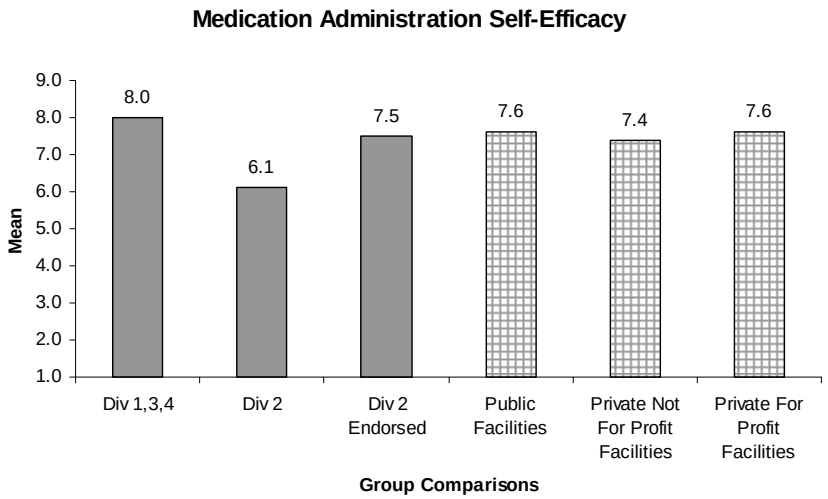


Group Comparisons

The following graph presents means for medication administration self-efficacy for the different groups based on job type and organisation type. Higher scores indicate

greater levels of confidence in relation to the administration of medications. In relation to the job type comparisons registered nurses Div 2 reported significantly lower levels of confidence in administering medications, with Div 1,3,4 registered nurses reporting the highest levels of confidence. In relation to the organisation type comparisons there were no significant differences across the categories in terms of reported levels of medication administration self-efficacy.

Figure 3.3.6

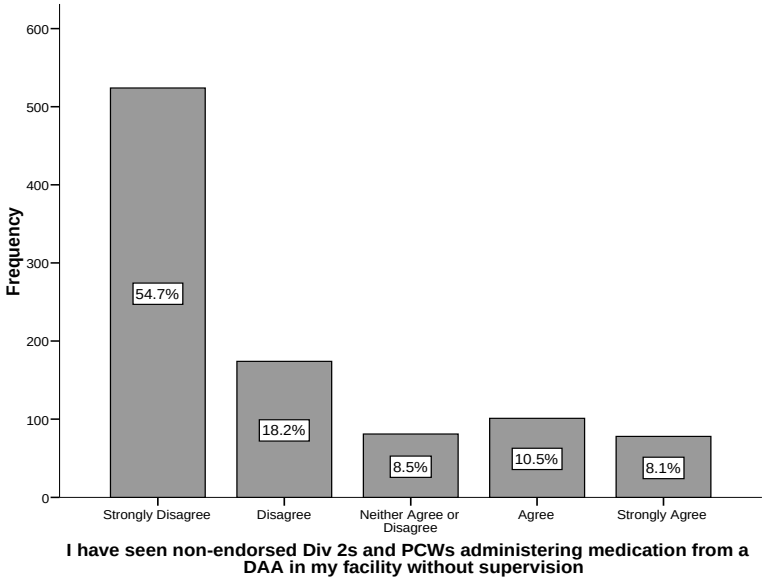


Medication Administration by Non-Endorsed Div 2s & Personal Care Workers (PCWs)

Total Sample

Participants were asked whether they had seen non-endorsed Div 2s and PCWs administering medication from a Dose Administration Aid (DAAs) (e.g., blister packs) without supervision at their facility. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate that the participant had witnessed medications being administered by non-endorsed Div 2s and PCWs. Appendix A provides the individual items for the scale. The proceeding graph indicates the dispersion of responses based on the entire sample for the item.

Figure 3.3.7

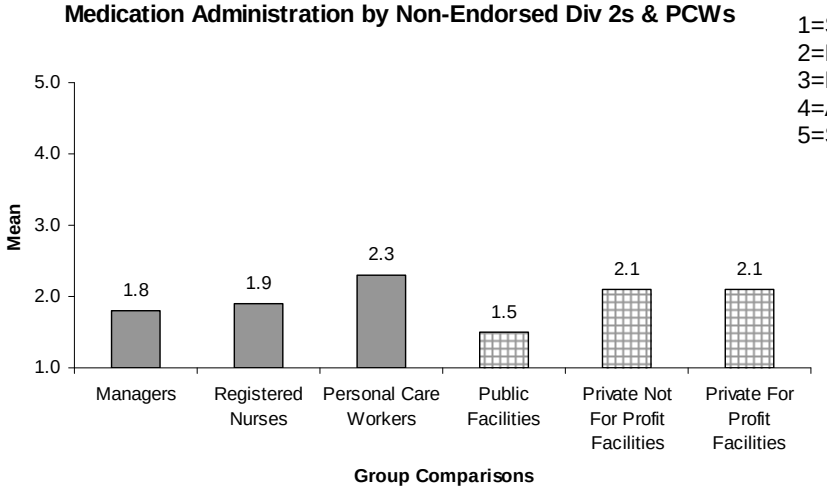


Mean: 2.0
SD: 1.3

Group Comparisons

The following graph presents means for medication administration by non-endorsed DIV 2s and PCWs for the different groups based on job type and organisation type. Higher scores indicate that the participant had witnessed medications being administered by non-endorsed Div 2s and PCWs. In relation to the job type comparisons personal care workers agreed significantly more strongly with the statement as compared to registered nurses and managers. Dive 2 endorsed nurses also agreed significantly more strongly with the statement compared to Div 1,3,4 and Div 2 nurses. In relation to the organisation type comparisons participants from public facilities agreed significantly less strongly with the statement compared to those participants from private not for profit and private for profit facilities. Participants from mixed care facilities agreed more strongly that they had seen medication administered by non-endorsed Div 2s and PCWs compared to those participants from high care facilities.

Figure 3.3.8



1=Strongly Disagree
2=Disagree
3=Neither Agree or Disagree
4=Agree
5=Strongly Agree

Medication Errors

Total Sample
These items asked participants to indicate the frequency with which a series of different medication errors were made at their facility. The response scale participants were asked to use ranged from 1 (Less than once per month or never) to 5 (Several times per day). Higher scores indicate the medication error was made more frequently. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

Figure 3.3.9

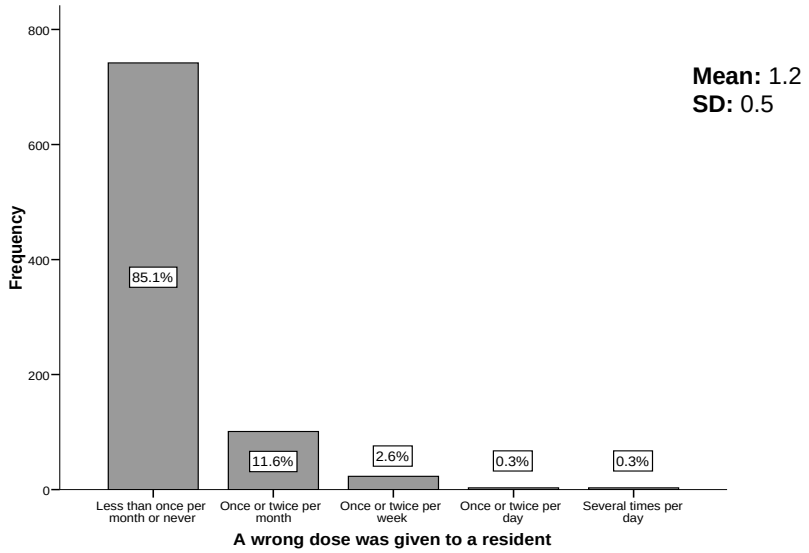


Figure 3.3.10

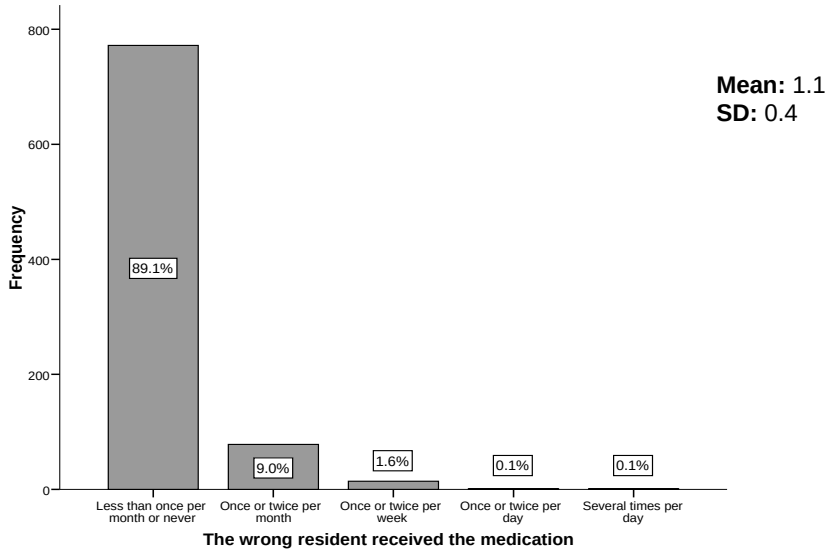


Figure 3.3.11

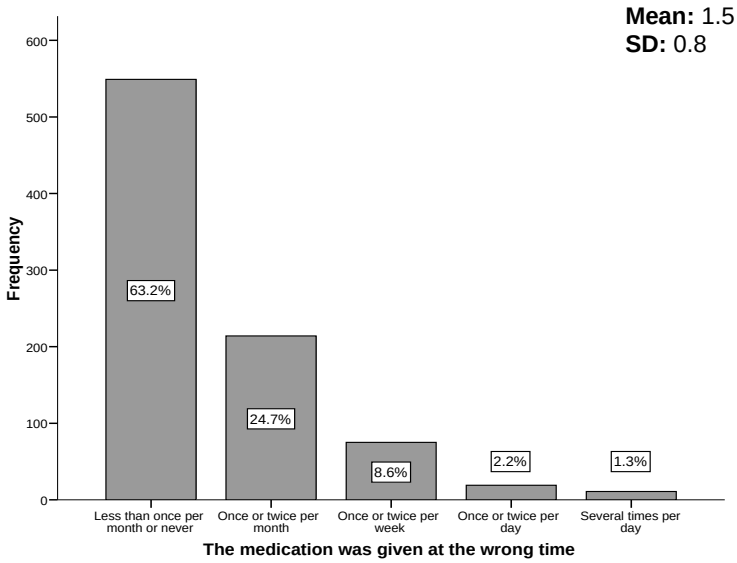


Figure 3.3.12

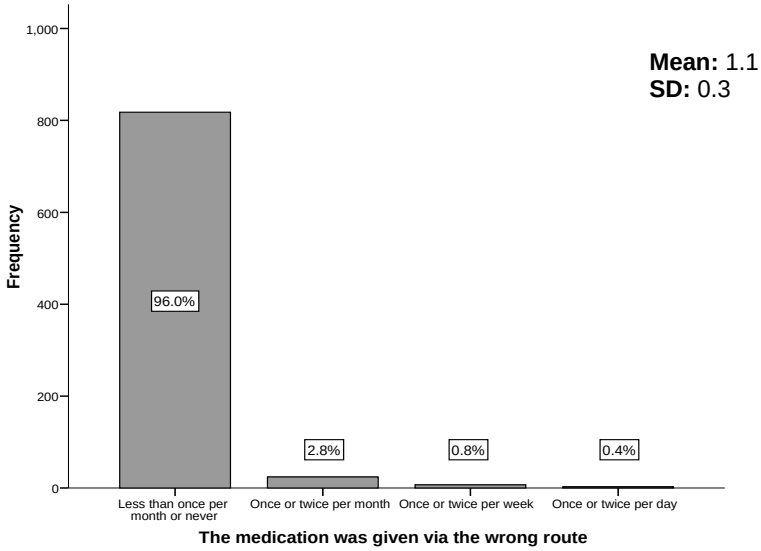


Figure 3.3.13

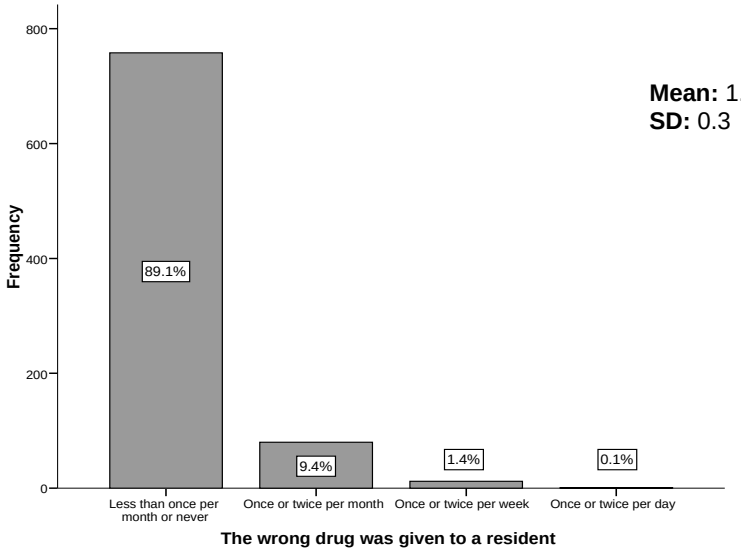


Figure 3.3.14

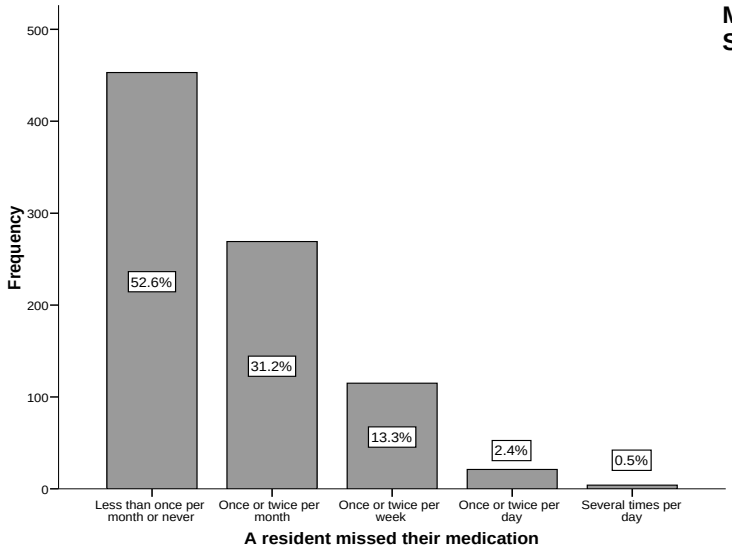
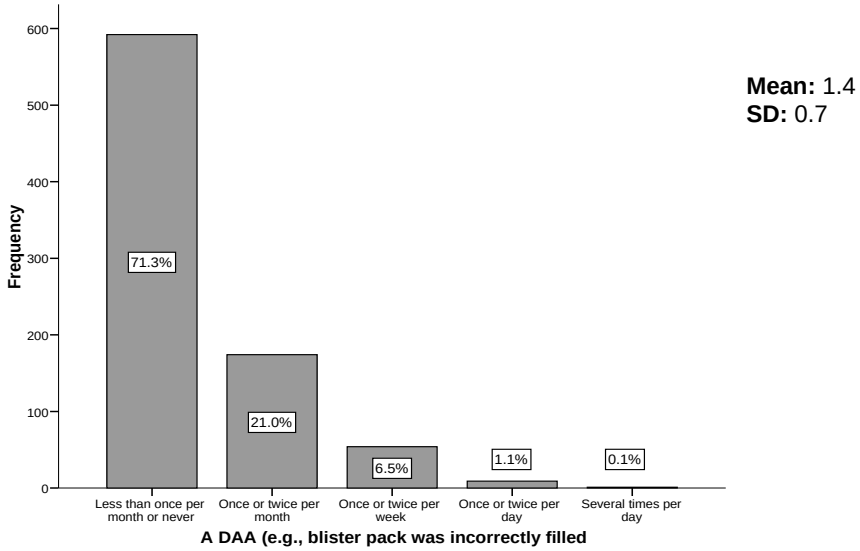


Figure 3.3.15



Group Comparisons

The following graphs present the means for each of the different medication errors for the different groups based on job type and organisation type. Higher scores indicate the medication error was made more frequently. For the job type comparisons personal care workers reported that the wrong resident received the medication and that the medication was given via the wrong route more frequently as compared to the rates reported by managers and registered nurses. In relation to the other types of medication errors there were no statistically significant differences between the different job types. In relation to differences in the reporting rates by the different categories of nurses, Div 2 nurses reported that DAAs were incorrectly filled as compared to Div 1,3,4 and Div 2 endorsed nurses. On all of the other medication error items there were no significant differences based on nursing category. There were no significant differences based on organisation type for any of the different medication errors. Overall, in relation to differences based on the type of care the facility provided participants from mixed care facilities, as compared to participants from high care facilities, reported that medication errors occurred more frequently. Only for two of the medication error items (medication given at the wrong time and

medication given via the wrong route) there were there no significant differences between mixed and high care facilities.

Figure 3.3.16

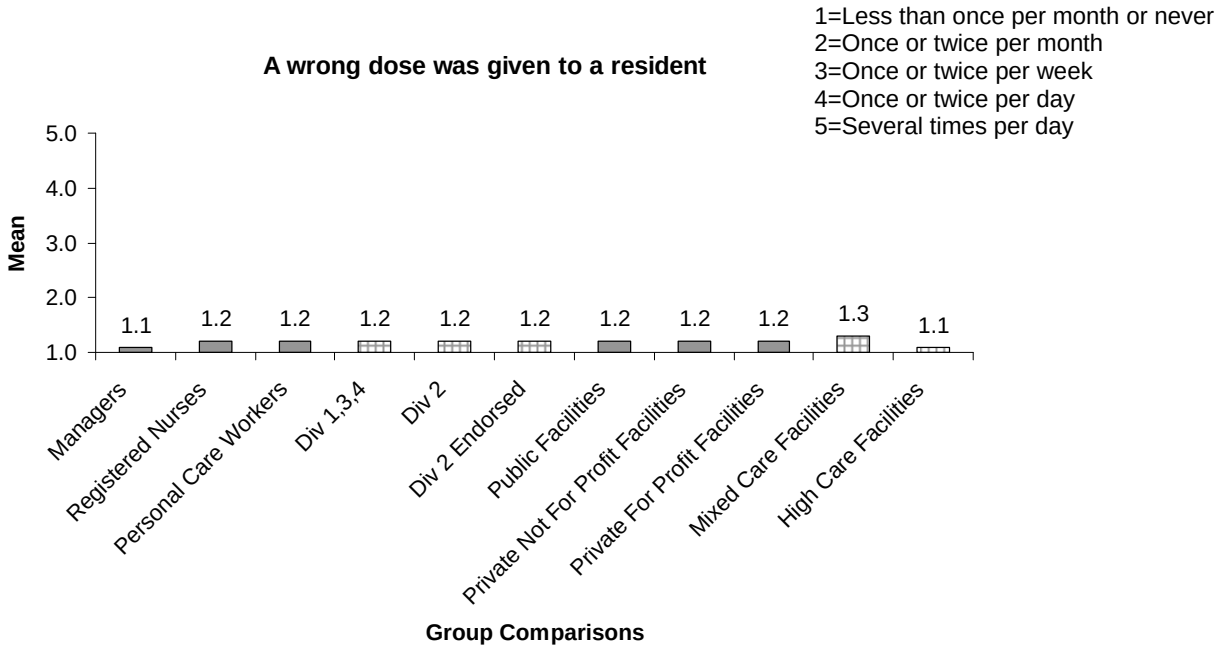


Figure 3.3.17

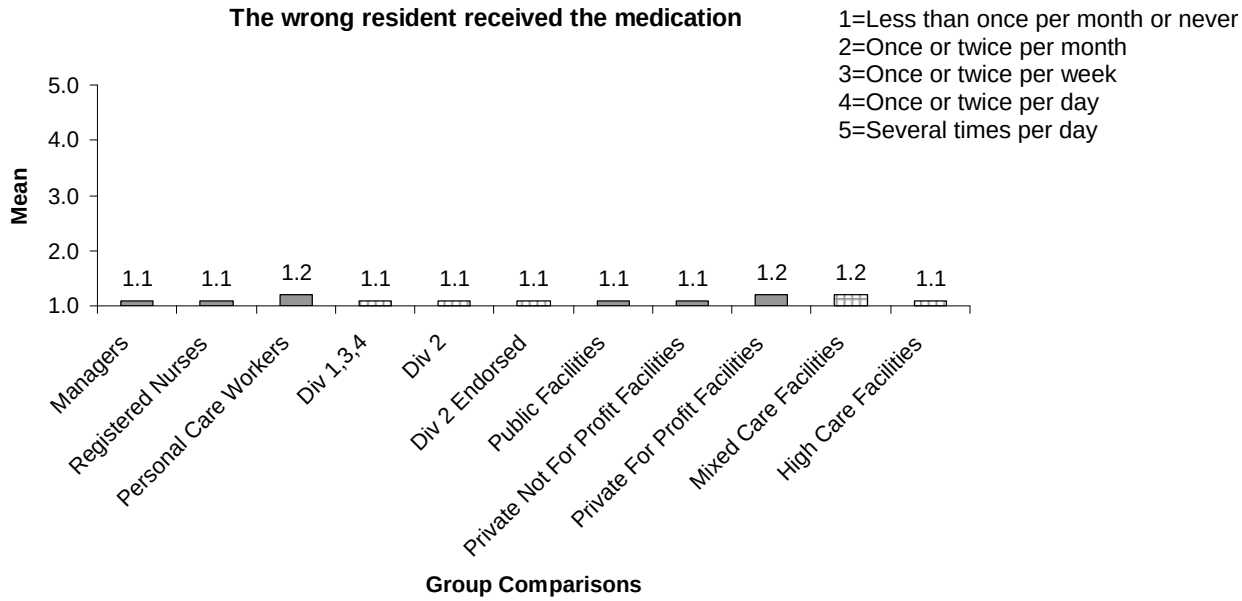


Figure 3.3.18

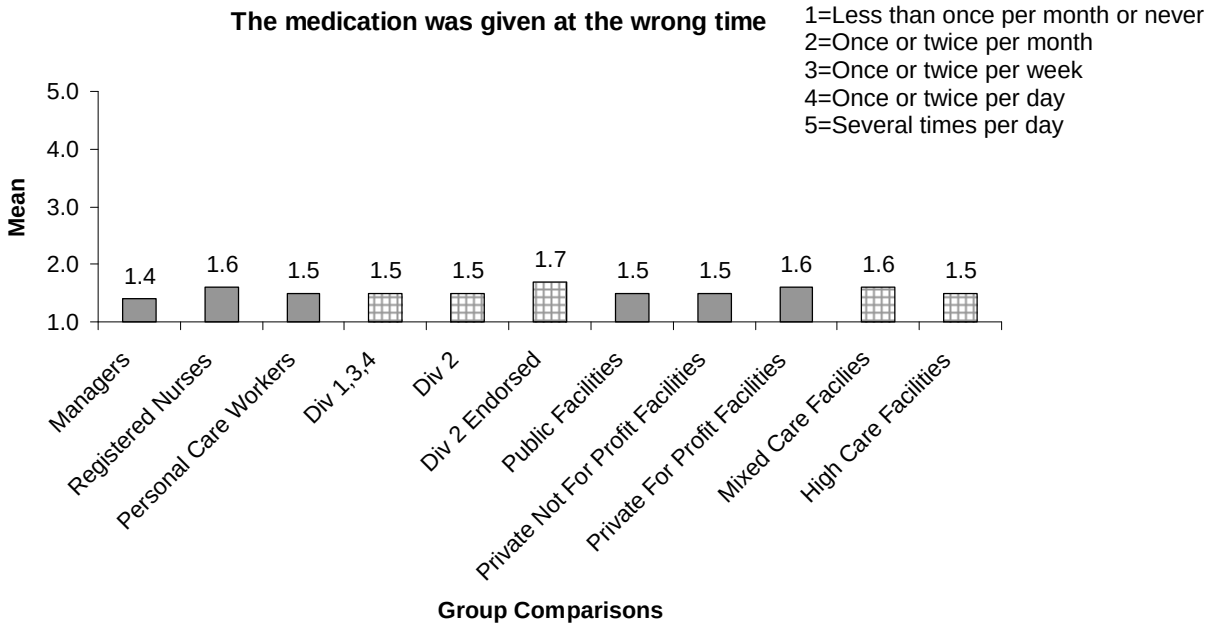


Figure 3.3.19

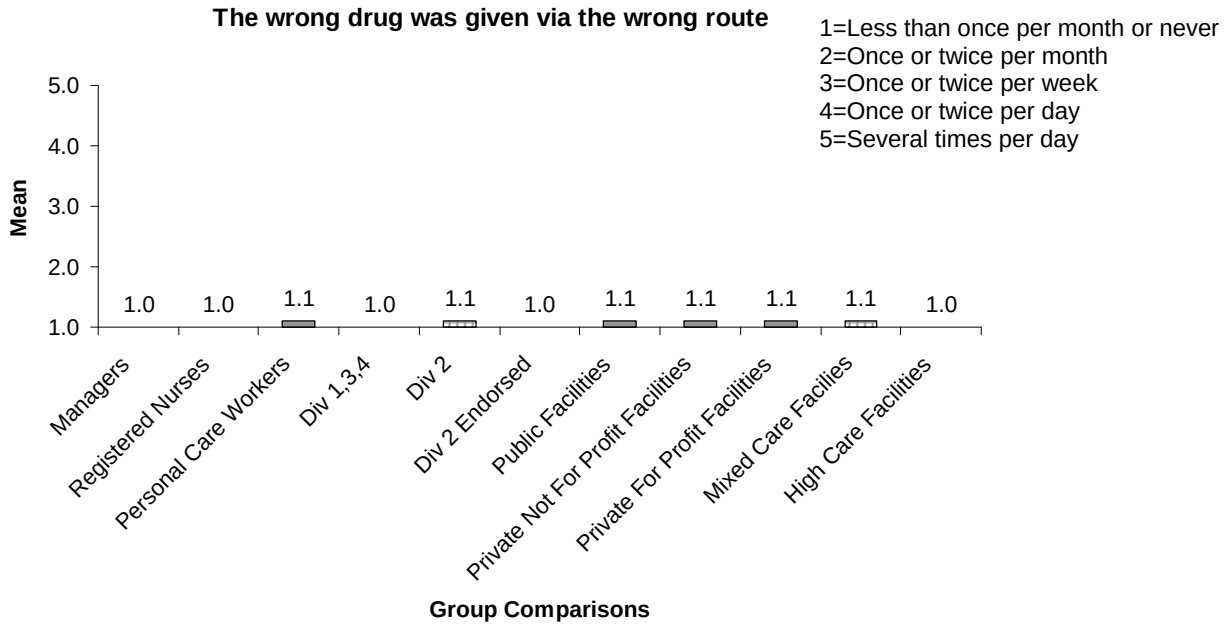


Figure 3.3.20

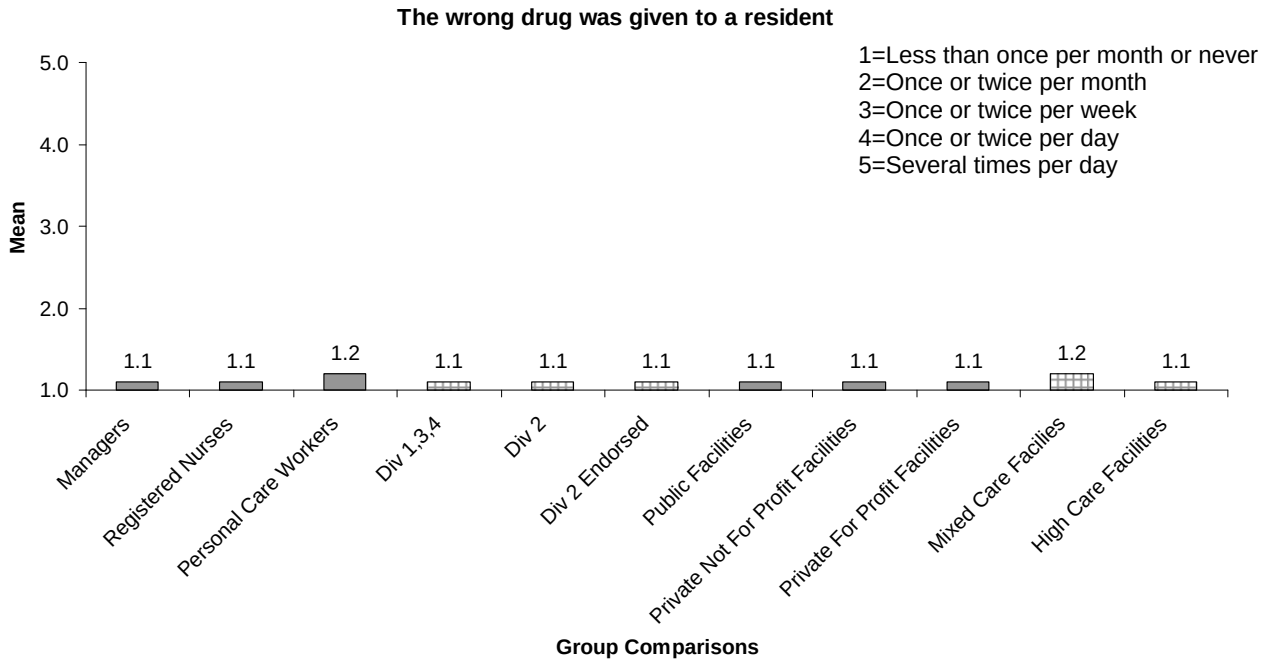


Figure 3.3.21

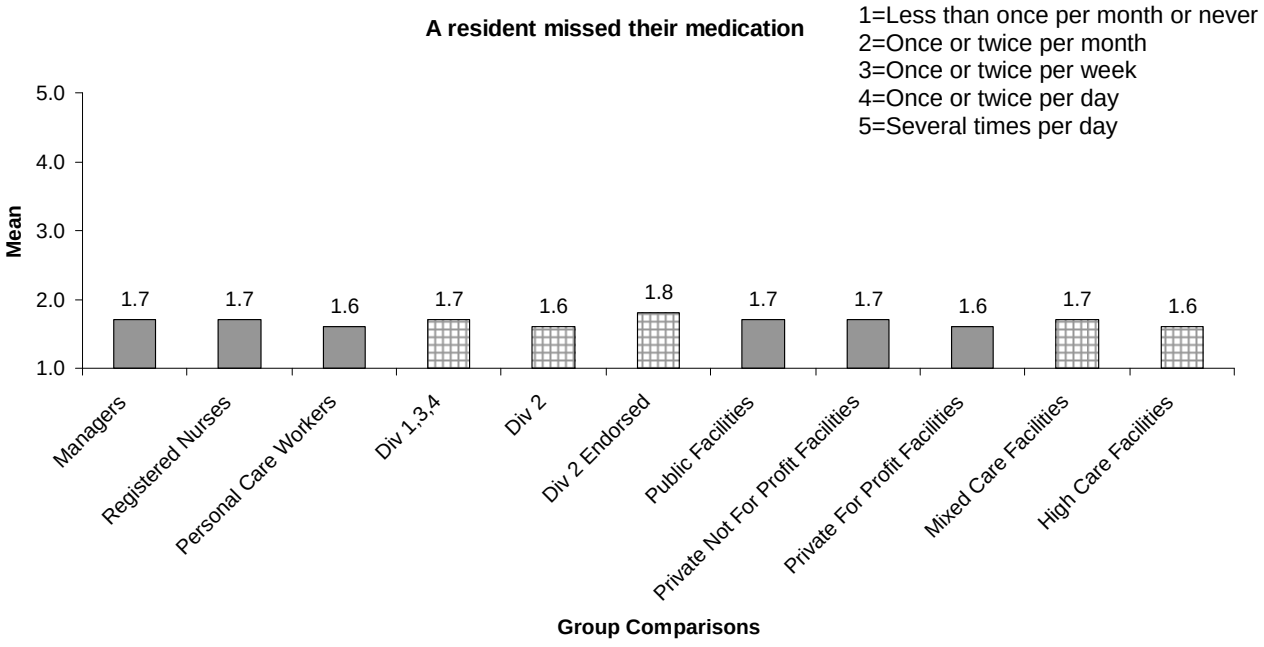
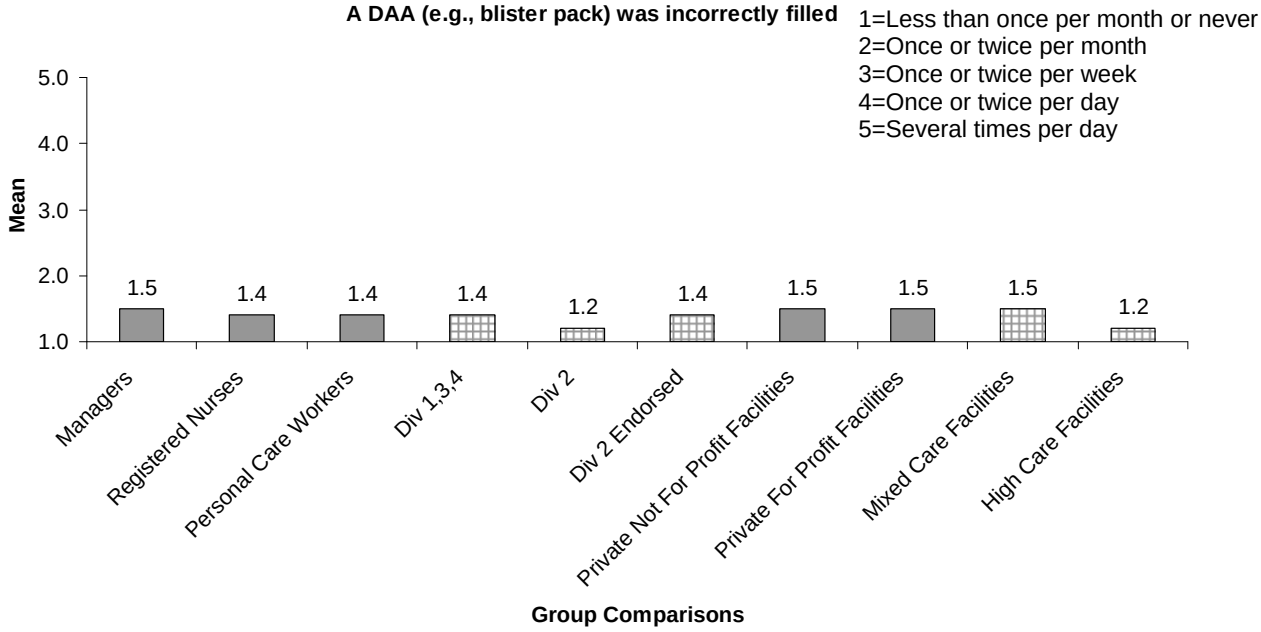


Figure 3.3.22



Predictors of Medication Errors

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the frequency with which medication errors were made (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Medication Errors:
  - Employee/Facility Variables
    - Nursing Qualifications: Individuals with higher/more advanced nursing qualifications tended to report that medication errors were made more frequently in their facilities. Unfortunately, the questionnaire did not ask participants to explain why this is the case. It may be that individuals with higher levels of education and training are more equipped to recognise medication errors when they occur.
  - Work Stressors
    - Role Conflict: Individuals who perceived high levels of role conflict tended to report medication errors were made more frequently at their facility.

- Work Stressors (cont)
    - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the more frequently they also reported medication errors were made at their facility.
    - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also report that medication errors were made more frequently at their facility.
- Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures tended to report that medication errors were made less frequently at their facility.
    - Training: Individuals who felt they received adequate training to do their job effectively tended to report that medication errors were made less frequently at their facility.
- Overall the employee/facility variables accounted for 7% of the variance in medication errors. The work stressor variables and the management practices variables each accounted for an additional 15.1% and 1.6% of the variance respectively[4].

Summary: Medication Practices

Most division 2 registered nurses felt they had received adequate training in relation to changes to their scope of practice with participants working at public facilities reporting the lowest levels of training. Similarly, most division 1, 3 and 4 registered nurses felt they had received adequate training in relation to the changes to their scope of practice. Again participants who worked at public facilities reported the lowest levels. Overall, most participants reported high levels of self-efficacy or confidence in relation to administering medications. There were no significant differences based on organisation type. Across the total sample participants reported that most medication errors occurred less than once per month or never. Personal care workers tended to report that medication errors occurred more frequently than did managers and registered nurses. No significant differences were found based on type of organisation. Medication errors were likely to happen more frequently in situations where levels of role conflict, co-worker aggression and resident quality of living cost-cutting were higher. Medication errors were likely to happen less frequently if the organisation had good grievance procedures and training practices.

3.4. Workplace Aggression

In this section of the survey participants were asked to assess the frequency with which they witnessed co-workers behaving aggressively towards residents and the frequency with which they experienced aggression from residents. Below a summary

[4] The simplest way to make sense of this is that it suggests that 23.7 per cent of the differences in the frequency with which medication errors are made can be explained by differences in these variables. The remaining 76.3 per cent of difference in the frequency with which medication errors are made must, therefore, be accounted for by other variables or factors. This logic applies whenever we report the percentage of variance accounted for by variables.

in relation to each of these different forms of aggression is provided. A bar chart for each scale indicating the dispersion of responses based on the entire sample is also provided. This is followed by comparisons for each of the scales across different job types (Managers, Registered Nurses, & Personal Care Workers) and organisation types (Public, Private Not for Profit, Private for Profit). Appendix A provides the individual items for each of the aggression scales.

Co-worker Aggression towards Residents

Total Sample

The items in this scale assessed how frequently in the past 6 months participants had witnessed co-workers behaving in either a verbally or physically aggressive way towards residents. Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times). Higher scores indicate participants witnessed co-workers behaving aggressively towards residents more frequently. The proceeding graphs indicates the dispersion of responses based on the entire sample for teach of the items in the scale.

Figure 3.4.1

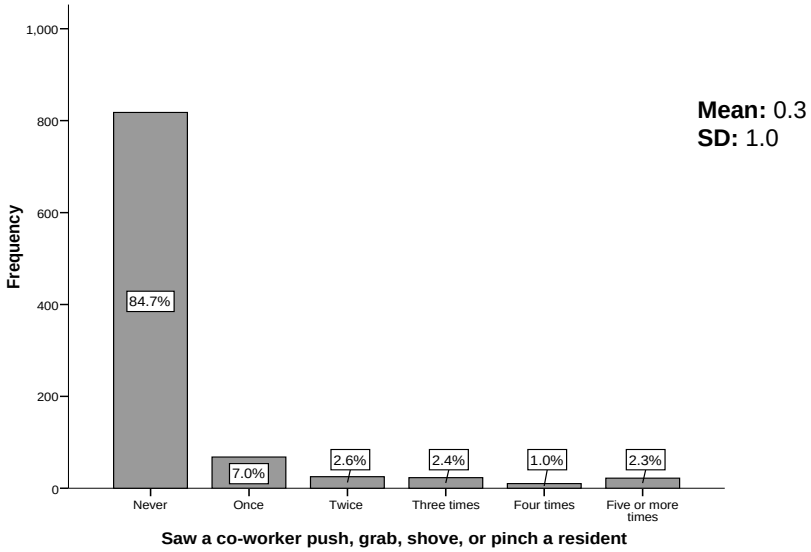


Figure 3.4.2

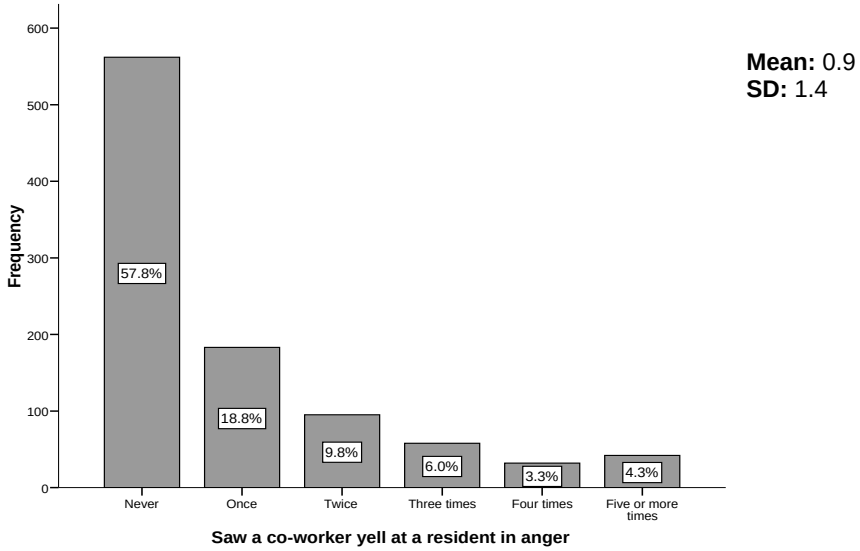
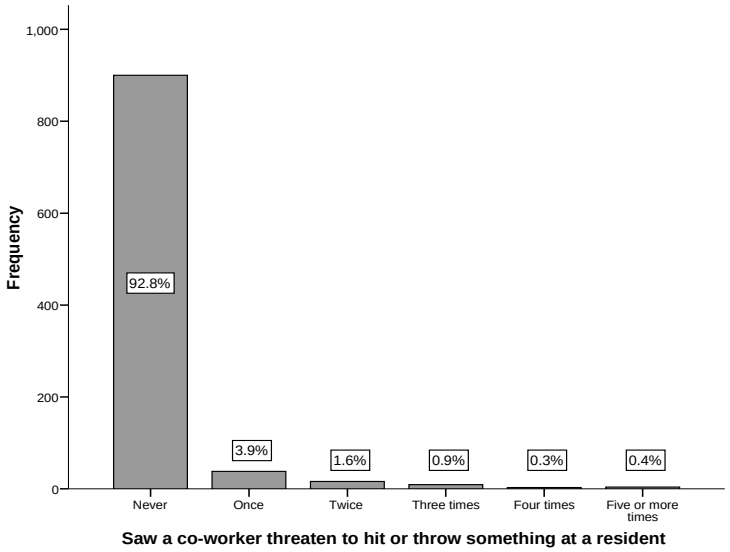
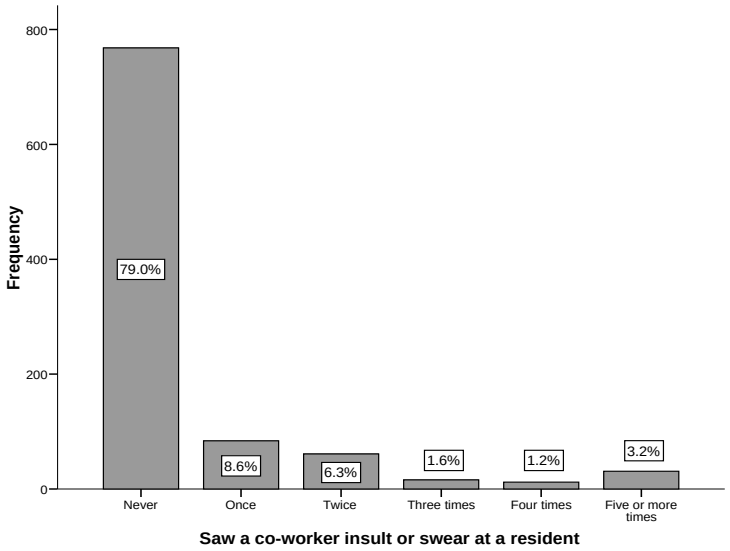


Figure 3.4.3



Mean: 0.5
SD: 1.1

Figure 3.4.4

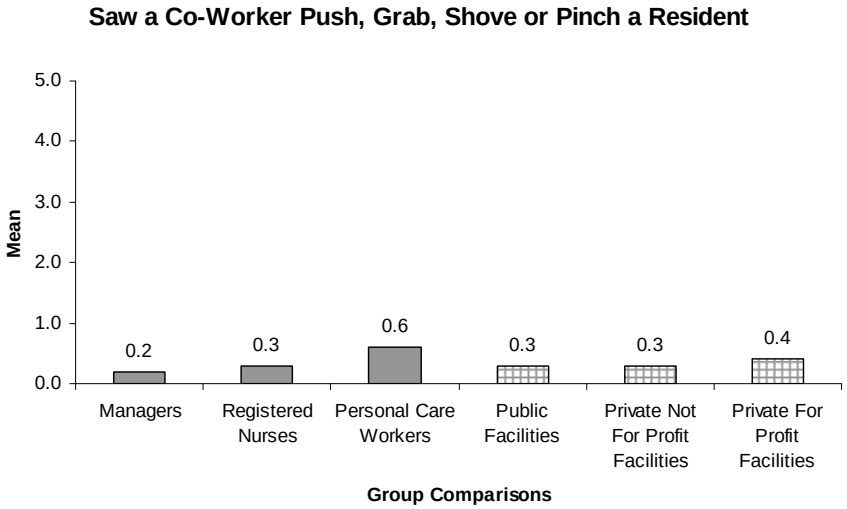


Mean: 0.1
SD: 0.6

Group Comparisons

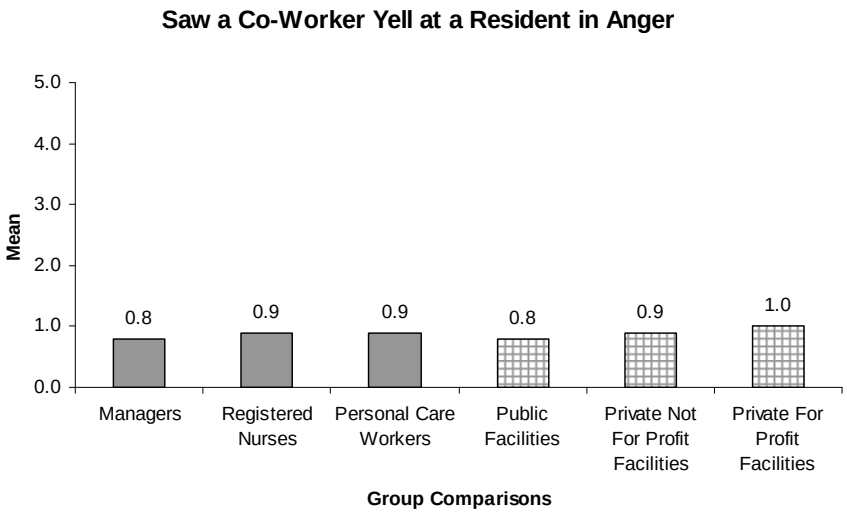
The following graphs present the means for co-worker aggression for the different groups based on job type and organisation type. Higher scores indicate participants witnessed co-workers behaving aggressively towards residents more frequently in the past 6 months. In the job type comparisons personal care workers reported witnessing co-workers yell at residents in anger significantly more frequently than did managers and registered nurses. There were no other significant differences across the different job types on the co-worker aggression items. In relation to the organisation type comparisons there were no significant differences for any of the items across the different categories.

Figure 3.4.5



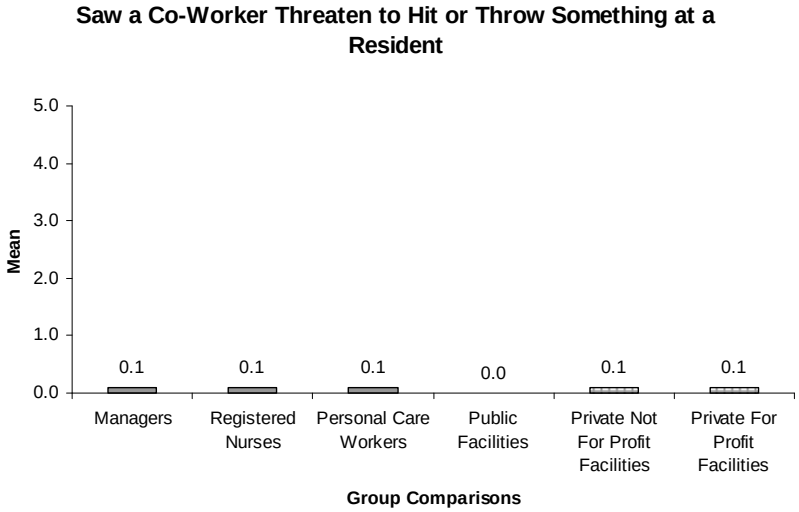
0=Never
1=Once
2=Twice
3=Three Times
4=Four Times
5=Five or More Times

Figure 3.4.6



0=Never
1=Once
2=Twice
3=Three Times
4=Four Times
5=Five or More Times

Figure 3.4.7



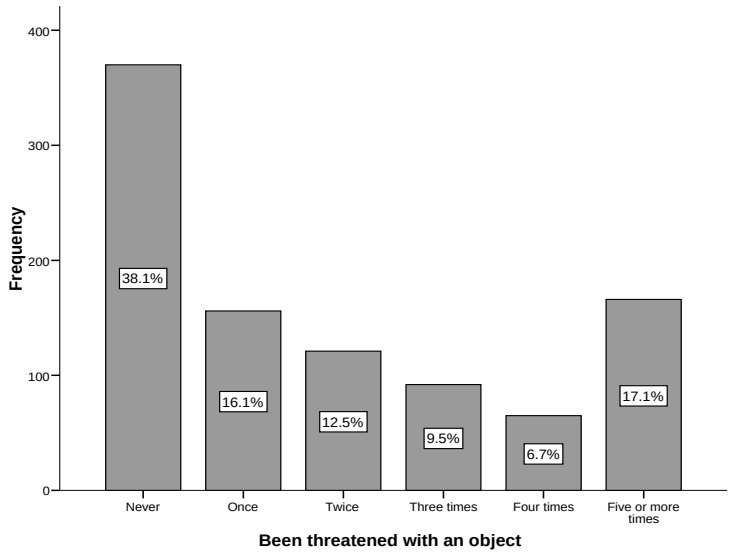
0=Never
1=Once
2=Twice
3=Three Times
4=Four Times
5=Five or More Times

Resident Aggression

Total Sample

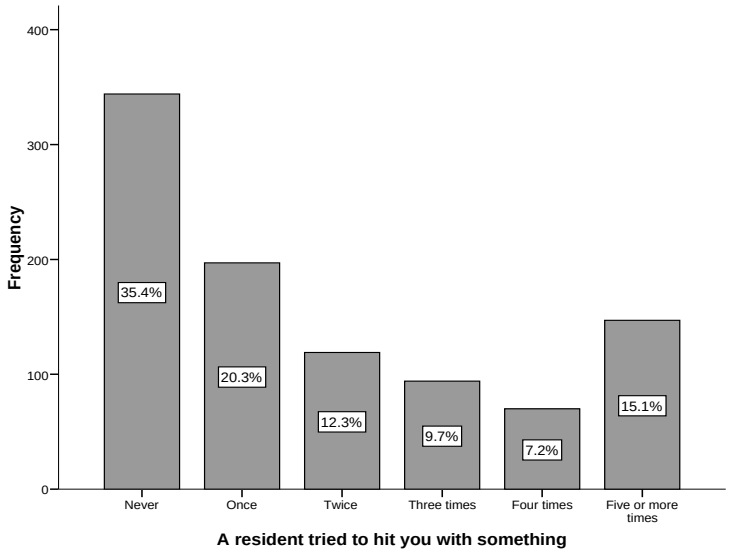
The items in this scale assessed how frequently in the past 6 months participants had personally experienced either verbal or physical aggression from residents. Participants were asked to record their responses using a scale which ranged from 0 (Never) to 5 (Five or more times). Higher scores indicate participants experienced aggression from residents more frequently. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

Figure 3.4.8



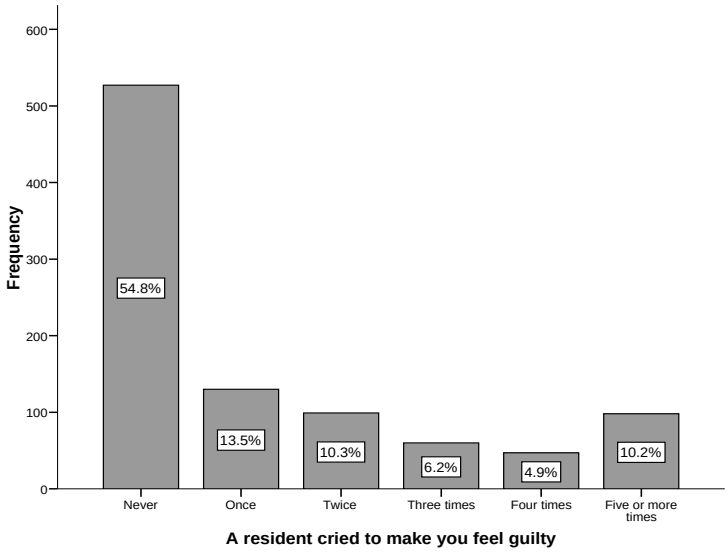
Mean: 1.8
SD: 1.9

Figure 3.4.9



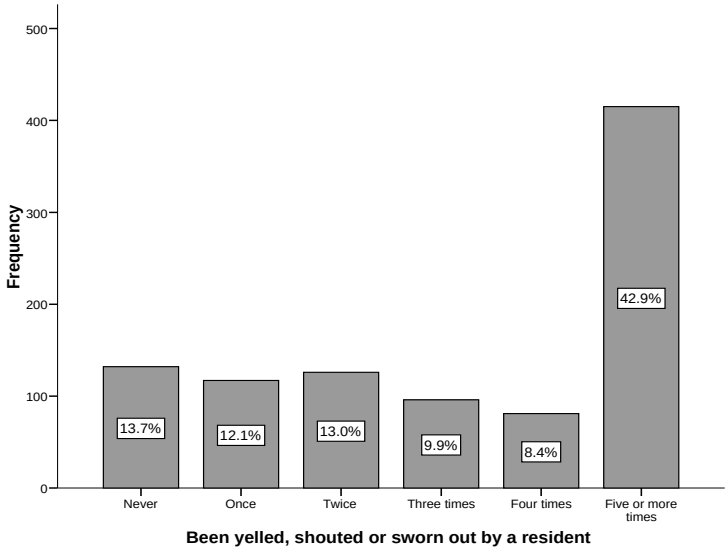
Mean: 1.8
SD: 1.8

Figure 3.4.10



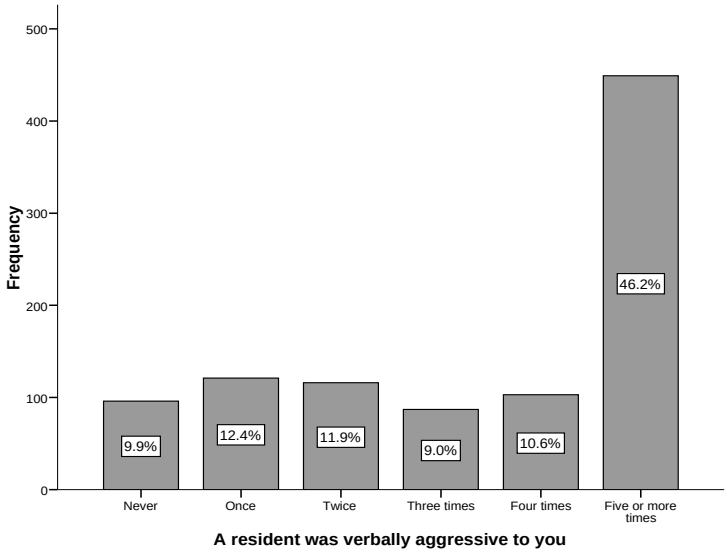
Mean: 1.2
SD: 1.7

Figure 3.4.11



Mean: 3.2
SD: 1.9

Figure 3.4.12



Mean: 3.4
SD: 1.8

Group Comparisons

The following graphs present the means for the resident aggression items for the different groups based on job type and organisation type. Higher scores indicate participants experienced aggression from residents more frequently in the past 6 months. In relation to the job type comparisons personal care workers reported having residents try to hit them with something significantly more frequently than did managers or registered nurses. Registered nurses and personal care workers reported that residents yelled at them and were verbally aggressive towards them significantly more frequently than was the case for managers. In relation to the organisation type comparisons participants who worked at private not for profit facilities reported significantly fewer incidents where they had been threatened with an object, hit or yelled, shouted or sworn at by residents than did participants who worked in public or private for profit facilities.

Figure 3.4.13

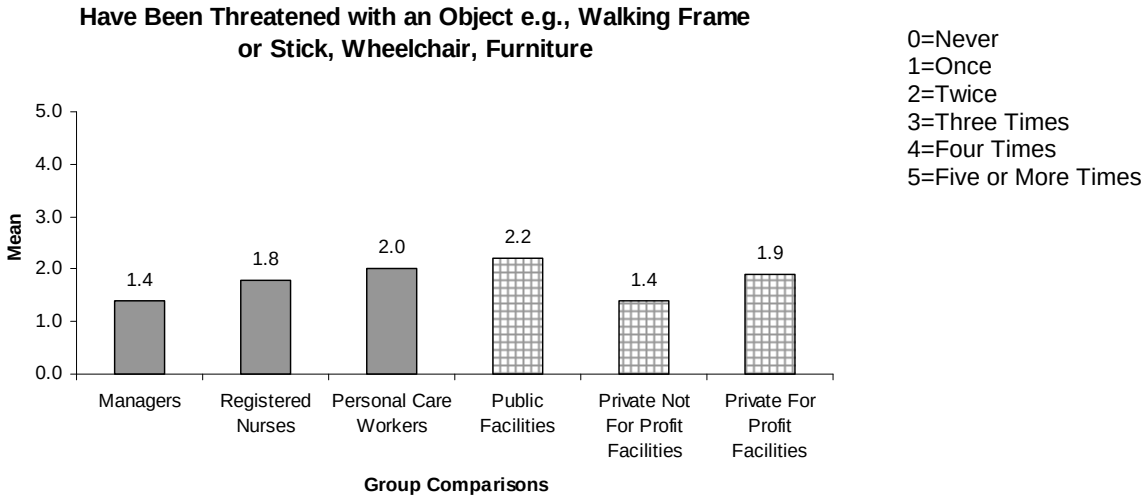


Figure 3.4.14

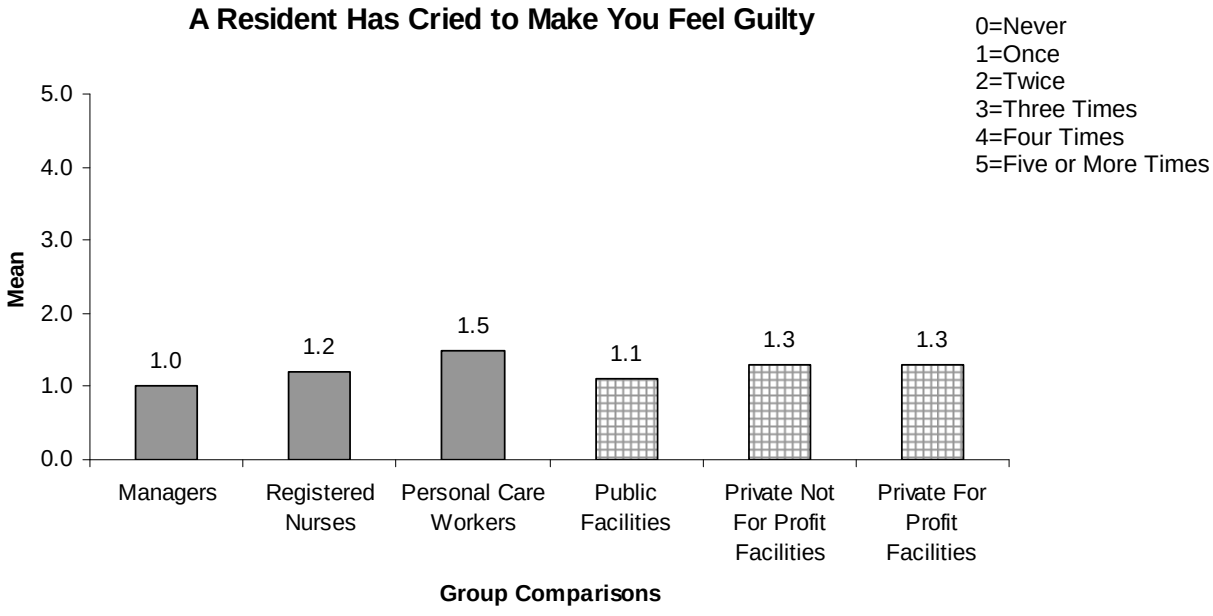


Figure 3.4.15

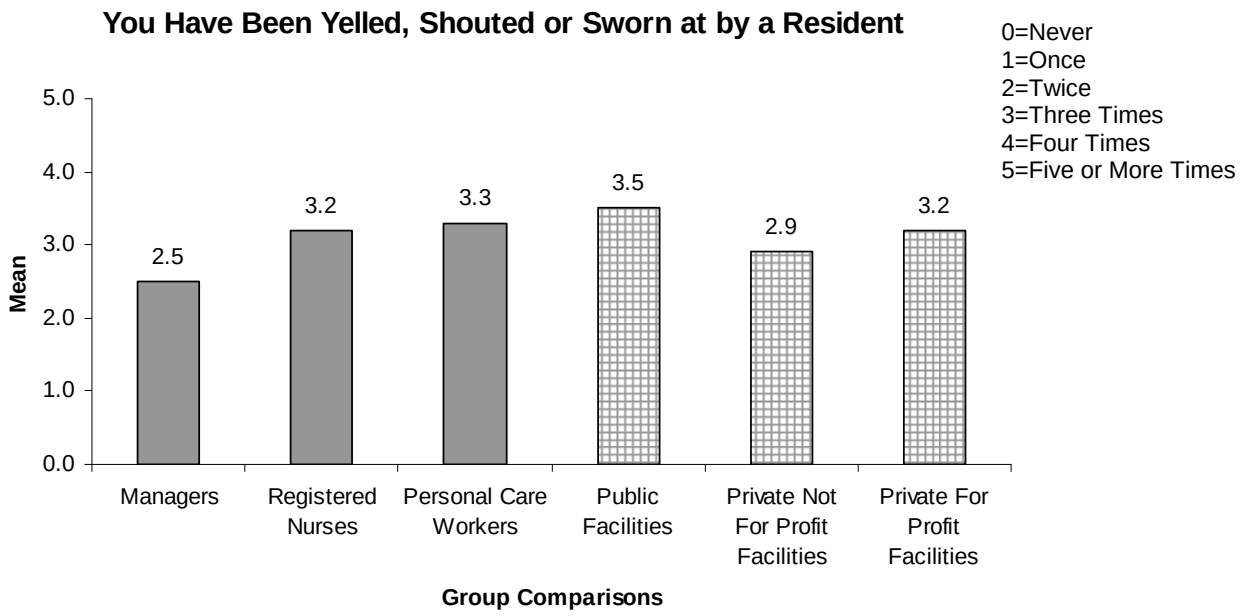
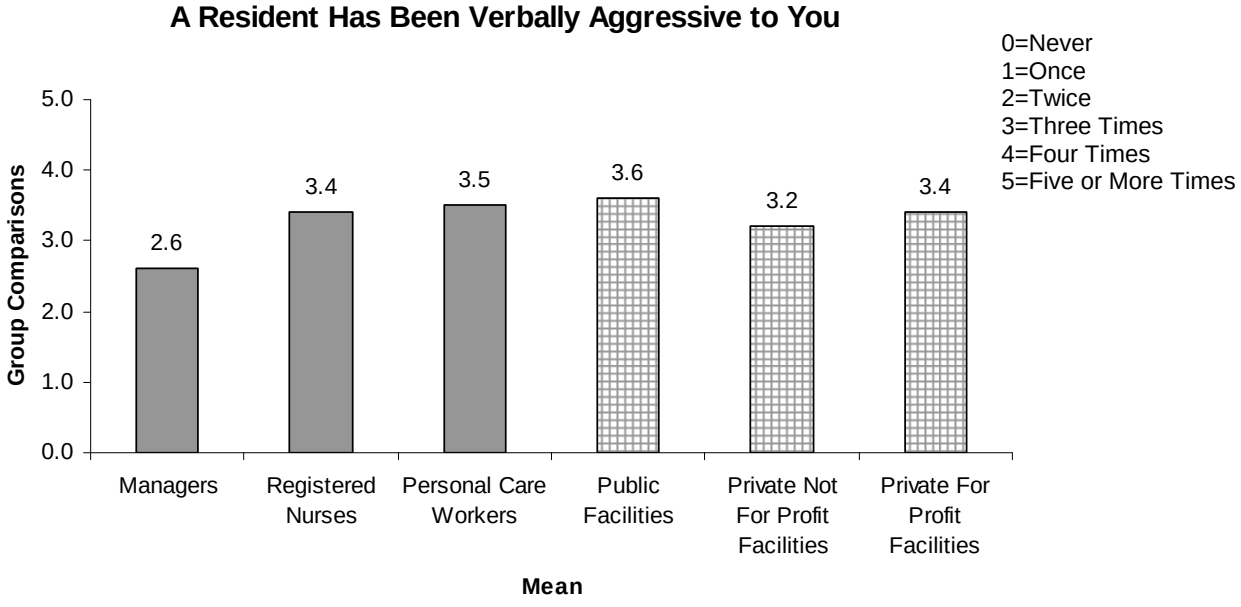


Figure 3.4.16



Summary: Workplace Aggression

Forty per cent of participants had seen a co-worker yell at a resident one or more times, and 15% had seen a co-worker push, grab, shove, or pinch a resident one or more times in the past 6 months. Other forms of aggression were reported less frequently. Managers tended to report witnessing significantly less co-worker aggression. No significant differences were found across the different types of organisations. The frequency with which participants' experienced resident aggression varied based on the type of aggression. Participants reported being

yelled, shouted or sworn at and verbal aggression by residents occurred most frequently. Registered nurses and personal care workers reported experiencing aggression from residents significantly more frequently than managers. Participants who worked at public facilities tended to experience aggression from residents more frequently than participants from private not for profit or private for profit facilities.

3.5. Work, Psychological & Physical Health Outcomes

The scales in this section were designed to assess the extent to which participants were satisfied with their current job, intended to leave their current job, were committed to their current organisation, were emotionally exhausted as a result of their job, were functioning well psychologically and were exhibiting a range of different physical symptoms. A summary of each these different outcomes are provided below. A bar chart for each scale indicating the dispersion of responses based on the entire sample is also provided. This is followed by comparisons for each of the scales across different job types (Managers, Registered Nurses, & Personal Care Workers) and organisation types (Public, Private Not for Profit, Private for Profit). Appendix A provides the individual items for each of the scales.

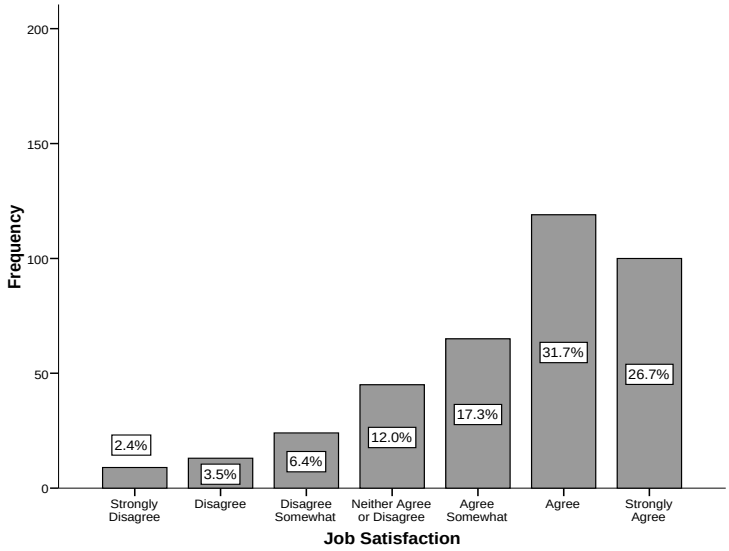
Job Satisfaction

Total Sample

This scale assessed the extent to which participants were satisfied with their current job. An example of one of the items used in the scale is “All in all, I am satisfied with my job”. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Higher scores indicate higher levels of job satisfaction. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

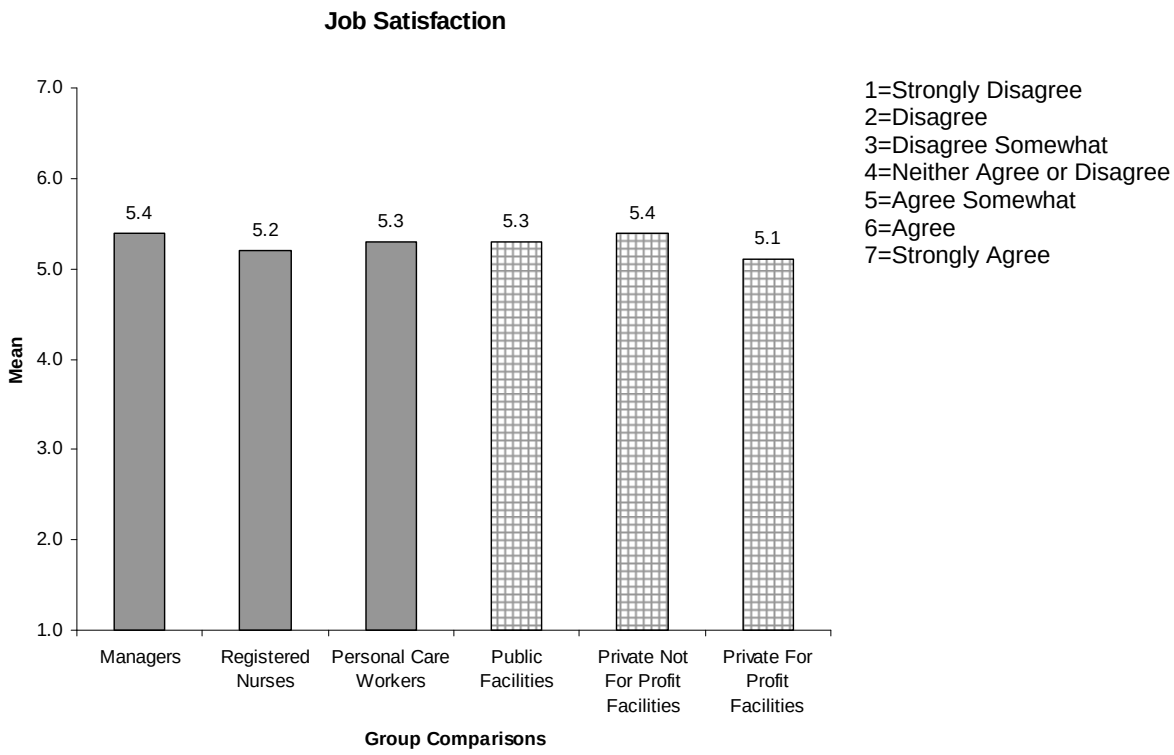
Figure 3.5.1

Mean: 5.3
SD: 1.4



Group Comparisons
The following graph presents the means for job satisfaction for the different groups based on job type and organisation type. Higher scores indicate higher levels of job satisfaction. In relation to the job type comparisons there were no significant differences in the levels of job satisfaction reported by participants across the different categories. For the organisation type comparisons participants who worked in private for profit facilities reported significantly lower levels of job satisfaction than participants who worked in public or private not for profit facilities.

Figure 3.5.2



Predictors of Job Satisfaction
A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the degree to which individuals were satisfied with their job (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Job Satisfaction:
  - Employee/Facility Variables
    - Gender: Females were more satisfied with their job.
    - Age: Older workers were more satisfied with their job.

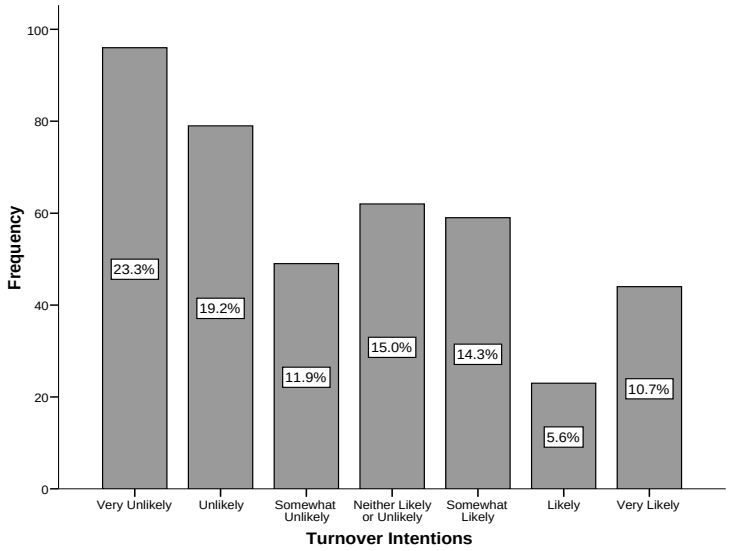
- Employee/Facility Variables (cont)
    - Negative Affect: Individuals who in general had a more negative outlook/attitude were less satisfied with their job.
    - Occupation Time: The longer an individual had been working in their current occupation the less likely they were to be satisfied with their job.
- Work Stressors
    - Role Conflict: Individuals who experienced high levels of role conflict reported lower levels of job satisfaction.
    - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living of residents were less likely to be satisfied with their job.
- Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to be satisfied with their job.
    - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more satisfied with their job.
    - Training: Individuals who received adequate training to do their job effectively were more satisfied.
- Overall the employee/facility variables accounted for 26% of the variance in job satisfaction. The work stressor variables and the management practices variables each accounted for an additional 9.7% and 5.5% of the variance respectively.

Turnover Intentions

Total Sample
This scale assessed the likelihood that participants would leave their current job and/or how much they would like to get a new job. An example of one of the items used in the scale is “How likely is it that you will look for a job outside of this organisation during the coming year?” Participants were asked to record their responses using a scale which ranged from 1 to 7. Higher scores indicate a greater likelihood participants will leave their current job. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

Figure 3.5.3

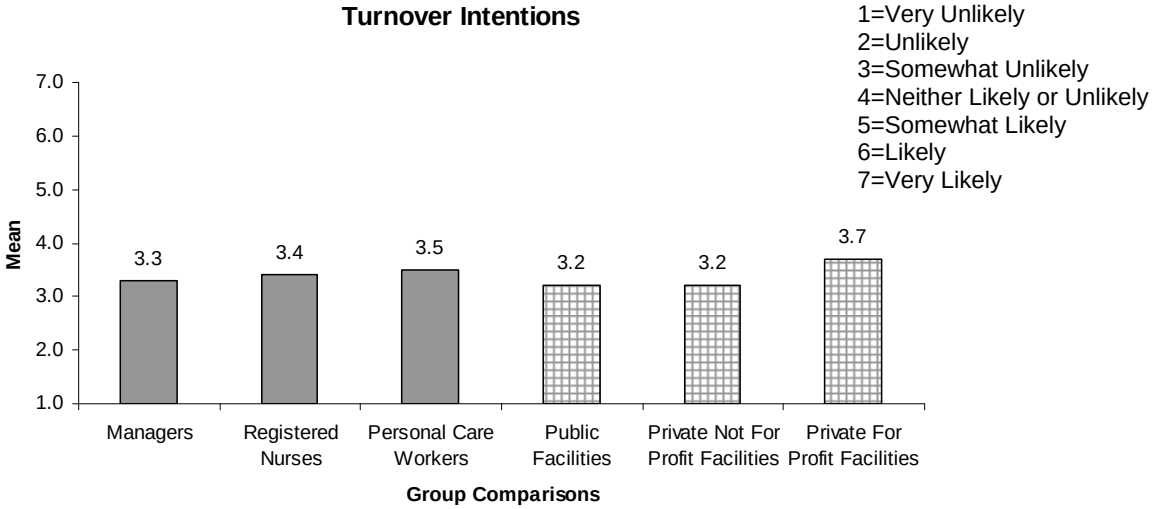
Mean: 3.4
SD: 1.8



Group Comparisons

The following graph presents the means for turnover intentions for the different groups based on job type and organisation type. Higher scores indicate a greater likelihood participants will leave their current job. In relation to the job type comparisons there were no significant differences in turnover intentions across the different job categories. In the organisation type comparisons participants who worked in private for profit facilities reported significantly higher intentions to leave their current job than participants who worked in public or private not for profit facilities.

Figure 3.5.4



Predictors of Turnover Intentions

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the likelihood an

individual would leave their job in the next year (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Turnover Intentions:
  - Employee/Facility Variables
    - Age: Older workers were less likely to leave their current job.
    - Relationship Status: Individuals who were currently in a relationship were less likely to leave their current job.
    - Negative Affect: Individuals who in general had a more negative outlook/attitude were more likely to leave their current job.
    - Organisation Time: The longer an individual had been working at their current organisation the less likely they were to leave.
    - Organisation Ownership: Individuals who worked at a facility that was privately owned were less likely to leave their current job.
  - Work Stressors
    - Workload: Individuals who felt they had heavy workloads were more likely to leave their current job.
    - Role Conflict: Individuals who reported high levels of role conflict were more likely to leave their job.
    - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff were more likely to leave their current job.
  - Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were less likely to leave their current job.
    - Training: Individuals who received adequate training to do their job effectively were less likely to leave their current job.
  - Overall the employee/facility variables accounted for 23.1% of the variance in turnover intentions. The work stressor variables and the management practices variables each accounted for an additional 11.4% and 3.7% of the variance respectively.

Further Qualitative Evidence on the causes of turnover in Aged Care

Qualitative comments provided by a small number of participants who had actually left the aged care sector in the last 12 months would seem to support the above findings and reinforce the particularly negative role excessive workloads and cost-cutting play in contributing to the likelihood that individuals will stop working in the sector. Of the small number of surveyed participants who had actually left aged care most had however remained in the health care sector with only a smaller number opting to leave the health care sector all together.

Table 3.5.1

Type of Occupational Drift	Number of Participants	
Voluntarily changed organisations & left aged care in the last 12 months	25	**Most common reasons for leaving:** • Didn't like job changes introduced by management • Redundancy • Retirement • Stress • Bullying • Desire for better working conditions • Wanted a career change **Most common new positions:** • RN position in a hospital • Palliative/home care nursing • Diversional therapies
Type of Occupational Drift	**Number of Participants**	
Voluntarily changed jobs and left the health care sector	10	**New Industries** • Teaching • Started own small business

Qualitative Comments

"I no longer work in aged care. I stopped working in aged care because I could not nurse the residents the way I would have liked to because of limited time."

"I stopped working in aged care due to management cost cutting which put extra strain on workers resulting in not enough time to care properly for residents."

"I no longer work in aged care due to the extensive cost cutting measures employed in aged care. Many jobs were subcontracted out, i.e., cleaning staff and kitchen staff (and these staff are only trained for 6 weeks to become PCWs). Division 1 nurses were cut from 3 on night shift to 1 for 150 residents – 90 were high level care. I did not agree with this and so I left!"

"I left aged care in March of this year after becoming increasingly disillusioned with the ever increasing amount of paper work, management that had 'no idea' and who lacked compassion, commitment, empathy and a general understanding of the ageing process. The facility where I worked has since lost a number of staff – older and not so old carers with life experience and aged care/dementia expertise who felt they could no longer work within the 'farce' that has become aged care".

"I felt I had to stop work in Aged Care out of complete frustration at the nurse to resident ratios and so many other issues".

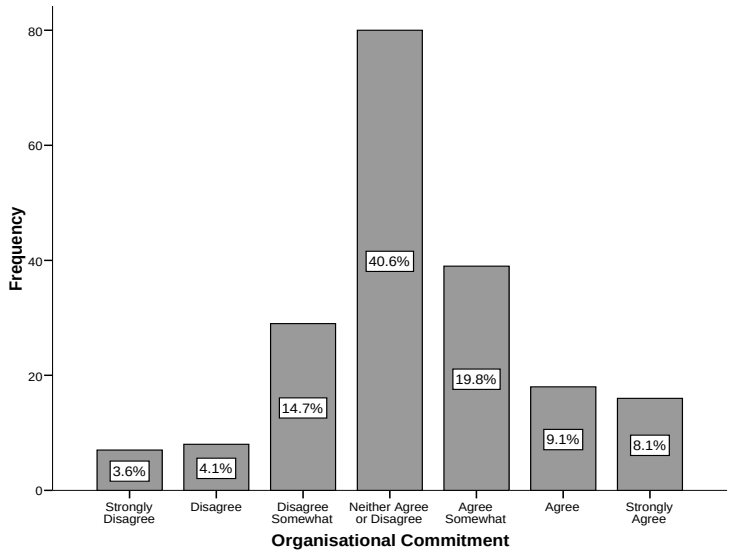
"I have not worked in aged care for the last year at least: conditions difficult – not enough time to give residents what I consider excellent care. I find it quite depressing".

Organisational Commitment

Total Sample

This scale assessed the extent to which participants felt committed or emotionally attached to their current organisation. An example of one of the items used in the scale is “I would be very happy to spend the rest of my career in this organisation”. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 7 (Strongly Agree). Higher scores indicate individuals are more committed to their current organisation. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

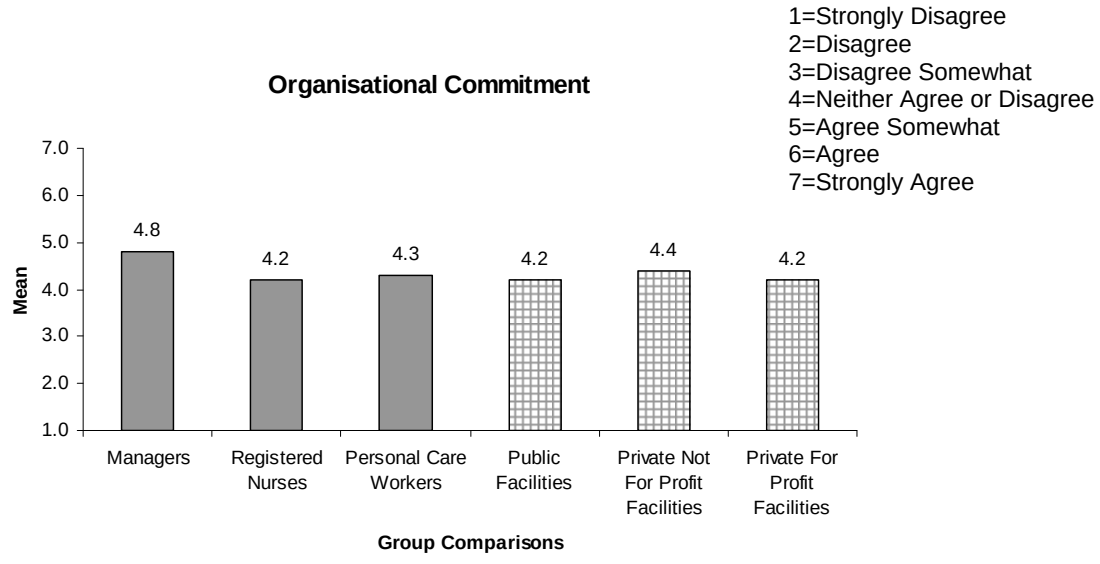
Figure 3.5.5



Group Comparisons

The following graph presents the means for organisational commitment for the different groups based on job type and organisation type. Higher scores indicate individuals are more committed to their current organisation. In relation to the job type comparisons managers reported significantly higher levels of organisational commitment than registered nurses and personal care workers. In the organisation type comparisons there were no significant differences across the different categories.

Figure 3.5.6



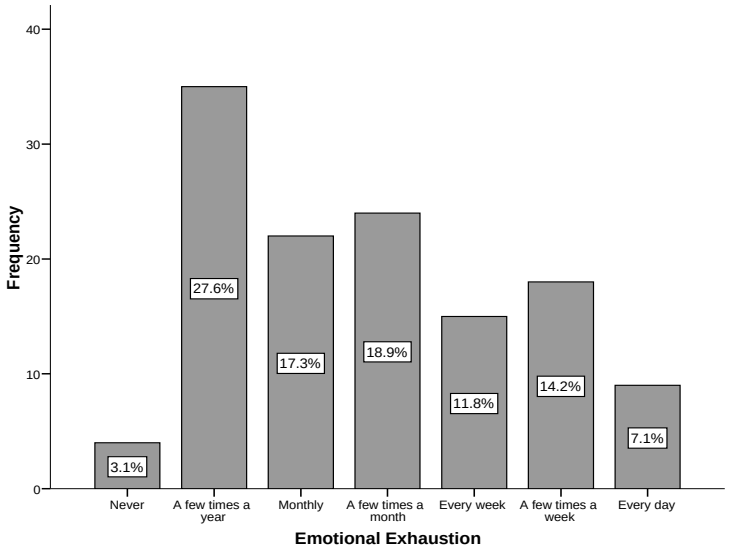
Predictors of Organisational Commitment
A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the degree to which individuals were committed to their organisation (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Organisational Commitment:
  - Employee/Facility Variables
    - Gender: Females reported higher levels of organisational commitment compared to males.
    - Negative Affect: Individuals who in general had a more negative outlook/attitude were less likely to be committed to their organisation.
    - Employment Status: Individuals who were employed on a full-time basis tended to report higher levels of organisational commitment.
    - Organisation Time: The longer an individual had worked for their organisation the more committed they were likely to be.
  - Work Stressors
    - Interpersonal Conflict: Individuals who experienced high levels of interpersonal conflict were more likely to report lower levels of organisational commitment.
    - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to report lower levels of organisational commitment.
  - Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of organisational commitment.
    - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report higher levels of organisational commitment.
  - Overall the employee/facility variables accounted for 14.9% of the variance in organisational commitment. The work stressor variables and the management practices variables each accounted for an additional 11.6% and 5.2% of the variance respectively.

Emotional Exhaustion

Total Sample
This scale assessed how frequently participants felt emotionally drained and fatigued as a result of their work. An example of one of the items used in the scale is "How often do you feel burned out from your work?". Participants were asked to record their responses using a scale which ranged from 1 (Never) to 7 (Every Day). Higher scores indicate that individuals reported that they felt emotionally exhausted more frequently. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

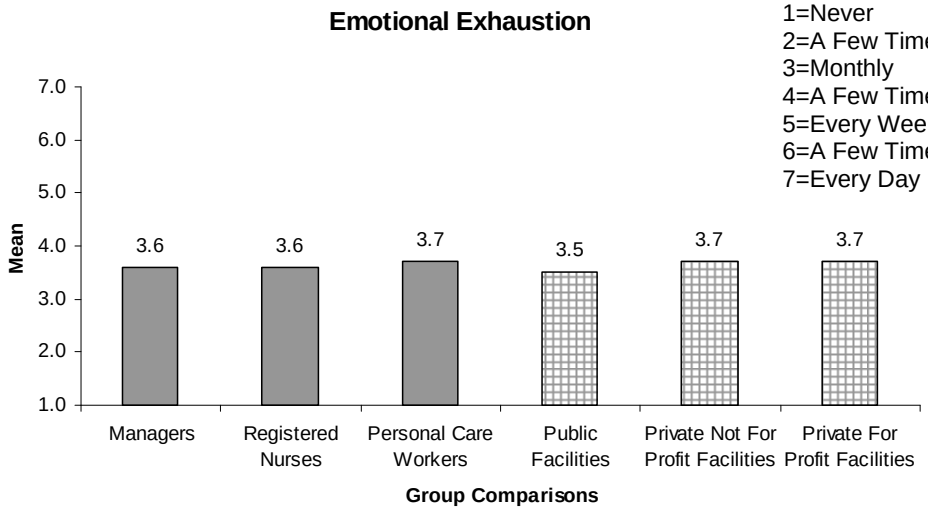
Figure 3.5.7



Mean: 3.6
SD: 1.6

Group Comparisons
The following graph presents the means for emotional exhaustion for the different groups based on job type and organisation type. Higher scores indicate that individuals reported that they felt emotionally exhausted more frequently. In relation to the job type comparisons there were no significant differences in emotional exhaustion across the different job categories. There were also no significant differences across the different types of organisations.

Figure 3.5.8



Predictors of Emotional Exhaustion

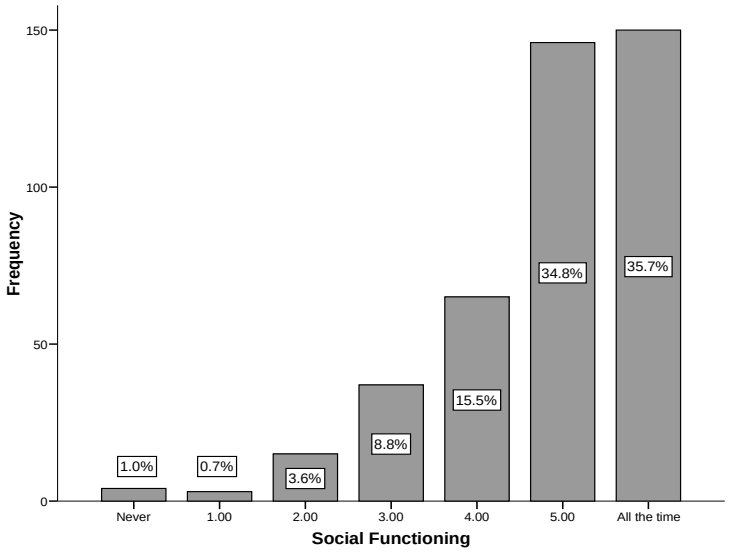
A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the frequency with which individuals felt emotionally exhausted as a result of their job (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Emotional Exhaustion:
  - Employee/Facility Variables
    - Negative Affect: Individuals who in general had a more negative outlook/attitude were more likely to feel emotionally exhausted.
    - Hours worked per week: The more hours per week an individual worked the more likely they were to report feeling emotionally exhausted.
  - Work Stressors
    - Workload: Individuals who felt they had heavy workloads were more likely to report feeling emotionally exhausted.
    - Role Conflict: Individuals who reported high levels of role conflict were more likely to report feeling emotionally exhausted.
    - Resident Aggression: The more frequently an individual experienced aggression from residents the higher their levels of emotional exhaustion tended to be.
    - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to report higher levels of emotional exhaustion.
  - Management Practices
    - Training: Individuals who received adequate training to do their job effectively tended to report lower levels of emotional exhaustion.
  - Overall the employee/facility variables accounted for 35.9% of the variance in emotional exhaustion. The work stressor variables and the management practices variables each accounted for an additional 15.9% and 0.05% of the variance respectively.
  - Qualitative comments provided by some participants also provide further evidence of the way in which heavy workloads and cost-cutting in particular contribute to feelings of emotional exhaustion amongst aged care workers. In the words of one participant: *"To sum up my feelings in aged care (15 years): Understaffing – not enough time for residents, ridiculous levels of paper work, resident care rushed by staff to get through work…. all of which causes too much burn out".*

Social Functioning

Total Sample
This scale assessed how frequently over the past few weeks participants had felt able to enjoy their life and capable of making decisions and dealing with problems. An example of one of the items used in the scale is “Have you recently been able to enjoy your normal day-to-day activities?”. Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time). Higher scores indicate a higher level of social functioning. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

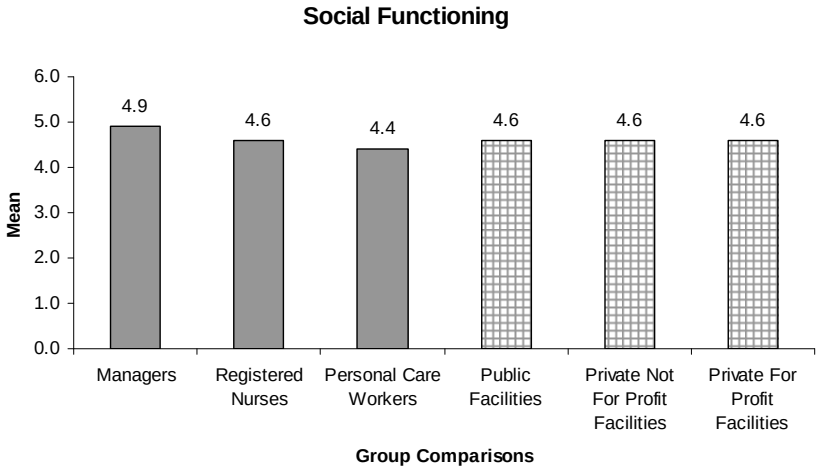
Figure 3.5.9



Mean: 4.6
SD: 1.2

Group Comparisons
The following graph presents the means for social functioning for the different groups based on job type and organisation type. Higher scores indicate a higher level of social functioning. In relation to the job type comparisons personal care workers reported significantly lower levels of social functioning as compared to managers and registered nurses. In the organisation type comparisons there were no significant differences across the different categories.

Figure 3.5.10



0=Never
6=All the Time

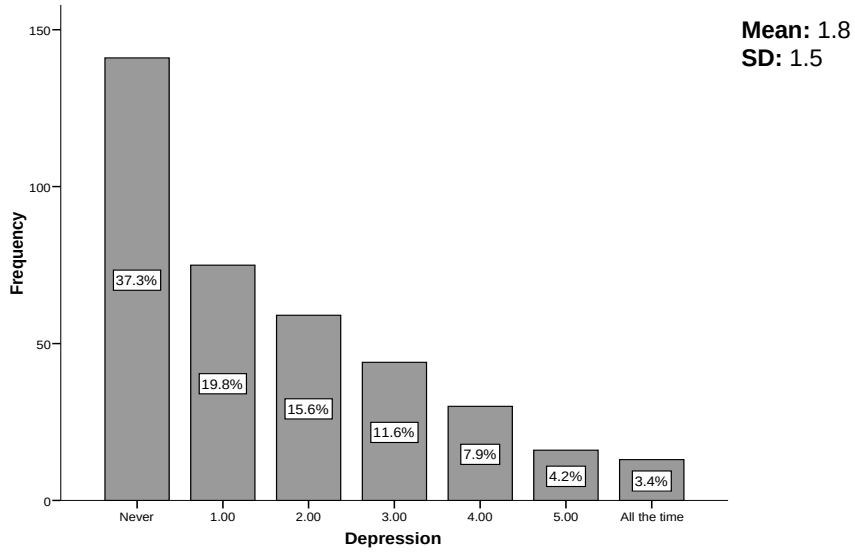
Predictors of Social Functioning
A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the frequency with which individuals reported they were able to function effectively socially (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Social Functioning:
  - Employee/Facility Variables
    - Age: Older workers reported more positive social functioning.
    - Negative Affect: Individuals who in general had a more negative outlook/attitude were more likely to report lower levels of social functioning.
    - Occupation Time: The longer an individual had worked in their current occupation the more likely they were to report positive social functioning.
  - Work Stressors
    - None of the work stressor variables were significant predictors of social functioning.
  - Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of social functioning.
    - Training: Individuals who received adequate training to do their job effectively tended to report higher levels of social functioning.
  - Overall the employee/facility variables accounted for 26.5% of the variance in social functioning. The work stressor variables and the management practices variables each accounted for an additional 1.5% and 1.3% of the variance respectively.

Depression

Total Sample
This scale assessed how frequently over the past few weeks participants had felt unhappy and unable to cope. An example of one of the items used in the scale is “Have you recently been feeling unhappy or depressed?”. Participants were asked to record their responses using a scale which ranged from 0 (Never) to 6 (All the time). Higher scores indicate individuals felt depressed more frequently. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

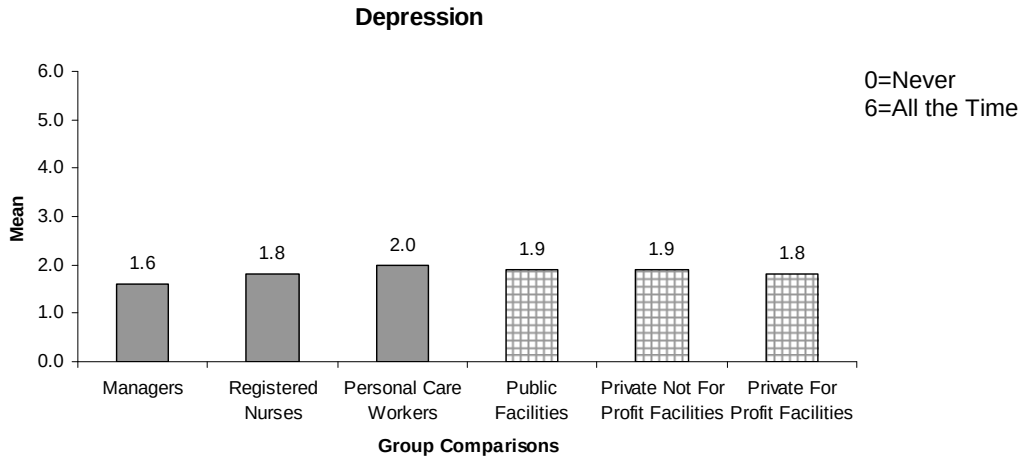
Figure 3.5.11



Group Comparisons

The following table presents the means for depression for the different groups based on job type and organisation type. Higher scores indicate individuals felt depressed more frequently. In both the job type and organisation type comparisons there were no significant differences in depression across the different groups.

Figure 3.5.12



Predictors of Depression

A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the frequency with which individuals reported feeling depressed (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables were also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Depression:
    - Employee/Facility Variables
        - Negative Affect: Individuals who in general had a more negative outlook/attitude were more likely to report higher levels of depression.
        - Hours worked per week: The more hours an individual worked per week the more likely they were to report feeling depressed.
        - Organisation Ownership: Individuals working in public/NFP facilities tended to report higher levels of depression.
    - Work Stressors
        - Role Conflict: Individuals who reported experiencing high levels of role conflict also tended to report feeling more depressed.
        - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also report higher levels of depression.
    - Management Practices
        - Training: Individuals who felt they received adequate training to do their job effectively tended to report lower levels of depression.
    - Overall the employee/facility variables accounted for 19.2% of the variance in depression. The work stressor variables and the management practices variables each accounted for an additional 3.9% and 1.2% of the variance respectively.

Physical Symptoms

Total Sample

This scale was designed to assess out of a total of 18 possible physical symptoms (e.g., had an upset stomach or nausea) how many the participant had experienced in the past 30 days. Ten per cent of respondents had experienced ten or more physical symptoms in the past month. The top five physical symptoms participants reported experiencing were:

1. Tiredness or Fatigue (80.7% of participants reported experiencing this physical symptom).
2. Headaches (66.7% of participants reported experiencing this physical symptom).
3. Backache (64.0% of participants reported experiencing this physical symptom).
4. Trouble Sleeping (62.9% of participants reported experiencing this physical symptom).
5. Eye Strain (35.7% of participants reported experiencing this physical symptom).

Across job and organisation type comparisons there were no significant differences in the number of physical symptoms reported by participants across the different groups. Appendix A provides the individual items for the scale.

Predictors of Physical Symptoms
A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the number of physical symptoms individuals reported experiencing in the past month (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Physical Symptoms:
    - Employee/Facility Variables
        - Age: Older workers tended to report experiencing fewer physical symptoms.
        - Negative Affect: Individuals who in general had a more negative outlook/attitude tended to report a higher number of physical symptoms.
        - Organisation Time: The longer an individual had been working at their current organisation the fewer physical symptoms they tended to report experiencing.
    - Work Stressors
        - Role Conflict: Individuals who perceived high levels of role conflict also tended to report experiencing more physical symptoms.
        - Resident Aggression: The more frequently an individual experienced aggression from residents the more physical symptoms they reported experiencing.
        - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also report experiencing more physical symptoms.
    - Management Practices
        - Training: Individuals who felt they received adequate training to do their job effectively tended to report experiencing fewer physical symptoms.
    - Overall the employee/facility variables accounted for 14.2% of the variance in physical symptoms. The work stressor variables and the management practices variables each accounted for an additional 5.8% and 1.1% of the variance respectively.

Summary: Work, Psychological & Physical Health Outcomes
Overall participants across the sample reported that they were somewhat satisfied with their current job. There were no significant differences based on job type, but individuals who worked at private for profit facilities reported significantly lower levels than individuals who worked at public or private not for profit facilities. In addition to some of the employee and facility variables, role conflict and resident quality of living

cost-cutting were key negative predictors of job satisfaction, while grievance procedures, performance practices and training were positive predictors.

Participants who worked at private for profit facilities reported significantly higher intentions to leave their current job than participants from public and private not for profit organisations. The significant work stressors that positively predicted turnover intentions were role conflict, workload and staff cost-cutting, while training and grievance procedures were negative predictors of turnover intentions. Across the sample participants reported some commitment to their current organisation. Managers reported significantly higher levels of commitment than registered nurses and personal care workers. There were no significant differences across the different organisation types. Organisational commitment was negatively predicted by interpersonal conflict, staff cost-cutting and positively predicted by performance appraisal practices and grievance procedures.

On average participants across the sample reported feeling emotionally exhausted monthly if not more frequently. There were no significant differences based on job or organisation type. Workload, role conflict resident aggression and staff cost-cutting were all found to be significant positive predictors of emotional exhaustion, while training was a negative predictor. Overall, participants reported high levels of social functioning. Personal care workers did however report significantly lower levels than managers and registered nurses. No significant differences were found based on organisation type. Social functioning was significantly predicted by grievance procedures and training. Participants across the sample reported relatively low levels of depression with there being no significant differences based on job or organisation type. Role conflict and resident quality of living cost-cutting were both significant positive predictors of depression while training was a negative predictor. Finally, on average participants reported experiencing five physical symptoms in the past month with there being no significant differences based on job or organisation type. Role conflict, resident aggression and resident quality of living cost-cutting were found to be significant positive predictors and training was a negative predictor of the number of physical symptoms reported by participants.

3.6. Resident Outcomes

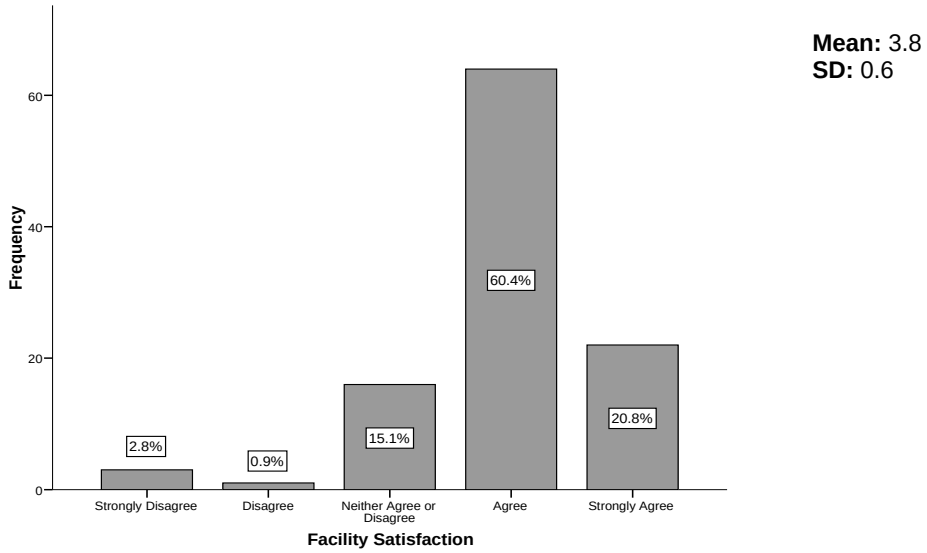
The scales in this section were designed to assess the extent to which participants felt the facility was of a high standard, staff were responsive to resident needs, resident safety was prioritised, resident care was of a high standard, residents had good sleep quality, and medication errors were made less often. A summary of results for each of these resident outcomes is provided below. A bar chart for each scale indicating the dispersion of responses based on the entire sample is also provided. This is followed by comparisons for each of the scales across different job (Managers, Registered Nurses, & Personal Care Workers) and organisation types (Public, Private Not for Profit, Private for Profit). Appendix A provides the individual items for each of the resident outcome scales.

Facility Satisfaction

Total Sample
This scale assessed the extent to which participants felt that residents' rooms and nutrition were of a high standard. The privacy of residents and the extent to which family and friends were welcome to visit residents were also assessed. An example of one of the items used in the scale is "When residents have a complaint something is done about it". Participants were asked to record their responses using a scale

which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Appendix A provides the individual items for the scale. Higher scores indicate higher levels of facility satisfaction. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

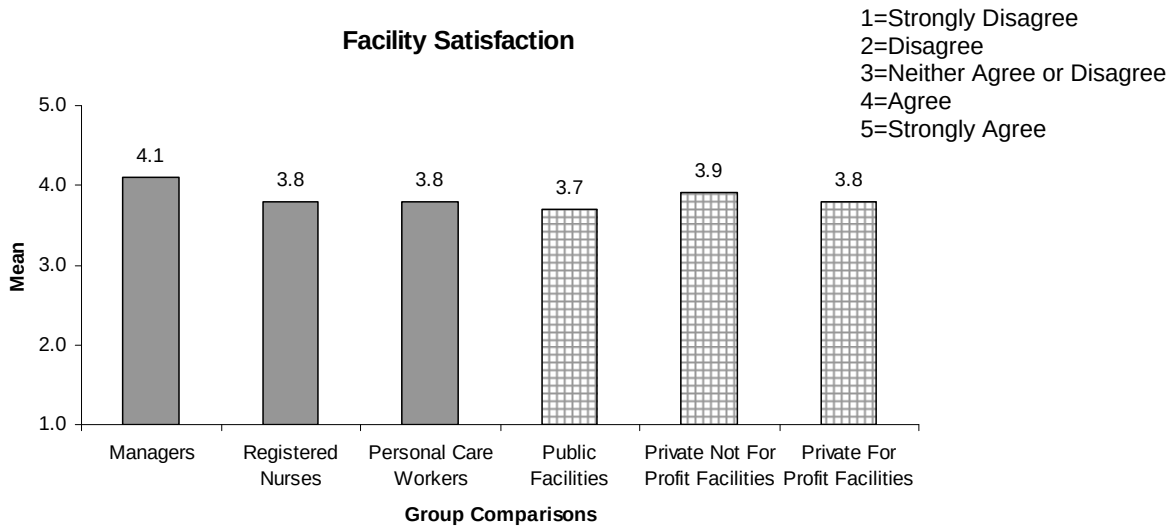
Figure 3.6.1



Group Comparisons

The following graph presents the means for facility satisfaction for the different groups based on job type and organisation type. Higher scores indicate higher levels of facility satisfaction. In relation to the job type comparisons managers reported significantly higher levels of facility satisfaction as compared to registered nurses and personal care workers. In the organisation type comparisons there were no significant differences across the different categories.

Figure 3.6.2



Predictors of Facility Satisfaction

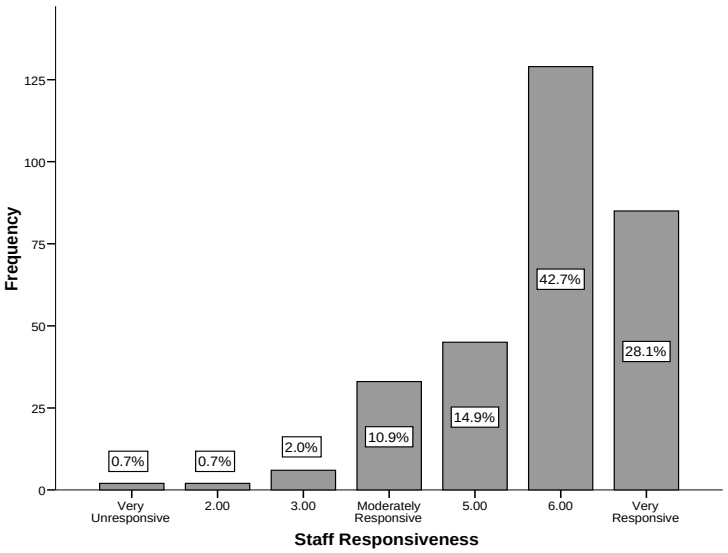
A set of statistical analyses (regressions) were conducted to assess the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the levels of facility satisfaction reported by individuals (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

- Signification Predictors of Facility Satisfaction:
  - Employee/Facility Variables
    - Negative Affect: Individuals who in general had a more negative outlook/attitude were more likely to report lower levels of facility satisfaction.
    - Organisation Ownership: Individuals who worked in privately owned facilities tended to report higher levels of facility satisfaction.
    - Percentage of residents with dementia: The higher the percentage of residents with dementia at the facility the lower individuals tended to report facility satisfaction as being.
  - Work Stressors
    - Interpersonal Conflict: Individuals who perceived high levels of interpersonal conflict tended to report lower levels of facility satisfaction.
    - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the lower they tended to perceive facility satisfaction as being.
    - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive lower levels of facility satisfaction.
- Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of facility satisfaction.
    - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report higher levels of facility satisfaction.
- Overall the employee/facility variables accounted for 18.6% of the variance in resident care. The work stressor variables and the management practices variables each accounted for an additional 25.7% and 12% of the variance respectively.

Staff Responsiveness

Total Sample
This scale assessed how responsive participants felt staff were to the different needs of residents. An example of one of the items used in the scale is “How responsive are staff to a resident requesting assistance using their buzzer or call system”. Participants were asked to record their responses using a scale which ranged from 1 (Very Unresponsive) to 7 (Very Responsive). Higher scores indicate higher levels of staff responsiveness. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

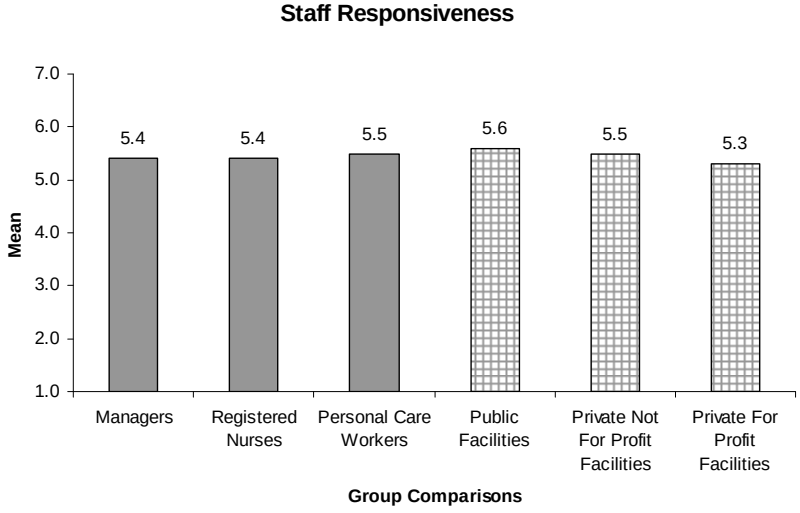
Figure 3.6.3



Mean: 5.4
SD: 1.1

Group Comparisons
The following graph presents the means for staff responsiveness for the different groups based on job type and organisation type. Higher scores indicate higher levels of staff responsiveness. In both the job type and organisation type comparisons there were no significant differences in staff responsiveness across the different groups.

Figure 3.6.4



1=Very Unresponsive
3=Moderately Responsive
7=Very Responsive

Predictors of Staff Responsiveness

A set of statistical analyses (regression) were conducted to assess the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the degree to which individuals felt staff were able to be responsive to residents' needs (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

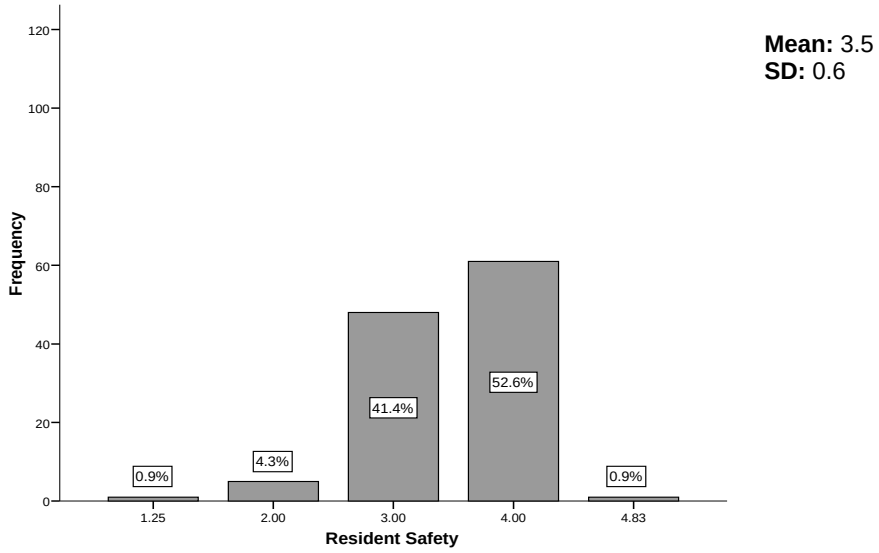
- Significant Predictors of Staff Responsiveness:
  - Employee/Facility Variables
    - Percentage of residents with dementia: The lower the percentage of residents with dementia the more responsive individuals reporting staff as being.
    - Ownership Changes: Individuals who worked at organisations where there had been an ownership change in the last 12 months tended to report staff as being less responsive to residents.
  - Work Stressors
    - Role Conflict: Individuals who perceived high levels of role conflict tended to report lower levels of staff responsiveness.
    - Interpersonal Conflict: Individuals who perceived high levels of interpersonal conflict tended to report lower levels of staff responsiveness.
    - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the less responsive they perceived staff to be.
    - Resident Aggression: The more frequently an individual experienced aggression from residents the more responsive they perceived staff to be.
    - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to also perceive staff as being less responsive.
    - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive staff as being less responsive.
  - Management Practices
    - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report staff as being more responsive to residents.
  - Overall the employee/facility variables accounted for 13.5% of the variance in staff responsiveness. The work stressor variables and the

management practices variables each accounted for an additional 20.5% and 1.8% of the variance respectively.

Resident Safety

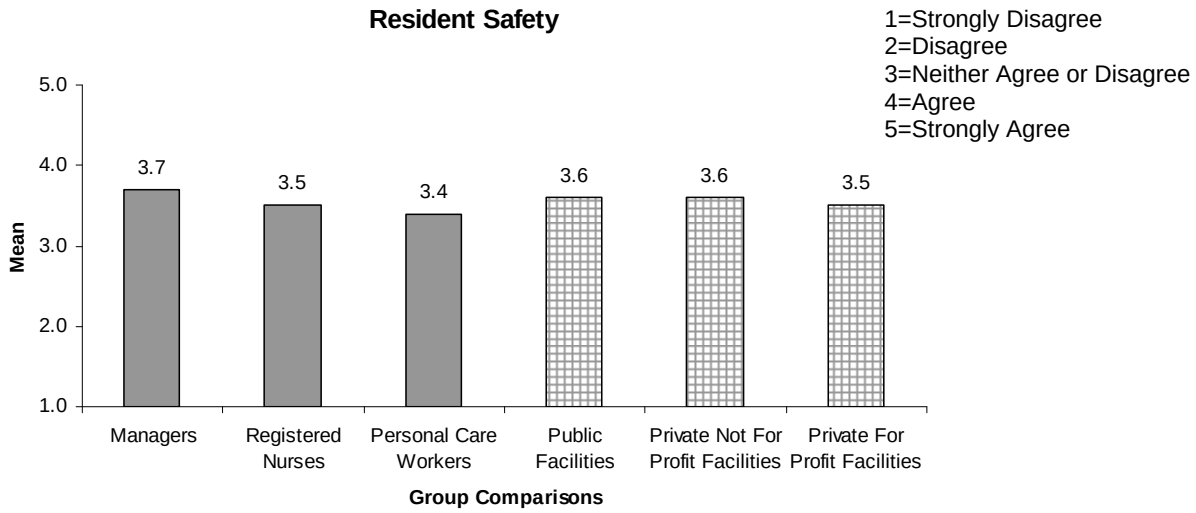
Total Sample
This scale assessed the extent to which participants felt resident safety was a high priority at their facility, with the extent to which management provided the resources, procedures and training needed to ensure resident safety being assessed. An example of one of the items used in the scale is “The actions of management show that resident safety is a top priority”. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher levels of reported resident safety. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

Figure 3.6.5



Group Comparisons
The following graph presents the means for resident safety for the different groups based on job type and organisation type. Higher scores indicate higher levels of reported resident safety. In relation to the job type comparisons managers reported significantly higher levels of resident safety as compared to registered nurses and personal care workers. In relation to the organisation type comparisons participants who worked in private for profit facilities reported significantly lower levels of resident safety as compared to participants who worked at public and private not for profit facilities.

Figure 3.6.6



Predictors of Resident Safety

A set of statistical analyses (regressions) were conducted to determine the extent to which job stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the level of resident safety individuals reported by individuals (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility, job stressors, & management practices) that were significant predictors is presented.

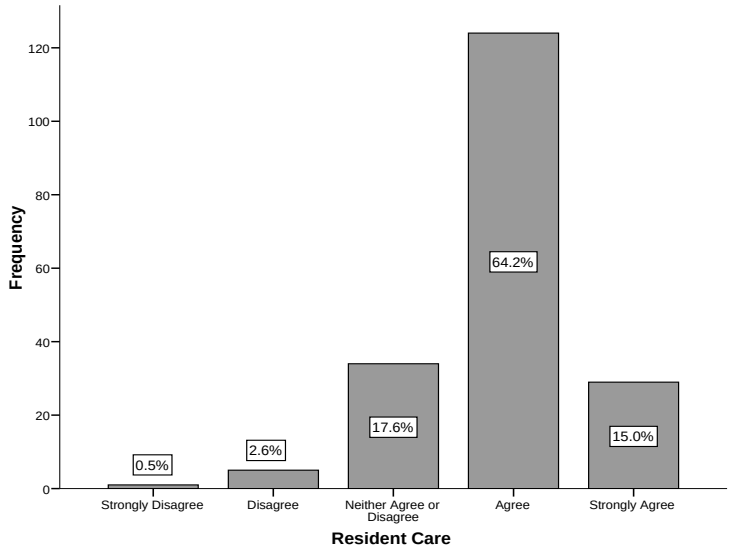
- Significant Predictors of Resident Safety:
  - Employee/Facility Variables
    - Age: Older workers tended to report higher levels of resident safety.
  - Work Stressors
    - Role Conflict: Individuals who perceived high levels of role conflict were more likely to report lower levels of resident safety.
    - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the lower they perceived resident safety to be.
    - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to also perceive lower levels of resident safety.
    - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive lower levels of resident safety.

- Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of resident safety.
    - Recruitment & Selection Practices: Individuals who felt their organisation devoted adequate time and resources to recruiting and selecting the right people for positions were more likely to report higher levels of resident safety.
    - Performance Practices: Individuals who worked in organisations where job performance was regularly assessed and tied to raises, promotions etc were more likely to report higher levels of resident safety.
    - Training: Individuals who felt they received adequate training to do their job effectively tended to report higher levels of resident safety.
- Overall the employee/facility variables accounted for 19.4% of the variance in resident safety. The work stressor variables and the management practices variables each accounted for an additional 28.1% and 9.8% of the variance respectively.

Resident Care

Total Sample
This scale assessed the extent to which participants felt residents were able to talk to staff as needed, staff showed a real interest in residents and residents in the facility were provided with appropriate care by staff. An example of one of the items used in the scale is “The nurses and personal carers have the skills to provide appropriate care for the residents”. Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicate higher reported levels of resident care. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

Figure 3.6.7

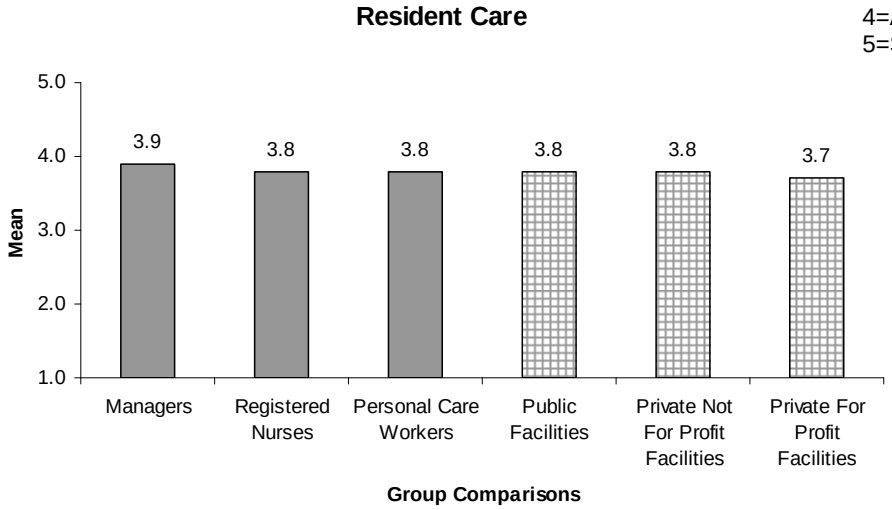


Mean: 3.8
SD: 0.7

Group Comparisons
The following graph presents the means for resident care for the different groups based on job type and organisation type. Higher scores indicate higher reported levels of resident care. In relation to the job type comparisons managers reported significantly higher levels of resident care compared to both registered nurses and personal care workers. There were no significant differences in the levels of resident care reported by participants across the different organisational categories.

Figure 3.6.8

1=Strongly Disagree
2=Disagree
3=Neither Agree or Disagree
4=Agree
5=Strongly Agree



Predictors of Resident Care
A set of statistical analyses (regressions) were conducted to determine the extent to which work stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment & selection practices, performance practices, & training) predicted the quality of resident care report by individuals (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility variables, work stressors, & management practices) that were significant predictors is presented.

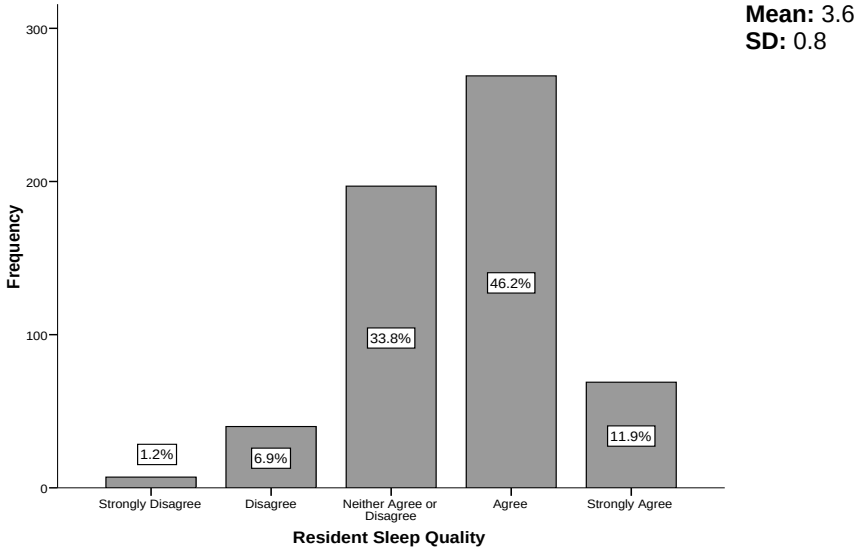
- Significant Predictors of Resident Care:
  - Employee/Facility Variables
    - Nursing Qualifications: Individuals with higher/more advanced nursing qualifications tended to report lower levels of resident care.
    - Percentage of residents with dementia: The higher the percentage of residents with dementia at the facility the lower individuals perceived resident care to be.

- Work Stressors
    - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the lower they tended to perceive resident care to be.
    - Staff Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to staff tended to also perceive lower levels of resident care.
    - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents tended to also perceive lower levels of resident care.
- Management Practices
    - Grievance Procedures: Individuals who felt their organisation had effective grievance procedures were more likely to report higher levels of resident care.
    - Recruitment & Selection Practices: Individuals who felt their organisation devoted adequate time and resources to recruiting and selecting the right people for positions were more likely to report higher levels of resident care.
- Overall the employee/facility variables accounted for 16.8% of the variance in resident care. The work stressor variables and the management practices variables each accounted for an additional 20.7% and 7.3% of the variance respectively.
- Qualitative comments provided by some participants also provide further evidence of the way in which heavy workloads and cost-cutting in particular contribute to lower levels of resident care. In the words of one participant: *"Our facility is purely profit driven. Residents get the least care as possible due to management greed". The CARE has been taken out of AGED CARE".*

Resident Sleep Quality

Total Sample
This scale assessed the extent to which participants felt residents were able to sleep free from noise and interruptions at night. An example of one of the items used in the scale is "The amount of noise disrupts residents' sleep". Participants were asked to record their responses using a scale which ranged from 1 (Strongly Disagree) to 5 (Strongly Agree). Higher scores indicated participants felt residents had better sleep quality. Appendix A provides the individual items for the scale. The proceeding graphs indicate the dispersion of responses based on the entire sample for each scale item.

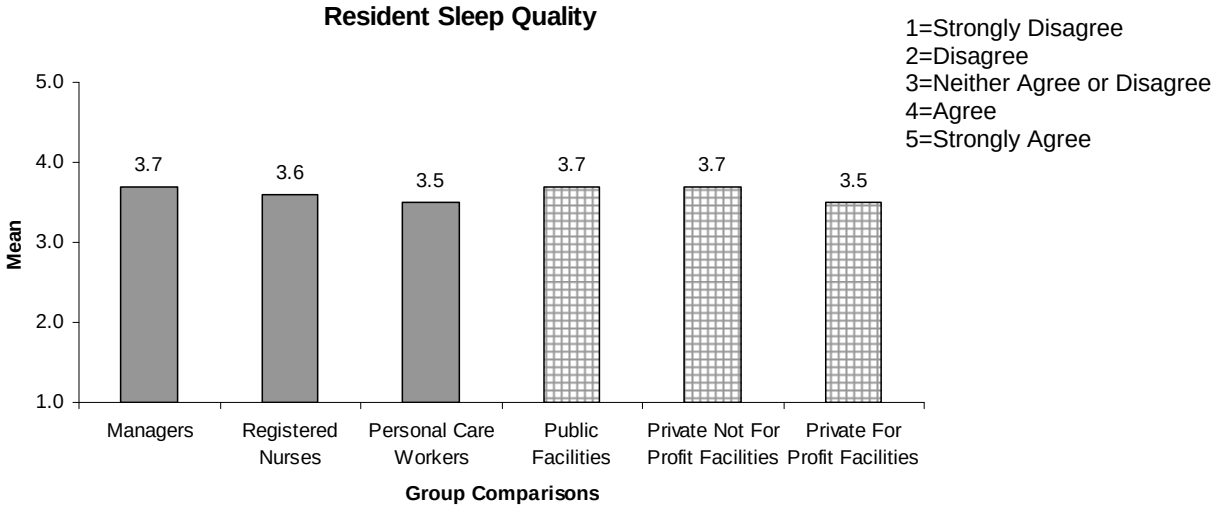
Figure 3.6.9



Group Comparisons

The following graph presents the means for resident sleep quality for the different groups based on job type and organisation type. Higher scores indicated participants felt residents had better sleep quality. In the job type comparisons there were no significant differences in the levels of sleep quality reported by participants across the different job categories. In relation to the organisation type comparisons participants who worked at private for profit facilities reported significantly lower levels or resident sleep quality as compared to participants who worked at public and private not for profit facilities.

Figure 3.6.10



Predictors of Resident Sleep Quality

A set of statistical analyses (regressions) were conducted to assess the extent to which job stressors (i.e., workload, role conflict, interpersonal conflict, co-worker aggression, resident aggression, staff cost-cutting, & resident quality of living cost-cutting) and management practices (i.e., grievance procedures, recruitment &

selection practices, performance practices, & training) predicted the level of resident sleep quality reported by individuals (Appendix A contains a complete listing of the individual items used to measure each variable). As part of the analyses the possible influence of a number of employee/facility variables was also controlled. Next, information on the variables in each of the three categories (employee/facility, job stressors, & management practices) that were significant predictors is presented.

- Significant Predictors of Resident Sleep Quality:
  - Employee/Facility Variables
    - Negative Affect: Individuals who in general had a more negative outlook/attitude were more likely to report that residents had lower levels sleep quality.
    - Organisation Time: The longer an individual had been working at their current organisation the better they tended to perceive resident sleep quality to be.
    - Percentage of resident with dementia: The higher the percentage of residents with dementia at the facility the lower individuals tended to report resident sleep quality to be.
  - Work Stressors
    - Role Conflict: Individuals who perceived high levels of role conflict were more likely to report lower levels of resident sleep quality.
    - Co-Worker Aggression: The more frequently an individual witnessed co-workers being aggressive towards residents the lower they tended to perceive resident sleep quality to be.
    - Resident Quality of Living Cost-Cutting: Individuals who worked in facilities where there was a high level of cost-cutting in relation to the quality of living for residents.
  - Overall the employee/facility variables accounted for 14.4% of the variance in resident sleep quality. The work stressor variables and the management practices variables each accounted for an additional 9.4% and 0.9% of the variance respectively.

Summary: Resident Outcomes

Overall participants reported relatively high levels of facility satisfaction, with managers reporting significantly higher levels than registered nurses and personal care workers. There were no significant differences based on organisation type. Higher levels of interpersonal conflict, co-worker aggression and resident quality of living cost-cutting, were associated with lower facility satisfaction, while grievance procedures and performance appraisal practices were associated with higher facility satisfaction. Overall participants reported high levels of staff responsiveness. There were no significant differences based on job or organisation type. Participants agreed that their facility was safe for residents, with managers reporting higher levels of resident safety than registered nurses and personal care workers. In addition to the employee and facility variables staff responsiveness was significantly and negatively predicted by role conflict, interpersonal conflict, co-worker aggression, resident aggression, and staff and resident quality of living cost cutting variables. Performance appraisal practices were positively related to staff responsiveness. Individuals who worked at private for profit facilities reported significantly lower levels

of resident safety than individuals who worked at public or private not for profit facilities. Resident safety was also significantly and negatively predicted by role conflict, co-worker aggression and staff and resident quality of living cost-cutting, but positively predicted by grievance procedures, recruitment and selection practices, performance appraisal practices and training. Across the sample relatively high levels of resident care were also reported with managers reporting significantly higher levels than registered nurses and personal care workers. There were no significant differences based on organisation type. Resident care was also significantly and negatively predicted by co-worker aggression, and staff and resident quality of care cost cutting, but positively predicted by grievance procedures and recruitment and selection practices. Finally, participants across the sample reported moderate levels of resident sleep quality. Individuals who worked in private not for profit facilities reported significantly higher levels than individuals from public or private not for profit facilities. Resident sleep quality was negatively predicted by role conflict, co-worker aggression and resident quality of living cost-cutting.

4. Conclusion

This report contains the findings from a cross sectional questionnaire study of 1038 members of the Victorian Branch of the Australian Nursing Federation. The majority of participants were married females who were working part-time as registered nurses and on average had been working in their current occupation for 17 years with them being on average in their current place of work for 8.6 years.

Forty-six per cent of the participants were employed at private for profit facilities. Staff to resident ratios ranged from 1:5 to 1:53. Analyses revealed that across the three different types of care provision (low, mixed, high) private not for profit and private for profit facilities had fewer staff per resident than public facilities where there are legally enforceable RN to resident ratios.

Most Division 2 registered nurses felt they had received adequate training in relation to changes to their scope of practice with participants working at public facilities reporting the lowest levels of training. Similarly, most Division 1, 3 and 4 registered nurses felt they had received adequate training in relation to the changes to their scope of practice. Again participants who worked at public facilities reported the lowest levels. Overall, most participants for whom medication administration was part of their job reported high levels of self-efficacy or confidence in relation to administering medications. Analysis revealed that medication errors were likely to happen more frequently, the higher the levels of role conflict, co-worker aggression, and resident quality of living cost-cutting were. Medication errors were less likely to happen if the organisation had good grievance procedures and training practices.

Forty per cent of participants had seen a co-worker yell at a resident one or more times, while 15% had seen a co-worker push, grab, shove, or pinch a resident one or more times in the past 6 months with no differences across facility type. Other forms of aggression towards residents were reported less frequently. The frequency with which participants' experienced resident aggression varied based on the type of aggression. Eighty-six per cent of workers reported being yelled, shouted or sworn at and verbal aggression by residents at least once in the past six months and 64% had a resident try to hit them with something at least once in the past six months. Registered nurses and personal care workers reported experiencing more aggression from residents than managers. Those who worked at public facilities tended to also experience aggression from residents more frequently than those from private not for profit or private for profit facilities.

Employees in private for profit facilities reported significantly lower levels of job satisfaction and were more likely to leave their job than those in public and private not for profit facilities. Over 30% of participants were somewhat likely, likely or very likely to leave their job. Across the sample participants reported relatively low levels of commitment to their current organisation. On average 70% of participants reported feeling emotionally exhausted at least monthly, with 30% being daily, a few times a day or weekly. There were no significant differences based on job or organisation type. Consistent with the emotional exhaustion finding workers on average reported experiencing five physical health symptoms in the past month with there being no significant differences based on job or organisation type.

In relation to predicting work and health outcomes such as turnover intentions and emotional exhaustion the main work stressor predictors were workload, role conflict, resident aggression, staff and resident quality of living cost cutting. As expected participants working in facilities with better management practices reported fewer negative psychological and physical health outcomes and had more positive work related attitudes.

Overall participants reported relatively high levels of facility satisfaction, staff responsiveness and resident care (and this did not differ by facility type) and agreed that their facility was safe for residents. With the exception of individuals who worked at private for profit facilities who reported significantly lower levels of resident safety compared to those at public or private not for profit facilities. In relation to predicting resident based outcomes such as resident safety, facility satisfaction the main work stressor predictors were role conflict, witnessing co-worker aggression, staff and resident quality of living cost cutting. Well developed grievance procedures and performance appraisal practices were shown to result in more positive outcomes for residents.

To conclude, the study finds that workers are under significant stress stemming from excessive workloads, cost cutting, a hostile work environment, and competing role demands. There appears to be few differences across job or facility type. It is noteworthy that participants said that they were not committed to their facility, were emotionally exhausted and almost a third of them were thinking about leaving their job. This is of concern because it suggests that they are disengaged from their organisation and are experiencing symptoms associated with ‘burnout’. On the positive side it appears that perceptions of facility satisfaction, resident care, safety and staff responsiveness were quite high. There does however, appear to be some concern with medication errors, particularly in private for profit and private not for profit facilities. In terms of scope of practice, public sector participants (Division 1, 2, 3, 4) would like more training. In general, more training, rigorous recruitment and selection practices, performance management and grievance procedures led to better resident and worker outcomes.

Appendix A: Individual Scale Items

Medication Practices

Until recently, Division 2 RNs in Victoria were not allowed to administer medication. Recent changes to the scope of practice for RNs Division 2 mean that administration of medication is now allowed by endorsed Division 2 RNs, under the supervision of a Division 1, 3 or 4 RN. We would like to ask you some questions about these changes. Please circle the number which best describes your response.

Scope of Practice Training – Answered by Div 2s

1. I have received training which has given me a good understanding of which medications I can administer and which I cannot.
2. I have received training which has given me a good understanding of my responsibilities and those of my supervisor when I administer medication.
3. I have received training which has given me the necessary understanding of pharmacology to administer and monitor medication.
4. My organisation has clear policies and procedures in place regarding the administration of medication.
5. I receive adequate and appropriate supervision and direction from my supervisor when I administer medication.

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Scope of Practice Training – Answered by Div 1,3,4s

1. I have received training which has given me a good understanding of which medications endorsed Division 2 RNs can administer and which they cannot.
2. I have received training which has given me a good understanding of my responsibilities when supervising Division 2 RNs as they administer medication.
3. My organisation has clear policies and procedures in place regarding the administration of medication.
4. I have received training on how to access the knowledge, education, and training of a Div 2 when allocating them to residents.
5. I have read the NBV "*Code for guidance in the management of high care residents in aged care services.*"
6. I understand fully my obligations under the NBV "*Code for guidance in the management of high care residents in aged care services.*"

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Medication Administration Self-Efficacy

Please indicate the degree to which you feel confident:

1. You can identify methods by which consent from the resident can be obtained prior to the administration of medication.
2. You can correctly identify different medications by name.
3. You can safely administer medications to residents.
4. You can accurately identify appropriate methods for monitoring unexpected and potential adverse reactions to different medications.

Note: Response scale ranged from 1 "Totally Unconfident" through to 9 "Totally Confident".

Medication Administration by Non-Endorsed Div 2s or PCWs

1. I have seen non-endorsed Div 2s and PCWs administering medication from a DAA (e.g., blister packs) in my facility without supervision.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Medication Errors

Please indicate how often each of the following has occurred at your facility in the past 6 months:

1. A wrong dose was given to a resident.
2. The wrong resident received the medication.
3. The medication was given at the wrong time.
4. The medication was given via the wrong route.
5. The wrong drug was given to a resident.
6. A resident missed their medication.
7. A DAA (e.g., blister pack) was incorrectly filled.

Note: Response scale ranged from 1 “Less than once per month or never” through to 5 “Several times per day”.

Workplace Aggression

Co-worker Aggression towards Residents

Sometimes when conflicts occur with residents, the staff may find it difficult to respond in ways they are supposed to. Please use the scale to indicate how frequently in the past 6 months you have seen others act in each of the following ways towards residents:

1. Pushed, grabbed, shoved, or pinched a resident.
2. Yelled at a resident in anger.
3. Insulted or swore at a resident.
4. Threatened to hit or throw something at a resident.

Note: Response scale ranged from 0 “Never” through to 5 “Five or more times”.

Resident Aggression

Please indicate how often you have experienced each of the following in the past 6 months:

1. Been threatened with an object e.g. walking frame or stick, wheelchair, furniture.
2. A resident tried to hit you with something e.g. cup, saucer, plate, furniture, walking stick.
3. A resident cried to make you feel guilty.
4. Been yelled, shouted or sworn at by a resident.
5. A resident was verbally aggressive to you.

Note: Response scale ranged from 0 “Never” through to 5 “Five or more times”.

Job Stressors

These questions deal with different aspects of work. Please indicate how often these aspects appear in your job.

Workload

1. How often does your job require you to work very fast?
2. How often does your job require you to work very hard?
3. How often does your job leave you with little time to get things done?
4. How often is there a great deal to be done?
5. How often do you have to do more work than you can do well?

Note: Response scale ranged from 1 “Rarely” through to 5 “Very Often”.

Role Conflict

1. I have to do things that I believe should be done in a different way.
2. I receive an assignment without the manpower to complete it.
3. I have to break a rule or policy in order to carry out my job.
4. I work with two or more groups who operate quite differently.
5. I receive incompatible requests from two or more people.
6. I do things that are likely to be accepted by one person and not accepted by others.
7. I receive an assignment without adequate resources and materials to execute it.
8. I work on unnecessary things.

Note: Response scale ranged from 1 “Rarely” through to 5 “Constantly”.

Interpersonal Conflict

1. How often do you get into arguments with co-workers at work?
2. How often do other co-workers yell at you at work?
3. How often are co-workers rude to you at work?
4. How often do co-workers do nasty things to you at work?

Note: Response scale ranged from 1 "Never" through to 5 "Very Often".

Staff Cost-Cutting

1. My facility focuses on cost saving by reducing staffing levels at the expense of resident care.
2. My facility has fewer registered nurses on than they used to reduce labour costs.
3. My facility emphasises getting the job done as quickly as possible.
4. My facility cuts corners to get the job done.
5. My facility focuses on saving costs by having fewer activities and diversional therapies for residents than they used to.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Resident Quality of Living Cost-Cutting

1. My facility has reduced the nutritional quality of food for residents to save money.
2. My facility has reduced the portion size of meals to save money.
3. My facility has reduced the quality of dressings available for wound care.
4. My facility has reduced the quantity and quality of incontinence aids.
5. My facility is using DAAs (e.g., blister packs) to reduce costs.
6. My facility has the air conditioning turned off/down during the day to save money.
7. My facility has the heating turned off/down during the day to save money.

Note: Response scale ranged from 1 "Strongly Disagree" through to 5 "Strongly Agree".

Management Practices

Grievance Procedures

1. My organisation has clear and effective policies and procedures in place for resolving complaints by residents or their families.
2. Complaints by residents or their families are resolved in a timely fashion in my organisation.
3. My organisation has clear and effective policies and procedures in place for resolving complaints by staff.
4. Complaints by staff are resolved in a timely fashion in my organisation.
5. Staff here are aware of the policies and procedures for resolving complaints by staff.
6. I have received adequate training from my employer in the policies and procedures for resolving complaints by residents or their families.
7. I have received adequate training from my employer in the policies and procedures for resolving complaints by staff.
8. Staff are allowed representation at meetings with management when a complaint is made against the staff member.

Note: Response scale ranged from 1 "Strongly Disagree" through to 7 "Strongly Agree".

Recruitment & Selection Practices

1. How rigorous is the employee selection processes for a job in this organisation? (e.g. Does the process involve tests, interviews etc?)

   Response scale ranged from 1 "Not rigorous" through to 7 "Very rigorous".
2. How much money is generally spent selecting people for a job?

   Response scale ranged from 1 "Very little" through to 7 "A great deal".

Performance Practices

1. How much effort is given to measuring employee performance?

   Response scale ranged from 1 “Very little” through to 7 “A great deal”.
2. How often is performance discussed with employees?

   Response scale ranged from 1 “Rarely” through to 7 “Daily”.
3. How closely are raises, promotions, etc., tied to performance appraisal?

   Response scale ranged from 1 “Not closely” through to 7 “Very closely”.
4. The wages in this organisation are not very competitive for this industry.

   Response scale ranged from 1 “Completely true” through to 7 “Completely false”
5. How closely is pay tied to individual performance?

   Response scale ranged from 1 “Not closely” through to “Very closely”

Training

1. During the past 12 months, how much training have you had, paid for by your employer? Include only training away from your normal place of work, but it could be on or off the premises.
2. To what extent do you agree or disagree that you get the training needed to do your job effectively?
3. To what extent do you agree or disagree that you’ve had sufficient training and education to do the work you’re doing?

Note: Response categories for question 1 were 1- none, 2- less than one day, 3 – one to less than two days, 4 – two to less than five days, 5- five to less than ten days, 6 – ten or more days. The response scale for questions 2 & 3 ranged from 1 “Strongly Disagree” through to 5 “Strongly Agree”.

Work, Psychological & Physical Health Outcomes

Job Satisfaction

1. All in all, I am satisfied with my job.
2. In general, I don’t like my job. [R]
3. In general, I like working here.

Note: Response scale ranged from 1 “Strongly Disagree” through to 7 “Strongly Agree”.

Turnover Intentions

1. How likely is it that you will look for a job outside of this organisation during the next year?

Response scale ranged from 1 “Very Unlikely” through to 7 “Very Likely”.

2. If it were possible, how much would you like to get a new job?

Response scale ranged from 1 “Not at all” through to 7 “A great deal”.

3. How often do you think about quitting your job at this organisation?

Response scale ranged from 1 “Never” through to 7 “All the time”.

Organisational Commitment

1. I would be very happy to spend the rest of my career in this organisation.
2. I really feel as if this organisation’s problems are my own.
3. I do not feel like “part of the family” at my organisation. [R]
4. I do not feel “emotionally attached” to this organisation. [R]
5. This organisation has a great deal of personal meaning for me.
6. I do not feel a strong sense of belonging to my organisation. [R]

Note: Response scale ranged from 1 “Strongly Disagree” through to 7 “Strongly Agree”.

Emotional Exhaustion

How often do you feel:

1. Emotionally drained from your work.
2. Used up at the end of the workday.
3. Fatigued when you wake up and have to face another day on the job.
4. Working with people all day is really a strain for you.
5. Burned out from your work.
6. Frustrated by your job.
7. You're working too hard on your job.
8. Working with people directly, puts too much stress on you.
9. Like you're at the end of your rope.

Note: Response scale ranged from 1 "Never" through to 7 "Every day".

Social Functioning

We would like to know how your health has been in general, over the past few weeks. Please answer the following questions by circling the answer which most nearly applies to you. Have you recently...

1. Felt capable of making decisions about things?
2. Been able to enjoy your normal day-to-day activities?
3. Been able to face up to your problems?
4. Been feeling reasonably happy, all things considered?

Note: Response scale ranged from 0 "Never" through to 6 "All the time".

Depression

We would like to know how your health has been in general, over the past few weeks. Please answer the following questions by circling the answer which most nearly applies to you. Have you recently...

1. Felt that you couldn't overcome your difficulties?
2. Been feeling unhappy or depressed?
3. Been losing self-confidence in yourself?
4. Been thinking of yourself as a worthless person?

Note: Response scale ranged from 0 "Never" through to 6 "All the time".

Physical Symptoms

During the past 30 days did you have any of the following symptoms? If you did have the symptom, did you see a doctor about it?

1. An upset stomach or nausea
2. A backache
3. Trouble sleeping
4. A skin rash
5. Shortness of breath
6. Chest pain
7. Headache
8. Fever
9. Acid indigestion or heartburn
10. Eye strain
11. Diarrhoea
12. Stomach cramps (not menstrual)
13. Constipation
14. Heart pounding when not exercising
15. An infection
16. Loss of appetite
17. Dizziness
18. Tiredness or fatigue

Note: Response scale 0 = "No", 1 = "Yes, but I didn't see a doctor", 2 = "Yes, and I saw a doctor"

Resident Outcomes

Facility Satisfaction

1. The food is good and nutritious here.
2. Residents are kept well hydrated.
3. Rooms and surroundings are clean.
4. Residents can keep many personal possessions in their room.
5. It is easy to arrange for a doctor to see a resident.
6. At night residents decide when they will go to bed.
7. Residents have privacy.
8. It is a cheerful place.
9. When residents have a complaint, something is done about it.
10. There are a range of activities for residents to be involved in.
11. Family and friends are welcome to visit residents and be involved in their care.
12. This facility utilises a community visiting scheme.

Note: Response scale ranged from 1 “Strongly Disagree” through to 5 “Strongly Agree”.

Staff Responsiveness

How responsive are staff to:

1. A resident requesting assistance using their buzzer or call system.
2. A resident calling out for assistance.
3. A resident requesting assistance to go to the toilet.
4. Resident incontinence.
5. Resident pain.
6. Resident nausea.
7. Residents’ inability to sleep.
8. Resident discomfort.
9. Resident difficulty getting around.
10. Personal grooming of residents.

Note: Response scale ranged from 1 “Very Unresponsive” through to 7 “Very Responsive”.

Resident Safety

1. Resident safety is never sacrificed to get more work done.
2. Our procedures and systems are good at preventing errors from happening.
3. Staff will speak up freely if they see something that may negatively affect resident care.
4. Staff feel free to question the decisions or actions of those with more authority.
5. Staff feel pressured to administer medications without appropriate supervision. [R]
6. Management provides a working environment that promotes resident safety.
7. The actions of management show that resident safety is a top priority.
8. This facility has a falls prevention program.
9. Staff at this facility receive education and training in resident safety on a regular and ongoing basis.

Note: Response scale ranged from 1 “Strongly Disagree” through to 5 “Strongly Agree”.

Resident Care

1. The nurses and personal carers have the skills to provide appropriate care.
2. Residents decide what they will wear each day.
3. Residents are able to talk to staff as needed.
4. Nurses show real interest in residents.
5. Personal carers show real interest in residents.
6. Life is better than residents expected when they first moved in.

Note: Response scale ranged from 1 “Strongly Disagree” through to 5 “Strongly Agree”.

Resident Sleep Quality

1. The amount of noise disrupts residents’ sleep. [R]
2. When a resident needs help someone will come within a reasonable time.

Note: Response scale ranged from 1 “Strongly Disagree” through to 5 “Strongly Agree”.